2dly, Vaccinate all these men. The place to perform the operation is of some importance; it ought not to be done directly above nor directly below the old cicatrix, but upon one side or other. Let these men then, with their immediate attendants, be kept separate and under observation for about a week; in the course of which probably more than the half of them may be discharged to duty, as in some the vaccine will not take at all, and in others but slightly.

3dly, Let a man who has had the disease be the only means of communication between the separated men and the galley or kitchen, etc.

It has not been my intention to speak dogmatically on this subject, as I have only myself to bring forward as evidence of the efficacy of the plan, in which I firmly believe. I would wish others who have the opportunities and facilities for making experiments on this subject to do so, and communicate the results arrived at to the profession; as all must admit, that if by any means the scourge of smallpox can be averted or disarmed of some of its more terrible phases, surely no stone should be left unturned to arrive at so desirable a result.

H. M. S. PSYCHE, *Malta*.

ARTICLE IX.—*On Temporary Insanity*. By W. LAUDER LINDSAY, M.D., F.R.S.E., Physician to the Murray Royal Institution for the Insane, Perth.

I. *History of a Case*.—About seven o'clock, one evening last winter, I was hastily summoned to a neighbour's, to see one of his servants, a cook, (of whom I may more conveniently speak hereafter as A. B.), who was said to have become suddenly and alarmingly ill. The messenger sent explained, on cross-examination, that the patient was "out of her mind;" that something had "gone to her brain." Losing no time in obeying the summons,¹ I found the household, a large one, thoroughly upset; its members, especially the domestics, consisting of three women and one man, in a state of great alarm, their energies paralyzed.

I first saw the family, and learned from them that nothing had been observed amiss in the patient's health, mental or physical, or in her behaviour, till she was dressing dinner about an hour before, when she suddenly dashed down the dishes, rushed to a window, and drove her hand through a pane thereof, becoming greatly excited, and weeping violently, protesting that the dinner was wrongly prepared, and that she was looked down upon by her fellow-servants. It appeared that she had, at some prior period,

¹ I may explain that my visit was altogether *non-official*, and, in one sense, *non-professional*; it was simply that of a neighbour and an old acquaintance of the family.

been a cook in the same house; that she had thereafter served in a similar capacity in a gentleman's house in the country; but at last term, only four days before, she had returned to her old master. She imagined that, in consequence of or in connexion with this return to her old master's house, she was despised by her companions. She had been sent into town in the forenoon of the same day, and this fact was connected, by the family, with the sudden outburst of mania: drink and delirium tremens being the supposed cause and effect. I had, however, a private interview with her sister, who was one of her fellow-servants. She assured me that neither drink nor disordered uterine functions had anything to do with the causation of the outbreak, which she attributed entirely to emotional excitement. All subsequent inquiry went to prove the correctness of the girl's surmise and statements. Her fellow-servants generally were ready with narratives of *prodromata*. They described the patient as having been "peculiar" all afternoon,— "fidgetty," "fast," "funny;" as naturally "touchy" or irritable; as having long complained of "pains in her head," which, however, her sister referred to *tic*.

Soothing measures were found not only useless, but the attempts made only added to the excitement. She raved and tore her hair violently, and all her actions for a time were those characteristically described as "frantic." She showed a determination to escape from the premises, which escape was—dreading some accident therefrom—very properly prevented by her master. Fortunately he—and he alone of the household—had the strength of arm, as well as firmness, friendliness, and tact necessary to her control. But this physical strength she tested to the utmost in more than one struggle with him, the results of which were fortunately for both parties, as well as for the household, in *his* favour. During her first paroxysm, he saw her alone; for all the other members of the household were too timid, too much alarmed to be capable of any effectual assistance. In a struggle which ensued, she smashed a window and endeavoured to get her head through the framework,—picking out the pieces of broken glass,—whether with a view to suicide or escape, or with no specific object, it is impossible to determine. It became necessary to shut her up by herself in a larder, where, however, she was surrounded by knives and other lethal weapons, which might have been rendered of deadly service.

