

A primer of psychology and mental disease : for use in training-schools for attendants and nurses and in medical classes.

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PRIMER OF PSYCHOLOGY
AND
MENTAL DISEASE

C. B. BURR, M.D.

Second Revised Edition



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A PRIMER
OF
Psychology and Mental
Disease

FOR USE IN TRAINING-SCHOOLS FOR ATTEND-
ANTS AND NURSES AND IN MEDICAL
CLASSES

BY

C. B. BURR M.D.

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MEDICO-PSYCHOLOGICAL ASSOCIATION, ETC.

Second Edition Thoroughly Revised



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PREFACE TO FIRST EDITION.

THE association of the concept embarrassment and the concept commiseration has produced the judgment to write this unambitious little book.

The embarrassment has been incident to simplifying in teaching what is at best an abstruse subject. The commiseration I have felt for the members of the Training-school Class, who have been compelled to stand "quiz" on the subject of a lecture without aid to memory other than an imperfect syllabus.

To the classes of 1892 and 1894, who have bravely struggled on without such assistance, this work is affectionately inscribed.

C. B. B.

EASTERN MICHIGAN ASYLUM,
PONTIAC, MICH., December 12, 1893.



PREFACE TO SECOND EDITION.

AT the suggestion of a medical friend there is published in connection with the second edition of this book, as a general guide in the management of cases of insanity, a valedictory address delivered to the class of 1895 of the Training-school for Attendants of the Eastern Michigan Asylum.

It is a source of much satisfaction that a field of usefulness has been found for the PRIMER OF PSYCHOLOGY as a text-book for medical students.

C. B. B.

OAK GROVE HOSPITAL,
FLINT, MICH., November 17, 1897.



GLOSSARY.

- ALBUMINOID: Resembling albumin.
- ARTICULATE: An invertebrate animal, having the body and members jointed. Example: spider or worm.
- ASSIMILATE: To convert into a like substance. (Lat. *ad*, to, and *similis*, like.)
- AUDITORY: Pertaining to hearing. (Lat. *audire*, to hear.)
- CEREBRAL: Relating to the brain. (Lat. *cerebrum*, the brain.)
- CONGENITAL: Dating from birth. (Lat. *con*, with, and *genitus*, born.)
- CONVOLUTION: (Lat. *convolutus*, rolled together.)
- CONVOLUTIONS, CEREBRAL: The round, undulating, tortuous projections observed on the surface of the brain.
- Co-ORDINATION: The act of bringing different parts or objects into similarity of condition, or harmony of action.
- EGO: The personality. (Lat. *ego*, I.)
- EMUNCTORY: An organ of the body which serves to carry off excrementitious matter.
- ENVIRONMENT: That which encompasses, or encircles, or surrounds.

EVOLUTION: An unfolding; development. (Lat. *evolvere*, to roll out, to unroll.)

EXCREMENTITIOUS: Consisting of matter evacuated, or proper to be evacuated, from the animal body. (Lat. *ex*, out, and *cernere*, to separate.)

FUNCTION: Action of an organ or set of organs; a special office or use. (Lat. *fungere*, *functus*, to perform.)

INARTICULATE: Not jointed. (Lat. *in*, not, and *articulus*, a small joint.)

INHERENT: Existing in something so as to be inseparable from it.

INORGANIC: Devoid of organized structure; unorganized; as rocks, minerals.

INVERTEBRATE: Destitute of a backbone. (Lat. *in*, not, and *vertebra*, a joint.)

MAMMAL: One that suckles its young. (Lat. *mamma*, the breast.)

MOLLUSK: An invertebrate animal, having a soft, fleshy body which is inarticulate, and not radiate internally. Example: an oyster.

MUCOUS MEMBRANE: Membrane lining all cavities of the body which open externally and are continuous with the skin. It secretes mucus.

NASAL: Pertaining to the nose. (Lat. *nasus*, the nose.)

OBJECTIVE: Outward; external; exterior to the mind.

PATHOLOGICAL: Pertaining to disease. (Gr. *pathos*, disease, and *logos*, discourse.)

PERCEPT: That which is perceived. (Lat. *percipere*, to take or receive.)

RADIATE: Animal in which all parts are arranged uniformly around the longitudinal axis of the body. Example: the star-fish.

RETINA: An expansion of the optic nerve, forming one of the coats of the eye.

SEGMENTATION: The process of dividing into segments; a self-division as a result of growth.

SENSORY: Of, or pertaining to, sensation.

SUBJECTIVE: Of, or pertaining to, a subject; pertaining to, or derived from, one's own consciousness.

SYLLABUS: A compendium containing heads of a discourse; an abstract.



PART I.

PSYCHOLOGY.

PSYCHOLOGY: *the Science of the Mind.*

The word *Psychology* is derived from two Greek words: *Psyche*, Soul, Mind; and *Logos*, Discourse.

The problems of the mind involve those of BIOLOGY: *the Science of Life* (*Bios*, Life; *Logos*, Discourse); and PHYSIOLOGY: *the Science of properties and functions of Living Beings* (*Physis*, Nature; and *Logos*, Discourse).

LIFE is defined as "a relation or combination of matter and force in which peculiar phenomena (appearances) take place, which are: (1) motion from inherent power, (2) a capacity for appropriating nourishing material, and (3) the capability of multiplication or reproduction for the preservation of species. In the higher forms differentiation¹ of structure and development occurs; and, in the highest, sensibility (feeling), intellection (thought), and will (volition)."²

¹ A production of diversity of parts by a process of evolution or development.

² The late Dr. A. B. Palmer.

That which distinguishes the living from the not living is the possession of the three qualities or attributes: *Motion*, *Nutrition*, and *Reproduction*,—as above mentioned.

The locomotive moves from the force exerted by expansion of water. Inorganic substances change their positions from force exerted upon them (as the rolling of a stone from an earthquake upheaval). Heat and electricity are so-called modes of motion. The acid and the alkali, coming together in solution, make disturbance in the glass (motion from chemical action). All these are illustrations of motion, but not motion from *inherent* power.

Stones enlarge by additions to their surfaces (accretion), but cannot appropriate substances with which to grow.

Two or more stones may be produced from one by a process of breaking or disintegration. They have no ability, however, to reproduce their kind.

Certain plants, on the contrary, demonstrably have motion from inherent power: as witness the sensitive plant, which closes when its leaves are touched; the morning-glory, which opens and closes its petals; the ivy, which climbs the conductor-pipe or the tree; the insect-eating plant, which closes about and absorbs the prey which alights upon it. Plants have also ability to appropriate nourishing material. This is absorbed from the soil, or from the atmosphere, or, as in the case of the insect-eating plant, as above shown.

Plants reproduce their kind by contact of the male and female elements. Conclusion (JUDGMENT): Plants possess life.

The lowest form of animal life is that of the amoeba. This consists of a simple mass of albuminoid matter, possessing irritability (rudimentary sensation), contractility (enabling motion from inherent power), the power of segmentation or division, through which it reproduces itself. From this low form of life up to man, showing the highest organization, differentiation of structure occurs.

The lowest form of animal life in which a nervous apparatus (and this very rudimentary) appears is the jelly-fish. This animal possesses a muscular, digestive, and circulatory system sufficient for its needs. The oyster has an imperfect nervous, muscular, circulatory, respiratory, and reproductive apparatus. The oyster has a bony system, its skeleton being upon the outside and constituting its shell. In the reptile and fish there is a higher development of the bony, muscular, digestive, circulatory, respiratory, nervous, and reproductive systems, with special adaptation of structure for the conditions in which the animal exists.

Special senses are not developed in the lowest animal organisms. In the very lowest form, as the amoeba, there is irritability; in higher, common sensation (impressions of pain). As the scale is ascended, the tactile sense, and from this on, other senses, as vision, hearing, etc., develop.

In the higher animals, accompanying certain nervous manifestations, there appears what is called consciousness (mind). Fishes can be taught to come at the ringing of a bell; Canary birds to perform various acts; domestic animals to do useful service to man; wild animals to perform tricks and to subordinate savage instincts to man's will. Dogs sometimes develop remarkable intelligence. In the highest form of life (mankind) the development of the brain and nervous system reaches its greatest perfection, and manifestations of mind are of the most complex character.

The BRAIN *is the organ of the mind.*

Simplicity in the structure of the brain indicates low mental development, as shown in idiots and imbeciles. As complexity in structure increases, convolutions grow deeper, and gray matter becomes more abundant, mental operations are correspondingly higher. The size of the head, unless it exceeds or falls far below certain limits, is not indicative of the degree of mental development.

The Brain is the organ of the mind, and in the CEREBRUM (the large brain) reside the higher mental faculties. This is shown:—

1. By experiments on the lower animals. The pigeon deprived of the cerebrum remains apathetic and drooping. If thrown into the air, contact with this element produces, through what is known as reflex action, the muscular movements of flying, but these gradually become feebler until the bird sinks

to the ground. If food is placed within its reach it is not voluntarily appropriated. If inserted far back in the mouth, food is swallowed through reflex action. The frog deprived of its cerebrum rights itself if an attempt is made to turn it over. If pricked or prodded, it jumps, but is quiet and motionless unless disturbed by contact with something. It initiates nothing. The behavior of animals thus deprived of the cerebrum is akin to that of human beings suffering from profound dementia.

2. By disease of the brain, which is so often associated with disturbance of the mental operations.

3. By the mental deficiencies which exist in connection with lack of cerebral development, as in idiots and imbeciles.

What is meant by the mind? This is impossible to define. Mind is known only through its operations. I am conscious of my mind from evidence within (subjective). I am conscious of mind in others because they act in obedience to outward, or apparent, circumstances as I do myself under similar conditions (objective evidence). Their so-called "reaction to their environment" is similar to my own.

The faculties of the mind are three:—

1. THINKING (intellection, thought).
2. FEELING (sensibility, emotion).
3. ACTING (will, volition).

Thinking.

Development of the Mind.—There is necessary to this the SENSES. Knowledge is derived through the medium of the Senses, of which there are six:—

1. *Hearing*: mental impressions through the auditory apparatus.

2. *Seeing*: mental impressions through the visual apparatus.

3. *Smelling*: mental impressions through nerves supplied to the nasal mucous membrane.

4. *Tasting*: mental impressions through nerves supplied to the tongue.

5. *Touch*: mental impressions through sensory nerves supplied to external parts of the body, skin, and mucous membranes.

6. *Muscular*: that sense through which we are made aware of the force exerted by contracting muscles.¹

There are necessary to the mental upbuilding:—

1. SENSATION.

2. PERCEPTION.

3. MEMORY.

4. IDEATION.

¹ Information as to weight and resistance is received through the muscular sense. Compare the impression received from compressing a rubber ball with that from a similar attempt upon a piece of steel. The essential difference between the touch and the muscular sense is plainly apparent.

5. REASONING.

6. JUDGMENT.

A SENSATION is an impression made upon an organ of sense, which organ must be composed of three parts:—

1. A nervous mechanism to receive the impression.

2. A sensory nerve, or nerve of special sense, to convey the impression to the brain.

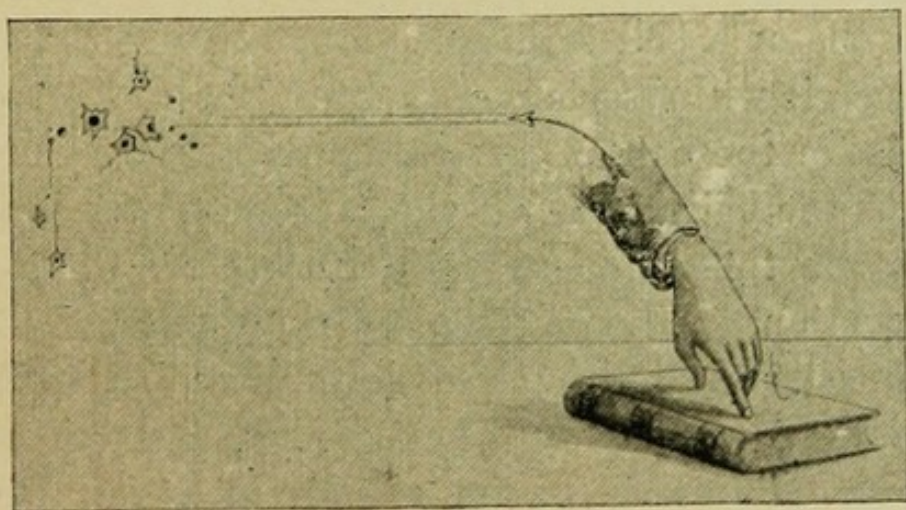


Illustration of simple sensation of touch. Arrow represents impression conveyed by sensory nerve to nerve-centre in brain.

3. A nerve-cell, or group of cells, to receive the impression.

Take the eye for illustration. A ray of light from some object falls upon the retina. An impression is conveyed through the optic nerve to the centre of sight in the brain and there received. This is a

simple sensation. SIGHT, or SEEING, is a different thing, however, and *involves*, just as hearing, smelling, touch, taste, and the muscular senses do, *something else*, which is called

PERCEPTION. This is *the conscious recognition of the external causes of a given sensation*.

To illustrate: For the first few days or weeks of a child's life its existence is vegetative purely. It pays no attention to objects about it. Later on, it is said to "notice,"—that is to say, it takes cognizance of what comes before it. It will follow with its eyes a candle or a ball of bright yarn. It will watch for them. It will associate a pleasant sensation with the candle or the ball of yarn. It *perceives* that the candle or the ball of yarn is the cause of this sensation,—it has the *conscious recognition of the cause*, or Perception. When first a nursing-bottle is placed to its lips, the lips close down about it and the operation of sucking begins,—this through reflex action. There is an impression conveyed by the touch- and taste- organs of the mouth, through corresponding nerves, to the sensory, or special sense, centres in the brain; from these centres reflected upon motor nerve-centres in the brain, and through motor nerves going from the brain to the muscles. Result: the operation of sucking. This is a purely reflex act at first. Later, the child watches for the bottle of milk, sucks upon it by a voluntary effort when it is offered, or perhaps helps itself, if the bottle is placed in the cradle. There is here Perception:

the recognition of the external causes of the sensations which the bottle and its contents furnish.

There are consequently necessary to Perception:—

1. A nervous mechanism to receive impressions.
2. Sensory nerves, or nerves of special sense, to convey impressions.
3. Nerve-centres in the brain to receive impressions.
4. Consciousness.

