THE SELECTION OF CASES OF INSANITY FOR DIFFERENT METHODS OF PRIVATE CARE.

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The time-honored warning against delay in removing a patient who is insane to an institution for that class—based, as it is, on the most conclusive evidence as to the great preponderance of recoveries in cases of early admission—is still needed, although statistics show much improvement in this respect of late years. This advice, however, applies with much less force to the well-to-do than to the poor ; but owing to the fact that early commitment to a public asylum is highly advantageous to the poor—for whom home or private care is, as a rule, impracticable if not impossible—and as the dependent class comprises, of course, the bulk of the insane, this custom has come to be looked upon by many as indicative of early asylum care for all classes—to the exclusion of non-institutional methods which, when properly selected, are attended with equally good results. The injunction should be, therefore, to place the patient as early as possible under treatment suited to the individual case, whether in an asylum or outside its walls.

The numerous requirements for satisfactory treatment and care of the insane, especially the private class, call for a variety of methods; but these are necessary and obtainable without as well as within the asylum. The former are of the natural, private and domestic order suited to the wants of the individual; the latter of a more artificial, public and official nature indispensable to the organized care of a large number. Each of these forms of care has its advantages, although the hospital for the insane, with its varied means of treatment, its safety, skilled attendance, regular exercise and mode of living, the administration of medicines and regulation of diet, has a great advantage over private care and treatment of the mass of the incurable, and a large proportion of the presumably curable, insane. It is almost unnecessary to say that there are more insane patients cared for at home, who from their lack of means would be benefited by asylum care, than there are inmates of asylums who would have been better situated under other surroundings. Still, we should recognize the fact that each kind of care has, besides its appropriate cases, certain unsuitable ones which should be in the other class, and that achievements in hospital construction, appliances and methods generally, and the advances thereby made in alleviating insanity, have attracted attention away from the *modicum* of good that is to be found in other surroundings.

Moreover, it is by no means an easy matter to strike the correct balance between the patient's well-being, physical and mental, and his happiness.

The former he may receive in a hospital, and it would often be a mistake to advise any other course; but there are many cases of the more appreciative class for whom outside care, though more difficult, is more comfortable, as conducive to happiness from more congenial surroundings.

Although we may not all be willing to follow Maudsley to the extent of accepting his dictum "that all the comforts which an insane person has in his captivity are but a miserable compensation for his entire loss of liberty—that they are petty things which weigh not at all against the nightly suffering of a life-long imprisonment," we should do well to keep in mind the necessity for the fullest freedom that is compatible with the welfare of the insane person, and the fact that to quiet and regularity of life may often be added the enjoyment of a comparatively domestic environment without detriment to the patient's condition or the safety of others.

But by far the most potent reason why the physician should be acquainted with the various expedients for caring for the insane person privately, is the injury to the patient's future career from the unjust and often absurd popular prejudice about hospitals for the insane. If a patient can be treated out of an institution and recover, it is better for the physician and for him. Often no alternative is left us than to cast about for the next best place for one for whom asylum care would be far preferable, but whose dread of an asylum life is as unconquerable as it is unreasonable. It is an axiom, also, that, given the means and knowledge of proper treatment, one cannot receive the same personal care when he is one of a large number as when treated alone, or with but few others, although there are certain insane patients whose self-feeling is so great that they are better off for finding that they do not receive more attention than others around them.

Again, the presence of a large number of insane people exerts, in many cases, a depressing influence which may be a serious drawback to improvement, not to mention social and other differences, which would keep them apart if they were well. While there are recovered patients who recall with the greatest pleasure their asylum experience, there are many more who fear a second attack chiefly because it means a return to a place that they only think of with dread. This is often true to some extent of any surroundings in which they may have been treated, but in the various gradation of methods from asylum to home care, I think the feeling is less strong as we reach the latter.

Private care and treatment may be had—

1. In travel.
2. At home.
3. In specially provided private quarters (single care).
4. At small private establishments for mental disorders.

