Rape, Unnatural and Indecent Offences. } 35 (4·0 p. c.)
Larceny and Petty Theft, 191 (22·1 p. c.)
Burglary and Housebreaking, 48 (5·6 p. c.)
Arson and other malicious offences, 57 (6·6 p. c.)
Vagrancy, 18 (2·1 p. c.)
Other Offences, 186 (21·6 p. c.)

The following shows the original judgments or orders for detention, and the proportion per cent.:—

Found Insane, 186 (21·6 p. c.)
Acquitted Insane, 242 (28·1 p. c.)
Insane, committed by Justices, 48 (5·5 p. c.)
Convicts becoming insane after trial } 386 (44·8 p. c.)

PART III.—PSYCHOLOGICAL RETROSPECT.

1. *French Retrospect.*

On the Nomenclature and Classification of Mental Diseases.

By Dr. Ach. Foville, Fils.*

(*Abstract by* Dr. T. W. McDowall.)

The nomenclature and classification of mental diseases are among the most important and most difficult of medico-psychological studies, and it is upon these subjects that physicians devoted to this speciality are most exercised. As Buchez has said, "When they consider that they have completed their studies, rhetoricians write a tragedy, and alienists arrange a classification." But this multiplicity of attempts is of itself the best proof that the task has not yet been accomplished, for none of the proposed classifications have been accepted by the generality of practitioners.

In attempting to obtain a classification free from the faults of those already in existence numerous difficulties are encountered. We have to contend against the imperfections of language. Unfortunately almost all the words which are employed in the nomenclature of mental diseases have received, from very early times, acceptations variable or even contradictory. Others of these words have, in ordinary language, meanings which do not at all agree with their medical significations. As with the word insanity, so with the names of its principal forms, mania, melancholia, monomania, and dementia; they are used in an inexact manner and with varying comprehensiveness.

* This paper appeared in the "Annales Médico-psychologiques" for July, 1872.

The meaning of the word dementia, as used in a medico-legal sense, differs from that attached to it when used in pathology. Besides, there are morbid states, as stupor and imbecility, which have been confounded with dementia by such eminent men as Pinel and Parchappe. Numerous other examples might be brought forward to show how loosely such words as mania and monomania are used.

Esquirol, struck by the confusion which existed in the nomenclature of mental diseases, attempted to introduce exactness and definiteness of language. The intention was excellent; the result was not so good. To achieve his purpose, Esquirol invented two words, lypemania and monomania. The former has a definite meaning, of which it has never been deprived. But it is not so with the second. Its inventor himself employed it indistinctly, sometimes at an interval of a few lines only, to point out two very different things, either partial delirium, whatever its nature, or partial delirium exclusively gay and expansive. Since the time of Esquirol the term monomania has been the subject of fierce discussion from this cause. General paralysis is another striking example of confusion caused by a faulty system of nomenclature. All the names by which it has been proposed to designate this disease are faulty. Even the term general paralysis, by which it is most commonly known, is a daily source of confusion.

In what concerns the nomenclature of mental diseases we are, even in the present day, in a state of chaos. Although in the last pages which he has written Parchappe has stated, "For a long time I have endeavoured to bring to an end, in connection with this subject, all inexactness and confusion in ideas and words," this author does not appear to us to have succeeded better than Esquirol and many others.

In such a state of matters, ought we, like Guislain, to throw aside all the old terms and invent a series of names entirely new? Even such an attempt would have few chances of being favourably received in the actual state of science, for the morbid groups to be so christened are still far from being distinctly defined. It is doubtless much better that we should still employ those already in use, provided that we indicate exactly how we use them.

It is greatly to be desired, for the perfecting of the medical sciences, that the natural method of classification should be applied to nosology in general, and to each of its great divisions. In the case of mental diseases, we agree with Jules Falret, who has insisted upon this point with much force and ability, that the common defect of all classifications, till now, is that they are all nothing but systems (by which the diseases are arranged according to a single character or a small number of characters), and that no new classification can be definitely adopted unless it conforms to the natural method. Unfortunately, in the actual state of science, if it be possible to indicate the leading characters of a good methodical classification, we are not yet able to complete the task.

The characters which, till the present day, have been taken as the basis of classification may be referred to four heads; these are:—

The presumed mode of alteration of the mental faculties;

The external manifestations of the disease;

The causes and origin of its development;

The anatomical lesions which are characteristic of it.

