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STATISTICS OF INSANITY.

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EMBRACING A REPORT OF

BETHLEM HOSPITAL,

FROM 1846 TO 1860, INCLUSIVE,

STATISTICS OF INSANITY.

BY

W. CHARLES HOOD, M.D.

RESIDENT PHYSICIAN OF BETHLEM HOSPITAL.

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LONDON: DAVID BATES, PRINTER AND PUBLISHER.

1862.

College of Surgeons
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ERRATA.

The asterisk at Tables V., VI., VII., XI., XIV., should be affixed to the word "Discharged;" at Table XII. to the word "Admitted;" and refers in each case to the blank columns.

In the following pages an endeavour has been made to increase the value of the Statistical Tables and Decennial Report presented to the Governors of Bethlem Hospital in the year 1855, by adding similar Tables for the past five years, thus making the present record to extend over a period of fifteen years. Sensible how much the last Report was capable of improvement, the whole has been carefully revised, and while a hope is encouraged that the additional matter will increase its value, it is anticipated that many errors and omissions have

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The Tables are on the plan proposed in 1855, since which date the form then advocated has been adopted in each Annual Report, and the greater utility of such Statistical Tables has been evident since the alteration in their construction was commenced.

We still hope that the day is not far distant when a uniform plan throughout the County Asylums may be recommended by the Commissioners in Lunacy, and carried into execution by the Committees of Management, and thus, information at present scattered, vague, and consequently unsatisfactory, may, by its uniformity, be capable of compilation, and assist in forming our diagnosis, prognosis, and many valuable, because practical, lessons, for our treatment of the Insane.

In making the Returns, care must be taken to separate Idiots, Imbeciles, and Cretins; for belonging, as they do, to a class proper to themselves, they should not be confounded with cases of ordinary insanity.

This error has given rise to many discrepancies, since in some Reports they are calculated as one class of Lunatics, while in another they are altogether excluded. In France, according to one arrangement, the number of Insane is stated to be 18,350, or 1 in 1,900; in another Report the number is computed to be upwards of 30,000.

It is now proposed to consider the statistical history of those Patients admitted into Bethlem Hospital, presumed to be curable, during the fifteen years ending December, 1860, by noticing in succession the following subjects:—

Chapter.

1. Patients admitted as Curable (Tables I., I *a.*,
and I *b.*)
2. Age (Tables II. and II *a.*)
3. Sex.
4. Domestic Condition (Tables III. and III *a.*)
5. Social Condition (Tables IV. and IV *a.*)
6. Education (Tables V. and V *a.*)
7. Religion (Tables VI. and VI *a.*)
8. Residence (Tables VII. and VII *a.*)
9. Apparent and Assigned Causes, (Tables VIII.,
VIII *a.*, VIII *b.*, and VIII *c.*)
10. Duration of Disease before Admission (Tables
IX. and IX *a.*)
11. Number of previous Attacks (Tables X. and
X *a.*)
12. Influence of the Season (Tables XI. and
XI *a.*)
13. State of the General Health of the Insane
(Tables XII. and XII *a.*)
14. Form of Insanity (Tables XIII., XIII *a.*,
XIV., and XIV *a.*)
15. Causes of Death and Post-mortem Appear-
ances of the Insane (Tables XV. and
XV *a.*)
16. Treatment of Insanity (Tables XVI., XVII.,
and XVIII.)

CHAPTER I.

TABLE I.

PATIENTS ADMITTED AS CURABLE,

From 1846 to 1860 inclusive.

	Admitted.				Discharged.											
					Cured.				Uncured.				Died.			
	M.	F.	T.		M.	F.	T.	PR. CT.	M.	F.	T.	PR. CT.	M.	F.	T.	PR. CT.
1846	125	168	293		66	95	161	54.95	—	—	—	—	3	7	10	3.41
1847	124	190	314		68	107	175	55.73	—	—	—	—	3	9	12	3.82
1848	118	188	306		74	82	156	50.98	—	—	—	—	2	9	11	3.59
1849	124	192	316		66	106	172	54.43	—	—	—	—	6	12	18	5.69
1850	135	209	344		74	123	197	57.26	—	—	—	—	20	11	31	9.01
1851	112	174	286		51	69	120	42.3	—	—	—	—	9	17	26	9.09
1852	101	167	268		49	94	143	53.35	—	—	—	—	15	12	27	10.07
1853	72	128	200		38	75	113	56.5	—	—	—	—	9	7	16	8.00
1854	77	110	187		40	70	110	59.35	—	—	—	—	4	7	11	5.87
1855	78	137	215		48	84	132	61.68	—	—	—	—	5	7	12	5.60
1856	61	110	171		41	70	111	64.91	31	47	78	45.61	3	3	6	3.50
1857	82	127	209		46	69	115	55.02	22	38	60	28.70	4	6	10	4.78
1858	68	142	210		33	79	112	53.33	16	42	58	27.61	7	5	12	5.71
1859	58	100	158		38	60	98	62.02	27	55	82	51.08	7	3	10	6.32
1860	75	116	191		41	62	103	52.02	20	32	52	26.72	5	5	10	5.05
	1410	2258	3668		773	1245	2018	55.01	116	214	330	35.14	102	120	222	6.05

TABLE 1a.
PATIENTS ADMITTED AS CURABLE,
From 1856 to 1860 inclusive.

	Admitted.			Discharged.											
				Cured.				Uncured.				Died.			
	M.	F.	T.	M.	F.	T.	PR. CT.	M.	F.	T.	PR. CT.	M.	F.	T.	PR. CT.
1856	61	110	171	41	70	111	64.91	31	47	78	45.61	3	3	6	3.50
1857	82	127	209	46	69	115	55.02	22	38	60	28.70	4	6	10	4.78
1858	68	142	210	33	79	112	53.33	16	42	58	27.61	7	5	12	5.71
1859	58	100	158	38	60	98	62.02	27	55	82	51.08	7	3	10	6.32
1860	75	116	191	41	62	103	52.02	20	32	52	26.72	5	5	10	5.05
	344	595	939	199	340	539	57.40	116	214	330	35.35	26	22	48	5.11

TABLE 1b.
Aggregate of the 100 years ending 31st December, 1860.

Admitted.	Cured.	Per cent.	Died.	Per cent.
19,649	8,539	43.45	1,481	7.53

The numbers of recoveries and deaths have varied greatly in different Lunatic Asylums, and it is not an easy task to procure a correct standard of comparison. We may obtain an approximate idea by the following table, taken from an excellent paper by Dr. Tuke, the Assistant Medical Officer in the York Retreat (*Psychological Journal*, July 1854, p. 466,) entitled "A Table which exhibits the Comparative Statistics of various Asylums in Great Britain, Holland, France, Germany, and Austria."

Name and Description of Asylum.	Remaining under care 1st Jan. 1854.	Numbers admitted.	Numbers recovered.	Numbers died.	Proportion of recoveries per cent. of admissions.	Mean Annual mortality per cent. of those resident.
Average of eleven Dutch Asylums for Pauper and private Patients	837	3087	1000	1125	32.40	14. 5
Average of nine English County Asylums receiving paupers only	3273	15548	5746	4551	36.95	13.88
Average of six English County Asylums receiving private and pauper patients	1127	7738	3627	1256	46.87	10.46
Average of Metropolitan Licensed Houses, 1839—43, (more than half paupers)	1827	5850	1501	1209	25.65	14.68
The York Asylum (one-third paupers) 1814—44	157	1375	475	297	34.54	7.24
The York Retreat 1796—1847	84	593	292	141	49.24	4.74
Average of seven Scotch Chartered Asylums (more than half paupers)	1324	7130	3021	931	42.37	7.52
Average of Ten Irish Asylums (pauper)	2147	10255	4957	1891	48.33	8. 7
Average of five American Asylums (private and pauper)	640	8675	4062	688	46.82	9.56
Charenton (private patients) 1826—1833	..	1557	518	546	33.26	14.96
Siegburg, 1825—40, (only curable patients)	..	1129	347	161	30.73	7. 4

The mean of these figures will give 39.74 per cent. of recoveries upon the numbers admitted, and

10 per cent. of deaths on the numbers resident. The greatest number of recoveries, and the fewest deaths, are at the York Retreat, the recoveries ranging as high as 49.24 per cent., and the deaths as low as 4.74 per cent. The lowest number of recoveries, and the highest number of deaths, (except at Charenton, where the deaths were a trifle higher,) are in the Metropolitan Licensed Houses, the recoveries being 25.65 per cent., and the deaths 14.68 per cent. It must be remembered, however, that the statistics in the table do not extend to the present day, and that the result would be very much more satisfactory if they did. The statistics of Charenton are not more recent than 1833, and those of the Metropolitan Licensed Houses only reach to 1843.

The experience of Bethlem Hospital is, in many respects, very interesting. On the authority of Stowe, who derived his information from Dr. Tyson, the Physician to the Hospital at that time, 1,294 patients were admitted between the years 1684 and 1703; and of these, 890, or about 2 in 3, were cured; but between the years 1784 and 1794, when 1,664 patients were admitted, the number of recoveries was 574, or only a little more than 1 in 3. We next learn from a report which Dr. Prichard obtained from Mr. Lawrence, (*A Treatise on Insanity*, 1835, p. 141,) that the number of recoveries increased after the Hospital was removed to its present site. This record extends from 1819 to

1833. During this period 2,445 patients were admitted; and 1,124, or 1 in a little more than 2, were discharged cured.

In referring to the recoveries in Bethlem Hospital, and comparing them with those occurring elsewhere, it is necessary to bear in mind the particular rules of the Institution, peculiar to it and St. Luke's. These regulations render ineligible all applicants who have been insane for more than twelve months; all who are afflicted with paralysis, epilepsy, or any other form of convulsive disease; all who have been discharged uncured from other Hospitals; and all aged and weak persons, and pregnant women. In addition to which, those who have not recovered at the expiration of a year after admission, are dismissed.* Rules so stringent must have considerable influence upon the number of recoveries and deaths; and it is useful to enquire what that effect is. It might be supposed that the number of recoveries ought to be increased by discarding unsatisfactory and hopeless cases; but on the other hand, many additional recoveries would undoubtedly be recorded, if the uncured patients were not discharged at the end of twelve months; the effect, therefore, of the

* Although the Rules of the Hospital limit the period of residence for Patients on the Curable Establishment to one year, the Sub-Committee have the power of extending, on the recommendation of the Resident Physician, that time to fifteen or eighteen months, if the character of the complaint justifies the hope of recovery or improvement; and the Committee so thoroughly recognize this advantage, that very few Patients are discharged "Uncured" who have not had the benefit of such extension.

rules of this Hospital upon these statistics is not made evident. That many patients would recover if they were allowed to remain in the Hospital for a longer time than twelve months is manifest, and that this is so, may at once be shewn by a table which gives the experience of the Salpêtrière, under Esquirol, for a period of ten years. (*Mental Maladies* 1845, p. 61.)

NUMBERS.	YEARS.											TOTALS.
Admitted.	1804	1805	1806	1807	1808	1809	1810	1811	1812	1813	1814	
209	64	47	7	4	3	2	0	1	1	0	0	129
212		73	54	4	2	2	1	0	0	0	1	137
206			78	49	10	3	1	1	1	0	0	143
204				60	55	11	1	0	2	0	0	129
188					64	57	4	2	1	0	2	130
209						48	64	9	4	1	3	129
190							48	51	7	1	3	110
163								44	30	8	3	85
208									75	41	11	127
216										50	49	99
2005												1218

Of these 2005 patients, who agreed in nothing except in being cases which were presumed to be curable, 604 recovered during the first year, 497 in the second year, 71 in the third, and 46 during the seven succeeding years. The numbers cured in the second year as compared with those in the first

year, are nearly as 5 to 6; sometimes even more patients in the second year than in the first; thus, in 1809, 209 patients were admitted, and of these 48 were cured in the first year, and 64 in the second year; and again in 1810, when 190 patients were admitted, 48 were cured in the first year, and 51 in the second. Such being the case, it is at once apparent that the number of recoveries must be greatly affected by a rule which limits the time for recovery to a single year.

It is not easy to estimate how much the Hospital gains in the number of recoveries from the rules which exclude cases presumed to be incurable; but we learn from Esquirol that 795 incurable cases, or cases considered incurable, were admitted, between 1804 and 1813, into the Salpêtrière, which is open to all classes of patients; and that, during the same period, (as appears in the preceding table,) 2,005 patients were admitted as curable, of whom 1,218 were cured. Of these 1,218 patients, 604 were cured in the first year, and 614 in subsequent years. In order, therefore, to arrive at any conclusion as to the influence of the rules of this Institution upon the number of recoveries, it is necessary to compare the number of cases which are not affected by the rule which limits the time of residence to one year, with the number of incurable or doubtful cases which, by other rules, are excluded. These, taking the experience of the Salpêtrière as a basis of calculation, will bear the

proportion of 614 to 795 ; hence it appears, that the increased chances of recovery, by extending the time of residence, are not quite equal to the number of doubtful or incurable cases, which are excluded by the rules. The number of recoveries in Bethlem is, therefore, somewhat augmented by the present regulations.

This is the conclusion to which we should arrive by the Report from 1819 to 1833, which was supplied to Dr. Prichard by Mr. Lawrence, (*Op. cit.*, p. 141).

Remain- ing from	Admis- sion.	DISCHARGED.				Died.	Remain- ing.
		Cured.	Uncured.	By request of Friends	Improper objects.		
1819	81						
1820	124	60	33	11	22	4	
1821	135	43	36	7	28	6	
1822	165	66	43	5	27	11	
1823	145	72	49	4	19	5	
1824	155	59	55	5	31	6	
1825	170	70	48	7	29	12	
1826	162	70	63	6	24	6	
1827	149	64	41	2	15	9	
1828	204	111	48	6	34	6	
1829	195	126	42	2	29	10	
1830	201	110	45	4	30	6	
1831	212	98	55	5	41	6	
1832	163	92	41	2	35	5	
1833	184	83	44	4	21	7	124
	2445	1124	643	70	385	99	124

Here were 385 improper cases in 2,445 admissions, consequently the number of proper admissions was 2,060, *viz.*, 2,445—385. Of these 2,060 cases, 1,124 were cured within the first year, and 643 were discharged uncured at the end of that time. Thus the comparison is between the 385 discharged as improper cases, and the 643 discharged uncured; and in order to arrive at a just conclusion, it is necessary to enquire, how many of those discharged uncured would have been cured if they had remained longer in the hospital? Now in the experience of the Salpêtrière, already referred to, the proportion of the cured to the uncured, in the patients remaining after the end of the first year, is as 614 to 787; hence it follows, if the same proportion holds good in the two cases, that 281 of the 643 cases under consideration would have been cured if they had remained longer in the hospital, and that 362 would not have been cured; a proportion which still shows that the number of recoveries in Bethlem is somewhat increased by the present rules of the institution: for the 281 recoveries, which were not effected for want of sufficient time, must be considered as more than counter-balanced by the 385 incurable cases which were rejected.*

* It is to be remembered, that this number of 385 incurable cases would have been considerably larger if the Hospital had been, like the Salpêtrière, open to all classes of patients.

It is very doubtful, however, whether this conclusion is perfectly accurate, and there is some reason to believe that Bethlem Hospital may in reality be not so much the gainer in the matter of recoveries. There is ground for this supposition, inasmuch as the recoveries after the first year appear to be under-rated rather than over-rated. This may be gathered from the experience of the Retreat, at York, which is, that nearly 50 per cent. of the entire number of recoveries occur after the first year of residence. (*Dr. Thurnam's Statistics of Insanity*, p. 61.)

At all events, there is no doubt that the rule which limits the time of recovery, must operate unfavorably with regard to the interests of some of the patients now discharged uncured, a considerable number of whom might possibly have recovered, if an *indefinite* time of residence in the Hospital had been allowed them.

