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CLIMACTERIC INSANITY.

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CLIMACTERIC INSANITY.

INSANITY occurring in women at the climacteric period, connected with, and dependent upon the physiological changes then taking place, has been noticed by most writers on female diseases as one of the gravest and most important of the morbid conditions which are incident to that time of life. Various psychological authors, as Esquirol, Conolly, Sir H. Halford, Laycock, and others, have also observed the frequency of insanity in women at that period, and have referred to the "change of life" as the exciting cause of a large proportion of those cases of insanity which are met with between forty and fifty years of age. I am not aware, however, that any special monograph has been devoted to the description of this class of cases; and as it forms a large and important natural group, I have thought that the history of a number of cases of climacteric insanity, with their symptoms, treatment, and results, might be of some interest and practical value as a contribution to psychological medicine. With this view I have carefully examined the case books, for eighteen years back, of the Royal Edinburgh Asylum, and having succeeded in collecting two hundred cases of climacteric insanity, I now proceed to a description of the results arrived at from a consideration of these cases.

Age.—Most writers are agreed in stating that the grand climacteric of female life takes place between 40 and 50 years of age. They also admit that there are many exceptions to this; that menstruation not unfrequently ceases before 40; and again, that the function may continue unimpaired up to 55 or 56 years of age. I have accordingly confined myself to cases of insanity occurring between 40 and 50 years of age, with the exception of a certain number of cases in which the insanity could be distinctly referred to climacteric changes taking place either before 40 or after 50.

The following table shows the age at which the insanity commenced in 200 cases:—

TABLE I.

Age.	Number of Cases.	Age.	Number of Cases.
38	2	Brought over	114
39	4	48	18
40	17	49	9
41	6	50	19
42	6	51	3
43	10	52	15
44	7	53	5
45	22	54	5
46	26	55	5
47	14	56	7
Carry over	114		200

It is seen from this, that the largest number of cases occurred between 44 and 51 years of age.

Symptoms.—Insanity occurring at the climacteric period generally manifests itself at first in the form of depression of spirits, sleeplessness, restlessness, and inattention to ordinary domestic affairs, followed by fear of undefined evil, with suspicion of the patient's most intimate friends and relations. From this the patients gradually pass into a state of profound melancholia, accompanied by various delusions, such as—that they have committed the unpardonable sin; that they are doomed to eternal punishment; that evil spirits constantly surround and haunt them; that their food can no longer nourish them; that they are unworthy to live any longer: they constantly express themselves as weary of life, and this, together with the conviction of their own unworthiness and wretchedness, leads to the development of one of the most dangerous, and at the same time one of the most prevalent of the symptoms of climacteric insanity, namely, suicidal tendency. In a great number of cases paroxysms of excitement alternate with the deep depression and gloomy despondency which are the general characteristics of this form of insanity. In several cases hallucinations of the senses occur, and, in a few, delusions of an exalted character also exist. Many are dangerous to others during the transient paroxysms of excitement, or in consequence of hallucinations of the senses; but distinct homicidal impulse is rarely developed. The bodily condition is commonly weak, although Dr Tilt and others describe an aggravated form of hysteria, amounting to insanity, as occurring at this period of life in connexion with a plethoric habit of body, and as dependent on an overplus of blood in the system. All those cases of insanity at the critical period which have come under my own observation, as well as those with whose history I have made myself acquainted, presented a marked asthenic type of disease; the patients were for the most part anæmic and emaciated. Apart from the delusion that their food could not nourish them, there was loss of appetite, frequently amounting to nausea at the appearance of food. The bowels were almost invariably constipated, the tongue dark and furred, the pulse thin

and easily compressible, the countenance pale, bloodless, and haggard. With regard to the condition of the catamenia, the records of the asylum were not such as to afford any information which could be thrown into a tabulated form. It appears, however, that in the great majority of cases the catamenia were extremely irregular at the time the insanity supervened, while in others the insanity developed itself a short time (two or three months) after their total cessation.

The following table shows the relative frequency of the mental symptoms above described:—

TABLE II.—SYMPTOMS.