Perception is made up from a number of distinct

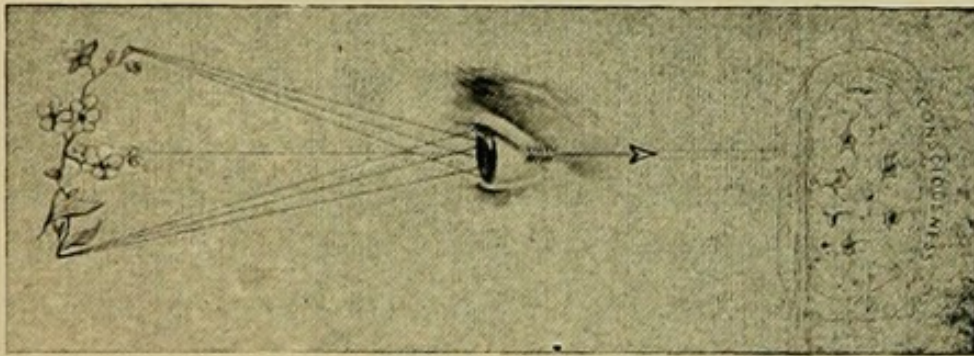


Illustration of visual perception.

percepts: as, for example, form, size, color, vibration, density, taste. These individual impressions united, and with the aid of consciousness, form a percept of the object.

In order that percepts once acquired may be stored up for future use, there is necessary another mental faculty, which is

MEMORY: *the retention in mind of impressions received.*

There are two kinds of Memory:—

1. Memory of percepts.
2. Memory of self (Organic Memory).

The memory of self (organic memory) permits the registration and storing up of impressions from all parts of our bodies: from our bones, muscles, and internal organs. Upon this storing up, the Ego—the Personality—depends. Sensations such as are here mentioned do not, as a rule, come into consciousness independently; but, taken together in health, they constitute our feeling of well-being: our sense of self. In disease we may become, at times, acutely conscious of some or all of them. The development of the personality is extremely interesting.

The child at first is unconscious of its own existence, of its own individuality. It refers to itself in the third person: "Johnnie wants it," "Mamie wants it." The Ego—I—is not present. The child inspects its fingers and toes, as it does that which is held before it, as something foreign to itself. Later, organic sensations proceeding from the fingers and toes and impressing themselves upon the consciousness give to the child the recognition of proprietorship. The organs become part of the child's body. The existence of the child at first seems to be of a dual character. Later, the Ego is formed—the personality—through sensations proceeding from all the organs and tissues of the body and registered in the organic memory.

The PERSONALITY is of great interest to those

studying insanity, for in disease of the mind it is frequently found that alteration in organic sensations has given to the individual an impression of bodily loss or of change in constitution. Change in sensation, proceeding from the foot, may lead to the belief that this member is lost or dead. Change in nervous action and checking or hindrance of mental operations may lead to the delusion that the mind is under the control of another. Disturbance in the internal organs may occasion the belief that poison is administered; change in the action of the nerves of the skin, that electricity or some harmful agency is at work upon the body. All sensations, indeed, may be so altered in insanity as to lead to the belief in a double personality.

This is not difficult to understand when we call to mind the clod-like, heavy, foreign feeling of a frozen foot. Here the sensory nerves are blunted, and sensations proceed from the unaffected tissues above the frozen point. The organic memory may be so vivid in its reproductions as to convey to the soldier the consciousness of the presence of an amputated extremity.

IMPRESSIONS taken cognizance of, or *perceived* by, the mind are hoarded by *Memory*.

The process of grouping percepts together (Re-presentation—Re-collection) by the aid of Memory to form concepts, or ideas, is called IDEATION.

Illustration: Take an object in the hand; receive all the impressions possible from it through the

medium of common sensation and the special senses. You have here a group of impressions coming into consciousness, constituting a percept of the object (Presentation). Remove the object, and associate the different individual percepts together through the aid of memory. You still see it, hear it, or feel it. This constitutes a *concept*, or *idea*, which is a group of percepts reproduced in memory (Re-presentation—Re-collection).



Illustration of concept, or idea. Each grape represents the memory of a percept. These united by the stem, Ideation, form the concept.

REASONING.—This faculty is also necessary to the development of the mental life. Reasoning is *the association of concepts, or ideas, to form a judgment, and the association of judgments to form new judgments*. In reasoning, we weigh and compare concepts, or ideas, by their likeness, or similarity, and by their unlikeness, or dissimilarity.

Take, for example, the naturalist's classification of the animal kingdom. A similarity in structure, in that all possess a spinal column, causes large numbers of animals of widely different appearance to be grouped under the designation *vertebrates*. So of other orders: essential differences in structure separate the *mollusks* from the *articulates* and the *articulates* from the *radiates*. To go further, closer anatomical or physiological resemblances cause the division of the vertebrate kingdom into families, or subclasses: mammals, birds, reptiles, and fishes. This process of weighing, comparing, and measuring is called Reasoning, and the result of the process, Judgment.

Apply heat to iron. The iron expands. Associate the concepts *iron*, *heat*, and *increase in size*, or *expansion*. Judgment: Heat expands iron.

Take the judgment, *heat expands iron*, and associate with it the concept *water*. Judgment: If heat expands a dense body, it will a body less dense,—heat will expand water.

Take concepts of *iron heated* and *iron cool*. The one required more room to contain it than the other. Associate with judgment, *heat expands water*, another judgment: Water expanded will require more room to contain it.

Take for concepts: *expansion* and *containing*. Associate them by reasoning, and the judgment is formed: Anything expanded requires more room to contain it, and, if compressed, great force is created.

Associate concepts of *compression* and *steam* (expanded water). There is called up the concept of force, of expansion, and something to resist the expansion (steel). Judgment: Expanded water confined in a receptacle of steel—a boiler—exerts great force, and may be used in moving powerful bodies (the locomotive).

Again: Compare the idea, or concept, *man*—which involves many percepts of his different attributes—with the concept *reptile*. Judgment: Man is the superior being.

Again: We look out-of-doors upon a cloudy sky. We perceive the absence of sunlight; we perceive the direction of the wind; we are conscious of, or perceive, a chilliness. We group these percepts together, and by the aid of memory reduce them to concepts. There is a re-collection of past experiences. We associate the concepts together by reasoning. Result: Judgment, that the day will be unpropitious for a picnic.

JUDGMENT: *The result of a comparison or association of concepts, or of the comparison or association of judgments.*

Let two telegraph-poles be taken as representing each a concept, or idea. Reasoning is the wire that unites the two; Judgment is the result of the union.

Or let each pole represent a judgment. The wire, Reasoning, unites the two, the whole forming a new judgment.

To recapitulate:—

Sensation + Consciousness = Percept.

Percept + Percept + Memory = Concept.

$$\left\{ \begin{array}{l} \text{Concept} + \text{Concept} = \text{Judgment,} \\ \text{or} \\ \text{Judgment} + \text{Judgment} = \text{New Judgment.} \end{array} \right.$$

The plus sign which stands between the words *Percept* and *Memory* is the equivalent of *Ideation*.

The plus sign which stands between the words *Concept* and the words *Judgment* is the equivalent of *Reasoning*.

As before stated, Sensation, Perception, Memory, Ideation, Reasoning, Judgment, enter into the thinking process. If any avenue to the brain is closed, as by congenital deafness or blindness, mental development and mental ability are correspondingly lessened, although scientific methods applied in the education of the remaining senses go far to remedy the deficiency.

Thought in man is usually, perhaps invariably, conducted in words or their visible signs. Let anyone try to think and he will find that he is mentally grouping words together into sentences and that his unspoken idea is framed as if it were to be expressed. The deaf-mute, who has not a vocabulary of words, thinks in visible signs; that is, in gestures which stand for the representatives of ideas.¹

¹ See foot-note on page 24.

Feeling: Emotion.

We come now to the consideration of the second function or manifestation of the mind: FEELING, or EMOTION. If taken up in logical order, it should have been considered previous to thinking, inasmuch as feeling (sensibility) must inevitably precede thinking. The term "feeling" must not be confounded with the sensation springing from the special sense of touch. What is understood by "feeling," as the word is here used, is a bundle of mental experiences of pain and pleasure that everybody can appreciate, but is difficult to describe. The majority of concepts are, to some extent, of a pleasurable or painful character; that is, there are few which may be classed as entirely neutral: from which some satisfaction, or the opposite, is not derived. To the extent to which ideas are accompanied by pleasurable or painful feelings they may be considered emotional. An emotion, therefore, may be defined as *an idea accompanied by a feeling of pleasure or pain*. As the feeling preponderates the idea grows less and less distinct until almost overshadowed. The word "Emotion" comes from two Latin words: *e*, from, and *motio*, motion. In the emotions lie that which moves to action. Motive, desire, and affection here have their abiding-place. The feelings have their own means of expression, their own language: the language of the emotions. Witness the blanched face, the contracted muscles, the dilated pupils, and

protruding eyes of Fear; the flushed face, swelling throat of Rage; the anxious or relaxed and down-cast physiognomy of Mental Depression; the bright eye, the clapping hands, and laughing expression of Pleasure; the cooing sound of Satisfaction.

The emotions lie close to the organic (bodily) functions. They find their quick reflex in the muscular expressions of fright, pleasure, despair, and comfort, already referred to, as the idea of unemotional character finds its slower expression by the organs of speech or voluntary action. Displaying in themselves the earliest states of consciousness, the emotions are among the first to suffer in mental disease, as will be hereafter shown. The individual breaking down with mental disease reacts to painful or pleasurable impressions with an unaccustomed intensity.

Feelings prompt desire. DESIRE forms the connecting link between feeling and that which we come next to consider, viz.:—

Volition.

VOLITION is defined as *action prompted by feeling*. Thus, it is to be distinguished from all other forms of action not so prompted: from simple reflex action, already spoken of, and from higher reflex (automatic) action.

In speaking of perception in the child, reference was made to the operation of taking food. At first

this was an unconscious and purely reflex act. There was transmitted to the child a nervous mechanism that, excited by the presence of the bottle to the lips, occasioned the muscular act of sucking. Through inherited transmission the child was endowed with this simple instinctive power. Through ages the nervous mechanism in use in the appropriation of food has acted in definite ways, and nervous channels, so to speak, have resulted. Sensory impulses have traveled from lips and tongue to the cerebral sensory centres; they have been reflected upon motor centres, and traveled back along the motor nerves to groups of muscles about the tongue and throat. A path, a rut, a definite route, so to speak, has thus been traversed; and impressions registered in the organic memory, and action prompted thereby, have enabled the appropriation of food to go on until such time as desire impels and voluntary action permits the gratification of appetite. This constitutes one of the few inheritances of the human infant.

The organic memory of pain and the reflex act of crying (the expression of pain in the absence of conscious suffering) is another inherited quality. It is the organic sensation of hunger, which expresses the demand on the part of the system for food, that impels to the taking of food before there is conscious recognition on the part of the child of its own wants or the ability to gratify them. Later on, voluntary action—action prompted by feeling, by desire—appears. Compare the child with the chick,

which, immediately after emerging from the shell, walks around in search of food and picks it up, takes refuge under its mother's wings when called, or flees from the cat, and displays, from the first, adaptabilities and powers which, in the child, are the result of education. Mental development, except under rare circumstances, however, goes little further in the chick. It is, in all essential respects, the mature animal. It is through prolonging the period of infancy that evolution has brought about in mankind the capacity for high mental development.

Again, certain acts which the child laboriously and tediously acquires become, by the assistance of the organic memory, automatic in their character. Take the illustration of walking: It is in the child the result of slow education of the nervous centres. Behind it there is at first a feeling of desire to walk; then comes the education of the voluntary muscles of locomotion. Eventually, by means of the nervous channels established in the brain, walking is carried on automatically, the initiation of the movement only being voluntary. The child walks, runs, and turns about, all without the conscious exercise of volition. Contact with the ground, the sensory impulse proceeding by the way of the spinal cord to the brain, its reception by the sensory centres, its reflection upon the motor centres, and, through the motor nerves, to the muscles concerned in the act are the steps in the process. So of self-defensive acts. At first the child requires to be protected from all

manner of harm. Later, through education, it acquires self-defensive ability and involuntarily shields itself from that which threatens. One is conscious of fleeing from danger, or of taking self-defensive measures, oftentimes after the act is completed. All sorts of habits of life are thus formed. Winding the watch before retiring frequently takes place without consciousness. The act of locking or unlocking a door is done automatically. Piano-playing, an accomplishment tediously acquired, is finally carried on through the organic memory without appreciable voluntary effort except in the act at its beginning. *These are higher cerebral reflex acts.*

The Higher Volition, like the other faculties of mind, is a plant of slow growth, and involves discrimination, comparison, weighing of ideas, and judgment as to the best course for the person to pursue. It is difficult to say when the child first exercises volition. The choosing between that which is sweet and that which is without marked flavor, but better for his needs is, to be sure, an action prompted by feeling; but the higher volition implies discrimination between that which is desirable and profitable and that which is undesirable and unprofitable. Cultivation of the reasoning and judgment are necessary to this.

The education of the will is most important to the future of the child. The matured judgment places an inhibition—a restraining influence—upon the actions, that decision between that which is ulti-

mately good and that which is immediately gratifying may result. It may be a source of present satisfaction to smite in the face one who has injured me, but the higher volition restrains the act.

The law rightly makes distinction between impulsive acts and those prompted by deliberation and choice. One in the heat of passion kills by a blow another who has seriously wronged him. Here the judgment was obscured by the emotional feeling, and a muscular act resulting in death occurred. On the contrary, brooding over a wrong, one deliberately decides to kill, and carries his plan into execution. In the one case the act was semi-instinctive, self-defensive in a way. It was prompted by feeling, to be sure, but the emotion obscured the judgment. Result: manslaughter. In the other case there was a deliberate choosing, a careful adaptation of means to ends, a judgment to kill. This was murder.

It is important to distinguish between

Simple Reflex Acts,
Higher Reflex Acts,
Volitional Acts, and
Inhibitory Acts (a variety of the volitional).

The first—Simple Reflex Acts—are instinctive: as the involuntary withdrawal from contact with that which is painful; winking; breathing.