We have not the same opportunity of estimating the relative number of deaths. The mean annual mortality in English public Asylums, from their first establishment, up to about fifteen years ago, exclusive of Bethlem and St. Luke's, was estimated by Dr. Thurnam at 11.86 per cent.: *viz.*, "that of county Asylums for only paupers 13.85 per cent.; that of county Asylums receiving both private and pauper patients, 10.46 per cent.; that of Asylums for patients of different classes, supported wholly

or in part by charitable contributions, 8.93 per cent. The mortality of seven Scotch Asylums has been 7.52 per cent.; and that of ten Irish District Asylums, during the comparatively short time they have been established, 8.7 per cent. Extended enquiry and consideration appear to justify our concluding, that taking as a basis for computation considerable periods of time, during which there have been no extraordinary disturbing circumstances in operation, a mortality in a mixed County Asylum, or in one for the middle and opulent classes, as well as paupers, which exceeds 9 or 10 per cent. is usually to be considered as unfavorable, and one which is less than 7 per cent. as the reverse. In regard to Pauper Asylums, we may conclude, under similar limitations, that a mortality which exceeds 12 and 13 per cent. is unfavorable, and one which is much less than 10 per cent. is favorable." (*Op. cit.*, p. 137, 138.)

Here the rules of Bethlem must influence the number of deaths, and in this case the effect is of an unfavorable nature; for more patients die in the earlier than in the later stages of the malady, when the disease has become chronic. This is seen in a decennial report of the Salpêtrière, as drawn up by Esquirol, thus:—

Annual Number of Admissions.	Years.										Totals.
	1804	1805	1806	1807	1808	1809	1810	1811	1812	1813	
271	46	21	15	8	1	6	2	1	1	1	102
301		48	29	16	7	2	4	1	0	2	109
292			49	22	9	2	1	4	2	1	90
297				64	25	3	2	2	4	1	101
252					35	23	8	1	3	1	71
299						35	31	7	3	1	77
260							30	22	9	3	64
233								26	20	9	55
301									23	10	33
298										26	26
2804											728

With these remarks we can in some measure appreciate the experience of the five years, which is contained in Table I. *a.*; and the conclusion must be satisfactory, when we find the recoveries recorded as 57.40 per cent., and the deaths so low as 5.11; and there is reason for congratulation in the fact, that the aggregate experience of the 100 years, ending the 31st December, 1860, represents the cures as 43.45 per cent., and the deaths as 7.53 per cent. We shall advert to particulars in another chapter.

CHAPTER II.

TABLE II.

THE AGES OF PATIENTS ADMITTED AS CURABLE.

From 1846 to 1860 inclusive.

Ages.		Admitted.			Discharged.								
					Cured.			Uncured.			Died.		
		M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Under	20	121	128	249	81	99	180	27	24	51	4	5	9
From 20 to 25		187	294	481	111	191	302	48	72	120	6	8	14
„ 25 „ 30		190	322	512	93	183	276	79	92	171	7	10	17
„ 30 „ 35		181	328	509	93	171	264	59	127	186	14	7	21
„ 35 „ 40		195	291	486	98	157	255	62	104	166	16	20	36
„ 40 „ 45		144	244	388	84	116	200	40	104	144	12	15	27
„ 45 „ 50		120	210	330	58	99	157	32	83	115	12	10	22
„ 50 „ 55		112	179	291	63	93	156	30	70	100	11	10	21
„ 55 „ 60		64	111	175	48	72	120	15	37	52	7	7	14
„ 60 „ 65		51	95	146	30	51	81	9	19	28	4	18	22
„ 65 „ 70 and over..		45	56	101	14	13	27	12	24	36	9	10	19
		1410	2258	3668	773	1245	2018	413	756	1169	102	120	222

TABLE IIa.

THE AGES OF PATIENTS ADMITTED AS CURABLE.

From 1856 to 1860 inclusive.

Ages.		Admitted.			Discharged.								
					Cured.			Uncured.			Died.		
		M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Under	20	29	36	65	21	31	52	6	7	13	1	..	1
From 20 to 25		51	76	127	33	53	86	9	15	24	2	3	5
„	25 „ 30	46	81	127	26	42	68	24	30	54	1	1	2
„	30 „ 35	37	94	131	22	52	74	16	34	50	1	2	3
„	35 „ 40	32	73	105	14	46	60	18	29	47	1	2	3
„	40 „ 45	39	65	104	21	33	54	15	28	43	4	3	7
„	45 „ 50	35	53	88	18	28	46	9	19	28	4	..	4
„	50 „ 55	36	51	87	21	24	45	8	20	28	6	3	9
„	55 „ 60	13	27	40	11	15	26	3	16	19	1	1	2
„	60 „ 65	11	25	36	6	9	15	3	5	8	1	3	4
„	65 „ 70 and over..	15	14	29	6	7	13	5	11	16	4	4	8
		344	595	939	199	340	539	116	214	330	26	22	48

M. Esquirol considered that the liability to insanity progressively increased after adult age; and this opinion has been retained by many eminent

Psychologists: but Dr. Thurnam believes that the conclusion was arrived at by an erroneous way of regarding the data. M. Esquirol assumed that the liability to insanity at different ages is represented by the proportion which the *existing* cases of insanity bear to the existing population of the country, and hence the mistake; for it is evident, that in two communities whose liability to insanity is really the same, the *existing* cases may be twice as numerous in one as in the other, and this for no other reason than that the period during which the patients are kept in the hospitals may be twice as great in one as in the other. The only way to arrive at any correct decision in the matter, is to take the number of cases occurring at particular ages, and when this plan is adopted, the conclusion arrived at by Dr. Thurnam is, that the liability to insanity is nearly twice as great from 30 to 40 as from 50 to 60, and much more than twice as great as at any age subsequent to 60. Various other important considerations lead also to the same inference. "In the earlier and middle periods of life," writes Dr. Thurnam, "when the powers, the feelings, and the passions of man have, in common with their corporeal organs, attained their destined degree of maturity, and when they are the most disposed to irregular action and to violent disturbance, it was only to have been expected that he would be more liable to those disorders which lead to, and consti-

tute insanity, (as distinguished from mere superannuation on the one hand, and from imbecility and idiocy on the other,) than he would be during the period of advanced life, when the powers of the body, and the faculties of the mind are, usually, all more or less blunted and enfeebled; and to those who have attained to mature age, and who are actively engaged in the duties of social and civil life, it would have been a painful reflection, were it true, that the longer men live the more obnoxious are they becoming to the greatest of all personal calamities, and the more liable are their families and dependents, by such means, to be deprived of their care and protection." (*Op. cit.* p. 165.)

Any conclusion upon this subject, in order to be absolutely correct, ought to be obtained from the number of cases admitted for the first time; for, as Dr. Thurnam again writes, "the influence which age may exert may be perfectly insignificant with the constitutional tendency to relapse, which remains after a first attack." The data, however, for this correction are yet insufficient, but there is no reason to doubt the accuracy of Dr. Thurnam's deductions. Indeed it is more than probable that these conclusions would be still more opposed to those of Esquirol, if they had been drawn from tables consisting only of patients admitted for the first time; for it may be assumed that the liability to relapse, does not diminish as life advances, and certainly

the relapse of the cases occurring in early years is superadded to the cases occurring in later years.*

The largest number of patients admitted into the Retreat at York, (and these not less than one-third of the whole,) were admitted between the age of 20 and 30; and there was a gradual decrease in the numbers for each subsequent decennial period of life. More cases were also admitted into the Ohio Asylum between 20 and 30; and in this respect the experience of the American Asylum, agrees with that of the Retreat. This is not to be easily explained. In America the feverish chase after wealth, (almost the only social distinction in the United States), the dyspepsia consequent upon a life of excitability from the cradle to the grave, and upon the diet and hurried meals, may have much to do with the matter; but this consideration can scarcely apply to the Quakers who find their way to the Retreat. Among the Society of Friends, the explanation may be in the care which is taken of the community—a solicitude which will single out a case as soon as the first symptom of the malady is manifested, and which does not allow poverty to be any hindrance to the necessary treatment. At any rate, there

* In order to secure correct data on this important topic, it would be well to imitate Dr. Thurnam's example, and form tables in our Reports which would give the *age* at the origin of the disorder. There would be some difficulty in acquiring the data, but none that might not be overcome by a little perseverance.

is no reason to doubt the general conclusion which is drawn by Dr. Thurnam from the whole body of evidence; and certainly the experience in Bethlem during the last fifteen years is in harmony with it. Thus, in our own table, the numbers admitted between 20 and 30, and between 30 and 40, are nearly the same; 993 being admitted in the former period, and 995 in the latter: and after 40, there is a gradual decrease in the numbers for each quinquennial period, 388, 330, 291, 175, 146, 101.

The influence of age upon the *recoveries* is very interesting. M. Esquirol gives tables which shew that the greatest number of cures was from the 25th to the 30th year, and from the 30th to the 35th year; and that they progressively diminish from the 45th year to the end of life—the diminution being more uniform in men, and more abrupt in women. Recovery, however, may take place at later periods of life; and these very tables shew that 20 men recovered after the 50th year, of whom 4 were upwards of 70. (*Statistique de la Maison Royale de Charenton*, p. 135.)

Dr. Thurnam concludes that the probability of recovery is greatest in the young; and that it undergoes a very regular diminution as age advances.

According to our own experience the recoveries under 25 amount to about three-fifths of the admissions, and to about one half, between 30 and 65, if we deduct certain inconsiderable fluctuations

After 65, as might be expected, the recoveries are greatly diminished, being about one-seventh.

The influence of age upon the number of deaths has also been carefully investigated; and Dr. Thurnam's conclusion is, that "the mortality of the insane increases in proportion to the age much more rapidly than is the case in the general population." (*Op. cit.*, p. 33.) In our own tables the mortality, as a rule, increases rapidly with the age. Under 20, it is 4.8 per cent.; between 20 and 25, 2.5 per cent.; between 25 and 30, 3.9 per cent.; between 30 and 35, 4.5 per cent.; between 35 and 40, 8.4 per cent.; between 40 and 45, 5.6 per cent.; between 45 and 50, 7.8 per cent.; between 50 and 55, 7.8 per cent.; between 55 and 60, 8.1 per cent.; and above 60, 16.9 per cent. The mortality, as a rule, increases with the age, but under 20 it is frequently found higher than in the decennium following, and between 35 and 45 it is much higher than in the years immediately preceding and following.

CHAPTER III.

SEX.

An opinion prevailed up to the time of Esquirol, that women were less liable to insanity than men; and such appears to be correct. Esquirol investigated the subject very carefully, and concluded that women were a little *more* subject to insanity than men, the proportions being about 38 females to 37 males; but Dr. Thurnam shews that he erred in his calculations, by forgetting that the proportion of adult females in the general population exceeds that of the males. The excess is 12 per cent. from the age of 20 to 30; 6 per cent. from 30 to 40, and 4 per cent. from 40 to 50. He also erred in comparing the *existing*, instead of the *occurring*, cases of insanity in the two sexes. This would have been a matter of no moment if the progress of the disease was the same in the two cases, but such is not the case. The number of recoveries is greater in women than in men; and the number of deaths is nearly 50 per cent. higher in men than in women. It is therefore evident, that to compare the simple number of cases existing at any one time, would give no

true result ; and we must take the cases *occurring*, and not the cases existing, if we would arrive at any correct view respecting the comparative liability of men and women to insanity. Dr. Thurnam was the first to direct attention to this subject ; and his conclusion, after a very careful examination of the evidence, was, that men are a little more liable to insanity than women. In the principal Hospitals for the insane in these kingdoms he shews “the proportion of men admitted is nearly always higher, and in many cases much higher than that of women ; and as we know that the proportion of men in the general population, particularly at those ages when insanity most usually occurs, is decidedly less than that of women, we can have no grounds for doubting that the male sex is actually more liable to disorders of the mind than the female.” (*Op. cit.*, p. 151.)

This, also, is the result to be drawn from the special examination of the statistics of the Retreat at York ; and as no reports can be more accurate, it may be relied on with much confidence.

“At first sight,” Dr. Thurnam states, “it might appear that women are more liable to insanity than men in the Society of Friends, for, without any greater facility existing for the admission of females, the number of women who have been admitted into the York Retreat has exceeded that of the men by 18 per cent., or in other words, only 45 men have been admitted to 55 women. But it is requisite to

know the relative proportion of the two sexes in the Society of Friends (as a body) before we shall be justified in determining that insanity is really more prevalent among the females of that community. By returns, however, from all parts of England and Wales, it appears, that in this Society the excess of women over men, at all ages, amounts to about 20 per cent.; and there can be little or no question that the excess of adult females is still greater. Indeed, after 15 years of age, before which insanity seldom occurs, we can, I think, scarcely estimate the excess of females over males in this community at less than 30 to 35 per cent. And thus assuming, as there is every reason for doing, that as respects the proportion of the two sexes attacked, the experience of the Retreat represents that of the Society at large, it will appear that in this community there are still from 10 to 14 per cent. more men than women attacked with mental derangement. This is an excess on the side of men in all probability considerably less than that which prevails in the kingdom generally." (*Op. cit*, p. 153.)

In former years more women than men were admitted both into St. Luke's and Bethlem, and the present data are in harmony with past experience:—2258 women having been admitted into Bethlem during the last 15 years, and 1410 men.

The influence of sex upon recovery is supposed to be *very* marked; and it is generally agreed that the

probability of recovery is *much* greater in women than men. But this is not the conclusion which is to be drawn from the experience of Bethlem during the 15 years under consideration, for this experience shews that 1245 out of 2258 or 55 per cent. recover among the women, and 773 in 1410, or 54 per cent., among the men—a difference in favor of the women, it is true, but far less considerable than that which is usually supposed to exist.

On the other hand, it is admitted that insanity is much more likely to terminate fatally in men than in women. The mortality among men, has been supposed to be nearly double that among women; and this is a very remarkable fact, for the excess in the general mortality is not more than 5 or 6 per cent. on the side of the males. In our own tables the mortality among the men is considerably higher than among the women, but not to the extent of being double. It is 7 per cent. among the men, and 5 per cent. among the women.

These facts are of great importance in estimating the effect of treatment in different Hospitals, for it must follow that the results will appear more favourable in direct proportion to the number of women admitted. This, for example, must be borne in mind in comparing the statistics of St. Luke's and Bethlem, for more women appear to be admitted into the former Hospital than into the latter.

CHAPTER IV.

TABLE III.

THE DOMESTIC CONDITION OF PATIENTS ADMITTED AS CURABLE.

From 1846 to 1860 inclusive.

Admitted.				Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Married....	719	1103	1822	405	623	1028	175	325	500	72	71	143
Single	633	979	1612	333	534	867	229	374	603	27	36	63
Widowed ..	58	176	234	35	88	123	9	57	66	3	13	16
	1410	2258	3668	773	1245	2018	413	756	1169	102	120	222

TABLE IIIa.

THE DOMESTIC CONDITION OF PATIENTS ADMITTED AS CURABLE.

From 1856 to 1860 inclusive.

Admitted.				Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Married....	174	284	458	103	175	278	52	89	141	19	12	31
Single	158	260	418	89	135	224	60	109	169	6	6	12
Widowed ..	12	51	63	7	30	37	4	16	20	1	4	5
	344	595	939	199	340	539	116	214	330	26	22	48

Dr. Prichard has collected certain data, from which it appears probable, that the condition of married life is *cæteris paribus*, much less liable to the excitement of madness than that of celibacy. The proportion of married and unmarried persons in the Saltpêtrière and Bicêtre, during the 20 years ending 1822, according to a report by M. Desportes, was as follows:—(*Prichard*, p. 185.)

	Females.	Males.
Unmarried	980	492
Married.....	397	201
Widowers and Widows ..	291	59
Divorced	5	3
Not noted.....	53	9
Total	1726	764

Dr. Prichard also refers to Dr. Jacobi's *statistics* to shew that the case is the same in Germany, thus:—

	Females.	Males.
Unmarried	599	974
Married.....	156	176
Widowed	80	30
Total	835	1180

How are these numbers to be accounted for? "Is it," Dr. Prichard asks, "through the restraints which the condition of celibacy imposes, or through the vices to which unmarried persons are more frequently abandoned? M. Esquirol is of opinion that where one case of insanity arises from the former cause, a hundred result from the latter." Again: "we must take into our calculation, that married persons lead, in general, more regular lives in all respects than the unmarried; that they are for the most part, more fixed in their pursuits and in their condition as to maintenance and employment; and that they are in a less degree subjected to causes which agitate the mind and excite strong emotions. These remarks, however, apply principally to men, and the difference observed in respect to numbers is almost equally great among females."

