Thesis

on

Dipsoomania

by

John Cameron, M.B., Edin.

Argyle and Bute Asylum, Auchenlochhead,
27th April 1877.
Dipsomania

The following remarks are chiefly
though not exclusively, a record of the results
of four years' experience in the treatment
of dipsomaniacs in the Erichton Royal
Institution, in the Argyle & Bute Asylum
and in private practice. I have also con-
sulted the works of the chief Authorities on
the subject of dipsomania. The number
of insane drinkers under treatment in
the two institutions above named during
the period of my connection with them was
thirty-six, all of whom with four exceptions
were voluntary patients. The four cases
depicted referred to were certified as insane at the
time of their admission; but they had been
dipsomaniacs for years before their mental
condition became such as to justify their
confinement as legally certified lunatics,
and they all succumbed speedily as soon as
the supply of stimulants had been with-
drawn.

It is also my intention to consider along
with the above twenty-one other cases of dips-
omania, none of which were ever confined
in an asylum, either as voluntary or as
certified patients, but all of whom were
personally known to me, and many of
whom came under my treatment at their
own homes. I do not deem it expedient
in this paper to treat of habitual drunken-
ness considered as a vice, or of mania
a poena, as strictly speaking neither of
them comes under the designation of dips-
omania proper. Of the fifty-seven cases
alluded
alluded to above, all without exception were
typical dysnomaniacs; that is, they drank under
the influence of an uncontrollable desire for
alcoholic stimulants and in solitude, while
in every instance they were quite unfit to
carry on any occupation continuously.

Dysnomania may be briefly
defined as an irresistible craving for al-
coholic liquors accompanied by paralysis
of the will and impairment of the moral
faculties. It is now by the great majority
of medical men regarded as a form of in-
sanity, and is described as such in works
on mental diseases. Bucknill and Jule
in their "Psychological Medicine" include
among dysnomaniacs those persons who
are addicted to the abuse of non-alcoholic
intoxicants, such as opium and hashish;
but this class will not be here referred to,
although in my experience all dysnomaniacs
will have recourse to other intoxicating
agents or narcotics, when they cannot ob-
tain alcohol in any form.

There are three generally recognised
forms of dysnomania viz: the acute,
the periodic or paroxysmal, and the con-
tinuous, the last being, by far, the most
frequent and hopeless, and constituting
ninety-five per cent of the cases that
have come under my observation. The
periodic form appears to be more common-
ly met with in the United States of Ameri-
can than in Great Britain. This statement
is true at least with respect to those ad-
mitted into Scotch asylums as voluntary
patients.
patients. An explanation may possibly be found in the fact that the very worst
and most chronic cases alone find their
way into the asylums of this country, and
only after residence in hydropathic estab-
lishments, boarding in the country, &c.
have been tried in vain. At this point
it may be remarked that the tendency of
the periodic form of dipemania is towards
a gradual shortening of the intervals of
abstinence until they have entirely disappeared.

It may not be out of place be-
fore proceeding further to enumerate as
concisely as possible the principal reasons
why dipemania should be considered a
disease rather than a vice;

The ordinary drunkard drinks for pleasure
in the company of boon companions and
at regular intervals, or to quote the words
of Thelot whenever an opportunity presents
itself. The dipemaniee on the other hand
drinks in obedience to an impulse which
he cannot control, even though the wish
to refrain may exist. After the paroxysm
has passed he frequently loathes alcohol
in any form, and is a rigid abstainer
for a time. He is in the great majority
of instances the offspring of drunken or
insane parents, and is thus constitutionally
susceptible to the influence of alcohol,
and to the desire for the excitement to
which it gives rise. Lastly, the disease
may suddenly manifest itself in persons
who have previously been temperate, and
even in very young children, who had
never
never been accustomed to strong drink.

Causes of dipsomania.—These vary to a certain extent according to the form of the disease. For instance Dr. Hutchinson states that the acute form may be due to haemorrhage in the puerperal state, or may occur in recovery from fevers, from sexual excesses and in some forms of dyspepsia. Acute dipsomania appears to be very rare, and I have never seen a case of it.

It is extremely difficult to obtain full and accurate information regarding the causes of dipsomania, more particularly in the case of persons under treatment in asylums, as they are apt to resent being asked questions regarding their previous history, and even when they do condescend to reply, their answers are frequently untrustworthy. The relatives are usually ready enough to tell when the drinking habit was first noticed, and also to assign a cause, which may or may not be the real one. Thus eight of the fifty-seven cases referred to at the beginning of this paper were those of persons who had lived for some time in tropical countries, and in every one of them the drink craving was said to have been due to sunstroke, a statement that might of course have been true; but it is well known that Englishmen are more liable to insolation than temperate people, and less likely to avoid exposure to the exciting cause of the disease. In five of the above cases it was satis-
factorily ascertained from other sources that
the patients had been intemperate before
leaving abroad.