Hence we have the names of psychological, symptomatological, etiological or pathogenic, and anatomical classifications.

All the ancient classifications belong to the first two classes.

Some are purely psychological. We may mention that of Felix Plater (1625), who considers the intelligence as constituted by the union of three internal senses—the imagination, reason and memory; and who classifies intellectual diseases according to the perversion, enfeeblement, or the abolition of these internal senses. Again, Weickard (1790) divides the diseases of the mind into two great classes, those of intelligence and those of sentiment. He subdivides each of these according to the augmentation and exaltation, the diminution and the depression of the various intellectual faculties or passions.

Other classifications are purely symptomatological. Such is that of Sauvages (1767), which admits four orders of vesaniæ and divides the third order, that of delirium, into five genera. Although varying more or less in details, this method was followed by Ploucquet (1791), Erhardt (1794), Valenzi (1796), and Cullen (1782). The classification of Cullen divides insanity into three genera—mania, melancholia, and dementia; a division adopted by Chiarugi (1794).

Others finally are mixed; psychological in the primary divisions, symptomatological in the secondary divisions. Gallian recognises three directing faculties—imagination, reason, memory, and considers them as each exposed to three orders of lesion—abolition, enfeeblement, perversion. He considers the various forms of delirium as constituted by perversion of the imagination and reason; then they are symptomatologically divided into pyrexial, phrenetic, and apyrexial. Arnold (1782) bases his first division upon the distinction between the sensation which produces the ideas and the reflection which generates notions. Hence we have ideal insanity and notional insanity. All his subdivisions are based upon symptomatology.

Pinel (1800) adopts the classification suggested by Cullen, and to the three genera established by that writer he adds idiocy, but without sufficiently distinguishing between it and dementia.

Esquirol, on the contrary, makes numerous changes. He introduces two new genera, lypemania and monomania, and divides all insanity into five genera:—

1st.—Lypemania (melancholia of the ancients), delirium upon one or a limited number of subjects, with predominance of sadness and depression.

2nd.—Monomania, in which the delirium is limited to a single or a small number of subjects, with excitement and predominance of a gay and expansive feeling.

3rd.—Mania, in which the delirium extends to every subject, and is accompanied by excitement.

4th.—Dementia, in which the patients are insane because the organs of thought, their energy, and the force necessary to the fulfilment of their functions are abolished.

5th.—Imbecility or idiocy, in which the organs have never been sufficiently developed to perform their functions correctly.

Esquirol's classification was for a long time the most perfect symptomatological classification of insanity. It was almost generally adopted, and even in the present day it prevails in science, literature, medical jurisprudence and official statistics. And yet to how many practical difficulties does not its application lead? To how many serious objections is it not open?

In Germany, about the same time, Heinroth (1818), although he had lived in Paris, with Pinel and Esquirol, based a new system of psychology on metaphysics alone. According to him, insanity is a disorder of the mind affected in its immaterial essence. Ideler, however, considers the forms of insanity to be but the reproduction, with an increasing intensity, of those of passion which was itself but the exaggeration of the ruling propensity.

These spiritualistic theories encountered, even in Germany, many opponents, notably Friedreich and Jacobi. The latter particularly, a devoted partisan of somatic doctrines, sees in intellectual disorders only a symptomal bodily disease, and the *point de depart* of the different mental affections should be found, according to him, in the lesions of the different viscera of the body. This is making all forms of insanity sympathetic diseases.

French physicians now devoted themselves to the clinical investigation of the various forms of mental alienation, and to follow out the work began by Esquirol, but this work put them more than once in opposition to the ideas of their master. Thus Foville remarked that there is not, properly speaking, any lunatic who has absolutely only one delirious idea. Falret added that in every case of insanity, however limited it may appear, there exists a general disorder of the faculties, which, mutually dependent, cannot be any more insulated in a morbid than in a diseased condition.

Ferrus simply divided insanity into general and partial delirium. It was objected, however, that partial delirium may, at certain moments, extend and become general, without the disease really changing; on the other hand, even in general delirium, there are moments when certain faculties or sentiments appear free from disorder. To avoid this difficulty, Delasiauve raised the integrity or loss of the syllogistic faculty into a criterion of the partial or general disorder of the understanding. Whilst retaining monomania and mania, he interposed, as an intermediate group, a new class, that of pseudo-monomania, or "monomanies diffuses."