Let the explanation be what it may, the conclusion must certainly be, that marriage does not "predispose to insanity;" that marriage, in short, is a natural condition. At the same time, it must be remembered, that "many of the cases of insanity among unmarried persons occur in a class, who, as regards bodily and mental vigour, are less likely to be married than the average of the community at large; so that in such cases the celibacy must be regarded as an *effect*, rather than a cause of the condition predisposing to insanity." (Thurnam. *op. cit.*, p. 72a.)

It is probable that more extended enquiries may alter materially the aspect of the case as it now stands. Thus the experience of Bethlem Hospital, during the last fifteen years, does not support the idea that unmarried persons are more likely to become insane than the married; on the contrary, the married patients were more numerous than the unmarried, in the proportion of 1822 to 1612. The question must therefore remain in abeyance for the present; and in the meantime we may notice the manner in which the probabilities of recovery or death are affected, or appear to be affected, by the domestic condition of the patient. We may not attach much importance to such deduction, but it is curious to know that these chances are not the same in the married, unmarried, and widowed state; thus among the recoveries we find 49.6 per cent. of the married, 53.5 per cent. of the unmarried, and 55.8 of the widowed; and among the deaths 6.7 per cent. of the married, 2.7 per cent. of the unmarried, and 7.8 per cent. of the widowed.

CHAPTER V.

TABLE IV.

THE SOCIAL CONDITION OF THE MALE PATIENTS.

		Admitted.	Discharged.		
			Cured.	Uncured	Died.
Members of the Learned Professions	Clergymen.....	10	1	4	
	Lawyers	3	4		
	Medical Men.....	9	5	2	1
	Students			2	
Officers in the Queen's Service	Officers in the Customs	3	2		
Members of other Professions	Accountant			1	
	Architects	4	1	1	2
	Artists	4	2	1	
	Engineers	2	2		
	Schoolmasters	5	4	2	1
	Surveyor				
	Musicians	4	2	2	
	Interpreter		1		
	Roman Catholic Priest	1	1		
	Veterinary Surgeon ..	1			1
	Tutor.....				
Persons engaged in Commerce	Auctioneers	4	1		
	Bookseller	1	2		
	Chemist.....	1	1		
	Cheesemongers	3	3	1	
	Clerks	48	28	20	2
	Corn Chandler		1		
	Drapers	3	3	2	
	Fishmongers	3	2	1	
	Fruiterer	1			
	Grocers	13	8	4	
	Hotel Keepers	4	2		
	House Agent.....	1	1		
	Ironmongers	2			
	Milkman	1			
	Music Seller	1	1		

SOCIAL CONDITION OF THE MALE PATIENTS,—*continued.*

		Admitted.	Discharged.		
			Cured.	Uncured	Died.
Persons engaged in Commerce, <i>continued</i>	Oilman	1			
	Publicans	2			1
	Shopmen	5	1	2	1
	Stationer			1	
	Stock Broker.. ..	1		1	
	Tax Gatherer	1	1		1
	Tea Broker	1	1		
	Timber Dealer	1			
	Tobacconist	1	1		
	Travellers	4	4		
	Wine Merchant	1			
	Wool Sorter	1	1		
Persons engaged in Indoor Manufactures	Basket Makers		1		
	Brush Maker	1	1	1	
	Carver and Gilder ..			1	
	Cigar Maker		1		
(a) In sedentary occupations	Clothworker	1	1		
	Compositors	7	1	2	
	Confectioners	2	3	1	
	Modeller			1	
	French Polishers	2	1	1	
	Feather Maker			1	
	Draughtsman	1			
	Hairdresser	1	1		
	Hatters	3	1	2	
	Iron Moulder	1	1		
	Jeweller.....	1		1	
	Leather Worker			1	
	Harness Maker.....		1		
	Pill-box Maker.....	1	1		
	Saddlers	2		3	
	Shoemakers	5	2	2	1
	Silk Printer	1			
	Tailors	10	8	2	
	Weaver	1			1
	Watch Makers			2	
(b) Persons engaged in non-sedentary occupations.	Bakers	6	4	2	
	Bookbinder		1		
	Blacksmiths	2			1
	Brazier	1			
	Butchers	5	4	1	1

SOCIAL CONDITION OF THE MALE PATIENTS—*continued.*

		Admitted.	Discharged		
			Cured.	Uncured	Died.
(b) Persons engaged in non-sedentary occupations— <i>continued.</i>	Carpenters	19	14	4	1
	Cabinet Makers	2	1	1	
	Coach Maker	1	1		
	Cooper	1		1	
	Cricket-ball Maker ..	1	1		
	Cutler	1	1		
	Dyer	1		1	
	Farriers			2	
	Gas Fitters	3	1	2	
	Japanner	1		1	
	Lath Render	1	1		
	Painters	3	4	2	
	Piano-forte Tuner ..	1	1		
	Plumbers	13	6		1
	Printers	2	2	1	
	Sawyer	1		1	
	Shipwrights	2		2	
	Smith			1	
	Stone Cutter	1			1
	Upholsterer	1			
	Tinmen	2	3		
Persons engaged in outdoor pursuits.	Bricklayers	2	1	1	
	Builder		1		
	Carriers		2		
	Carmen	3			
	Cattle Dealer	1	1		
	Chapel Keeper	1		1	
	Farmers	18	9	5	3
	Flyman	1		1	
	Gardeners	7	4		2
	Labourers	12	6	5	
	Omnibus Conductor ..	1	1		
	Sailors	2	1		
	Shepherd	1	1		
Servants	Band-master		1		
(a) Public Servants ..	Coast-guard Man	1			1
	Policemen	4	3	1	
	Postmen	1		1	1
	Soldiers	2		1	

SOCIAL CONDITION OF THE MALE PATIENTS, - *continued.*

	Admitted.	Discharged.		
		Cured.	Uncured	Died.
(b) Private Servants ..				
Porters	2	4	1	
Butlers	1		3	
Grooms	3	1	2	1
Ordinary Servants ..	5	2	2	
Waiter		1		
Cook			1	
Persons without Occupation or Trade	14	3	1	1
Person of unknown Occupation		1		

TABLE IV a.

THE SOCIAL CONDITION OF THE FEMALE PATIENTS.

		Admitted.	Discharged.		
			Cured.	Uncured	Died.
Wives, Widows, and Daughters of Professional men, Officers, Merchants, or Tradesmen.		229	125	69	6
Wives, Widows, and Daughters of Mechanics, Labourers, or Servants.		87	54	27	5
Persons occupied in Professional pursuits.	Artist.....			1	
	Governesses	38	22	17	
	Musician			1	
	Schoolmistresses	13	8		1
	Midwife.....			1	
Persons engaged in Indoor Manufactures, &c.	Baker.....		1		
	Dress Makers	32	16	16	2
	Embroideress	1			
(a) In sedentary manufactures, &c.	Envelope Maker	1	1		
	Flower Maker	1		1	
	Milliners	16	14	2	
	Needlewomen	8	3		
	Shopwomen	6	3	4	
	Shoebinders	2		1	1
	Stay Maker	1		1	
	Upholsteress.....		1		
	Waistcoat Maker....	1			
(b) In non-sedentary occupations, &c.	Confectioner			1	
	Pew Openers	2			2
	Eating-house Keeper		1		
	Lodging-house Keepers	4	1	1	
	Publicans		2	1	

SOCIAL CONDITION OF THE FEMALE PATIENTS,—*continued.*

		Admitted.	Discharged.		
			Cured.	Uncured	Died.
Persons occupied in out-door pursuits	Hawker	1			1
	Milk Carrier		1		
Servants	Cook			1	
	Housekeepers	16	5	4	2
	Ladies' Maids	5	1	1	
	Laundresses	8	3	6	1
	Nurses	11	3		
	Servants	75	51	38	1
Persons having no Occupation.		37	25	19	

In these tables we have arranged the patients admitted into Bethlem Hospital according to their social position, so that a glance may serve to shew, in some degree, the circumstances affecting groups of patients. The actual tables are arranged alphabetically; but a classified table, however imperfect, is to be preferred, for some such table must be traced from the alphabetical list before it is possible to form any opinion upon the data contained in it.

At present, however, the data are far too scanty to allow the formation of any sound opinion; and all that we can do is to notice a few salient points

which present themselves on a cursory inspection of the columns. It is to be noticed that the medical men are nearly twice as numerous as the lawyers : and this, perhaps, is what might be expected, when we consider the mental and bodily fatigue to which a large majority of the medical profession are exposed, for if it is sufficient to shorten the average duration of their lives appreciably, it must also affect very seriously their mental health. Nor is it surprising that the number of schoolmasters and musicians should be so high. Under the head of schoolmasters are included a large number of tutors, which, no doubt, is a sufficient reason why schoolmasters, as a class, so considerably increase the list, for the unsatisfactory social position in which such gentlemen are too often placed, tends necessarily to fret and irritate their minds. Musicians, on the contrary, more excitable than the majority of the population, may be in danger, by being too much flattered in that society where they are constantly welcomed. The number of clerks is high, though not higher, perhaps, than the extent of this class would lead us to expect. Comparing the number of those engaged in *sedentary mechanical in-door pursuits*, with those engaged in *non-sedentary mechanical in-door pursuits*, we find a marked difference, the preponderance being with the latter. Among the former, the tailors are most numerous, and then the compositors ; among the latter, are

first the carpenters, (including the cabinet makers,) and then the plumbers.

Among the female patients, the only point which seems to require notice, is the very large number of governesses and dressmakers, (including milliners and sempstresses.) It is no wonder that an elegant, accomplished, and otherwise delicately nurtured lady, should pass from unhappiness to misery, and from misery to insanity, in a position which too often is not half so desirable as that of a domestic servant; and of the causes which operate upon thousands of the class of dressmakers, who are driven mad by penury, trouble, and perhaps remorse, it is not necessary to advert.

CHAPTER VI.

TABLE V.*

THE EDUCATION OF PATIENTS ADMITTED AS CURABLE,
From 1846 to 1860 inclusive.

Admitted.				Discharged.								
				Cured.			Uncured.			Died		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Superior ..	127	145	272									
Good	406	459	865									
Moderate ..	783	1369	2152									
Indifferent.	74	219	293									
None	20	66	86									
	1410	2258	3668									

* No tables kept from 1846 to 1855.

TABLE V a.

THE EDUCATION OF PATIENTS ADMITTED AS CURABLE,
From 1856 to 1860 inclusive.

Admitted.				Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Superior ..	48	67	115	28	38	66	8	25	33	7	2	9
Good	113	165	278	73	98	171	48	56	104	7	9	16
Moderate ..	167	338	505	90	184	274	56	124	180	12	9	21
Indifferent..	15	19	34	7	14	21	2	9	11	..	1	1
None	1	6	7	1	6	7	2	..	2	..	1	1
	344	565	939	199	340	539	116	214	330	26	22	48

It is desirable to arrive at some conclusion as to the effect of education upon those affected with insanity, but the evidence is wanting which would enable us to do this, and we cannot supply the deficiency. The table is incomplete, and we are unable to form an opinion as to the influence of education upon the probability of recovery or death. It however appears certain, that a very large proportion of educated persons are admitted into Bethlem: a fact which shews that little alteration would be necessary, so far as the patients are concerned, if it were thought desirable, to send the uneducated poor to the Asylums which are provided for them on the most princely scale in every county, and to reserve Bethlem Hospital for the reception of the poor though educated insane of the middle class.

CHAPTER VII.

TABLE VI.

THE RELIGIOUS PERSUASION OF PATIENTS ADMITTED AS CURABLE.

From 1846 to 1860 inclusive.

Admitted.				Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Church of England }	1035	1700	2735									
Roman Catholic }	52	64	116									
Wesleyan ..	79	134	213									
Dissenters ..	244	360	604									
	1410	2258	3668									

TABLE VIa.

THE RELIGIOUS PERSUASION OF PATIENTS ADMITTED AS CURABLE.

From 1856 to 1860 inclusive.

Admitted.				Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Church of England }	272	449	721	154	258	412	86	169	255	19	14	33
Roman Catholic }	8	9	17	4	4	8	5	2	7	1	1	2
Wesleyan ..	24	48	72	15	33	48	7	16	23	1	1	2
Dissenters..	40	89	129	26	45	71	18	27	45	5	6	11
	344	595	939	199	340	539	116	214	330	26	22	48

It is very difficult to determine the real influence of religion upon insanity, although it has been constantly repeated that Protestants are much more liable to insanity than Romanists; and that Protestants are subject just in proportion to the degree in which they allow their feelings to enter into their religious exercises. The Society of Friends has been thought to shew that a quiet religion is a preservation against insanity, and the Methodists the reverse, but these conclusions, as Dr. Prichard has well shewn, have been hastily formed.

With regard to the comparative influence of Protestantism and Romanism in favouring or checking mental disease, it is not easy to form an opinion, for the differences, both of habit and climate, are as worthy of consideration as the mere distinctions of religion. The Prussian States on the Rhine may be considered as almost the only locality in which, habit and climate and other matters being similar, a comparison may be fairly instituted. Of these States Dr. Prichard gives the following particulars from Dr. Jacobi, as elements for the formation of an opinion. (Date of Table 1824.) (*Op. cit.*, p. 197.)

	Romanist.	Lutherans.
Dusseldorf.		
Population	395,031	239,840
No. of Lunatics	544	241
Aix-la-Chapelle.		
Population	320,793	9,382
No. of Lunatics	301	11
Trèves.		
Population	301,505	32,804
No. of Lunatics	202	18
Cologne.		
Population	323,283	50,001
No. of Lunatics	283	48
Coblentz.		
Population	250,613	121,595
No. of Lunatics	236	101

Hence it appears that the proportion of lunatics in the Catholic part of the population of the Provinces, compared with that in the Lutheran, is as 11 to 10, or one-tenth part greater; so that, arguing from this single fact, Romanism, and not Protestantism, would seem to be more favourable to the manifestation of insanity.

With regard to Methodism as predisposing to insanity, Dr. Prichard has some very admirable remarks. Cases of insanity falling under his own notice, he says, "have occurred among persons who have frequented churches or chapels, where the ministers were remarkable for a severe, impassioned, and almost imprecatory style of preaching; and for enforcing the terrors rather than setting forth the hopes and consolations which

belong to the Christian religion." Foreign writers have supposed this to be the practice of the Methodists in particular; and M. Fabret, persuaded by the assertions of Darwin and Perfect, mentions the prevalence of Methodism in England as a presumptive cause of the frequency of suicide among our countrymen. That none of the preachers of this sect have been deserving of such a censure I shall not venture to affirm; but in the present time, at least, it cannot justly be laid, either generally or exclusively, to their charge. A vehement and impassioned mode of preaching has often been the practice in other sects, both among Protestants and Catholics, and in no instances more remarkably than among the itinerant missionaries of the latter Church." (*Op. cit.* p. 188.) And then Dr. Prichard proceeds to give a quotation from M. Berthollet in illustration:—"In the kingdom of Naples, a custom exists of preaching in favor of missions, by a particular set of priests; in order to animate the faith of believers, they accompany their orations with particular acts, which are often of such a nature as to produce too powerful an effect on weak minds; they hold their hands over flaming torches, and whip themselves with scourges garnished with iron points; their sermons are prolonged till the close of day, and the feeble glare of a few flambeaus heightens the effect of the scene." One of these sermons gave occasion to the case I am about to

describe; the subject was *Hell*: to heighten the colouring of the frightful picture which the preacher had traced, he took a skull in his hand, and having raised a question as to the abode of the soul to which it belonged, he exclaimed, invoking it, "If thou art in heaven, intercede for us! If thou art in hell, utter curses! He then cast it from him with violence." The lady whose case is subsequently described in M. Berthollet's memoir was instantly affected by a morbid change in the nervous system. Strong emotions, excited by vehement preaching, produce continually in females and very sensitive persons fits of hysteria; and in those who are predisposed to mania, there can be no doubt that similar causes give rise to attacks of madness.