Under all the circumstances of the case, *as described to me*, for I had not as yet *seen* the patient, I suggested that this excitement would probably prove a mere paroxysm, and would be transient; that it would, as yet, be not only unnecessary but injudicious to commit her to a Lunatic Asylum; that it was probably better I should not visit her, inasmuch as being known as the head of an Hospital for the insane, the effect on the patient at some subsequent period, if not at the time, might be prejudicial; that should it be necessary to have her visited by a physician, the proper person was

the ordinary family physician ; and that removal from the sources and scenes of her irritation, seclusion and quiet, with sleep, were the measures immediately indicated as likely to be beneficial. The patient's sister, however, as well as the family generally, were urgent that I should see her forthwith ; the more so that she was now heard to be kicking violently at the door of the larder in which she was confined, and there was a general impression or dread that some accident to life or property might occur. The only course open to me was to comply with this request, and I accordingly accompanied the master of the house to the patient's temporary place of confinement. I found her a stout, plethoric, bloated woman, apparently about forty—a subject for Bantingism—weeping violently, and in a state of great excitement. The burden of her plaint was that she wanted away—must be away—forthwith—now—anyhow—anywhere. Her master's house had evidently become, for some reason not explained, unbearable for the moment, and she was determined to leave it by any manner, promising, however, to return next day and resume work. When soothingly addressed by her master, who expressed his good opinion of her services as cook, she at once shook her head decidedly, weeping bitterly, and exclaiming, No, no ! sobbing forth that she had been “ a bad servant,” and had “ done nothing that was right.” I was desirous of having her removed from the larder, both on account of its coldness, and of the danger arising from the numerous weapons that might, in a fit of frenzy, be turned to desperate account. I therefore proposed, with a view to prevail on her to go to bed, that she should go up stairs to her own bedroom. She gave her promise that she would go quietly up stairs were the larder door unlocked. It accordingly was so ; but the moment egress was given she fled along the passages of the large house. The household were neither to be heard nor seen ; apprehending violence from coming in contact with the patient, they had given her the widest possible berth, and had secluded themselves for their own safety in distant parts of the premises. No assistance, therefore, was at hand, while the patient was furious and ready to brave all obstacles. She was overtaken in a passage, and another struggle ensued with her master, whom she would have assaulted and overcome, had not his strength of muscle been superior to hers. We guarded her up stairs to her room, the window of which was carefully fastened, and two of her fellow-servants were ultimately placed beside her, on the understanding that her master and I would be at hand, and that additional assistance would be forthwith supplied. Afraid to leave her alone with her custodiers until we could be thoroughly assured of their courage and vigilance, we merely adjourned to an adjoining room. But scarcely had we done so when we were startled by sudden screams and a scuffle in the room we had just left. On re-entering we found the window-shutters thrown back ; the window itself open nearly to the top ; the patient on the floor ; one attendant exhausted by terror, and the

other by her struggles to prevent the patient jumping over the window. It appeared that the two attendants had just sat down, anticipating no immediate danger, door and window being alike secured, when the patient, who was sitting on her bed in a corner of the room, rushed in a moment to the window, threw open all its fastenings, and was half out, when her dress was seized by one of her two companions, who by main force pulled her back on the floor. It now became evident that no part of the house was sufficiently secure for her incarceration; none of its household trustworthy as custodiers; while the risk of accident was imminent, and the necessity of incessant and careful watching apparent. Additional temporary assistance was obtained of a similar untrustworthy kind; a hasty consultation was held, and various plans of treatment suggested themselves. All, however, were found, on consideration, impracticable or inexpedient save one, immediate removal to the adjoining Lunatic Asylum. The following were the chief proposals hastily discussed:—

1. Removal to her mother's house in town; but it transpired that domestic unhappiness, connected especially with her relation to a sister, who resided with or kept house for her mother, was the immediate, as well as ultimate, cause of her illness. This, then, was the *last* arrangement that could be thought of, so far as the poor woman's welfare was concerned. Fortunately for the patient, her welfare was by her master considered before the convenience of his own family. Besides, in her mother's house there would have been even greater difficulty in procuring suitable attendants.

2. Removal to an isolated lodging in town. Here, again, the difficulty as to custodiers at once presented itself. It was evident that the girl's sister was utterly unfitted, by reason of nervous prostration, induced by intense excitement and alarm, to act as nurse or attendant; and, as will be shown in due course, the dangers of intrusting so violent a patient to untrained, stranger-attendants are of such a kind as should not be lightly encountered.

3. Removal to the police-office. But the subsequent effect on the patient's mind of having been treated as a criminal, while suffering from disease, would almost inevitably have been prejudicial, while it was altogether repugnant to the feelings of a kind, indulgent master.

