Analysis of the Mind
in Cases of
Mental Stupor,
with a New Classification.

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Introduction.

Resumé of Literature.
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Resume of Literature.

This thesis is the outcome of two series of investigations which I pursued during several years of asylum work. The first one was an inquiry into the nature of the so-called "higher reflex functions of the mind" and the modifications which these underwent in disease.

The second was a study of that form of insanity known as "intellectual psychosis." The former arose from a desire to place the mental process—whence it is preferable in my opinion to that of the "mind"—upon the same footing as the nervous, as regards methods of investigation. The hitherto prevailing modes of studying the mental state in the insane appeared to me extremely unsatisfactory, omitting, as they did, if one of the most important points, viz. the working out of the condition of the higher reflexes.

The second investigation I was led to undertake after observing the degree of
confusion existing with regard to the whole question of stuporous states in the actual condition of the mind in cases of stupor. 

This, I attributed to the deficient methods of mental analysis which had been in vogue, and came to the conclusion that the remedy lay in paying close attention to the state of the mental reflexes. Whether or no I was correct in this supposition, this thesis (as the results recorded therein will sufficiently show) the two series of investigations therefore merged together: out of the combined research these crystallised, as it were, a new classification of stuporous cases; and a classification which was no mere index serviceable for purposes of labelling, but one which will be found to express in itself both the intrinsic nature of stupor, and the inherent differences which characterise the various cases included under it. On this account the consideration of this classification of the question of mental analysis in stuporous cases will be taken coincidently in this dissertation, since the one is expressive
of the other.

Considering the amount of attention which the subject of phthisis, along with other diseases of the mind, has received at the hands of writers, it is advisable that I should give a short resume of the literature devoted to this particular disorder.

The first forms of phthisis which came to be recognized as such were those known as "Acute Dementia" and "Melancholic acce-

tent" respectively. The former of these had for long been regarded as a form of true (i.e., permanent) dementia, or the litter-
of them simply as a complication of melancholia, but after it became evident that some of these cases recovered completely, occasionally in a rapid, almost sudden, manner, minds of specialists began to assume that there must be a distinct form of mental disorder, consisting in a temporary suspension of mental function, as contrasted with a permanent abolition.

It was not however until 1874 that a description of phthisis as a distinct class of disease, or a classification of the cases, was given.
This was done by Dr. Hayes Newington, who divided the cases into "Anergic" and "Delusional," practically corresponding to those previously known as acute dementia, and melancholia acute phlegmatic respectively. The table which he drew up was as follows:

Newington's Table.

Anergic. Invasion very rapid, intellect evidently greatly impaired, memory gone, no sign of emotions, features relaxed, eye vacant and not constantly fixed, volition absent, motor system weak, &c.

Delusional. Invasion slow, intellect not impaired, memory preserved, features contracted, eye fixed on one point, usually upwards or downwards, &c obstinately closed, &c.

The above will be seen to consist of little more than a conglomeration of outward symptoms; there is no indication of the real nature of the disorder, no nor is there any attempt to describe the analysis of the mental state. Nor has any such been given from that time forth, so far as I can ascertain, except—

standing all that has been written on the subject, + the above classification, which merely consists of a catalogue of signs, without any explanation of the intrinsic differences existing between them, remains practically the same up to the present time. Thus Dr. Rees Lewis 1 divides the cases into 'Insane melancholia' and 'Acute Dementia'. Dr. Clouston 2 divides them into 'Melancholic Stupor' (including delusional) and 'Anergie Stupor' (Acute Dementia'), with three other classes, which however merely indicate the occurrence of stupor as a complication of epilepsy, general paralysis of the insane, + other forms of mental disease.

In Dr. Hack Tuke's Dictionary of Insanity 3 the most recent work published, the cases are divided into 'Delusional' + 'Anergie', + a comparison of the description given in this work with that given by Clouston is sufficient to indicate the degree of confusion which has arisen with regard to these terms. In the former, Anergie cases are described as follows: "Some of

The cases are restricted — it would seem that some amount of consciousness is present here.” In the latter, we read of the same class as “the symptoms are complete unconsciousness — no muscular resistance.”

It is apparent therefore that as such confusion exists with regard to this term energetic, so there must be the same with regard to the classifications in which the term plays such an important part.

It is (1) in consideration of this fact that (2) because the descriptions or classifications consist at best of a list of outward signs for the most part, without being founded on any rational basis. It (3) because apart from this again there are many cases of stupor which do not correspond in any way to any of the above classes.

That I have come to the conclusion that a fresh inquiry into the whole question of mental stupor, a new classification, are required.
But it appears to me that it is impossible to form a rational classification (by which I mean one which shall express the rationale of the cases), merely from a comparison of the outward signs presented by the various cases, this must be done either by an analysis of the mental state, or by a study of the morbid anatomy. The latter can of course assist us but little, for the following reasons.

1. It is rarely that a patient dies whilst in a state of stupor, so that opportunities for post-mortem examination are few; comparatively speaking.

2. If death does occur, or it do so during the earlier periods of the disease, say in the first year, the only morbid conditions which one would expect to find in the cranial contents, would be circulatory changes in the brain or its membranes; I infer this from the fact of the occurrence of sudden recoveries during the course of stupor.

Now considering that death in these cases is usually due to pulmonary disease, such
suffer forms of pneumonia etc. which have of
themselves caused a comatose state for some
time before death takes place, it is impossible
to say, on post-mortem examination, how far
the changes found are to be considered as
connected with the stupor previously existing,
and how far with the coma which supervened.
(3) If death occur at a later stage of the
stupor, say during the 2nd or 3rd year, another
difficulty would come in, for from what
we know of the clinical history of similar
cases which have survived, an element of
dementia would have been superadded to
that of the stupor. (The distinguishing points
between dementia + stupor, I shall point
out presently.) Consequently, it would be
difficult to judge as to how far the organic
changes found in the brain + its membranes were
connected with the stupor, and how far with the
progressing dementia.
Taking these facts into account, it is evident
that the only satisfactory classification
which can be made is one which is founded
on a psychological basis, derived from an
analysis of the mental state.
In making this analysis, the point upon which I would lay special stress is, to repeat what I have already pointed out, the consideration of the higher reflexes of the mind, for it is in my firm belief that it is in this manner, and this only, that a clear view as to the subject of stupor can be obtained.

I regard stupor as occupying much the same position in the mental system, without that 'paralysis,' holds in the nervous diseases of the nervous system. In each we have a term expressing a symptom, but giving no clue as to the seat of its cause. The term 'paralysis' gives us no indication as to whether the cause of the disease is in the brain, the spinal cord or the nerves; in like manner the expression 'stupor' does not inform us as to what part of the mental system it is which is at fault; and just as in the former case the study of the various reflexes, hunger, skin etc. is essential to the elucidation of this point, in like manner it is of the highest importance in the latter case to work out the higher reflexes of the mind in a similar.
connection.

The importance of this fact is indeed apparent on reading Lobanov’s definition of stupor, in which he asserts that “the higher reflex functions of the mind are paralyzed.” Yet neither in this treatise, nor in any other work on mental diseases have I been able to find any account of the state of these reflexes in cases of stupor. Even in Maudsley’s “Pathology of Mind,” the sequel to the “Physiology of Mind,” in which latter an elaborate description of the higher reflexes in peace conditions is given – the subject of stupor is barely mentioned, and no statement is made as to the higher reflexes in that condition.

As I shall have occasion to refer frequently to these reflex functions, it requires to introduce several new terms to describe modifications of them in disease. I propose now to give a short account of them, before passing on to the subject of stupor itself; the detailed account of their working I shall of course leave to be described, each in its proper place, under the various divisions of the

subject, as they are taken up in turn. I may here state that with regard to the clinical cases, which will be described, that I shall be required to designate the latter by means of initials, as the most typical cases, and therefore those which have been taken as illustrations, are those of patients belonging to the middle and upper ranks of life, who have come under my care in Private Asylums or in the private wards of a Public Asylum.

For the same reason I am unable to supply photographs of the various patients.
The Reflexes of the Mind.
Plan of the Mental Reflexes:

Highest Mental Reflexes:
- Radiation of Ideas (coordinated)
- Association of Ideas (incoordinated)

Combination of Ideas with previously-registered Ideas.

Perception: Idea with Emotional Feeling

Direct Idemotor Reflex

Sensori-motor Reflex

Motor Intuition

A. Previously-regarded Ideas with their perspective Emotional Feelings.

A'. Previously-regarded Ideas with their perspective Emotional Feelings.
The Higher Reflexes of the Mind.

In order to demonstrate the plan upon which I purpose arranging and describing these, I here append a diagram for the purpose of representing the various reflex arcs of the mental system.

In this I have included the sensori-motor reflexes, although strictly speaking they do not belong to this category because of their intimate connection with the higher ones, a connection which appears to me fourfold:

1) Processes which at first require for their performance, consciousness and attention, attributes of the higher mental powers — may after frequent repetition be achieved without either of these factors, thus becoming purely automatic. For instance, reading aloud can at first only be done with the application of close attention, but with practice an individual may accomplish it without paying the least regard to what he is doing, his thoughts being, perhaps, fixed upon some other topic of an entirely different nature.
In connection with this point it is interesting to observe that in cases of acquired dementia, in which the faculties are being gradually lost, automatic movements are retained to the last as a rule: thus it is rarely that any of the chronic lunatics in the Asylums forget the steps & figures of the various dances. (Typical examples of acquired automatic movements) however demented these same patients may have become in other particulars.

(2) The application of attention to automatic acts, after these lastfer have been thoroughly mastered, is apt to impair their execution. The case of a nervous man reading aloud is, I believe, an example of this, the individual in his anxiety to conduct himself creditably, fixing his attention too closely upon the matter in hand, instead of allowing it to go on unconsciously for the most part. The converse is well illustrated by the case of a lunatic under my charge, Mr. J. H. aged 46 years, who was in a state of advanced dementia, but had a remarkable faculty for playing music at first sight, an act
which becomes purely automatic by practice. She
manifested an utter absence of all interest in
or attention to what she was doing, but that
was no hindrance, but rather an aid, to the
performance; was evident, for if the page
were suddenly turned over in the middle
of a passage, so as to bring into view another
piece of totally different time and nature, she
could pass without a break from the one
to the other, taking up the latter at the
corresponding part of the page at which
she had been playing the first one. This
it would be almost impossible for anyone
to achieve, however proficient in the art
of playing at sight they might be, were
they judging any attention to the matter.

8 (3). Acts which at first are purely senso-
motor (automatic) are after controlled by
the higher centres.
This is evidenced by the proverb which a
child, as it grows in intelligence, acquires
over the act of deception, and it is again of
interest to note that this faculty, which
is one of the first to be gained, is one of
the first to be lost when an individual passes into a state of dementia, or other form of mental disorder. This loss of control over defecation, the symptoms of _dirty habits_ as it is called, is one which it is important to consider at this stage, on account of its frequent occurrence in cases of stupor. The causes of this symptom have been almost entirely neglected in psychological medicine, notwithstanding the importance of ascertaining the point, both on the grounds of diagnosis & prognosis, as well as of treatment.

I have therefore collected a number of cases of various kinds, mania, dementia, melancholia etc., in which this symptom had occurred, in order to ascertain the various causes which give rise to it, & have come to the conclusion that these latter are three in number.

(a) Loss of sensation. Thus a melancholic, H. D. K. whose intelligence was not impaired, would occasionally defecate into his breeches, & have no knowledge of the fact until he was made aware of it by the unpleasant
odour; the only explanation which could be given of the symptom was that from time to time he appeared to temporarily lose the power to experience the sensation of a loaded rectum and the act of defecation taking place.

(b). Through loss of the instinct of cleanliness. In such cases, which are most commonly those of advanced dementia, but occasionally also those of commencing manic-depressive attacks, the patient behaves in the same way as an untrained animal, in which the instinct has not been developed. Dirty habits in the insane, when proceeding from this cause, appear to indicate organic changes in the brain, for clinical experience has long proved that if the prognosis in such cases is almost hopeless.

(c). Through lack of attention to bodily functions. By this I mean that the patient’s attention is devoted in
some other direction; thus & a general paralysis of the insane, I.A.R. act 36 years, Boston Asylum, would sometimes dirty himself as he was engaged in giving an account of his wealth, this achievement in general; he became so deeply interested in his description, which were of course as the most exaggerated scale, that he appeared to become insane to our proper impressions. This class must be carefully distinguished from class (a), in which there is less of sensation, a very different method to the one we are now considering, in which the sensation is present but is not noticed by the subject of it, the bodily feeling being overwhelmed at the time by the emotional. These cases are of special interest in connection with the question of phagia, for I believe that in this latter disorder it is this factor of want of attention which frequently accounts for the symptom of dirty habits. As will be seen when the classification fo
physicous cases is taken up, one important element in the induction of this disease is that of concentration of the attention upon some particular train of thought, and it seems to me feasible to infer that this has a similar effect in rendering the patient insensible to bodily impressions that the course of the ideas through the mind of the general paralysis had. Thus the same factor may be responsible for this symptom, both in its present form and in such a case of general paralysis of the insane as I have referred to. Two forms of mental disease widely separated on almost all other points.