It is a question how far the theological doctrines of the Calvinists, gloomily considered, may or may not predispose to insanity. There is, at present, little evidence from which a correct opinion may be drawn, but there is a statistical statement, in a paper by Dr. J. R. Hubertz, upon the State of Mental Diseases in Denmark, which deserves very careful consideration—(*Journal of Psychological Medicine*, July, 1853, p. 441)—This statement is, that the proportion of idiots and insane in every 1000 inhabitants varied considerably with the different sects to which these inhabitants belonged; the Romanists showing 3.34 in every 1000; the Jews, 5.85; and the Calvinists, 9.16: we are

warned however that these data are not altogether trustworthy. Our own tables, except during the last five years, do not throw any new light upon these questions, for we do not know the entire numbers belonging to these different churches; neither do they shew the extent of the influence of religion, as affecting the chances of recovery or death, for the manner in which the cases terminated is not recorded.

CHAPTER VIII.

TABLE VII.*

RESIDENCE,

From 1846 to 1860 inclusive.

Admitted.				Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
London and its immediate neighbourhood.	639	970	1609									
The Provinces, and those not ascertained	771	1288	2059									
	1410	2258	3668									

* No tables kept from 1846 to 1855.

TABLE VII_a.

RESIDENCE.

From 1856 to 1860 inclusive.

Admitted.				Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
London and its immediate neighbourhood	218	375	593	130	224	354	76	130	206	18	11	29
The Provinces	126	220	346	69	116	185	40	84	124	8	11	19
	344	595	939	199	340	539	116	214	330	26	22	48

The conclusion arrived at by Sir Andrew Halliday, that insanity is more prevalent in agricultural than in manufacturing districts, will be found to be fully substantiated by the returns, both of the Commissioners in Lunacy, and the Poor Law Commissioners. The twelve counties selected by Sir Andrew Halliday, where the inhabitants are principally employed in agriculture, were,—Bedford, Berkshire, Bucks, Cambridge, Hereford, Lincoln, Norfolk, Northampton, Oxford, Rutland, Suffolk, and Wilts. The total number of inhabitants in these twelve counties, was 2,012,979, and the total number of insane persons, 2526, that is 1 insane person in 796 inhabitants. The twelve counties which he selected, where the inhabitants were not principally employed in agriculture, were,—Cornwall, Cheshire, Derby, Durham, Gloucester, Lancaster, Northumberland, Nottingham, Stafford, Somerset, York (West Riding), Warwick. The total number of inhabitants in these twelve counties was 4,493,194, and the total number of insane persons, 3910, or very nearly 1 insane person in every 1149.

Taking the same twelve agricultural, and the same twelve non-agricultural counties, selected by Sir Andrew Halliday, we find from the reports of the Commissioners in Lunacy, as follows:—

Agricultural Counties.

In 1836,	proportion of the insane to the population	1	in	614
„ 1843,	„ „ „ „	1	„	810
„ 1847,	„ „ „ „	1	„	712

Non-Agricultural Counties.

In 1836,	proportion of the insane to the population	1	in	1420
„ 1843,	„ „ „ „	1	„	1109
„ 1847,	„ „ „ „	1	„	939

The same result is shewn by the Poor Law Commissioners' returns. In 1851 the number of insane paupers in the same twelve agricultural counties was 8,743; and their proportion to the population of the same twelve counties, 1 in 718. In the twelve non-agricultural counties, the number of insane paupers was 12,189, and their proportion to the population of the same counties is 1 in 1,015.

The experience of Norway, as set forth in a report by Professor Holst, is to the same effect, and the proportion is calculated as 0.201 in the towns, and 0.339 in the country; nor is it otherwise in Denmark. "Among the dense population of the isles, idiots and insane are found in the proportion of 2 to 3 in 1,000; amongst the scattered population of the lignite formation of the west of Jutland, the proportion is 3 to 5 in 1,000." (Dr. Hubertz in the *Journal of Psychol. Med.*, July 1853, p. 443.)

It appears, however, that M.M. Brierre de Boismont, Renardin, Guislain, Parchappe, and De

Bouteville, have deduced an opposite conclusion from the experience of Belgium. (*Psychol. Medicine*, D. Noble, M.D., p. 270.

At first sight also, an opposite conclusion would seem to be deducible from the experience of the Retreat, at York, for of 415 patients, 228, or about 55 per cent., were admitted from cities and large towns, (including in this class, all places having a population much exceeding 5000 ;) 101, or 24 per cent. were from small towns and villages ; and 86, or 21 per cent., from more completely rural districts. Still, there is, perhaps, some reason for concluding that insanity is somewhat more prevalent in the country than in the town members of the Society of Friends, for there can be no doubt, that a much larger portion than 55 per cent. of this community reside in cities and large towns.

There is no doubt indeed, that the general voice of experience is in favor of the idea, that insanity is less likely to originate in large towns than in the country ; and this is certainly the lesson which we should deduce, if any, from the experience of Bethlem during the last fifteen years ; for out of 3668 patients, 2059 were from the "provinces ;" whereas only 1609 were from "London, and its immediate neighbourhood."

It might have been expected that cases of insanity would have been developed more frequently where the mind is most excited, and where the struggle

for existence is most eager and arduous; and it is not easy to find an explanation for the contrary state of the case. "The fact that insanity prevails so much in agricultural districts," says Dr. Prichard. "indicates that its development is favored by some of the circumstances connected with the condition of agricultural life." The labouring of women in the field during pregnancy is, perhaps, as Halliday suggests, one cause. Hard labour and low diet, to which males may be subjected, may perhaps have an influence on the offspring propagated by them; and in Wales and Scotland particularly, this may enter into the number of causes which render idiotism so prevalent: "It may be," suggests Dr. Thurnam, "that young persons who are deficient in mental power or in self-government, and who are so far more exposed to insanity, are not only more frequently put to agricultural pursuits by their friends, but that such individuals in after life will generally be but little inclined to exchange their rural pursuits for those of a city." (*Op. cit.*, p. 74a.) The explanation indeed, is not at all obvious; still we cannot but think that the human mind, with its high capabilities, is more likely to become deranged from having too little wherewith to exercise those capabilities fitly, than from having too much. If these faculties be not exercised, the mind will prey upon itself, and become diseased; and surely this is more likely to happen in the country than in the town.

Dr. Rubio gives the following statistical return of the different countries in the year 1848 :—

1	in	223	in	Holland
1	„	417	„	Scotland
1	„	446	„	Canton of Geneva
1	„	550	„	Norway
1	„	700	„	England
1	„	816	„	Belgium
1	„	1167	„	Spain
1	„	1200	„	Germany
1	„	1733	„	France
1	„	3690	„	Italy
1	„	5818	„	Piedmont.

CHAPTER IX.

TABLE VIII.

THE APPARENT OR ASSIGNED CAUSES IN THE MALES.

From 1846 to 1860 inclusive.

Admitted.			Discharged.					
			Cured.		Uncured.		Died.	
	M.	T.	M.	T.	M.	T.	M.	T.
HEREDITARY, without any other apparent cause	121	121	81	81	27	27	4	4
Not ascertained	447	447	55	55	38	38	4	4
MORAL.								
Anxiety	165		104		43		20	
Disappointment	38		25		10		..	
Reduced circumstances	100		56		33		16	
Excessive study or over-work ..	96		63		25		14	
Religious excitement	49		33		14		1	
Mental	39		28		8		6	
„ distress	24		15		5		2	
Fright	9		4		1		1	
Jealousy	5		2		3		..	
Sudden prosperity	6		1		3		2	
Death of relations	26		17		4		4	
		557		348		149		66
PHYSICAL.								
Bodily illness	38		26		7		4	
Fever	21		9		10		..	
Intemperance	123		91		24		10	
Coup de Soléil	13		7		5		1	
Rheumatism	9		7		5		..	
Cholera	1		1		..		..	
Sensual excess	11		10		1		..	
Onanism	30		17		10		..	
Dyspepsia	14		11		3		1	
Concussion	22		13		7		2	
Phthisis Pulmonalis	2		1		..		1	
Pneumonia	1		1		..		..	
		285		194		72		19
		1410		678		286		93

TABLE VIII^a.

THE APPARENT OR ASSIGNED CAUSES IN THE MALES,

From 1855 to 1860 inclusive.

Admitted.				Discharged.							
				Cured.		Uncured.		Died.			
				M.	T.	M.	T.	M.	T.		
HEREDITARY, without any other											
apparent cause				32	32	17	17	5	5	1	1
Not ascertained				97	97	55	55	38	38	4	4
MORAL.											
Anxiety				35		20		12		5	
Disappointment				12		6		3		..	
Reduced circumstances				32		20		10		7	
Excessive study or over-work ..				21		14		13		..	
Religious excitement				12		8		2		1	
Mental				13		10		6		..	
,, distress				4		1		1		..	
Fright				5		1		..		1	
Death of relations				8		3		2		2	
				142		83		49		16	
PHYSICAL.											
Bodily illness				5		2		2		..	
Fever				6		1		3		..	
Intemperance ..				33		23		8		4	
Coup de Soléil				2		..		2		..	
Rheumatism				1		2		2		..	
Onanism				18		9		6		..	
Dyspepsia				..		..		1		..	
Concussion				5		5		..		..	
Phthisis Pulmonalis				2		1		..		1	
Pneumonia				1		1		..		..	
				73		44		24		5	
				344		199		116		26	

TABLE VIIIb.

THE APPARENT OR ASSIGNED CAUSES IN THE FEMALES,

From 1846 to 1860 inclusive.

	Admitted.		Discharged.					
	F.	T.	Cured.		Uncured.		Died.	
	F.	T.	F.	T.	F.	T.	F.	T.
HEREDITARY, without any other apparent cause	240	240	137	137	62	62	14	14
Not ascertained	738	738	84	84	77	77	10	10
MORAL.								
Anxiety	184		106		62		19	
Disappointment	97		72		24		4	
Reduced circumstances	48		38		13		2	
Excessive study or Over-work ..	40		17		18		9	
Religious excitement	46		25		14		2	
Mental "	69		42		21		6	
" distress	47		31		8			
Fright	58		49		14		1	
Jealousy	10				2		1	
Death of relatives	153		108		37		7	
		752		488		213		51
PHYSICAL.								
Bodily illness	56		43		9		4	
Fever	21		16		5		1	
Intemperance	54		34		15		4	
Rheumatism	9		9					
Dyspepsia	6		4		2			
Concussion	9		3		3		1	
Puerperal	163		117		38		4	
Over-lactation	68		43		21		3	
Hysteria	26		16		14			
Uterine disturbance	104		68		12		6	
Phthisis Pulmonalis	1		1					
Opium eating	2				2			
Softening of the brain	3				1			
Erysipelas	2		1				1	
Pneumonia	1		1					
Onanism	3		1		1			
		528		357		123		24
		2258		1066		475		99

TABLE VIIIc.

THE APPARENT OR ASSIGNED CAUSES IN THE FEMALES,
From 1855 to 1860 inclusive.

	Admitted.		Discharged.					
			Cured.		Uncured.		Died.	
	F.	T.	F.	T.	F.	T.	F.	T.
HEREDITARY, without any other apparent cause	69	69	23	23	19	19	..	..
Not ascertained	150	150	84	84	77	77	10	10
MORAL.								
Anxiety	31		17		17		..	
Disappointment	26		16		11		2	
Reduced circumstances	19		16		6		2	
Excessive study or Over-work ..	8		7		4		1	
Religious excitement	35		17		12		1	
Mental „	11		10		1		..	
„ distress	20		8		4		..	
Fright	10		12		4		..	
Jealousy	..		..		..		1	
Death of relatives	47		31		13		2	
	—	207	—	134	—	72	—	9
PHYSICAL.								
Bodily illness ..	1		..		1		..	
Fever	9		6		4		..	
Intemperance	14		9		4		..	
Rheumatism	5		5		..		..	
Dyspepsia	1		1		..		..	
Concussion	4		3		1		1	
Puerperal	51		34		12		1	
Over-lactation	18		10		7		..	
Hysteria	9		6		7		..	
Uterine disturbance	45		21		6		..	
Phthisis Pulmonalis	1		1		..		..	
Opium eating	2		..		2		..	
Softening of the brain	3		..		1		..	
Erysipelas	2		1		..		1	
Pneumonia	1		1		..		..	
Onanism	3		1		1		..	
	—	169	—	99	—	46	—	3
		595		340		214		22

TABLE VIII.
SUMMARY OF THE APPARENT OR ASSIGNED CAUSES.

	Admitted.		Discharged.		
			Cured.	Uncured.	Dead
Hereditary tendency.	Males	121 in 1410, or 8.58 per ct.	81 in 678, or 11.94 per ct.	27 in 286, or 9.44 per ct.	4 in 93, or 4.3 per ct.
	Females	240 in 2258, or 10.62 per ct.	137 in 1066, or 12.85 per ct.	62 in 475, or 13.05 per ct.	14 in 99, or 14.14 per ct.
	Total	361 in 3668, or 9.83 per ct.	218 in 1744, or 12.5 per ct.	89 in 761, or 11.69 per ct.	18 in 192, or 9.37 per ct.
Causes not ascertained.	Males	447 in 1410, or 31.7 per ct.	55 in 678, or 8.11 per ct.	38 in 286, or 13.28 per ct.	4 in 93, or 4.3 per ct.
	Females	738 in 2258, or 32.68 per ct.	84 in 1066, or 7.87 per ct.	77 in 475, or 16.21 per ct.	10 in 99, or 10.1 per ct.
	Total	1185 in 3668, or 32.3 per ct.	139 in 1744, or 7.97 per ct.	115 in 761, or 15.11 per ct.	14 in 192, or 7.29 per ct.
Moral Causes.	Males	557 in 1410, or 39.5 per ct.	348 in 678, or 51.03 per ct.	149 in 286, or 52.09 per ct.	66 in 93, or 70.96 per ct.
	Females	752 in 2258, or 33.3 per ct.	488 in 1066, or 45.77 per ct.	213 in 475, or 44.84 per ct.	51 in 99, or 51.51 per ct.
	Total	1309 in 3668, or 35.68 per ct.	836 in 1744, or 47.99 per ct.	362 in 761, or 47.56 per ct.	117 in 192, or 60.93 per ct.
Physical Causes.	Males	285 in 1410, or 20.21 per ct.	194 in 678, or 28.61 per ct.	72 in 286, or 25.17 per ct.	19 in 93, or 20.43 per ct.
	Females	528 in 2258, or 23.38 per ct.	357 in 1066, or 33.48 per ct.	123 in 475, or 25.89 per ct.	24 in 99, or 24.24 per ct.
	Total	813 in 3668, or 22.16 per ct.	551 in 1744, or 31.59 per ct.	195 in 761, or 25.62 per ct.	43 in 192, or 22.39 per ct.

It is usual to divide the causes of insanity into *predisposing*, and *exciting*, but there is infinite difficulty in carrying the division into effect. It continually happens, indeed, that predisposing causes are also exciting causes, or *vice versa*; and hence we prefer to disregard the division, and speak of the causes of insanity according as they are *moral* or *physical* in their nature. In practice, moreover, there are many cases in which the only cause which can be assigned is, what is called *hereditary tendency*; and there are not a few in which from the want of necessary data, the cause is not ascertained.

We will speak, then, of the causes of insanity in the following order:—

Hereditary tendency,

Cause not ascertained.

Moral Causes.

Anxiety and Distress,

Uncontrolled Emotions and Passions,

Perverted Religion.

Physical Causes.

Injuries to the Head,

Disease of the Nervous System,

Fevers,

Intemperance,

Sensuality,

Intestinal Disorders,

Causes related more or less to the Uterus.