The family history of twenty-three patients
was ascertained more or less completely,
and the results are here tabulated:—

<table>
<thead>
<tr>
<th>No.</th>
<th>Family History</th>
</tr>
</thead>
<tbody>
<tr>
<td>I + II (Brothers)</td>
<td>Father a dyspeptic. Grandfather, very</td>
</tr>
<tr>
<td></td>
<td>sociable and eccentric and a drunkard.</td>
</tr>
<tr>
<td>III IV V (2 Bros. 3 Sisters)</td>
<td>A brother insane. Maternal Aunt a dyspeptic.</td>
</tr>
<tr>
<td></td>
<td>Father temperate.</td>
</tr>
<tr>
<td>VI VII (Brother 4 Sisters)</td>
<td>Father a habitual drunkard. Paternal Uncle</td>
</tr>
<tr>
<td></td>
<td>a dyspeptic. Another Paternal Uncle weak-</td>
</tr>
<tr>
<td></td>
<td>minded. Sister a dyspeptic and thief.</td>
</tr>
<tr>
<td></td>
<td>Two cousins German dyspeptics.</td>
</tr>
<tr>
<td>VIII</td>
<td>Father a habitual drunkard. Brother an idiot</td>
</tr>
<tr>
<td></td>
<td>Cousin German insane.</td>
</tr>
<tr>
<td>IX X (Brothers)</td>
<td>Another a dyspeptic. Maternal Aunt a</td>
</tr>
<tr>
<td></td>
<td>dyspeptic. Maternal Uncle a habitual</td>
</tr>
<tr>
<td></td>
<td>drunkard</td>
</tr>
<tr>
<td>XI</td>
<td>Father insane</td>
</tr>
<tr>
<td>XII</td>
<td>Brother a dyspeptic. Mother insane</td>
</tr>
<tr>
<td>XIII</td>
<td>Sister committed suicide</td>
</tr>
<tr>
<td>XIV</td>
<td>Father, a brother, and sister and several</td>
</tr>
<tr>
<td></td>
<td>cousins drunkards or dyspeptics.</td>
</tr>
<tr>
<td>XV XVI</td>
<td>Paternal aunt insane. Maternal grand-</td>
</tr>
<tr>
<td></td>
<td>mother insane. Mother a dyspeptic</td>
</tr>
<tr>
<td>XVII</td>
<td>Mother of Nos. XV + XVI</td>
</tr>
<tr>
<td>XVIII</td>
<td>Brother a general paralytic. Sister eccentric</td>
</tr>
<tr>
<td></td>
<td>and weak-minded</td>
</tr>
<tr>
<td>XIX</td>
<td>Father was insane and committed suicide in an asylum</td>
</tr>
<tr>
<td>XX</td>
<td>Uncle and cousins dyspeptics</td>
</tr>
<tr>
<td>No.</td>
<td>Family History</td>
</tr>
<tr>
<td>-----</td>
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</tr>
<tr>
<td>XXI</td>
<td>Father and mother temperate. Family sthenous.</td>
</tr>
<tr>
<td>XXII</td>
<td>Father and mother temperate. Family history good.</td>
</tr>
<tr>
<td>XXIII</td>
<td>Parents and rest of family temperate.</td>
</tr>
</tbody>
</table>

From the table it will be seen that there is a history of drunkenness or insanity or of both in twenty out of the twenty-three cases. The result agrees with the generally received opinion that dipsonmania has its most frequent origin in hereditary predisposition. In the remaining thirty-four cases it was found impossible to obtain any reliable account of the family history. No one can doubt, however, that if equally full information had been obtained regarding these, it would have been found that a large proportion were the descendants of insane, drunken, or diseased ancestors. The greater number of these unfortunate people therefore laboured under the “tyranny of a bad organization” and the drink-craving must be regarded as the result of a constitutional tendency to disease of the nervous system, which in their case took the form of dipsonmania, but which under different exciting circumstances might have developed into one or other of the ordinary forms of legally recognized insanity. Dr. Dodge of Binghamton United States found that hereditary taint existed in fifty per cent of three hundred and sixty dipsonmaniacs.
diabetes under his care. According to Dr. Stewart late of the Crichton Institution, heredity existed in upwards of sixty-three per cent of the cases of diabetes admitted into that asylum prior to April 1864. If the family history could have been fully traced out in every instance by these gentlemen the percentage would in all probability have been much larger. Evil associations, bad training and especially the practice of giving them wine at table are apt to awake the dormant tendency to drink in the children of drunkards, and may even create it in the offspring of parents who are themselves temperate; for example the families of innkeepers frequently fall victims to alcoholism. Intemperance of one parent, blows on the head, sunstroke, anxiety, grief, losses in business, looseness of spirit, overstudy and overwork were assigned as causes in the case of male patients. The women variously attributed their malady to heredity, prescription of alcoholic stimulants by doctors, the excitement of fashionable life, disappointment in love, influenza, painful diseases, pregnancy and dysmenorrhoea. Country doctors and ministers are liable to be maimed by the love of drink— the former indulging in order to refresh themselves after fatigue and exposure to cold and wet, and the latter to relieve the monotony of existence, and supply the want of rational amusement. When a person has once become a confirmed diabetarian any slight annoyance or a fit of indigestion is sufficient to
bring on the craving in full force. It was not uncommon in the Etrichton Institution to find that a patient had succumbed to the desire for drink after he had received a letter from home containing unpleasant news. Remorse, illness, the reproaches of relatives and even pleasurable treatment furnished our voluntary patients with an excuse for getting drunk.

