Occasional Notes.

The Classification of Insane States in Revised Statistical Tables.

THE Statistical Table (No. IV) dealing with the classification of the forms of mental disorder is certainly by far the most important point of the revision.

This table will be taken to represent the highest and latest views of insanity held in this country, and it is intrinsically of the utmost value in affording the basis of a possible comparison of the forms of insanity, or the results of treatment, in different communities, or in the same community at different periods. The utmost consideration, therefore, should be given to insure the adoption of a table that shall be clear and stand the test of criticism and experience. The committee that has given such careful thought to it will welcome discussion on this point as a recognition of the importance and the difficulty of the task which they have so zealously attacked and so admirably overcome. This table, however, is worthy of the vigorous discussion that it has excited, since it may be described, without undue exaggeration, as the hub around which the others revolve.

Dr. Mercier, in the last number of this Journal, with convincing cogency, laid down the essential principles of a good classification, insisted on the necessity for its being easy of application to suit "all sorts and conditions of alienists," and demonstrated that the only possible classification at the present time must be based on "symptoms," qualified by the principle of subdivision by intensity of the symptoms.

Dr. Mercier, having pointed out the path that should be followed, straightway departs from it and constructs a table which would appear not to render it "easy" in practice for "any sort of alienist" to classify insanity.

Subacute insanity, for example, is divided into eight subclasses, termed neurasthenic, depressed, suspicious, obsessed, etc. Now, several of these symptomatic states may co-exist in

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the same case, and vary in their predominance from day to day. The sub-class in which a case would be placed would depend on the temporary condition of the patient, together with the bias of the alienist. There are eight sub-divisions given; and yet Dr. Mercier, like another Clive, must be astonished at his moderation; for there seems to be every reason that he should have added hysteric, hypochondriac, and many others, in the absence of which his table falls short of his chief principle of classification—of finding a place for every case.

Dr. Mercier apparently implies that the committee has erected melancholia, mania, etc., into "kinds" of insanity, or definite diseases. Now, the heading of the table distinctly describes these as "forms," and so accurate a philologist should recognise that "form" refers to contour and outward appearance as distinguished from structure, and so can only have a clinical observation significance and not a pathological one.

Diseases have long ceased to be regarded as due to special entities, and are universally recognised as ordinary physiological processes, whose excess or defect tends to abbreviate the individual vital cycle. Sutton has demonstrated that physiological processes that constitute disease in one class of animals may be advantageous and normal in another.

Normal mental phenomena are based on physiological changes in the brain, and in the above view of disease this must be true of the abnormal. Of the nature of these organic substrata ignorance practically prevails, and this should always be clearly stated in any statistics, to avoid misconceptions of expression such as that which Dr. Mercier has raised.

Until the exact site and nature of the organic changes accompanying specific abnormal mental phenomena are known, these symptoms obviously bear the nearest ascertainable relation to the pathologic condition, and cases thus symptomatically described would be distinctly recognisable whenever pathology comes to the aid of clinical observation.

Insanity, therefore, is a clinical term for the symptom, unsoundness of mind—a complex symptom of great variability; but its varieties admit of being grouped by the predominance of certain abnormal psychologic phenomena which must of necessity follow the grouping of normal psychology. This the Committee has practically done, although not quite

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systematically, and with this Dr Mercier agrees for his primary divisions.

The primary divisions, therefore, should be into emotional, intellectual, volitional, and general psychological disorder, with states of defect, acquired and developmental.

In subdividing these primary classes, the Committee has taken the basis of time (recent and chronic), but Dr. Mercier prefers that of intensity of disorder (acute and subacute), and it would appear that both principles require recognition, and may be combined so as to avoid difficulty and error in classification. Recent cases may be subacute or practically chronic, while acute, intense disorder may occur in chronic conditions—*e.g.* of imbecility, epilepsy, general paralysis, etc. The subdivisions, therefore, should be into "recent and acute" and "subacute or chronic."

The time element is as much a matter of clinical observation as the intensity of disorder, and requires expression also in those cases which pass from one state of insanity to another (circular). Similarly in idiocy, the time element in relation to development should be expressed in "congenital" and "acquired," as well as the intensity in "idiocy" and "imbecility."

Having thus classified all cases on a symptomatic basis, it would appear desirable to distinguish them into two primary classes:

(1) Those in which the pathological condition is unascertained.

(2) Those in which there is an associated pathological condition, or definitely related pathological condition.

The second division would, of course, be extended with the progress of pathological knowledge. The table I would suggest would take the following form, several groups coming under each of the three sub-divisions of the second class.

Under the subdivision of ascertained pathological relation to brain would come such groups as arrested development, microcephaly, general paralysis, etc.; in the second group, epilepsy, etc.; and in general bodily disease (somatic group), myxœdema, etc.

It might be desirable to adopt Dr. Mercier's suggestion of a separate set of headings for idiocy.

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TABLE IV.

States of Mental Unsoundness.

	Pathological association unascertained.			With ascertained pathological relation								
				To brain.			To nervous system.			To bodily disease.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
I. Emotional states												
1. Of depression												
a. Acute and recent												
b. Subacute or chronic												
2. Of exaltation												
a. Acute and recent												
b. Subacute or chronic												
II. Intellectual												
1. Obsessional												
2. Delusional												
III. Volitional												
1. Disordered control (moral, etc.)												
2. Anergia (stupor)												
a. Simple												
b. Resistive												
c. Exalted												
d. Depressed												
IV. General												
1. Circular												
2. Confusional												
3. Dementia												
a. Primary												
b. Secondary												
4. Idiocy												
1. Acquired												
a. Imbecility												
b. Idiocy												
2. Congenital												
a. Imbecility												
b. Idiocy												

I have to apologise to the Statistical Committee for making suggestions which I ought to have submitted earlier. I think it right to express my dissent from the sub-divisions proposed by Dr. Mercier, which would not, I consider, give a basis that would accord with future pathological discoveries, and would render the task of classification very difficult. Indeed, in face of his table I fear that any sort of alienist would be in the condition of a man finding his way through a maze ending in a morass.

HENRY RAYNER.

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