Hereditary tendency. “The constitutional peculiarity,” says Dr. Prichard, “whence arises the predisposition to insanity, is not generally distinguished, or to be certainly recognized by any remarkable external characters. The fact that it exists, and is a necessary condition to the development of mental disease, is to be inferred from the consideration, that the causes which induce madness in one person are precisely similar to those, which in other individuals are observed to call forth disorders of a different kind; for example, we may observe that among the physical agents which give rise to madness, there is none more influential than intemperance and the habitual use of ardent spirits. A very considerable proportion of lunatics in the lowest class of society, in some countries, owe their disease to this habit; but it is only in a certain proportion of persons addicted to intemperance that the phenomena of insanity make their appearance. Others, under the influence of the same noxious cause, are affected with apoplexy or paralysis; in many the brain escapes and the liver becomes disordered, or dropsy takes place, with or without disease of the liver; in some, the lungs become the seat of morbid changes. It is evident that there must be an original difference in the habit of body, whence arises the diversity of results brought about by the same or very similar external agencies. This original difference is apparently a peculiarity

in the congenital constitution of each individual; it may be transmitted from parents, or it may arise *de novo*, as other varieties in the congenital structure are known to do: hence it is of comparatively little moment, so far as the individual is concerned, to inquire whether his morbid predisposition has been derived by hereditary descent, or has sprung up with himself." (*Op. cit.*, p. 157.)

And not only is it of comparatively little moment to enquire whether the morbid predisposition is hereditary or acquired, but it is also exceedingly difficult to arrive at any correct conclusion upon the subject; for either the friends of the patients are apt to disguise the truth; or, as is frequently the case among the poor, little is known about ancestry, even so recent as the immediate parents.

There is nothing mysterious in hereditary tendency to insanity: and when the characters of the malady are better known, this tendency, no doubt, will appear to be little more than a definite bodily state, which may be acquired under given circumstances, and when acquired may be transmitted. That it is a physical condition, implying chiefly weakness and imperfection in the brain, may be inferred from many facts. According to Van Sweiten, "almost all the insane have had convulsions during their infancy;" (*Esquirol, Op. cit.* p. 50,)—and this fact is an argument, not only that the nervous system was unusually weak and delicate, but that

it was rendered more weak and delicate by the convulsions. A similar conclusion may also be drawn from the very great number of idiots who appear in families producing lunatics; a fact which is very well established, and from which Dr. Prichard argues that mental derangement, considered generally, or with respect to the great aggregate of cases, may be looked upon rather as a congenital imperfection, than as a disease resulting from internal impression. Again, insanity is closely allied, not only to congenital idiocy, but to paralysis, epilepsy, and other diseases, which imply a want of power in the nervous system: in a word, the idea of hereditary tendency is definite enough, if care be taken to apprehend it, though not so clear as to decide the question of the direct transmission of any given form of insanity.

Now, unquestionably, there are many cases in which hereditary predisposition is the only cause to which insanity can be referred. In the Bethlem tables the total number attributed to this cause simply, is 361 in 3,668, or 9.59 per cent.; *i.e.* 8.58 per cent. among the males, and 10.62 per cent. among the females. It appears, also, that these cases are more unsatisfactory than the others, so far as the probability of recovery is concerned, and less so in the question of death. Thus, while the per centage of recoveries in both sexes is 35.6, where the cause of the disorder was of a moral

character, and 22.1 where the cause was of a physical character, the per centage is only 9.59 where the only cause that could be detected was hereditary predisposition; and, again, while the per centage of deaths in the cases of insanity arising in moral and physical causes, are respectively 8.93 and 5.28. the per centage is only 4.9 where the disorder was simply due to hereditary predisposition.

There is no opportunity in Bethlem of calculating the influence which the hereditary tendency to insanity has upon the liability to relapse, but there is every reason to believe that the effect is very unfavorable. Thus we gather from Dr. Thurnam, that "of the cases in which a hereditary or congenital predisposition existed, as many as 47 per cent. have experienced second attacks: whilst of those in which no such predisposition was ascertained, not more than 32 per cent. have hitherto sustained relapses, or second attacks of the disorder." (*Op. cit.* p. 85a.)

Cause not ascertained. The reports which are furnished with many patients are scanty, and often so entirely uninformative, that a large number can only be entered under this head. In the Bethlem tables the numbers so classed during the fifteen years under consideration, are 1185 in 3668, or 32.3 per cent.; which though large is not more so than might be expected, remembering that stran-

gers are rarely sufficiently interested in the poor, carefully to notice their monotonous and dispiriting history.

Moral Causes. It is now generally admitted that insanity is due more to moral than to physical causes. M. Georget (*de la Folie*, Paris, 1820, p. 80,) says, that at least 95 in every 100 lunatics have become lunatic from moral causes. M. Esquirol also thinks that more cases of madness originate in moral than in physical causes, the proportion being about 4 to 1; and M. Pinel arguing from an experience of five years, arrives at a somewhat similar conclusion. Thus, (*Guislain, de l'Alienation*, v. 1 p. 149.)

	Arising from	
	Moral Causes.	Physical Causes.
Mania	285	165
Melancholia	148	46
Suicide	31	8
Dementia	26	31
Idiotism.....	26	31

The experience of Bethlem, as gathered from the tables of the fifteen years under consideration, shews that the cases originating in moral causes are nearly double those arising from physical causes; the numbers being 1309 and 813 respec-

tively. It also shews that the chances of recovery and of death are both greater, in cases arising from *moral* causes; thus the mean per centage of recoveries in the cases arising from moral causes, is 51.5, and of deaths 62.5; whereas the mean per centage of recoveries in cases arising from *physical* causes is 33.8, and of deaths 24.3. It is also interesting to learn that the probability of recovery and of death is greater, in the case of men becoming insane from moral causes, the numbers being 55.3, and 74.6; whereas the women have slightly the advantage, where the insanity has been induced by *physical* causes.

Anxiety and Distress, in their varied aspects, appear to be the principal influences of insanity; and in the tables of Esquirol they form considerably more than one-half of the entire number of the category of moral causes. In the Bethlem table 60.2 per cent. among the men, and 70.9 per cent. among the women, may be classed more or less directly under these heads. It is very doubtful moreover, whether insanity ever arises from causes of an opposite nature, as from excess of joy. Esquirol has observed, that the excess of joy which destroys life never takes away the reason; and he endeavours to explain away certain cases which are supposed to support a contrary conclusion. In answer to a statement of Mead, that

fortunes rapidly acquired produce insanity in England—he asks, for instance, whether the persons thus becoming lunatic may not have become so in consequence of laying aside their former habits for idleness and luxury, and so on. He says, moreover, that no case of insanity which could be fairly attributed to excess of joy, has fallen under his own notice, and he mentions two cases in illustration of the mistake. A minister informed his relative of his nomination to an important appointment, and this relation immediately fell into a state of hypochondriacal melancholy—joy was thought to be the cause of this misfortune, but the real cause proved to be *despair* at having to quit a mistress. A young man gained a prize in a lottery, and a few days afterwards was seized with insanity; excessive joy was thought to be the cause, but the real cause proved to be the *fear* of losing his treasure. It is no argument to the contrary, that insanity originates occasionally in “sudden prosperity,” as in the six cases in the Bethlem tables; for here, *ennui* and many other analogous causes may have combined to unhinge a mind accustomed to action, and not trained to enjoy the “*otium cum dignitate*.” At any rate, nothing is known of these cases to contradict the *dictum* of Esquirol.

Uncontrolled Passions and Emotions. Arguing from the statistics of Esquirol, Dr. Prichard con-

siders that the uncontrolled passions and emotions deserve to rank next to anxiety and distress in causing insanity, but this opinion is scarcely borne out by our own tables. Jealousy is not an unfrequent cause, and we find in the fifteen years under consideration, the insanity of 5 men and 10 women referred to it: neither is fright rarely met with, for 58 cases in 752 among the women, and 9 in 557 among the men, are attributed to its influence; nevertheless the numbers are not so great as the statement of Dr. Prichard might have induced us to anticipate.

Perverted Religion. It is only necessary to notice the number of the cases ascribed to this cause; which are 49 in 557 among the men, and 46 in 752 among the women. The numbers are high, but we doubt very much whether they would not be still increased, if more was known of the real history of the patients.

Physical Causes. These influences have been thought to act more powerfully upon women than upon men, and the Bethlem tables do not contradict the idea. The difference, however, does not appear to be very great, for the per centage among the men is 13, and among the women 23.

Injuries to the Head. Accidents of this kind, as

Dr. Prichard states, "are more frequently causes of delirium than insanity;" but instances sometimes occur in which insanity is the consequence, delirium being the intermediate link. In the Bethlem tables 22 cases among the men, and 9 among the women, are referred to "concussion."

Diseases of the Nervous System. It is not easy to estimate the importance of these diseases, in relation to insanity; epilepsy is not an uncommon cause, but we have no authentic data to determine the degree of frequency. The same remarks apply also to paralysis. Insanity is often referred to by insolation, or coup-de-solêil: a condition which acts by exciting inflammation, or a state akin to inflammation, in the encephalon. The heat of the kitchen fire acts in the same manner occasionally upon cooks: coup-de-solêil, indeed, and "coup-de-feu," as it may be called, are frequently mentioned in Esquirol's tables, and they occur not unfrequently in the Bethlem reports, in which 13 cases, all among the men, are referred to coup-de-solêil.

Fever. There is no doubt that the foundation of insanity may frequently be traced to the delirium of typhus; and that the mental malady is often connected with a metastatic inflammation of the brain and of its membranes, connected with rheumatism or gout. At the same time it is not less true, that

active fever and insanity must be regarded as antagonistic conditions rather than otherwise. Galen cites a case of insanity which was terminated by a quartan fever; and Belgarrie states a similar fact. M. Esquirol also tells us that he has known several instances of insanity terminated by fever, either continued or intermittent. (*Op. cit.*, p. 57.) Where insanity is connected with fever, it is generally by the suppression of certain cutaneous eruptions, as of small pox, &c.

In the Bethlem tables, the cases referred to "fever" are 21 among 1,410 men, and 21 among 2,258 women; while the cases referred to "rheumatism," are 9 among the men, and 9 among the women.

Intemperance. Intemperance produces many among the physical causes of insanity, as here set forth: the numbers being 123 out of 285 among the men, and 54 out of 528 among the women. This contrasts unfavorably with the experience of M. Esquirol, who says, that among 336 lunatics staying in his own establishment, there were only three whose derangement was ascribable to this cause; but there is every reason to believe that intemperance is far more frequently the cause of insanity in this country, at the present time, than was the case in France in the days of Esquirol.

Sensuality. Here, as in the case of intemperance in stimulating drinks, it is difficult to arrive at a correct conclusion, owing to the want of accurate data. In our own tables, however, the mental disorder is referred to "onanism" in 30 cases, and to "sensual excess" in 11 cases. M. Esquirol says, that one-twentieth of the lunatics in the Salpêtrière had been prostitutes. It is nevertheless a question, whether grief, anxiety, and broken hours, may not have had a greater share in dethroning the reason than sensuality.

Intestinal Disorders. Dr. Prichard lays great stress upon intestinal disorder as a frequent cause of insanity. "The state of the intestinal canal," he says, "to which I allude, is itself much more frequently of an inflammatory nature than it has generally been imagined, or, at least, than it was formerly supposed to be. In that condition of the canal which gives rise to costiveness, alternating with diarrhœa, and accompanied with indigestion, flatulency, and eructations, anorexia and nausea, transient but often acute pains in the hypochondria, livid and yellow suffusions of the skin, viscid secretions in the mouth, or redness of the fauces and palate with a glazed and dry surface; the whole train of symptoms often depends upon a low degree of chronic inflammation in the mucous membrane of the intestinal canal; and this is perhaps a fre-

quent, if not an ordinary state, in those cases in which disorders of the nervous system supervene in complaints of the stomach and bowels." (*Op. cit.*, p. 206.) This disorder may originate from various causes, but generally owing to errors of diet. Worms can very rarely be traced as a cause of insanity.

Dr. Prichard's opinion is scarcely borne out by the present tables, inasmuch as the cases referred to "dyspepsia" are comparatively few; 14 among the men, and 6 among the women. It is not at all improbable that intestinal disorder has very often been overlooked by the persons supplying the past history of the patient; indeed, the subsequent account often makes it appear certain that this is the case.

Physical Causes peculiar to Females. Arguing from the history of *hysteria*, we are at once prepared to expect that uterine disorder, in one form or another, will prove to be a frequent cause of insanity; and such is the fact, when the process of menstruation is insufficient and painful, there are often, as is well known, symptoms which may be said to foreshadow insanity; an irritable and quarrelsome disposition, a marked waywardness, a willingness to despond, which condition is still more evident when the menses are altogether suppressed: amenorrhœa is very frequently one of the causes

of insanity, particularly of dementia; certainly, menstruation is often suppressed in insanity, and its reappearance is as frequently contemporaneous with recovery.

The importance of uterine disturbance and hysteria, as physical causes of insanity, is well shown in these tables; for in 528 cases, 104 are referred to them. It is also more than probable, that uterine disturbance, or hysteria, has something to do with the cases ascribed to puerperal mania, and over-lactation.

The general conclusion which can be drawn from a consideration of the causes of insanity, is, that they are more or less obviously of an exhausting or depressing character; a view which shows indirectly that insanity is a disease of depression, exhaustion, and irritation.

CHAPTER X.

TABLE IX.

THE DURATION OF DISEASE BEFORE ADMISSION,
From 1846 to 1860 inclusive.

Duration of Attack prior to Admission.	Admitted.			Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Not ascer- tained	31	54	85	1	4	5	1	1	2	..	..	..
Under												
1 month	572	785	1357	390	537	927	129	233	362	41	51	92
2 months	261	437	698	148	264	412	67	117	184	23	25	48
3 "	182	297	479	86	168	254	60	92	152	16	20	36
4 "	116	202	318	56	103	159	42	72	114	10	8	18
5 "	58	129	187	18	58	76	24	51	75	3	2	5
6 "	50	95	145	22	30	52	22	64	86	1	6	7
7 "	46	85	131	21	26	47	16	38	54	2	2	4
8 "	30	68	98	9	23	32	16	34	50	2	2	4
9 "	30	48	78	14	15	29	11	21	32	2	1	3
10 "	16	31	47	4	11	15	10	17	27	1	2	3
11 "	18	27	45	3	6	9	8	11	19	..	1	1
12 "	..	..	..	1	..	1	7	5	12	1	..	1
	1410	2258	3668	773	1245	2018	413	756	1169	102	120	222

TABLE IX *a*.

THE DURATION OF DISEASE BEFORE ADMISSION,

From 1855 to 1860 inclusive.

Duration of Attack prior to Admission.	Admitted.			Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Not ascer- tained....	8	8	16	1	4	5	1	1	2	..	..	..
Under												
1 month	111	165	276	74	108	182	25	45	70	8	4	12
2 months	64	100	164	44	62	106	20	30	50	5	5	10
3 „	54	82	136	25	60	85	13	28	41	6	4	10
4 „	37	65	102	19	32	51	20	27	47	4	3	7
5 „	22	54	76	9	27	36	6	17	23	2	1	3
6 „	12	22	34	8	9	17	6	10	16	1	3	4
7 „	14	33	47	10	16	26	8	22	30	..	1	1
8 „	6	24	30	2	11	13	8	11	19	..	..	..
9 „	8	22	30	4	6	10	2	8	10	..	..	..
10 „	3	9	12	1	2	3	4	8	12	..	..	..
11 „	5	11	16	2	3	5	3	7	10	..	1	1
12 „	..	..	..	..	..	..	..	..	..	..	..	..
	344	595	939	199	340	539	116	214	330	26	22	48

According to the experience of the York Retreat, the probability of recovery in cases brought under care within three months of the first attack, has been found to be as 4 to 1, and excluding cases

complicated with serious bodily disorders, as 9 to 1 ; whilst in those not admitted until more than twelve months after the attack, the probability of recovery is less than 1 in 4. It is desirable to have a table in which the duration of the disease before admission is set forth, for, without this knowledge, it is impossible to form any correct idea as to the results of treatment. The precise form of the table is of secondary importance, and that which is adopted in this Hospital answers the purpose sufficiently well. At the same time it might be better, so far as the rules of the Institution permit, to arrange a table similar to that in use at the York Retreat, and in many other Asylums, by which comparison could be facilitated. This table divides the cases into four classes. The *first*, consists of cases of the first attack of not more than three months duration ; the *second*, of cases of the first attack, of more than three, but not more than twelve months duration ; the *third*, of cases not of the first attack and of not more than twelve months duration ; the *fourth*, of cases whether of the first attack or not, and of more than twelve months duration when admitted ; the last class would not be applicable to Bethlem Hospital. The following table, which is from Dr. Thurnam's work (p. 56,) exhibits the average proportion of recoveries, and the mean annual mortality, in cases of recent and longer duration, when admitted into the Retreat between 1796 and 1844.