Symptoms of Dipsomania.—The appetite for strong drink usually though by no means invariably first manifests itself in youth, that is before the age of twenty has been attained—such at least has been the case in my experience. It gradually acquires a mastery over its victim, who passes through the stage of habitual drunkenness until at last the desire becomes an irresistible passion, which is gratified without regard to consequences. The onset may however be sudden, as it always is in acute dipsomania, and sometimes in the periodic form. The tendency of both is to develop into continuous dipsomania, which is the most chronic and incurable of the three. Moral degradation always occurs in true dipsomania at an early period of its course. When the disease is periodic, the paroxysm is ushered in by premonitory symptoms in many cases. The patient becomes excited and jubilant, laughs and talks more than usual, and perhaps proclaims his firm resolution never again to yield to the craving for drink. In the course of a week or so a change takes place.
Depression follows stiletment. The patient becomes silent and moody, feels out of sorts, and ceases to take pleasure in his former amusements. He sleeps badly, is very restless, looks worn and anxious, loses his appetite and complains of an unceasing sensation at the pit of the stomach. Alcohol is stimulants will afford immediate relief, and he has recourse to them accordingly. One man may drink till he becomes insensible, another may consume large quantities of liquor yet never become drunk, but remain in a confused or "dazed" state for days, until sickness and great prostration are induced. Delirium tremens may supervene, but this is not a very frequent occurrence. The most common sequel is an outburst of alcoholic mania. In this state the patient is violent and dangerous, becomes the subject of hallucinations of sight and hearing, threatens all who would interfere with or restrain him, and may even commit homicide or, during the depression which follows, attempt self-destruction.

A total change of character takes place during the delirium, the sexual appetite asserts itself imperiously, and the patient whether male or female is apt to rush into the most open and shameless promiscuity. Lies are told with unblushing effrontery, and criminal acts such as theft and arson may be committed. Gastric and bilious disturbance, headache, sleeplessness, lassitude and frequently loathing of alcoholics stimulants wind up the series of events.
The patient then assumes his business and conducts himself with propriety for weeks or months until his malady again overpowers him. A description of two cases of periodic dipsonania illustrative of the above remarks is here subjoined.

I Case of paroptomyal dipsonania - Exortion

- Attempt to commit Suicide

W. C., aged 37, clerk, possessed of independent means, admitted into the Argyle Asylum, November 1874. His father, brother, sister, and several more distant relatives are dipsonanies, or drunkards. Patient has had delirium tremens twice. He says that he began to drink when very young, and that the love of drink was born with him. For a considerable period he was able to attend to business; but periodically, an irresistible craving for drink took possession of him. The paroptomy usually lasted from four to six weeks during which he neglected everything in order to gratify his passion. Various plans of reformation had been ineffectually tried before his admission into the asylum. For instance he was sent to a hydrostatic establishment, and afterwards to a farm house in a remote district of the Highlands. In this latter place he was freely supplied with whisky by his landlord, and after a prolonged debauch he attempted to commit suicide by cutting his throat, inflicting a severe but not a dangerous wound. On the following day the patient was certified to be insane and sent to the asylum. Stimulants were at once...
once completely withdrawn; but he remained dull, stupid and subject to hallucinations for about a fortnight. After this rapid improvement took place and he was in a few weeks discharged recovered, but readmitted on the same day at his own earnest request as a voluntary patient. During the first six months of his residence he was rather shy and reserved. He soon emerged from this condition however, became cheery and talkative and formed ambitious business projects, but showed no signs of mental aberration. The condition was succeeded by depression, discontent, querulousness and, drinking craving. While in this state which generally lasted about a month the patient's liberty was restricted and the paroxysm thus prevented. He then assumed his normal condition, was active, obliging and assisted the clerk of the asylum in his duties, never thinking of strong drink until the period of depression came round again. While drinking the patient was given to boasting, lying and promiscuity; but during the intervals he was truthful and well behaved. After a residence of upwards of two years the patient was inadvertently allowed to go out of doors while in a depressed state, and with the craving strong upon him, and returned in a state of intoxication in little more than an hour. A few months previously he had been permitted to visit his relatives, who lived in the south of Scotland. During his absence he
he was able to resist temptation, and returned

of his own accord after the expiration of his leave. He is still under treat-

ment, and his case is probably hopeless.