Thus these are the various causes of dirty habits in the insane. To return to the subject of the connection of sensorimotor movement with the higher mental functions,

(4) The same stimulus may cause either a sensorimotor reflex or an ideomotor one. Thus supposing an individual to be engaged with a book, an insect happens to settle
on his neck, he will probably put up his hand to knock it off. He may do this quite unconsciously, the action being simply sensori-motor, or on the other hand, it may arouse in his mind the idea of a wasp or other stinging insect, or the consequent fear of pain, so that perception + emotional feeling here come into play, the emotional feeling giving rise at once to the appropriate movements on the part of the individual. To these reflexes in which ideation takes a part, the term 'Ideomotor' is applied, for those in which emotional feeling exists without the intervention of other ideas, I would suggest the term 'Direct Ideomotor Movement.'

Instead of acting, however, in this direct manner, the idea in hand may call up other ideas, previously registered in the mind, these latter becoming associated with the first, modifying its course of action; for each of these previously-registered ideas has its own accompanying emotional feeling, which either inhibits or
encourages the tendency of the first-named. (For convenience sake I shall speak of the idea, which has just arisen in the mind, as the "present idea," and those which have been previously registered, as the "past ideas.")

Thus to continue the illustration of the man who feels the insect on his neck, in whom the idea of a wasp is accompanied by the desire to brush the insect off. This idea may become associated with two past ideas.

(a). The remembrance of a sting previously received under similar circumstances; in this case there would be emotional feeling tending in the same direction as that of the present idea, thus encouraging the movement which the individual tends to make.

(b). The thought that it would be best not to brush the insect off, or it will certainly use its sting, whereas if left alone it may take to flight without doing so. In this case the tendency is to inhibit the movement.

The final effect depends upon the pre-
-Prominence of the tendency to action, or of the tendency to inhibition of movement. The general term "association of ideas" is used to designate these higher reflexes, in which not only the newly-arisen idea, but also a number of previously-registered ones take a part. It must be kept in mind, however, that the regular, coordinated association of ideas, which takes place in a well-balanced mind, is very different to the purposeless irregular association which goes on in many of the insane, especially during manic-depressive attacks. I am of opinion that one person, why these higher reflexes have not received their due amount of attention in the study and description of phthisis and other mental disorders, is that we have hitherto had no terms to differentiate the orderly from the irregular combinations of ideas.

I propose therefore to call them respectively "Coordinated" and "Incoordinated" associations of ideas.

The application of the word association to all cases would imply that there is invariably a connection between the various
ideas as they arise in the mind. No doubt in most cases it is possible to discover
a link of some kind or another between them, it may be in the nature of the subject, or
may be simply in the sounds of the words used, but there is still left a certain propor-
tion of cases in which such a connection cannot be found, especially in the ravings
of delirious mania.
In this account I think it desirable that we should have a term in readiness to
express the course of the ideas in such cases, and therefore beg to suggest the use of
the term "Radiation of Ideas" for the purpose.

These higher reflexes are of course capable of infinite variety, rendering it all the
more necessary that we should have some system upon which they can be described
and referred to. The arrangement, which I have suggested, will I think meet the
difficulty. After using it for some time I feel confident that there are few, if any,
combinations of ideas found in the insane, which will not correspond. It cannot be described
By one or other of the following terms:—

1. Sub- or motor reflex. (automatic).
2. Direct Ideomotor reflex.
3. Radiation of Ideas.  
   (a) Coordinated.
   (b) Associating Ideas.
   (c) Incoordinated.

As to the manifestation of these various reflexes in the insane:—

The Direct Ideomotor is especially liable to occur under the following conditions.

(a) In cases in which emotional feeling, or some especial phase of it, is in excess. In homicidal mania, for example, the desire to kill may come on with such intensity and suddenness as to obliterate for the time being all other ideas and feelings from the mind. Thus J. B., male, aged 42 years, a patient at the Broomfield Asylum, was a quiet, depressed man, in whom the homicidal impulse would suddenly come in with such force, that he would immediately rush at the person nearest at hand, with no other disregard of the consequences. For a few moments indeed his only thought...
Seemed to be 'to kill', but as soon as he
had made the attempt, the desire had
spent itself in action, the thought of the
consequences of the deed would flash
upon him; the association of ideas which
had been paralysed by the intensity
of emotional feeling, was again set free
as soon as the latter had expended
itself.

(3). In cases in which there is a deficiency
of ideas, with which to become associated,
do in patients suffering from secondary
dementia, in whom the ideas once
existing in the mind have become obliter-
cated. Such persons are very apt
to react at once to any emotional feeling,
impulse or desire, which they may
experience.
It is even more marked however in the
case of idiots, in whom the ideas have
never existed, for in such cases even
emotional feeling is often present, at the
same time, to a very high degree, whereas
in secondary dementia, emotional feeling
frequently disappears coincidently with the other faculties.

(9) In cases in which ideas exist, but are with difficulty recalled. Thus in commencing senile insanity, in which the memory is often described as "slow," an idea arising in the mind frequently takes some time before it resolves past ideas into association with itself. Hence these patients are liable to give way at once to any impulse which may strike them, so that direct ideomotor movement is of common occurrence as a symptom of the mental derangements of old age.

As to the various manifestations of the highest reflexes, of the elements of attention to which influences them, I do not mean to further enlarge upon them at this stage, but shall take them up, each under the headings, with which they are most closely connected, in considering the mental state and classification of insanity, to which I now pass.
The Classification of Stuporous Cases.
The Classification of Stuporous Cases.

I would define this disorder as being "a morbid suspension of mental function, other than that occurring as a complication of bodily illness or accident."

This last phrase I have inserted in order to eliminate cases of coma due to such conditions as pneumonia, typhoid fever, fracture of the base of the skull to, in which the suspension of mental function is a mere secondary matter, not forming the chief element in the disease, such as it does in what we would regard as true mental stupor.

Keep in also a suspension of mental function, but is excluded from the definition by the insertion of the word "morbid."

Any less general definition than the above, seems to me to fail to include all cases of the disease, that will be observed that instead of any attempt to express more closely the particular elements of the mind which are affected, the broad term "mental function" has been used. I did this, considering it inadvisable to attempt a more detailed description of the mental state.
in a definition, because of the fact that the elements which are at fault in one class of stuporous cases may be totally different to those affected in another class, of the same disease.

In fact, it is on these differences in the parts of the mind which are affected in the various cases that I have constructed a new classification. Each heading in the latter is based upon some mental faculty or other, the derangement of which plays a prominent part in certain cases. The method upon which I proceeded in forming this classification was by analyzing all the cases of stupor which came under my notice during several years of asylum service, studying the state of each patient the state of the various constituents of the mind before, during, and after the stuporous period, and the connections which each of these elements appeared to have with the latter.

In this way, I found that stuporous cases required to be just under three main headings, involving consciousness, ideation, and emotion respectively. But the two latter classes I again
made subdivisions, thus:—

A. Stupor with Unconsciousness.

B. Stupor with Ideational Peculiarities.
   (a). Concentration of thought upon one
       train of ideas.
   (b). Delusional + Resistant Stupor.
   (c). Cataleptic Stupor.

C. Stupor with Emotional Peculiarities.
   (a). Deficiency of Emotional Feeling.
   (b). Excess of Emotional Feeling in
       some particular direction.

This forming the most convenient plan
upon which to describe the various modifications
of the mental state in stupor, it will be
followed throughout this Thesis. The various
points being taken up as follows.

A. Stupor with Unconsciousness.

The general question of consciousness,
and the importance of 'receptive conscious-
ness' in particular in connection with
stupor.
Phases of Consciousness + Unconsciousness in the Insane.
(1) Total Unconsciousness.
(2) Semi-consciousness.
(3) Consciousness with limited Ideation.

Clinical Cases.
Diagnosis of Unconsciousness in Stupor.

B. Stupor with Ideational Peculiarities.

(a) Concentration of attention upon one train of Ideas.
Clinical Cases.
Effect of Concentration of attention in various conditions, + application to this form of Stupor.
Two Clinical cases, illustrating the differential diagnosis of these conditions from Retienece.

(1) A case of Melancholia with Commencing Stupor.
(2) A case of Melancholia with Delusional Retienece.
Retienece + Stupor.
(b). Delusional + Resistant Stupor.
Clinical cases + analysis.
General consideration of delusions.

(i). The cause of delusions.

(ii). The effect of them. The question of stupor as a result of delusions.

(iii). The difference between resistive + non-resistive delusions in this connection.

(c). Stupor with Catalepsy.
Clinical cases.
The relation of stupor to hypnoses;

(i). As to bodily + mental states.

(ii). Induction.

(iii). Resolution.

C. Stupor with Emotional Peculiarities.

(a). Deficiency of Emotional Feeling.

(b). Excess in some particular direction.

Clinical. Illustration of these two conditions at different points in the case of T. A. M.
Emotional feeling, its nature, + various phases + effects in the insane.
Relation of emotional peculiarities to stupor...
Stupor with Unconsciousness.
A. Stupor with Unconsciousness.

General question of consciousness in the insane.

The subject of consciousness is one of the most difficult with which we have to deal in mental disease, owing largely to the fact that we have no clear definition of the condition. The term 'consciousness' being used in so vague a general a manner. The same difficulty is found even in those describing modifications of consciousness in healthy conditions; thus in the case of people who are what is called 'half-dying', it may be extremely difficult to say as to whether or no such persons are conscious, or if this be so in a doubtful point to decide in those who are healthy, it is infinitely more so in such conditions as stupor, unless some standard or basis is taken to upon which to work.

Now after analyzing a number of cases to which would certainly be regarded by most observers as unconscious, I have come to the conclusion that the phrase of consciousness to which it may be without knowing that we are doing so, we may most
attention, is that which may be termed
'Receptive Consciousness.' Unless it is
made clear as to which phase of consciousness
is absent, when we call an individual unconscious,
it will be impossible to gain any clear insight
into the subject, or to make a lucid classifi-
cation, I suppose.
My purpose, therefore, is to define 'receptive
consciousness,' and to work from this.
The definition which I would give of this
condition is as follows:

A state in which the individual is aware
of impressions made upon his senses,
or if unaware, is so merely because his
attention is devoted in some other
direction.

A man in good bodily and mental health, who is not asleep, may, in a fit of so-called 'absent-mindedness' be totally unaware of impressions made upon his senses, but only because his attention is fixed upon some other train of thought, passing through his mind.

Similarly, as we shall see when discussing
the next class of ideational peculiarities, a
patient in a state of physis, may be unaware of sense-impressions for the same reason, so that he is conscious according to the definition laid down. It is as important that such a case as this should be kept separated from cases of true unconscious physis, so that absent-mindedness should be distinguished from sleep.

The question naturally arises as to whether a man who is dreaming must be considered conscious or not. A difficulty which comes in here is that a person's mental state must be different towards the end of a dream to what it is at the commencement of it, so in the latter case the man is certainly "near-consciousness" if one may be allowed the expression.

Looking at the matter, however, from the standpoint of the above definition, little difficulty will be found in designating the person as unconscious, for in a dream he is certainly unaware of impressions made upon his senses; he is aware of ideas passing through his mind as consequence of those sense-impressions, as in the case of a person who dreams of a thunderstorm, when a gong is sounded in
the vicinity, but he cannot be said to be aware of the sense-impressions themselves, or that from other causes than mere deviation of his attention.

A more difficult point is that of sleep-walking. Here an individual reacts to sense-impressions, as in avoiding obstacles, walking along narrow passageways, but he cannot be said to be actually conscious of them. The fact of his having no recollection of them afterwards is no evidence of want of consciousness, on the other hand, for as Dr. Clark has shown, this fact is by no means infallible.

Contrasting with such a case as this, in which an individual reacts to sense-impressions, of which it is doubtful whether he is conscious for not, there are others in which an individual is cognizant of the impressions, but betrays no evidence of it at the time. Thus I have seen cases of insomnior, in which the patient, upon their recovery, recounted scenes which they had witnessed at times when apparently they were oblivious of all around them.
It is necessary for the due elucidation of this matter, that the various modifications of consciousness should be differentiated from one another. I would divide them into five classes.

1. Total loss of consciousness.
3. Consciousness with limited delusions.
4. False consciousness.
5. Dual consciousness.

The two last-named are not important for our present purpose, but the other three are of great consequence in connection with the subject of Insanity.

1. Total loss.

This we find in two classes of mental disease, which are at opposite poles to one another, viz. Insanity, + delirious mania. In the latter condition, the maniacal excitation frequently reaches such a pitch, that the patient raves + mutters without apparently any knowledge of what he is saying + doing, and certainly without...
Knowing anything of his surroundings. The condition is doubly interesting in connection with hypnagogic states, as the patient frequently passes out of this state into one of hypnagogic, closely allied to the phantoms' condition.

(a) Partial loss.

This bears the same relation to the last class, as drowsiness bears to sleep. A person in a drowsy state has some knowledge, however indistinct, of what is going on around him, in like manner there are cases of hypnagogic states in which the patient has a vague indefinite perception of events. As will be explained when treating of such cases below, this state of semi-consciousness is much more closely allied to total loss of consciousness, than to the following class from which it ought to be clearly differentiated.