To select appropriate cases for these different methods, without

including those for whom the asylum is best adapted, is no easy matter, for no rules can be laid down, patients are so variously disordered in mind and so variously circumstanced. Consequently, only general suggestions are offered, which in many instances may require modification to meet the special circumstances of individual cases.

It is very largely a question of means whether a patient should be treated in either of the ways indicated or at an asylum. The more violent, difficult and prolonged the case, the greater the expense. The worst cases can be cared for in special private quarters with a sufficient number of nurses and frequent medical visitation—although even the continuously disturbed incurable cases and the desperately homicidal, suicidal or self-mutilating can never be managed privately with anything like the efficiency of a well-conducted asylum, with all its resources in the way of modern principles of treatment and arrangements adapted to the requirements of the present time. For, the moderately wealthy, the acute curable cases, and certain of the chronic class to be specified later, may properly receive private care, and a fair proportion of them at home, under proper supervision and nursing. Cases of the remaining forms of insanity in this station of life should, broadly speaking, have asylum care. If the patient be poor, the cases are rare that can with safety or benefit be kept from a hospital for the insane.[1]

But first, as to travel. This should be prescribed for cases that can hardly be called insane, as they are mainly on the threshold of mental disturbance. It is rare that the continued diversion and exercise attendant upon travel is of use when the disease has become pronounced (when actual delusions have set in), even though they occur early in the disorder. The most carefully selected early cases are benefited by travel, because brain-rest is usually the indication from the start rather than diversion and change.

I have known more than one melancholiac for whom travel had been tried at this stage who became bewildered by the frequent change of scene; irritated at having to meet people when they wished to avoid them, and were worse for the change. One patient, in addition to her other false beliefs, contracted the delusion that she was being taken about to different places to be exhibited. It is very hazardous, also, to advise travel for a patient in whom there is even a suspicion of suicidal intent, as it is impossible for the most careful to be watchful enough upon a journey.

Suitable cases for travel are for the most part those who are simply

[1] But even among the poor we meet exceptional cases where the delay of a week in proposed removal to the asylum has been attended with sufficient improvement to warrant the hope of a speedy recovery. Such instances, however, are only mentioned to emphasize what is possible in the way of home life for the insane, and to show that they sometimes do well *in spite of* their surroundings.

depressed, have been suffering from insomnia, who perhaps lack their former energy and interest in life generally, to whom petty annoyances have assumed the guise of great troubles, whose affection for their family is lessened, and who are in a lowered physical condition.

For such, travelling—preferably by land—is often beneficial. The object is to take the patient away from the painful subjects of thought about him at home, to awaken his interest, and to substitute new and pleasant ideas for morbid and distorted ones. A companion is essential. This is not a superfluous caution. Depressed patients will sometimes beg to be allowed to go away alone, as did a gentleman who came under my observation recently, and who, for want of proper insistence on the part of his advisers, actually crossed the ocean alone, but was so wretched that he fortunately returned on the next steamer. The companion should be cheery, tactful, and alert. A friend is better, as a rule, than a relative, who will be apt to let the patient have his own way too much. A young physician may be of great service. In the more anxious cases an intelligent nurse, if it can be managed, will help greatly. Travelling should be done by day to secure sufficient night rest. Fatigue should be avoided, it being better to remain in a few places of interest than to travel about and change the scene too frequently. Often a higher latitude than that in which the patient lives proves a tonic, while a southern climate is found too relaxing and depressing. Long sea voyages rarely prove useful: in most cases within my knowledge these have been failures, and Blandford finds that there is something about the seaside which tends to convert the preliminary stage of confusion and depression into wild excitement, and prefers for this reason to send patients for change to an inland place. Convalescing cases are particularly susceptible to the advantages of travel, and often gain faster in this way than in any other change. Another class who are especially benefited by slow travel or change to a country life, with plenty of fresh air, are mild cases of mental disturbance, due simply to the exhaustion of fever—post-febrile insanity.

