of residence, as half the total weight is gained in these first two weeks and I felt this would create an error in finding out the influence of the various open-air factors on the general mass of cases. I may have been wrong in this because it is during this period that the change from their homes to complete fresh air occurs, and perhaps it is by studying this period that one would find the real cause of the benefit of fresh air. To do this properly of course one would have to take these records in the patients' homes for two weeks before admission and then compare. This is of course difficult to do but the tuberculosis officer might assist in this direction. A scrutiny of the meteorological conditions of a county in relation to the morbidity and mortality of tuberculosis in the county could be done by a county tuberculosis officer and would be of great value. It has been done in relation to rainfall by Dr. Gordon of Exeter, in relation to Devon and Derbyshire, and in India by Sir Leonard Rogers. Why is there such a high death-rate from tuberculosis in the Isle of Lewis? Granted it is partly due to poverty of the inhabitants, but it also may be due in great part to climatic factors, the great rain and fierce wind of the Atlantic.

We do not really know the value of the different factors in the air on the human system, healthy or diseased. Our ancestors believed in living under a lucky star. I am not going so far as to say we should find out which star suits each patient and put his bed in the meridian of his appointed star. Yet on the other hand Professor Millikan has studied the cosmic radiation from nebulæ, the embryoplasm of stars which penetrates 5 yards of lead, and Professor Jeans says this radiation is the most fundamental physical phenomenon of the whole universe. Our bodies are traversed by it night and day and it is so intense that it breaks up several millions of atoms in each of our bodies every second. To escape it we must go down in a submarine or into a mine. How many of us ten years ago would have dreamed that we in London could hear and see people speaking in America? Surely then there is much to learn from a scientific research into the medico-physics of open-air treatment.

CRIME AND INSANITY. LECTURE III.

GIVEN AT THE MAUDSLEY HOSPITAL, MAY 14, 1929.

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(*Continued from p 27*)

CRIME is frequently associated with dementia præcox, and it may be difficult to distinguish between the symptoms due to the simple or hebephrenic type of the disease and those of mental deficiency, particularly when both conditions occur in the same offender. A gradual change in personality, accompanied by increasing apathy, foolish behaviour, a withdrawal from reality, mild depression, occasional emotional outbursts and impulsions, and progressive mental deterioration suggest dementia præcox. But Tredgold[1] points out that certain types of retrogression in mentally defective persons correspond in all essentials to the simple type of dementia præcox, and to the dementia due to senility. In criminal cases associated with dementia præcox prolonged observation may be necessary before an accurate diagnosis can be made. A man, aged 23, was in the VI standard on leaving school, and was afterwards engaged for a short time as a porter, and then for three years as a carman. He served for two and a half years in the Army during the war, and was for some months in a hospital under treatment for neurasthenia. On discharge

[1] "The Relationship of Mental Deficiency to Mental Disease in General." A. F. Tredgold.

from the Army he received a disability pension for an injury to the hand. Three years later he came under observation when arrested for sleeping out, and was noted to be indolent and apathetic. Dementia præcox was suspected. Five months later he came under observation again, now charged with wandering. He had gained weight, and the bodily organs appeared normal, there were no tremors and the reflexes were normal. His memory was fair, and he was well informed on matters of ordinary interest and common knowledge, and had some insight into his condition, but he took no notice of his surroundings, was mildly depressed, self-centred and unconcerned at his position. He was lost in his day-dreams. He fouled his bed with urine and solid fæces, and appeared too indolent to use the lavatory accommodation provided in the ward. The mental deterioration had progressed and the diagnosis was no longer in doubt.

Indolence, irritability and impulsiveness may be the only indications of dementia præcox for some months. They are also characteristic features in the mental make-up of certain criminals. Morbid impulsive conduct may be the earliest noticeable indication of the disease, and is a marked feature in some cases. A man who previously had been detained in a mental hospital for three years struck two strangers as he passed them in the street. Whilst under observation, he suddenly smashed three of the windows in the hospital ward with a chair. He had vague ideas of persecution, but careful investigation failed to trace the acts to any delusions or hallucinations; they appeared to be blind impulses. These patients often seem puzzled at their outbursts; like the short maniacal attacks which occur, they are of great medico-legal importance.

No particular class of crime is attributable to this disease. I have seen it associated with murder and other crimes of violence, with attempted suicide, threats, arson, damage to property, housebreaking, theft, fraud, sex offences, insulting behaviour, obstructing the police, wife maintenance, &c. The crimes are not usually of a serious character. Indolence and apathy give rise to vagrancy and petty theft, depression may lead to violence and attempts at suicide, defective inhibition may lead to impulsive sex offences, violence and theft. Delusions and periods of excitement may precede bodily assaults, threats and damage to property. Wandering may occur as the result of delusions and hallucinations, or if the patient is otherwise out of touch with realities. Neglect of family may be due to emotional apathy.