II. Case of periodic dipsochamia

E. B., commercial traveller’s wife, aged 29

admitted December 1873. Patient has been

married fourteen years, and is the mother

of nine children, of whom only two survive.

Family history is unknown. She has been a

dipsochamia for seven years, but began to

tipple several years earlier. She drinks

whisky or brandy, but prefers the latter. Her

husband states that she drinks for a week

or ten days a bottle of brandy or more
daily, and then remains sober for a

month or so. She recently attempted to

cut her eldest daughter’s throat. Three

years ago she eloped with another man;

but after a time returned to her husband

promised amendment and was forgiven.

Patient on admission was remorseful, very

much depressed and lamented her un-
happy propensity. The complexion was dirty

and sallow, the tongue clean red and

glazed with papillae prominent, pupils

dilated, pulse 96, temperature normal.

She didn’t sleep during the first night.

Three glasses of brandy per diem with

beef tea and milk ad libitum were or-
dered. She was confined to bed at first,

and was unable to rise on account of

weakness and giddiness. The bowels were

constipated. On the second night after ad-

mission
mission thirty grains of chloral were adminis-
tered at bedtime, also a basin of strong
beef tea containing one glass of brandy,
and she slept for eight hours. She con-
tinued to feel very miserable and depressed
for a few days, but soon recovered her
health and appetite. Her husband attribute
her acquisition of drunken habits to the fact
that she was left much alone, and recently
her malady has been aggravated by grief
for the loss of a favourite child. She used
to pawn everything she could lay her hands
on in order to obtain money to purchase
drink, and has nearly ruined her hus-
band. Patient is very deceitful and a
most insatiate liar. She is very violent
and unmanageable when under the in-
fuence of drink. At the end of a month
the patient was removed contrary to the
advice of the medical superintendent, who
warned the husband that his wife would
immediately relapse, which she did a few
days after her discharge. Two weeks af-
terwards she was admitted into Queen's-
berry House as an inebriate, since which
time she has been lost sight of.

I shall now proceed to treat of
chronic or continuous dipsomania. In it
the greatest amount of moral degradation
is seen, and it is not infrequently accom-
panied by impairment of the intellectual
faculties also. There is no power of self-
control, the sense of shame is lost, and
lying becomes habitual. Its victims are
liable to commit criminal actions, and they
are generally short lived or become insane. In this form the disease remorse is rare, and the patient often takes great pleasure and even pride in describing the scenes of immorality and debauchery in which he has taken part to any one who will listen to him. He is utterly vile and depraved. His mind is a cesspool ever brimming over with thoughts of alcoholic and sexual excesses. The calls of religion, honour or duty have no power to restrain or reform him. He is utterly unprincipled, without affection for his species and a monster rather than a man.

Case of Chronic Alcoholic Mania.

A.B., aged 40, an army surgeon, and served in India. No information could be obtained regarding his family history. This patient began to drink when about seventeen years of age. He is married, but has no family. While serving in India he led a very dissolute life, and was frequently guilty of great immoral excesses. When his wife attempted to limit his potations, he became violent, addressed her in the most disgusting language, threatened to kill her, and smashed furniture and everything fragile he could lay his hands on. At one time he went out to shoot in the middle of the night, and on being missed and searched for was found to have undressed and lain down to sleep on the ground. After a debauch he sometimes fell into a strange nervous or hysterical condition, which usually ended in a violent paroxysm of weeping.
weeping and trembling. At all times his conversation was characterized by 
aggeration and falsehood. There was also slight mental confusion and loss of memory. 
Having been complained of as dangerous, he was induced to enter the asylum as a voluntary patient in 1872. Here he 
remained for nearly a year, and then, having become impatient of restraint, he 
returned home and immediately resumed his former habits. His wife now refused 
to live with him, and in the course of a few months he again returned to the 
asylum, where he was a thorn in the flesh to the Superintendent, worried the assistant 
almost beyond endurance, and took 
supreme delight in annoying the Matron 
and making himself disagreeable to the 
staff generally. He complained of the food and accommodation provided, and it was 
impolosible to please him in any way. He 
quarrelled with patients and attendants, 
was cunning and deceitful, and stirred 
up mischief whenever he could. When al 
lowed to go beyond the grounds on parole, he sometimes feigned illness in front of the houses of people he knew in order to 
excite their sympathy, and to furnish him with an excuse to ask for liquor. On two 
occasions he ordered and was supplied 
with drink in Whisky Shops before it had 
been discovered that he had no money to 
pay for it. After taking even a small quan 
tity of liquor he became subject to halluc 
cinations, and complained that people 
were...
came into his bedroom to annoy him. After a drinking bout he once had an epileptic seizure. When unmistakably drunk he often used to declare solemnly that he had not tasted strong drink for months. After a residence of one year, during which he continued to puff himself with spirits frequently, notwithstanding every precaution, he left to the great delight of all with whom he had to do. This man could speak of two things only, namely, drink and women. He delighted in describing the debauchies in which he had taken part, and boasted of the number of women he had seduced. The subsequent history of this case is a sad one. The patient after leaving the asylum sank deeper and deeper into the mire, was sentenced to six weeks imprisonment for stealing a China case, and shortly after his release re-committed to prison for a year with hard labour for another theft.