(3) Consciousness with limited mentalisation.

By this term I express that part of the mind is in operation, while the remainder has its function suspended.

In this class part of the mind is active,
Whilst in the last-named class the whole mind is partially active, two widely different conditions.

One of the best-marked examples of this class is that of hypnations, in which one part of the mind, under the influence of the operator, may be fully active, whilst the other channels are completely closed for the time being.

Similarly, there are cases of phasms, in which mental function is limited to perception of what is taking place within sound or sight of the patient; memory of past events appears to be totally absent for the time, as no other ideas are aroused in the patient's mind by what he hears or sees. The whole of the higher reflexes, radiation and association of ideas, being evidently at a standstill.

Now it is apparent in itself that such conditions as these are widely different to those of semi-consciousness. Whether or not the latter have been classed with them, as in Cramton's work, for instance, but it seems to me that one might as well call drowsiness

with hypnoses, instead of with sleep, & I believe that this method of classifying the semi-conscious with the conscious has been one of the causes of the confusion which has existed in reference to stupor.

So long however as the term consciousness was used in a vague manner, no attempt being made by writers on mental disease to define it, or any phase of it, so long was a lucid differentiation of cases impossible. I think however that it will be found that most of the difficulty is done away with by adopting the plan, which I have suggested, viz. that of defining receptive consciousness, & taking that as a starting-point.

Having said this much in the subject of consciousness & its modifications in insanity, I shall now proceed to describe unconscious stupor clinically. As however all cases of this class of the disorder present great similarity, I intend merely to describe one case of the kind, referring to another one, presenting a point of special interest.
Mr. C. G., aged 36 years. Admitted to Boston Asylum, 11th May 1889. Hotel-keeper, & pacing "book-maker?"

He had a bad hereditary history, his mother having been insane, although from what form of mental disease she suffered could not be ascertained.

The patient himself had had good health all his life, and this was his first attack of mental disorder. He had however led an exciting and dissipated existence, drinking and gambling to a great extent, and during the pacing nearest preceding his admission to the Asylum had lost heavily, in consequence of which he became depressed and reticent, with occasionally displays of violence towards his wife, as hitherto unheard of occurrence with him.

He acquired the delusion that his wife had conspired against him, & was plotting to rob him, & finally he lost his self-control to such an extent that he had to be sent to the Asylum.

On his admission there he was found to be restless & depressed, saying that he
would do for himself: He had hallucinations of sight and hearing, it was suspicious of everyone who came near him. If made to go in any direction, he would resist violently, or try to go in any other, or if a door were opened he would make a wild rush for it, as if trying to escape from some imaginary enemy. When spoken to he would make no notice at first, or it was only by shouting at him, or shaking him, that he could be made to pay any attention, and even then he would merely look up in a dull manner, as if merely to say that he could be got to make any reply to what was said to him.

He remained in this state for twelve months, spending his time in muttering to himself, or in playing at frogs, which he thought he pawed crawling about. He rarely addressed a word of any kind to anyone, it appeared to take little notice of what was going on, his attention being evidently taken up with his hallucinations, so much so indeed that during part of the time, whilst he was muttering to himself, he did not seem to take any notice
even when a pin was stuck into him.
He frequently refused food, and for several months had to be fed daily with bread and milk, for several months had to be fed daily with bread and milk

In September 1890, at the time when he came under my care, he was gradually passing into a stuporous condition, until at last he ceased to answer even, and for days together would show no signs of consciousness, merely lying with his eyes closed, saliva dribbling from his mouth, his hands blue and cold, and tapping on the forehead he would take no notice, though occasionally if he were shaken violently, or at the same time spoken to in a loud tone of voice, he would half open his eyes for a moment, though he would close them again at once, and into his lethargic state again. Very occasionally he might be seen to shake his head or to say, in a low mutter, "I'm all right," but otherwise his condition was one of absolute unconsciousness, as far as could be made out, in which he remained for two months, up to the end of November.

The first sign which he gave of returning consciousness, was to open his eyes one morning.
say "good morning" to me as I was going my rounds. From that time he gradually wakened up so to speak, and began to look about him, though for some weeks nothing in the shape of conversation, but at least I was able to get him to describe to me what he had had for dinner that day.

By the end of January he had so far improved as to be able to recognize his wife, for the first time since his admission to the Asylum.

After that he relapsed again, and gradually took less notice of what was going on, could only half difficulties, he got to make any reply. His condition at this time resembled closely that during the two months when he was deeply unconscious, except that the loss of consciousness was less complete. He was dimly aware of what was going on, could apparently think in a confused sort of manner. It was his state at this time which first drew my attention to the relation of the semi-conscious forms of sleep with the unconscious.

During the next four months he remained in this condition, except for short intervals in which he roused up to make remarks. During
these brighter intervals he appeared to have lost the slightest recollection of what had occurred during the stuporous periods, not even the semi-conscious ones. After that I lost sight of him, on his transportance to another asylum.

The subject of diagnosis of the presence or absence of consciousness is one which needs further explanation at this stage. The matter may be investigated in the following ways.

1. By studying the general expression of the patient. This test is of value only as supplementary to the following one, for it is rarely that evidence of consciousness can be obtained by means of it, since in most cases patients, proved by one of the other tests, to have been conscious, have given no evidence of such by their expression or general conduct.

2. By the responses which the patient makes to stimuli. These may be in the form of loud noises, pseudo with a private wish the patient gives sign of being aware of.
Then, it is of course ample proof of the presence of consciousness. (By giving signs of being aware of them, I mean that he actually experiences the sensations, not that he merely draws up his leg when piqueted with a pin, for this of course, as one of the superficial reflexes, may occur in states of the deepest unconsciousness.)

The reverse cannot however be regarded as a proof of unconsciousness, for patients have been known to show no sign of pain or to make any movement whatever when piqueted with a pin, although on their recovery they have stated that they felt it, that it caused them pain, but that they could not cry out.

(3) By the recollection which the patient has of events which happened during the stuporous periods.

This again is valuable when affording positive evidence, for if a patient repeats a conversation upon his recovery, which was held by persons within his hearing during the period when he was stuporous, it is ample proof that he was conscious at the time.
as in the last case, the reverse does not of necessity hold true, for if we consider how many of the events which we witness daily fade from our memory in a short time, it is evident that the fact of a patient having no recollection as to what occurred when he was in a state of stupor, cannot be regarded as proof of his having been unconscious at the time.

To recapitulate therefore, the value of these tests is as follows:—

(a). As proofs of consciousness. The first test is purely of avail, but the 2nd and 3rd are either of them able to furnish proof positive.

(b). As proofs of unconsciousness. Each test is insufficient in itself, but if supplementing one another, so that a patient presents every aspect of unconsciousness, makes no perfect response to repeated severe stimuli, and has no recollection of anything that was said or done to him, a diagnosis of unconscious stupor is, I think, justifiable.
In D.J.'s case, all the tests pointed to the absence of consciousness, the only evidence against this being that occasionally during the deeply stuporous periods, he might be forced to help open his eyes for a moment. This however does not, in my opinion, militate against the diagnosis of unconsciousness, for he could never be forced sufficiently to be regarded as aware of pain impressions, or even were that not so, it does not necessarily follow that the stupor was as deep at one time as another.

As this case of D.J. would have been regarded, by most writers, as a typical example of 'Korby Dementia', it is necessary that I should at this point discuss the two conditions, Stupor Dementia, in their relation to one another. Arguments upon this subject are very apt to become mere play upon words. The term 'dementia, signifying absence of mind', might of course with correctness be applied to states of stupor, in which the faculties are temporarily absent. Indeed in all prob-
ability. The best terms to use would be "permanent
dementia" for cases in which the faculties are
permanently lost, or "temporary dementia"
for those in which they are "temporarily suspended.
The introduction of these terms would however
tend to the same confusion, which existed when
these two conditions were thus associated
before, as "psphoral" has now become a recog-
nized term for cases of temporary suspension
of function, I think it best to retain it
as such, reserving the term "dementia" for
cases in which a permanent abolition of
faculties has taken place.
As to the essential nature of the two conditions,
I would say that in dementia we have a
condition in which the mind makes full
use of deficient faculties, whilst in psphoral
the mind is unable to make the most of
its faculties, whether these be good or bad.
The chief difficulty lies in the differentiation
of these two conditions, when they occur
together in the same patient; as we shall
see illustrated in the case of P. E. to be
described presently,
In such cases it is essential to form an
opinion as to how far the symptoms are due to stupor, or how far to dementia. There is, to
an experienced eye a "something" in the con-
sequence of the past patient, which determines
his opinion that part of the symptoms are
due to lack of the use of faculties, which are simply lying dormant. What this
something is it is impossible to describe,
any more than one could enumerate the points
by which he judged a person to be honest
or dishonest, or the case might be.
In the case of J. E. I had no doubt of the
fact that his condition was one of suspension
of faculties. Of course when his stupor was
intense, there could be no question of
this, but during the semi-conscious period
his manner closely resembled at times
that of a case of dementia, I may say.
Even then however there was evidence in his
general expression, that he had "more in
him" than he was capable of manifesting
at the time, so that this was correct
was shown by his conversation during the
bright intervals, which occasionally occurred.
Towards the latter part of his stay in
the Asylum.

Of course I do not wish to imply that when
he emerges from the stupor, he will possess
the same quality of mind as when he passed
into this state, for a prolonged attack
such as his must be only too likely to
have permanently damaged his intellect;
what I have no hesitation in saying is
that he will regain, to some extent at any
rate, the use of faculties, which are at
present lying dormant.

Without wishing to multiply cases of this
nature, I shall describe one more which
was remarkable for its emergence from the
stuporous state coincidently with recovery
from an attack of pneumonia.

J. J. male, aged 34 years. Admitted to the
Plymouth Borough Asylum, 16 November 1891,
having been transferred from Albermarle Asylum,
Salisbury.

On his admission he was in a state of apparent
unconsciousness, in which he had been for
twelve months at least, as far as could be
made out, on inquiry.
He simply sat or lay wherever he was placed, with his head bent forward and his eyes shut, without evincing one sign of consciousness. If tapped on the head frequently he might at times be made to open his eyes for a moment, but no word of any kind or sign of recognition could be got out of him.

Everything had to be done for him as regards feeding, washing, &c. His circulation was feeble, his extremities being blue & cold.

He remained in this state for six weeks after his admission, when developed extensive lobar pneumonia on both sides of the chest, & for ten days was just alive & no more. At the end of this time however improvement set in, his temperature falling & the consolidation of lungs beginning to clear up. As it did so, a remarkable change came over his mental state, for he began now to open his eyes & to look about him with interest, then to make remarks, & to hold out his hands to shake.

In a few days he had become most hilarious, laughing at everything & everybody, & making absurd remarks. By the time that he was able to walk about, he was in a state bordering
simple mania, spending his time pacing up and
down the ward, shaking hands with everyone he
met, laughing and talking, almost without cessation.
He could talk on any subject that was mentioned,
but he did not appear to have any recollection
of what had occurred during the period preceding
the pneumonia, not even of his railway journey
from Salisbury to Plymouth.
During the remainder of the time that he remained
under my care, which was a period of four
months after his recovery from pneumonia, he
showed no sign of a return to the euphoric state.
Stupor with Ideational Peculiarities.
Stupor with Ideational Peculiarities.

(a.) Concentration of thought upon one train of ideas.
The following case will serve to illustrate this class.

Mr. R. C. C. aged 34 years, a private patient at Buxton Asylum, of which he had been an inmate for 13 years, having been admitted at the age of 21 years.

Previous to this he had had, whilst a youth in his teens, several attacks of mental disorder, but it cannot now be ascertained of what nature these were. Apart from this he is said to have been irritable and eccentric.

He is described as being on his admission to the Asylum, of semi- idiotic appearance, talking incoherently, violent and difficult to control.

After that he seems to have become duller, and have spent his time sitting or standing in one place for hours, with a vacant stare on his countenance, except for a brief interval to have remained in this state, if until he came under my care in September 1890.

At that time his condition was as follows:—

he was a stout, very short, and flabby looking man, who did
little else except stand in one particular corner of the room all day, his head bent, and his eyes closed, fixed on the ground, his face devoid of all expression. Indeed to a superficial observer his countenance would have appeared destitute of any indication that mentalisation was taking place within him. His lower jaw was heavy and protruding, this whole aspect was more that of a pig, than of a human being.

On examining his face more closely however, it became evident that thoughts were passing through his mind. After observing him frequently it was apparent that his mind was fixed for the most part upon his sexual organs.

From such information as could be obtained on the point, he seems to have been a confirmed masturbator in his youth, which fact, would be safe to infer as having had considerable influence as a primary cause of his mental derangement, especially when we consider the age at which his insanity came on.

For several years however before he came under my care his sexual power had been null, but he would stand for hours holding his penis
Articles with both hands, even when his arms had been forcibly removed to his sides time after time, would resume this position. This was almost the only spontaneous action which he made; he took no interest in what was going on, and never moved his position unless made to do so, though he did not offer any resistance. He could, however, be got to help to move furniture etc., but whilst so engaged had to be constantly prompted to go on, or he would stop and resume his usual attitude, apparently oblivious of all around him.