4. Removal to a public Lunatic Asylum, which happens to be close at hand. This appeared to be the only alternative left; and, on being appealed to, I found it impossible to recommend any other procedure that would be equally safe for patient and community. The master of the house dreaded suicide, or assaults of a dangerous kind; he declined the responsibility of having her watched and treated in his own house; and he equally desired to avoid the possible results of sending her to town as suggested under proposals Nos. 1, 2, and 3, immediately preceding. He therefore felt himself constrained to contemplate sending her to the Lunatic Asylum, and measures were forthwith taken to have this procedure adopted.

In order to the admission of a patient into an asylum, however, certain legal forms are necessary,—implying not only trouble and expense, but what is of more consequence at such a crisis, *delay*. A petition must be presented to the sheriff; two medical men must certify to the insanity; the sheriff must grant an order for admission; and somebody must come under obligation to pay the patient's board, and to conform to the regulations of the institution as to clothing, removal on recovery, and so forth. [Unless under what is termed a "*Certificate of Emergency*," which "authorizes the detention of a patient in an Asylum for a period not exceeding three days, without any order by the Sheriff." There are, however, so many and such serious technical difficulties in such a procedure, that I have never myself taken action under this certificate.] Hence arose a fresh set of difficulties; but, during our deliberations, the night was waxing on. The family physician and another medical man were at once sent for to town; and, meanwhile, an asylum schedule was procured, which the master of the house proceeded to fill up as law requires. He was immediately staggered by two points: 1st, That *he* must, *in his own person*, not only take all the responsibility of sending the patient to the asylum,—contrary to the wishes of her sister, who was consulted on the subject,—and the chances of recriminations from her friends, with, perhaps, an action of damages; but also, 2dly, Bear all the expense of her transmission thither and detention there. For neither of these steps did he find himself prepared, and there was a consequent pause in this line of procedure.

Meanwhile, the doctors from town had arrived; and meanwhile, also, the patient, finding all her efforts at escape for the time futile, had acted on my advice, and had laid herself down on bed. Her attendants, however, male as well as female, had, probably in alarm, left her *alone*, a proceeding that *might* have led to the most disastrous consequences, for precipitation from the window would probably have proved fatal. Being quiet, she was reported as being sound asleep. I considered it advisable, however, that we should be assured of her really being in the room—in bed—and asleep, as well as take measures for more careful watching for the future. Accordingly, one of the physicians who had just arrived, entered her room, forcing the door; he found her in bed, but awake, though comparatively composed. He gradually succeeded in engaging her in conversation, and in the presence of her sister alone, in eliciting some history of her illness. There was a good deal of hysterical excitement and weeping during the narration; but the unbosoming of her grief had an immediate and most salutary effect.

It appeared from the testimony of both sisters—the one corroborating the other—that some unhappiness had long existed between the patient and the sister, who keeps house for their mother, of such a nature as to prevent the former visiting her mother. She had not been in Perth for a long period, and, consequently, had had no oppor-

tunity of seeing her mother, but the matter had preyed on her mind for months while she was at service in the country. On the forenoon of the day of her illness, she had had an opportunity of visiting her mother, having been sent to town on a message by her mistress. She felt most acutely her inability to avail herself of her opportunity, and came home in a state of great hysterical excitement. This she contrived to subdue till she was preparing dinner, when she felt it impossible further to control herself, and at once gave the rein to her pent-up emotions and passions. Now—that is, three hours after the outbreak of the paroxysm—she perfectly remembered, with shame and confusion, her behaviour; expressed her contrition, and gave every evidence of returning restoration to physical and mental composure.

This being the case, and it being now nearly 10 P. M., it was agreed to try the experiment of allowing her to remain in her own bed and bedroom all night: several attendants, male and female, arranging to sit up with her or otherwise watch her, while a large dose of “Battley” was administered. Next morning I was informed she had not slept well, but was down at work as if nothing had happened, and was to all appearance in perfect health, mental and bodily. The family physician, when he called, was recommended not to see her, and the family also had the good sense and taste not to go near her, or otherwise show that anything amiss had occurred on the previous evening. From this period she has continued quietly at work, and has been uniformly reported to me, by master and servants alike, as in all respects “quite well.”