Duration of Disorder when admitted.	Proportion of recoveries per cent. of the Admissions.			Mean annual Mortality per cent. of the Residents.		
	M.	F.	Mean.	M.	F.	Mean.
<i>First Class.</i> First attack, and within three months }	79.24	77.19	78.18	8.05	6.76	7.3
<i>Second Class.</i> First attack, above three, within twelve months }	46.15	43.75	45.	5.14	4.06	4.37
<i>Third Class.</i> Not first attack, and within twelve months }	55.55	65.03	60.95	6.78	5.1	5.82
<i>Fourth Class.</i> First attack, or not first attack, and more than twelve months }	14.65	23.38	19.16	5.24	3.98	4.57
Average	43.46	50.26	47.07	5.65	4.35	5.51

The information contained in this paper is interesting and important. In the first, second, and fourth classes, the probabilities of recovery are almost directly proportionate to the short duration of the malady before commencing treatment. In the third class, where the patients are not attacked for the first time, and the disease is within twelve months from its commencement, the recoveries are more numerous than in the preceding and apparently more favorable class; and how is this? Is it that many of these cases had very recently relapsed, and that the fact of one or more attacks in other cases was of less importance than the delay which had been allowed to elapse before the commencement of the treatment?

This is the only conjecture we can offer. In the deaths there is not the same progressive series; the per centage is higher in the first than in the three other classes. It is also higher in the third class than in the second and fourth; the numbers appear to show that the chances of death are considerably greater in the earlier stages of the malady, for the increased number in the third class can only be accounted for on the supposition that it is augmented by the recent cases which find their way into this class with the rest.

In the tables under consideration, the lesson taught is the same, and we are able in some degree to corroborate what has just been said respecting Dr. Thurnam's tables. The general conclusion is, that the chances of recovery diminish considerably and progressively as the time before commencing treatment increases in length, and this, whether the cases be those in which the patients are attacked for the first time or not. We learn, also, that insanity is more likely to be fatal in the earlier stages of the attack. This is evident; but are we to consider, in addition to this, that the disease is also fatal in direct proportion to the delay which has taken place before commencing treatment? If we are, then we may understand that the per centage of deaths should rise higher and higher where a delay of six months, or more, has taken place. The tables show that such is the case.

CHAPTER XI.

TABLE X.

THE NUMBER OF PREVIOUS ATTACKS,

From 1846 to 1860 inclusive.

Admitted.				Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
First attack..	913	1519	2432	450	773	1223	290	538	828	72	85	157
Several.....	479	703	1182	306	448	754	120	202	322	30	35	65
Not ascertained	18	36	54	17	24	41	3	16	19	..	..	..
	1410	2258	3668	773	1245	2018	413	756	1169	102	120	222

TABLE X_a.

THE NUMBER OF PREVIOUS ATTACKS.

From 1855 to 1860 inclusive.

Admitted.				Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
First attack..	225	410	635	123	231	354	85	143	228	17	13	30
Several.....	119	185	304	76	109	185	31	71	102	9	9	18
Not ascertained	..	..	..	..	..	..	..	..	..	..	..	..
	344	595	939	199	340	539	116	214	330	26	22	48

The information which may be drawn from this table is interesting. It might be supposed that the per centage of recoveries would be higher, and that of the deaths lower, in cases of the first, than in those of several attacks; but such is not the fact: on the contrary, the per centage of recoveries after the former is 48.3, after the latter 64.8; while the corresponding per centage of deaths is 7 and 5.3. It would appear therefore that a large number of *first attacks* terminated unsatisfactorily, and that the chances of cure were not inconsiderable where recovery had taken place on previous occasions.

From this table, it is possible that we may form an opinion as to the liability to relapse, for it may be represented in some measure by the proportion of those attacked for the first time, with those who have been seized more than once, that is, 2,432 to 1,182; a proportion which would show that 48 in every hundred may relapse. It is, no doubt, very difficult to arrive at any correct conclusion upon this point, and hence the diversity of opinion that prevails. Esquirol considers that about 10 per cent. of the recoveries relapse; Pinel and Desportes fix a higher number, 17 per cent.; Mr. Farr thinks 30 per cent. not too great, and Dr. Thurnam calculates that, at the York Retreat, the re-admissions were 23 per cent. of the admissions, and 50 per cent. of the recoveries; but, it is only by following through life a large number of cases after

recovery from the first attack, that the real liability to recurrence can be satisfactorily determined.

The only trustworthy information we possess is that which is furnished by the records of the York Retreat, on which perfect reliance may be placed, for we may assume that all the recurrent cases were brought back to the Retreat; added to which the peculiar constitution of the Society of Friends is such as to make it easy to preserve a correct history of each patient. This evidence may be found in the following table, in which Dr. Thurnam shows the history of 244 persons, who died at, or after discharge from the York Retreat, between 1796 and 1840, distinguishing the number of those who died during, and after recovery from the first, from those who died during, or after recovery from, any any subsequent attack of mental disorder.

Cases followed through life.	Died insane during the first attack.	Recovered from the first attack.				
		Total.	Recovery permanent, died sane.	Had subsequent attack.		
				Died sane.	Died insane.	Total.
Males 113	55	58	21	6	31	37
Females 131	58	73	24	14	35	49
Total 244	113	131	45	20	66	86

“With these facts before us,” writes Dr. Thurnam, “we may readily ascertain the proportion of second attacks, by dividing the total number of those who

experienced such, whether one or more in number, by the number who recovered from the first attack, according to the rule of proportion, thus:—131 : 86 : : 100 : 65.6. The proportion was as high as 65.6 per cent.; in other words, a relapse or recurrent attack occurred in two of every three cases in which there had been recovery from the first attack. * * *

Of 224 persons attacked with insanity, under all circumstances as to sex, age, and form of disorder, and as to proper care during the early stage of the disorder, 131, or 53 per cent., recovered from the first attack; during which the rest died. And in following the 131 through life, it appears that there was only one-third of these, *viz.*, 45, or 18.4 per cent. of the whole, where recovery was permanent. The remainder experienced one or more subsequent attacks, the majority dying in a state of insanity; so that of the whole number, rather more than one-fourth only, 65 (45 + 20), or 26.6 per cent., were in a state of mental health at the time of death; in round numbers, then, of ten persons attacked by insanity, five recover, and five die sooner or later during the attack; of the five who recover, not more than two remain well during the rest of their lives, the other three sustain subsequent attacks, during which at least two of them die. But although the picture is thus an unfavorable one, it is very far from justifying the popular prejudice, that insanity is virtually an incurable disease; and

the view which it presents is much modified by the long intervals which often occur between the attacks, during which intervals of mental health, (in many cases of from ten to twenty years duration,) an individual has lived in all the enjoyments of social life." (Thurnam, *op. cit.*, p. 122.)

CHAPTER XII.

TABLE XI.*

THE INFLUENCE OF THE SEASON,

From 1846 to 1860 inclusive.

	Admitted.			Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
January . . .	96	174	270	33	55	88				14	15	29
February ..	101	173	274	51	91	142				5	10	15
March	142	187	329	70	93	163				8	6	14
April	120	191	311	55	86	141				7	11	18
May	131	220	351	48	107	155				9	5	14
June	139	217	356	65	112	177				8	10	18
July	145	200	345	49	89	138				13	14	27
August	122	181	303	63	107	170				4	12	16
September ..	113	190	303	80	128	208				8	6	14
October	110	194	304	78	99	177				8	7	15
November ..	94	178	292	97	133	230				8	12	20
December ..	97	153	250	84	145	229				10	12	22
	1410	2258	3668	773	1245	2018				102	120	222

* No Tables kept from 1846 to 1855.

TABLE XI^a.

THE INFLUENCE OF THE SEASON,

From 1855 to 1860 inclusive.

Admitted.				Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
January	18	51	69	7	15	22	7	26	33	5	3	8
February ..	20	53	73	11	22	40	10	18	28	..	3	3
March	39	48	87	18	20	38	15	16	31	1	..	1
April	30	55	85	18	24	42	12	19	31	2	1	3
May	32	56	88	10	29	39	9	20	29	..	..	..
June	27	56	83	14	28	42	2	14	16	1	5	6
July	42	52	94	14	22	36	13	17	30	4	2	6
August	32	48	80	20	27	47	8	17	25	.	3	3
September ..	26	53	79	22	35	57	12	20	32	3	1	4
October	24	50	74	13	31	44	9	18	27	4	1	5
November ..	26	38	64	22	35	57	12	18	30	2	3	5
December ..	28	35	63	30	45	75	7	11	18	4	..	4
	344	595	939	199	340	539	116	214	330	26	22	48

Insanity is much influenced by the season, and the fact has for a long period been generally recognised. Esquirol first expressed a definite opinion on this subject, in a report of the Salpêtrière, from which we learn that the admissions were more numerous during the months of May, June, July, and August; and that the proportion decreased from September

to December; and diminished still more in February and March. The admissions during nine years (1806—1814) were, (Esquirol, *op. cit.*, p. 32,)

January . . .	162
February . . .	173
March . . .	187
April . . .	196
May . . .	243
June . . .	251
July . . .	265
August . . .	239
September . . .	206
October . . .	188
November . . .	198
December . . .	191
	2499

M. Esquirol also states that the recoveries were more numerous in spring and autumn than during the other seasons of the year.

The mortality in the same locality, and during the same period, was found to be greater in autumn and winter, than in spring and summer months; and the early months of the year were considered the most favourable for cure, inasmuch as more recoveries and fewer deaths were recorded at this season: 790 deaths occurred at the Salpêtrière between 1804 and 1814, and were distributed in the following manner,

March, April, May	175
June, July, August	174
September, October, November . . .	234
December, January, February . . .	207

The different forms of insanity were all affected with the same symptoms ; and the general impression that more melancholic patients were admitted during the cold and dreary seasons of the year, than during other months, was found to be incorrect.

The experience gathered from records of Indian practice is in harmony with the opinion of M. Esquirol ; for we learn from Dr. Wise that the greatest number of patients are brought into the Dacca Asylum between the months of April and November, (that is in the hottest period of the year,) that the largest number of recoveries occur during the cold months, and that the largest number of deaths are during the most unhealthy season of the year, which is from July to January. When the hot weather occurs suddenly, the number of admissions is increased, but cold has always the contrary effect. (*Psychol. Journal*, July 1853, p. 359.)

The influence of the season is very evidently written upon the course of insanity, and as a rule, the condition of the patient in summer and winter varies ; in summer and spring the disorder is more often acute than in autumn and winter, and there is also a strong disposition to relapse at the season corresponding to the first attack. These and some

other observations are made by Esquirol, but he does not give us the evidence upon which they are founded.

The experience of Bethlem Hospital during the last fifteen years agrees with that of the Salpêtrière, as reported by Esquirol, in the matter of admissions, but it differs in some degree as regards the question of recoveries and deaths. The admissions are more numerous in the six summer than in the six winter months, and particularly during the months of May, June, and July. The recoveries are almost equal in the winter and summer months, the highest numbers being in September, November, and December, and the deaths are also very similar, being 115 and 117 respectively, the highest numbers are in January and July, the lowest in September and March; but the differences are not sufficient to lead us to the conclusion that season has the same influence upon the deaths as upon the admissions and recoveries.

The subject of periodicity is connected with the influence of seasons, and the changes caused by season are periodical. They respond to the movements of the sun in his annual orbit and hence we are naturally led to ask whether there are changes in insanity responding to the diurnal rotation of the earth, and to the movement of the moon. The term *lunacy* would certainly connect insanity in an intimate manner with the moon, and in ancient time lunar influence was thought to

be important though such an opinion now receives very little sympathy. M. Esquirol says, "I have been unable to verify this influence, though I have been at some pains to assure myself of it. It is true that the insane are more agitated at the full of the moon, as they are also at early dawn. But is it not the light of the moon that excites them, as that of the day, in the morning?" (p. 32.) Much has been written on each view of the subject, and more will doubtless be written before we can be justified in arriving at any definite conclusion. Dr. Allen, of the York Asylum, for example, observed the times of death in 30 patients, and found that the deaths were more numerous at the new and full moon than at the quadratures; but Dr. Thurnam, on investigating the subject in the York Retreat, arrived at an opposite conclusion. This was also Dr. Thurnam's opinion on examining the deaths in the State Lunatic Asylum, at Worcester, in the United States of America. The question, indeed, may be considered as unsettled, and therefore it is desirable to obtain further facts by constructing tables which shall represent the daily, and perhaps hourly, changes in the symptoms of the insane. Much trouble would be involved in such an arrangement, but the result, we believe, would be more than compensatory, since great and practical truths are dependent upon the solution of the problem of periodicity.

CHAPTER XIII.

TABLE XII.*

THE STATE OF THE GENERAL HEALTH,

From 1846 to 1860 inclusive.

	Admitted.			Discharged.								
	M.	F.	T.	Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Good	..	..	..	616	918	1534	330	592	922	44	64	108
Bad	..	..	..	157	327	484	83	164	247	58	56	114
				773	1245	2018	413	756	1169	102	120	222

* No Tables kept from 1846 to 1855.

TABLE XII^a.

THE STATE OF THE GENERAL HEALTH,

From 1856 to 1860 inclusive.

	Admitted.			Discharged.								
	M.	F.	T.	Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Good	244	441	685	147	237	384	84	171	255	6	7	13
Bad	100	154	254	52	103	155	32	43	75	20	15	35
	344	595	939	199	340	539	116	214	330	26	22	48

The state of the general health of the insane is very uncertain, and it is doubtful whether it can ever be spoken of as good. Frequently there are signs of dyspepsia, and these symptoms are marked and distressing; indeed, so common and important are they, that Pinel was disposed to refer to them as the primary cause of insanity. Some attacks of mania are accompanied by more or less fever, and by symptoms indicative of an inflammatory condition of the brain; but, as a rule, the condition of the brain is the reverse to that of fever and inflammation. In the depressed forms of insanity, particularly dementia, the circulation is languid and feeble, the hands and feet, as well as the skin generally, are cold, clammy, and discoloured, and many of the usual and healthy secretions are interfered with.

A large proportion of the insane are obviously in *bad* bodily health. In the Bethlem table the proportion is 30 per cent. on admission, but this we believe to be no fair representation of the real case, for persons are often classified as being in "*tolerable health*," whose condition is not *indisputably* bad. It is of great importance to have correct information upon this point, for the physical state often has much influence in deciding the prognosis of the case. The chances of recovery, as one might expect, are less where the condition

of the health is bad, the proportion being 57 to 60 per cent.; but the chances of death are much greater, the per centage of deaths being only 4.7 where the health was good, and 13.6 where it was bad.

CHAPTER XIV.

THE FORM OF INSANITY.

The Tables in use at Bethlem Hospital do not describe the different forms of the disorder, and though from Nos. 13 and 14 certain indirect inferences may be drawn, none can be considered of real value. The classification of insanity is unquestionably a matter of great difficulty, and often, all attempts may be thwarted by the Protean manner in which the several cases change and interblend with each other. It is difficult, as a rule, to arrange all which are admitted, under the heads of *mania*, *melancholia*, or *dementia*, which conditions are sufficiently distinct to be understood, and we think that it would have been better to have followed this rough arrangement, as a provisional measure, rather than no classification at all. Certainly, we are of opinion that some table should be formed for future use, as it is scarcely possible to arrive at any correct conception of the varieties of insanity, and of their results, from the present tables, as it is we are able only to form a few detached

inferences from the records of Bethlem Hospital on the subject now under consideration.