His habits were filthy in the extreme, for he would eat his food in a disgusting manner, habitually reaching his hands in the pemol. If spoken to he would make a reply, or would merely give a low grunt, never being heard to utter a sentence of any kind.

He continued in this state until the winter of 1892-3, during which he had an attack of multiple arthritis, from which he suffered great pain for several months. Then that time a marked change came over his mental state, his face assuming an
expression of some intelligence, he now began to look around with interest and to take notice of what was going on. Of spoken to he would not answer readily, nor in a rational manner, able to give expression to what he might feel or desire, or to describe events which had just been taking place, although his memory was deficient with regard to past circumstances, such as his place of residence before he came to the asylum, &c.

He began to read newspapers & periodicals, to look at pictures, taking interest in what he saw or heard.

During the twelve months which have elapsed since he began to improve, he has never once been seen to handle, or fix his attention upon his generative organs in the manner in which he had previously done; his habits in other respects have become clean & tidy.

His case is one which presents points both of dementia & of infirmity, for although his mental state during this latter period just described presented vast improvement compared with what it was previously to that time, yet as
contracted with a mind such as one would expect to find in a man of his education and standing, it was undoubtedly deficient. He could read, take an interest in his surroundings, but could not compose a letter, or manage the simplest business affairs.

What we are chiefly concerned with however, is the cause of the stuporous state.

If we go back to the onset of the stupefactions, 16 years ago, we find an adequate cause for it in the habit of masturbation, to which he had been addicted to such a degree, but it is impossible to believe that this cause had prolonged the stupefactions for such a number of years, seeing as it has lasted in his case, for his personal cure seems to have disappeared soon after his admission to the Asylum.

Unless some subsequent cause had come into operation, it is almost safe to say that his case would have taken one of two courses, i.e. would either have recovered, or would have progressed into a state of Complete dementia.

Some other factor therefore must have subsequently come into operation, to keep up the stupor, & the most feasible one which can be
just forward is that of concentration of the patient's attention upon his sexual organs, a cause closely connected with the original one, but differing from it in its mode of operation; for while the primary one acted by means of physical exhaustion on the part of the brain, whatever that may actually mean, the subsequent cause acted in a purely psychological manner, in my opinion, by blocking the paralysis of the higher reflexes of the mind, so that all radiation of ideas came to a standstill.

It will be easier for me to make my meaning clear, if I now give an account of the effect of concentration of thought as I have worked it out in various regards to various conditions.

**Effect of Concentration of Thought.**

1. Consider it first of all in the case of persons, mentally healthy, an individual is, let us say, writing upon some subject or other, and after a time experiences great difficulty in bringing any fresh ideas to bear upon the subject. The more he applies his attention to the matter in hand, the more his ideas seem to come to a standstill.
until at last he gives it up, & devotes himself to some other pursuit: in the nature of work or of relaxation. It is not unfrequently happens that on his resuming once more the special work in which he was engaged, he finds that his ideas flow freely: the explanation for this phenomenon seems to me, to be simply that the close attention to the matter, which he had paid at the previous venture, had hindered all radiation of ideas; & that the relaxation of this attention had released the higher reflexes: & thus allowed other ideas to come into play.

In most cases where there is this close application to one line of thought, the individual is perfectly aware of what is being said or done to him. Thus if the be spoken to, he will usually answer, even though the remarks made to him refer upon some other subject, than that with which he was engaged at the time. If however the application of the mind to one subject be severe or prolonged, he may take no notice of what is said or done to him, & if spoken to, will probably make no reply, or else one which is totally...
irrelevant, being in the state known as "absent-mindedness" (though I think that "depersonalized-minded" would be a more correct term.) Such persons must be regarded as conscious, i.e., looking at them from the standpoint of the definition laid down as a basis for the differentiation of conscious and unconscious conditions, there is no difficulty in designating him as such. The person may not be aware of impressions made upon his person, but this is simply owing to the fact that his attention is devoted in some other direction of thought.

This condition of absent-mindedness has been mentioned here, because of the close resemblance which it bears to the class of phantasy, which is now under consideration. This resemblance is indeed in some cases so close that it is not an easy matter to state the essential differences between the two. I would however describe it as follows:

In conditions of absent-mindedness, the individual can be recalled to the full use of his faculties, provided that the stimulus be severe or prolonged enough; whilst in
Stephens states the patient cannot be recalled to the full use of his faculties, if recalled, how factually, relapses again as soon as the stimulus is removed.

In contrast to these cases in which the application of attention hinders the radiation of ideas, we shall now consider others in which the absence of this element of attention allows the higher reflexes to glide unimpeded. This may be seen in the case of musical persons, listening to an instrumental performance, for instance; in such people, at such a time ideas will rush through their minds at great speed, though as a rule in a somewhat incoherent manner, and these people may be able to add speec, in imagination, with an unbounded flow of eloquence, in the same way that a man may do when he is dreaming. The moment the music stops, however, the coming up of ideas collapses to a great extent, and their eloquence is at an end.

My opinion as to the mode of action of the music in a case of this kind is, that the emotion which it sets up diverts the attention, and thus allows the radiation
I ideas to proceed freely.

(2) In the dreams, the effect of attention, and of loss of attention, may be studied with advantage in such conditions as mania and melancholy.

Thus in any case of maniacal excitement, the point that strikes one most is that the patient has lost the power of arresting the course of his thoughts. Ideas follow one another with great rapidity, being around generally either by some connection with the previous idea, or by objects or incidents in the vicinity. They follow one another with such rapidity, that although the patient is probably talking as quickly as it is possible for him to get the words out of his mouth, he has to frequently leave a sentence unfinished, in order to start a fresh one, as a new idea occurs to him. The topics of conversation often comprise a great variety of subjects, from one to another of which he may appear to pass with great abruptness, although if carefully looked into, a bond of union between the two can usually be found.
Compare such a case of maniacal excitement, with one of melancholy. In the latter the ideas present in the patient's mind will generally be found to be limited in extent of operation, the his thoughts being confined to a few out of which it is difficult to lead them. His attention is devoted to his own feelings, or to some painful topic, with the consequence that his conversation is wearisome in the extreme, so much so indeed that even sympathizing friends at last lose their patience with him. The patient, finding that none will converse with him upon the one subject, on which he himself cares to talk, probably ceases to speak at all, or even to move about or attend to his own wants in any way, his thoughts becoming more and more fixed in one line.

At such a stage as in the case as this, it would seem that but a small part of the man's brain is in action, the motor centres being almost nothing to do; while little as we know of the ideational portions of the brain, it is not unfair to assume that only a small section of them is at work, that section
being constantly in operation however, In con-
sequence this small section is liable to become
exhausted from over-work, whilst the other
parts of the brain become dulled for want of
use, so that the patient tends to pass
from the state of petition, in which he had
ceased to speak and act, into that of a further
state in which he is unable to express himself
or to act on his own account, a condition in
fact of true mental stupor.

What I have here pictured theoretically
was brought out in the case of melancholia with
commencing stupor, which will now be
described.

W.O. H.A. aged 34 years. Admitted Buxton
Asylum, October 4th, 1890.

There was a history of insanity in the
family, the patient's mother having been
insane at the climacteric periods, having
committed suicide after suffering from
melancholia for some time.

The patient herself had always enjoyed
good health, mental and bodily, up to the
commencement of the present attack which
took place in September 1889.
months after her admission to the Asylum. Her husband had treated her badly during seven years of married life, and at short time before the date mentioned above he had been expelled from his situation for intemperance, and about the same period the patient began to suffer from symptoms of early secondary syphilis.

These two circumstances preyed upon her mind, and she became depressed. Her husband having been sent away, the patient took a house for the purpose of taking in lodgers, but when about to enter upon her duties lost all confidence in herself. From that time she ceased to talk or act for herself in any way; she would simply sit or lie wherever she might be placed, though offering no resistance to being moved. Her whole thought was concentrated upon her domestic troubles, being engrossed with them to the exclusion of all other topics.

For five months she remained in this state, almost her only spontaneous action during the whole time being to send one of her boys to buy landannas for the purpose of committing
Suicide.
On her admission to the Asylum in October, 1890, the chief points to be noted in her condition were negative ones. She did not show any sign of lunacy, either of a jovial or of a painful nature, she was not angry or irritable, but she took scarcely any notice of what was going on and did not attempt to fact for herself in any way, though she did not offer any resistance when made to move about or to take her food, whilst her habits were clean in every respect.
If spoken to she would raise her eyes, but would either not answer at all, or would do so in a hesitating or faltering tone of voice, whilst any attempt to draw her into conversation was of no avail, except on the subject of her home troubles, of which she was already always ready to speak, which shows the prominent place which they still occupied in her mind. If given a book to read she would sit staring at one page for hours, but was unable to say what it was all about, though it was evident that she made an attempt to fathom it, for she might be seen to contract her brows, as if
She was trying her best to understand it.
For several weeks she remained in this state, when one day after prolonged persuasion I was able to induce her to sing. From that time an improvement was manifest in her mental state, as she gradually roused up, and began to take more notice of her surroundings, and to answer more readily when spoken to. In a short time she was able to start a conversation, and to act for herself in many ways. Her recovery was, of course, interrupted by intervals of depression, but it was interesting to observe that as the lethargic state passed off, her emotional depression returned coincidently with the use of her other faculties. Finally she ceased to have these fits of depression, and within twelve months time of her admission to the Asylum she was discharged recovered.

This case bears out largely what was above described as the effect of close attention to one train of thought. The patient had a great trouble, which occupied her mind, to the exclusion of all other subjects of thought,
until she had ceased to do anything except brood over this trouble. From this state of refusing to think or act, she was passing into a further one in which she was unable to do either of these. The only part of her mind left in action being that which was directly concerned with the subject of her trials; from the edge of this seemed to have been taken off for as we have seen she gave no sign of emotional depression when she came to the Asylum. I have no doubt that had she not been forced by being made to sing, she would have passed completely into a state of apathy; the mechanical act of singing did for her, in preventing her from passing into this condition, what the attack of meningitis did for B.C.J. & E. in preventing him from the same condition. It took her attention away from the subject, upon which her mind had concentrated, & thus allowed other centres of ideation to come into play, setting free the higher reflexes & restoring the brain to the use of its functions.

It will be seen that this case of Mrs. H. A. had
crowded the borderland, separating reticence from stupor; but had not passed far into the latter state, before being brought out of it by a change in the occupation of her attention. In the following case on the other hand, the condition was one solely of reticence, as the patient firmly refused to speak or to act for herself, but had not lost the power of doing so, as was conclusively proved by an incident, which will be described in the course of her case. The patient is one of great importance, involving as it does the question of the intrinsic nature of stupor, its differential diagnosis from reticence.

W. E. B. H., age 30 years, admitted Plymouth Borough Asylum January 1892. Married 8 years, had three healthy children.

The patient had a previous attack of melancholia for which she had been treated at Rainhill Asylum, four years before the present illness. Neither of these attacks had any connection with pregnancy or the menstrual periods.

There was no cause of any kind to be found to account for her present illness, which
began, 9 months previous to her admission to the Asylum, with depressions of spirits, suicidal tendencies. She lost all interest in her pursuits, her affection for her husband and children, though she did not manifest any actual dislike towards the latter.

In her admission in January 1872, her condition was as follows:
She was a well-built, fairly stout woman, of healthy aspect physically, but with an melancholic expression, and wept easiest at times, though she could give no reason for doing so.
She was intelligent, could converse on ordinary subjects when spoken to, though rarely starting a conversation herself.
In the course of a few weeks a change came over her, as the appearance of misery passed off, and she acquired instead of it an absorbed look, with a curious insensate expression about her eyes, as if she were gazing without seeing anything. She ceased to speak, or to act on her own account, until at last it was with difficulty that she could be got to make a response of any kind when spoken to, and would resist violently at times if made
To go to the dining-hall, recreation ground &c.
She would pace or sit in one place, or would
promenade slowly up & down the rooms, with her
eyes fixed on the ground, or gazing straight in
front of her, apparently seeing nothing of
what was going on. Even at the dances &
concerts she would remain like this, appearing
to take no interest in what was taking place,
whilst all attempts to induce her to take
part in the amusements were in vain.

Two months after she had passed into
this state, her husband & children came
to visit her, but she paid little attention
to them, & they could hardly get a word
out of her in reply to their remarks about
her home &c. The only remark which
she made was to inform her husband that
he must not think she was his wife, for
she had found that she was married to the
one of the Asylum doctors. From this circum-
stance, & from what transpired subsequently,
I came to the conclusion that her mind
was engrossed with the thought of this medical
officer &c. her relation to him, & that this
fact accounted for her absorbed manner.
Yet even when he was in the room where she
might happen to be, she did not relax her
fixed expressions, or show that she was even
aware of his presence. In fact at times
it was a matter of difficulty to ascertain
whether or no she were in a stupor, or whether
she were simply adopting this peculiar manner
forcibly.