Melancholia,	107
Suspicions,	63
Fear of undefined evil,	68
Fear of soul's loss,	46
Excited,	84
Suicidal,	68
Refusing food,	39
Dangerous to others,	28
Homicidal,	3
Exalted delusions,	4
Demonomania,	9
Hallucinations of hearing,	14
..... of vision,	3
..... of both these senses,	6
..... of smell,	2

I may here remark of the symptoms above enumerated, that although they are met with individually in other forms of insanity, their existence as *a group* is so peculiar and characteristic of the insanity I am here describing, that any one accustomed to observe them could, I think, almost with certainty pronounce any case to be one of climacteric mania, from the symptoms alone, irrespective of a knowledge of the patient's age and history.

Melancholia.—It is seen from Table II. that melancholia is the prevailing characteristic of this class of cases, and was present in 107 of the 200. Indeed, melancholia existed in almost all the cases at some time, either previous or subsequent to their admission, although those only who manifested this symptom on admission are placed in the table. The melancholia of climacteric insanity is somewhat peculiar, and differs materially from that which is met with in insanity occurring earlier in life, as at puberty, or in puerperal mania, and it has less of the demented type than that which is seen in phthisical mania. It is distinct also from that idiopathic melancholia which is met with in persons of the true melancholic temperament at various ages. In climacteric insanity this characteristic symptom generally first shows itself in the form of transient fits of depression of spirits, accompanied by a desire for solitude, a disinclination to perform the most ordinary and trifling domestic

duties, and a morbid sensitiveness and irritability quite at variance with the patient's natural disposition. It is somewhat curious to remark, that these "fits of low spirits," as the patient's friends call them, generally occur in the morning, and gradually pass off towards evening. The morbid sensitiveness and irritability shows itself in the way in which the patient magnifies the most trifling annoyances into grievous domestic afflictions, and regards slight disappointments as special visitations of Providence. They look upon all their friends who are not continually pitying and sympathizing with them, as treating them slightingly and with neglect, and yet the pity and sympathy of their friends almost invariably aggravate their disease, by ministering to a morbid craving. The patient begins to suffer much from sleeplessness, frequently passing the night lying awake, and brooding over fancied wrongs, sins, and misfortunes, and rises unrefreshed in the morning, to regard her domestic duties as a grievous burden, and to view all things through an atmosphere of gloom and despondency, which gradually becomes more and more permanent. At the same time, the patient's general health becomes affected, the appetite, at first capricious, becomes gradually more so, and is often entirely lost, and there is frequently nausea at the appearance, or even the idea of food; the patient, in consequence loses flesh, and has a worn, haggard look; the bowels are irregular, generally constipated; there is frequent headache and dizziness; the tongue is dark and furred; the breath offensive. In a great number of cases the patients have a great desire for, and are constantly taking, purgative medicine, which affords them no relief and almost invariably increases the general derangement of their health.

The above description applies to the commencement of the disease. As it progresses, the melancholia becomes either fixed and permanent, or alternates with periods of restlessness and excitement. At this stage a craving for stimulants frequently manifests itself, which, if not checked, is apt to lead to confirmed dipsomania, which latter disease is very often developed at the critical period in women. As the melancholia becomes more permanent, it is very frequently associated with the next symptom I notice, namely, suspicion.

Suspicion of Others.—It is seen by referring to Table II., that this symptom was present in 63, or nearly one-third of the 200 cases. This suspicion is generally first shown in the patient's regarding the want of extravagant expressions of sympathy in her friends not merely as indifference, but as an intentional slight and designed neglect; in fact, the first symptoms of suspicion are merely an aggravation of that morbid sensitiveness and irritability before noticed; but as this impression gains strength upon the mind, the patient becomes watchful of the words and looks of those around her, investing them with a meaning of grave import which they are far from possessing, and attributing artful and evil motives

