be a state prisoner, who must not be treated so hard ... (Gruner, 1789).

These strongly condensed translations only yield a dim impression of the original vivid and lengthy reports. They may perhaps cast some doubt on the issue that hallucinatory voices did not vex schizophrenics before 1800.

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SIR: I was intrigued to read some of the observations of Hare (*Journal*, October 1988, **153**, 521–531) about accounts of schizophrenia in the late 18th century. It is noteworthy that frequent, good descriptions of schizophrenia (and several other chronic mental illnesses) first appeared when there was a change in the selection of cases for publication, combined with improved methods of case description. This change probably explains the appearance of these descriptions.

The only description of cases of chronic madness from between 1750 and 1810 are those of Thomas Arnold (1782), who only quotes cases from classical authors, Perfect (1787), Haslam (1798, 1809) and Ferriar (1810). The other published case histories are all of people who recovered. They were published by private madhouse proprietors, who were not keen to publicise their failures. This 100% recovery rate shows that most of the published cases do not form a representative sample of the mental illness then prevalent, especially when compared with the cure rates contemporarily advertised of 30%.

Only about 25% of the large series of cases cited by Perfect (1787) were chronic. These chronic cases appear to have been published to illustrate points that Perfect wished to illustrate, such as the dangers of inexpert treatment with mercury, his skill with healing severe wounds, and the danger of trusting lunatics. Despite this, at least two cases he cites could be examples of schizophrenia (cases 8 and 36).

Chronic cases were first cited in quantity by Haslam and Ferriar, who both worked in charity asylums. The cases cited in Haslam's 1809 edition that are generally accepted to be probable cases of schizophrenia were copied from the 1798 edition (e.g. cases 16 and 23 in both editions), and some of these cases had been admitted 30 years earlier. Unfortunately, Haslam's series of cases must have been biased towards organic cases because it is a series of post-mortems. Ferriar's case descriptions were very brief, and therefore of limited use.

Interestingly, the classificatory systems of mental illness that were published during this period all have categories that would accommodate modern images of schizophrenia: Arnold (1782) in his description of *Ideal insanity*, which includes people who imagine they are conversing with imaginary people, but who are not delirious; Cullen (1810) in his group of *Manias* (and in his classification of *Paracusis imaginaria* – where the sounds are not existing without, but are excited by internal causes, and are distinguished from false hearing); and Darwin (1801) in his species *Mania mutabilis*.

Regarding Harper's claim that insanity was not common in young persons: it is noteworthy that this was part of his argument that insanity was not due to brain disease, but to nervous stimulation and the retention of secretions such as semen. This was a highly unusual view for the period. This compares with the fact that the cases described by Perfect, Ferriar, and Haslam were frequently young.

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Elementary, My Dear Freud

SIR: I rise to defend Rollin (*Journal*, August 1988, **153**, 241–242) against the unjust criticism of Johns (*Journal*, November 1988, **153**, 712), who uses a succession of specious arguments. Firstly, Dr Johns quotes and implicitly agrees with Holmes' remark that "It is a capital mistake to theorise before one has data". At a stroke, one of the lynchpins of the