In this disorder the tendency to commit crime cannot be measured by the apparent degree of mental alienation; the characteristic discrepancy between thought and action precludes any such assessment. Delusions which appear only mildly persecutory may cause crimes of violence, others which appear to press more heavily upon the subject may not; and the smiling and apparently cheerful patient may burst into tears a minute later for no apparent reason, and attempt suicide with little or no warning. But patients may unexpectedly control their impulses: one youth imagined people discussed his appearance as he passed them in the street, he believed invisible persons pursued him and hurt his teeth, and he said that "he could flatten them out," and he clearly felt like doing so, but no violence had occurred so far as was known up to the time he came under observation remanded on a charge of loitering.

Crimes due to this disorder sometimes bear the hall-mark of fatuity. A young man was observed by a police officer attempting to pick the pockets of three men who were in each others' company. When questioned he protested that he was doing nothing wrong, and in a few moments was trying to pick another pocket under the eyes of the same officer. On examination I found a considerable degree of mental deterioration; apathy and echolalia were marked; he was unable to occupy himself. He knew nothing

about a book he appeared to be reading, and although he wished to write a letter he took no steps to let anyone know so that he could be provided with writing materials. He had no idea he was in prison, or that he was remanded for mental observation. He came of respectable parents, but he wandered from home and they had been unable to trace his whereabouts.

These prisoners often remember and discuss the events connected with the crime. They may make fictitious statements as a result of rationalization or to mislead, their statements are often obviously false, and appear at times associated with their phantasies. They may refuse any information about themselves as part of a general negativism, as a result of mental confusion, or because they take no interest in their position. On the other hand, they may realize the possible consequences of a criminal act. They frequently make stupid and contradictory statements from inability to concentrate their attention on the subject, but, unlike the pathological liar, their untruths arise in answer to questions and are not spontaneously volunteered.

In the early stage of the disease, at least, the patient has some insight into his condition. A lad of 17 who did well at school, at home and with his first employer, became later indolent, apathetic and hypochondriacal. He set a common on fire, aware that a police officer was watching him, and was arrested on the spot. He informed me that he felt there was something wrong with him, and he wanted to get arrested so that he could be examined by a doctor. I had no reason to doubt him.

The sexual instinct exercises an important influence on adolescent thought and conduct, and it is not surprising to find that the phantasies, delusions and hallucinations of præcox patients are often sexual in character. They may be heterosexual or homosexual, incestuous or auto-erotic, but in some the delusional grouping may appear at first inconsistent. One case believed he was God and cast devils out of people's minds, but he accused himself of revolting homosexual practices, and actually was an excessive masturbator. He believed a man mesmerized him and that sexual relations then took place between them, and that people in the street avoided him, aware of his homosexual habits. His grandiose ideas appear to have been compensatory to his humiliating beliefs concerning his sexual perversions, many of which were certainly imaginary.

The prisoner suffering from dementia præcox may be incoherent in speech and exhibit manic excitement and a flight of ideas; he may be slow in movement and in thought and be emotionally depressed. The symptoms may suggest a manic-depressive psychosis, but the diagnosis will be established if the patient is under observation for sufficient time. A man, aged 23, with a bad family history as regards mental disease, was charged with the murder of a young woman with whom he had been cohabiting for some months. Their relations testified to the happiness of the union. The accused and the girl were tent dwellers, and he had worked for four years with one employer. Three months before the murder he consulted a doctor, complaining of sexual excesses, and that he wanted to be put away for a rest as he could not eat or sleep. He consulted two other medical men "for his nerves," and apparently had some insight into his condition. The girl asked him to go with her and pick some flowers on the downs; four hours later he returned and informed his father he had killed the girl. He took his father to the body, and the police and a doctor were summoned. The former said the accused seemed vacant and showed no emotion as he stood by the dead girl. The doctor found forty wounds about the head, face and neck of the deceased girl, which he considered might have been caused by a pair of scissors. The outer table of the skull was penetrated. He observed that the accused was dull and apathetic. After

arrest the prisoner made various statements. In one he said he did not know why he killed the girl, in another that he had lost his head, that he had no grip over himself and killed the girl because he was down and out; he had so many thoughts that he could not keep them in his head for many seconds, that the girl had never done anything to displease him, but she did say she would leave him, and he added that he took the scissors out with him for the purpose of killing her. On reception into prison he was depressed and did not appear to appreciate his position; he wept a good deal unostentatiously, and did not occupy himself at all. He became morose, wandered aimlessly about the ward, was dirty, slovenly, and developed a degree of stupor. He became hallucinated, and about three months after the murder passed through a short attack of maniacal violence. He was placed in a padded room, and in two hours the attack passed off. He explained it by saying he had been into a beer-house and become affected by the beer, but he had been in custody throughout and had had no alcohol since arrest. His conversation was usually carried on in an expressionless monotone, and echolalia and verbigeration were pronounced. His facial expression was vacant. He was totally unconcerned at his position, which he did not appreciate; he did not realize he was awaiting trial, but said the doctor was going to get him fit and find him work. He was disorientated and confused, and although he was under observation awaiting trial for some five months, believed it to be only four weeks; he did not know where he was, and seemed to have no recollection of the murder soon after it was committed. He took no interest in anything, and the aural and visual hallucinations persisted. It was clear that at the time of the murder he knew what he was doing, but it was doubtful if he knew that what he did was wrong. These matters did not arise at the trial, as he was by then unfit to plead, and was so found by the jury, and was sentenced to be detained during His Majesty's pleasure.