That the latter was actually the case was
proved by an incident which occurred several
months after she had passed into this state,
which, though apparently trivial in
itself, was of great consequence in connection
with the diagnosis of her case. At this time
the medical officer in question happened
to be talking to her, and she was standing
in her usual attitude with her eyes fixed
on the ground, apparently almost
insensible of her surroundings. They chanced
however to be left alone for a short time,
unobserved by others, and soon as this
occurred the patient at once looked up,
began to speak in a lively, cogitative,
manner. The next minute, however, seeing
that they were again within sight of others,
she suddenly ceased to speak, and at once adopted her phlegm-like expression. During the remainder of the time, in which she remained under my notice after that, she was never seen to change this again, even for a moment.

This incident, if it itself shows that this case was one of inactivity, not of stupor, for it revealed the fact that the patient had simply been refusing to speak and act, and that there was no suspension of her mental faculties.

Contrasting it with the case of Mrs. H. A., many points of resemblance between the two may be found, as in the expression, mode of behavior, whilst in each there were depression of spirits, an absorbing topic of thought, although in the case of Mrs. H. A. the absorbing topic was the cause of the depression, while in Mrs. B. it was implanted in the latter. The essential difference between the two lies in the fact, that in the former case there was suspension of mental function, while in this case of Mrs. B. A. the patient had the use of her faculties, had she
cared to exercise it.
The one case demonstrates as to how reticence
can pass into phlegm, the other shows the
necessity of clearly differentiating the two
conditions.
(3). Resitative and Delusional Stupor.

The following case is an example of this class.

Mr. B. C. E., aged 25 years. Single. Accountant's Clerk. Admitted to the Boston Asylum July 23rd, 1890.

No hereditary history of insanity.

For three years preceding his admission to the Asylum, the patient seems to have been eccentric in his behavior, having left his pituitary because, as he said at first, 'The transactions of the firm were not honorable,' afterwards because 'he was not fitted for the business.' In other respects also his character seems to have been most fickle. He was impulsive, violent at times, having given his grandmother a black eye, without provocation, a few weeks before he was brought to the Asylum. For some time he had been acquiring unreasonable antipathies to various members of the family. He does not seem to have exhibited depression of spirits at any time.

From what could be made out, he seems to have been addicted to excessive masturbation. On his admission to the Asylum, he was
in the following state:—

He would stand for hours in one position, with his head bent down, a vacant, or more frequently a jumbled, expression on his face, his hands hanging listlessly by his side.

He showed no interest in what was going on, nor did he either amuse or occupy himself in any way. He exhibited no sign of emotion of any kind, or of affection or antipathy towards those around.

At times he was dirty in his habits, and would grease his mind and grease into his clothes, but apparently without knowing that he was doing so.

He did not offer any resistance at that time, nor did he refuse his food, but whether taking his meals or being made to walk about in the airing-court, he had to be constantly prompted to go on, or he would simply cease whether he happened to be doing, gazed at the ground in a helpless fashion.

He could take part in the dances, provided that he got a partner who would constantly
Start him in whatever figure he had to go through; if told to ask a lady to dance with him, he would get halfway across the room, would then stand still, his head bent halfway down, with a ludicrously jumbled expression on his face, with his hands placed in front of him as if he were just going to dive. I would remain in this position until someone went to his assistance. He rarely spoke of his own accord; in fact, during a period of eight months I only remember him making two spontaneous remarks. (During the subsequent periods, about to be described, when he was in a state of deep stupor, he never uttered a word of any kind.) If spoken to he would sometimes answer, but it was in a jumbled, hesitating manner, and the reply consisted merely of the first few words of a sentence, after which he would stop, wrinkle his brow, as if unable to think of anything further.

He remained in much the same state for seven or eight months, but in February 1891, he became rapidly worse, until he
could not be got to give the slightest sign that he noticed what was being paid or done to him. He simply lay or sat, wherever he was placed, and did not make a movement of any kind, except to resist violently when fed. He could be pinched or pricked without giving any sign that he felt it, but if food was put into his mouth he would struggle with all his might, and it was evident that he had not the delusion that the food was intended to do him harm, for one of the other patients, whose statements could be trusted, informed me that Mr. B.C.S. had told him some time before that she "had everything except carrots and something else contain'd poison."

He appeared to know absolutely nothing of what was taking place around him, but that he was here at this time perfectly aware of events taking place. I was afterwards able to prove, as will be described presently.

His circulation was poor, his hands being blue and cold, his heart sounds feeble, and his feet oedematosous. His palate was
extremely viscid, so much so that at times his mouth would be filled with it, and it required to be removed by means of a finger introduced, as even rinsing of the mouth out with liquids could not get rid of it. This state of profound stupor remained unchanged for several weeks, until one day he was observed to have a widespread erythema, affecting his neck, trunk, and extremities. This lasted for three days. As it began to fade away, an improvement manifested itself in his mental condition, so he now began to look around, and was even able to respond when spoken to, though only to the same limited extent as before.

This improvement was maintained however for only a fortnight, after which the stupor returned, though not to such a profound degree as during the three weeks preceding the occurrence of the erythema. From time to time resistance and refusal of food were marked symptoms in his case, being usually most prominent when the stupor was deepest. He remained in this stuporous state for a year and a half after this, but in December 1892.
he began to brighten up, & to answer questions readily, & at last he was able to start a conversation, & for the first time during the whole of his stay in the Asylum he called me by name. I did not see him again during the following four months, but on my examining him again at the end of that time I found him in a state of mental elation, excited & restless, constantly walking about, laughing & making foolish remarks to everyone he met. His eye was bright, his circulation vigorous, the blueness & tenoans of the limbo having disappeared whilst the secretions of his mouth were in a healthy condition. He was taking his food well, & was cleanly in his habits. While talking to him at this time, he proceeded of his own accord to give me an account of a patient, who had behaved in a peculiar manner during the period when Mr. C. B. was in a phlegmatic condition, & apparently taking no notice of what was going on. He imitated accurately the gestures & behaviours of this patient, an excited melancholy, & repeated the expressions which the latter had used. This fact
Itself was sufficient to prove that B.C.E., whatever he might appear, was at the time that this occurred, in a state of consciousness.

It will facilitate the consideration of this class of patient, if I now give a brief analysis of the points in the mental state of this case of delusional patient.

Commencing with the sensori-motor (automatic) movements, we have already seen these to be unaffected, as evidenced by his power of dancing to a tune, at any rate during the period when the patient was not at its worst. It was however simply the sensori-motor part of the movements which were thus retained, for he had no power of taking the initiative with regards to these.

According to perception, it found this to be unaffected, even when the patient was most profound, so the patient could afterwards give a faithful account of events which he had then witnessed. The ideas thus produced were however evidently merely registered in his mind, without radiating to other centres of ideation, for from what
I could make out, both at the time and subsequently, they did not seem to arouse in his mind any other trains of thought, so that in this case, as in the other cases of phthis, which have been described, the higher reflexes of the mind appear to have been paralyzed. The only other reflex indeed, besides the sensori-motor, which was in operation, was the direct ideomotor. This merely in connection with one idea, that of poison in his food, which gave rise to the symptoms of resistance. His mental life, during the deeply phthisic period, seems to have consisted of registration of events which he witnessed, if the presence of the delusion as to his food. He appeared to have at that time no memory of past events, and certainly had not the power of thinking for himself in any way.

The chief difficulty in his case comes in with regard to the emotional faculties. There was at the time no evidence that these were in action, but there was also no indication of perception taking place, though it was afterwards proved that it had done so.
The test of "recollection upon recovery" in little value in connection with the emotional faculties, for it is vastly more difficult to bring to mind the emotional feeling, which one may have experienced at any time, than it is to recall the ideas, which were the cause of the emotional feeling. When B.C.S. was giving his account of the doings of the melancholic patient, he was much amused at the thought of it, but it does not therefore follow that he had experienced a similar sense of amusement at the time that he actually witnessed it.

There was also nothing in the mode of onset of his phymorous attacks to denote the character of his emotional qualities, such as we shall find to be the case with another patient, whose case will be described under the heading of 'straps with emotional peculiarities'.

In connection with this want of emotional expression, which term I prefer to use instead of "want of emotion", considering the obscurity by which the subsequent subject is beset, it is necessary to discuss the state of the vaso-motor functions, the general state of the
circulation, for between these two the expression of emotion, there is often as marked connection. In B.C.E.'s case the lack of emotional expression was invariably associated with a low state of the circulation, edema of the limbs, unhealthy secretions, etc. Whereas after his emergence from the phrenot, when he presented every appearance of emotional feeling, there was a vigorous state of the circulation.

The question is, which was cause, which was effect? Was the lack of emotional expression due to the feeble state of the circulation, or vice versa? So far as it is possible to form a judgment on the point, I incline to the view that the state of the circulation was, in part at any rate, responsible for the emotional conditions, for the only times, during the course of the phrenot, when the patient showed signs of emotion, there were at the dances, when after being pulled through the various figures vigorously, he would sometimes begin to laugh, but this was always after a marked improvement in the state of his circulation was apparent, consequent on the exercise.
At the same time it must be borne in mind that a deficiency of emotional feeling would be likely to influence the state of the circulation by rendering the sinewless muscular movement so that it is possible that both of these conditions may have acted, each upon the other.

We now come to what is the most important question in connection with this class of phrenetic cases, viz: that of delusions, and their relation to this form of mental disorder.

**Delusions.** The study of this symptom is of great importance in cases of insanity; it demands much greater attention than it usually receives. It is not sufficient merely to ascertain the presence of a delusion, any more than in a medical case it would be considered as an ample diagnosis, if the physician found that a patient had a cough; without investigating the cause of it. In any case in which a delusion is found, a further examination should be made to ascertain (1) the cause of the delusion.

(2) The effect which the delusion has
upon the mental operations of the patient.

As this question has an important bearing upon the forms of insanity now under consideration, it is advisable that I should discuss the general subject of delusions from these two points of view. It is a matter, which does not appear to have received much attention at the hands of authors, notwithstanding its great importance, for I can find no work in which the causes of delusions receive anything more than a bare mention.

In order therefore to rectify what was in my opinion an omission, I investigated all the cases of insanity with delusions, which had come under my notice, with a view to working out these points.

1. The causes of delusions.

These I have divided into five classes, but it is almost unnecessary to state that any case may belong to more than one of these; in fact it will as a rule be found that several causes have combined to produce
This symptom.

(2) Misinterpreted sensations.
Examples of this class may be found in the visceral delusions, which form a feature of the chronic delusional cases, in which a the presence of a morbid growth or some part of the intestines, rectum, for instance, has given rise to a misinterpreted sensation, which has set up in the patient's mind, the morbid idea that he has complete obstructive, or never has his bowels moved, or some such notion.

One of the most marked examples of this class, which has come under my notice, was that of D.C., a male patient at the Bexton Asylum, who had the delusion that the whole world was to burn up on his account, since his body was a "mass of corruption," smelling like the odor of a corpse. In this case a perversion of the sense of smell was at the root of the latter delusion, which in its turn caused the former one to be developed.

(6) A special phase of emotional feeling.
J. M., at 42 years, a patient at the Bexton
Asylum, was an excentable egotistical man, who had the delusion that all the great buildings in the country had been built from his designs, and at his suggestion. He used to draw the plans, or put them down the W.C. &c. Imagined that as they reached the authorities in London or other cities in some way or another. After conversing with him on the subject on many occasions, I came to the conclusion the still object in his reasoning power, which enabled him to believe such a manifestly impossible occurrence, was due to a strong feeling of personal vanity, prevailing in his whole mental life. As I shall describe, when treating of emotional feeling, an excess of this element will paralyse the higher reflexes completely, so it is my opinion that in his case it was this factor which prevented radiation of ideas, so that this morbid idea did not come into association with other ideas which would have assisted in correcting it.
In such a case the treatment ought to be directed with a view to taking the attention
of the patient away from himself as far as possible.

(c) General excess of emotional feeling. These are seen to perfection in the early stages of General Paralysis of the Insane, in which disease the patient invariably describes himself as being the happiest, handsomest, wealthiest, ablest, man who ever lived. He may be made to express delusions on any subject, as in the case of T. A. P. at 32 years, a patient at the Broadmoor Asylum, in the first stage of General Paralysis. One had merely to suggest a subject to his mind, and a delusion was at once forthcoming; speak of boating, and he was, according to his own account, the finest oarsman who had ever existed, had rowed both for Cambridge & Oxford, and always won by at least 200 boat-lengths. Talk to him of degrees, and he would proceed to give you a list of those which he possessed, which were, as few them up, all the degrees in Arts, Sciences & Medicine, which could ever conferred by every University on the face of the globe.
In this case the rational seemed to me to differ somewhat from that of the last class, for there was here abundant radiation of ideas, but no association. The radiation occurring in an incoherent manner, owing to the excess of emotional feeling having paralyzed the faculty of attention to the mental operations.

(d) *Fixed* delusions.

Here I am compelled to name the delusions. Instead of stating the case, as it is, in these cases, impossible to find a psychological explanation of the latter. They are seen in cases of monomania, in which the presence of a delusion constitutes the chief part of the disease, apart from any emotional condition.