The history of all these drunkards before admission was in almost every case alike. They drank at first periodically, and during the intervals attended to their business. By degrees however, as the appetite for drink grew stronger, the periods of abstinence became shorter, until at last almost continual drunkenness ensued. They were liable under the influence of drink to become furious and assault those about them, and were often the victims of hallucinations. For example they imagined the bed to be on fire, that they were to be arrested.
arrested for some horrible crime, that coarse
some animals were crawling about them. As
all this frequently, ended in profound depres-
sion and in suicidal or homicidal attempts.
Epileptiform seizures if they occurred at all
did so after a prolonged drinking bout, and
rarely exceeded one or two in number. They
did not appear to differ in any respect from
ordinary epileptic convulsions except that
they were the consequence of alcoholic poison-
ing, and that they almost invariably ceased
whenever the patient refrained from
drinking. Five cases of this kind occurred
in my practice, and all of them in males.
Two of these had each two successive sei-
zures. There was an interval of about an
hour between the fits in each case. Both
patients remained tolerably temperate for
several months afterwards, but had no
occurrence of the Epilepsy. Two more had
one fit each, and in the fifth the epilep-
tic seizures became chronic, and had
continued for several years at the time
when I first saw him. This complication
appears to occur more frequently in private
practice than in asylums, as in the latter,
there are fewer opportunities for prolonged
indulgence. A neighbouring practitioner
informed me recently, that he had in one
year had three cases of Epilepsy in disso-
maniacs, one of whom at the time of the
seizure was drinking the enormous quan-
tity of half a gallon of strong Whisky per
day. All the cases referred to, including
my own, occurred in Whisky drinkers. Whisky
appears
appears to produce epilepsy more readily than brandy. It is still more frequently the result of indulgence in absinthe according to Magnan. I have never seen a case of alcoholic epilepsy in a female. The mental peculiarities of dipsomaniacs are often brought out after a small quantity has been swallowed. One gentleman in the Brighton Institution always quarreled with his attendant after his return from town if he had tasted drink when absent. Another, who was an Episcopal clergyman, used under the same circumstances to amuse his fellow patients and any others who would listen to him by parodying the marriage service of the Church of England and by making irreverent jokes; and a third was in the habit of telling filthy stories of his debauches and sexual excesses, while he gloated over the most disgusting details. In many cases they do not appear to derive any gratification from the taste of the liquor they imbibe. This is evident not only from their own statements, but from the fact that they prefer, not the drink most agreeable to the palate, but the strongest, and that they literally toss the contents of the glass into the pharynx and gulp them down. When deprived of drink for a considerable time the dipsomaniacs is not incessantly tormented by the craving for it. If his attention be occupied with other things, and his general health be good, he may remain steady until something occurs to excite or depress him, when he inevitably breaks down. The mere
mere mention of drink is however, often sufficient to set the craving. A gentleman at present under treatment in the Argyle asylum once said, "When I smell whisky my whole frame quivers as if I were to be shot." A patient in the Creigton Institution described his own sensations as follows: "Drink fascinates me as the serpent does the bird, yet I hate the taste of it." Pleasurable sensation seems equally with depression to give rise to a fit of drinking; thus if any special amusement such as a ball were in prospect some of the dysomaniacs got drunk in anticipation of the event. Dysomaniacs have recourse to various drugs besides the alcoholic stimulants in ordinary use, especially when the latter cannot be obtained. Many of those I knew took opium; one gentleman steeped tobacco in whisky and drank the resulting mixture; two others drank methylated spirits; another added chloral to his brandy; and a lady patient drank ink when nothing better could be got.