Certain symptoms presented by the præcox delinquent may bear a superficial resemblance to malingered insanity. The false statements they make are generally patently foolish and are obviously not intended to deceive. Their mannerisms, grimaces and neologisms may suggest an attempt at deception, but are associated with other symptoms of the disorder, and are sometimes more obvious when the patient believes he is unobserved. This is precisely contrary to the practice of the malingerer. Echopraxia and flexibilitas cerea are not likely to be assumed, and if present are to be accepted as genuine. Echolalia is, however, sometimes assumed, and is also observed in feeble-minded persons. Uncontrolled objectless laughter is less certainly genuine than sudden weeping. I cannot recall any case of a male offender possessing the capacity of bursting into tears without reason unless he presented some mental abormality. Attention has been drawn already to the discrepancy between thought and action in these patients, and this characteristic feature must be borne in mind before the symptoms of insanity can be considered to be assumed. The physical stigmata associated with dementia præcox, if present, may assist in the diagnosis.

In early cases of dementia præcox the prisoner may be responsible in law for his crime. He may know what he is doing, that is, the nature and quality of his act, in comparatively late cases. The capacity to know that what he is doing is wrong is often lost first. Many are found unfit to plead when they come to trial. In the case of a youth, aged 21, an appreciation between moral right and wrong, and a knowledge that a crime is an act punishable by law resulted in a charge of arson. The accused was born in England of German parents, and during the war was interned in Germany. He appears to have studied hard during this period, but did no work after the Armistice. He sat about all day doing nothing. After two years he improved

sufficiently to assist his father in his business, and later returned to London to work with an uncle. He suddenly left this relation and travelled to several towns in the north of England; he retained a faint recollection of his wandering, and was at length found lying by the roadside in an exhausted state. He was sent back to his relative, but shortly after left and walked into the country, and was found sitting by a straw rick he had set on fire. He was reported to have gone through the stereotyped motion of striking matches for some hours after arrest. A further inquiry into his history showed that he had attempted suicide by drowning when 11 years old, later by jumping out of a train, and still later by taking poison and cutting his wrist. He had been depressed for a considerable period before the incendiarism; he admitted excessive masturbation. He felt he was unworthy to live and had withdrawn himself from relations and friends in consequence. He appeared to have lost all family affection, he lacked any capacity for sustained effort, was preoccupied, hallucinated, suffered from sleeplessness, and flexibilitas cerea was present. He stated that he had been thinking of doing something wrong since his last attempt at suicide, as he considered he deserved punishment for his bad sex habits, and selected arson as he thought the penalty would be severe and probably a life sentence. He was dealt with at court as insane.

A concluding observation. The remissions which occur in this disorder are of medico-legal importance, and if an accused person has made an apparent recovery from an attack, the subsequent commission of a crime may be the first indication of a relapse. The condition of the accused may not justify evidence of insanity then, but the medical witness may properly testify that the crime may be due to undeveloped mental disorder.

CORRESPONDENCE.

Royal Medical Benevolent Fund Christmas Gifts.

TO THE EDITOR OF THE POST-GRADUATE MEDICAL JOURNAL.

Dear Sir,—It has been the practice of the Royal Medical Benevolent Fund for many years to give a Christmas gift to each annuitant and some of the most necessitous of the grantees.

Both the annuitants, who are over 60 years of age, and the grantees are deprived of those little amenities of life which the more fortunate of us enjoy.

Many of our beneficiaries are alone in the world as their friends and relations have passed over and consequently they will not receive any gift or extra comfort this Christmas.

Last year the Fund gave to each 30s., this meant an expenditure of £500. Many readers will wish that the recipients of this gift in former years should not be deprived of it this year.

But unless I am favoured by a generous response to this appeal our funds will not allow of this gracious and friendly act.

Will every reader of this letter please consider if he or she cannot send to the Honorary Treasurer, Royal Medical Benevolent Fund, 11, Chandos Street, London, W.1, a Christmas donation?

I shall be grateful whether the donation be large or small.

Yours faithfully,
(*signed*) Thomas Barlow,
President.

POST-GRADUATE NEWS.

It is not possible to arrange for more than three Special Courses in December by reason of the Christmas vacation, and these have been fixed to take place December 2 to December 14. Under the direction of Dr. Eric Pritchard a course will be held at the Infants Hospital, Vincent Square, S.W.