Thus H. J. aged 71 years, had been an inmate of the Buxton Asylum for 30 years. He was an intelligent, well-read gentleman, able to converse on all subjects, well-behaved in every respect, except when thwarted with regard to certain peculiar ideas, the chief of which were that he could control the elements by kissing his hand to the sky.
+ that fresh air, salt, eggs & milk were most injurious to the health. It was impossible to discover any cause for these ideas, as his reasoning on all other points was good; he simply believed these things, & wondered that we did not see them in the same light as himself.

(2) Incoherence of ideas, other than that due to excessive emotional feeling.

In the commencement of an attack of mania ideas rush through the mind with great speed, the faculty of attention being paralyzed, so that the individual has not time to compare the different ideas, or to reason from them.

For instance J. H. was admitted to the Buxton Asylum, suffering from an attack of mania. He was restless, walking rapidly from room to room, talking of the robbers who had broken into his house, this being altogether a delusion, as no such robbery or attempt at it had been made.

If it had been possible to arrest the course of ideas in his mind for a few
minutes, to give him the chance of thinking over the matter, it might have been possible to have convinced him that it was all in your imagination; as it was, his mind was in such a tumult, that he had not time to form any opinion on the matter. In fact, he could not be said seriously to believe so the delusion, as it was simply the rate at which his mind was working, which prevented him from disbelieving it.

(f) Lack of radiation of ideas, apart from emotional conditions.

It may be from a deficiency of ideas to which, radiation, with which association, can take place, as in the case of the delusions of ignorant persons, or of patients in a state of secondary dementia, in which ideas are gradually being obliterated from the mind.

On the other hand, it may be due to a temporary suspension of mental function, that conditions of stupor. In fact, for I pointed out in the analysis of B.C.E.'s case, that all radiation + association of ideas
may for a time be at a standstill.

It seems strange, to my mind, that while so much has been written on the subject of phantasm as a result of delusions, that if delusion as a result of phantasm does not appear to have received consideration. And yet if delusions can arise from want of association of ideas, when this does latter is due to excessive emotional feeling, or to permanent obliteration of ideas, there seems no reason why they should not originate in a similar lack of association, when the latter is due to a temporary suspension of mental function.

Take the case of the delusion as to poisoning B.C. B. It is almost safe to say that this delusion arose during the course of the phantasm, as the onset of the latter condition occurred in July 1870, whilst there was no evidence of the presence of the delusion until January 1871, when he expressed it to one of the other patients, so it was not for some weeks afterwards that his furious resistance to food was made. How had the delusion been present for any length of time before
This period, one or other of these evidences if it
should in a likelihood have been present,
that the delusion been in any degree prominent
in his mind the symptoms of refusal of
food would almost certainly have occurred.
Granting therefore that the delusion arose
during the course of the atropin, what explana-
tion can be given if the influence of the
latter in A production of the morbid
idea.
One factor which might probably have some-
thing to do with the origin of this delusion,
was the unhealthy state of the palatine
otions, for these must have caused an
unpleasant taste, which to a disordered
mind would easily be misconstrued into
that of poison.  

The mental
defect which allowed this perversion of sense
be taken place, can only be explained, or a
paralysis of the higher reflexes, so that
the ideas, which would have corrected the
erroneous impression, failed to come into
association with it.

This paralysis of the higher reflexes being due
to a suspension of mental function, it
Seems to me that the explanation of phrenos as a cause probable cause of delusion is fairly complete. There can be little doubt that such must have an influence in the production of delusions, and the above appears to be the only feasible explanation, which can be offered, on the subject.

The Effect of Delusions

(a) They may influence the whole mental life and the behaviour of the patient.

Thus J. S. at 72 years, a male patient at the Boston Asylum, imagined himself to be an Archangel, and every thought, word and deed were imbued with this idea. If asked to take a seat, he would flatly refuse, but if told that the throne was ready, would sit down at once. His whole conversation was centred round this delusion, and had been so during the thirty years of his residence in the Asylum.

(b) There are other cases in which a delusion exercises no perceptible effect upon the mind of behaviour, unless direct reference...
be made to the subject of the delusion; thus
h.s., whose case I have already mentioned,
would frequently show no sign of any mental
defect, unless he were directly thwarted
in his peculiar ideas.

c. A delusion may cause resistance to
movement, as in many cases of melancholia,
in which the patient will resist in every way,
owing to the fact of his being possessed by
some delusion, such as that he is going to be
murdered or maltreated, in some way, whilst
one of the commonest of delusions, that of
suspecting some presence of poison in
food, is the cause of almost all cases of
refusal to eat.

As it will be necessary for me to make
frequent reference to the question of resis-
tance in connection with delusions in phrenos-
cases, I have coined a new term, by which
to distinguish delusions causing resistance,
from those which do not produce this symptom,
by that of "resistive" delusions, by which
to designate the former, "non-resistive"
being applied to the latter.
A delusion may cause delirium, in some cases because the patient imagines that if he speaks he will be killed, or that he has no language; or it may occur, as already described, under the heading of concentration of thought, from the fact that he will not speak on any other subject than his delusion, and finding that no one will converse with him on this, ceases to talk at all.

Stupor as a result of delusion.

The difference of opinion existing on this subject between different authorities, is evident on comparing the statements made on the point by Dr Lewis and Clouston respectively.

The former evidently attaches much importance to the part played by delusions in the production of stupor, for in referring to cases of melancholy with stupor he says, "They (the patients) are generally laboring under some frightful delusions, which utterly swamps their consciousness and will. The outside world may be a blank to them.

* Text Book of Mental Diseases. Edition E. pp 155-6
Their whole mental life is subject to this all-absorbing delusion. --- This concentration of the mind upon one painful idea, which sways like an automaton the whole organism, has been figuratively alluded to as a "crystallized delusion." Body and mind are crystallized around one morbid idea."

Clouston* on the other hand says, in reference to a case of melancholic phthisic with delusions, "I conceive it would be a mistake to describe the phthisis as being caused by this profound delusion. --- I we find that delusions alone never cause phthisis, whatever their character. They may cause protracted feebleness for years, but that is totally different from phthisis."

For my own part I hold much more with the view taken by Lewin, than with that taken by Clouston, for I have seen a case (which will be described) under cataleptic phthisis, in which there was every indication that the phthisis had resulted from a delusion. As studying the question clinically, I have been struck with the

fact that there is a distinct difference
with regard to the power of delusions in
this respect, according to whether they
are resistive or non-resistive, for the
presence of resistance appears to lessen
their power of inducing this condition,
and there is a decided cause theoretically, why
this should be so, as I shall describe in
dealing with cataleptic stupor.

Hence it is that in classifying phrenic
cases I thought it necessary to make a
distinct class in connection with resistive
delusions, calling it "Delusional & Resistive
Stupor", in which the delusions occur as
a complication or result of the stupor, but
not as its cause. The other form of delusion
will come under the heading, either of cataleptic
stupor, or of "Concentration of the mind" stupor,
of which non-resistive delusion may
be the cause.

Before leaving this part of the subject,
I wish to refer to a term, which has
hitherto occupied a prominent place in
all descriptions of phrenic cases, viz,
that of "melancholic stupor." D. Clouston applies the term to all cases of conscious stupor, not occurring as a complication of other forms of mental disease.

The term is, in my opinion, a bad one, in whatever sense the word melancholic is used. This word is applied, according to various authorities, to signify either depression of emotional feeling, or depression of function, or both together.

If used in the former sense, the term "melancholic stupor" would imply that the patient had experienced emotional depression, whilst this is frequently not the case.

Again supposing that the word was used as signifying depression of function, stupor is also a depression of function, so that the term "melancholic stupor" would then mean "depressed depression," which is manifestly absurd.

I contend therefore that the term is an undesirable one, in whatever way it is used, and should be discontinued.
(c). CATALEPTIC STUPOR.

(1). Induction from without.
(2). Induction from within.

The nature of this sub-division, which I have made, of this form of stupor, will be described, after I the account of the two following cases has been given, these cases being examples of the two forms of induction respectively.

Ellen B. aged 34 years, domestic servant. Admitted to the Derby County Asylum, August 4th, 1887, suffering from acute mania. There was a history of hereditary weakness in the family, another sister having been insane.

Up to the time of the present attack, the patient had enjoyed good health, bodily and mental. This attack commenced suddenly, four days before her admission to the Asylum, with perplexities and restlessness, while she was destructive and violent, used foul language, contrary to her usual custom, asked to be allowed to drown herself.

On her admission she was in a state of great agitation, rolling about on the floor,
giving absurd & irrelevant replies to any 
questions that were put to her, & saying that 
the other patients were rats & mice.
This continued for several weeks, after which 
there was, what is described in the case-books 
as an improvement in her condition. 
She then became dull & stupid, & would sit 
for hours in one position, with her eyes shut 
& her mouth open, apparently taking no 
notice of anything. She remained in this 
state for four years, rarely speaking or 
showing any interest in anything that 
went on, but making hideous grimaces & 
adopting grotesque attitudes. 
In 1891, four years after her admission, she 
began to have fits of excitement, throwing 
herself about & talking incoherently, these 
alternating with stuporous periods. She has 
continued thus up to the present, November 
1893, her condition being now as follows:-- 
Except for these occasional attacks of 
excitement, she is in a state of stupor 
usually, standing or sitting in any part of 
the room, where she may have been placed, 
not attempting to move about, though she
does not offer any resistance when made to change her position, nor does she refuse to take her food. She has however no power of acting on her own account, as she never goes to bed, or gets up, or walks to her meals, or even to attend to the calls of nature, without being started off by some attendant or other, and constantly prompted to go on. Thus if taken to the table, and told to take her food, she will begin eating, but unless attended to, will soon be sitting motionless with her eyes half-closed, apparently oblivious of every -thing.

Her Habits are dirty. Her circulation is feeble; the extremities being blue and cold, the pupils are dilated, and do not react to light.

The chief interest in her condition lies in the cataleptic element, which is a marked feature in her case. Her limbs may be made to assume, and retain any position, if she be placed in any attitude, however unnatural; it may be, provided it be possible for her to maintain her balance, she will remain in it for long periods, even though
The position be one of great discomfort.

What is especially remarkable however in her case is the ease with which she can be thrown into this cataleptic state, as the effect of another person looking her full in the face is sufficient to bring this about. Thus I have seen her taking her tea, and have approached her while she was just taking in the middle of a bite, and have suddenly looked straight into her eyes, with the result that she at once ceased to move her jaws, and simply sat rigid, with her arms raised in the gesture of lifting the bread to her mouth, her eyes wide open, at a fixed stare on her face. Although I have remained there for a considerable time she did not make a movement of any kind, not even closing her eyes when brought directly in front of a bright light. When led into the middle of the room, she has remained there without moving a muscle, or when her eyes have been forcibly closed for her, she has not opened them again. When I have finally left the room after a prolonged examination of this kind, she has still...
had in her mouth the piece of bread, which she had just bitten off, when the observations began. I should have liked to have performed the experiment of leaving her for a long period, days or nights if need be, in order to ascertain how long she could remain in this condition, but unfortunately such proceedings do not meet with the approval of Asylum Committees. It is however within my knowledge, that on one occasion the lady curled up, after the fashion of a cat, upon a small polished wooden chair, on which it was just possible to retain the balance, and remained in this position for between three or four hours, after which she was lifted down by one of the nurses in charge.

It is impossible to bring her out of the cataleptic condition by any known means, and I could not discover how or when she came out of it, for the fact of being observed seems to keep up this condition, just as the act of gazing at her threw her into it at the first. While she is in this state she cannot be made to change the position of her limbs by being told to do so. The only way in which it is
Ruth Annott, aged 43 years. Admitted to the Derby County Asylum, October 28th, 1891.
Patient is a married woman, with five children. For two years before her admission to the Asylum she had been strange in her behavior, refusing to do her household work, and towards the last had been talking incoherently and walking about in a reckless manner.
On her admission she was found to have hallucinations and delusions, standing frequently to listen to various noises, which she imagined she heard, and saying that she was prevented by one of her neighbors, who were her enemies, of causing all her trouble.
In this case, as in that of Ellen B., the symptoms of resistance and refusal of food were absent, although from the nature of her delusions one or other of them might have been expected. Her delusions seemed to have occupied a prominent place in her mind, and to have continued to do so for some time.
In June 1892, nine months after her admission to the Asylum, she became cataleptic and stuporous, and since then has done nothing for herself, but has to be attended to in every way. This has continued up to the present, November 1893, when her condition is as follows:-

She sits in a chair all day long, staring fixedly in front of her with her eyes wide open, her face destitute of all expression, betraying no indications of knowing what is going on in the room. If spoken to or even if pinched sharply, she makes not the slightest response, and there is no sign to show that she is aware of what is being done to her. When her eyeballs are pressed upon, she does not blink; there is a slight bent observable in the upper lids, but that is all.

The cataleptic signs are well-marked; her limbs retaining any position in which they may be placed, whilst she will remain for indefinite periods in any attitude into which she may be thrown.
that of Ellen B. That while the latter patient emerged from the cataleptic state, though not or when it could not be ascertained, in this patient the phantasm is invariably associated with a degree of catalepsy.