II. *Commentary.*—Short and simple though this case may appear, it offers matter for serious reflection on questions bearing on the Treatment of the Insane in Private life. Seldom, if ever, has the the Asylum Physician the opportunity of seeing insanity in its earlier stages, during its first outburst, or of a transient character. Seldom, therefore, can he put himself exactly in the position frequently occupied by his brethren in private practice. The result is, I think, *want of due understanding of, and sympathy with, the frequent difficulties of the latter.*

Such a case as that above recited, illustrates—

I. *The extremely short duration, the paroxysmal or ephemeral character, of certain forms of insanity; their sudden incursion and equally sudden disappearance; the occasional composure and sanity of a patient represented to have been only a short time before in a state of “furiousity.”* This attack began suddenly about 6, and was over long before 9, P. M.; it could not, therefore, have lasted more than two or three hours. The permanency of the recovery is another question, upon which I do not at present enter, further than to remark, that in a patient so evidently predisposed to nervous derangement, a slight exciting cause may at any time produce another paroxysm of

mania; or melancholia may be gradually, quietly, and imperceptibly developed; or delusions may arise and become permanent—the case ultimately assuming the characters of monomania, or of delusional insanity. Several months, however, have now elapsed since her attack, without, as is reported to me, any indication of eccentricity or peculiarity, mental or bodily.

It occasionally happens that patients sent to asylums, with the reputation of dangerous and unmanageable furiosity, are composed and apparently sane from the moment of admission. In such cases the asylum physician is apt to suppose some terrible exaggeration of the symptoms by the friends or custodiers; some maltreatment; some improper motive in consigning the patient to the asylum; while, on the other hand, so sudden and so complete is the change for the better, that the patient's friends are astounded and ashamed, feeling themselves open to the accusations or suppositions above referred to. Such sudden changes in a patient's behaviour or character are due either to the natural cessation of the paroxysm, or to the removal from sources of irritation; to the effect of new scenes and associations; to the sense of being under discipline and control—of being mastered. Had the patient, whose history has been above given, been transferred to an asylum when it was proposed, she would either have appeared quite well next day [and doubt would have arisen in the minds of its officials, whether she had ever been insane,—there being left no vestige of either violence or delusion]:—in which case removal would have proved unnecessary. Or, the result of finding herself suddenly torn from what was to her home, and from friends, and under confinement in a lunatic asylum, would have produced a relapse, or induced permanent insanity: in which case the removal would have been most prejudicial.

Again, patients are occasionally hurriedly consigned to asylums, who, with moderate patience, might recover rapidly at home, where there is no real necessity for such a step,—a step which is always to be avoided when there is a reasonable chance of speedy restoration without it. [Only the other day I was requested to make arrangements for the reception of a patient represented by his physician as affected with violent Mania. The patient did not present himself at the expected time; and I subsequently found that narcotism by belladonna for a single night had brought about immediate and satisfactory composure and recovery. Cases of a similar kind are of no infrequent occurrence.] Under all the circumstances of the case of A. B., it is impossible, or at least it would be unjust, to blame her master, had he, after her attempt to jump from the window, transferred her forthwith to an asylum. The risk equally to herself and others, and the impossibility of properly managing her where she was, would fully have justified the step. Nor could any expert have predicted, with any degree of certainty or assurance, that a delay of a few hours or a

night, or any particular course of treatment, would have led to or ensured composure and safety. The issue of the case proved, however, that it was fortunate *delay* had been a necessity, and unsurmountable obstacles occurred to the procedure contemplated.

II. *The extreme difficulty of properly naming and classifying all the phases or forms of mental aberration, and the unsatisfactory character of all modern nosologies thereof.*

I have ventured to call the case of A. B. one of "temporary insanity." Had she succeeded in her attempt to leap from the window, she would probably have been killed; in which event, had a coroner's inquest or procurator-fiscal's examination followed, the verdict would assuredly have been, that the woman had committed suicide "in a fit of *temporary insanity*." The main objection to such a term is, that it is too vague and comprehensive, embracing many *other* forms of mental disease besides that under consideration. If, however, a popular designation such as this has the disadvantage of including more than we bargain for, the species and genera of modern nosologies have the equal disadvantage of excluding much that enters into the composition more or less of every case of mental aberration.¹

The case of A. B. might be denominated, according as we view it, or according to the prominence given to certain of its symptoms,—one of

a. *Hysteromania*; for it appeared in a certain sense to be an exaggeration of *hysteria*; a paroxysm of mania terminating a course of *hysteria*; a transition from the one into the other. But in certain respects it was something more, and in others something less than *hysteromania*; or either *hysteria* or *mania*; or any combination thereof.

b. *Delusional Insanity*; for she exhibited two distinct sets of delusions, viz.:

- 1, That she was despised by her fellow-servants; and,
- 2, That she had done nothing properly since her return to her master's service; that she was eminently an "unprofitable servant;" and that in particular her culinary duties on the day of her attack had been imperfectly performed.

c. *Monomania*; inasmuch as the intellectual aberration was visible in one or two channels only.

d. *Suicidal Melancholia*; for the attempt at precipitation might have been regarded as the result of a suicidal impulse or tendency; though it was more probably a reckless determination to escape from the house, by whatever means, with no specific view to immediate or ultimate self-destruction.