The second—Higher Reflex Acts—were originally voluntarily acquired,—learned,—but, once learned, go on, in a measure, automatically, the volition, if

exercised at all, merely initiating the movement: as the act of walking.

Volitional Acts are those which spring from feeling and represent choice, desire: as the putting on of rubbers in wet weather, to protect health.

Inhibitory Acts—a variety of volitional acts—are those which check the immediate response to desire and feeling, and introduce a restraining influence—a “will not to do,” so to speak. Both the higher

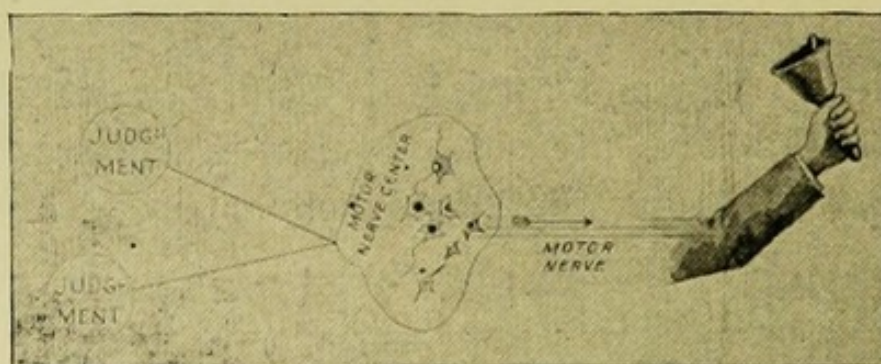


Illustration of volition.

volitional and inhibitory acts imply the exercise of judgment.

LIMITATIONS OF THE WILL.

1. The will has no prolonged power over involuntary muscles. Let one try to stop breathing, and demonstrate this for himself.

2. The will does not control movements which have not been acquired by practice. One may satisfy himself of the truth of this in his first bicycle ride.

3. Painful thoughts cannot be dismissed from the

mind by an effort of the will. They must be supplanted and crowded out by introducing others.

General Considerations.

All of the foregoing has its bearing upon the study of mental disease. In insanity any or all of the functions of the mind may be disturbed.

SENSATION may be impaired or lost. The special senses of taste and smell may be so much at fault that the vilest substances placed in the mouth do not excite disgust. In such a case PERCEPTION also fails. Faulty perception may further manifest itself in Hallucinations and Illusions.

An *Hallucination* is a false perception without an objective reality. Example: One, looking upon the bare floor, fancies he sees a snake. There is nothing whatever upon the floor which could lead to that perception. He is suffering from a visual *Hallucination*.

One looks upon a carpet with bright figures and irregular tracings, and sees in the bright figures birds of brilliant plumage, and in the tracings of duller colors snakes or rats. He is suffering from an *Illusion*, that is, a false perception with an objective reality.

He hears the sound of escaping steam from the radiator, and, in this sound, the voice of some one threatening to kill him; in the ticking of his watch he hears commands; in the locomotive whistle he perceives calls and shrieks. He is suffering from

illusions of hearing. He hears a cry when all is still; he has an auditory hallucination. Thus, in smell, taste, touch, and the muscular sense hallucinations and illusions may develop. The weight of the bed-clothes may give the impression, through the muscular sense, of a heavy load; or one may fancy himself exerting great muscular strength, may even perspire and become manifestly exhausted through efforts to sustain bodies which in fancy are burdening him, while, in fact, he is entirely free from any weight or pressure.

Hallucinations of hearing exist in insane patients who have deafness, acquired; of vision in those who have become blind: there could be no better illustration of the fact that we hear and see with the brain—the mind—not with the eye and ear. The inference follows that hallucinations of hearing or vision in one congenitally deaf or blind would be impossible,—the cerebral centres which preside over these senses in health never having been in action. No true conception of sound can exist in one congenitally deaf, or of color in one totally blind from birth. Consequently no hallucination can be present.¹

¹ In the *Journal of Mental Science* for July, 1895, an interesting account is given of the hallucinations of a deaf paranoiac. The case reported by Dr. Cramer to the Psychiatric Association at Berlin is, in brief, as follows: He was 37 years old and had been born deaf; but had been educated and learned to be a portrait-painter. When admitted to the asylum at Eberswalde he was much excited and violent.

Hallucinations and illusions give rise to *Delusions*. Hallucinations may be present in the mind of one not insane. As long as they are corrected by the reasoning and judgment they do not amount to delusions. Believed in, however, and present because of a diseased condition, they become delusions.

A *Delusion*, therefore, is a *false belief due to disease*. The qualification "due to disease" is introduced because there are multitudes of false beliefs in the world not due to disease, but to faulty education, as the belief in witchcraft, satanic possession, the evil eye, the visitation of ghosts, Christian Science,¹ etc.

"He was very suspicious, not at all communicative, and very difficult to handle. In about ten months he began to improve and engaged in out-door work. A year afterward he again resumed his painting and was willing to converse. Dr. Cramer framed a number of questions which the deaf man answered in writing. Instead of hallucinations of hearing, for he could not hear, he imagined that communications were made to him by the ordinary signs used by the dumb, and through the words which he had been taught to utter by muscular exercises of the mouth and throat, and also by studying the motions of the lips in others. In these ways he thought that obscure ideas were introduced to his mind. Cramer took occasion to observe that it was an error to believe that in all our thinking heard words are used. In this he is convinced that there are great differences, some even transacting thought through the acoustic form of words, others through the revival of images formed from the movements of the organs of speech or the sensation of accomplished muscular efforts."

¹ ———, Ill., February 23.—Mrs. ——— ——— died

In estimating the importance of a false belief as bearing upon the mental state of the subject, it is necessary to take into consideration his natural habits of thought, his previous education and mode of life. A philosopher suddenly expressing a belief in witches might be justly regarded as having an insane delusion. It would not be safe to conclude, however, in the case of an illiterate Southern negro, that an expression of a belief in witchcraft implied insanity.

The IDEATION, REASONING, and JUDGMENT may be at fault in mental disease: *Ideation*, in the imperfect grouping of percepts into concepts (incoherence); *Reasoning*, in the irregular association of ideas (incoherence); *Judgment*, in erroneous conclusions (delusions).

Two classes of delusions are spoken of: *Fixed Delusions* and *Changing Delusions*.

The MEMORY may be at fault, both in the recollection of percepts and in the registration of organic sensations, as heretofore mentioned in connection with the personality.

here a few days ago after a brief illness of inflammation of the bowels. She and her husband and other members of the family were Christian Scientists. An attempt was made to cure Mrs. ——— by prayer and other practices usually resorted to by members of that faith before summoning a regular physician. The physician was called too late to be able to render any assistance. It is thought by the neighbors and friends of the deceased that the woman could have been saved if medical aid had been summoned sooner.—
Press Report.

The EMOTIONS—feelings—may be at fault. As previously mentioned, disturbance of the emotions is an early manifestation of mental disease in many of its forms.

In the graver forms of insanity, associated with nervous degeneration, the HIGHER REFLEXES (the co-ordination) are disturbed.

VOLITION, which in conditions of sanity is checked and governed by the judgment, may be abolished or very much impaired. Examples: The irregular muscular movements, shifting glance, and inattentiveness of mania; the unwillingness to put forth muscular effort in melancholia.

PART II.

INSANITY.

INSANITY is defined as "*a prolonged departure from the individual's normal standard of thinking, feeling, and acting.*"

It is a *prolonged* departure, because there are many conditions in which there are temporary departures from the normal standard of thinking, feeling, and acting which are not called insanity. Thus, in intoxication one neither thinks, feels, nor acts as when sober, but this condition is not accounted insanity, and the subject is fully responsible in the eyes of the law for his conduct. In the delirium of fever—due to overheating of the blood, its too rapid circulation, and its conveying deleterious or poisonous substances to the brain—the subject is temporarily deprived of his ability to think, feel, and act normally. It is true of shock, a blow on the head, fright, an epileptic convulsion, fainting (from loss of blood or heart-failure), and apoplexy, that there may be temporary loss of consciousness and the mind does not act naturally; but the person thus suffering is not re-

garded insane. Insanity may develop in consequence of injury, in consequence of the delirium of fever, in consequence of the loss of blood, and in consequence of apoplexy or epilepsy; but the condition itself is not an insane condition.¹

The definition speaks of the *individual's* normal standard. This means that every case is a law unto itself: that there is no fixed standard of thinking, feeling, and acting. It cannot be said, for example, because one does not act under certain conditions as his neighbor acts, because he does not show the same amount of feeling that his neighbor manifests, or because he does not think in the same lines that his neighbor thinks, that he is insane and the other sane. In giving an opinion as to whether insanity exists, it is necessary to compare the person's *present* with his *former* habits of thinking, feeling, and acting.

The "*departure*" may display itself in complete change of characteristics, tastes, and tendencies; in simple perversions of the feelings and judgments; or in an exaggeration of natural traits of character.

Causes of Insanity.

These are as numerous as the causes of disease in general. They may be classified, for convenience, as follows:—

Direct physical causes, 36 per cent.

Indirect physical and emotional causes, 8 per cent.

¹ The word "insanity" means literally "unsoundness," but it is the medical, not the literal, meaning which is here given.

Vicious habits, 25 per cent.

Constitutional and evolutionary causes, 28 per cent.

1. *Direct Physical Causes.*—These are such as affect mental operations through direct action upon the brain: as a blow on the head; injury; hæmorrhage; disease of any kind, as cancer, consumption, Bright's disease; child-bearing and its attendant perils; prolonged nursing, etc. In each of these there is a direct action upon the brain, either from violence, through increase or diminution of its blood-supply, through deleterious substances carried in the blood, or through altered nervous sensations going from the part affected to the brain.

2. *Indirect Physical and Emotional Causes.*—Under this head are grouped: fright; shock (not shock from injury, but mental shock); grief; care and anxiety; business failure; trouble of all kinds; domestic infelicity; disappointed affections; the feigning of insanity, etc. Causes such as these affect the brain indirectly through the physical system. The man who has failed in business, for example, loses sleep over it; he does not take the proper amount of exercise, perhaps through fear of meeting acquaintances and having his troubles brought vividly before his mind; his appetite is impaired—he takes food indifferently or refuses it altogether. He has actual distaste for food,—this because his changed habits of life have brought about disorder with the emunctories of the system: the bowels, kidneys, skin, and lungs. What food he takes is imper-

fectly digested and badly assimilated. The blood-supply to the brain is insufficient and impoverished in quality. Sleep is troubled by painful dreams, it does not rest him, and the process of repair which constantly goes on in the brain during sleep in the normal state is not carried on naturally during the period of emotional strain. Eventually, through all these causes, he loses his ability to think, to feel, to act naturally; and there comes to be a prolonged departure from his normal standard in these respects, constituting insanity.

3. *Vicious Habits*.—Under this head are classed: intemperance; opium, chloral, and cocaine habits; sexual excess; self-abuse; and all habits of life which directly undermine the physical constitution and thus affect the brain.¹

4. *Constitutional and Evolutional Causes*.—Under this head come all causes of insanity which operate because of some innate defect in constitution or development of the individual. Here hereditary tendency figures to a great extent. One inherits a susceptibility, so-called, to mental disease from intemperate, vicious, insane, or delicate ancestors. His nervous constitution is unequal to the task of carrying him through certain inevitable crises in development. There is known hereditary tendency to mental dis-

¹ It will be observed that vicious habits are, after all, but direct causes; but for convenience and clearness they are separately considered.

ease, either remote or immediate, in about 50 per cent. of all cases under treatment in large institutions. Probably if the facts were invariably discoverable, the percentage would be found vastly greater.

Among the constitutional and evolutionary causes are:—

Pubescence.—The pubescent period is that during which the boy or girl passes to manhood or womanhood. At this period the organs of reproduction take on development, and a change in the characteristics of the person occurs. Certain desires, aspirations, and tendencies not before felt are then first experienced. It is a critical time in the life of the person, and, unless he or she is well organized, mental overthrow is apt to occur. A form of disease known as recurrent mania frequently develops at this stage of life. The age at which pubescence is established varies in different climates. For this climate it is approximately from 13 to 16 years.

Adolescence.—Possibly the individual may have passed safely the pubescent period, having inherited sufficient nervous strength to carry him beyond this first physiological crisis, but at the next developmental period (that of adolescence) he breaks down, without direct assignable cause, or from some cause which would be insufficient to produce insanity in one well constituted. The adolescent period comes at the age of 30 to 35.

Again: The mile-stones Pubescence and Adoles-

cence may be left behind in the march of development, and the person go on mentally well until the change of life,—the so-known *Climacteric Period*. This change in the woman takes place at the age of about 45; in the man, between 50 and 60. It marks in both a stationary plane. The period of development is past, and those organs which took on activity at the time of the pubescent epoch begin to cease active functioning.

About fifteen years later—in the woman of 60, and the man of 70—*Senile* changes (those due to old age) make their appearance, and mental and bodily feebleness ensues. Frequently mental feebleness reaches such an extreme that insanity is said to exist.

We have thus the four periods: *Pubescence*, marking the advance from youth to manhood; *Adolescence*, that from manhood to maturity (these two periods are developmental or evolutionary); *Climacteric*, the stationary period; and *Senile*, the dissolutional period, or period of decay.

Causes of insanity may be conveniently grouped under one of the four heads above mentioned. In every case the natural constitution of the subject figures to a greater or less extent. It is true of the direct and indirect physical causes, as well as of vicious habits, that a cause feeble in its intensity may produce a disturbance of balance in one not well organized, whereas one having a good nervous inheritance and strong mental equipment may be able to resist the cause and retain his integrity of mind.

Forms of Insanity.

There is no such thing, strictly speaking, as a disease of the mind; but the expression is commonly employed, and is a convenient one for describing disturbances of those operations of the brain which involve consciousness. Mental disease is always associated with disturbance of function or structure of the brain. Among the pathological conditions are congestions, effusions, anæmia (lack of blood-supply), opacities of the membranes, thinning of the gray matter, adhesions of the membranes to the cortex¹ of the brain, and degeneration of brain-matter.

The names commonly employed in the classification of mental disease chiefly stand for groups of *symptoms*: *Mania* being a Greek word, meaning furor; *Dementia* being derived from two Latin words: *de*, without, and *mens*, the mind; *Paranoia*, from Greek words *para*, defective, and *nous*, understanding. One notable exception is in the name *Melancholia*, which comes from two Greek words meaning "black bile," it being supposed by the ancients that this affection was incident to disorder of the liver.

