directed to Professor's Kraepelin's system of classification of mental diseases made Dr. McConaghey's paper of special interest at present. With regard to this classification, its success must be judged by the degree of ease with which one is able to place each individual case in its appropriate division. Speaking for himself he could not say that he had been as successful as he could have wished, many cases being referable to several divisions or exceptionally to more. One other weak point in Kraepelin's system is that he makes the termination of the disease of great importance in the classification. This may be scientifically correct, but one can seldom wait till this stage is reached before making a diagnosis or giving a prognosis. With respect to the special subject dealt with in this paper, he quite agreed with Dr. Clouston in deprecating the use of the term "dementia" to cases a very considerable number of which ultimately recover. This is by no means in accordance with the already deeply grounded definition of the term which is prevalent in this country.

Dr. McCONAGHEY replied.

Statistics in Insanity: a Universal Scheme.

By C. C. EASTERBROOK, M.A., M.D., F.R.C.P.Ed., Medical Superintendent, Ayr District Asylum, Ayr.

THE following paper is an attempt to deal with statistics in insanity according to a scheme which observes the fundamental canon of statistical accuracy, which interprets the true spirit of lunacy legislation, and which serves the essential purpose of medical utility. I may divide the paper into three parts:

I. The Methodology of the statistics of Insanity in Asylums and similar Institutions.

II. The Statistical Data of Insanity, and their Embodiment in a Medical Register of Insane Persons for Private or Institutional Use.

III. The Construction of Medical Tables for the Annual Statistics of Insanity in Asylums.

PART I.

The Methodology of the Statistics of Insanity in Asylums and similar Institutions.

The psychiatrist, whether he be in private or in asylum practice, who keeps notes of his cases for purposes of study and treatment, regards his patients from the medical point of view in the same way as other physicians do. Should he desire to publish his statistics of, say, a particular variety of mental disease, he is careful to include all the cases which he has kept

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record of, and to include no patient more than once, and he is unconcerned in this connection as to whether his patients be voluntary, certified, transfers, or the like. Should he desire to publish his experience with, say, a special kind of treatment, he similarly will take care to include all the patients who have had the treatment, and if the same patient has had several trials of the treatment he will mention the fact, and not count each trial as a separate case or person treated. In short, to the psychiatrist publishing his own statistics "cases" mean "individuals" or "persons," and he is not fettered with technicalities of lunacy administration nor with the snares of annual statistics.

The asylum physician, however, who is publishing the annual statistics of an institution, must take cognizance of such technical considerations. I do not wish to dwell unduly on the difficulties which are introduced into asylum statistics by the legal considerations of psychiatry and by the differences in lunacy administration and statutory terminology in England, Scotland, and Ireland—difficulties which are apt to greatly complicate the construction of a uniform scheme of statistics for the asylums of the three countries, and similarly of other countries. The difficulties, however, exist, and unless they are remedied, statistical confusion will ensue and misrepresentation of truth go on as before, and the more so if the central lunacy authorities of the three countries summarise the statistics of the asylums and similar institutions under their respective jurisdictions, and take to comparing notes with one another, and perhaps with the lunacy authorities of other countries who publish medical statistics. In the construction of a uniform scheme for the annual statistics of asylums there are, I think, three main difficulties:

First, there is the difficulty of the "voluntary boarder" as distinguished from the "certified patient." The voluntary boarder is an inhabitant of our asylums—English, Scottish, and Irish; he is not certified, and so is not technically "insane"; he must therefore be excluded from "insanity" statistics (though not necessarily from private psychiatry statistics); how then is the "voluntary" to be dealt with statistically in asylums? This raises the further question, Is it desirable to record the statistics of voluntary boarders in the tables at all? For statistical accuracy the voluntary boarders must be excluded from the tables which have to deal with certified

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patients and the statistics of insanity; and when thus considered apart, they are so relatively few in number in even the largest institutions which receive them, that one is practically, from motives of delicacy, restricted to a mere numerical statement of their movements during the year; and the question thus resolves itself into this: Should this numerical statement be introduced as a parallel insertion into the similar tables showing the movement of the certified patients, or should it be kept separate and distinct, and known as the "voluntary" table? As in the meantime, at any rate, the great majority of asylums in this country do not receive voluntary boarders and so could not fill this statement, I think the latter course preferable, and so would make the voluntary table separate, and put it amongst what may be called a local or optional group of tables, which would follow the other recognised groups of tables, and would place it last of all, inasmuch as every other table has to do with certified patients. The Statistical Committee of the Association, whose Report on the proposed new tables was presented last July and is still being discussed and criticised by the various Divisions, possibly anticipating in the near future the more general presence of voluntary boarders in asylums, have adopted the other procedure, having made provision for this numerical statement of the voluntaries in General Table I, and in the titles of the other tables they have deemed it advisable to add "Voluntary boarders excluded," a precaution which will hardly be necessary if the valuable suggestion be carried out as to the adoption of a Medical Register for the certified patients, from which all the data for the medical tables will be obtained.

Secondly, there is the difficulty of "cases" as distinguished from "persons" in annual statistics. This difficulty obviously does not arise in connection with the statistics either of the "deaths" or of those resident on December 31st. It arises only in connection with the admissions and the discharges of the year under report (the current year, so-called). It is obvious from what has been said before that for purposes of accuracy in annual medical statistics we must reduce "cases admitted" and "cases discharged" in any given year to terms of "persons admitted" and "persons discharged." For statistical purposes we must deal with "persons admitted" as at the time of their first admission during the current year, and with "persons

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discharged" as at the time of their last discharge during the current year; consequently, to reduce such cases to terms of persons we have merely to deduct from the "total cases admitted" the "re-admissions of the current year," and from the "total cases discharged" what may be conveniently termed the "pre-discharges of the current year." The latter naturally are less numerous than the former; and not uncommonly, indeed, a person may be admitted not only twice in the current year, but thrice; and so to cover such cases it is useful to employ the term "re-readmissions of the current year." The various reasons for "re-admission during the current year" comprise the following: onset of another attack, relapse during same attack, expiry of interim order, expiry of emergency certificate, and irregularity of admission papers. In this connection I think that the term "re-certification" should be avoided, because (1) "re-admissions of current year" is a phrase applicable to voluntary boarders as well as to certified patients, and so can be similarly used for reducing cases to terms of persons in the "voluntary" table; (2) all "re-admissions of the current year" into asylums are, of course, re-certifications in the case of certified patients; and (3) the term "re-certification" already has a very precise meaning quite apart from the admission or re-admission of patients in the ordinary sense; *e.g.*, the annual re-certification of chronic insane patients in Scottish asylums. By reducing cases to terms of persons admitted or discharged in any given year, not only is one common source of error avoided in the medical statistics of asylums, but it is evident that the Central Lunacy Authority also is enabled to avoid the same error, provided that the said Authority is supplied with a copy of an annual Medical Register of the insane persons admitted, and takes care to eliminate those persons who, after being admitted into one asylum in an earlier part of the year, are transferred, or admitted after discharge (that is, in the eyes of the Central Authority, "re-admitted") into another asylum later on.