to the most innocent and harmless actions. She fancies she is regarded as an encumbrance, that her relations are tired of her and anxious to get rid of her; and, as this suspicion deepens, she imagines they mix drugs and poison with her food, watch her at night and when she is alone for an opportunity to rid themselves of her for ever. This suspicion of poison is very common, and extends not only to her relatives, but to those under whose care she may be placed, and it is a cause, though by no means the most common one, of refusal of food. Suspicion of others, while it tends to deepen the melancholic condition, very often gives rise to paroxysms of excitement, during which the patient is dangerous to, and frequently threatens the lives of those whom she suspects of having designs upon her own. And not only does it strengthen any suicidal tendency which may already exist, but it is apt of itself to induce it, by giving rise to the impression on the mind of the patient that her life is an encumbrance, and that her death would be a relief to all. Suspicion is principally directed to the patient's nearest relatives, very frequently her children, and their efforts to remove it, generally clumsy and exaggerated, tend rather to confirm it; and I have frequently observed that patients continue to suspect their relatives long after they have ceased to entertain any suspicion of their medical attendants in an asylum.

Fear of Undefined Evil.—A very common and characteristic symptom of this form of insanity closely associated with the melancholia and suspicion above described, is fear of undefined and impending evil. This symptom was present in 67 of the 200 cases, or one-third. Its presence gives rise to a very peculiar expression of vague terror in the patient's face, accompanied by a shrinking, startled manner, sleeplessness, and restlessness. This terror sometimes takes such complete hold upon the patient, that she shrieks out and calls loudly for help, although unable to tell what she is afraid of, except that "she feels that something awful is going to happen." When interrogated as to the nature of the fear, the patient generally describes it as a "something hanging over her," "an impending doom,"—a catastrophe which may happen at any moment, the fear of which is ever before her. Fear of undefined evil is frequently associated with hallucinations of the senses, more particularly that of hearing. It is also often seen in connexion with, though perfectly distinct from, the next symptom I notice, viz.:—

Fear of the Soul's Loss.—This was present in 46, or nearly one-fourth of the 200. The most common way in which this delusion is expressed is in the patient's maintaining that "she has committed so many sins," and is so "utterly unworthy," that there is no hope for her either in this world or in the next. But besides entertaining this general opinion of their irremediable unworthiness, more than one-half of the above number expressed the distinct delusion that they had committed "the unpardonable sin," and on that

account were eternally lost. It is in those patients who exhibit this symptom, and who are constantly expressing the delusion of their eternal loss and consequent extreme misery, that the melancholia is most profound, and in whom the suicidal tendency is most common and most determined. This fear of the soul's loss is undoubtedly more commonly met with in this form of insanity than in any other, and marks well, I think, the distinction between the melancholia of climacteric insanity and that which is seen in phthisical mania, which, as described by Dr Clouston, consists in a general depression without any fixed delusions.[1]

Excitement.—Of the 200 cases, 84 are noted as labouring under excitement, which varied in degree,—in most cases being merely a temporary aggravation of the sleeplessness and restlessness, and in a very few amounting to acute mania. Excitement, although a very common, is by no means a very characteristic symptom of this form of insanity. It almost invariably, as before mentioned, shows itself in the form of brief and transient paroxysms, alternating with periods of deep melancholy and gloom. During these paroxysms the patient may be violent, threatening, and dangerous to others, or she may be moaning and raving incoherently about her fears, wringing her hands, and crying loudly for help. The first or dangerous form of excitement is the result of deeply-rooted suspicion that others are conspiring against her life and property, and is rarely accompanied by suicidal impulse. The last and most frequent form is caused by the intense fear of terrible evil, or the conviction of eternal ruin, and is very often accompanied by suicidal impulse; both forms are transient, lasting only a few hours, rarely more than a few days. In some cases the excitement recurs regularly at the menstrual period, and may do so for some time after the catamenia have ceased to appear; in others, the reappearance of the catamenia after these have been some time absent, is ushered in and accompanied by an attack of excitement. I have said that the excitement may amount to acute mania, and this, occurring in patients of weak and emaciated condition, not unfrequently causes death by exhaustion. Attacks of excitement sometimes occur in connexion with hallucinations of the senses.