Next, as to home care and treatment. Everyone knows that there are a large number of insane persons living at home, some comfortably situated, some among tolerable surrouudings, and others wretchedly cared for. We also know of not a few patients who recover at home quite as quickly and thoroughly as do asylum cases. What is the character of these cases who do well at home, and how can we prevent their haphazard disposal, some at home and some in confinement? Which are the neglected cases that need asylum care?

If some very general laws can be indicated and followed as to the selection of cases, more would enjoy the liberty and comfort of home who should have it, and others the skilled treatment of a well-equipped hospital for the insane. As a step in this direction the form of insanity

must be considered, as well as the make-up of the patient's family, his attitude toward them, and the character of his surroundings generally.

But whatever the form of the malady or situation of the patient, it is often the amount and kind of attention the physician gives to the case that will ultimately determine between home and the asylum for the patient, and perhaps between recovery and confirmed insanity. This is not platitude. There is little doubt that more cases would do well at home if they were as carefully and regularly observed as are cases of physical disease. It is not enough to study an apparently mild case of melancholia occasionally and at long intervals; to have him come to the office, or to inquire of the family how he is getting along. It is a lack of attention to details, of close inquiry into the patient's line of thought, both from him and the members of his family, to ascertain the progress of the disease, that has made more than one case turn out disastrously. The fear of suggesting suicide to melancholic patients by inquiries in that direction I am convinced is exaggerated. I have never known it to occur, but on the other hand, the instances when occasional unobtrusive but minute inquiry of the patient and family as to this particular has been avoided, and disaster has come, may well make us consider whether one's whole duty is done when this precaution is not taken. The neglect of attention to the details of the patient's requirements has led to the disrepute into which home treatment of proper cases of insanity has fallen, quite as much as the attempt to treat unsuitable cases in that way. Home treatment for curable cases seems to me to bear to that of ordinary disease the same relation as does the capital operation and the after conduct of the case. It requires much time, constant watchfulness, attention to a variety of minor details and the summoning of special skill in emergencies. Before counselling home treatment, the feeling of the patient toward the members of his family is an important matter. If he has strong and increasing antipathies toward one or more of them, and dangerous delusions about them are persistent and uppermost in his mind, or if suicidal thoughts and attempts are prominent manifestations, little is to be gained and much valuable time may be lost in delaying his removal from home, unless the physician is prepared to convert the house into a hospital on the presumption that the case is a curable one. Often, however, the home feeling remains strong, as is shown at more rational intervals, and at no time is alienation from those dear to him appreciable. To such patients it is an immense satisfaction to have their friends at hand. Moreover, the influence of a relative in calming a patient can often be exercised by no other. Cases marked by great anxiety in which ordinary petty annoyances are so magnified as to weigh down and distress a patient are better for a change from home. The effect of the patient upon the family, also, is important. If he keeps the household in tur-

moil and wears upon his relatives so as to affect their health and spirits by the constant attention he requires, or unnecessarily exacts, home is not the place for him. It is sometimes best, if the patient remains at home, to send away any children there may be in the family, as they are an especial source of anxiety and unnecessary worry, particularly to a mother, because of their unthinking demands or because she imagines they are being neglected, and sometimes because there is danger to them from the mother's homicidal tendencies.

Melancholia, of all the forms of insanity, is oftenest treated at home, because cases of this variety are vastly more numerous than those of any other, because its manifestations are usually far less pronounced and less difficult to deal with, and because it is especially frequent in a mild form. There are quiet cases simply depressed, who for a long time are able to live in the family without harm, who perhaps have tried travelling and change of scene unsuccessfully. Their life can be regulated and made much more comfortable by the physician with intelligent help from the relatives, and nursing or companionship. But the mildness of an attack of melancholia is by no means incompatible with unexpected suicidal and other impulsive outbreaks, and here is applicable the attention to details advised above.