Insane conditions may be conveniently grouped under four general heads:—

1. *States of mental elation.*
2. *States of mental depression.*
3. *States of mental weakness.*

¹ The covering of gray matter.

4. *Structural brain disease, with prominent mental manifestations.*

Under *States of Mental Elation* are found Mania Acute, Mania Chronic, Mania Recurrent, and Hystero-mania.

Under *States of Mental Depression*: Melancholia Simple, Melancholia with Stupor, Melancholia with Frenzy, Hypochondriacal Melancholia, and Hystero-melancholia.

Under *States of Mental Weakness*: Dementia Chronic, Dementia Monomania, Dementia after Melancholia, Dementia after Mania, Paranoia, Imbecility, and Idiocy.

In the last group—*Structural Brain Disease*—may be included Paretic Dementia, Dementia with Paralysis, and Epileptic Dementia.

MANIA ACUTE.

Mania Acute is *an insanity of recent onset, the leading characteristics of which are elation, changing delusions, and active excitement.*

The development of Mania is usually somewhat sudden, although it will be found, as a general thing, that the patient has suffered, for some time before excitement occurs, from depression, emotional disturbance, sleeplessness, loss of appetite, and bodily derangements. When excitement appears, the patient becomes noisy, restless, incoherent in his conversation, and lacking in self-control. All of the faculties of the mind are affected.

The THINKING is much disordered, manifesting itself along the following lines:—

Sensation is lively; impressions travel quickly, and are chiefly objective and pleasurable.

Perception false. Hallucinations of sight and hearing are frequent, are of a changing character, and are usually pleasurable. Illusions are rare.

Memory temporarily impaired; percepts registered inaccurately or in a distorted way.

Organic Memory changed. Personality changed, leading to delusions such as those of great strength and power,—that of a superior being.

Ideation much interrupted; percepts come into consciousness one after another irregularly, are not grouped into concepts accurately (incoherence), and are fleeting and disorderly.

Reasoning and *Judgment* impaired. Incoherence in grouping of concepts. Delusions of a changing character, usually pleasurable. Delusions of divine patronage, a call to preach, and inspiration are not uncommon.

FEELING:—

Emotions exalted and pleasurable.

ACTING:—

Will impaired. Mental reflexes prompt: Inhibitory control lost or greatly impaired. Assaults are made impulsively, or blows and kicks are dealt to others because of the irregular and excited muscular action constantly present. Destructiveness. Attention is fixed with difficulty—one thing after another

engaging it temporarily. Impressions, largely objective and being derived from different objects in rapid succession, are fleeting and inaccurate.

Physical Symptoms.—The circulation is rapid; the skin hot; the tongue dry and coated; the eyes suffused and congested; the temperature elevated; the urine scanty; bowels at times loose, at other times costive; sleep fitful; headache and other evidences of pain rare. There is no actual distaste for food, but occasionally refusal of food,—this from inattention, and not from delusions.

In Mania there is no tendency to suicide. The habits are frequently untidy by reason of inattentiveness to bodily wants.

Termination.—The tendency of simple Acute Mania is toward recovery, provided the physical health can be maintained.

In this connection it is desirable to speak of a form of acute mania partaking more of the nature of inflammatory action of the brain. In this disease, called Acute Exhaustive Mania, all the above symptoms are extremely intensified; the excitement is more of the nature of delirium; there are low muttering, picking at the bed-clothes, accumulation of sordes upon the teeth, higher fever, increasing debility. Death is very apt to occur from rapid exhaustion.

MANIA CHRONIC.

Mania Chronic is *an insanity of long duration the leading characteristics of which are elation, greater*

fixity of delusions than in acute mania, restlessness, irritability, and mental impairment.

The termination of mania acute, when recovery does not ensue, is usually in dementia chronic, or in Mania Chronic—the form of disease under consideration. This is, therefore, a secondary condition.

In Chronic Mania:—

Sensation is less lively; impressions are less rapid. They are, as in acute mania, largely objective, but, as a rule, less pleasurable.

Perception false. Hallucinations of any or all of the special senses may be present, are of fixed character, and are not invariably pleasurable. Illusions are occasionally present.

Memory permanently impaired.

Organic Memory impaired. Personality changed.

Ideation interrupted. Percepts less rapid, and more regular, than in acute mania; incoherence less marked.

Reasoning and *Judgment* impaired. Incoherence in grouping concepts frequent, but not invariable. Fixed delusions.

Emotions superficial; easily stirred. Irritability.

Will impaired. Attention is more easily fixed. Mental reflexes prompt. Inhibitory control impaired, but not lost; assaults are made from this cause, from delusions, or from excessive irritability.

Physical Symptoms.—These are of no especial significance. As a rule, vegetative functions are carried

on normally; appetite and appropriation of food good.

Tendency to suicide, none. Habits are very frequently untidy because of failure to correct degraded tendencies in the acute stage of the disease.

Termination.—Recovery from Chronic Mania is not apt to occur.

RECURRENT MANIA.

Recurrent Mania is *a disease characterized by periods of excitement, periods of depression, and, at times, periods of composure and complete lucidity.* All powers of the mind are more or less affected in Recurrent Mania, the symptoms presented varying with the stage of the malady. In excitement the demeanor of the patient is similar to that of acute mania, but excitement is rarely so high. *Well-marked delusions, illusions, and hallucinations are frequently absent, and there may be perfect coherency.* The conduct of the patient during excitement is mischievous, and apparently attributable to moral perversion. He seems to be prompted by malicious feelings. If destructive, he appears to be so deliberately. In the period of excitement he misconstrues motives, makes unfounded accusations, sets patients up against each other or patients against attendants. There is *impairment of the inhibitory control.*

The increased capacity for cerebral effort and the heightened emotional tone shown early in the period

of excitement are well illustrated by the following letter from a patient:—

EASTERN MICHIGAN ASYLUM.

PONTIAC, MICH., July 29, 1894.

Dear Dr. Burr: Please allow me to take a minute to tell you that I am fully aware that my present condition is one of "elation." But I believe and hope I shall go safely through without a "bust-up." Your kindness and the consideration extended me by all your staff are highly appreciated. I am sleeping fairly well now, have good appetite, and, of course, life has a good deal of sunshine for me just at present. As you know, about the only time that I can write, or compose, anything worth anybody's reading is during a period of elation; so I feel as though I should "make hay while the sun shines"; but I do not intend to inflict much or many (?) of my lucubrations upon yourself.

Very respectfully yours,

During the period of depression the patient is dull and listless. He lacks energy and application. His conduct is similar to that of one suffering from melancholia, but there is usually an absence of fixed delusions. As the excitement is less than that of acute mania, so the depression is less pronounced than in melancholia. The patient is frequently remorseful for unpleasant acts which he has done during excitement. Depression may shade off into complete composure and lucidity of weeks', months', or years' duration, or on its subsidence excitement may again slowly make its appearance.

Physical Symptoms.—In the period of excitement all of the bodily functions are carried on normally. In the period of depression there is apt to be constipation, sleeplessness, headache, distaste for food, painful sensations coming from the internal organs, and dyspepsia.

HYSTERO-MANIA.

This is a form of insanity consequent upon the *unchecked impulses arising from an hysterical mental organization*. These unchecked impulses of the hysterical patient may become to such an extent habitual that a true insanity develops. The acts of disorder, the noisiness, the destructiveness, so prominent in these cases, are due to impairment of the will and the inhibitory control. There is an absence of delusions, although the patient may feign their existence. Patients of this description are very imitative and are apt to do what they see other patients about them doing. Along with the excitement there are the usual *Physical Signs of Hysteria*: the pallid countenance, flushed only during active mental disturbance; the cold, clammy hand; the relaxed and perspiring skin; the dilated pupils; the sensation of a ball in the throat.

MELANCHOLIA SIMPLE.

Melancholia Simple is *a form of insanity presenting depression and fixed delusions*. It is, in almost every particular, the complete reverse of acute mania.

Its development is slow. Disturbances of the emotions are the earliest manifestations. As in mania, there are sleeplessness, loss of appetite, and bodily derangements, but from different causes than those which obtain in excitement.

Sensation is dull; impressions travel slowly, and are chiefly subjective and painful.

Perception false. Hallucinations of hearing are frequent, of sight rare. Hallucinations are of a *fixed* character and usually painful. Illusions may be present.

Memory not much impaired. Percepts registered accurately, but slowly.

Organic Memory impaired. Personality may be changed, and in consequence the delusion of demoniacal possession, or others equally unpleasant, appear.

Ideation slow. Percepts are grouped coherently, but with difficulty, leading to the delusion that the mind is hopelessly lost, that the mental operations are checked by some external power.

Reasoning and Judgment.—Coherency unimpaired. Delusions are almost invariably present; they are of a more or less uniform character; a belief in unworthiness; that the unpardonable sin has been committed; that the conduct of the patient has brought harm upon others; that he is responsible for the sins of the world; that his family is coming to want. Delusions are always of a painful nature.

Emotions depressed, painful. Emotions are depressed to such a degree, at times, that the patient believes himself incapable of mental feeling.

Will slow to act, because every act involves distinct effort. Inhibitory control unimpaired. Attention can be fixed, but the effort is wearying. Mental reflexes slow. Assaults upon strangers or people not related to the person are rare. Homicidal assaults are sometimes made upon children, or near and dear relatives, because of the delusion that want or sorrow stares them in the face, and that they would be better off dead than living. There is no tendency to destructiveness.

Physical Symptoms.—The circulation is slow; the skin pale and cold; the tongue moist and coated, and shows indentations from the teeth because of deficient tonicities; the pupils are large, and respond slowly; the sclerotics are pearly white; temperature is normal or subnormal; urination sometimes profuse, because of intense emotion; bowels invariably costive; sleep poor and troubled by painful dreams; headache at the vertex or occiput (anæmic headache) almost constant,—as a rule, worse in the early morning; appetite lost; food is refused from delusions of unworthiness to eat or of bringing want upon others.

In Melancholia there is strong tendency to suicide. The habits are usually tidy.

Termination. — Recovery, or chronic dementia. The relatively frequent termination of Melancholia

in dementia is due largely to the marked disturbances of reasoning and judgment, shown by the fixed character of the delusions.

MELANCHOLIA WITH STUPOR.

This form of Melancholia gives to the physiognomy of the patient the appearance of one suffering from mental impairment. There is a dull, sodden expression. There are great torpor and apathy. Delusions exist, and are of a painful character, but are much less active than in simple melancholia. The circulation is feeble, the hands are blue and cold, and temperature is frequently subnormal. All the mental faculties are blunted. Volitional acts are performed feebly and after much urging. The mental reflexes are very slow. The appearance, in brief, is that of extreme mental and bodily depression, feeling (emotion) being also depressed to the extent that acute mental suffering does not exist. Food is refused because of torpor and dejection; if placed in the mouth, it is permitted to remain unswallowed—if fluid, it may run out upon the face. Untidiness of habits is frequently present. There is not, as a rule, tendency to suicide.

Termination.—In this disease there is a strong tendency to dementia, with fixed habits, as that of holding the hands in unnatural positions or assuming constrained attitudes.

MELANCHOLIA WITH FRENZY.

This is a *form of disease having characteristics of both mania and melancholia*. There are noisy excitement, restlessness, destructiveness, tendency to self-mutilation and self-injury. Because of having certain features in common with mania, it can best be studied by comparison of the two forms of insanity. Thus, we have, both in Mania and in Melancholia with Frenzy, excitement and sleeplessness. In the latter case, however, the excitement and sleeplessness occur in consequence of delusions of persecution; in Mania, in consequence of exalted emotions. In both, sensation is lively, attention is fixed with difficulty, and perception is false; but, while in Mania impressions are chiefly objective and pleasurable, in Melancholia with Frenzy they are both subjective and objective and painful. The attention, in Mania, is fixed with great difficulty, because of the rapidity with which impressions come from without; in Melancholia, because of the concentration of attention largely upon that which is within. Hallucinations, in Mania, are frequent and changing, and usually pleasurable; illusions are rare. In Melancholia with Frenzy, hallucinations are almost constant, are of fixed character, and painful; illusions are common. The memory and organic memory are in both cases altered. Organic sensations are changed. There are disturbances of sensation in the skin in Melancholia with Frenzy, leading to picking of the

face and scalp to remove fancied insects or vermin. The ideation, and reasoning and judgment, are in both cases impaired; but, while in Mania there are incoherence and delusions of a pleasurable character, in Melancholia with Frenzy there are partial coherence and distressing delusions. The emotions, in Mania, are exalted and pleasurable; in Melancholia with Frenzy, lively, but painful. The one suffering from Melancholia with Frenzy shows prompt mental reflexes, makes assaults, is destructive and disorderly; but for a different reason than the one suffering from Mania. In the latter case it is because of the rapidity with which the confused mental operations are carried on, inattention, and changing mental impressions; in the former case, because of the existence of delusions. If the man suffering with Mania makes an assault, it is from lack of inhibitory control, or because of the irregular and excited muscular action which is constantly present. If one suffering from Melancholia with Frenzy makes an assault, it is to ward off fancied injury.

The *Physical Symptoms* in both instances are very much the same. If food is refused in Mania, it is because of inattention; if in Melancholia with Frenzy, because of delusions of poison.

In Mania there is no tendency to suicide, while the *tendency to suicide in Melancholia with Frenzy is extreme*. One cannot be too watchful of these cases. In Melancholia with Frenzy self-mutilation frequently occurs, sometimes in an abortive attempt

to commit suicide; again, from the belief in an offending member,—that the eye “offends” and should be “plucked out,” or that the presence of the sexual organs has contributed to the distress of the patient, and that they should be removed.

Termination.—The tendency of Melancholia with Frenzy is toward recovery, provided sufficient food can be introduced into the system, either by natural or artificial means, to keep up the strength, upon which there is a constant and tremendous drain because of excitement.

HYPOCHONDRIACAL MELANCHOLIA.