Thirdly, there is an important difficulty due to the *want of a proper differentiation, for the purposes of the medical statistics of insanity, of the persons admitted into asylums, or of the persons discharged from asylums*, and the logical outcome of this *essentially medical differentiation of persons raises the further difficulty of* instituting *a true comparison*, upon an equivalent basis, *of the persons* concerned, whether they be *in England, in Scotland, or in*

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Ireland, and therefore subject to varying legal and statutory conceptions of insane persons owing to differences of lunacy law and lunacy administration in the three countries. For purposes of medical statistics, the persons admitted into asylums and the persons discharged from asylums must be fundamentally differentiated into two natural classes, which we may meantime call Direct and Indirect. Taking first the persons discharged, we recognise that they are either recovered or unrecovered. The *recovered* are persons who leave the asylum as sane and free agents, and *directly* rejoin the sane and free community. The *unrecovered* leave the asylum as insane persons, and therefore continue to live under certificate so long as they remain unrecovered. The persons admitted into an asylum are either *direct admissions (or admissions proper)—that* is, *persons coming directly from the community who have not been previously certified as insane during the existing attack;* or *indirect admissions—that is, persons who have previously been certified during the existing attack, and who therefore were already insane unrecovered persons, medically and legally, before their admission to the asylum was contemplated*, and whose removal to the asylum in all cases requires further medical certification and legal sanction by judicial or lunacy authorities. It is obvious that for the purposes of medical statistics bearing on the freshly occurring and recurring insanity of the community and of the country at large, only the direct admissions must be considered. They alone will give true information as to what may be called the birth and re-birth, or the production and reproduction, of insanity in the communities served by asylums, and so in the country generally, and to include amongst them the statistics of the indirect admissions is only to introduce falsification and error in the information about insanity. It is medically important to recognise amongst the direct admissions the "first attack" cases, and so for statistical accuracy we would need to differentiate persons directly admitted into (1) persons with first attack; (2) persons with one or more previous attacks; and (3) persons in whom it is unknown whether the attack is the first or not. Similarly, in regard to the recoveries, it is necessary for statistical accuracy, in calculating the *recovery rate*, from the direct admissions (as is the usual way) to differentiate the recoveries of direct admissions and the recoveries of indirect admissions,

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and by deducting the latter from the former to arrive at the *net recoveries*, and by taking the percentage of net recoveries on direct admissions we estimate the true recovery rate. The unrecovered, from the point of view of treatment, are distinguished into (1) *improved* (which, I think, is a preferable term to the statutory "relieved," inasmuch as the latter has a distinct significance in Poor-Law administration, meaning "relief" or aid from the rates, and has, to my knowledge, given rise to confusion between asylum and parochial authorities); and (2) *unimproved*, which, being a single adjective, is preferable to the statutory terms "not improved."

And now let us consider for a moment the further differentiation of the indirect or unrecovered admissions, and of the indirect or unrecovered discharges, from the point of view of their movement (immediate source or destination) as regards the asylum concerned, and still regarding them in the broad medical sense as "insane persons" and not as administrative units in the strict statutory sense of England or of Scotland or of Ireland. And here it is necessary to emphasise that the terms of this scheme of classification of the unrecovered persons admitted and discharged are to be interpreted in a medical sense, and that the statistical tables of the association are not statutory, but are essentially medical tables, constructed on the principle of ascertaining the medical truth about the insanity, not only in any one asylum, but in all asylums, and not only in any one of the three countries, but in all three, and possibly in other countries who adopt or imitate our tables, and without at the same time violating the spirit of the law and statutes in any country. The following definitions of the necessary terms are therefore to be interpreted in a medical sense.

Institutions or establishments for the insane include: asylums, registered hospitals, licensed houses, idiot and imbecile institutions, lunatic workhouses, or lunatic poor-houses, or lunatic departments of the same, lunatic State prisons or lunatic departments of the same, lunatic departments of State military and naval hospitals, and we may add colonies for insane epileptics and other lunatics.

In short, "establishments" in the medical sense are for the institutional care and treatment of the insane, with a recognised medical and nursing staff in attendance.

Dwellings for the insane include unlicensed houses for single

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certified patients, and in Scotland "specially licensed houses" for two, three, or four insane patients, and in England or Ireland any similar provision which may arise in view of recent or future legislation, which will enable a similar small number of lunatics to be gathered together under one roof for the enjoyment of "home care" as distinguished from institutional care and treatment, which many of them already have experienced, while many others of them have not previously been in establishments. It is, perhaps, hardly necessary to add that an "insane person" may stay in his own residence, being looked after by his relatives who make no "profit" out of the transaction.

With the above medical distinctions of establishments and dwellings, it is now possible to differentiate, in the medical sense, the indirect, or unrecovered, or previously certified insane, admissions and discharges of asylums in equivalent terms for the three countries.

A transfer is an insane person who passes from one establishment to another in the same country.

A transference is an insane person who passes from an establishment in one country to an establishment in another country.

A home care is an insane person who either passes from (discharge) an establishment to the community (either to his own home or to a "dwelling") or who passes from the community (admission) to an establishment.

It will be seen at once that this scheme is of universal application. In the medical sense a lunatic sent from an asylum in England to one in Scotland gives no information about the insanity in Scotland, and so, *in the medical sense*, is an indirect admission—"a transference"—and not a direct admission in the medical sense in Scotland, though he may have been so in England, and though he joins for the first time the General Register of the Central Lunacy Authority in Scotland. I think that the adoption of such a term as "transference" for all such cases would facilitate statistical accuracy and medical utility. Similarly, from direct admissions must also be excluded certified patients already existing as such in the lunatic departments of poor-houses, prisons, idiot and imbecile institutions, and the like, and also what I have termed the home cares (including "boarded out" patients in Scotland, and "single care" patients in England), if accuracy in a medical sense is to be secured for the medical tables.

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To sum up, in the annual statistics of insanity in asylums, which are the main source of medical information as to the growth of insanity in the country, and as to the facts of the insanity in the individuals concerned in this growth, and as to the results of the treatment of insanity in asylums, it is necessary in the interests of statistical and medical accuracy to (1) exclude voluntary boarders; (2) to reduce cases admitted and cases discharged to terms of persons admitted and persons discharged, by eliminating the re-admissions and pre-discharges of the current year; and (3) to differentiate medically the persons admitted into direct admissions and into indirect admissions (including home cares, transfers, and transferences), and the persons discharged into recovered and into unrecovered (including home cares, transfers, and transferences), the direct admissions being the only true source of information of the growth of insanity in individuals and in the community, while the results of treatment are expressed by the statistics of the annual discharges and deaths and of the residues at the end of the year.

It follows, therefore, that for purposes of statistical accuracy the groups of persons to be dealt with in the annual medical statistics of an asylum comprise the following:

(1) Persons admitted: (1) direct; (2) indirect.

(2) Persons discharged: (1) direct (recovered); (2) indirect (unrecovered).

(3) Persons dead.

(4) Persons remaining on the Register on December 31st who are not in any of the preceding groups; that is, therefore, total persons on the Register on December 31st *minus* the admissions of the current year who are still on the register (and who are, therefore, included in the first group), leaving what may be conveniently termed the residue persons, or simply persons remaining.

PART II.

The Statistical Data of Insanity and their Embodiment in a Medical Register of Insane Persons.

Since entering the specialty of psychiatry, it has been my practice to keep, for purposes of private study, records of all the patients who came under my care in asylum work. This is

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done by means of a Medical Register of persons, each patient appearing only once in the Register, but provision is made in the last column of the Register—that for "remarks and further history"—for continuing the record of each patient according as he or she comes under observation again in future years. The Register consists of a series of vertical columns, in which provision is made for recording all the statistical data of medical or allied nature likely to be met with in one's cases. In actually recording the data themselves in the various cases, I endeavour, so far as lies within my power by means of personal observation, inquiry, and judgment, to insure that the data so recorded have the validity of facts, and so may be relied upon as a basis for the study and treatment of the insanities. I find it convenient to keep separate registers for the two sexes. In cases of particular interest I keep special reports filled in on private case-taking schedules, and containing full notes with charts, photographs, patients' literary effusions and the like. Anyone who has had to compile the statistics for the annual tables will know that such medical registers are an invaluable help. As the Statistical Committee of the Association mention in their Report, the English Commissioners already employ such a register (Annual Register) in the case of the direct admissions, and the suggestion of the committee to employ an annual medical register of admissions will be found most useful in compiling the tables. Such an annual register, from what has been said before, must be essentially a register of persons admitted, and as it is advisable to use separate registers for the two sexes, it will be found useful to enter in each register the direct admissions in black ink and the indirect admissions in red ink. In compiling the medical tables of the last two annual Reports (33rd and 34th) of Ayr Asylum, I have used my own form of medical register, and as this makes provision for practically the whole field of the statistical data of the insanities, I propose to enumerate the thirty heads of the thirty columns of this register *seriatim* below, on the left side of the page; and on the right side is the key to each head, giving a guide to the nature of the entries made in the register itself.