¹ On the subject of the various classifications or nosologies of insanity—old and new—the reader may refer with advantage to the chapter on *Classification*, in Bucknill and Tuke's "Manual of Psychological Medicine," which has now reached a second edition.

e. Delirium tremens ; some of the features whereof it may be said to have presented.

This single case, then, might, by various physicians following different systems of classification, be designated perhaps in a dozen different ways,—all in one sense equally correct, all in another equally incorrect ; all probably more open to objection than that quoted as my heading.

I know of no classification so generally and so practically useful as the old one of half-a-century ago, viz., that which divides all forms of mental aberration into,—

1. <i>Mania</i> ;	3. <i>Melancholia</i> ;
2. <i>Monomania</i> ;	4. <i>Dementia</i> ; and,
5. <i>Idiocy (or Amentia)</i> ;	

—as indicating their main symptoms, features, or phases : violent excitement, monoideaism, depression and despondency, silliness or fatuity, and congenital negation of intellectuality. That this experience or belief is general among practitioners in insanity is proved unmistakably by the fact that, almost without exception, Asylum Reports, in all parts of the world, adopt this classification, sometimes with a slight splitting up into genera or species, which is usually no improvement. At the same time *practical usefulness* and *scientific accuracy* are very different things ; and while universal testimony points to the fact that the *older* classifications are the more useful, it equally indicates that they are far from being rigidly accurate when applied to particular cases. If, however, the old classifications are to be regarded as failures, I look upon all recent attempts at nosologies of insanity as equally so ; while the latter have the additional disadvantage of being generally *unintelligible* to the mass of the profession, characterized frequently, as they are, by a copious new coinage of Greek terms, ingeniously anglicised, manufactured to indicate what are too frequently unstable symptoms of the most protean nature,—or features that do not deserve to have attributed to them the value of specific or generic, which ought to be permanent as well as thoroughly distinctive, characters. Modern nosologies err in the direction of too great complexity or minuteness, whereas no species of mental disease can be so rigorously defined as to *include all* the phases of a particular case from the origin to the disappearance of disease,—or all its symptoms at any one phase ; while it *excludes* the phases and symptoms of all other forms of insanity.

In truth, *there can be no classification of insanity absolutely correct or scientific*, inasmuch as the phases of abnormal mentalisation are as infinite, as varied and varying, as contradictory or capricious as the phases of human nature, of normal mentalisation, of emotional exhibition, of the play or display of the passions. Neither normal nor abnormal mind has been or can be accurately defined so as to *include* all the phenomena of the one, and *exclude* all those of the

other. I believe a scientific definition to be impossible. The principles of nomenclature and classification as applied to such sciences as botany and zoology are inapplicable, cannot be carried out, at least into the details of species and varieties, without sacrifice of truth; and while this is so, all attempts at such classifications are simply mischievous and absurd, leaving the subject more confused than they found it, rendering the Science (?) called "Medical Psychology" a bugbear to the student, a butt for satire and abuse by the lawyer, a subject of suspicion to the public.

III. *The frequent extreme difficulty of dealing—for the best—with sudden outbursts of violent insanity in private life.*

Patients like A. B., in the lower ranks of life in this country, and in all ranks in our colonies (*e.g.*, New Zealand and Australia), are sometimes, or always, committed to gaols or police-offices; and it is customary to condemn such a practice or proceeding as cruel and unnecessary. Are we, however, prepared to recommend, or would we ourselves submit to, the risk of suicide occurring on our premises, or of some member of our household being seriously assaulted or murdered, rather than commit a dangerous lunatic,—under certain circumstances,—to the custody of the law? I for one would certainly neither run such a risk myself, nor would I recommend any family to do so. Nor did I in the case of A. B.; though *now* that the issue of the experiment of retaining her in her master's house has proved favourable or fortunate, the recommendation of removal on the score, firstly, of safety, to a large household may appear to have been uncalled for. A. B. may, however, again at any time become insane,—dangerously so,—from some slight exciting cause, or she may be insane now,—delusional or monomaniacal for instance,—though doing her duty quietly and in an apparent state of perfect mental composure or health. Though, therefore, the *immediate* issue of the experiment of home treatment has been fortunate, the *ultimate* result may not be equally so.