Until that time, the principal forms of insanity, mania and

melancholia, continued to be considered as distinct and independent morbid entities. It was objected, however, that this theoretic distinction was not supported by experience, and that in many lunatics, exaltation and depression, instead of excluding each other, alternate or are intimately mixed, without our being able to say that these patients are alternately, or at the same time, afflicted with two different affections.

This difficulty was partially removed by Baillarger proposing to classify these cases under the names of *folie à double forme*. Falret suggested the title *folie circulaire*.

To obviate the undoubted difficulties experienced in the application of Esquirol's classification, many methods were proposed.

Some, recognising the existence of mania and melancholia as distinct pathological entities, admitted that these diseases might frequently be transformed, the one into the other, or alternate. Hence we have the *trepomanie* of Brierre de Boismont, and the *formes mixtes* of Marcé.

Others, considering that the division of insanity into genera and species was in opposition to an enlarged view of the subject, reduced mania and melancholia to the position of simple varieties of a single disease. Thus Parchappe recognises only simple and complicated insanity, and the authors of the *Compendium* and Griesinger view the different divisions of mental disease only as forms of one malady.

Others, finally, maintain that mania, melancholia, and monomania are not morbid entities, but merely symptoms which do not constitute the essential characteristics of mental diseases. These authors base their classification on etiology or rather pathogeny.

Attempts in this direction have been made by Skae and Batty Tuke; but the most important is that of Morel (1860). He divides mental diseases into six groups:—

1st.—Hereditary mental diseases, arranged in four classes, from simple predominance of the nervous temperament to idiocy.

2nd.—Insanity caused by intoxication, alcoholism, narcotism, pellagra, &c.

3rd.—Insanity caused by transformation of certain neuroses, or hysterical, epileptic, hypochondriacal insanity.

4th.—Idiopathic insanity, including feebleness of the mental faculties following organic lesions of the brain and general paralysis.

5th.—Sympathetic insanity.

6th.—Dementia, or common terminal form.

This classification, though a decided advance in a scientific direction, is open to many and obvious objections.

It is necessary to refer to the anatomical system of classification. It has been attempted, quite recently, by Auguste Voisin, who has relied chiefly upon the results of numerous microscopic examinations. But the four species of acquired insanity which he considers anatomically distinct, and which he calls congestive, anæmic, atheromatous

insanity, and that arising from cerebral tumours or other lesions, appear far from being exactly defined, particularly from a symptomatic point of view, and they do not by any means include all the varieties of mental disease.

The mass of cases of mental derangement is not actually known to be dependent upon any constant anatomical alteration. They have merely the character of simple neuroses, and form a genus by themselves.

We propose to study, in detail, this genus of insanity uncomplicated with specific anatomical lesion.

The species of simple insanity which appear to us ought to be regarded as distinct morbid entities are the following :—

I. *Mania.*—We are far from giving this name to all the pathological states in which, as Esquirol says, "the delirium extends to all kinds of subjects and is accompanied by excitement." This very comprehensive definition is applicable to maniacal delirium, and this delirium may be observed in many forms of insanity which are not mania in our opinion. We consider mania to be a special form of insanity, of which the following are the principal characters :—Maniacal exaltation with general incoherence constitute the predominating symptoms; it breaks out under the influence of various, chiefly moral, causes; it may be produced accidentally, by violent shocks, in subjects not hereditarily predisposed. It generally runs an acute course, and ends in some months in recovery, which may be permanent. In other cases, it passes into chronic mania, and finally into dementia which almost always preserves a certain exaltation, a relic of the primitive form of insanity.

It is of the utmost importance that we distinguish between maniacal delirium, an accessory or transient symptom in most forms of insanity, and mania properly so called.

II. *General Lypemania.*—The predominating symptom of this species is a general state of melancholic delirium, with despondency, sadness, fears, &c. We call it general lypemania, the better to indicate that we distinguish it from those partial deliriums of which melancholia was formerly considered the type. It is not because all the ideas of patients suffering from this disease are delirious—that never happens—but because there exists a general lesion of the intelligence which causes them to see everything *en mal*. In its other features, general lypemania corresponds pretty nearly to those of mania.

It may appear under three principal aspects :—

1st. Anxious lypemania (aliénés gemisseurs);

2nd. Calm or apathetic lypemania (simple melancholia);

3rd. Stupid lypemania (stupidité).

It often happens that a lypemaniac passes successively through several of these forms.