Suicidal Tendency.—With the exception only of homicidal impulse, this is undoubtedly the gravest and most important symptom of any form of insanity, and it is manifested more frequently in climacteric insanity than in any other form, with the sole exception of puerperal mania. Of the 200 cases, 68 were suicidal, or one-third of the entire number. All of those 68 had meditated and threatened suicide: more than one-half of them had attempted it. Suicidal tendency is almost invariably associated with melancholia, fear of the soul's loss, and monomania of suspicion; and it is most determined and persistent in those who express the delusion of the soul's loss. But it may undoubtedly exist without any of those

[1] See Journal of Mental Science, No. 45, April 1863.

symptoms, and it is sometimes seen thus in connexion with and apparently dependent upon demonomania, or it may be seen with hallucinations of hearing alone. In not a few cases the manifestation of suicidal tendency was the cause of the patients being placed in an asylum, that being looked upon by their relatives as the first unmistakable proof of insanity. Suicidal tendency has two specially marked and well-known characteristics, which demand the most careful watching,—the one is the fact, that the accidental presence of the means of committing suicide, as a knife, a razor, or a rope, will at once give rise to the impulse in patients who would not take deliberate measures to procure those means, which impulse may arise instantaneously; the other is the no less fully ascertained fact, that suicidal tendency may continue to exist, carefully masked and concealed, long after the other symptoms of insanity which accompanied it seem to have disappeared. By this I mean that the delusions of the soul's loss, suspicion of relatives, etc., still remain, and nourish, as it were, the suicidal tendency, but that the patient ceases to express them, because she perceives that so long as she continues to do so, she is carefully watched and prevented from effecting her purpose. These delusions, although the patient no longer talks of them, are very frequently expressed in her *letters*. Concealed suicidal tendency, with apparent abandonment of the delusions with which it is associated, sometimes has the effect of inducing the patient's friends to remove her from the asylum, under the idea that she is recovered, and contrary to the remonstrances of the physician; and not unfrequently the consequence is that she takes an early opportunity of carrying out her concealed but fixed purpose, to their very great surprise and distress.

It would be quite out of place here to describe the various modes by which suicidal patients have attempted to destroy themselves, although some of them are curious enough, as showing how persistent and determined the impulse may be. Starvation, hanging, drowning, cut-throat, precipitation, are the most common; but the patient will sometimes employ the most *outré* methods of putting an end to herself, as swallowing her garters, or pieces of blankets, or she will attempt to strangle herself with her hands, dash her head against the walls, or plunge it in water, and keep it submerged with a determined persistency hardly conceivable. In one case transferred to Morningside from the Crichton Institution, the patient, as described by Dr Browne, had shown peculiar ingenuity in attempting to effect her purpose. Having accidentally discovered that she was receiving calomel, and believing that it was dangerous under such circumstances to be exposed to cold, she managed to fill her shoes with water, and sit with them on, in the hope of inducing fatal illness. Very frequently suicidal patients persistently refuse all food; but as this is also often the case with those who cannot exactly be called suicidal, inasmuch as they would not take direct means to destroy themselves, and as it is often seen in con-

nexion with delusions and suspicions in those who are not suicidal at all, I notice it separately.

Refusal of Food was met with in 39, or nearly one-fifth of the 200. In those who refuse food as an indirect means of committing suicide, the patient suddenly expresses her determination not to eat anything more, and it is rarely that any amount of persuasion can induce her to alter that determination. Hunger in these cases seems not to be felt at all, or if felt, its cravings are disregarded or subdued with incredible perseverance, as food may be left for days untouched beside the patient. But refusal of food may arise from suspicion; in which case the patient at first shows much caprice in her appetite, taking a violent dislike to certain articles of food, saying they produce extraordinary effects, as burning pains, giddiness, faintness, and the like. She will then say her food and drink are tampered with, and finally refuse it entirely, declaring it is poisoned. Sometimes delusions are the sole cause of refusal of food, the patient saying her "inside is gone, and that food cannot nourish her;" or that food "makes her swell up enormously;" or that "noxious vapours arise from her food and ascend to her brain." In almost all cases refusal of food is only to be overcome by feeding with the stomach-pump; but even when this is used, the patient, if determined and persistent, will contract the habit of vomiting everything that is given her unless carefully watched. Refusal of food is undoubtedly one of the most troublesome and perplexing of the symptoms of this disease; for, although it frequently happens that a patient only requires to be fed once or twice with the stomach-pump to induce her to eat voluntarily, it is sometimes the case that a patient will rather submit to all the disagreeable annoyance of being so fed, than forego her resolution and take food of her own accord. And when this obstinate refusal of food is long continued, the patient gradually becomes weaker and more emaciated, and must eventually die of inanition, notwithstanding that the most concentrated forms of nourishment, together with stimulants, may be given her by the stomach-pump; as it is well known that food taken involuntarily, although it may support life for a time, is not properly assimilated, and fails to afford sufficient nourishment to maintain the vital powers for any great length of time. This remark does not apply to those rare cases of catalepsy, where patients may be fed for many months, and the body continue to be well nourished, for in these last there is no direct effort of the will exerted against the reception of food.