Violent lunatics in all ranks of life are frequently treated at home by powerful attendants,—male or female,—strangers generally, selected on account of their physical qualifications alone. Usually these men or women belong to the lowest ranks of society; not necessarily vicious or depraved, but uneducated, unpolished, untrained as cutodiers of the insane, unacquainted with the phenomena of insanity and its accredited treatment. Untutored human nature, moved by no higher influence than that of temporary and small *pay*, cannot be expected, when left to itself,—in the absence of the relatives or guardians of a patient, with no witness of their conduct save the latter,—to sustain "assault and battery," taunts and impertinences, all manner of vile usage, at the hands of a lunatic, with great forbearance. It *will* and *must* resist and repel such treatment. Hence, my too frequent experience has been that in one class of cases,—the violent,—*bruises and injuries*,

*even to the death, are the fruits of such supervision.*¹ In a second class, where the patient is frequently a melancholiac with suicidal tendency, quiet, docile, but cunning and enduring, stealthily watching the opportunity that may be offered by any carelessness or relaxation of vigilance on the part of the attendant, to effect his cherished purpose, the unaccustomed fatigue of *night*-watching, superadded probably to arduous *day*-labours cannot be resisted; exhausted nature *will* assert her requirements; sleep *will* steel over the senses, even of the willing and faithful nurse; and the patient is then left to his own line of action,—whether that may be in the direction of suicide, escape, or otherwise. In a third class of cases, frequently those of anæmic, enfeebled, abstinent melancholiacs or monomaniacs, stimulants have been provided for the sustenance of the flickering flame of life in the patient; or the injudicious kindness of indulgent friends has placed spirituous liquor at the command of the attendant, to enable him to sustain the fatigues of night-watching. The temptations of an unusual position are too much for the low moral tone and strong animal appetites of the attendant; and the result is, sometimes, what I have myself seen: that a nurse has been found “dead drunk” by the side of a dying or dead patient, whose wine and spirits she had appropriated to her own use and bestiality!

In truth, skilled or suitable attendants or custodiers are not to be obtained *out* of an asylum, and frequently scarcely *in* one; for the emoluments are usually so small and the work so irksome, that only the lowest classes of our population will accept such appointments on the terms offered. Trained attendants on the insane for use in private life, and especially in country districts, are a desideratum. The general practitioner in a midwifery case seeks and readily obtains the assistance of a midwife or lying-in nurse, to whom he can delegate a portion at least of his duties, and whom he finds an efficient and indispensable assistant; and, in London, large bodies of nurses are being trained, systematically, for service in private houses, as attendants in medical and surgical diseases of every kind. Are *mental* maladies, may I ask, of inferior interest or consequence? No one who has had equal experience of the three great classes of the ills to which our flesh is heir,—medical, surgical, and mental,—will class the last as in any respect inferior to the others. On the contrary, there will probably be no difference of opinion in regarding the latter class of cases as more imperatively demanding proper attendance than the two former, in so far as the interests of a far larger circle are involved: that of whole households, families, clans, or villages, instead of individuals. I have no wish to depreciate the claims of medical and surgical cases; I think it of infinite importance for *them*, as well as for *mental* affec-

¹ Illustrative cases are given in the published Annual Medical Reports of the Murray Royal Institution for the Insane, Perth; *e.g.*, 32d (for 1859), p. 10; 37th (for 1864), p. 13.

tions, in private or home life, to be attended by thoroughly competent and trustworthy persons; and, until this can be done we must submit to endless accidents and injuries,—the results mainly of ignorance, and the impossibility of securing proper treatment. I have elsewhere¹ repeatedly called public attention to this subject, —*the training of attendants on the insane for service in private homes*; and I continue to hope that some philanthropist will do for the insane what Miss Nightingale and her disciples are doing for the sufferers from ordinary medical and surgical disease. We are in the habit, too much perhaps, of depreciating the customs of our continental neighbours; but I have often had cause fervently to wish we had in this country *any* corporation equivalent to the “*Sœurs de Charité*” of France, or the “*Deaconesses*” of the Rhine,—devotees to duty,—to conviction;—whose trustworthiness cannot be for a moment doubted, whose qualifications for their self-imposed duties are of the best kind, and whose labours possess the highest possible value.

