Climacteric Insanity. By W. J. Conklin, M. D., Assistant Physician to the Southern Ohio Lunatic Asylum, Dayton, Ohio.

The physiological development of the human organism is attended with two eras of peculiar nervous instability, the first at puberty, and the second at the change of life. Distinctly marked as are these eras in the male, the greater changes which the female economy undergoes, marking the beginning and the end of that uterine life so distinctive of the sex, render them of especial interest. The symptoms of the mental disease lighted

up at each of these revolutionary periods, are so uniform and characteristic, that authors are now generally agreed in describing them as distinct families, under the names of Insanity of Pubescence and Climacteric Insanity. The mental irregularities of puberty have been well studied by many writers, while those of the climacteric period have scarcely received the attention their frequency and importance deserve. In the present paper we hope to point out some of the peculiar phases assumed by mental disease at this latter period, and with this view shall analyze fifty-seven cases of climacteric disease observed in this institution.

The advocates of the physical theory of insanity find no stronger proofs of their position than the close inter-relation existing between disorders of the reproductive organs and disordered intellection. That irregularities or even radical changes of the menstrual function should lead to unsoundness of mind, is the more readily believed, when we recall how much the female organism all through life is controlled by the activity of the ovaries. The ordinary affections of the uterine organs, amenorrhœa, menorrhagia, dysmenorrhœa, and especially leucorrhœa, are almost invariably attended with greater or less disorder of the affective faculties.

It is well known that many insane women suffer painful exacerbations of their disease at their menstrual periods. Every asylum presents cases in whom, save alone during the few days associated with the catamenial flow, it is difficult to discover any departure from sanity. However, at these periods, they pass through a short but violent attack of mania, characterized by lewdness of thought and act contrasting strongly with their usual habit. With each recurring period the same experience is gone through with, or, perhaps, one or two periods are passed safely lighting up false hopes. At length the return to health in the intervals becomes less marked and the sufferers gradually become demented.

A very decided alteration in the mental and physical natures is experienced by most women while the system is accommodating itself to the changes which this crisis ushers in. The derangement of the sympathetic system of nerves is shown in the sense of heat, flushing, sinking sensations at the epigastrium, irregular heart action and kindred phenomena which are almost invariably present.

The mental symptoms are equally prominent; the patient is sleepless and restless; she becomes moody, vacillating in purpose and capricious in temper. Wandering pains and palpitation of the heart beget fears of graver troubles; the ordinary trials of every-day life unduly annoy her. This gloomy atmosphere in which she lives may clear up in the sunshine of restored health, or the clouds may grow darker, until her fancies become a part of her mental existence influencing and controlling her actions, when her insanity is placed beyond question.

It not infrequently happens, that where avowed insanity is not lighted up, an evident alteration in the character of the individual can be traced

from this date: a morbid distrust of every one around her, a habit of drinking or other eccentricities may embitter her life. In this manner we see the natural disturbance of mental equilibrium due to a physiological process transformed into a pathological disturbance. Why this should be so, we can only partially answer. It is certainly not the law of life that a physiological phenomenon should in and of itself become a pathological one. Statistics seem to show that a larger percentage of the female population between the ages of forty and fifty years become insane, than at any other decennial period. When the absence of puerperal causes is taken into account, which are reputed to furnish one out of every eleven insane women, it will be seen that there must be something especially causative in the changes which the organism undergoes at this period.

The causes must be sought for in some acquired or inherited deterioration of nerve element. Many have laboured all through life with a predisposition to nervous troubles like a load weighing them down, and it only required the natural instability of nerve element at this crisis to precipitate an attack of insanity. In others the insanity is simply the expression of a combination of causes: the cares and troubles of life reaching their climax when physical infirmities press heaviest and the reserve forces are least, the mental health breaks down under them. If single, or married and childless, the bitter disappointment at her aimless life; if married, successive pregnancies with their debilitating influences may enter as important factors in the causation.

This view receives support from the nature of the causes usually specified by friends and examining physicians, such as grief, family troubles, religion, ill health—a symptom in many cases being mistaken for the cause.