Dangerous to Others.—Of the 200 cases, 28 were either stated in the description of their symptoms previous to admission to be dangerous to others, or were subsequently found to be so. Those patients who threaten or attack others generally do so during the transient paroxysms of excitement produced by monomania of suspicion, and as the suspicion is, as we have seen, principally directed against the patient's relatives, such cases rarely prove dangerous in an asylum.

But there are cases in which patients are dangerous, not as the result of suspicion, but in consequence of their being subject to hallucinations of hearing, or demonomania. When violence is the result of these last, it is a far more serious symptom than in the former case, inasmuch as being dependent on hallucinations or delusions at all times present, the impulse to commit violence may arise at any moment, without any general excitement to act as a warning; and a patient not described or supposed to be at all dangerous, may thus violently attack those near her, from a fancied supernatural instigation or command. Of the 28 who were dangerous to others, 3 only manifested *homicidal impulse*. In two of these the patients signified their deliberate intention to destroy their children. Both of these patients became demented. The other was the case of a woman who had frequently threatened and once attempted to kill her sister. This patient died in the asylum from exhaustion, after prolonged maniacal excitement.

Exalted Delusions.—I have before stated that delusions of an exalted kind are very rare in this form of insanity. Of the 200 cases 4 only had any such delusions; in these 4 instances the patients expressed the delusion that they were possessed of vast wealth, power, or occupied a very distinguished position in society; the delusions in these cases resembled those of general paralysis with this exception, that in none of the above cases did the patients manifest that propensity to hoard up rubbish, as stones, pieces of glass, iron, etc., regarding them as articles of immense value, as is so commonly seen in general paralytics.

Demonomania.—In 9 of the 200 cases the patients were demonomaniacs, or believed that they were possessed by an evil spirit or spirits, and were thus instigated to commit various acts against their will. Such patients I have said are frequently dangerous, but more frequently still the idea that they are possessed seems to add intensity to that vague terror before described, and is often the cause of a most determined suicidal tendency. I may here remark that nearly all the cases of demonomania recorded by Esquirol were those of women at the change of life.[1]

Hallucinations of Hearing.—It has been stated that persistent hallucinations of hearing generally indicate deep seated disease of the brain, that the insanity associated with such hallucinations is incurable or nearly so, and they are consequently apt to be regarded as a very grave and serious symptom. There can be no doubt that hallucinations often exist with hopeless and incurable forms of insanity; but that they do not of themselves give any evidence of serious brain disease is apparent, I think, from the fact that of the 14 mentioned in Table II., who had persistent hallucinations of hearing, 7 recovered, and only one died, the recoveries being in the ratio of 50 per cent., which is very nearly equal to the percentage of recoveries in those who had no such hallucinations. In cases of

[1] De Maladies Mentales, tome i. p. 490.

hallucinations of hearing, the patient generally declares that she hears a voice or voices speaking to her at certain times, most frequently at night: sometimes she will stand for an hour or more at the door of her room, with her ear at the keyhole, answering imaginary questions. In other cases the patient, while working or at meals, will suddenly pause in an attitude of attention, and listen to fancied remarks or injunctions.

Hallucinations of both Senses (*Hearing and Vision*) were present in 6 cases, of whom 4 recovered, 1 died, and 1 was removed unimproved.