Patients are occasionally presented at asylums with their arms fastened by the “*camisole*” (*vulgo*, “*strait-waistcoat*”), or hands and feet alike tied together by ropes. We, Asylum Physicians, are in the habit of cutting these bonds in our entrance-halls; and with an air of superior virtue and intelligence, rebuking the imposers of such unseemly restraint: announcing that, within the asylum walls, there is no such thing known or used as “*mechanical restraint*,” “*moral suasion*” and the “*law of kindness*” being the motive power of all its machinery. Now, it by no means follows that, because in an Hospital specially constructed for the insane, with its padded rooms, full staff, trained officers, and every appliance for the treatment of every symptom, mechanical restraint can be dispensed with,—it can be equally so in private life and in the absence of all these advantages. Nor do I admit that it can be judiciously or properly dispensed with, at all times, and under all circumstances, even in the best regulated asylums.

The truth is, the whole system of treatment of the insane, whether in asylums or out of them, is one essentially of *restraint*: find a more euphonious or less objectionable term if you *must* or *can*; but the thing is *restraint* and constraint. Under different circumstances this restraint may be *moral* or *physical*; and the latter, again, may be *mechanical* or *personal*. *Mechanical restraint* is, however, at *present* unfashionable. The public has a vague and ignorant horror at everything in the form of *camisole*, *polka*, *muff*, or fastening for hands or feet, of any kind. The mere name “*restraint*” suffices to conjure up to the fertile imagination, visions of dark, slimy, subterranean dungeons; clanking chains and fetters; straw pallets; filthy nakedness; glaring eyeballs; and the shrieks of demoniacs.

¹ Annual Medical Reports of the Murray Royal Institution; 30th (for 1857), p. 35; 36th (for 1863), p. 24. “*Excelsior*,”—the Literary Gazette of the said Institution: Nos. 19 and 20, 1864, p. 7.

But *physical restraint is, nevertheless, a necessity under certain circumstances*; and hence *personal restraint* is employed; that is, in order to prevent destruction of life or property, the patient is dogged or held by one or more physically powerful attendants. The fruits of this practice, the present customary substitute for *mechanical restraint*, include the following:—Perpetual struggles for the mastery; struggles which generate animosities of the most permanent and dangerous kind; struggles, moreover, which lead directly to broken ribs, pierced lungs, ruptured viscera, and to death itself, resulting from these injuries; besides minor mishaps, such as black eyes and bruises of every degree. If the result of the struggle is unfavourable to the *patient*, a loud outcry is immediately raised of malpraxis or cruel usage, and all parties concerned in his treatment or custody get into bad odour from an accident, which, *under the present system of personal restraint*, it was impossible to prevent. But if the unfortunate *attendant* is injured, if the matter is noticed at all, it is with a tone of simple and superficial regret that he should have suffered in the discharge of his duty; generally he receives neither sympathy nor recompense. There is also a constant recurrence of sudden and furious assaults, or homicidal attempts, which, unfortunately, are occasionally fatal. I am assuming that the struggles, injuries, assaults, and deaths referred to, are *unavoidable under the system of personal restraint* or supervision. That deliberate and unnecessary violence is occasionally committed on a turbulent patient by a bad attendant cannot be denied; but such outrages are exceptional, and may well be omitted from a catalogue of the fruits of personal restraint,—restraint by *persons* instead of by *things*; which fruits are sufficiently numerous and important without such an addition.

In my own practice, of eleven years' duration, among the insane, *I have never myself used mechanical restraint*, save in trivial forms, in a few surgical cases, where, I may add, even the sticklers for absolute non-restraint so-called are forced to permit its use. I have been anxious to give the fullest trial to every possible substitute for mechanical restraint. But looking back, I am bound to confess, that I have seen cases, which probably would have been benefited, lives that might have been saved, by its application in some form. The same belief is the result of what I have seen of the insane and their treatment in very different parts of the world, between Iceland in the northern, and New Zealand in the southern, seas, including England and Ireland. I have, moreover, frequently discussed this subject with my brethren at the head of other asylums in this country; and so far as I remember, their *experience has been almost uniformly in favour of some form of mechanical restraint in certain exceptional cases or conditions*. Their *sympathies* and their *practice* may be somewhat at variance occasionally with their *experience*. There may be a strong inclination to avoid the very semblance of harshness, by the total disuse of any form of fastening of hands or feet, and there may be a difference of opinion as to the best forms

of such fastening where required; but general *experience* sets it down that in every asylum, in every community of the insane, there do and must occur *exceptional conditions, wherein some form of mechanical restraint is, for the time, not only the most, but the sole, efficient and humane mode of treatment.*

From what I have said it will appear, then, that "*absolute non-restraint*" is *absolute nonsense*. Restraint is occasionally necessary in the proper treatment of the insane, and the only question that remains is, what form is the most efficient in the interests of medicine and humanity, for the welfare equally of the patient and society?