It is extremely difficult to gather the facts as to the mental condition of the ancestry. It is now a well-recognized fact, that in estimating the hereditary taint, the ancestry should be interrogated with reference to the whole class of neuroses, since any of them may, in the next generation, lead to insanity, or, at least, the insane neurosis, which requires only a trivial cause to excite an attack of insanity. I regret that I cannot offer full statistics on this point, but the records of the asylum only furnish information as to the presence of insanity. In the following table I have included insane members of the same family as affording, in the absence of precise information, strong presumptive evidence of hereditary taint.

Grandmother had been insane in	2 cases.
Mother	3 "
Father	2 "
Sisters or brothers	8 "
Cousins	2 "
Relatives not specified	8 "
Unknown	10 "
Not hereditary	22 "
Total,	57 "

Putting this table in another form, we have—

Hereditary	25
Not hereditary	22
Unknown	10

Thus it will be seen that hereditary taint was found in about 44 per cent. of the whole number of cases, and in about 55 per cent. of those whose history could be satisfactorily traced.

The change of life is usually reckoned between the ages of 40 and 50 years. Some women, however, cease menstruating at an earlier age, while in others this occurs later in life.

The age and civil condition of each case at the time the insanity was developed are shown in the following table: —

Ages.	Number of cases.	Civil condition.			Ages.	Number of cases.	Civil condition.		
		Married.	Single.	Widowed.			Married.	Single.	Widowed.
38 years	1	1			48 years	5	4	1	
39 "	1	1			49 "	6	4		2
40 "	4	3		1	50 "	3	1	1	1
41 "	3	2		1	51 "	3	2	1	
42 "	6	1	4	1	52 "	2	2		
44 "	3	1	1	1	54 "	2	1	1	
45 "	7	3	3	1					
46 "	5	3	1	1	Total,	57	31	15	11
47 "	6	2	2	2					

The larger number of cases occurred between the ages of 45 and 50.

Climacteric insanity is, as a rule, gradual in its onset: with a few exceptions the above cases showed the prodromatory symptoms already described.

In the majority of them, the mental trouble became apparent during the irregularity that preceded the final cessation of the menses.

In two, the characteristic mental symptoms were the first indication of the menopause.

In four, the insanity was suddenly developed after a terminal flooding.

In a few cases, the mental disease did not become fixed until from one to three months after the cessation, yet through despondency and minor alterations in conduct the connection was easily traced. In two sisters chorea was developed simultaneously with the mental disease. The chorea proved very severe and persisted through life. They both passed through a regular attack of insanity attended with paroxysms of excitement, and died demented.

It is hardly necessary to remark that we have not included in the above enumeration all cases of insanity occurring in the fourth decennial period.

As many women pass through their change without an unpleasant symptom, so many women become insane at the climacteric period, without the character of the mental disease being in any way modified by it.

Classifying the cases according as exaltation or depression was the prominent symptom, we find—

Mania in	5 cases.
Mania with paroxysmal excitement in . .	11 "
Melancholia in	41 "
Total . . .	57 "

From which we infer that acute mania is of rare occurrence, being the form assumed in only five of the fifty-seven cases. Two of these were the ones before alluded to, as occurring after a terminal flooding, and in which the mental symptoms were suddenly manifested. The form of disease assumed in any case of insanity is, as Dr. Blandford strongly urges, largely due to the physical condition on the supervention of the mental disease. The larger number of climacteric cases are much broken in general health —the countenance is haggard, tongue coated, appetite lost, bowels constipated; everything, in fact, indicates the lowered bodily vitality, and the mental manifestations point to a like condition of the brain centres, hence the insanity is usually asthenic.

In compiling my tables, I have only taken those cases of first attack. The liability to a recurrence of insanity at the climacteric, in those who have suffered from an attack in early life, is very strong. In recurrent disease, cases exhibiting the motility of mind and body peculiar to mania occur in a very much larger proportion of cases, but the beginning and general history of the attacks are usually sufficient to indicate their climacteric origin.

In eleven cases periods of excitement were associated with the melancholia. These paroxysms were usually transient in duration, rarely persisting longer than a day or two, and followed by the deepest melancholia.