Objections to the treatment of dysomaniacs are voluntary patients in asylums. Dysomaniacs are a great pest both to the officials and to the other patients in asylums. They are selfish, greedy, and grasping, and must have the best of everything. At picnics and other amusements they crowd out the ordinary insane, whom they regard with dislike and contempt. They choose the most objectionable persons in the institution as companions, make love to the female attendants and servants, and show a bad example to the other inmates generally. It is almost impossible to get from them a
a strict observance of the regulations. They demand and obtain special privileges which cannot be accorded to certified patients; they require a totally different system of treatment and discipline, and they adopt at mischief-making and fault-finding. It is usual for them to invade the privacy of the officials without scruple and at all hours. A favourite custom is, under the pretext of feeling ill or of sleeplessness, to wheedle the medical officers into giving them beer, brandy, or drugs, such as chloral, opium, or alcoholic tinctures of any kind. It is bad both for the insane patients and also for the legally certified patients to admit the former into asylums. Where vicebeats are associated together, they demoralize each other and many of those with whom they come into contact, and are constantly devising schemes to elude the vigilance of the asylum authorities and obtain stimulants. Their expedients for procuring drink are almost endless; they conceal money in their clothing at the time of admission, ask loans of casual visitors, write acquaintances requesting them to send postage stamps, and as their letters are usually delivered unopened, the means of gratifying their deplrest appetites may sometimes be thus obtained. Parole is granted in most instances after a short probationary residence, and not infrequently these patients break their word of honour and come back either drunk or showing plainly by their appearance and manner that they have been indulging in liquor. Finally, they give an asylum a
a bad name, both by circulating false reports concerning it, and by their own disreputable conduct.

Effects of dipsomania on reproduction. Confirmed dipsomanias are as a rule sterile. If children have been born to them, they are in the majority of instances few in number, rarely exceeding one or two, and the longer the drinking habit has been indulged in before marriage the less is the chance of the marriage proving fruitful. These remarks apply equally to men and women. Of twenty-five married dipsomanias notes of whose cases I have taken, seven men and five women had no offspring; six men and three women had families numbering one or two; while the remainder viz. two men and two women had each more than two children. According to Sir James Simpson the proportion of unproductive marriages among the general population is one in ten. The ratio is evidently much higher in dipsomania, although it would be rash to conclude from the statistics given above, which refer to only a small number of individuals, that fifty per cent of that class are barren.

Curability of dipsomania. I do not know of a single permanent cure among the fifty-seven cases that have come under my observation; and the general opinion among medical men seems to be that, with the means at present at our disposal, the proportion of recoveries is exceedingly small. In America some physicians claim to have cured from twenty to fifty-six per cent of the cases under their care. There are a few institutions for intemperates solely in England and Scotland,
Scotland; while in the latter country there are besides some lunatic asylums into which dipsomanics are admitted as voluntary inmates. A patient can however leave an inebriate institution, whenever he chooses; and a voluntary inmate in a lunatic asylum can demand his discharge after having given three days' notice of his intention to go, even although he may have signed a document before admission pledging himself to remain for a definite period. This being the case, it is not unusual for a voluntary patient to intimate that he intends to stay no longer after he has been resident only a few days in the asylum. The superintendent of the Manchester Royal Asylum, who used to detain dipsomanics illegally and against their will in his establishment, after having previously taken an indemnity from their relatives, claims to have cured seven per cent of those committed to his care. Many, feeling the inconvenience of being restrained from drinking and deprived of their liberty in asylums, go at the end of one month; and comparatively few remain longer than three months. The great number of so-called voluntary patients are only so in name, as pressure has generally been brought to bear on them by their friends before they consent to place themselves under treatment. According to Dr. Parish of Media dipsomanics when treated in special institutions recover in a great rate than the ordinary insane do in asylums. The same authority also states that the results of their treatment as voluntary
voluntary patients in the lunatic asylums of America have been very unsatisfactory; and this agrees with what has been observed under precisely similar conditions in Scotland. The success of the American specialists in the treatment of dipsonania is doubtless due to the fact that they are invested with the power of detaining their patients for long periods; that many of their cases are admitted at an early stage of the disease, before the desire for reformation has ceased to exist; and while the patients still feel shame and remorse after having given way to excess. Dr. Parrish states that of patients who were themselves anxious to reform fifty-six per cent recovered, while the percentage of recoveries all over was only thirty-three. It is extremely probable however that a greater or less number of the reputed cases of recovery relapsed after they had been lost sight of. It may here be observed that some American physicians refuse to believe in the accuracy of the statistics of those who claim to have effected a high percentage of cures. It is often difficult today when recovery has taken place, as a dipsonania at present under my care once relapsed after having been a total abstainer for two years and nine months, and subsequently after abstinence for two years and two months. A case of relapse after seven years' abstinence is also recorded. Dr. W. A. F. Browne says he knows of only three recoveries, all of them being doubtful. One of the three individuals referred to has merely substituted opium for alcohol.
The experience of Dr. Gilechrist, medical superintendent of the Crichton Royal Institution, has been more favourable; but it is still the reverse of encouraging, as though he has had a greater number of dipsemaniacs under treatment than any other asylum physician in Scotland, the recoveries have been few and far-between. Dr. Gilechrist states that not more than five per cent of those who come under his care ever recover, and he is by no means painless that a permanent cure has taken place in even that small proportion. To sum up, dipsemania is one of the most intractable forms of insanity, as so many of its victims are the children of insane or drunken parents. Very few well authenticated cases of recovery have been recorded in this country; and when they did occur it was generally after prolonged treatment, and when the drinking habit had been comparatively recent. Many so-called cases of recovery relapse. Confirmed dipsemaniacs are incurable by any means of treatment that can at the present time be legally adopted in Britain. It is highly probable however, judging by the results obtained in American asylums, that if dipsemaniacs in this country could be legally relegated to establishments specially set apart for their care and cure, a considerable proportion of them might again become useful members of society.