In this form of disease, frequently occurring at the climacteric period, the thoughts of the patient seem to be entirely self-centred. The idea of unworthiness, which is so common in simple melancholia, and that of persecution, which pertains to melancholia with frenzy, are, as a rule, absent. Impressions are wholly subjective and arise from disturbances of Organic Sensation and Organic Memory. These lead to the belief that the bowels are removed; that they are closed up; that the brain is sodden and can no longer act; that the blood does not circulate; that food does no good, is not digested, and not absorbed; that the kidneys are gone; that the sexual organs are without activity, and the like. Patients having Hypochondriacal Melancholia suffer much distress of mind, and are a source of great drafts upon the sympathy and resources of those having the respon-

sibility of their care. Appearing, as the disease does, so frequently at the change of life, just before nervous decay sets in, the organic sensations which give rise to the delusions may often be attributed to failure in nervous supply to the internal organs, with consequent impediment to their functioning.

HYSTERO-MELANCHOLIA.

While hystero-mania at its inception is largely the result of unchecked impulses determining muscular movements, Hystero-melancholia is *the result of the habitual lack of restraint upon the emotions*. Patients with Hystero-melancholia present the ordinary signs of hysteria. In addition, they are extremely emotional, but rarely give way to active excitement, as in hystero-mania. They weep easily; they suffer, in fancy or actually, much mental distress; they are incapable of exertion. They permit their limbs to become contracted from disuse. They present paralysis of motion and anæsthesia (lack of sensation).¹ Such patients are without delusions, aside from those which strictly pertain to bodily sensations and movements. Cases of Hystero-melancholia are not, as a rule, suicidal,—delusions

¹ One patient with whose case I was familiar, who subsequently recovered, remained for eighteen years in bed, exacting the most constant care from her relatives. She believed herself paralyzed, and when she first came under my observation her knees were flexed at a right angle and the muscles of the lower extremities withered almost to nothingness from disuse.

as to unworthiness, the unpardonable sin, poison, or persecution, which impel to suicide in melancholia and melancholia with frenzy, not being in existence in these cases. *They often threaten suicide, and one may, under strong impulsion, seize a favorable opportunity to destroy himself.* I have known the approach of a train of cars to furnish this opportunity to one whom I have every reason to believe was not seriously contemplating self-destruction. It should be remembered, further, that acts committed for the purpose of exciting alarm or sympathy, and not intentionally suicidal, may result fatally.

DEMENTIA CHRONIC.

This is a terminal stage of mania acute and other uncured forms of insanity. It is defined as *mental impairment acquired*, to distinguish it from imbecility and other *congenital* mental impairments. There are all degrees of Dementia, and the extent to which Dementia is apparent upon slight acquaintance with the person depends a great deal upon his original mental capacity. To take a concrete illustration: One possessing originally a hundred concepts, or ideas, and losing one-half of them through Dementia, would show mental weakness less than the originally in possession of fifty who had lost one-half. The capital remaining in the first case would be much larger than in the second, and leave a better basis to do mental business on. Dementia, therefore, is a relative expression. All of the faculties

of the mind are impaired in Dementia. This is particularly true of the Memory, the Reasoning and Judgment, and the Volition.

Sensation is slow.

Perception of ordinary objects may not be inaccurate. There frequently remains, however, a residuum of the hallucinations and illusions of the earlier period of the mental disorder—the grounds in the tea-cup, so to speak. These, however, are less active, less pleasurable, or less distressing, as the case may be.

Reasoning and *Judgment* are impaired.

Memory is impaired.

Attention is feeble.

Habits formed in the acute stage of disease—for instance, the habit of grasping the hands tightly, or of passing the hand over the face, or of moving the arms, at one time expressive of painful emotions—may be, and frequently are, continued in Dementia, without any emotional basis. Likewise the habit of picking the skin, plucking out the hair, or mutilating the finger-nails may be continued.

Physical Symptoms immaterial. Sleep, appetite, digestion, and assimilation usually good.

Demented patients act slowly. They initiate (begin) very little, and frequently require close supervision and painstaking effort on the part of others to direct their energies successfully into useful channels. Habits of employment, however, which have become so definite as to be, in a measure, auto-

matic, may be well carried on, even where there exists incapacity for mental application and fixing of the attention.

Patients in Dementia are frequently childish. They react to little pleasures, trifling pains, and disappointments much as children do. The *Inhibitory Control* is always impaired.

Irritability is more or less constantly present, and assaults are made from this cause. Usually for assaults there is some real or fancied provocation, though it may be nothing more than the inadvertent jostling of one by another in passing.

Carelessness in habits is invariable; neglect of personal appearance so constant as to require to be corrected by others. Degradation in habits is sometimes present—this largely because of lack of effort on the part of somebody else to correct improper tendencies during the acute stage of the patient's disease.

Termination.—Dementia Chronic is hopeless as regards recovery; but much can be done by well-directed endeavor to form the patient's habits, correct vicious and degraded tendencies, and establish systematic employment, rendering life fairly comfortable.

IDIOCY AND IMBECILITY.

These are mental defects from *congenital causes* or arrest of development in infancy. In Idiocy there is a complete absence of mental action, the operations of life being purely vegetative.

Imbecility is of all grades; from that which is extreme up through the so-called defective types to paranoia, the highest form of congenital mental infirmity. Imbeciles are lacking in self-control, are irritable, impulsive, mischievous, and imitative of improprieties. The higher faculties of the mind are feebly developed. Powers of thinking are circumscribed. The emotions of imbeciles are easily aroused, and inhibitory control is feeble; consequently they often do acts of violence. They are not, as Imbeciles, proper subjects for treatment in institutions for the care of the insane,—measures adapted to them being more of an educational than medical nature. Imbeciles, like sane people, however, may become insane.

PARANOIA.

Paranoia is a form of disease occurring in one of congenitally defective nervous organization, and marked by certain well-defined symptoms which seem to be due to defects of development, and frequently appear as an exaggeration of the natural characteristics.

One suffering from Paranoia is from childhood somewhat peculiar. He may be bright and receptive in certain ways, may learn readily in school, but shows eccentricities of conduct; is self-conceited, introspective, and develops asymmetrically. Without obvious exciting cause, or with some slight cause, as a fever, a trifling injury, or a disappointment, he becomes suspicious. This feeling is usually at first

vague and indefinite. Mental depression may proceed to a considerable degree. There are associated with it, however, no fixed delusions of unworthiness, or of poison, as in melancholia, but vague ideas of conspiracy and disposition on the part of others to deprive him of his property or business rights. A business failure, perhaps, which has been the natural outcome of poor methods and indifferent application, is charged up to the machinations of those inimical to him.¹

This is the so-called "persecutory stage." Following this is what is known as the "transition stage." Some event may occur in the patient's life—a visual hallucination, a vivid emotional experience, a dream, a fortuitous circumstance, a casual remark by another, or the encounter of a passage in reading—which may furnish to the patient a key or clue to the mysteries surrounding his past career. He begins then to see that things have thus been planned out for him from the beginning; that he was to be brought up by those claiming his parentage, to conceal his noble birth; that he is a prophet, or even Christ. He diligently cons the Scriptures for references to him-

¹ I once knew a patient who, in this condition, enlisted in the army. He felt himself watched and checked in his laudable undertakings, on every hand; he believed that the generals of the army—Sherman and Grant—were conspiring to keep him in the position of private, and prevent his meeting that reward in promotion to which his abilities and meritorious conduct entitled him.

self, and finds in this passage and that the prediction of his coming; of the persecution to which he will be subjected; of his ultimate triumph. He sees now the reason why he has been persecuted in the past. It has been because of the envy of others, or because those who knew of his mental gifts or his true social position desired to keep him from coming into his inheritance.

It is not difficult to see in the foregoing a description of the *cranks* of the world—the “harmless insane,” the physician’s office-bore and the neighborhood nuisance. The usual quiet conduct, the continued application to business, the ability to converse rationally on current topics, the bright memory, the logical method of presenting beliefs, the perfect volitional control, frequently deceive as to the true nature of the patient.

As a matter of fact, the so-called cranks, of this description, constitute a dangerous element in society. They are apt to make sudden homicidal assaults in consequence of delusions.¹ Many of the

¹ They believe that in committing acts of homicide they are benefactors of society. Thus:—

CHICAGO, December 8.—Prendergast, the assassin, made a formal protest against the plea of insanity being introduced in his case to-day. When he was led into Judge Brentano’s court-room, he handed his attorney, Mr. Essex, a letter in which he asked that the insanity plea be withdrawn, declaring that he believed people will get an idea that he did not kill Carter Harrison for the benefit of the people at large,

assassins of distinguished persons have belonged to the Paranoiac class. In asylums, such patients are frequently very comfortable and able to control unpleasant characteristics. They accept their confinement as part of the scheme in their lives, believing that some good will eventually accrue to them or the world in consequence. They often show a sort of proprietary interest in the institution, and are useful in various lines of work.

Dementia is not rapid in these cases. Some retain until late in the disease a tolerably full possession of their original power to think correctly, except in the line of their delusions; to reason upon subjects foreign to themselves; to recollect perfectly; to acquire new facts; and even to display ability in the line of construction or invention.

To recapitulate. In Paranoia we have:—

Sensation unaffected.

Perception unaffected, as a rule. Occasionally hallucinations occur.

Memory unimpaired.

Organic Memory and *Personality* changed.

Ideation unimpaired.

Reasoning and Judgment.—No incoherence in grouping of concepts; but, reasoning from false premises, a logical delusion results.

but rather from a personal or selfish motive. Attorney Essex declined to state whether he would give the letter any consideration.—*Press Report.*

Emotions, in persecutory stage, painful; after transition period, as a rule pleasurable.

Attention unaffected.

Will unimpaired. Reflexes unimpaired. Assaults, if made, are because of delusions of conspiracy or fraud.

Physical Symptoms, immaterial. There is frequently a distinct lack of symmetry of the head.

There is rarely any tendency to suicide. *Exceptional cases, however, are extremely suicidal.* The habits are tidy.

Termination: chronicity. Tendency to Dementia is not as pronounced as in the acute forms of disease, such as mania and melancholia.

DEMENTIA AFTER MANIA AND DEMENTIA AFTER MELANCHOLIA.

In these disorders *there is a condition of temporary impairment consequent upon the prolonged disorder of the mental operations.* The patient thinks, feels, and acts slowly, but in other respects in a manner approaching the natural. The time is a critical one, and great caution is necessary that the patient be not mentally overstimulated. Overstimulation occurring,—too much introduced at once into the mental life,—confusion is apt to result and recovery to be hindered or prevented. The patient must not overstrain his mind at first, but by degrees come into its full exercise. The blacksmith convalescing from

typhoid fever should not at first wield the heavy sledge all day.

DEMENTIA MONOMANIA.

The symptoms of Dementia Monomania are those of *mental impairment, with a single delusion, or several delusions of the same general type*. Three classes of patients show this disease in its purity: those suffering from insanity due to prolonged, steady alcoholic indulgence; traumatic cases; and those having mental trouble due to constitutional disease, as consumption and cancer. Hallucinations of sight and hearing of a persecutory type commonly accompany the alcoholic cases; and visceral illusions, delusions of poison, unseen agency, and suspicion attend constitutional disease. Visceral illusions are due to perverted organic sensations. Clouston, a distinguished Scotch alienist, once made the extreme assertion that a pure and uncomplicated monomania of suspicion points to the existence of consumption. Certain it is that this particular symptom is almost universally found in insanity from constitutional disease.

SENILE DEMENTIA.

This is a variety of *Chronic Dementia occurring in consequence of old age and general nervous and mental breaking-down*. There are impairment of all the mental processes; irritability; perversions of feeling,

especially toward near relatives; and oftentimes extreme mental confusion and incoherence. At times a recollection of remote events is present, but recent events are not recorded in memory. Such patients frequently require, toward the last, the same attention it would be necessary to bestow upon little children.

EPILEPTIC DEMENTIA.

This is *mental impairment associated with Epilepsy*. There is slowly increasing feebleness of thinking, feeling, and acting. Just before, during, or immediately following epileptic convulsions there are apt to be great mental confusion, irritability, and impulsiveness. Assaults are made and outrageous conduct is indulged in, without subsequent recollection (Disorder of Higher Reflexes).

Epileptic patients are apt to be untidy, especially during convulsions, when involuntary expulsion of the contents of the bowels, bladder, or seminal vesicles may occur. These patients are extremely dangerous to others. I have known suicidal attempts among epileptics, and accidents which require surgical intervention are common.

There is great danger to epileptic patients in going to high places, from the use of cutting instruments, or from being near machinery. I have known one to fall from a boat while in a seizure, and drown immediately, despite the well-directed efforts of his companions to save him.

PARETIC DEMENTIA (SYN.: PARESIS, GENERAL
PARALYSIS OF THE INSANE).

This is a disease displaying slowly increasing mental impairment, disorders of muscular movement, disturbances of higher reflexes (inco-ordination), mental and physical decay. It is a disease of adult life, and observed chiefly in those whose habits have been irregular; who have been addicted to excesses of various kinds; have had syphilis; have been steady drinkers; or who, from one cause or another, have rapidly exhausted their nerve-force.

It is a structural brain disease. There exists degeneration of the cortex (gray covering) of the brain, and a low grade of inflammation of the cortex and membranes. A patient breaking down with paretic dementia is at first visionary and erratic. He is full of pleasurable emotions; has large ideas of business; entertains impracticable schemes; perhaps loses much money because of poor investments and improper ventures. His handwriting becomes somewhat irregular, and he drops words. In executing the finer movements of the fingers and of the face, he shows lack of precision. Hesitation and thick-ness in speech early occur, giving to those knowing the person, but unaware of his nervous breaking-down, the impression that he is drinking to excess. Later there is frequently shown a lack of respect for the rights of property, and appropriation of what comes within reach, under the impression that it

belongs to the patient. The feelings are easily stirred, and the patient is extremely irritable if opposed in his impracticable notions. Delusions grow more and more extravagant as muscular inco-ordination and debility increase. The patient believes himself possessed of thousands of millions; that he is the strongest man in the world; that he can set out worlds in the heavens; that he is God; that train-load after train-load of diamonds is coming to him direct from the mines; that he owns all the banks and the fleetest horses; that, in order to fly, all that is necessary is to make the first attempt. The fine lines of expression of the face become slowly obliterated. The pupils are unequal or strongly contracted. There is often a glassy appearance of the cornea. From bad to worse the patient's condition goes on, with occasional periods of remission. Seizures of an epileptiform or apoplectiform character occur. Sometimes death comes suddenly; oftener as a result of slow exhaustion, and after a tedious period of confinement to bed, during which bed-sores, dependent upon a lack of nutrition of the skin, develop. Toward the close of life the patient requires the same degree of attention as a little child, but as long as consciousness remains there is a feeling of strength, of power. *Choking from paralysis of the throat*, anæsthesia, and *paralysis of the bladder*, which may result in *overdistension and rupture*, are symptoms encountered from time to time and should be especially guarded against. There is often ex-

treme fragility of bones, and fractures occur from muscular action or trifling accidents. The expression "first rate," which has been termed the "verbal formula of a hopeless malady," is used in reply to inquiries as to the health. Periods of furious, unreasoning excitement are apt to occur. In these, fortunately of brief duration, as a rule, the patient loses all self-control, throws himself about, grates his teeth, and is noisy and extremely destructive.