Besides close inquiry as to the possibility of suicidal ideas, the patient's heredity should be investigated. It is an established fact that this propensity is highly hereditary and colors the insanity of descendants in the large majority of cases. Melancholia without delusions is a fertile soil for such tendencies. I recall a patient in a large asylum who made repeated sudden and desperate attempts at self-destruction, who in the intervals was sociable and agreeable, though with a tinge of sadness, and appeared otherwise entirely rational, having no delusions whatever. In her case the family history was very bad as to suicide, but was ignored by her relatives when she became depressed until she suddenly attempted to hang herself, and nearly succeeded, when she was committed to an asylum, where it proved to be a marked suicidal impulse.

Other quiet patients are the *acute dements*, young people who usually make good recoveries. Their state of inertness—stupor—renders them good subjects for home care. They require to be dealt with in many cases like babies, as they cannot be roused to make the slightest exertion. Often it is only a matter of nursing. Here it is necessary to guard against injury by the struggles of certain of this class who resist doggedly all attempts of any sort to help them, as well as the sudden and most unlooked-for outbreaks which sometimes occur.

As to disturbed *violent cases of the acute, curable class*, there are more, especially among those in good circumstances, who should have the benefit of home treatment than is now the case. I fully accept Folsom's belief, who reports several instructive cases of this kind successfully

treated by him at their homes, in support of his opinion that many cases at least of mental disease are to be treated precisely like typhoid fever or rheumatism, or a broken leg, so far as removal from home is concerned, and that home associations are no more harmful in properly selected cases than in pneumonia or phthisis. When this course is adopted, the home must be converted into a hospital, and the case conducted methodically with the aid of nurses, or, in exceptional cases, members of the family. The patient should have apartments entirely separate from the rest of the family, especially arranged to meet the emergencies and other requirements of his attack.

In *insanity connected with the puerperal state*, when acute and recent, special exertion and sacrifice should be made to treat the patient outside of the asylum, not only to avoid the stigma of residence there, but because these are highly favorable cases for recovery and are usually of short duration. This applies to difficult, violent patients, as well as to the puerperal melancholiacs, the majority of whom are mild, easily-treated, transient cases. A special precaution is to remove the child from the mother in most cases as soon as possible and to watch her closely. Attempts to destroy the child are specially frequent and suicidal tendencies a common manifestation. The rare cases of insanity of pregnancy should unquestionably be kept at home, at least until after labor, to avoid the sad fate for the child of being born in an asylum.

Of chronic cases *senile insanity and dementia* is by far the best adapted for outside treatment and care. It is only the worst patients one sees at the asylum, while subjects of the milder states of senility in which there is decided mental complication are a numerous class and apt to be provided for at home. Old people, even when insane and regardless of their condition or surroundings, are often disastrously affected by a complete change from home. In consequence of their extreme age they are no longer receptive of new ideas or adaptable to a new environment. The same advice applies to the allied state of mental impairment following hemiplegia and similar attacks following destructive cerebral lesions.

The mass of cases of *insanity of doubt*, are cared for at home. Most of these are on a par with mild delusional patients, who rarely show except to their nearest friends their mental weakness. Very much may be done by the physician in the way of advice, assurance, encouragement, and consequent help to those doubting, but otherwise most intelligent patients, by keeping track of them, and methodically visiting them. Change of abode is often considerable help in these cases. It is only when their doubts become terrible fears that they have made, or will make, fatal mistakes, will contaminate others by their touch, etc., which lead them to take absurd precautions, which withdraw them from others, and interfere continually with their comfort and health—in short, put

them entirely out of harmony with their surroundings, that removal from home becomes urgent.

Chronic degenerative insanity is not often suitable for care outside the asylum, except during the initial stages, while the patient is comparatively appreciative. With the advent of delusions of suspicion comes often more or less violence, noise, self-neglect, refusal of food, destructiveness, perhaps—conditions which cannot be properly met by ordinary means.

There are certain classes of cases the treatment of which is often improperly tried at home. I refer to *hysterical insanity and dipsomania*. The former rarely improve until they come under systematic control and judicious neglect—unless years are consumed in the process—whereas asylum care and discipline will sometimes give young women so afflicted a wonderful and speedy start in health and control.