Progeny of dipsemaniacs. - When dipsemaniacs have children, their families are generally small, as has already been remarked. Among
Among the poorer classes the condition of the children of a drunken father or mother is one of equal or and misery, which are themselves the fruitful causes of disease; hence rickets, hydrocephalus and other manifestations of the pernicious diathesis are frequent, but are due probably, not so much to the unhappy propensity of the parents, as to the poverty and wretchedness which are the direct consequences of their excess. When the parents are in comfortable circumstances the tendency to diseases of defective nutrition is not seen to the same extent, because the children are not in the latter case so much exposed to the eternal conditions that favour the development of these affections. The offspring of inebriates are peculiarly liable to affections of the nervous system in every form. They often suffer from chorea, neuralgia and epilepsy. All the ordinary forms of insanity are seen in them more frequently than in the children of healthy parents. Congenital imbecility rarely fails to select at least one child as its prey; the sons are apt to become drunkards or dipsomaniacs, and occasionally the daughters also. Sometimes the symptoms of mental instability consist in an inordinate propensity to theft, immorality and falsehood. One of the sons of a dipsomaniac under my care began a career of vice and crime when only nine years of age, and was convicted of theft more than once before he had attained the age of eleven. He had been brought up by an exemplary mother, who used
used every means of reformation in her power, but all to no purpose. A brother of this child is phthisical, another brother died of hydrocephalus, and a sister, at present alive, is weak-minded.

The pathology of chronic alcoholism and the diseases to which dyspepsia are subject. Alcohol when taken into the stomach, coagulates any albuminous food it may contain and interferes with digestion. It is chemically attracted by the mucous secretion and probably initiates degeneration of tissue by paralyzing the trophic nerves. By retarding the circulation of the blood it produces congestion of the lungs, liver, kidneys etc., this condition being due partly to paralysis of the vasomotor nerves, and partly to the direct action of the alcohol upon the tissue of these organs. The elimination of effete matter is impeded, and the amount of fat contained in the blood is greatly increased. Atrophy of the nervous substance of the brain takes place, together with a development of fibrous tissue, fat granules and other products of retrograde metamorphosis. The bones of the skull become thick and dense in structure. Blood and fatty changes take place in other organs, and the result is cirrhosis of the liver, fatty or granular kidney and atheroma of the valves of the heart and of the arteries.

Partial paralysis of the trophic fibres of the pulmonary branches of the vagus appears to cause a rapidly fatal form of disease known as drunkard’s phthisis. The chronic dyspepsia is seldom free from a short, tickling cough.
lough; his eyesight is usually impaired and he may become the victim of apoplexy or paralysis. Allusion has already been made to the occasional occurrence of delirium tremens and epileptiform convulsions. The chief mental diseases to which he is liable are mania a fortis, cerebellar paralysis and dementia.

Treatment of Dipsomania.—The treatment must vary greatly according to the circumstances of the case and the degree of restraint which it is possible to impose. Alcoholic stimulants must be withheld, and narcotic drugs also when that can be done without risk to the patient. If he can be induced to enter an asylum voluntarily, the chances of recovery, slender though they be at the best, are much better than when an endeavour is made to treat the case at home, where the disease is always allowed to become confirmed before any active treatment is adopted. When the friends are awake to the necessity of doing something the first step is usually to send him to board in some remote part of the country, a system which is never successful. It is also very objectionable on the grounds, as dipsomania is prone to sexual immorality, and are detained by no considerations of honour, shame or gratitude from making attempts on female virtue. No man who has a family of his own should, on that account receive a dipsomaniac into his house.