These two cases have been described for the purpose of illustrating what I conceive to be two distinct methods of cataleptic induction, of which, as has been remarked already, they are examples respectively; also because they are well adapted for comparison with states of hypnosis, in which connection it is advantageous to consider them.

The relation of cataleptic phantasm to hypnosis will be taken up under three headings, viz. bodily and mental state, induction, resolution.

(i) Bodily and mental state.

Points of resemblance are here found between catalepsy and hypnosis, in the fixed gaze, the dilated pupils, the light non-reacting character of the limbs, +
The manner in which the latter may be made to assume and retain any position in which they may be placed.

The essential difference lies in the fact, that in cataleptic stupor the limbs cannot be reached "through the mind", as they can be in states of hypnosis, in which the attitude can be changed by means of suggestions from the operator to the mind of the subject. In cataleptic stupor this change can be effected only by direct manipulation of the patient's limbs.

The mental state in cataleptic stupor is one of which we cannot speak with certainty; so it is impossible to ascertain what is going on in the patient's mind. There can be little doubt of the presence of consciousness, for as we saw in the case of Ellen B. the fact of its being observed kept up the cataleptic state. From what we know of the mental state in other cases of stupor, from which catalepsy is absent, it is possible to assume that the condition is one of consciousness with limited ideation,
some track or other in the patient's mind being "open", while others are "closed". In this respect it would resemble the mental state of the hypnotized subject, with the important difference however, that in the latter the open track is under the influence of the operator, whilst in cataleptic subjects external agency has no perceptible effect upon it, once the cataleptic condition has been induced.

(2) Induction of the cataleptic state.

The first method of cataleptic induction, that of induction from without, was manifest in the case of Ellen B, in whom this condition was set up always by external agency, for when left to herself the patient was in a state of sleep. Simply, the catalepsy coming on after some other person had fixed their gaze upon her. A resemblance to the induction of hypnosis, by directing the patient look fixedly at a bright light, or at some movement of the operator's hands, is at once apparent.

The second method, induction from within,
manifested in the case of Ruth Ann St. requires further explanation. In this patient, the cataleptic state was always present more or less, external agency having no part in its induction, and the explanation, which seems to me most feasible, is that it was caused by some factor within the patient's mind, the most probable being a concentration of her attention upon the delusions, which occupied so prominent a place in her thoughts. The induction takes place, not as in hypnosis by fixation of the eyes upon a bright light, but by fixation of the mental gaze, if I may be allowed the expression, upon some type of thought.

The question of resistance in connection with delusions, has an important bearing upon this question, for it is a well-known fact that the absence of this element greatly facilitates the induction of hypnosis. It appears probable therefore that its absence would also facilitate the onset of the cataleptic element in patients. My own clinical experience certainly bears out this suggestion, which I
have offered.

(3) Resolution. In this point we have presented

no one of the chief points of difference

between these conditions of catalepsy and

hypnosis; for in the latter the resolution
can be effected by the operator, whilst in the

former no means can be found to have
any influence upon it.

These two conditions therefore, while they

present striking points of resemblance,
differ in several essential particulars,

which are, to recapitulate, as follows:—

(1) The observer has no perceptible influence

over the mind of a cataleptic, as he

has over that of a hypnotised subject.

(2) Cataleptic states can in all probability

be induced from within; whilst in

hypnosis no such method of induction

is known.

(3) The observer cannot release the patient

from a state of catalepsy, such as he

can from that of hypnosis.
Stupor with Emotional Peculiarities.
C. Stupor with Emotional Peculiarities.

By the use of this expression I do not wish to imply that the patient exhibits these peculiarities whilst in the physiognomist state, but that emotional characteristics, closely associated with this state, are present during the course of the case. They may precede, or possibly cause the stupor, or they may follow it; my aim is to work out the connection between the two.

It will enable me to discuss the subject more easily, if I first give a short account of emotional feeling, and its various phases and effects as they are manifested in insane conditions.

Emotional feeling is that feeling which accompanies all ideas, as distinguished from the feeling known as bodily sensations of various kinds, common sensations, pain. The latter are the cause of purpose, motor movement, just so are the former the cause of other movements following an idea, for it will be found on studying the joint, that almost all, if not all, our voluntary movements are due to the influence
of emotional feeling. In children the subject is easy to brook, but, as their emotions are as a rule very apparent, but in adults the question is more complicated, as the emotions are not so much on the surface, in addition past experiences are largely brought to bear upon present ones, and it may be a matter of great difficulty to ascertain the nature of the emotional feeling which has prompted a movement on the part of an individual. Indeed the man himself may be scarcely aware of it, for part of this feeling may have come from an idea previously registered in the mind. This idea being brought into association with the present one, association ideas is a process which takes place to a great extent without any knowledge of the fact on the part of the individual.

In children, the subject is, as in children, a source of study, for in them the emotions are more apparent than in adults. The melancholic and the manic give free vent to their feelings, while in the depressive and the dysthymic, their emotions often remain unexpressed.
of mental diseases in which any difficulty in the study of emotions is experienced, is that of stupor. As I pointed out in the case of P. C. E. it is almost impossible to discern, during the continuance of the disease, the state of the emotional feelings, whilst in most cases the recollection of them, which the patient has, or has not, upon his recovery, is too uncertain to be trusted to as a source of information.

In cases, however, in which the patient exhibits special emotional characteristics before or after the stuporous period, much can be done by studying the connection of these characteristics with the stupor itself. This idea, as to their being a direct connection between the two, first occurred to me whilst studying the case of T. A. M. which I shall presently describe. Since then I have worked the point out, both clinically and in theory, and my surprise is that this form of stupor should have that hitherto so entirely escaped the notice of writers upon this subject.

In order to enable one the better to state
the conclusion, to which I have come upon this subject, is my intention to first take up "emotional feeling" in general, taking up the various phases of it, which I have observed in the insane, and discussing briefly the influence which it exerts upon the other elements of the mind.

Various Emotional Conditions.

(i) There are those of increased emotional feeling, not dependent upon any particular ideas or set of ideas, but tending rather to "assimilate" these with itself. For example, in cases of General Paralysis of the Insane, there is often a great increase of emotional feeling, with which are associated delusions of an exaggerated nature. As I pointed out however, in speaking of these in connection with the "causes of delusions," the delusions result from this increase of feeling, it not being due.

I believe that it is much more common than is generally regarded, that for ideas to result from emotional feeling, it being usually taken for granted, that the
latter always results from the former). It has been on no theoretical grounds, that I have formed this conclusion, but from the fact that the point has been, in my experience, exemplified in so many cases of mental disorder of various kinds. In the case of the General Paralytic, T.A.K., already described, it was borne out, not only in connexion with the joyous emotions to which he was usually subject, but also during attacks of mental pain, which he occasionally went through. I have seen him suddenly commence weeping without any apparent cause; if asked why he was miserable, he would not be able to give any reason at first, but would shortly add: 'I feel so wretched, nothing can come to his mind, and so it seems he would then attribute his distress. The same phenomenon is present in the case of many melancholics, who will feel miserable when they rise in the morning, but will at that time be unable to express any reason for the feeling of wretchedness which oppresses them, examining them again however an hour or two
afterwards, it will frequently be found that they in the meantime acquired some delusion of a painful nature.

(2) Emotional feeling resulting from one idea or set of ideas.

In the case of S. I. previously described, the mention of the delusion, which the patient had, that he was an Archangel, raised him into a state of great emotion, which he did not otherwise exhibit.

(3) Natural deficiency of emotional feeling.

In some cases it is that the emotional faculties fail to develop, but as a rule this peculiarity is more frequently seen in the insane, than in the insane, being exemplified in the case of persons, who are devoid of all enthusiasm, in whom emotion, either of a painful or joyous nature, is never experienced to any great extent.

One reason why this condition is seldom seen in cases of insanity, may be that as a rule, people individuals have little tendency to mental disease.
(4) Loss of emotional feeling.

This I have observed both as a permanent, and also as a temporary condition.

Permanent loss has occurred, in patients under my notice, as an after-effect of melancholia. One of the most marked cases was that of Mrs. Palmer, of the Plymouth Borough Asylum. This patient had been insane for several years, and when she first lost her reason she had several children, of whom one was a very baby. By the time she had recovered from the attack, she appeared to have lost all affections for them, for even when she had the chance of visiting her children, she did not care to make use of it. She had recovered the use of her faculties in all other respects, and this loss of affection appeared to me to indicate a dementia, which had confined itself to the emotional faculties.

As to temporary loss of emotion, I have already pointed out the difficulty of estimating this in cases of phrensy, as it is a difficult point to decide during the
course of the disease, as well as by questioning
the patients, upon their recovery, as to their
recollection of the emotions, which they had
experienced whilst the phrenos was on them.
The cases from which conclusions can be
safely formed on this point, are those in
which a period, characterized by loss
of emotion, precedes or follows the phre-
nosic one.

The Effect of Emotional Feeling.

I. According to the Character of this Feeling.

This character depends largely upon the
natural temperament of the individual,
upon the mood in which he may happen
to be. That "moods" have a decided influence
upon a man's thoughts in some states is well
known, or a similar effect may be seen in
mental cases, especially in melancholies,
in whom the emotional excitements of
mental pain influence largely their
thoughts or words.

How I find that the character of this
feeling, whether accompanying an idea
just arising in the mind, or one which
has been previously registered therein, may act in either of the following ways.

(1) It may determine the nature of the ideas, which come into association with the present one.

An idea, which is accompanied by a feeling of pleasure, tends to arouse in the mind of other pleasant ideas, whilst ideas of a melancholy nature arouse other painful ones. With regard to the latter class, however, I have frequently observed, as has been already pointed out in this Thesis, that they have less tendency than the former, to cause radiation of ideas at all.

(2) It influences the value of an idea as a component of reasoning processes. Thus in the case of a child tempted to steal, the fear of punishment consequent on detection, and the moral sense of honesty, act as deterrents of the act. If, however, as in some cases of idiosyncrasy, the child be deprived of those feelings, their reappearance on the point of action accordingly.
II. According to the extent to which emotional feeling is present.

1. When the feeling is weak or absent, radiation and association of ideas are correspondingly small in extent. In the case of dull heavy people, in whom any idea excites but little interest, it has little tendency to arouse further trains of thought in their minds. In the insane, this point is well borne out in cases of monomania, in which disorder a delusion exists apart from any emotional feeling: as we have already seen, such a delusion exerts little effect upon the other mental operations of the patient.

2. If there be a moderate amount of this feeling present, an idea has greater tendency to arouse up other ideas in the mind. In many cases of mania, in which there may be a delusion along with well-marked emotional feeling, this delusion will be found to make its presence manifest in every thought to which the patient gives expression.
"(3) If the feeling be strong, it destroys the power of attention, as in other cases of mania, in which ideas rush through the mind at great speed, without order or control, as manifested by the incoherent utterances to which such patients give vent.

(4) If the feeling be excessively strong, it may completely destroy all radiation of thought, and result either of the following:

(a) Direct ideomotor movement, or in

(b) Concentration of the mind.

Thus in impulsive disorder, such as those of homicidal mania, the impulse may come as with such force, that the patient gives vent to it at once without any thought of the consequences of the act. All reflection is, for the moment suspended, the higher reflexes being paralyzed by the intensity of the desire.

The second effect, concentration of the mind, may be seen in the case of persons, who have 'witnessed visions,' they have gone into ecstasies over them, the whole attention being concentrated upon the vision to the
exclusion of all other topics of thought. (The fact that the vision itself may have arisen from an excess of emotional feeling in the first place, does not affect the present argument.)

It is evident therefore that excess of feeling may have a similar effect to that of absence of this element, in preventing radiation of ideas, but I wish to lay stress on the fact that the excess of feeling is in some particular direction. I do this on the grounds of clinical experience, for all the examples, which have come under my observation, bearing out this point, have been those of excess of some particular phase or other of emotional feeling.

By this prevention of radiation, there is the tendency to that concentration of the mind, which I have already shown to be an important cause of stupor. Thus we have evidence that two emotional conditions may act as primary causes of the stuporous state, viz:

1) Lack of this feeling.
2) Excess of it in some special direction.
which is of special interest in the present connection, for these correspond to the two
divisions of this class of phren., which I made on the ground of clinical observ-
vation, before I was enabled thus to write them out satisfactorily from a
theoretical point of view.

The case of Mrs. J. A. M. presented them two conditions at different periods, & the
description of her case enables me to discuss the whole question in a connected manner.

Mrs. J. A. M., aged 42 years. Admitted to
the Buxton Asylum, April 24th, 1893.

There was no history of insanity in the
family, & the habits of the patient had
always been strictly temperate. Her
previous health, mental & bodily, had
been good.

The present attack began a fortnight before
her admission to the Asylum, with melancholy,
paid to have been brought on by a disappoint-
in loss, & by the death of a sister-in-law.
For several days the patient was depressed,
but after that she became excited, & began
to break windows to, to threaten her nurse with violence, to attempt suicide by swallowing some hair - brush, & jumping out of a window. On her arrival at the asylum, she is described as being in a dazed condition, sitting down on the floor with her eyes tightly closed, answering questions in a frightened manner.