Cases of dipsomania, although not properly coming into the category of insanity, are surpassed in difficulty of management by few of the actually insane, and in far-reaching effect of the malady upon the patient and his family: 1. Because of the length of time before their condition is realized, and the credulity of the family in the victim's promises of reform, and particularly by the fond mother's natural trust and long-sufferance of the son's disgraceful life, which fatally delays proper treatment. 2. The absence of proper provision for such cases in the shape of a closed asylum exclusively for that class, under a board of disinterested trustees and State control. 3. The difficulty of keeping them in a lunatic asylum when once committed thence, owing to their cunning, the dislike of the medical officers for that class of cases, who are a disturbing and otherwise trying element, and the importunities of the patient, and his relatives sometimes, before he has become sober. Advice of great value is not to be had concerning these patients under these circumstances. All that I can say is, that a State lunatic asylum to which the patient is legally committed, as is the case in Massachusetts, is after all by far the best place for him; that the friends should be discouraged as long as possible from removing him, and the superintendent begged, as often as we can decently do so, to keep him there. Small private asylums, particularly where there are insane inmates, are unsuitable places, and but temporary makeshifts, for the inebriate class.

The separate care of *acute cases of insanity* in a house or villa hired for the purpose—what is called single care—is practised but little in this country. In England it is more in vogue, and looked upon as specially valuable. The treatment should be undertaken in a house belonging to a physician, or in a private house taken by the friends for the purpose. It is essential that the attendants should be under immediate control and supervision of the physician to whose hands the patient's care is entrusted. It is perfectly easy to manage matters for excitable and even noisy and violent patients, if the house be in a quiet neighborhood, and

with the advantage of perfect privacy. This method is practically the same as that of turning the house into a hospital, except that the latter course is best adapted to a milder class of acute cases.

The small private establishment for nervous and insane cases stands as a means of care between the home and the large asylums. Many patients whose surroundings in a variety of ways are unsuitable for the separate hospital-at-home care, the milder acute, and presumably curable cases of mania and melancholia, are best treated in this way. The patient's family, for example, is scattered, and no single member is ready to bear the anxiety and be responsible for the patient's care at home, and its expense. The case may be of too severe a type for home management without greater sacrifice than the family is willing to make, and they shrink from sending him to a large asylum. The patient has possibly been living at home until he has grown too difficult to have in the family, who have been tried to the utmost. The anxiety and care may be telling upon the health of the husband or wife. Beside recent cases there are varieties of the chronic class of insanity, the subjects of which can be made very comfortable in this way. Examples of suitable cases are the man or woman with fair intelligence, but deficient self-control, whose mind is weakened (congenitally, or by an attack of insanity), for whom family life has proved unsuccessful, owing to bad tendencies and mistaken indulgence; the case of doubting insanity which has gradually grown to dread everything, and by whom no authority that can be exercised at home is respected. Hysterical and neurasthenic cases, of a severe type, are often most amenable, when thus situated away from too sympathetic friends, and under control amid fairly congenial surroundings. The demented general paralytic can be treated at a well-conducted home-hospital of this character, where separation of uncongenial patients is available, at considerable saving of family worry, mortification and expense. The life of the chronic melancholiac, so situated, can also be made fairly bright; many border-land cases, also, for whom domestic life has proven a failure, are especially susceptible to guidance and control, when exercised among such conditions in a semi-domestic environment. Such establishments thrive largely on a public dread of asylum-care for a relative, as well as upon the greater privacy to be secured by the method. For the same reasons, patients are often sent from home to irresponsible people for care, who are subject to no supervision themselves, and seek for no medical advice for the patients under their charge. Without a resident physician, none of the classes mentioned can be properly treated in a home devoted to the care of the insane, and expert supervision, capable nurses, companions or attendants to meet the requirements of widely different cases, as well as regular inspection by State medical officials, are essential for the best results. The public, or large private asylums, are subject

to public scrutiny, and have supervisory boards, which divide to some extent the responsibility of the patient's care with the medical head of the institution. Consequently, although, largely, each is what its superintendent makes it, and each has its individual merits, a good and fairly uniform standard of care is reached by all. But the smaller private hospital is conducted largely according to the individual ideas of the physician in charge, so that the standard of care varies greatly in different places, and greater pains must be taken to ascertain how the establishment to which a patient is to be sent is conducted, and only that having the essentials of the most appropriate methods should be selected.