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Medical Register for the Statistical Data of Insanity.

(*N.B.*—Separate Registers for the two Sexes.)

Heads of Columns.	*Key to each Head.*
1. Number of person admitted (No.)	
2. Direct or indirect admission (D. or I.)	
3. Whence admitted . . .	Home, "dwelling," asylum (name), or other establishment (specify), ordinary hospital, or prison, or poor-house, etc.
4. Name of patient . .	
5. Date of admission . .	
6. Chargeability (social status).	Private, pauper (specify parish), criminal, etc.
7. Family tendencies and members affected, hereditary potentialities	Insanity (father), phthisis (mother and brother), alcoholism (father), cancer (grandfather), etc.
8. Age	
9. Conjugal state . .	Single, married, widowed, (separated or divorced), unknown.
10. Nationality . . .	English, Scottish, Irish, Welsh, Mixed British, Colonial, U.S.A., foreign (specify), unknown.
11. Religion . . .	Episcopalian, Presbyterian, Roman Catholic, Nonconformist and others (specify), unknown.
12. Education . . .	Unable to read or write; reads only; moderate, *e.g.*, primary; well educated, *e.g.*, secondary; highly educated, *e.g.*, technical or professional; unknown.
13. Occupation, vocation .	Clergyman, butcher, shoemaker, farmer, wife of banker, schoolboy, etc.
Occupation, class (Registrar-General's classification)	Professional, commercial, industrial, agricultural (and fishing), domestic, unoccupied, unknown.
14. Habits, as to work, food, drink, tobacco, sexuality, etc.	Hard-working, lazy, gluttonous, intemperate (specify form of alcohol), dissolute, etc.
15. Temperament . .	Optimistic, pessimistic, moody, reserved, solitary, irritable, excitable, phlegmatic, etc.
16. Mental and nervous diathesis, with ages at onset of any neuroses	Congenitally deficient, eccentric, neurotic, degenerate, hysteria at 20, epilepsy at 13, etc.
17. Previous mental attacks, with form and ages at onset of each.	Mania at 23, melancholia at 45, etc.
18. Bodily diathesis and previous bodily illnesses, with ages	Spare, obese, gouty, rheumatic, diabetic, cancer, sarcoma, tubercle, syphilis at 26, malaria, etc.
Present Attack or Illness.	
19. Proximate etiological factors, or apparent "causes"	Alcohol, worry, child-birth, etc.
20. Duration on admission of attack, period	A week, 2 months, 3 years, etc.
Duration on admission of attack, class	Recent or acute (under 6 months), sub-recent or sub-acute (6 months to 2 years), persistent or chronic (over 2 years).
21. Suicidal tendency before admission	Threats or attempts (specify form of attempt).

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Medical Register for the Statistical Data of Insanity—continued.

Present Attack or Illness.	*Key to each Head.*
22. Homicidal tendency before admission	Threats or attempts (specify form of attempt).
23. Diagnosis, symptomatological: form	Depression; exaltation; excitement; hallucination and delusion; delirium, confusion and stupor; passivity and resistiveness; obsession; inhibition; moral imbecility and perversion; and enfeeblement (idiocy, imbecility, facility, and dementia).
Diagnosis, symptomatological: degree	Mild or simple, moderate, severe or intense.
Diagnosis, nosological: variety	General paralysis, puerperal insanity, etc.
24. Bodily condition: physique .	Deformities, stigmata (specify).
Bodily condition: diseases .	Of skin, bones, joints, muscles, glands, blood, and of nervous, circulatory, respiratory, alimentary, and urino-generative systems.
Bodily condition: general health: degree	Fair, poor, or weak.
25. Prognosis on admission .	Good, doubtful, bad.
26. Progress during residence .	Chief changes, mental and bodily.
27. Treatment during residence .	General, or special (specify).
28. Termination (with date) .	Recovered, improved, unimproved, died.
29. *Post mortem* . . .	Cause of death and other *post-mortem* findings.
30. Remarks and further history	Whither sent, re-admitted on (date), with (specify disease, etc.).

Such a register is, of course, very comprehensive, but it is intended to provide for the recording of all data which may be required in connection with the private study of one's cases. It will be useful to make a few general remarks about some of the data before indicating our selections for the tables dealing with the admissions. *Sex*, of course, is a necessary datum in all medical tables. *Age* is a factor which appears in several tables, and in all of these which have to deal with the statistics of insanity I think that we should indicate the broad mental life-periods of development (under 30 years), maturity (30 to 60 years), and decadence (over 60 years), and divide them merely into decades (under 10 years, 10 to 19, 20 to 29, etc.), and not into quinquennia, which are unnecessarily small and just reduplicate work without much gain. It should be noticed in passing that the mental life-periods are not co-terminous with the reproductive life-periods. *Conjugal* is the phrase of the census Blue-books, and so is probably preferable to "marital state," and still more to "civil state." *Nationality* may become an interesting factor in connection with questions of alien immigration, and insanity as a genetic variation, but its true significance in relationship to insanity, like that of *religion*,

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with which it could be instructively correlated in a table, and, in fact, like the true significance of conjugal state, age, and sex also, all of these being biological and sociological rather than etiological factors proper, could probably be intelligently gauged only in terms of a census of the population on these points, and this, of course, would be possible only once in every ten years; so for statistical purposes in relationship to insanity the annual inclusion of some of these data is of questionable value.

Duration of mental illness.—This also is a factor which appears in several tables, and here, too, while recognising appropriate smaller periods in each class, I think that, as in disease generally, we should indicate a broad division into three classes according as the attack of insanity is recent or acute (under six months), sub-recent or sub-acute (six months to two years), and persistent or chronic (over two years). The taking of one year as the limit of the term "recent," and the recognition simply of "chronic" in contradistinction to it, to the exclusion altogether of sub-acute, is, I think, inadvisable; for one year is both too long a period in which to regard a case as recent or acute and too short to regard it as chronic. In this connection I would desire to draw attention to the very prevalent misuse of the terms "acute," "sub-acute," and "chronic" in the literature and daily parlance of psychiatry, these terms being employed in psychiatry to express the degree of "intensity" instead of the length of "duration" of the disease, this use—or rather abuse—of terminology being entirely at variance with the usage in general medicine. Disease, generally speaking, may be said to be due to the action of an "irritant," in the wide sense, upon an individual. Each of us may be said to be (1) what our parents and ancestry have made of us (our inherited organisms, qualities, and potentialities); (2) what environment has made of us (especially in our tender years, when we could not help ourselves); and (3) what we make of ourselves; and with knowledge we may outgrow adverse hereditary potentialities, and the results of adverse environment we may neutralise more or less; for, as a wise physician hath said, "Nature forgives, but never forgets." And so at any given time in life the strength or resistive power of the individual is the sum of these three factors, and the action of the "irritant" on him depends upon its strength and length of application, and accordingly the disease which may or may

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not result, is said to be, as regards the virulence of the process, mild or simple, moderate, severe or intense, and as regards the duration of the process, acute, subacute, chronic. What is more common in psychiatry than to hear "acute mania" spoken of or described in the books where "severe mania" is meant? And who has not heard a chronic maniac during one of his attacks, described as being "acutely maniacal"? How a person can be described as being at one and the same time both acutely and chronically ill is difficult of comprehension in the ordinary medical meanings of these terms. The misuse is most common in the case of the terms "acute" and "sub-acute," these being employed to describe the degree of severity of the symptoms and disease present, instead of the proper terms for this purpose "severe or intense" (instead of "acute") and "moderate" (instead of "sub-acute"). I have formerly drawn attention to this matter in the pages of the Journal, but psychiatrists have so got into the habit of misusing the terms "acute," "sub-acute," and "chronic," that it would almost seem advisable to suggest that these terms should meantime be given a rest in psychiatry, and that such terms as "recent," "sub-recent," and "persistent" be employed instead to express degrees of duration of mental disease.