TABLE XIII.

THE BEHAVIOUR,

From 1846 to 1860 inclusive.

	Admitted.			Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Violent or Dangerous }	744	1094	1838	686	1064	1750	373	664	1037	88	105	193
No indication of being violent or excited.. }	666	1164	1830	87	181	268	40	92	132	14	15	29
	1410	2258	3668	773	1245	2018	413	756	1169	102	120	222

TABLE XIIIa.

THE BEHAVIOUR.

From 1856 to 1860 inclusive.

	Admitted.			Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Violent or Dangerous }	158	240	398	113	159	272	79	123	202	13	8	21
No indication of being violent or excited }	186	355	541	86	181	267	37	91	128	13	14	27
	344	595	939	199	340	539	116	214	330	26	22	48

TABLE XIV.*
SUICIDAL TENDENCIES,
From 1846 to 1860 inclusive.

Admitted.				Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Have meditated or attempted Suicide	460	867	1327									
Intentions not manifested, or unknown	950	1391	2341									
	1410	2258	3668									

* No Tables kept from 1846 to 1855.

TABLE XIV a.
THE SUICIDAL TENDENCIES.
From 1856 to 1860 inclusive.

Admitted.				Discharged.								
				Cured.			Uncured.			Died.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Have meditated or attempted Suicide	125	238	363	81	148	229	36	82	118	9	9	18
Intentions not manifested or unknown	219	357	576	118	192	310	80	132	212	17	13	30
	344	595	939	199	340	539	116	214	330	26	22	48

In Esquirol's time, out of 1898 women admitted, during six years, into the Salpêtrière, 198, or a little more than one-tenth had made attempts to commit suicide. Dr. Thurnam calculates that about one-seventh of the whole number admitted into the York Retreat had exhibited suicidal tendencies. These proportions fall far below the numbers in the preceding table, which shew, that 460 against 950, or 32.6 per cent. among the 1410 men, and 867 against 1391, or 38 per cent. among the 2258 women, have meditated or attempted suicide.

It is not easy to offer a reason for the magnitude of these numbers. At first it would seem to countenance the idea, long since rendered obsolete by Dr. Burrows, that the inhabitants of Great Britain are particularly disposed to self-destruction. But, assuredly, there is no evidence to shew that suicide is more frequent in this country than elsewhere. On the contrary, the statistics of Dr. Caspar, in 1825, (and there is no cause to suppose that the figures are different in the present day,) shew the number of suicides to be 1 in every 10 inhabitants at Copenhagen, 1 in 41 at Paris, 1 in 50 at Hamburgh, 1 in 80 at Berlin, and 1 in 250 in *London*. (Esquirol, *op. cit.* p. 316.) The number of suicides among men and women varies in different places. Thus at Berlin, men commit suicide 5 per cent. more frequently than women; and in Paris 3 per cent. (Esquirol p. 316.) In our own tables, on the contrary, we

find the numbers altered, 38 per cent. among the women, and 32 per cent. among the men, having meditated or attempted suicide. Perhaps, it would be different if the patients in Bethlem had carried their design into effect; for then the preponderance in numbers might have been on the side of the men, they having the firmer purpose. It is an established fact, moreover, that suicides are more numerous in the spring and summer than during the autumn and winter.

CHAPTER XV.

The deaths which occurred in Bethlem Hospital, during the fifteen years, from 1846 to 1860, were from the following causes.

TABLE XV.

CAUSES OF DEATH,

From 1846 to 1860 inclusive.

Cause of Death.	M.	F.	T.
Acute Mania.....	8	15	23
Exhaustion	18	27	45
Fever	1	..	1
Asthma	1	..	1
Epilepsy	2	1	3
Disease of the Heart	..	4	4
Phthisis.....	12	22	34
Apoplexy	12	7	19
General Paralysis.....	19	9	28
Pleurisy.....	..	5	5
Dysentery	3	..	3
Erysipelas	2	4	6
Dropsy	1	..	1
Diarrhœa	1	5	6
Bronchitis.....	1	1	2
Pneumonia and Disease of the Lungs ..	10	4	14
Inflammation of the Brain and Membranes ..	6	10	16
Strangulation or Suicide	1	3	4
Decay of Nature	1	..	1
Scrofulous Disease of Knee joint	1	..	1
Suppression of Urine	1	..	1
Exhaustion from Suppuration caused by fracture of Tibia.....	1	..	1
Effects of a Burn.....	..	1	1
Cancer of the Stomach.....	..	1	1
Menorrhagia.....	..	1	1
	102	120	222

TABLE XV a.

CAUSES OF DEATH,

From 1856 to 1860 inclusive.

Cause of Death.	M.	F.	T.
Acute Mania.....	5	10	15
Exhaustion	..	1	1
Disease of the Heart	..	1	1
Phthisis.....	5	4	9
Apoplexy	4	2	6
General Paralysis	7	1	8
Inflammation of the Brain and Membranes ..	1	..	1
Decay of Nature	1	..	1
Scrofulous Disease of Knee joint.....	1	..	1
Suppression of Urine	1	..	1
Exhaustion from Suppuration caused by fracture of the Tibia	1	..	1
Effects of a Burn	..	1	1
Cancer of the Stomach.....	..	1	1
Menorrhagia.....	..	1	1
	26	22	48

A comparison of the causes of death among the insane, with those among the population at large, evidences a remarkable difference, which is well seen in a table by Dr. Thurnam, exhibiting the per centage of deaths from different forms of disease in the general population of England and Wales, and in the York Retreat (*op. cit.*, p. 108); the per centage in the latter being calculated from 139 deaths occurring during a period of 42 years. The fatal diseases are arranged upon the same plan as that adopted by

Mr. Farr in 1838, under the sanction of the Registrar-General, in his Annual Report, 1840, appendix p. 58.

TABLE shewing out of One Hundred Deaths, the number from each of twelve classes, and eight distinct forms of Disease in England and Wales, and in the Retreat at York.

Causes of Death.	In England and Wales, 1838.	In the Retreat, at York, 1796—1840.
1. Epidemic, Endemic, and Contagious Diseases	20.538	8.633
2. Diseases of the Nervous System	15.016	19.424
Including Convulsions (almost entirely of Infants)	7.879	..
" Apoplexy	1.703	11.510
" Paralysis	1.505	1.438
" Epilepsy.....	.330	4.316
" Diseases of the Brain	.425	2.158
3. Diseases of the Respiratory Organs . . .	27.484	24.460
Including Inflammation of the Lungs..	5.445	4.346
" Consumption.....	17.613	14.388
4. Diseases of the Heart, &c.	1.075	6.402
5. " Digestive Organs	5.387	14.388
6. " Kidneys, &c.	.493	.719
7. " Uterus, &c.....	1.007	.719
8. " Bones, &c.	.635	..
9. " Skin, &c.....	.126	..
10. Diseases of uncertain or variable seat....	13.389	13.669
11. Old Age	10.781	7.913
12. Deaths by violence	3.617	3.597
Including Suicide	.320	3.597

In this table the difference in the two columns is considerable, the per centage of deaths from epidemic, endemic, and contagious diseases, being 20,538 in the first, and 8,633 in the second; but this is an apparent, rather than a real inequality, for the per centage in the first is swelled to the extent of the difference by deaths among infants

and youths, since such persons did not find their way into the Retreat. The per centage of deaths from diseases of the nervous system is more nearly the same, that in the first being 15,016, and that in the second 19,424; but here, again, is a cause of error, for in order to institute a fair comparison we must deduct from the first the deaths caused by convulsions, since these, occurring principally in infants, have no perceptible place in the deaths at the Retreat. Thus the per centage of deaths from diseases of the nervous system in the general population, and at the Retreat, is not 15,016 to 19,424, but 7,137 (15,016—7,879) to 19,424, a difference which gives a great preponderance to the deaths at the Retreat. This excess appears all the more marked when the comparison is carried into the distinct forms of the diseases of the nervous system: thus, in the general population, the deaths from apoplexy are 1,703 per cent, from paralysis 1,505, from epilepsy 0,330, from disease of the brain 0,425; whereas, at the Retreat, the deaths from apoplexy are 11,510 per cent., from paralysis 1,438, from epilepsy 4,316, and from disease of the brain 2,158. As to the rest, the only varieties between the two columns, which demand attention, are to be found in the deaths from diseases of the heart, and from diseases of the digestive organs, the per centage at the Retreat being much higher in both cases; viz : 6,402 to 1,075 in disease of the heart, and 14,388

to 5,387 in diseases of the digestive organs. The difference is explained, so far as the diseases of the digestive organs are concerned, for such disorders are of frequent occurrence in insanity, and are considered by some to be a primary cause of the mental malady, but the same explanation cannot be offered as regards cardiac diseases.

Compared in this manner, the causes of death in Bethlem Hospital are different, both from those in the population at large, and also from those in the Retreat at York, the principal variation being in the great preponderance of deaths from diseases of the nervous system. The per centage of mortality from diseases of the respiratory organs is nearly that which is met with in the population at large, except in (what is not easily accounted for) an excess in deaths from inflammatory affections. The per centage of deaths from diseases of the heart and digestive organs bears a close similarity to the public return. Such, then, are the principal differences; to which may be added the number of deaths from diseases of uncertain and variable seat, the small numbers in Bethlem only shewing that the diagnosis had been carefully studied.

With regard to the evidences after death, we may disregard most of those as non-essential which are not met with in the brain, for it is now generally believed that the principal physical signs of in-

sanity may be met with in this organ. Pinel found obvious disease of this organ in not more than 68 out of 261 autopsies, and Esquirol in 77 out of 277; recent researches however, have led to different conclusions, partly because other signs besides those of inflammation are looked for, and and in some measure because the microscope and chemical analysis are brought to assist the naked and enquiring eye in such observations.

What in reality is the essential character of the alteration of the brain in insanity it is not easy to define. Is it, as Dr. Bucknill considers, atrophy, positive or relative? the former being the actual shrinking of the brain, the latter an interstitial change wherein the proper cerebral cell and fibres are replaced, to a greater or less extent, by the deposition of inert material. This was the experience derived from the annual examination, for ten years, of about thirty lunatics. During the first six years, the only view taken by Dr. Bucknill was that which influenced Esquirol, *viz.* — that morbid anatomy, in this case, afforded none but negative results. But he says, “I gradually became aware of this leading fact, that the brains of all persons dying insane, except those of some epileptics, presented well-marked appearances of deficient or degraded nutrition: they were all more or less atrophied, in a far greater degree than I had ever observed to occur in the brains of per-

sons not dying insane.” (See a paper on the Pathology of Insanity in the *British and Foreign Med. Chir. Review*, Jan., 1855.)

If we take as most recent evidence upon the subject, Dr. Gauster's retrospect of 179 autopsies, performed in the Vienna Lunatic Asylum in 1853, (*Jour. of Psychol. Med.*, Oct., 1855, p. 588,) we find that the facts most frequently noticed were, serous effusion into the cavities of the brain, and hardness of the substance. The presence of serum, in excess, within the skull, implies positive atrophy of the brain, and the hardened condition would seem to point to that relative atrophy in which the proper brain substance was replaced by common or degraded fibrinous deposits. This inference is the more probable, because the hardened condition was most frequent in cases which were marked by depression during life.

The conclusion is not different to that drawn from the experience of Bethlem Hospital, for of 113 autopsies, the particulars of which have been collected and published by Dr. Webster, (*Jour. of Psych. Med.*, Jan., 1855, p. 147; and April, 1855, p. 282,) the epitome, which requires no comment, is as follows:—

“ In 87 effusion had taken place into the ventricles; in 81 the pia mater was infiltrated; in 57 turgidity of the brain and membranes was observed; in 55 the arachnoid had become thickened

and opaque ; in 19 the colour of the brain appeared altered from its natural hue ; in 19, also, bloody points were both large and numerous upon the cut medullary surfaces ; whilst in 10 blood was effused, sometimes to a considerable amount, within the cranium."

CHAPTER XVI.

THE TREATMENT OF INSANITY.

The treatment of insanity varies according as the case to be treated is acute or chronic, and we will refer to it in accordance with this division, thinking it better to do so, than to consider the subject by reference to the means used, since in practice it is difficult to draw the line between the remedies which are called *therapeutical* and those which are recognized as *moral*.

I. In acute cases, properly directed therapeutical means are of much importance, and this fortunately is no longer a contested point. The days are past when the skill and experience of the physician was thought to be less important than the watchful care of the matron or steward, and when the patients were shut up for many years without any proper medical attention. This is no exaggerated or imaginary grievance. In proof we have the evidence of Dr. Weir, who visited the lunatic naval officers and seamen confined in Haslar House in 1814—15, and his evidence is fully borne out by other observers, that “some of them (the patients) have been

there for fourteen years, to whom a single grain of medicine had never been administered for the cure of their insanity." (*Report of the Commissioners in Lunacy*, 1847, p. 851.)

One question for consideration is, "Do the symptoms require the use of antiphlogistic treatment?" At one period no other measures were suggested. In this Hospital, forty years since, "the system of treatment consisted of bleeding, purging, and vomitings in the spring months. A certain day was appointed when patients were to be bled, another to be purged, another during which they were vomited. They were bled again in May and June, the precise time depending upon the weather." "All this had been the practice for many years, and no better practice, it was stated, was then known." (*Report of Commissioners in Lunacy*, 1847, p. 85.)

Many different opinions have been entertained with respect to the propriety of antiphlogistic measures, the difference depending more or less upon the theories of disease prevailing at the time, and upon the habits of the people themselves. There is no doubt, that formerly it was too frequently the habit to refer all diseases to inflammation, and to suppose that condition invariably required lowering measures. Inflammation of the brain was presumed to be the constant cause of insanity, and great authorities may be cited in favour of this opinion, and of the treatment founded upon it. At the same

time it is not less true that men of authority since Pinel and Esquirol, have been disposed to take a different view of the importance of inflammation, and to ascribe the phenomena of insanity to an irritated, rather than to an inflamed condition of the brain, and such is the prevailing opinion at the present day.

Inflammation of the brain is undoubtedly an important element, either directly or indirectly, in the phenomena of insanity. But what is inflammation? It may be either sthenic or asthenic, and which is it in the case under consideration? If we argue from the causes of insanity, all of which are more or less exhausting or depressing, we should certainly argue that any inflammatory condition in insanity was asthenic rather than sthenic in its nature; and this opinion is not contradicted by the results of a treatment which now for the most part is the reverse of antiphlogistic. Again, it is very possible that the character of the inflammation may have changed since the time when antiphlogistic measures were more prevalent than they are at present, since the habits of the people are more temperate and abstemious than they were at that time.

Be this as it may, there can be no doubt that experience has decided against the expediency of loss of blood in insanity. Pinel and Esquirol both agree in discountenancing altogether the use of the lancet; and, arguing from their own experience,

they report, that general bleeding not only does no good, but that it tends to accelerate the advent of dementia, which is frequently the sad issue of insanity. If there be any cases which would require such depletion, they would certainly be those admitted into this Hospital; but we have not any hesitation in saying, that no more reason has been seen for venesection than in the chronic cases admitted into the Colney Hatch Asylum.

These remarks do not apply to local bleeding, as leeching or cupping, but even these moderate measures are seldom necessary. Shaving the head, and the continued application of cold to the scalp, either by ice or in some other way, as a general rule, will most frequently answer the purposes required.

It is, no doubt, difficult to arrive at a positive conclusion respecting the necessity of abstracting blood in cases of mania; but, among other facts bearing upon the subject, there is one, at least, which ought to be borne in mind, and this is the experience of the Gloucester Asylum, when the Institution was under the superintendence of Dr. Hitch and Dr. Shute. At that time we learn, from Dr. Prichard, (*op. cit.*, p. 261,) that the use of the lancet, leeches, cupping glasses, blisters, drastic purgatives, and the practice of shaving the head, were totally proscribed; and yet the experience of the asylum afforded a "very large proportion of re-

coveries, and *no cases* of sudden apoplexy, or hemiplegia."