The situation of the patient's future abode is always a matter of importance. Some do better whose friends live near at hand, and can visit them often. Others, for whom visits have proved inadvisable, are constantly unsettled by the thought that their family is within easy reach but that they cannot go to them. Consequently, a distant residence is preferable. The disposal of the patient varies also according to the stage of the disorder in other ways than those mentioned. Just as there are patients who should enjoy family life, during such a time, in the initial stages, as they are appreciative and not unsettled, but for whom too long delay in commitment to an asylum is dangerous, so there are others who require asylum care and no other at the outset, but who should have a trial at home later, the opportune moment for which should be seized without delay. This includes many in the early stage of convalescence (for whom travel is not advisable) when the home can be properly arranged for their reception, as it may often be well to avoid too great a strain by the change involved in a complete resumption of family life and duties at once. Emergence from an attack of insanity to the unfamiliar surroundings of an institution, although rarely actually disastrous, should be prevented if possible. As to the chronic insane in asylums, the more I see of them the more I am impressed with the good effects of change in individual cases. Of course, the proportion to be safely removed from the asylum is small, and of these but a small number will remain away long if not kept under a physician's observation. Still, there is room for improvement in the way of trial outside of the asylum. Even when it does not succeed, the satisfaction of giving the patient another chance before dooming him for life to separation from the world is great, and the effect such a step has in gaining and keeping the confidence of the patient is a great help to all concerned.[1] The experience gained in boarding out in private dwellings the chronic harmless insane

[1] For further advice on this point, a recent article by Schüle on the "Value of Early Discharges from Asylums," is useful. (Report of the annual meeting of German alienists at Berlin, September 17 and 18, 1888.)

taken from asylums in this and other countries, indicates the possibilities in this direction.

A great deal might be written upon the details of treatment peculiar to the kinds of care here considered, but it only remains to be said that modern asylums, under progressive management, by introducing new styles of buildings and arrangements looking to the greater segregation of the insane, are doing much to fill the want of natural domestic surroundings.

THE MALARIAL ELEMENT IN OÖPHORALGIA.

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The terms "oöphoralgia" and its hybrid synonym "ovaralgia," have been used somewhat vaguely to describe pain in the region of the ovary which does not seem to be due to actual disease of that organ. Olshausen is the only writer on diseases of the ovaries who devotes a separate chapter to oöphoralgia, which, with Charcot, he seems to regard as a hystero-neurosis. Now, I know no reason why we should not regard certain pains in the ovarian region as purely neuralgic in their character, even though they may be primarily due to disease in or around the ovary which is not appreciable clinically. The question of the anatomical cause of ovarian pain I have discussed at length in a paper in Wood's *Reference Handbook;* it is sufficient to state that I believe it to be more frequently of extra- than of intra-ovarian origin, *i. e.*, it is due rather to the inclusion of nerves in perimetric adhesions than to the pressure upon terminal filaments by cicatricial tissue within the diseased gland, as is shown clinically by the relief afforded by separating such adhesions without removing the affected ovary. The subject of ovarian pain, whether menstrual or inter-menstrual, assumes no little importance from its bearing upon abdominal section, though happily it is now, *per se*, seldom regarded as a sufficient indication for laparotomy. Contributions to the palliative treatment of ovarian troubles should always be welcomed, and this is my excuse for presenting the following case:

Mrs. M., aged twenty years, was first seen by me four years ago, soon after she had had an abortion at six weeks. She was suffering with severe pain in the right ovarian region, unaccompanied by evidences of acute inflammatory trouble. Examination showed well-marked anteflexion, with prolapse of the right ovary, the gland being neither much enlarged nor especially tender. Her husband, himself a physician, treated her locally, and she was soon up and about. She had had moderate dysmenorrhœa before marriage, which continued afterward,