Hallucinations of Vision alone existed in 3 cases, of whom 2 recovered and 1 died. And hallucinations of the sense of *smell alone* were present in 2 cases, of whom 1 recovered and 1 died. Two of the patients described their hallucinations of vision as a vapour which rose up suddenly before them, taking no very definite form, but appearing all at once on their opening a door, a box, or a drawer, remaining stationary before them for a few seconds, and suddenly vanishing. In the other cases, the patients declared that the deity in bodily shape appeared to them, as also the apostles. In the two cases in which there were hallucinations of the sense of smell, one of the patients said that her food, clothes, and the air of certain rooms smelt strongly of brimstone; the other declared that every one who came near her had an overpoweringly disagreeable smell, and she constantly held her nose when approached or spoken to.

Results.—I now come to consider the results of the 200 cases, which are as follows:—

TABLE III.

Of 200,	. .	104 recovered.
"	. .	44 became demented.
"	. .	24 removed improved.
"	. .	22 died.
"	. .	3 removed unimproved.
"	. .	3 convalescent.
		200

From this it is seen that the recoveries took place in the ratio of 52 per cent.; or ~~53·5~~ 56 per cent. if we include the three convalescent cases. This, I may remark, is higher than the percentage of recoveries from melancholia in general, which is stated to be only 27 per cent. by Haslam, although Dr Tuke found it as high as 54·88 at the Retreat. But it is the most aggravated cases only which reach an asylum; many are treated successfully at home; and I have no doubt that if such cases could be included here, the average would be found to be nearly as high as it is in puerperal mania, the most curable of all forms of insanity.

The following table shows the duration of the disease in those who recovered:—

TABLE IV.

	Number of Cases.
Under 6 weeks,	9
... 2 months,	10
... 4 ...	28
... 6 ...	20
... 8 ...	15
... 10 ...	8
... 12 ...	2
... 18 ..	8
... 2 years,	4
Total,	104

Duration.—It is seen from this that the duration of the disease was only four months in the largest number of recoveries, which is a most important point in favour of the curability of this form of insanity, it being undoubtedly true, as pointed out by Brierre de Boismont, that the more quickly any form of insanity can be cured, the less danger is there of any impairment of the mental faculties remaining. 44 of the 200 cases, after their disease had continued in a chronic form for a year or more, during which there were occasional attacks of excitement more or less maniacal, gradually passed into a state of hopeless dementia. 24 of the 200 were removed by their friends improved. Of these, as ~~some~~ of them were brought back, it is reasonable to conclude that at least the majority ultimately recovered, which would raise the percentage of recoveries very considerably.

Deaths.—Of the 200 cases 22 died in the asylum during the period of eighteen years, over which this investigation extends, thus giving a mortality of 1·22 per annum, or ·61 per cent. per annum. This rate of mortality is so very low as to demonstrate, that, apart from suicidal tendency, organic disease, or other morbid complications, this form of insanity has but little tendency to a fatal termination. The causes of death were as follows:—

TABLE V.

Exhaustion from prolonged excitement, or obstinate refusal of food,	5
Phthisis pulmonalis,	5
Cardiac disease,	3
Diarrhœa,	3
Dysentery,	2
Pleurisy,	2
Bursting of bronchial abscess,	1
Cancer of uterus,	1
Total,	22

In those 5 cases only in which death took place in consequence of exhaustion from prolonged excitement or obstinate persistence in refusal of food, can insanity be regarded as the direct cause of death.

The 5 who died from phthisis all manifested the symptoms of that disease on admission, and there was every reason to believe that the phthisis had existed before the insanity, which, in its general character, symptoms, and duration, differed markedly from phthisical mania, properly so called.

It may be said generally of the other diseases which were the immediate cause of death, that they all presented the asthenic type which is characteristic of this form of insanity.