The above are the usual manifestations of this form of disease. Occasionally the mental symptoms are those of extreme depression, and then there is an intensity, an exaggeration, so to speak, of depression which, taken in connection with the physical signs, enables the observer to distinguish the condition from melancholia. There is absence of grandiose delusions. Deep-seated disturbances of Organic Sensation and Organic Memory occur, leading to the belief that a portion of the organism is dead or that the body is "all gone." Such cases as this—lacking the one element which is present in those of the other class, —viz., that of good feeling—are pitiable in the extreme.

Sensation—at first lively, later slow—may be abolished.

Perception false. Hallucinations or Illusions at times present.

Memory hopelessly impaired.

Organic Memory impaired. Personality totally changed.

Ideation feeble; irregular.

Reasoning and *Judgment* progressively impaired. Grandiose delusions.

Emotions, as a rule, exalted and pleasurable; sometimes extremely depressed.

Will impaired; inhibitory control impaired and lost; higher cerebral reflexes impaired and lost. The Attention is fixed with difficulty.

Physical Symptoms.—Progressive lack of power in the voluntary muscles, and inco-ordination of movement; change in pupils; constipation or diarrhœa; enormous appetite; lack of control over the bowels and bladder; retention of urine; cystitis; bed-sores; fragility of bones; convulsions or apoplectic attacks.

In Paretic Dementia there is, as a rule, no tendency to suicide, but self-mutilation may occur, in the belief that a dead or offending member should be removed.

The homicidal tendency is met with in occasional cases. One patient planned to crush another's head in a door.

Habits careless from the first, and toward the close of the disease untidy and degraded.

Termination: death.

DEMENTIA WITH PARALYSIS.

This is a form of dementia *produced by, and dependent upon, previous damage to the brain* by an apoplectic attack, the occlusion of some blood-vessel

cutting off the nutrition of certain parts of the brain, or cerebral degeneration in some of its forms. Here well-defined delusions are rare, but there are great irritability, emotional disturbance, perversions of feeling, and a tendency to misconstrue the motives of others.

The outlook in this disease is unfavorable. Impairment of the bodily and mental health is apt to go slowly on. Death may occur from apoplexy or an epileptiform or apoplectiform seizure.

PART III.

MANAGEMENT OF CASES OF INSANITY.

THE successful management of cases of insanity necessitates recognition of the physical basis of mental disease, and the directing of treatment to the brain the organ of the mind.

It is the duty of those having the grave responsibility of caring for the insane intrusted to them to have in mind these two great aims:—

1. To promote the recovery of patients.
2. To limit the amount of dementia in unrecovered cases, and thereby promote their well-being and happiness.

As every case of mental disease is a law unto itself, so must each be individualized and treated upon its own merits. There can be no wholesale plan of management.

Quickness of perception, kindness, tact, and good judgment are qualities indispensable to the success of an attendant upon the insane. Kindness implies thoughtfulness, attentiveness, conscientious devotion: sentiments which find their reflex in judicious, well-directed effort. Coddling, demonstrativeness, and display of warmth of affection are always unnecessary and frequently detrimental to the interests of patients. Kindness should find its chief expression in good deeds, not in words.

The recovery of patients is promoted by

1. *Building up the general health;*
2. *Correcting pernicious habits; and*
3. *Checking morbid impulses.*

To build up the general health, there are necessary good food, exercise, abundance of sleep, and possibly medication.

The ADMINISTRATION OF FOOD is the most important duty of an attendant, and upon its successful accomplishment everything depends. Food should be delicately prepared, temptingly served, and presented to the patient in an inviting manner. Dishes and utensils should be scrupulously clean and bright; the tray covered with a clean spread; a napkin provided for the patient's use, which, in case he is fed by the hand of another, should be placed about his neck to protect the clothing. Before giving food, the person of the patient should be cleansed, the face sponged, and hands thoroughly cleaned by the use of the nail-brush; the nails trimmed. The patient should have an opportunity to rinse his mouth with cold water, and a tooth-brush or a cloth should be used upon the teeth to remove unhealthy accumulations.

Where food is refused from inattentiveness, as in Mania, it is often impossible to give more than a few spoonfuls of liquid at a time. In such cases the administration of nourishment should be repeated every hour or every half-hour, as may be, those times being selected during which the patient's attention

can be gained—when it is the least occupied with other matters. Inattentive patients sometimes take food better at night, when all is still, than in the day-time.

Where food is persistently refused because of delusions,—as in Melancholia or Dementia Monomania,—a careful study of the patient's characteristics and peculiarities will commonly point a way to the end, and resort to rectal alimentation or mechanical feeding will become more and more rare as experience increases. Milk is an ideal food for the insane, and in debilitated cases it is often well to give it in connection with egg and liquor, as in an eggnog. In meeting capricious and delicate appetites, gruels, custards, broths, wine-whey, beef-tea, koumiss, jellies, and fruits will all be found of service. In states of acute exhaustion or threatening exhaustion attended by unhealthy conditions of the mouth and digestive tract, lemon-juice or lemonade in small quantities is often of the greatest value. Certain patients will take liquid food in small quantities where solid food is altogether refused. A patient having delusions of poison may accept eggs boiled in the shell, or potatoes baked in the skins, particularly if the cooking goes on in his presence, naturally believing that no poison can be introduced into these articles. One who ignores the request of his attendant or physician may eat in obedience to that of some fellow-patient. Another will take food from the dining-room after the others have left,

picking up something here and there, who is unwilling to eat in the presence of others, or who believes that he is unworthy to be served until they have finished. One will eat if left alone and apparently unnoticed. Another will take food if he can acquire it surreptitiously; and opportunity should be afforded suspicious patients to thus appropriate it. One will eat crackers or bread, or fruit, if placed in his pocket. Another will exchange plates with a neighbor, and take the food prepared for him, believing that no poison has been introduced into that particular plateful. One suffering from active delusions of poison may accept part of a glass of milk if his attendant shows sufficient confidence in it to drink a portion in the patient's presence. One believing it wicked for her to eat, will often take food if it is forcibly placed in the mouth—the least show of force being all that is necessary to effect the entrance of the spoon. Under this coercion she feels that she escapes responsibility for the doing of that which her conscience disapproves. In giving food, as well as bestowing other attentions upon suspicious patients, an affectation of indifference is often very efficacious. Under these circumstances a patient believes that the attendant has no personal interest, has no ends to serve.

Whatever delusions or morbid impressions influence the patient, whether of repugnance to food or delusions of suspicion or poison or extravagance (which latter cause the patient to believe that he is

of finer fibre than those about him and not dependent as they upon nutritive substances) the careful attendant or nurse will, as a rule, be equal to the occasion, and the necessity for forced feeding will be avoided. There is a wide variety of liquid food of unquestioned value from which to make selection; among these milk, malted milk, Mellin's food, broths of various kinds, and Phillip's digestible cocoa are convenient for administration and adapted to weak digestions.

Mechanical feeding should be the last resort, and the operation invariably be performed by the physician. It should be borne in mind in this connection that there is oftentimes danger of overfeeding; that where a condition of much debility exists, harm may be done by the introduction into the stomach at one time of what would be, under ordinary conditions, a proper amount of food; the assimilative powers are arrested, the secretions deranged, and the organs of digestion in no condition to care for it. For the purposes of nutrition in these cases a teaspoonful to a tablespoonful of milk given in the natural way after intervals of an hour is better than the administration of a larger amount artificially. Milk, preparations of beef, milk-toast, and other albuminous foods may be pancreatinized—artificially digested—before administering, and in certain instances a purely liquid food may be advantageously administered by the rectum.¹

¹In certain cases this is helpful for its moral effect. I have known patients to take food with avidity to escape the humiliation of rectal feeding.

In the ADMINISTRATION OF MEDICINE only the smallest amount of force in opening the mouth is justifiable. It is far better, under ordinary circumstances, to give medicine by enema than to force it into the mouth and compel its being swallowed by holding the mouth and nose—an expedient which is, I fear, too frequently resorted to, and of which I personally very much disapprove. In giving food or medicine by enema, however, the anatomical relations of the parts should be borne in mind and plenty of help provided, so that no danger will be encountered of doing the patient injury. I have known a fatal accident to occur from the administration of an enema. In the introduction of the syringe-nozzle the assistance of vision will be, in the case of an excited or frenzied patient, indispensable.

PERSONAL ATTENTION AND NURSING.—The patient *should be kept tidy and neat at all times*. Everything about him—clothing, bedding, furniture—should be changed and laundered or aired at frequent intervals. Clothing and bedding must be changed immediately if soiled, and the person of the patient at each changing must be carefully bathed. Efforts should be made to inculcate fixed habits of tidiness, by getting the patient to sit upon the chamber or taking him to the closet at stated times if he is strong enough to be gotten up from bed. The condition of the bowels should be carefully looked after, that constipation or other derangements may not ensue. Heed should be given that the patient

urinates at regular intervals. Patients laboring under excitement fail to empty the bladder, from inattention; patients suffering from melancholia, from apathy and indifference. Paretic patients often have distension of the bladder because of lack of power to expel its contents, or because of the absence of the impulse to urinate, arising from sensory paralysis. It is important to call to the attention of the physician any suspicions of failure of the patient to empty the bladder, that the dismal accident of rupture may not occur. The details of catheterization, giving of enemata, attention to bed-sores, and care of the feeble pertain to ordinary sick-nursing.

In nursing the insane it should be constantly borne in mind that symptoms of any disease, as, for instance, pneumonia, may be masked by the mental condition, and that complaint may not be made of pain, discomfort, or even severe distress.

EXERCISE.—It is of the utmost importance that one suffering from mental disease, whose strength will permit, should be taken out-of-doors for exercise every day in pleasant weather. Great caution should be observed to assure one's self that the patient's physical condition will admit of his going. He should not be taken for exercise to-day because of a general direction to this effect yesterday, but the advisability of the act should be invariably determined before a step is taken. There should be care that the walk is not too long; that the patient is not fatigued by it; that he is not taken into places

of danger; that he is not exposed to the cold, or to the heat of the sun, unduly; that he is suitably clothed; that he is not permitted to sit upon the damp ground or loiter in places where he may be seen by others and his condition made the subject of remark. In maniacal excitement, unless the strength is too much reduced (and in a decision of this kind the opinion of the physician should be taken), walks are well borne and are profitable. The restlessness of mania must have vent. To repress it too much is to intensify excitement and do the patient harm. In the occupation of walking out-of-doors there is a diversion of the nervous energy into healthy channels. The sleep and the appetite are better, and all the bodily functions are more satisfactorily performed in consequence of it. Fresh air in abundance is introduced into the lungs; the blood is more rapidly and perfectly oxygenated,—it is of a more favorable quality to nourish the brain. The bodily secretions are quickened. That form of exercise is the best in which the largest number of muscular groups can be utilized, and, as a rule, that the most satisfactory which introduces a variety of healthy percepts into consciousness. This is true for obvious reasons, it having been shown under “Limitations of the Will” that a thought cannot be dismissed by mental effort, but must be supplanted by another in order that it may be removed. Patients suffering from mental depression are frequently averse to going out-of-doors, or even to the society

of their fellow-patients. In overcoming this disposition, the attendant is promoting his patient's well-being and lessening the intensity of his morbid mental operations by presenting healthy subjects for contemplation. Pleasurable emotions stimulate vital activity. All are aware of the depressing effects of trouble, bad news, mental shock—how they take away the appetite and derange the bodily functions. The contrary is true of pleasurable emotions. All of the vital functions are stimulated by these to greater activity; hence their importance as aids to the recovery of the insane.

In Hypochondriacal Melancholia there is, generally speaking, a disinclination to take exercise, and it is important that this disposition should be met and the determination of the patient to remain in-doors, in his room, or in bed be thwarted. Much caution should be observed, however, that undue exercise is not taken, and the patient's complaints and protests should be duly weighed.¹

EMPLOYMENT AND DIVERSION are desirable for the same reasons that exercise is desirable. Through them healthy topics of thought are introduced to dis-

¹ I once knew an hypochondriacal patient to be sent out-of-doors for a walk by her physician, it being believed by him and by all who had dealings with her that her objections to going out were purely mental, and that there was no physical condition which would be a barrier to the exertion. On the morning in question she had gone but a few steps when she fell dead from heart-failure.

place those of a morbid character; muscular action is diverted from unhealthy into healthy channels; voluntary control is stimulated; the ability to fix the attention is increased; restlessness, disorder, and destructiveness are diminished; sleep, appetite, and the bodily functions are improved. The furnishing of a congenial diversion, such as taking a patient to a concert or a church-service, often supplies an effective motive for self-control and is a stepping-stone to his recovery.

In recent mental diseases, employment is of service for the immediate well-being of the patient, substituting new topics of thought and directing the energy along useful lines.

In *arresting the tendency to dementia*, employment is of the utmost value. In settled dementia we not only find employment an outlet for nervous energy, which is apt to expend itself in moving restlessly to and fro, in picking at the clothing, and in degraded habits, but we possess in it a means of re-education of the brain, of opening new routes of nervous travel, and bringing into action groups of nerve-cells not formerly in commission. As my experience increases, I am more and more convinced of the practicability of employing almost all patients, no matter what their mental condition may be—save those, of course, enfeebled in body from paralysis or other cause—in some line of work. The employment may be simple, but will be found sufficient to contribute materially to the welfare of the patient and that of others.