The method of treatment pursued in the case of dipsomaniacs confined in the Asylums of

Dumfries
Dunfranc and Argyll will now be described, my observations referring in the first place to persons admitted in a state of intoxication and who had been drinking for weeks previously. In the Crichton Institution, the supply of drink was gradually diminished and cut off after a few days had elapsed, whereas in the Argyll Asylum total abstinence was strictly enforced from the time of admission, and no injurious effects ever followed the sudden withdrawal of stimulants. With this exception, the treatment in both Asylums was essentially the same. The depression which followed the cutting off of the accustomed stimulant was relieved by Cayenne pepper administered in soup or in currant jelly. A mixture containing iron and magnesia was also found useful. Capricum has been much valued for its beneficial effects in such cases. It is said not only to relieve depression, but also to act as a hypnotic. In my experience sleep did not always follow its use, but it certainly appeared to dissipate the wretchedness and misery of the patient. If sleep could not be procured by any other means chloral in doses of from twenty to forty grains seldom failed to produce the desired effect. To relieve the gastric disturbance and vomiting bismuth combined with rhubarb and carbonate of potash was given for a day or two. The diarrhea so frequent in newly admitted cases generally yielded readily to morphia administered in the form of suppository. The diet consisted of milk and beef-tea or meat juice until the feeble digestion had improved.
Improved so far as to permit the assimilation of solid food. After a period varying from a few days to a fortnight the patient usually felt better than he had been for a long time, and the appetite became almost ravenous. The patient sometimes suffered from sleeplessness for months, and in a few instances been informed by them that they had been "bad sleepers" all their lives. Quinine given in doses of one grain three times daily as recommended by Dr. Anctic proved very efficacious in some of these cases. After every other remedy had failed in a greater or less degree much benefit was derived from the extract of Indian hemp in doses of one or two grains and upwards. Diplomaniacs seem to have a tolerance of this drug not possessed by the ordinary insane at least, as I have found decidedly unpleasant if not alarming effects produced in the latter by fifty minims doses of the tincture. Chloral, if it be used at all in these cases of chronic sleeplessness, to be effective must be administered in doses too large to be absolutely safe. When doses of from forty to sixty grains had been taken the results were often unsatisfactory, for the patient as a rule did not sleep more than four hours and kept morning awoke in a peevish and irritable state. The daily use of the shower bath, especially when a course of chalybeate medicine was administered at the same time, had the effect of lengthening the intervals between the drinking fits, the patient becoming buoyant and cheerful, and for a time appearing to have
have permanently returned to habits of sobriety. After two or three weeks' residence the majority feel quite well, sleep and appetite are restored, and they are apt to declare that they have no longer any desire to drink, and that there is no further reason for restricting their liberty. Their friends unfortunately are only too ready to believe in their statements and promises of amendment, and contrary to the advice of the medical officers, sometimes at the end of the first month of residence or even sooner remove them from the asylum. I know of repeated instances in which a newly discharged dipsomaniac has resumed the drinking habit within an hour after recovering his freedom, and been sent back in a state of intoxication at the end of a few days or weeks.

As is evident from the foregoing remarks the great obstacle to success in treatment lies in the fact that there is no power to restrain the dipsomaniac when he drinks to excess whether he resides in a private house or has entered an asylum as a voluntary patient. I am convinced that most cases of continuous dipsomaniacs are absolutely incurable under any system of treatment. There is however reason to take a much more hopeful view of the periodic form, as in it the disease has not yet become incurable. It has been proposed that establishments should be built and maintained expressly for the care and treatment of "habitual drunkards," under which term dipsomaniacs are included, and that legal
legal powers should be obtained to confine persons coming under that category with a view to their cure. In these institutions total abstinence would be strictly enforced and provision made for the occupation and amusement of the inmates. It is hoped that by these means the power of self-control might be restored and ultimate recovery take place.

We have already seen how seldom this desirable consummation has been attained by any of the existing means of treatment. If the legislature should authorise the exclusion of lunatics of this class for lengthened periods the number of recoveries, at least in recent cases, would in all probability be greatly increased. It is not however likely that the ratio of recoveries would ever become so high as it is said to have done in some of the institutions for inebriates in the United States of America.

John Cameron M.B.

Dr. John Cameron,
Rockefeller Asylum,
Loudon, 27th April 1877.

A list of the works that have been consulted by me on the subject of Dipseomania is here subjoined:

"Stimulants and Narcotics"—Anstie
"Dipseomania or Drinking Insanity"—Peddie
"Psychological Medicine" by Bucknell and Inke.
Article on "Dipsomania".
"Journal of Mental Science", July, 1867—Article on "Inebriate Asylums" by Dr. Arthur Mitchell.
"Report of the Royal Edinburgh Asylum" for 1872 by Dr. Skae.
"A System of Medicine" edited by Dr. Russell Reynolds. Vol. II—Article on "Alcoholism" by Dr. Austin.
"Report from the Select Committee of the House of Commons on Habitual Drunkards" 1872—Evidence of Dr. Arthur Mitchell, Dr. Parrish, Dr. Dodge and Mr. Mould.
"De L'Alcoolisme, des diverses formes du Délice Alcoolique et de leur Traitement" by Dr. Magnan—Article on "Dipsomania"
"British and Foreign Medical-Chirurgical Review" April 1874—Article on "Alcoholism"
"Four years' Experience in the Treatment of Inebriates" by Dr. Gilchrist in "Medical Temperance Journal" Vol. V. 1875.

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