During the following four weeks she seems to have presented a great variety of symptoms, from hysterical, melancholic, to. At the end of that time she came under my care, & her condition was as follows:

The most striking point in her case was the extraordinary change of symptoms, her illness then & during the following five months, consisting of a series of periods, peculiar emotional periods, stable alternating with stuporous ones, varied occasionally by lucid intervals, so that her case presented three sets of periods, viz.

Emotional, Stuporous, Lucid, these each being as a rule of short duration, it rarely happening that any one of them exceeded three days, sometimes being as short as twenty-four hours. The longest
were, on the whole, the lucid ones. For some time it was difficult to ascertain any precise order, in which these periods occurred, but after watching the case closely for some time I came to the conclusion that the order, in which they most frequently took place, was as follows:—

Emotional to Stuporose, Stuporose to Lucid. The transition from the first to the second was usually abrupt and well-marked, while from the second to the third was more gradual.

I shall describe the three periods separately, commencing with the Stuporose Period.

This usually lasted for two or three days, during which the patient exhibited all the signs of stupor, sitting or lying in one position without making any attempt to move, her head bent down over her chest, her eyes closed or nearly so, saliva dribbling from her mouth, her features destitute of all expression, and circulation at a low ebb.

In some of the stuporose periods she appeared
to be totally unconscious, it was only by repeatedly shaking her, that she could be got to open her eyes even for a moment. At other times it seemed as if consciousness was present, as she would then sit with her eyes wide open, staring the front of her, although nothing that was said or done could elicit any response. She never offered any resistance to being moved or fed, during these periods. Gradually she would pass out of this state, and begin to look about her in a dazed manner, whilst her circulation became more vigorous, until at last she was in the state, which I have termed the lucid interval.

**Lucid Interval.**

During these periods her condition was one of childlike, or she would sit with a feeble smile on her face, and could do what she was told, and answer questions in a simple manner, but had little idea of looking after herself, or of making remarks to those about her. If told...
to look out, interest herself in what was going on, she would walk up to the window, stare with a fixed smile on her face, but would stand there for an unlimited period, unless someone told her to do something else.

During these intervals she was occasionally depressed, and would spend an hour or so at a time. This general depression was however far compared with the following, which were so prominent & frequent, as to constitute distinct periods, which were frequently the precursors of the phrenoses.

**Emotional Periods, or Periods with Emotional Characteristics.**

Of these there were two classes, one consisting of an absence of emotion, the other of an excess of it in some particular direction.

(a) Absence of Emotion.

After a brief interval the patient would gradually cease to smile, would sit with a face like a stone, able to answer questions & to do a little work even, but with no
apparent interest in anything. At such times nothing could be found to excite a shade of emotion in her, either of pleasure or pain; during one of them, in which she could understand all that was said to her, she received the news of her father's sudden death with comparative indifference. After this had lasted for a day or two, sometimes even as long as three days, she would cease to look, and merely sit still, though perfectly conscious of all that was said to her, but not responding when spoken to.

From this she passed, often abruptly, into a state of stupor.

(b) Excess of Emotion in some particular direction.

During these periods the patient would sit gazing up at the ceiling, or straight in front of her, with a look of intense repose on her face, as though she were transported with joy. If addressed by any of the nurses, she would take no notice, but if one particular medical
officer came into the room, she would press his hand, gaze into his same expression at his face, and would even do whatever he might tell her. In fact, I came to the conclusion, that her excessive emotional feeling consisted in that morbid disposition towards the male sex, which is one of the characteristics of insanity in women approaching the climacteric period. During these periods she frequently behaved in a hysterical manner, throwing back her head as far as she could get it, keeping herself rigidly fixed in this position, constantly blinking her eyelids, or else keeping them tightly shut. These periods of excessive emotion passed abruptly into a state of stupor, after having lasted for a few hours only as a rule. Sometimes they emerged into a state of deficient emotion, and thence into stupor.

It remains now to discuss the connection between these emotionally characterized periods, and the putative one.
With regards to the absence of emotion, it may be urged by some that it is the result of some common physical cause. It seems to me however, that were this so, the ideational functions of the brain would have been affected along with the emotional, whereas we have just seen that the latter are preserved. Perhaps changes some time before any defect in the ideational was apparent. Such a sequence of events, impairment of the emotional followed by that of the ideational, and the onset of stupor, occurring time after time seems to me strongly to suggest that the former was largely concerned in the production of the latter. The manner in which this was brought about I have already explained, viz. by the fact of the absence of emotional feeling, paralyzing the higher reflexes, thus causing that limitation of train of thought which has been previously demonstrated in this thesis, as being one of the causes of stupor.
With regard to the excessive emotion, the argument as to a common cause can scarcely be urged, for it is impossible to believe that two such widely different conditions could be put up by the same cause; whilst the frequency with which this excess of emotion was followed by an affection of the intellectual faculties, and the onset of stupor, was strongly suggestive of the fact that the latter resulted from the former.

In describing this period in the case of J. A. M. I stated that it passed into stupor in two different ways, either directly, or via a period of absence of emotion.

With respect to this latter it is feasible to suppose that the excess exhausted the emotional faculties, and thus caused the period of deficient emotion, which caused a stuporous state in the manner I have already suggested.

As to the direct production of stupor by an excess of emotion, I have also previously, when speaking of the influence of emotional feeling offered an explanation, showing
That excessive motion, when it tended in any special direction, had a similar effect to that of deficient motion, viz. paralytic of the higher reflexes, and consequent concentration of thought, tending to stupor.

An example of this direct mode of producing stupor may be found in that state known as nervousness, in marked cases of which the patient may be thrown into a stupor-like state by simply being asked a question of some sort. Especially is this to be observed in the case of American children, some of whom I have seen designated as imbecile, although a careful examination made in a kindly manner has revealed the fact that the child was of average intellect and had known the answer, but had been unable to give it, having been thrown into a state of what may be termed 'nervous stupidity.'

The most marked example that I have seen was that of John C., aged 34 years, Plymouth House Asylum. He was a quiet, hard-working patient, who never gave any trouble, and who could be trusted.
in every way. Of course he was spoken to,

even kindly, by any of the officials, he

pressed at once into a state of extreme

newness, which appeared to paralyze

his faculties, for he could then stand

with his gaze riveted on the official in

question, unable to speak or to go on with

this work. The remarks made to him

seemed to fix itself in his mind, and to

constitute his whole mental life for the

time. The only explanation which appears

to me to be feasible, is that the intensity

of the emotion paralyzed the radiation of

ideas, so that the patient could not

find the reply, which would readily have

occurred to him, had his emotional

faculties been in a normal state.

In this case the condition was of short duration, passing off as soon as

the cause was removed, but in other cases,

as that of Dr. J. A. M. a suspension of

mental faculties, a true stupor, occurs,

which may persist for some time.

Such, then, is the explanation, which I

have to offer of this method of induction,
of phrenic, + some will ask, "Why then do not maniacal conditions, in which there is almost invariably an excess of emotional feeling, result more frequently than they do, in states of phrenic. To this I reply, in the words I have already used several times, that the excessive feeling must be in some particular direction. In maniacal conditions the emotional feeling takes various forms + occurs in connection with widely different ideas, + it is, in my opinion, this constant change, which frequently saves the patient from passing into the further state of phrenic.

In the cases of maniac, in which this condition does supervene, it occurs, in my experience, in the indirect way, viz by exhaustion of the emotional faculties, so that the patient passes into a state of deficient emotion, this in its turn resulting in a torpor, in which the ideational faculties are affected equally with the emotional.
Conclusion.

Motor Intuitions.
Conclusion.

During the course of this Thesis it has been my endeavour to demonstrate and prove that cases of Mental Stupor, though presenting the closest similarity in their external appearances, exhibit great diversity of characteristics in regard to their mental state. The elements of the mind, which are at fault in one set of stuporous cases, may be totally different ones to those at fault in another set.

1. In some, loss of consciousness is the chief characteristic, and in these cases the various constituents of the mind, ideation, emotion, to are as a rule equally affected.

In treating of these cases, I pointed out the importance of making it clear as to which phase of consciousness it is, to which reference is made, instead of using the terms 'Conscious' and 'unconscious' in the vague manner in which they are usually employed. Before discussing this class of stupor, therefore, I defined the term 'receptive consciousness,' which
this particular phase of consciousness as a basis to work upon. This step has, I believe, been justified by the degree of lucidity with which I was enabled to treat of the whole question of unconscious stupor.

2. In others, the affection of the Ideational Faculties is the main characteristic.

In some of these cases, a concentration of the attention upon some idea or set of ideas accounts for the stuporous state; in others again, resistance to movement, refusal of food, are prominent symptoms, due in almost all, if not all, cases to the presence of a delusion. As connection with the latter, I pointed out the necessity of separating these delusions, which cause resistance, from others which have no such tendency; for whilst the former occur merely as a complication, it may be a result of the stupor, the non-resisting delusions act as a direct cause of the stuporous state, as demonstrated in the
description of the onset of cataleptic stupor. As referred to this latter condition I stated that, in my opinion, there are two distinct methods by which catalepsy is said to be induced in stupor, viz.

(a) From without, by a method analogous to that by which hypnoses is induced through external agency.

(b) From within, in a manner closely allied to that of concentration of the attention upon some trains of thought. In connection with this, I pointed out that the absence of resistance, as an accompaniment of delusions, plays an important part in facilitating the onset of a cataleptic stuporous condition.

(3) In another class of cases an affection of the _Emotional Facilities_ is a prominent feature, one which plays an important part in the causation of stupor. This latter statement, an original one on my part, I endeavoured to prove, on the grounds both of clinical experience, & of theoretical considerations. By comparing the working
of the emotional faculties, upon the other mental constituents, in this class of stupor, with their various effects in other forms of mental disease, I was able to offer a feasible explanation of the production of stupor by two such widely opposed conditions, as those characterizing the two subdivisions of this class, viz., absence of emotional feeling, and excess of some special phase of it.

It is evident therefore that the mental state in stupor is one of great diversity of character. That this should not have hitherto been demonstrated by writers on this subject, has been largely due, in my opinion, as was stated at the earlier part of this thesis, to a neglect of the study of the reflex functions of the mental system. It was on this account that so much attention has been devoted to these higher reflexes in this Thesis, or a special section devoted to a description and systemizing of them, in addition to the frequent references made to them in connection
with the various forms of Stupor. The one point, which we have found these latter to have in common, is a paralysis of the higher reflexes; it is evident therefore that without due consideration of these functions, no advance could be made in the study of stuporous conditions.

Before leaving the subject, I desire to allude to one other element of the mind, which it is my firm belief will ultimately be found to have an important bearing upon the subject, viz. the Motor Instincts. These are the faculties which give us "the exact and definite idea of the end to be effected? They constitute the last step in the higher reflexes, as is indicated in the diagram on Page 146 of this Thesis.

The various other constitutions of the mind have each been shown to be influential, when most closely affected, as causes of stupor, and should this last one take its place as another cause, a complete classification of the causes could then be made, consisting

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Mandley, Physiology of Mind, 3rd Edition, p. 467
of affections of consciousness, ideation, emotion, and motor intuition respectively.
I have refrained however from adding this last class, as the data, which I have been able to collect on this point, are too meagre to form any conclusions upon, as it is not my wish to commit the error of grounding a theory upon one case. What brought the subject under my notice, was a case which came under my observation, presenting all the aspects of the stuporous condition, in which no other element except the motor intuitions could be found at fault. Consciousness was unimpaired, and the ideational powers were in full working order, as proved by the patient's account afterwards. In this case also the recollection which the patient possessed of his emotional experiences during the stupor-like condition, was so vivid, that little doubt could be felt of the fact that the emotional faculties had been unimpaired, notwithstanding the blankness which, as I have already pointed out, the remembrance of any emotional experience must always be received.
There was no motor paralysis, for the patient's muscles were strong, and achievement of movements, but the latter were of a purposeless and involuntary nature. The patient could not speak, nor do anything for himself, and by a process of exclusion I formed the opinion that this motor intuition must be at fault, and this fact accounted for his stupor-like state.

The question is, however, one which will require prolonged investigation, as it is but rarely that we can expect to come across a case such as I have just described, and it is a subject which still needs to be considered in relation to aphasia and various symptoms of disease of the nervous system.

If, however, this suggestion, which I have offered, as to there being a distinct form of stupor due to an affection of the motor intuition, be correct, it is to be hoped that from it light may be obtained with regard to the connection of the nervous system with the mental. Of all the faculties included under the latter heading, that of motor intuition comes most closely into
relating with those included under the former, yet it is the 'adjacent link', if one may be allowed the expression, to motor functions of the nervous system.

Lastly it will have been observed, that in the course of this Thesis, frequent reference has been made to the state of the various mental functions in the case of persons who are mentally healthy. This has been done, because of the fact that in my opinion such reference is a prime groundwork in the study of mental diseases. As none is more true than in the case of Stelzer, for I am convinced that it is only by constant comparison with the healthy standards, + with those slighter departures from it, which are not regarded as amounting to insanity, that any insight will be obtained into the nature of this interesting form of mental disorder.

Charles David Musgrove
MB. CN.