I thought that it might not be uninteresting in connection with this matter of terminology to take the opinion of three eminent men in the medical world, who are generally recognised as being careful in their use of terms and at the same time worthy of imitation in their literary styles. My selections were Sir William Gowers, Professor Clifford Allbutt, and Professor Osler.(1) Sir William Gowers writes: "I entirely agree with you. . . . I should myself speak of acute mania passing into chronic insanity with reference only to duration." Professor Clifford Allbutt writes: "I do not think there can be a moment's hesitation in answering your question concerning the meaning of 'acute' and 'chronic' in medicine. Acute means, say in Hippocrates, etc., a quick or hasty disease. . . . Scarlet fever, however mild, would be an acute malady. . . . All the best medical writers have always used 'acute' in the above sense."

Surely with such testimony it is desirable to keep the terminology of psychiatry in harmony with that of medicine in

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general. Another point in connection with the duration of an attack of mental illness, for which treatment in an asylum becomes necessary, is the important question, When is the attack to date from? From the time of onset of the mental symptoms or from the time of the "insanity" proper—that is, the date of certification? Here we would seem to be on the horns of a dilemma, for we are dealing with the statistics of "insanity," and yet the illness must have been going on for some time before the actual date of certification. The midway stage of "certifiability" is altogether too vague and indefinite to be of any assistance. Now, when it was decided that the statistics of the tables were to mean the statistics of "insanity," this decision was made for the purpose of, in the first place, defining the group of persons to whom the statistics should refer; but once that this is done, we must obviously regard our patients in the medical aspect for purposes of medical statistics, and so make the duration of the disease date from the time of onset of the earliest morbid mental symptoms. To do otherwise would simply mean that there was no such thing as the duration of insanity on admission—an impossible view; and again, for purposes of diagnosis and especially of prognosis, the duration of the illness before admission is an essential datum in forming an opinion. If the patient is congenitally deficient, or has a neuropathic diathesis, and becomes the subject of a distinct attack of insanity, as such are especially prone to do, these facts are recorded, and the attack is dated from the time of onset of the unusual mental symptoms.

What, then, are the statistical data which it would seem most useful to select for the tables dealing with the *direct admissions*, from which we derive our reliable information as to the new insanity of individuals, and of the community and country generally? Sex, age, and conjugal state (? nationality and ? religion); education and occupation; hereditary potentialities; occurrence of previous attacks, with age at first attack; duration of illness on admission; etiological factors, including all pathological conditions, bodily and mental, crises and other events which are associated with the attack, apparently in the relationship of cause to effects; suicidal and homicidal tendencies before admission; mental state on examination; bodily state on examination; diagnosis and prognosis.

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In the case of the *indirect admissions* is it necessary to record the same or any of these data, keeping them, of course, distinct from the corresponding data of the direct admissions?

The indirect admissions will give no information as to the new insanity of the community. The transferences, the transfers, and the great majority of home cares have already been direct admissions in some other institution, and so have already yielded the information required of them as such, at the time when it was of statistical value to the physician and to the country. The only new points about them are: (1) an increase in age and a corresponding lengthening in the duration of their attack; (2) a possible alteration in bodily health; (3) a possible alteration in the mental diagnosis, and in the great majority a probably increased mental reduction; and (4) consequently a probable alteration for the worse in the prognosis. These points (age, duration, diagnosis, etc.) can easily be recorded as parallel insertions in the corresponding tables for the direct admissions. The chief reason, however, for recording the statistics of the indirect admissions is not so much a medical as an administrative one. It is to meet the case where a large number of transfers are sent to an asylum, say in its year of opening, or perhaps in some subsequent year. They may thus dominate the character of the total admissions, but they are clearly differentiated from the direct admissions for statistical purposes, and, of course, if numerous, they will materially affect the character and prognosis of the resident population. As to the *discharges*, the chief points in connection with the *recoveries* which it is useful to know are: the diagnosis of the insanity from which they have recovered; the duration of attack on admission, length of residence (and the length of residence for statistical purposes must be held to include absence on pass or probation), total duration of the attack, and the age on recovery. It is doubtful whether much information of medical value can be learned from the *unrecovered*, so many of them being removed simply for administrative reasons, but the diagnosis may, if desirable, be recorded by means of a parallel column in the corresponding table for the recoveries. It will be seen that the medical points in connection with the discharges are comparatively few in number, and they could easily be provided for in the register of discharges, which would thus become a medical as well as a civil register.

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As to the *deaths*. The chief statistical points of interest are the age at death, the cause of death (and whether ascertained by *post-mortem* examination or not), and the duration of the attack, showing the period before admission and the period after admission (length of residence). It is doubtful whether it is of any value to show the diagnosis of the previous mental state in those who died; mental states don't kill, but insanities do; for example, general paralysis, paralytic insanity, epileptic insanity, and many cases in which the death is attributed to exhaustion, but is more probably due to a toxæmia resulting from some morbid bodily condition, *e.g.*, catarrh of the stomach and intestines. If there were a proper nosological classification of the insanities, there would be some show of reason for correlating the mental disease—which is a bodily disease with mental symptoms—with the fatal bodily disease. It will be seen that the medical data in connection with the annual statistics of the deaths are few in number and could without difficulty be incorporated into the civil register of deaths.

As to the *residues*. As these include all persons on the asylum register at the end of the statistical year, except those admitted during the year reported upon, it is obvious that they comprise the main bulk of the population in most of our asylums, and represent mainly unrecoverable patients, though a few of them do ultimately recover, and many of them improve sufficiently to rejoin the community later on, where they live under the care and supervision of relatives, friends, or others. The chief points about the residues for statistical purposes are the age, total duration of the insanity up to date, diagnosis, and prognosis as to recovery and improvement.

Part III.

The Construction of Medical Tables for the Annual Statistics of Insanity in Asylums.

The most instructive method of dealing with the medical statistics of insanity would be that which is adopted by the psychiatrist who publishes the results of his observations on the study and treatment of any special variety of insanity. He is dealing with the statistics of persons whose mental disease has come under his observation and has been treated to a finish, ending in recovery, improvement, non-improvement, or

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death. He takes, say, a definite variety of insanity, such as general paralysis, epileptic insanity, alcoholic insanity, and so on, and in connection with each would deal with as many points as he has kept a record of in his Medical Register of patients observed, showing, for example, in the case of each variety of insanity, and expressing in percentages, where possible, the following statistics:

(1) The persons with hereditary potentialities towards insanity, phthisis, alcoholism, or any of the other so-called hereditary affections.

(2) The persons exhibiting original mental deficiency, or an insane or neurotic diathesis, and those with a previous attack or attacks of insanity (with average age at onset of first attacks).

(3) The previous bodily illnesses, with average age at onset of each (*e.g.*, epilepsy, hysteria, tubercle, alcoholism, syphilis, etc.).

(4) Average age at onset of present illness.

(5) Conjugal state.

(6) Occupation groups.

(7) Duration on admission.

(8) Apparent causal factors.

(9) Symptomatological forms of the disease.

(10) Bodily conditions present.