In the progress of mental disease brain-waste is rapid. Restoration and repair are brought about during SLEEP. It is consequently important that nothing should interfere with the patient's obtaining a suitable amount of rest. Exercise and employment in the day-time and the establishment of fixed habits of living go far to bring this desirable state of things about. Inability to sleep depends frequently upon actual starvation of the nerve-centres. Under such conditions the taking of a little food just before retiring—as a glass of hot milk or a cup of cocoa or chocolate—may be all that is necessary to induce repose. A warm bath or cool sponging to the spine will also be found of value in some cases. Where medicine is prescribed for the purpose of producing sleep it should be administered under the careful direction of the physician; should, as a rule, not be given where circumstances warrant its temporary withdrawal; and should be discontinued as soon as habits of sleep are measurably re-established. In this matter, as well as in others connected with the management of such cases, the patient's individuality should be carefully studied. The reason why he does not sleep should be discovered, if possible, and means taken to meet the indication. One persistently wakeful and noisy at night—this from sheer timidity when sleeping alone—may be quiet and calm and rest well in a dormitory with others. A patient whom I once had under observation, who for years was thought to require an hypnotic at night because of noisy demon-

strations, slept like a child after being placed in a covered bed, because he believed that while there his enemies could not steal his sheep. Another patient, suffering from chronic mania, was noisy the night through until afforded one day the opportunity to lie down for an hour. That night she slept, and on succeeding nights, if she had napped in the day-time, she rested well.

Prolonged rest in bed is frequently necessary. Certain cases of Recurrent Mania are, in disturbed periods, quieter and more comfortable if permitted to remain alone in bed than if up and about. Here exhaustion of the brain is less, the horizontal position affording a means for more perfect nutrition of that organ. Fewer percepts are introduced into consciousness, and mental confusion is less. In ordinary cases of Recurrent Mania this plan would be inadvisable, but in those exceptional cases attended by much confusion and a high grade of excitement it is frequently of great service. In Acute Exhaustive Mania the patient should be kept in bed to prevent further physical decline, and should be nursed as one in the delirium of fever. In Melancholia attended by great physical depression, the mental operations are often surprisingly improved by a few days in bed in a horizontal posture—this for the reason already given.

The *objections to rest in bed* are: the dangers of *suicide*, of the *formation of habits* of inactivity, and of the development of *untidiness*. These objections may be met by watchfulness and attention.

CORRECTING PERNICIOUS HABITS AND CHECKING
MORBID IMPULSES.

As the tendency of the insane person's mind is toward neglect in personal appearance, disorder, lack of self-control, contemplation of morbid subjects, and impulsive acting, so should the energies of those having the responsibility of his care be directed to the establishment of neatness, the correcting of habits of neglect, the repression of evil or pernicious tendencies, the substitution of natural for unnatural thinking, and the restoration of habits of self-control. This is symptomatic treatment.

The custodial care of an insane person in an asylum or hospital may be *necessary* or *expedient*. It may be necessary: (1) to protect the patient from himself; (2) to protect others from the patient. It may be expedient when not necessary.

Treatment away from home, or in an institution, often accomplishes much for the patient; this for a number of reasons. In the first place, one is apt to exercise greater self-restraint among strangers or acquaintances than among relatives. Latent powers in this direction often become active after the transfer of the patient from home. He falls readily into the discipline and *régime* of an institution, and spontaneously displays powers of self-control not before apparent. The withdrawal from scenes with which former delusions have been associated contributes to this. Regular modes of life prescribed by others

take the place of self-appointed rules of conduct. The routine itself is favorable—there is less to stimulate, less to annoy. In an asylum, the patient laboring under excitement is not, as too often happens to one in the care of relatives, threatened or punished for disorderly conduct. If depressed he is not adjured by everyone he meets to “brace up.” In an asylum he becomes less introspective. He is thrown into the society of those similarly afflicted, and finds that his trouble is not more deep and abiding than that of his neighbor. He perhaps recognizes in his neighbor a deluded condition and can criticise in him the conduct which springs from morbid ideas. Each may be suffering from the same general class of delusions, and each recognize the error of judgment in the other.

Removal from home is often an advantage through substituting a real trouble for a fancied one. At home the mind is occupied by morbid ideas to the exclusion of everything else. Apart from familiar scenes homesickness perhaps develops. As two subjects cannot occupy consciousness perfectly at the same time, there is here substituted a healthy for an unnatural feeling, and a motive to recovery is supplied.

It is often expedient to withdraw the patient from his family; this in consequence of the influence of his conduct upon the minds of his growing children. The example of an insane member of a household, and the anxiety and worry attendant upon his care,

are often to the last degree harmful, and tend to the mental deterioration of others.

It may be expedient to withdraw one from the marital relation. There is, in some forms of insanity, marked sexual excitement, and indulgences growing out of this condition may prove a serious obstacle to the patient's recovery.

An insane person's removal from home may be expedient for the benefit of society. While not actively dangerous, he may become so under provocation or through the development of new delusions. Though apparently harmless, if he is disposed to wander about and indulge in eccentricities of conduct and conversation he becomes a nuisance, an annoyance, and his presence is demoralizing to the community.

In the care of the insane *punishment should never be employed.*

Punishment is the infliction of pain for a crime or fault. The insane person, having lost by disease his ability to feel, to think, and to act in a natural manner, is not responsible and should never be punished. It is appropriate, in my judgment, to supply certain motives to self-control: as, for instance, withdrawal of tobacco from those untidy in its use; or denying those who have been guilty of improprieties the privilege of attendance upon assemblies. These disciplinary measures, though possibly regarded by the patient himself as punishment, cannot justly be thus considered. They are steps taken with the end

in view of promoting the patient's self-respect and establishing habits of neatness and self-control. *The withdrawal of food or any of the necessities of life, as a correction for a fault, could never be, under any circumstances, excusable*, though, on the contrary, on rare occasions the furnishing of a reward—as fruit, candy, or a delicacy—because of some particularly praiseworthy and commendable conduct, might be justifiable. *Scolding or harsh and ungentlemanly or unladylike language should never be indulged in.* It does no good and is the source of no end of disagreement and trouble. *One is never excusable for incivility*; and any tendency in this direction which the attendant is conscious of in himself or which he sees in others—patients or attendants—should be corrected where practicable.

Employ the prefix “Mr.” or “Mrs.” invariably in addressing your patient. Make requests; do not command. A request pleases; a command antagonizes. An attitude of imperiousness toward the patient diminishes his regard for the attendant and if the “order” is obeyed it is at the cost of his self-respect. The attendant should be equally careful not to be patronizing. To the majority of patients a patronizing air is highly offensive.

In the government of patients, a firm, judicious position should be taken and maintained. *Be sure of the right and propriety of the course, then consistently pursue it.* Let the judgment be made up calmly. Waste no time in arguing or in reiterating again and

again what will be done in case compliance with a request is not forthcoming. The repeated *You shall's*, which only call forth the *I shall not's*, anger both parties and are unseemly. After calmly and dispassionately telling your patient what course will be taken in case of an indulgence in some particular line of conduct, carry out the plan without further talk if the offense is repeated.

"How do you get on with this patient so well nowadays?" I once asked an attendant. "I guess it is because I've quit having the last word," she replied.

Avoid too much talking; heed reasonable requests; take a firm and judicious position and maintain it.

MANUAL RESTRAINT, when necessary, should be applied with the least possible show of force, and never with violence. Forcible control may be necessary to protect the patient from himself and to protect others from him. It is also expedient to prevent bad habits and improprieties, to correct tendencies to restlessness and excitement, and to promote self-control. In my experience, force judiciously applied and used as a last resort is rarely, if ever, complained of, and does not give rise in the mind of the patient to a permanent grudge or grievance. If, however, the exhibition of force is the last link in a chain of unpleasant circumstances, for which the attendant is to blame, its employment is not apt to be forgiven. To illustrate: A command to do some particular act is made, and is opposed because of the gruff or authoritative manner behind it; a dispute arises; at-

tempts to coerce are made and resisted; both attendant and patient become angry, and in the end the patient suffers forcible control for that which was not his, but the attendant's, fault. He is irritated and affronted, and justly so. He has been treated badly.

The surroundings and person of the patient should be spotlessly clean. An effort should be made, by the introduction of pictures, books, pretty furnishings, musical instruments, and games, to substitute healthy for morbid topics of thought. Seek to get the patient employed. One is always more self-respecting when useful.

In the *correction of certain vicious habits*, more or less frequent among those whose self-control is weak, hard manual employment in the day-time and watchful attention at night are the only agencies upon which safe dependence can be placed.

The *suspiciousness* of patients is best met by frankness and consistency, or, as mentioned under "Administration of Food," by apparent indifference.

It is important that the attendant should be in the confidence of the patient; hence the necessity that the latter's early impressions of his surroundings should be favorable. In order to counteract morbid impulses, the attendant must know about his patient's mental operations. Unless in his confidence, these may not be revealed.

Patients are suspicious of what they do not see. It is unquestionably true that numberless accusations of abuse are based upon sounds which patients hear

issuing from rooms with closed doors. Hence, so far as is consistent with modesty and propriety, permit patients to see how others are cared for.

In the matter of delusions, be frank, but do not antagonize. If a patient states that he is God, it is entirely unnecessary to retort: "No, you are not." If, however, he asks: "Am I God?" it is the duty of the attendant to say: "We are taught that the Lord has never appeared upon earth but once, and then in the person of Christ, many years ago." In this or in some other way the question may be evaded, or the attendant may quietly and pleasantly say, "No, sir; that is an erroneous belief." Further discussion of the matter is unnecessary and inadvisable. This applies to recent cases, on the one hand, and, on the other, to cases having confirmed delusions of long standing. In the case of a convalescent patient, however, just as the mental cloud is lifting, timely, judicious conversation may contribute much toward assisting him to correct morbid judgments and control diseased impulses. "He" (pointing to the nurse) "is the first man that ever told me those ideas of mine were not right," said a patient. "At home, when I said 'I have the light here' (opening his coat), they told me it shone all over the room. He told me that wasn't so and that such ideas would not be believed here."

Homicidal assaults may arise in consequence of delusions, or impulsive acts not intentionally homicidal may result in death. The delusions which lead

to homicide are: first, those of persecution or of conspiracy; second, those of impending want and misfortune. The only effective precaution against homicide is vigilance. It is the duty of the attendant, in cases of quarrels between patients, to interfere. This may often be cleverly done by requesting of one his assistance in some form of work at another part of the room. Knives, scissors, and sharp instruments should always be kept under lock and key. Brooms, mops, dusters, and articles of this kind which may be used as weapons, should never be left about, but locked up immediately after using. Chamber utensils should be dealt out only under the watchful supervision of an attendant. Bath-tub keys, which may be used like a brass knuckle, or with which hot water may be drawn, should never be permitted to come into a patient's possession. The searching of clothing, bedding, and rooms should be systematically done,—in many cases daily, in the majority of cases twice a week. A threatening blow may sometimes be arrested by seizing the roll of the coat with both hands, and quickly drawing the coat down upon the arms.

Homicidal impulses may exist for years under control and then suddenly develop; hence the importance of being fully informed of the character of the patient's mental operations, and being ever on the alert for the "unexpected," which is said always to happen.

Suicide and self-mutilation may also be prevented

by close watching and attention to the care of knives, sharp instruments, broken glassware and crockery, and other articles with which injury may be inflicted. Suicide by precipitation is relatively frequent; hence the necessity for watchfulness when patients are out walking, that they do not go into dangerous localities; that they have no opportunity to throw themselves before locomotives or street-cars, from high places (as ladders or fire-escapes), under loaded wagons, or into water. Care should also be exercised that they pick up nothing with which they may injure themselves subsequently. In-doors, attention should be given to suicidal patients when going up- and down- stairs, and the door to any shaft should be kept closed and locked every moment when the attendant is not standing in it. Be watchful lest such patients throw themselves into open fire-places, scald themselves, drown themselves in the bath-tub, hang themselves in roller-towels, in sheets tied at the window-guards, or in skeins of yarn suspended from gas-fixtures. A patient whom I once knew jumped up from the rocking-chair in which she had been quietly sitting, faced the chair, and sprang into it, only to throw herself backward upon her head. She died almost at once. Unavoidable accidents of this nature will sometimes arise, notwithstanding the most careful watching; but let no patient be afforded the means of committing suicide, homicide, or self-mutilation through the carelessness of an attendant. *Do not make the mistake of believing that because a*

patient continually talks of suicide he will not carry threats into execution. Several fatal suicidal attempts have occurred in my knowledge among patients of this class.

Irritability.—This is frequently an expression of physical pain of which the patient does not complain. Its source should be looked for in sleeplessness, headache, aching teeth, abdominal pain, constipation, distended bladder, etc.

MECHANICAL RESTRAINT.—In the early days of my asylum experience it was thought necessary to use mechanical restraint often. Employment, night-nursing, and personal attention have done away with this necessity, until now in a well-ordered institution resort to it is a conspicuous rarity. It may be necessary in exceptional cases, but should never, except in a grave emergency, be applied without the previously expressed sanction of a physician.

SECLUSION.—The isolation of a patient may be expedient for his own benefit, or for the good of others. When done, this should be with as little demonstration and display of force as possible, and only after due warning has been given. The course may be necessary: first, because of noise and disorderly conduct; second, in hysterical patients as a measure of good (lack of self-restraint in these cases being always greater when the patient is among other people); third, because of obscenity or indecency; fourth, to withdraw the nervous subject from perturbing influences and thus diminish mental con-

fusion.¹ After secluding the patient, the door should be locked quietly and without ostentation, or may be left unlocked if it is believed that the patient will respect the injunction to remain within the room.

Patients in seclusion should be visited frequently. After *quietly* unlocking the door (doors should always be unlocked quietly) the key should be withdrawn and placed in the pocket before the door is opened. Both hands of the attendant are then free. The practice of unlocking a door and pushing it forward, hand on key, is *extremely reprehensible and dangerous*. In entering the room of one who has broken some piece of furniture and is making threatening demonstration with a weapon thus secured, an effective protection is a mattress held before the foremost attendant. By means of this the patient may be crowded back and disarmed.

The *objections to seclusion* are: the danger of suicide; the danger of increasing irritability; the danger of untidiness. *Suicidal patients should never be secluded* except with the previously expressed consent of the physician, and, if apart from others, should be carefully looked after. Seclusion sometimes increases irritability, ill-feeling, and waywardness. When this occurs, harm results and the measure is inexpedient.