In 1853, the Commissioners in Lunacy for England invited the opinion of all the Asylum practitioners of that country on this subject,—of the use or non-use of mechanical restraint. The result was that, of those who gave a decided opinion, about 70 per cent., or nearly three-fourths advocated its *qualified* use, that is, its use in certain exceptional cases or conditions; while nearly 30 per cent., or upwards of a fourth recommended its *total abolition*. The first category, that of the great majority, included the most distinguished Alienists in England, such, for instance, as Commissioners Wilkes and Bucknill; Drs Forbes Winslow; Sutherland and Monro of St Luke's; Fox of Bridlington; Newington of Ticehurst; Thurnam of Wilts; and Samuel Hill of the West Riding of Yorkshire, Asylums.¹

Public opinion and professional practice are at present, in regard to mechanical restraint of the insane, alike in a state of reaction. Disgusted with the revelations of Old Bedlam and the Bicêtre, with the chains and fetters, which are said to have constituted the *all-restraint* of these days, we have resiled to the opposite *extreme* of *no-restraint*. Now both extremes—as extremes generally are—are mischievous, though the latter is probably not so vicious as the former. Rational practice and opinion lie *in medias res*; and the *permanent* belief, both of the public and the medical profession, I doubt not, will in course of time be, that *under certain exceptional circumstances, some form of mechanical restraint is equally necessary and humane*. It is impossible to define what these circumstances are, or foretell what they may be. Every case should be judged and treated on its own merits, and not prescribed for apart from the circumstances of its occurrence, according to the "wise saws" of text-books; which are sometimes compilations by persons, who have never themselves experienced the difficulties, which they dismiss so summarily, treat so deftly, with no consciousness of the consequences involved. The revulsions, antagonisms, and extremes of opinion and action in regard to the treatment of the insane have their parallels in the history of prison discipline during the last

¹ The results of the inquiry will be found given at length in the Eighth Report (for 1854) of the said Commissioners, Appendix G: as well as in the "Journal of Psychological Medicine," vol. vii. p. 543, 1854. In the latter the reader will find criticized the professions *versus* the practice of the Total Abolitionists.

century or half-century, or even within the last twenty years. At one time, Asylums, in common with Prisons, were the foulest blot in our civilisation. *Now*, probably too much is made of them by philanthropists and doctrinaires, who teach one-sided, and consequently unfair, views of things. A latitude and liberty are permitted, indulgences granted, which undoubtedly lead frequently to the most grievous consequences to the wellbeing of society; and this conviction, which is gradually growing in the public mind, may reach such dimensions that it may carry us back to a state of matters equally to be deplored. The tendency of our present laws and procedure in regard alike to the criminal and insane classes is to exhibit undue leniency and indulgence; to protect what is supposed to be their rights at the expense too greatly of those of the sane and well-behaved; to show *more* than justice to the one, *less* than justice to the other,—an equivocal, absurd, and most mischievous state of affairs. Laws unnecessarily minute, public opinion unnecessarily indulgent, have much to do with the present frequency of Murder and Suicide; the liberty of one class of Her Majesty's subjects may be protected too far, and that of others—the general public—too little.

III. *Resumé*.—The foregoing paper is intended to be *suggestive*, rather than descriptive. The main points mooted therein, and to which I would earnestly invite the attention of the medical profession, and through it of the general public, are these:—

1. The necessity for training a body of Attendants on the insane for service in private life.

2. The consideration of the best means of Mechanical Restraint of the insane in cases where this is required.

3. The responsibilities, helplessness, and difficulties of masters of insane servants and guardians of insane patients under certain exceptional circumstances.

4. The responsibilities and difficulties of Physicians in the same classes of cases.

5. The medico-legal and other relations of sudden, violent, ephemeral insanity.

6. The non-necessity for, or impropriety of, sending *all* insane patients to Lunatic Asylums.

7. The distinctions that ought to be drawn between the treatment of the insane in well-appointed Hospitals and in private life.

8. The effects of a false philanthropy in multiplying and aggravating the evils resulting from insanity.

9. The dangers arising from revulsions in public opinion and practice, as illustrated by prison and asylum discipline.

10. The necessity for re-adjusting the equipoise in the relative treatment by the law and by public opinion of the insane and sane in certain circumstances.