(11) Termination in recovery, improvement, non-improvement, or death. If there were a true nosological classification of the insanities, this would also be the most instructive way of dealing with insanity statistics in asylums, but of course the method would be applicable in the annual statistics only to those patients who had been treated to a finish during the year reported upon, and probably not to all of them, those patients being excluded who had left the asylum before a final issue as to recovery or non-recovery had declared itself. The psychiatrist's method of dealing with insanity statistics would thus cover only a limited number of persons dealt with in the annual statistics of asylums; and while it might be well worthy of consideration to include such a table for a specified list of the insanities agreed upon by all as distinct nosological entities (this is almost too Utopian a suggestion for practical politics amongst alienists at present, but I think the time will come), the asylum physician has to deal statistically with all his patients, and consequently I now propose to submit a series of tables suitable for asylum statistics, and carrying out the ideas sug-

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gested in the preceding parts of this paper. These tables (except the first) are not printed in tabular form, in order to avoid encroaching unduly on the valuable space of the Journal. This, of course, will not make the tables so clear as a pictorial representation would do; but given the essential headings, my readers will be able to imagine the rest.

TABLE I. GENERAL.—*Showing the Statistical Analysis of the Movements of Population and Results of Treatment in the Asylum during the Year* 19 .

(*N.B.*—Only certified patients referred to in the tables. For voluntary boarders, see last table.)

	Male	Female	Total
On January 1st, 19 —			
Total persons on asylum register, of whom there were—			
Persons resident in asylum			
Persons absent on pass or probation . .			
Total cases admitted during year—			
Minus re-admissions of current year, owing to—			
1. Onset of another attack			
2. Relapse during existing attack . . .			
3. Expiry of interim order			
4. Expiry of emergency certificate . . .			
5. Irregularity of admission papers . .			
And *minus* re-re-admissions of current year, owing to (specify reasons)			
Thus leaving *total persons admitted* during year, *viz.*—			
1. Transferences (specify countries and establishments) .			
2. Transfers (specify establishments)			
3. Home cares			
Total indirect admissions			
4. *Direct admissions*, of whom there were—			
1. Persons in whom unknown whether first attack or not .			
2. Persons who had had one or more previous attacks .			
3. Persons with first attack			
Total cases under treatment during year			
Persons under treatment during year			
Total cases discharged during year—			
Minus pre-discharges of current year, owing to (specify reasons)			
Thus leaving *total persons discharged* during year, *viz.*—			
1. Transferences (specify countries and establishments) .			
2. Transfers (specify establishments)			
3. Home cares			
Total indirect or unrecovered discharges . . .			
Of whom there were *improved* . . .			
And *unimproved*			
4. *Direct discharges or recoveries*, of whom there were—			
1. Recoveries of direct admissions, *minus* . .			
2. Recoveries of indirect admissions . .			
Thus leaving *net recoveries*			
Deaths during year			

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TABLE I. GENERAL—*continued.*

	Male	Female	Total
Total cases discharged and died during year			
Persons discharged and died during year			
On December 31st, 19 —			
Total persons on asylum register, of whom there were—			
Persons resident in asylum			
Persons absent on pass or probation			
Average daily number on register during year			
Average daily number resident during year			
Recovery rate during year (percentage of net recoveries on direct admissions)			
Death rate during year (percentage of deaths on average daily number on register)			
Residue persons resident on December 31st, 19			

Comments.—If there are both rate-paid and private patients in the asylum, separate columns and a total column can be easily substituted for the three columns shown for males, females, and total. Definitions of the terms transferences, transfers, home cares, indirect admissions, indirect discharges, direct admissions, and residues have been given in Part I of this paper, and would be appended as footnotes to this table. The advantage of placing such a table first is that it defines precisely the terms employed to demarcate the groups of persons to whom the statistics apply in all the subsequent tables. The death rate is calculated on the average daily number on the Register, because, even though a person be on probation (say) and die, the death is included among the asylum deaths for the year. The average daily number resident during the year is added merely for convenience of financial considerations, in order to calculate annual rate of maintenance, absence on pass or probation being allowed for in making out the asylum accounts.

TABLE II. *General.*—Showing a general survey of the movements of population and results of treatment in the asylum for each year since its opening in .

The heads and sub-heads of this table are, of course, arranged horizontally, and from left to right read as follows:

(1) Year.

(2) Persons on Asylum Register on January 1st of each Year (M., F., T.).

(3) Admissions { Total Cases (M., F., T.). / Direct (Persons) (M., F., T.). / Indirect (Persons) (M., F., T.).

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(4) Total Persons under Treatment (M., F., T.).

(5) Discharges { Total Cases (M., F., T.). Recovered (Persons) (M., F., T.). Improved (Persons) (M., F., T.). Unimproved (Persons) (M., F., T.).

(6) Deaths (M., F., T.).

(7) Average Daily Number on Asylum Register (M., F., T.).

(8) Recovery Rate (Percentage of Net Recoveries on Direct Admissions) (M., F., T.).

(9) Death Rate (Percentage on Average Daily Number on Register (M., F., T.).

(10) Numbers of each Year's Persons admitted remaining on Register on December 31st, 19 (M., F., T.).

(11) Year.

Comments.—This table embodies the essential information of the present Tables II and III, and of the last column of present Table IV, which is an interesting fact to record in a general survey, namely the survivals of each year's admissions who still remained on the Asylum Register at the end of the year reported upon.

Other tables of a general nature are probably more suitably left to an optional group of tables coming at the end of the series. For example a table, like the present Table II A, showing the admissions and recoveries of persons as distinguished from cases since the opening of the asylum, or as far back as possible, is undoubtedly interesting, but so troublesome that but few asylums present it. There are things to be said both for and against such a table; but though the psychiatrist finds it most interesting and valuable to follow his cases through in this way, and to keep records of their re-appearances after recovery, the labour spent in doing this annually in asylums would be more profitably spent in an investigation into the subject of recurrent insanity, folie circulaire, and the like. A table showing the ratio of insanity to population in the community served by the asylum, where this is a definite census area, is a similar table of more local interest, and the data are procurable from the census returns and lunacy Blue-Books. This table would be most valuable in census years, and also in census years tables showing the sex and age distribution of the population, and the conjugal state, nationality, and religion, so that the direct admissions might be compared

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with the prevalent conditions in regard to these points. A table showing the chargeability of rate-paid patients to the various parishes or unions, etc., served by the asylum, will indicate in a rough way the distribution of insanity in the community served by the asylum when this covers a wide area. A table showing the monthly incidence of admissions, discharges, and deaths is also of local interest, but is of little value except in relation to fatal epidemics.

TABLE III. *Admissions. Age and Conjugal State.*—Showing in the direct admissions during 19 the ages in main mental life-periods, and decades, correlated with the conjugal state in single, married, and widowed groups; and similarly but separately the ages in the indirect admissions during 19 .

Comments.—The heads of the table from left to right would be ages, direct admissions (single, married, widowed, unknown), total, indirect admissions. And the ages column would be subdivided thus: under 10 years, 10 to 19, 20 to 29 (total period of mental development); 30 to 39, 40 to 49, 50 to 59 (total period of mental maturity); 60 to 69, 70 to 79, 80 years and over (total period of mental decadence); grand total.

TABLE IV. *Admissions (direct). Occupation and education.*—Showing in the direct admissions during 19 the occupations in main classes correlated with the state of education.

Comments.—The heads of this table from left to right would be: occupations, education (unable to read or write; able to read only; moderately educated, *e.g.*, primary education; well educated, *e.g.*, secondary education; highly educated, *e.g.*, university or college education; unknown). The occupations column would show merely the Registrar-General's main classes —namely, professional, commercial, industrial, agricultural, fisheries, domestic, unoccupied, unknown. It would hardly serve any useful purpose to give in detail the actual vocations of individual patients, because the numbers for each vocation are too small in any one asylum to be of statistical value; and the summarising of the actual vocations included in each occupation class would be best left to the Central Lunacy Authority of each country, who can obtain this information from its civil register, or from the copy of the annual Medical Register which it is suggested should be supplied from each asylum.