But if blood is not to be abstracted, how are we to combat those symptoms of inflammation, frequently very violent, with which we have to deal? Are we to apply cold to the head, and to give purgatives, or nauseates, or opium; or are we to leave the disease to its natural course, so far as pharmaceutical measures are concerned, and merely prevent the patient from doing harm to himself or others?

It is sometimes of importance to cut the hair short, or to shave the scalp in the first instance; and afterwards to keep the head cool by the application of ice or spirit lotion. The removal of the hair will often produce a marked tranquilizing effect. The application of ice is preferable, in our opinion, to the cold water douche, as a means of cooling the head, for the ice being enclosed in a bladder, or oil-skin bag, the rest of the body is not chilled by the overflow of cold water nor the patient alarmed by the violent shock. Often, indeed, the temperature of the body is below par; and it is desirable to employ means to raise its temperature, while the ice is applied to the head, and in these cases the application of cold, by the douche, should altogether be avoided. It is certain, also, that the application of the douche, or shower bath, is very liable to be followed by reaction and renewed

excitement, and is generally attended with alarm and anticipated with dread.

Purgatives are powerful means for depressing the system; and they have been favourite remedies in the treatment of insanity from remote antiquity. Hellebore was once, indeed, the remedy, "*par excellence*," for madness. There is no doubt indeed, that purgatives, used with discretion, are of great value, and that they answer nearly all the purposes for which blood-letting was resorted to, without impoverishing the system to the same extent; but it is not less true, that they often act injuriously when, as frequently happens, the mucous membrane of the alimentary canal is in a diseased state. Esquirol was the first to direct attention to the caution which is necessary in their use.

Digitalis was once employed, to a very considerable extent, as a means of reducing the excitement of insanity; but antimony is now found to answer more effectually the same purpose. Dr. Prichard says, that one or two grains of tartarized antimony, every three hours, with the addition of a small quantity of opium to prevent its speedy rejection by the stomach, will often induce a general relaxation, free perspiration, a soft pulse, and a cool skin, purgations being associated, if there is constipation. This practice is now both general and effectual. In Bethlem Hospital we commence with much smaller doses of the antimony, generally one-half, or a third

of a grain, and do not add the opium, unless the mixture causes purging.

Opium, in some of its forms, is a very important remedy, and one which is continually required, though many are prevented using it freely, from fear of inflammation. Often, indeed, it is almost the only remedy (as when depletory measures have failed) to calm the excitement of the patient. It is valuable to notice, as tending to shew the present disposition to regard insanity as depending upon irritation rather than upon inflammation, that morphia *may* be given in very large doses, and with undeniable benefit.

Hyoscyamus is indicated in certain idiosyncracies, but, in the majority of instances, there is no doubt that morphia, or opium, alone, or in combination with antimony, on the one hand, or with various stimulants, remedial or diatetic, will answer every requirement.

But are we to resort to mechanical restraint, or to various mechanical contrivances, such as the muff, strait-waistcoat, or gloves, &c., in order to quiet the excitement of the insane? All are willing to abandon the more severe agents for mechanical restriction, but all are not agreed upon the question of restraint in a modified form. This appears very clearly in the answers to the circulars which were addressed by the Commissioners of Lunacy to the Superintendents and Medical Proprietors of the

principal Lunatic Asylums, public and private, in England and Wales, requesting information upon the necessity, or non-necessity, of seclusion and instrumental restraint in the treatment of insanity. Among the answers to these circulars there were seven which advocated the qualified use of mechanical restraint; twenty-eight which were for its total abolition; thirteen in which the writers did not use restraint, but who gave no opinion on the abstract question; four which advocated the use of restraint in surgical cases; and two which gave a qualified opinion on the subject of non-restraint. For my own part, I think that temporary seclusion in the bed-room, or, if the patient be dangerous, in the padded-room, will *usually* be found sufficient; if not, the administration of sedatives or depressants, in the manner I have described, will generally be found effectual. It may be asked, whether more harm may not result from the medicine than from the restraint, and whether, considering the general want of power in the insane, we can afford to sacrifice any to medicine: but this is avoiding the whole question, for it is assumed that the medicines are given with ordinary care, and in conformity with established rules. If the medicines are prescribed, it is presumed they would be administered whether restraint was required or not.

The experience of Bethlem Hospital, as regards the subject of restraint, is a matter of considerable

interest, since from 1850 such a measure has been entirely discarded, and before this time the use of it had been gradually diminished.

II. In chronic cases the use of medicines, though occasionally necessary, is less imperative than in acute form. It is important to correct the several physical errors connected with insanity, and restore the general health of the body, since it often happens that the mind regains its standard when this is done.

One great feature in the treatment of insanity is to sever the patient from the associations of home; and, therefore, it is desirable to prevent the too early visits of relatives and acquaintances. This is an important rule, upon which all authorities are agreed. M. Pinel, in his *Treatise on Insanity*, has pronounced seclusion to be the foundation of all rational treatment of mental diseases. Dr. Heberden says "that if insane persons are taken away from their friends and servants at the beginning of the attack, and placed under the care of strangers, in a short time they recover without any remedies." (*De Insania comm. cap. 53.*) Dr. Burrows says, "I have known the sight of the handwriting, so also of a garment, ornament, book, or any trifle of a beloved, or respected, or detested object, destroy in a moment, the most marked proofs of amendment; and the same effect will, sometimes, be produced

from merely mentioning persons or things with which there was a morbid association of ideas." (Dr. Burrows *on Insanity*, p. 700.) Again, "Willis, who acquired great celebrity by having assisted towards the happy termination of the first attack of madness experienced by George III., removed the furniture from the King's apartment, dismissed his courtiers and domestics, and engaged strange servants to attend on His Majesty. Willis asserts, moreover, that insane persons from the Continent, who came to seek his advice, recovered more frequently than his countrymen." (Prichard, *op. cit.*, p. 281.) There are, of course, exceptions to this general rule, which must be recognized by the skill and observation of the physician in attendance, but that removal from home and its associations is a most valuable element in the treatment of the insane, and that the unnecessary and injudicious visits of friends will do much to prevent the successful termination of many cases, cannot be doubted.

Another important point in Asylum management is to associate and classify the inmates in a judicious manner, and as Dr. Prichard pointed out, it is desirable to allow the melancholy patients to have among them those who are joyous, though eccentric, since these latter may assist in dispelling some of the gloom which overshadows the minds of their companions.

Exercise is a great incentive to mental restoration,

and at a certain period of convalescence, frequent change of scene, and long walks beyond the precincts of the Asylum are, with proper care, of much benefit. Cricket, bowls, or skittles, and other games requiring skill and activity are also of value, as well as any amusement which can be commanded within-doors, but occupation, where it is practicable, must not be neglected, as it is even of greater importance than amusement; indeed systematic employment, in various forms, is now duly recognized as essential to successful treatment in all properly conducted Asylums. Pinel recommended that every asylum should have a farm connected with it, by which occupation could be provided for the patients, and great credit is due to the late Sir William Ellis for having called attention to this subject, by giving appropriate work to the patients successively under his care at Wakefield and Hanwell. Esquirol mentions a fact from Bourgoise's *Travels in Spain* which speaks volumes on this subject, and requires no comment: it is, "that the rich in the Hospital for the Insane at Saragossa are not restored in the same ratio as the poor, *because* they are not obliged to labour."

TABLE XVII.

THE NUMBERS ATTENDING CHAPEL.

From 1847 to 1860 inclusive.

Year.	Number of Patients.	In attendance on Chapel.	Per Centage.
1847	292	147	37.5
1848	399	138	34.58
1849	406	138	33.9
1850	391	147	37.59
1851	388	133	34.28
1852	374	132	35.56
1853	343	141	41.1
1854	311	159	51.1
1855	334	170	51.5
1856	340	179	52.64
1857	321	171	53.27
1858	354	192	54.23
1859	353	195	55.21
1860	341	194	56.89

The minds of most invalids are comforted and fortified by religious instruction and advice, and the insane are much more capable of receiving such consolation than was once supposed to be the case, indeed there cannot be many Asylum Chaplains who could not narrate some instances in which they have witnessed, how happily a few verses of Holy Scripture, or a short prayer appropriately worded, has tranquillized the reeking passion of mania, or removed the heavy cloud of gloom which was bowing down the melancholic sufferer. The table which gives the numbers attending Chapel in Bethlem Hospital, exhibits a considerable annual increase during the last fifteen years.

TABLE XVIII.

THE DIETARY.

BREAKFAST.			
Every Day ..	Males ..	Tea, with 7 oz. of Bread and Butter.	
	Females..	6	ditto
DINNER.			
Sunday ...	Males .	{ 6 oz. Boiled Beef } free from bone	4 oz. Bread, $\frac{3}{4}$ lb. Vegetables, 1 pt. Beer
	Females..	5 ,,	4 ,, $\frac{1}{2}$,, $\frac{1}{2}$,,
Monday	Males ..	6 ,, Roast Mutton,	4 ,, $\frac{3}{4}$,, 1 ,,
	Females..	5 ,,	4 ,, $\frac{1}{2}$,, $\frac{1}{2}$,,
Tuesday ...	Males ..	6 ,, Boiled Mutton,	4 ,, $\frac{3}{4}$,, 1 ,,
	Females..	5 ,,	4 ,, $\frac{1}{2}$,, $\frac{1}{2}$,,
Wednesday..	Males ..	6 ,, Roast Beef,	4 ,, $\frac{3}{4}$,, 1 ,,
	Females..	5 ,,	4 ,, $\frac{1}{2}$,, $\frac{1}{2}$,,
Thursday.....	Same as Monday.		
Friday.....	Same as Tuesday.		
Saturday...	Males ..	16 oz. Meat Pie,	4 oz. Bread, 1 oz. Cheese, 1 pt. Beer.
	Females..	14 ,,	4 ,, $\frac{1}{2}$,,
SUPPER.			
Sunday, Monday, Tuesday, } Thursday, and Friday	Males.... Same as Breakfast.		
Wednesday and Saturday ..	Males....	7 oz. Bread, 2 oz. Cheese,	1 pint Beer.
Every Day	Females..	Same as at Breakfast.	

Patients in employment in the Grounds, Workshops, or Wards, to be allowed 4 oz. of Bread, 1 oz. of Cheese, or $\frac{1}{2}$ oz. of Butter, and $\frac{1}{2}$ pint of Beer for Luncheon, and $\frac{1}{2}$ pint of Beer in the Afternoon.

Every patient to be allowed $1\frac{3}{4}$ oz. of tea, 8 oz. of sugar, 8 oz. of Butter, and $1\frac{1}{2}$ pints of milk weekly.

The Dinners to be further varied by the occasional substitution of Pork and Bacon, when Peas and Beans are in season; and also by Fish, and Fruit Pies, when such are plentiful and good.

The Sick to be dieted at the discretion of the Resident Physician.

Experience has shewn the necessity of providing a liberal diet for the insane. Dr. Thurnam has very carefully investigated this point, and with a desire to arrive at some general conclusion as to the influence of diet upon recovery or death, he examined the statistics of several County Lunatic Asylums in England. He refers only to the past, and it must be understood that alteration has long been made in the majority of cases where correction was then needed; and the result of the increased liberality fully confirms the accuracy of Dr. Thurnam's conclusions. His table is the following:—
(Thurnam, *op. cit.*, p. 96.)

	DIET.					RESULTS.	
	SOLIDS.			LIQUIDS.		Prop. of Recoveries per cent. of the Admissions.	Mean Annual Mortality per cent. Resident
	Cooked Meat and Cheese.	Bread, Pudding, Flour, &c.	Total Solids, except Vegetables.	Porridge, Milk, Soup, Broth, &c.	Beer.		
	ounces.	ounces.	ounces.	pints.	pints.		
Nottingham 1812-40.. }	46	202	248	15	14	43.09	7.34
Stafford, 1818-40.. }	46	192	238	7	14	43.08	13.53
Gloucester, 1823-32.. }	46	144	190	9	14	44.94	7.19
Average of the three }	46	179	225	10	14	43.7	9.35
Lancaster, 1816-40.. }	24 $\frac{3}{4}$	113 $\frac{1}{2}$	138 $\frac{1}{2}$	7	3 $\frac{1}{2}$	40.17	18.01
York (West Riding), 1818-41.. }	18	116	134	25	..	44.18	16.16
Suffolk, 1829-41.. }	16 $\frac{1}{2}$	152	168 $\frac{1}{2}$	12	5 $\frac{1}{2}$	40.53	12.32
Middlesex, 1831-39.. }	18	122	140	18	3 $\frac{1}{2}$	22.12	11.69
Average of the four.. }	19 $\frac{1}{4}$	125 $\frac{3}{4}$	145	15	4 $\frac{1}{8}$	36.75	14.54
Middlesex, 1839-43.. }	35 $\frac{1}{2}$	126	161 $\frac{1}{2}$	9	7	28.75	8.56

These seven Asylums, Dr. Thurnam proceeds to state, (*op. cit.*, p. 95,) may be fairly divided into two groups; in one of which the diet is, or *was* at the time to which the table refers, considerably above, and in the other considerably below, the average diet of the county asylums as a class. In the first group, as regards solid food, the diet was

50 per cent. better than that in the second. The difference in the relative amount of solid animal food, considered separately, was still greater, and amounted to 130 per cent.; the weekly allowance of meat and cheese being, on an average, 46 ounces in the first, and only $19\frac{1}{2}$ ounces in the second group. In the first group, also, a larger quantity of beer, (2 pints daily,) was allowed than in the second group, (not more than half-a-pint in two cases, and three-quarters of a pint in one.)

“That in institutions in every way of the same character,” writes Dr. Thurnam, (p. 96,) “there should be so large a difference in the quantity and description of the food is, of itself, sufficiently surprising, and would, without any reference to results, appear to call for enquiry, and equalization upon some ascertained principles, as regards the requirement of the insane in this respect. But should it be found, as from the preceding table appears highly probable, that the diet of the insane does, in truth, exert a material influence upon the results of treatment, and upon the proportion of recoveries and mortality, the necessity for some such enquiry into, and equalization of the diet in different Asylums and Hospitals for the insane becomes still more obvious. In the three Asylums with the more liberal diet we find that the recoveries averaged 43.7 per cent., and that the mean mortality was 9.35 per cent.; whilst in the four Institutions in

which the diet was less liberal and nutritious, the recoveries only averaged 36.75 per cent., and the mean mortality was 14.54 per cent. It must not, however, be forgotten that there may be, and no doubt are, other circumstances in the condition of these Asylums, which materially influence the results of treatment, and which will thus explain many of the discrepancies in the results which the table exhibits; but, though this is the case, I cannot but conclude that the amount of the difference which does exist, is, in a great measure, dependent upon the difference in the diet."

Colliquative diarrhoea and dysentery appear to have prevailed to a very considerable extent where the diet was insufficient and unnutritious, and were the cause of frequent deaths in many of our pauper Asylums, but this has not been the case since a better diet was adopted. It is also a very interesting fact that these affections made their appearance in the Bicêtre, in 1795, after a great reduction in the diet had been made by order of the revolutionary Government.

The Diet Table of the Bethlem Hospital has always been liberal and satisfactory; and we are not able to confirm what has just been stated by our own observation.

It has been well proved that kindness and firmness on the part of the physician in charge, and the attendants under his orders, are essential to the

success of any treatment, and, that the patient, though not to be controlled by coercion and fear, can, with gentleness and persuasion, be *easily managed*, is the experience of each day in every large Lunatic Asylum. When chains were abolished at the Bicêtre, by Pinel, there was a remarkable diminution in the number of furious lunatics, and of the accidents from which they suffered. How far it is desirable to acquiesce in the delusions of a lunatic, when conversing with him, it is difficult to say, certainly they will not be dispelled by contradiction. The attention of the patient must be diverted in every possible way, and by occupying his mind with fresh ideas, impulses, and scenes, a new career of thought and action will be provided which may erase the lingering delusion from his mind.