They were generally controlled by delusions previously existing, and assumed one of two forms: either that of terror from fear of some terrible calamity that overhung them, and attended with desperate suicidal impulses; or from the idea that they were the victims of a conspiracy in which nearest friends were engaged, and associated with homicidal impulses. In one case, the lady, usually an affectionate mother, without the slightest provocation, struck her daughter with a smoothing-iron, breaking her arm. In several other cases, attacks were repeatedly made upon kindred and friends; which assaults afterwards furnished food for the most terrible self-recrimination.

These exacerbations were usually observed at the regular monthly periods, even after the cessation of the catamenia, and especially on their return after a short absence.

Melancholia was the form assumed in about 72 per cent. of the cases observed, and presented certain well-marked characteristics.

The personal appearance of the patient vividly portrays the depressing thoughts that have so completely taken possession of her mind. Her countenance is furrowed with the lines of pain and despair; negligent in dress, she rocks to and fro, or paces her room, wringing her hands and bewailing her unhappy lot. She is led about by a vague feeling of restlessness, a desire to go—whither she neither knows nor cares; but hopes against hope to flee from her bad feelings. Not infrequently, while lamenting that she is lost beyond hope of redemption, she will show a morbid craving after sympathy, and you often hear "Oh, doctor, isn't it awful that I am so miserable?"

Hallucinations of the several senses are rarely found, occasionally hallucinations of hearing do exist and are of unfavourable omen.

Illusions of sight are not infrequent, and sometimes give rise to great terror.

Delusions are almost invariably present, at some stage in the progress of the case. The tendency is to project self upon the foreground around which cluster all her false beliefs. These may be divided into two groups.

The members of the first group fancy themselves innocent victims, and attribute their sufferings to the evil-doings of others. These are more frequently found in that form of disease attended with paroxysmal excitement. This class is very suspicious, especially towards friends and relatives: they have a fear of poison, which often causes them to reject food; and, above all, an ever-present fear of some impending evil haunts them, and thus explains their restlessness and frightened appearance. This feeling might possibly be called a hyperæsthesia of the mind centres, and has much in common with the hyperæsthesia of the skin so frequently found. The creaking of a door or any unusual noise startles and leads them to imagine the immediate execution of plots against them. As a direct outgrowth of this class of delusions, homicidal impulses are usually found. A lady now in the asylum, whose husband owned a planing-mill, was possessed of the idea that the noise of the machinery so annoyed the neighbours that they were determined to mob him and kill the family. She used every means to persuade her husband to give up the mill, which failing, she set fire to her house and burned it to the ground. Another lady, the wife of a prosperous merchant, whose married life had been a pleasant one, began to entertain groundless suspicions of her husband's constancy, and finally instituted proceedings for a divorce, much to the mortification of all her friends.

The second group includes those who consider themselves the authors of their own misery, and believe their sins have removed them from the pale of God's mercy. These are the common delusions in the purely melancholic form, and, besides being the most painful ones met with among

the insane, are those considered distinctive of climacteric disease. In a large proportion of the cases—fully two-thirds of the number entering into this analysis—that indescribable feeling of the soul being lost was present. Its origin can be traced to an overwhelming conviction of their utter sinfulness. They quite often labour under the distinct delusion of having committed the unpardonable sin. When interrogated, you will find it oftener to be a sin of omission than of commission.

The feeling of being compelled to pass through some terrible punishment in expiation of their sins is quite common. Several of the above cases imagined that a bottomless gulf, filled with all the torments that the mind of a fiend could invent, was open before them, and which they were slowly approaching, without power to turn back or escape. The delusions of this group are usually associated with suicidal impulses. The unhappy sufferers meditate suicide either as offering means of escape from their gloomy feelings, or with the hope that they can thus atone for their crimes. According to my observation, a larger number and more determined cases of the suicidal propensity are found in climacteric than in any other form of insanity.

In 57 cases	26 were suicidal.
	25 were not suicidal.
	6 unknown.

Showing suicidal tendencies to have been present in about 50 per cent.; more than half of whom made one or more distinct attempts.

Like all suicidal patients, there are two periods of especial danger: 1st. Early in the morning, when they are very liable to give way to their morbid impulses. Often a lunch before rising will, for the time being, scatter all such notions. 2d. During the period of convalescence. When everything seems to promise a speedy and complete recovery the nurses are apt to be less watchful, and the patient may make a successful attempt during a temporary exacerbation to which all are so liable.