TABLE V. *Admissions (direct). Heredities.*—Showing amongst the families of the direct admissions in whom a good family

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history was obtained the percentage of families acknowledging "hereditary affections" (specified).

Comments.—The heads for this table, which I have employed in the 34th Annual Report of Ayr Asylum (1904), are as follows, from left to right: "Hereditary" affections; first degree, parents (both parents, father only, mother only); second degree, brothers and sisters (two or more, brother only, sister only); third degree, grandparents (both sides, one side only); fourth degree, uncles and aunts; fifth degree, cousins, remote and indefinite relatives; number of families acknowledging heredities (each disease acknowledged to be present in any family to be recorded only once—namely, in the column for the nearest relative affected by it); and percentage of families acknowledging heredities. The "hereditary" affections column is differentiated thus: psychosis (congenital, acquired); neurosis (hysteria, epilepsy, chorea, asthma, etc.); paralysis (chiefly apoplexy); metabolic diseases (chronic rheumatism, chronic gout, diabetes); malignant tumours (carcinoma, sarcoma); chronic infections (tubercle, syphilis); other bodily diseases ("heart" disease, Bright's disease, etc.); congenital bodily deformities, bad habits (alcoholism, and vice, vagrancy, crime, etc.)

TABLE VI. *Admissions (direct). Previous attacks and age on first attack.*—Showing in the direct admissions during 19 the number of previous attacks, correlated with the ages (in main mental life-periods and in decades) on first attack. The heads of this table would be, from left to right, direct admissions, and ages on first attack, viz., development (under 10, 10 to 19, 20 to 29); maturity (30 to 39, 40 to 49, 50 to 59); decadence (60 to 69, 70 to 79, 80 years and over); total. The direct admissions column is differentiated into (1) persons with no previous attack; (2) persons with one previous attack; (3) persons with two previous attacks; persons with more than two previous attacks; (5) persons in whom it was unknown whether this was first attack or not.

TABLE VII. *Admissions (direct). Etiological factors*, showing the causal and associated factors of the attack in the direct admissions during 19 , as ascertained from the personal history and state on examination, their total incidence, and the instances in which they were regarded as the main or chief factor in the pathogenesis of the attack.

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The heads adopted in the 34th Ayr Report are, from left to right, etiological factors as ascertained from the personal history and state on examination, total incidence of factors, and instances in which regarded as the chief factor.

The *etiological factors* column is differentiated into the following main divisions (the individual factors cannot be given in detail here): (i) psychoses (congenital mental defects, neuro-insane diathesis without previous attack, neuro-insane diathesis as evidenced by previous attack); (ii) neuroses; (iii) paralyses; (iv) metabolic diseases; (v) malignant new growths; (vi) chronic infections; (vii) acute infections; (viii) traumata; (ix) other bodily diseases, etc. (congenital deformities and stigmata, and diseases of skin, fat, bones, joints, and muscles, blood-glands and blood, circulatory organs, respiratory, alimentary, urinary, and generative organs); (x) epochal and reproductive crises; (xi) bad habits; (xii) mental factors (emotional strains and crises). The influence of "heredity" is shown in Table V.

Comments.—To correlate the list of etiological factors in the left-hand column with the same groups of factors arranged as a horizontal heading would, in my opinion, prove nothing more in such a table, which deals with "all sorts and conditions" of insanity, than what we know already, namely, that in hardly any attack of insanity is there only one causal factor, and that in most attacks there are several such factors. Such a table of correlated factors would simply have the effect of showing the possible number of combinations of the causal factors of insanity, for insanity generally. If, on the contrary, in any particular variety of insanity, *e.g.*, general paralysis, the incidence of the various factors were shown, this would be valuable; but for this purpose the incidence of the actual factors themselves, and not of groups of factors, would be necessary.

TABLE VIII. *Admissions* (*direct*), showing the suicidal and homicidal tendencies before admission in the direct admissions, distinguishing between threats and attempts, and specifying the form of the latter.

TABLE IX. *Admissions. Diagnosis.*—Showing in the direct admissions on admission during 19 the symptomatological diagnosis (forms of mental disorder, or morbid mental states), correlated if possible with the nosological diagnosis (true varieties of insanity); and the symptomatological diagnosis in the indirect admissions during 19 .

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Comments.—As this table must provide for the inclusion of any form or any variety of insanity which may be exhibited by any patient admitted into our asylums, it must virtually contain a classification of mental diseases; and if there is to be a classification, it must be a logical classification. Any scientific classification must at the least be logical. Thus it is unscientific and illogical to group forms of insanity and varieties of insanity as equivalent "members" in the same classification scheme, as in present Table XI. We may classify mental diseases according to the time element only, as the ancient physicians did with diseases generally, and say of them that at the time of admission they were acute or recent, subacute, and chronic or persistent; or we may differentiate them according to their degree of intensity into mild or simple, moderate, and severe or intense; or we may divide them into the suicidal only, the homicidal only, the both suicidal and homicidal, and the neither suicidal nor homicidal. But when a classification of diseases is spoken of what is generally pictured in the mind is a nosological arrangement of diseases, according to a clinical symptomatology associated with an underlying pathology and a more or less known etiology. Pathology and symptomatology are the anatomy, chemistry, and physiology of the body—typical in the majority of the race, atypical in the predisposed—perturbed or run riot under the influence of some "irritant" or combination of "irritants." It is possible, even probable, that the aforesaid tripod forms an insufficiently wide basis, a too limited number of *fundamenta divisionis*, upon which to rear a true nosological or natural classification of the insanities, for biological and sociological and other considerations loom largely in the world of mind and its maladies. However, for present purposes, for the purposes of a classification of mental diseases which will suit the needs of any physician engaged in asylum work, we must select that leg of the tripod which is established most firmly, that aspect of insanity which is most accessible to direct observation, and about which therefore there will be least variety of opinion, though even here there is by no means unanimity, for in the world of mental phenomena different people see the same things differently. A classification of mental diseases according to the morbid mental states (forms of insanity) exhibited by insane patients and therefore accessible to direct observation by the clinician, would therefore, in the

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present state of our knowledge, seem the most suitable for use in the medical statistics of asylums. Such a classification is essentially one of morbid mental physiology, in other words of morbid psychology, and so includes the various morbid manifestations of the "faculties" of knowing, feeling, and willing, of desires, instincts, moral sense, and the like; and in labelling each of our patients with the symptomatological name of his disease, we must select that morbid mental symptom, state, or phase which at the time of observation seems to be the essential feature of the clinical picture. As we know, various mental symptoms or phases are often present in the clinical picture at one and the same time; for example, excitement in a melancholiac (in whom the opposite phase of passivity, passing perhaps into resistiveness, is the more common accompaniment), or in a delusional case, or in a dement; and in all such conditions it is necessary, for "labelling" purposes, to select the more constant, more permanent, feature—in the above cases the depression, the delusions, the mental enfeeblement—as being more truly descriptive of the real mental state of the patient. With these few explanatory remarks I would suggest that the following list of morbid mental phases—what may be called the cardinal symptoms of mental disease—makes provision for all the morbid mental states exhibited by insane patients to the clinician:

(1) Morbid depression.
(2) Morbid exaltation.
(3) Morbid passivity and resistiveness.
(4) Morbid excitement.
(5) Morbid inhibition.
(6) Obsession.
(7) Morbid impulse and desire.
(8) Delusion, hallucination, and illusion.
(9) Delirium, confusion, and stupor.
(10) Mental enfeeblement, with its varieties—idiocy, imbecility, facility, dementia.
(11) Morbid moral sense.