Treatment.—The means of treatment which are indicated by the symptoms and general character of this form of insanity, and which appears to me most likely to be successful, are as follow:—

1*st*, The immediate removal of the patient from home, and from the scenes and associations in connexion with which the disease was first developed, and the separation from the society of relations and friends who, in their mistaken kindness, minister to a morbid craving for sympathy, or endeavour to combat delusions and remove suspicions in a manner which, however well-intentioned, rarely, if ever, does any good, and very frequently tends to aggravate the disease. I do not wish it to be inferred from this that the patient should forthwith be placed in an asylum. On the contrary, as I have before stated, many cases may be, and undoubtedly are, treated out of asylums successfully; and there can be no doubt whatever that in this form of insanity, more perhaps than in any other, there are a large number of cases where there is no suicidal tendency, refusal of food, or monomania of suspicion, and where the excitement is merely an aggravated form of restlessness that, if placed early under proper treatment would recover without the necessity for seclusion in an asylum at all; but I repeat, that in all cases, change of scene and removal from the influence of misdirected sympathy is absolutely necessary.

2*d*, One of the most important means of treatment consists in placing the patient under a regulated system of moral discipline and control, by providing occupation, amusement, and exercise at regular hours.

3*d*, Good nourishing diet, together, in many cases, with a regulated amount of stimulants, is of the utmost importance as a means of treatment, the more so as in the majority of cases there is great caprice in the appetite, and in many a desire to abstain from food entirely. In regard to the use of stimulants in such cases, I think they can only be prescribed with propriety when the patient's regimen is entirely within the control of the physician and her attendants, as the temporary relief which they produce is very apt to lead to undue indulgence on the part of the patient if left to her own discretion. As before stated, the obstinate and persistent re-

fusal of food is only to be met with by using the stomach-pump, and in most cases it only requires to be used two or three times to convince the patient of the necessity of submitting to control.

4th, We have seen that the general health is commonly much deranged, the bowels frequently obstinately constipated, and the patient very often in the habit of taking large doses of purgative medicine, whereby the natural action of the bowels is destroyed. This requires tonics, gentle laxatives, and exercise.

5th, Narcotics form one of the most efficient means of alleviating and curing this form of insanity. It is somewhat difficult to lay down general rules for their administration. In some cases they obviously aggravate the restlessness and excitement, in others they act apparently like a perfect charm in procuring sleep, and allaying nervous irritation and despondency without interfering with the general health. The cases most suitable for this method of treatment appear to me to be those chiefly which are characterized by a general feebleness of the circulation, and a well-marked anæmic state of the system. In some such cases I have seen large doses, such as two drachms of the solution of the muriate of morphia, given nightly for a lengthened period, attended with the most beneficial effects and without any disturbance of the general health. The exhibition of such powerful doses must always be continued under the strict supervision of the medical attendant, and they must be carefully diminished and gradually withdrawn by him before the patient is left to her own control. In many cases where morphia seemed to disagree with the patient, other narcotics were used with advantage, such, for example, as the tincture of hyoscyamus and tincture of cannabis indica. These medicines require to be used in larger doses than in ordinary practice to produce the desired results, but the requisite dose can only be arrived at by a gradual increase from the ordinary medicinal dose up to that by means of which the desired object of natural repose is attained.

6th, The other indications of treatment consist simply in the removal of all local causes of irritation by the cure of local disease, and the re-establishment of the general health in accordance with the recognised code of therapeutics.

The principal conclusions to be drawn from the foregoing description of this disease are:—

1st, That the symptoms of insanity occurring at the climacteric period in women are so uniform, characteristic, and peculiar as to render it easily recognisable, and entitle it to be referred to a distinct natural group or family, which may be distinguished as climacteric mania or insanity.

2d, That this is one of the most curable forms of insanity accompanied by melancholia.

3d, That the duration of the insanity in curable cases rarely exceeds from three to six months.

4th, That this form of insanity, apart from suicide and organic disease, rarely tends to a fatal termination.

5th, That the most important indications of treatment are, the early removal from associations and friends; careful watching; nutritious diet; and the judicious administration of narcotics.

In conclusion, it has been pointed out by Sir Henry Halford and also by Dr Conolly, that a climacteric period occurs in the male between the ages of 50 and 60, during which insanity is frequently developed. I will only here add that I have seen many such cases, and I am satisfied that it presents in the male the same characteristic group of symptoms as it does in the female; but I shall reserve the consideration of this subject for some future opportunity.

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