The appetite is capricious. In many cases there exists a morbid propensity for stimulants, and the temporary relief they afford often leads to the formation of unfortunate appetites. A lady, lately under treatment, had such an irresistible craving for alcoholic stimulants, that she would drink everything within her reach containing alcohol—as camphor, hair-oil, &c. She was constantly on the search for stimulants, and would drink to intoxication at every opportunity. Often they crave the most indigestible articles of food. But the most troublesome irregularity, and one which occurs in a large percentage of the cases, is the refusal to eat. In some cases, especially in the earlier stages of the disease, it results from actual loss of appetite, the mere presence of food oftentimes being sufficient to cause nausea. Again, it is the legitimate outgrowth of delusions, arising in some cases from fear of poison, and others will say that they are "too wicked to eat," "it is not God's will," "I will be lost anyway," etc.

Others, again, refuse food through suicidal intent; they hope to starve themselves to death. But whatever may be the cause, owing to the already broken-down physical condition, it is attended with danger; and the effect is speedily seen in an increase of the mental symptoms, and in the furred tongue, foul breath, and sordes on teeth. It must be promptly met by the adoption of the ordinary means in every asylum, and in the failure of these, the use of the stomach pump or nasal tube must not be delayed.

Since so many of the cases upon which this report is based are still under treatment, I am unable to compile a satisfactory table showing the terminations of this form of insanity. The following table gives the terminations of the 57 cases:—

Recovered		25
Removed	Improved	6
	Unimproved	4
Remaining	Demented	3
	Termination uncertain	15
Died		4
	Total	57

From which statement we gather that the prognosis is favourable. Of those still, remaining under treatment, three are now demented; of the fifteen others, several afford fair prospects of a speedy recovery, while for some the outlook is dreary indeed.

Two of the deaths were evidently from exhaustion following continued depression and refusal of food. For quite a while before death in each case we were compelled to administer nourishment by means of the pump. The other two deaths were the choreic sisters before alluded to.

The following table shows the duration of the disease in those who recovered:—

Under two months	2 cases.
" four "	5 "
" six "	6 "
" eight "	4 "
" ten "	3 "
" one year	3 "
" two years	2 "
Total	25 "

From which it will be seen that about two-thirds of the cases recovered in less than eight months from the beginning of the attack.

Many of the milder cases can be safely treated out of an asylum, but change of scene and removal from the sympathy of friends, which too often only feeds the disease, will materially shorten the attack.

Light occupation, out-door exercise, and amusements, anything in fact that can call into action the defective will-power and raise the thoughts to a higher plane than self, will prove highly beneficial.

The friends must in all cases be warned of the danger of suicide, even when no such intention appears on the surface.

In many cases opium administered in large doses proves a very valuable agent, but a drawback to its use is the liability to the formation of the opium-habit—a liability stronger at this than at any other period of life. While the depression is most marked, or during the paroxysms of excitement, the following prescription is useful: ℞. Chloral hydrat., potassii bromidi, āā ʒij; spts. frumenti, syrupi simplicis, āā fʒj. M. Sig.: Tablespoonful in a wineglassful of water every four hours.

A glass of ale will often act like a charm in calming an excited patient.

Tonic medicines, however, constitute the chief therapeutical means. First among tonics we must urge the virtues of a good nutritious diet. In this, as in so many other nervous disorders, liberal allowances of food, taken at least four times a day, will be attended with immediate improvement. Long abstinence must be especially guarded against; a lunch before getting up in the morning, and again before retiring at night, is advisable. Under this feeding, the pain in stomach, foul breath, coated tongue, and constipation which may be pleaded for not eating, will often rapidly disappear. I have frequently seen great benefit result from the administration of small doses of quinia in combination with the pyrophosphate of iron and Horsford's acid phosphates.

Constipation is almost invariably present, and is a source of much annoyance to the patient, who frequently resorts to the most active cathartics. These often fail to move the bowels, and occasionally do much harm. The real seat of the torpidity is in the brain, not in the intestines; in fact, when purgatives have failed, a good dose or two of opium will often accomplish the object. As a rule, gentle laxatives and tonics will accomplish all that is necessary, and leave the intestinal tract in much better condition.