I have avoided the terms "melancholia" and "mania" because if "melancholia" be substituted for "morbid depression" then it would be expected that "mania" should be substituted for "morbid exaltation," whereas the term "mania" is more truly applicable to "morbid excitement." Where morbid excitement is the essential mental state we always describe the

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patient as being maniacal, and the maniac may be happy and hilarious, or furious and angry, or quite commonly may present no particular emotional phase, being just excessively excited, mentally and motorially. In its original meaning the term "*μανία*," madness, frenzy, meant the madness of the raving, raging lunatic. It is true that exaltation is commonly accompanied by excitement, just as depression is commonly accompanied by the opposite condition of passivity, but it would seem advisable to differentiate these four conditions, because each of them may be met with by itself as a characteristic mental state or phase amongst insane persons. Just as exaltation and depression are the morbid phases of the two normal antithetical states of pleasurable and painful feeling, so may excitement and passivity (with or without resistiveness) be regarded as opposite phases in the executive stage of action. But preceding this executive stage is the deliberative stage, in which motives and impulses to action are weighed and scrutinised. Morbid inhibition expresses the condition met with in that comparatively small number of insane persons who, though quite clear in their intellectual faculties, characteristically cannot "make up their minds"; they cannot decide to which side the arm of the balance of motives is to fall, and so they constantly are in a state of undue hesitancy and doubt, which is the essential feature of the mental state. Obsession expresses the condition in which some particular "imperative idea," notwithstanding due deliberation, dominates all other motives and impulses and impels to action. Morbid impulse and desire express the condition in which there is no real deliberation between motives at all, but simply the sudden arising of an overwhelming impulse or desire to action, which is carried out at once on the spot, regardless of consequences or of any warning by the moral sense, which in these cases seems to be temporarily obliterated. Delusion, hallucination, and illusion are derangements of intellectual faculty which are so commonly met with together that they are best grouped conjointly as one mental state; and, indeed, though in many cases they are distinguishable, in some cases it is impossible to distinguish them; for example, can anyone say that a delusion as to the identity of, say, the doctor, is not in some cases an illusion of sense-perception? Similarly, delirium, confusion and stupor form parts of a conjoint mental state, and though it

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is possible in many cases to say that the delirium or the confusion, or the stupor predominates, in a number of cases it is impossible to differentiate delirium from confusion, or confusion from stupor, and so it would seem best to group these as one mental state. It may be said that there is just the same difficulty in telling where stupor ends and dementia begins, but until we are certain of the dementia it is best to regard the state as stupor; for there can be no doubt as to the advantage to the psychiatrist of having a distinctive term like "dementia" to denote the condition of terminal and incurable acquired mental enfeeblement in which so many of our patients unfortunately end; and, again, we know that a dement may become stuporose, or confused, or even delirious, the mind that still remains being in some cases capable of such manifestations. Idiocy, imbecility, facility, and dementia are forms of mental enfeeblement differing from one another according to the time of life at which the enfeeblement occurs and according to the degree of enfeeblement present. Possibly it might be advantageous to recognise a fifth form of mental enfeeblement, namely, that minor degree of imbecility which may be called "defectiveness," and which is partially distinguishable from facility, and so amongst insane persons who are enfeebled in mind it would be possible to differentiate and to speak of idiots, imbeciles, defectives, faciles, and dements. It is perhaps advisable to mention that the terms "idiots," "imbeciles," and "defectives" include, not only the congenital, but also the acquired cases, and that when, say, "congenital idiocy" is spoken of, we are talking, not only of a form of mental disorder or morbid mental state, but also of a variety of insanity. Similarly, morbid moral sense, or the condition in which the moral sense is deficient or perverted, is met with both in congenital cases and in the subjects of acquired moral deterioration.

The above-mentioned list of eleven morbid mental states may therefore be said to form a classification of the forms of mental disorder. Like any other artificial classification, it has only one *fundamentum divisionis*, or principle of division, namely, the chief mental symptom, phase, or state exhibited by the insane patient at the time of observation; and, further, it is a logical classification because (1) "morbid mental state, phase, or symptom" can be predicated of each of them; (2) each mental state represents a definite group of individuals; (3) the eleven mental

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states are mutually exclusive, there is no "cross-division"; and (4) the eleven mental states apparently comprise all the morbid phases exhibited by insane persons. Finally, it is a practical working classification for the asylum physician, for it should not be difficult for him to decide in each case what is the essential morbid mental feature present at the time of examination —and by "time of examination" one does not mean the actual moment of examination. As in the case of any other disease in which a diagnosis is being made, the physician must be acquainted with the "history" of the illness, and must have the patient under observation a sufficiently long time in order to interpret the relative significance of the symptoms present.

Nosological diagnosis.—A "natural" classification of the insanities has not yet been arrived at by psychiatrists, though there have been many attempts. The term "diagnosis" is used properly only in reference to the terms of such a classification. There are, however, several well-recognised nosological varieties of insanity, and unless provision is made for them in a classification table no asylum physician will rest satisfied, and rightly so. The only way, then, in which this can be done, the principle of a symptomatological classification for all cases having been accepted, is by means of correlation. Consequently, the symptomatological classification will form the left-hand column of the table, and the nosological varieties decided upon will occupy each a column to the right; *e.g.*, congenital insanity, general paralysis, alcoholic insanity, and as many other varieties of insanity as can be diagnosed; and those cases in which a nosological diagnosis cannot be made should be grouped together in a column headed "varieties unknown"; and as probably only a symptomatological diagnosis will be attempted by asylum physicians in the case of the indirect admissions, the final column to the right hand will conveniently be retained for these cases, and so headed "indirect admissions." In the 33rd and 34th Ayr Reports for convenience of printing I have put the nosological classification in the left-hand column of the table, and the symptomatological forms in a series of columns to the right. I do not intend to enter into the subject of a true nosological or "natural" classification of the insanities here. Such a classification cannot be merely anatomical, or physiological, or psychological, or sociological, or biological, or etiological, or pathological, or

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symptomatological; it must be all these, for mind and the insanities include all these aspects. I do not even propose to suggest a minimum list of varieties of insanities which it would seem desirable to include in such a table, because of the variety of opinion in the matter. I shall merely mention two, congenital insanity and general paralysis, and even of these there are some who will deny that they are nosological entities. Be that as it may, the subject of congenital insanity comes into this world with a brain which sooner or later declares its possessor to be a congenital idiot or a congenital imbecile. It does not concern us so much here to know the past history of that brain, although this is an interesting branch of study; we are more concerned as to its behaviour in the future, and we find that the congenital imbecile, and naturally to a less extent the congenital idiot, may exhibit attacks of insanity in the more ordinary sense, and so may become morbidly depressed, exalted, excited, impulsive, stuporose, and the like, and may even become still more enfeebled in mind or demented than before; and further, these morbid mental manifestations do not in all cases arise simply because the subject is a congenital idiot or imbecile, but often come about in the same way as do attacks of acquired insanity in other individuals. Thus many imbeciles who are sent into asylums in a state of maniacal excitement are more truly congenital imbeciles with the "mania" of adolescence. In short, congenital cases start life as idiots and imbeciles; and imbeciles, and to a less extent, of course, idiots, who have hardly any "mind" at all, may take attacks of true insanity as distinguished from mere morbid mental phases. In order to bring out in the classification table the fact that congenital idiots and imbeciles may become morbidly excited, etc.—for it is this reason which often sends them into asylums—I would suggest that the "congenital insanity" heading be divided into idiots and imbeciles; and if there is nothing more than the idiocy or imbecility present this can be recorded opposite the idiocy or imbecility in the symptomatological column, whereas if the idiot or imbecile is characteristically excited or stuporose or the like, the fact can be recorded opposite these symptomatological forms. Similarly, the general paralytics would be differentiated according as they on admission are characteristically depressed, exalted, resistive, excited, impulsive, delusional, confused, stuporose, facile, or demented, for a general paralytic may exhibit

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all these phases in the course of his disease; and what is also true, he may exhibit none of them to such a morbid extent that he requires asylum treatment. Many a general paralytic can be, and is, treated at home or in hospital.