III. *Partial Lypemania.*—Under this name are included the *lypemania* and *monomania* of Esquirol. Both consist of a partial delirium; but in the former, sadness and depression predominate,

while in the second (*amenomania* of Rush) there is excitement, with a gay and expansive delirium.

Partial lypemania, as we understand the term, is intimately associated with hallucinations and illusions. In all forms of insanity hallucinations play a more or less important, but not a leading part. Here, on the contrary, they predominate, and are really specific.

Hereditary predisposition plays, in the etiology of this disease, a greater part than in mania and general lypemania. Its beginning is almost always very slow, and the intellectual process, which originates the delirium, from its being based upon false sensations, remains long latent, but once it really has appeared, it progresses, so that the delirium becomes more and more complicated and organised. Its progress is usually slow from the beginning, interrupted in many cases by acute paroxysms at long intervals. Its termination is seldom favourable, but its transformation into dementia is often slower than in cases of mania and general lypemania, which do not recover.

Sometimes the sensorial disorders consist in illusions and hallucinations, which relate to the body of the patient. Such cases are examples of *hypochondriacal insanity*.

Much oftener the disordered sensations appear to the patient to come from without, and affect at once the general sensibility and the special senses. These effects are attributed to some unknown and mysterious power, as magnetism, the Jesuits, &c. Such cases have usually been known as examples of "insanity of persecution."

These "hallucinés persécutés" may labour under a delirium still further systematised. We have, elsewhere, attempted to show how ideas of persecution in these patients give rise to ideas of grandeur, these being constantly based upon an imaginary modification of their individuality, and chiefly upon the belief in themselves being of princely or royal descent. To this class of cases we apply the title *megalomania*.

Finally, there is *demonomania*, which now rarely appears in an epidemic form.

IV. *La Folie à Double Forme*, or *Folie Circulaire*.—This species is one of the most natural and best defined. It is the result, more than any other, of hereditary predisposition. Its features are well known. This disease, once fairly established, persists, with great variations in intensity, during the life of the patient, and although rarely curable, it often passes into dementia.

V. *Instinctive Insanity*.—This species includes what is usually called *manie sans delire*, *manie raisonnante*, and moral, impulsive, or instinctive insanity. It corresponds to the second and third classes of the hereditary insanities of Morel. Its chief cause is hereditary tendency. In many points it resembles *folie à double forme*, but it presents less regularity in the return of the paroxysms, and in the alternation of depression and excitement. It is rarely curable, and often degenerates into dementia.

VI. *Epileptic, Hysterical, and Choreic Insanity*.—Although the

symptoms of this species of insanity may vary somewhat, they ordinarily present certain special characters, such as the return in paroxysms, the suddenness of the impulses, and the excessive mobility of the ideas and sentiments. The evolution of these forms of insanity is essentially connected with that of the neuroses with which they are associated, Such cases ultimately end in dementia.

VII. *Puerperal Insanity.*—This species includes all the forms of mental derangement which are developed in women in connection with the different phases of the generative functions—gestation, parturition, and lactation. The symptoms observed are exceedingly various, and there is nothing specific in the erotic delirium.

Such are the seven species of insanity which we consider as possessing a true pathological individuality.

Following these divisions of simple insanity, we must now place, as forming a very characteristic and distinct group—

General Paralysis.—Notwithstanding a great mobility in their external manifestations, all its characteristics have a real fixity, and by their harmonious union they form a very distinctly marked species.

Finally, to complete our classification, we must add—

Dementia, *Idiocy*, *Imbecility*, and *Cretinism*.

The following table exhibits our classification:—

I. *Simple Insanity, without specific anatomical lesion.*

1st. Mania.

2nd. General Lypemania
- Anxious lypemania.
- Calm or apathetic lypemania.
- Stupid lypemania.

3rd. Partial Lypemania (essentially hallucinatory)
- Hypochondriacal Insanity.
- Delirium of persecution.
- Megalomania (monomania of pride).
- Demonomania.

4th. Folie à double forme.

5th. Instinctive insanity.

6th. Epileptic, hysterical, choreic insanity.

7th. Puerperal insanity.

II. *Insanity with specific anatomical lesions.*

Paralytic insanity or general paralysis.

III. *Acquired cerebral and intellectual infirmities* (Atrophies).

Dementia.

IV. *Congenital cerebral and intellectual infirmities.*

1st. Idiocy.

2nd. Imbecility.

3rd. Cretinism.