¹ Epileptic patients during confusional states are frequently benefited by confinement to bed. Noise and disorder are lessened, and, fewer percepts coming into consciousness, reaction, as manifested in impulsive assaults, is diminished.

The *disposition to burn and the tendency to steal* are observed in different forms of insanity. The fact that these symptoms are conspicuously manifested in some cases has led to their being improperly dignified by special names for disease: as pyromania and kleptomania. The tendency to burn is most frequently observed in connection with chronic mania; the tendency to steal, in the early stages of parietic dementia, property being appropriated by the patient under the delusion that it is his own. Patients who are demented are apt to secrete articles of no value, or little value, and unless carefully observed get together accumulations of rubbish and useless trumpery.

Searching the clothing, the bedding, and possessions of patients for matches and other articles collected, and extreme watchfulness on the part of the attendant to prevent things of this nature falling into the patient's hands, are safeguards against accidents from these sources.

ESCAPES.—In these days of open-door halls, employment out-of-doors, and the giving of larger and larger liberties to patients, escapes will unfortunately occur. They should never be chargeable to a lack of vigilance or to disobedience of rules or regulations by the attendant. Escapes, as other accidents, only too frequently occur as the result of neglect of printed rules. Remember that the escape of a patient may mean a homicide, an act of arson, or a suicide, and

let the attendant beware lest the accountability for this be his.

Never, under any circumstances, talk of the condition of any patient to any person not entitled to receive information about him.

The attendant is the agent of the people and represents them. He should be manly, high-minded, and never frivolous. His position is an exalted and responsible one. His work is appreciated by those most familiar with his frequent acts of self-sacrifice, heroism, and devotion. He should ever possess exalted ideals, and in his rest from labor be able to enjoy the satisfaction which springs from these and from the consciousness of duty well-performed.

PART IV.

SUGGESTIONS AS TO WHAT TO DO AND WHAT TO AVOID IN CARING FOR THE INSANE.

**Being an Address to the Training-school Class of
1895, Eastern Michigan Asylum.**

MY DEAR FRIENDS:

You have reached an important mile-stone in your lives, and are to-night reaping the first public reward of hard study and devotion to the highest duties of the calling in which you are engaged. I congratulate you upon the successful accomplishment of the work in which we set out together two years ago. I stepped aside, and the benefits of the last year which you have received have been lost to me. The invitation to address you to-night gives me a much-prized opportunity to say how deeply I have felt our separation and how difficult a task has been the severing of the bonds which attached me to this school. Aware, as you are, of my affection for it, you will not doubt that withdrawing my connection with this dear institution, in which I have spent many of my best years, was made doubly hard by the thought that it involved separation from this class

and its agreeable associations. My heart is with you, and will always remain true to the school, from which I expect great results for good. Indeed, its fruits and its influence have already justified its establishment. Though it were to cease operations with the graduation of this present class, the good it has wrought would endure through all time. It is impossible to estimate what its usefulness has been and will be. No one can measure the importance of a worthy aim earnestly followed. It is true of our school that, were its house to fall to-day, its mission would be found to have been to a great extent fulfilled, and the results would be commensurate with the outlay of time and study on the part of both pupils and instructors. Fortunately, the good reports I hear of your examinations, and the enthusiasm for the school on the part of those who have not yet enjoyed its advantages, convince me that it stands in no danger, that its work will go on uninterruptedly, and that its corner-stone was not laid in vain.

It was a proud moment in my life when the members of the first class in the training-school received their diplomas; a prouder when the second class graduated. It is the proudest now, when I stand before you as valedictorian of this class which I feebly assisted to instruct. Albeit, now one of the "has-beens," and identified with the school only as a, so to speak, *quasi-emeritus* instructor, I share your pride in your work. I am with you heart and soul, and would, if I could, assist you to assume the new

responsibilities which the reception of your diplomas carries with it.

There is a pump at the Baldwin Building which performs an important function. Steam, as you are aware, is supplied to the different direct and indirect radiators in the building for the purposes of heating. On cooling, the steam condenses and forms water, which is returned to the boilers both for purposes of economy in pumping, and because, being once deprived of its mineral ingredients by conversion into steam, it becomes distilled, and no longer forms deposits in the pipes and on the boiler-shells. In this, the old building, the radiators being higher than the boilers, water returns by gravity. At the Baldwin Building, on the contrary, the water is lower in the lower portion of the heating apparatus than in the boilers and must be forced back. The little pump has the work of forcing back this water, and operates as will be more intelligible to you by explanation of this black-board sketch.

Water falls from the radiators into this receiver, "A"; reaching a certain level, a float is acted upon, which in turn pushes up a lever, "B," which acts upon a valve, "C," in a high-pressure steam-pipe, opens it, and releases steam. The steam flies to the steam-chest of the pump, "D"; the pump-piston thereupon begins to travel, the suction, "E," to act, and the water in the receiver is lowered to this line. When this is accomplished, the valve "C" closes, and the pump ceases; but stands ready to resume opera-

tions the moment the normal water-level in the receiver is raised by pressure of the condensation from below. Over and over this proceeding takes place. I have watched this little pump again and again. I never go to the Baldwin Building without looking in upon the busy, contented, energetic, and determined little fellow. He looks almost human, his expression varying with the work he has in hand. If idle, he is alert, and always stands ready to catch up the broken thread. He has taught me some lessons, which it is my good pleasure to communicate to you.

First.—He never changes his position or swerves from a straight line. There he remains where placed: calm, unassuming, serene, and self-poised; but as determined as if the fate of the world depended upon the faithful performance of his work. With unerring stroke the piston travels back and forth, back and forth, never making a false motion.

How much time is lost by false motions and what a vast amount of work requires to be done over because not well done originally!

Do we remain where placed? Not always, I fear. Do we deviate from a straight line in our daily tasks? Sometimes we do, I am sure; but I am equally certain that much suffering, humiliation, and self-censure would be spared if our walk and conversation were always above reproach. Perhaps it is too much to expect of erring mortals that this shall be, but we can make a strong effort to emulate the example of the pump, align our conduct by

principles of rectitude, hold fast to that which is good, and abate naught of the written law which governs our relations with men, or of the Higher, which forms the mainspring of right-doing.

Lesson 2.—The pump does whatever called upon to do, and does it well. When there is water in the receiver above the proper level he does not rest until it is drawn out. The lives of men are fountains of good and evil. In certain states, when the mental balance is destroyed and the brake, which in health the will places upon vicious tendencies, refuses to operate, we may be the humble instruments of drawing from our patients the good, and developing it. A kind word, a generous act, a polite attention, the “soft answer” which “turneth away wrath,” are daily and hourly employed by the conscientious attendant to draw out and nourish the latent spark of good which disease has caused to remain dormant.

Using the words in another sense, we may draw out the evil which is within by directing the attention of the patient to things that are pure, and diverting misdirected energy into healthy channels.

We can do whatever called upon to do, which our physical and mental strength permits, even as the pump performs his mission.

Lesson 3.—The pump does not overdo. He does just enough, and no more. It is the judicious and far-seeing attendant, who, in his relations with his patient, knows just how far to go without antagonizing or arousing irritability and resistance.

Some of the best-meant efforts fail from overdoing. This is notably true of those which are attended by too much talking. Talk often tires. In conversation with one whose mental powers are weakened by disease, one should always remember the danger of overstimulation producing mental fatigue and confusion.

Lesson 4.—The pump never complains unless there is lack of oil, or unless some part of his machinery is out of condition. When there is lack of oil, or when any mechanical obstruction to his operation exists, he groans until his physician, the engineer, by some attention starts him right. Trifles do not annoy. It is only when quite seriously hampered that he fails to do his work properly. I doubt if he gives a thought to the Fenton Fair or Sunday-evening permissions, and if called upon to do extra work forges right ahead until all is accomplished that is blocked out. Let the engineer raise or depress the lever at this point, his speed decreases or increases in proportion to the amount of steam released by the valve. If hurried, he rises to the situation, and is never cross when called upon to accelerate his movements.

Lesson 5.—He does his whole duty. So long as there is a particle of water above the level in the receiver, he keeps at work. The self-satisfied man may flatter himself that he is doing his duty when attending to the great things of life. The pump does not ignore the little things. He works all the

time that is necessary, attending to the trifling details which pertain to his small sphere of action.

Life is made up of little things. Simple duties neglected, greater ones arise. Let the pump neglect his work for a time, there is clogging of the entire heating system of the building in which he presides. The experiences of life teach that it is better to take a few strokes with regularity—"to keep on sawing wood," as the expression goes—than to let work accumulate. The disadvantage under which one labors in the latter instance enhances the weight of the burden.

Lesson 6.—When the pump has nothing to do he rests perfectly. He is like the normal heart in this respect, which, between *diastole* and *systole*, is perfectly quiet, and receives in its walls the blood-supply necessary for its nourishment. Some people do not know how, and never can learn how, to rest. They carry their business with them constantly. At their reading, in their games, during their sleep, the spectre of some duty unperformed haunts and disturbs. This should not be the case. When off duty, let your aim be to rest as completely as possible; let there be perfect mental relaxation and physical change. Rest does not necessarily imply sleep or idleness, but change and diversion. This is physiological rest.

Lesson 7.—In normal conditions the pump does not make any noise. When there is a screw loose, or oil is lacking, or something is wrong with the

machinery, there is some commotion, but not otherwise. He performs his duties noiselessly, spends no time in getting ready to do, wastes no words about what he is planning, but quietly and determinedly carries out that purpose for which he was created. There is no assumption of arrogance in his demeanor, no blow and bluster, no fuss and feathers. He merely displays a quiet assertiveness and a fixed resolve, the effect of which latter is intensified by the unostentatious, unobtrusive manner behind it.

I think I have told you about "Charles," a special attendant who was here many years ago, and cared for a disturbed patient. Charles was not his name, but he had been thus affectionately dubbed by the gentleman for whose wants he was providing. "How do you get on with Charles," I asked the patient one evening after having during the day, myself unobserved, witnessed the relations of the two while out walking, noticed the self-contained manner of the attendant, and his judicious meeting of what might have proven a serious episode. "Very well," was the gentleman's reply, "very well, indeed. He has his own way usually. Charles is a very determined man, a man of very few words; but when he says come, you might as well come."

Be determined, but humble and always polite. Insistence against the will of another upon a course of action is robbed of its offensiveness if it is politely made. Do not say "come" unnecessarily. Be very careful never to take a position with a patient which

you cannot defend. Never threaten something which you could not do with proper regard for the welfare of the patient, and the institution whose reputation you have in your keeping.

When necessary to say "come" say it kindly. "I would if I were you," is an expression infinitely less repellant than "you must"; but even these unpleasant words may be deprived of offensiveness by a gentle apologetic manner in the speaker. Never say "you must" unless you are compelled to. If what you ask is not complied with, do not repeat the request, but gently and firmly enforce compliance with it.

Lesson 8.—The pump is small, but efficient. The matter of size, except it be size of brain-cells, is of less importance in your work than might be supposed. It is the tactful, the discreet, the judicious man, not necessarily the one of great physical strength, who best succeeds in the management of cases of mental disease. Great physical strength is desirable only if there is present with it that gentleness in its exercise which one of well-disciplined mind displays. There is danger if its possessor is led into the error of relying upon it to the neglect of those means of management which are the result of thought, good judgment, and careful study.

What to avoid do the lessons of the pump teach us.

First.—We have seen that he cannot remove obstacles to his operations and is helpless under mechanical difficulties. We, fortunately, in the exercise of our reason and judgment and volition, can

straighten the crooked path for ourselves, and cause obstructions to melt away like snow before the sun, if we but set about the task earnestly and hopefully. We cannot afford to be cast down by difficulties, or fold our hands and lament our misfortunes. We must rise superior to all these, ever remembering that the greater the difficulty, the greater the reward when overcome.

Second.—The pump cannot move if it would. We may change our positions. Let us be assured beyond a reasonable doubt, however, before making decisions, that benefit, socially and financially, will follow the change. Let not mere restlessness prompt it. Let well enough alone, as a rule, and, in every act of life, let good sense and reason act as a check upon feeling and impulsiveness.

Third.—The pump is a machine. In our relations with our patients we should aim to escape from being machine-like. While there are certain acts in our daily life which are better done in a routine fashion, in doing the little things for patients, which together constitute our general management, we must closely individualize cases. By introducing variety (not too much variety, but a little diversion and change) into the daily lives of patients, we are helping mental action, substituting new topics of thought, and widening the mental horizon. Aim to induce patients to do different things or the same thing in different ways. If a morbid tendency induces one to remain in the same position for hours at a time, interrupt

the current in some way. Present something new in exchange for the old. If a particular seat is selected in obedience to some habit of dementia, change the location of the chair, or furnish another surreptitiously. If your patient insists upon sitting in his room unoccupied, and absorbed in morbid thoughts, induce him to work, break up in some way the dry routine, and force, little by little, little by little (not too rapidly, lest he tire) some healthy concepts into his consciousness. The use of games should be general and frequent, and in patients who have no natural desire for amusements a taste should be cultivated. Be it ever so simple and childlike, occupation or amusement of some kind introduced into the patient's life will be of service to him.

In one way, however, we may become machine-like, to our own benefit and the good of the patient. The machinery of self-repression may be, by constant exercise, so delicately adjusted as to operate automatically, and inhibit (restrain) impulsive acts. Anger and loss of self-control may be thus held in check by the reflex exercise of nerve-centres well disciplined. We may follow the example of the pump even to becoming machine-like in this particular.

In conclusion, I enjoin upon you, members of this graduating class, a due appreciation of the responsibilities you take upon yourselves with the reception of these diplomas. Your relations with the asylum will be infinitely closer from this time forward than they have been in the past, your example, whether

for good or ill, incalculably stronger. You have in your keeping the good name of the institution as well as your own. May your works show that the new responsibility is well placed and well assumed. For good attendants my many years of experience has taught me to entertain the highest respect. They are a self-sacrificing, earnest, enthusiastic, and devoted body of men and women. Too often, I regret to say, their merits fail of due appreciation by the many who must necessarily be unfamiliar with their achievements, their self-denial, their discouragements. As one's best reward, however, comes from a consciousness of rectitude and honest effort, the attendant has, with his boundless opportunities for doing good, a source of satisfaction fully commensurate with his self-sacrifice.

May the class of '95 never fail in its duty! My sincerest wish is for the happiness, health, and prosperity of its members.

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