TABLE X. *Admissions; intensity of the attack on admission.* —Showing in the direct admissions, and separately in the indirect admissions during 190 , the intensity of the mental states and bodily conditions on admission, in three main classes.

Comments.—This table is an attempt to consider in juxtaposition the characteristic mental state and the bodily health with a view to prognosis. It is impossible in such a table to consider the mental and bodily conditions apart. Thus, if a diagnosis of general paralysis has been made, the case is serious and must go into the third class, even though the mental state be one merely of mild depression, mild exaltation, mild excitement, or mild confusion. For the purposes of this table both the mental states and the bodily conditions must be differentiated into three grades of clinical importance, and the mental state and the bodily health must be judged separately, each on its own merits; if both pass the first test the case is "mild or simple"; if either fails to pass the first test, and if either is second class or third class, the case is "moderate" or "severe" accordingly. There is, of course, great room for variety of opinion in such a table, but I would suggest the following tests for the three classes:

First class: mild or simple.—(a) *Mentally*, mild degrees of morbid depression, exaltation, excitement, delirium, or confusion; *and* (b) *bodily*, health fair, not specially below par, and no local disease or injury of consequence.

Second class: moderate.—(a) *Mentally*, more marked degrees of the preceding mental states, or the presence of passivity and resistiveness, hallucination, delusion, or stupor; *or* (b) *bodily*, health poor, distinctly below par, or some local disease or injury of distinct significance.

Third class: severe.— (a) *Mentally*, still more marked degrees of the preceding mental states, or the presence of morbid inhibition, obsession, morbid impulse, morbid moral sense, idiocy, imbecility, facility, or dementia; *or* (b) *bodily*, health weak, much below par, or some local disease or injury of serious significance.

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TABLE XI. *Admissions: duration of the attack on admission.*—Showing in the direct admissions, and separately in the indirect admissions during 19 the duration of the attack on admission, in three main classes.

First class: recent or acute (*under* 6 *months*).—Differentiated into: under 1 week, 1 week to under 1 month, 1 month to under 3 months, 3 months to under 6 months.

Second class: sub-recent or sub-acute (6 *months to under* 2 *years*).—Differentiated into: 6 months to under 1 year, 1 year to under 1½ years, 1½ years to under 2 years.

Third class: persistent or chronic (2 *years and over*).—Differentiated into: 2 years and under 5 years, 5 years and under 10 years, 10 years and over. As a footnote to this table there may be added: "Of these there were congenital cases, M. , F. , T. ."

TABLE XII. *Admissions; prognosis on admission.*—Showing in the direct and separately in the indirect admissions during 19 the prognosis as to recovery on admission, in three classes: 1st class, good; 2nd class, doubtful; 3rd class, bad.

Comment.—This table is the sequence of Tables IX, X, and XI.

TABLE XIII. *Discharges* (*recoveries*); *diagnosis* (*final*) *of attack and age on recovery.*—Showing in the recoveries during 19 of direct admissions, and separately of indirect admissions, the symptomatological diagnosis, correlated if possible with the nosological diagnosis, and with the ages on recovery in main mental life-periods and decades.

Comments.—It would, of course, be more instructive to put the column of nosological diagnosis to the left so as to correlate it with (1) forms of mental disorder, and (2) ages on recovery; but as many would object to such a proposition it would be necessary to put the column of forms of disorder to the left hand, and to correlate them, as in Table IX, with such varieties of insanity as were diagnosed or unknown, and then further to the right to correlate them with the ages on recovery, arranged as in Table III. Then the comparatively few indirect admissions who recover could be shown in two or three lines at the foot of the table, under the same headings.

TABLE XIV.—*Discharges* (*recoveries*). *Duration of attack on admission and length of treatment.*—Showing in the recoveries during 19 the duration of the attack on admission, corre-

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lated with the length of residence; and separately the total duration of the attack.

Comments.—The heads of the columns from left to right would be (1) duration of attack on admission, differentiated down the left side as in Table XI; (2) length of residence (differentiated into similar periods); (3) totals; and (4) total duration of attack.

TABLE XV. *Deaths; causes of death, sex, and number of post-mortem examinations made, correlated with the ages at death* in main mental life periods and decades.

Comments.—The heads run as above mentioned from left to right. The causes of death column embraces: (1) general diseases, *e.g.*, acute infections, chronic infections, carcinoma, etc.; (2) diseases of skin, fat, bones, joints, and muscles; (3) diseases of lymph and blood glands, and of blood; (4) diseases of nervous system; (5) diseases of circulatory organs; (6) diseases of respiratory organs; (7) diseases of alimentary organs; (8) diseases of urinary organs; (9) diseases of generative organs; (10) injuries (accident or violence).

TABLE XVI. *Deaths; duration of attack* on admission correlated with the length of residence, and separately, the total duration of the mental illness in these who died during 19 (*cf.* Table XIV).

TABLE XVII. *Residues.* Showing the *forms of mental disorder* (symptomatological diagnosis), correlated if possible with the varieties of insanity, in the residues on December 31st, 19 .

TABLE XVIII. *Residues.* Showing the *total duration of the attack* in the three main classes (recent, sub-recent, persistent), *correlated with the ages* in main mental life-periods and decades, in the residues on December 31st, 19 .

TABLE XIX. *Residues.* Showing the *prognosis* as to menta recovery or improvement in the residues on December 31st, 19 , distinguishing three classes—recoverable, improvable, incurable.

TABLE XX. *Optional tables*, e.g., *Voluntary table, etc.*

Conclusion.—As a member of the statistical committee, it behoves me to offer a short explanation and apology to my colleagues of committee for the appearance of the preceding paper in the Journal. I sincerely trust that this communication will not be taken in the spirit of carping criticism. Nothing is farther from my mind. Any one who fairly compares the Committee's pro-

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posed new tables, which are at present being discussed and criticised by the various Divisions of the Association, with those at present in use cannot but recognise that greater statistical accuracy and medical utility have been secured. But is it not possible to secure still greater accuracy and utility? I think it is; and seeing that the Association is going to the trouble and expense of a revision, is it not desirable in the interest of science and truth to make the tables as accurate and useful as possible?

The compilation of the Ayr Tables during the past two years has led me to review practically the whole field of the statistical data of the insanities, and has brought me face to face with the many difficulties which attend the construction of a series of strictly comparable medical tables suitable for English, Scottish, and Irish asylums, notwithstanding the varying lunacy administrations and practices in the three countries. I feel that it has been a valuable experience to have met these difficulties single-handed as it were, and to have had to deal with them from the point of view of the same individual (as distinguished from the necessarily varying points of view of different individuals), who has kept his eye steadfastly throughout upon the goal to be attained, the assurance of statistical accuracy combined with medical utility and without violation of legal integrity, in the statistics of insanity. For given a sound methodology in asylum statistics, reliability in the statistical data themselves, and in the ultimate formation of the statistical tables, an intelligent conception of the kind and value of the information to be sought, the more nearly will the statistics of insanity bring us to a knowledge of the truth. This is my apology, and I trust that it will be accepted in the spirit in which it is given.

(1) Professor Osler's reply had not arrived at the time of going to press.

A classification of the literature of insanity with relative index, on Dewey's decimal system. By A. R. URQUHART, M.D., F.R.C.P.E.

While the Association is engaged in considering the proposals of the Statistical Committee, it may be helpful to note what has been written about insanity from the point of view of

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