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Dr. Turner's Paper on Classification and Other Matters.

By C. MERCIER, M.D., F.R.C.P.

IN Dr. Turner's paper on the classification of insanity in the January number of the Journal occurs this passage: "It is from cases of this class" (epileptic insanity, psychasthenia, morbid obsessions, and impulse) "that subtle dialecticians seek to prove there may be disorder of conduct without disorder of mind." As I am the only person who has ever made any distinction between disorder of conduct and disorder of mind, or has ever said that the one may be disordered without disorder of the other, it is manifest that I am the subtle dialecticians referred to by Dr. Turner, and I must express to him my obligation for justifying me in the future use of the royal WE. We must point out to him, however, that after the manner and

habit of members of this Association, he attributes to Us views that We have never expressed and never held. We have, indeed, taught for many years, and iterated and reiterated, that disorder of mind may exist without disorder of conduct, and this view is again expressed in Our paper published in this Journal in October, 1910, but We have never expressed the opinion, subtle dialecticians though We may be, that disorder of conduct ever exists apart from disorder of mind. Perhaps Dr. Turner will be so good another time as to verify his references.

Dropping now the royal plural, which sits a little uneasily upon me, I will refer to some other matters that I find interesting in Dr. Turner's paper. It is twenty-two years ago since I formulated (*Sanity and Insanity*) the definition of insanity as disorder of the process of adjustment of the organism to the environment. Dr. Turner appears to have read this, or heard of it, and to have retained in his mind a hazy notion, which he now produces, I dare say quite *bonâ fide*, as his own, which is evidently founded on my definition, but reproduces it as the crazy occurrences of a dream reproduce our waking experiences.

"Broadly speaking" says Dr. Turner, "every individual" [he means every person, at least I suppose so, for he can scarcely intend to say, though he does say, that every individual dinner-plate, coal mine, watch-guard, etc., can be insane] "every individual whose conduct is out of harmony with his environment is insane." It is to be noticed here that Dr. Turner explicitly takes conduct as the criterion of insanity, and ignores altogether the element of mental disorder. In erecting conduct into the criterion of insanity, Dr. Turner is, I need hardly say, in my opinion, right, and I claim him as the first disciple I have made after being for twenty-two years the voice of one crying in the wilderness. But when he says that every person whose conduct is out of harmony with his environment is insane, he goes beyond my teaching, and he goes beyond the facts. The conduct of a schoolboy who "sneaks" to the master is distinctly out of harmony with his environment, a fact that is apt to be brought home to him in very unpleasant reaction of his environment on him: and yet he is not necessarily insane. The conduct of a suffragette who goes uninvited to a private party, and there assaults a Cabinet minister, is very distinctly out of harmony with her environment, but yet she is

neither considered nor treated as insane. The conduct of a welsher on a race-course is so much out of harmony with his environment that he hastens to change his environment and get with all practicable speed into another, and yet he is not regarded as insane.

Transient states of insanity, says Dr. Turner, are outside the sphere of the alienist. In Heaven's name, why? If I am called to a man who has stripped himself naked and is smashing the furniture, am I to refuse to treat him because he is "only drunk," and to-morrow, when the drink is out of him, he may be sane? If we are to treat as lunatics those only who are persistently out of harmony with their environment, then we must know, in the first place, what is meant by "persistent." In the ordinary sense of the word it would prevent us from considering any lunatic who recovers as having ever been insane at all. Incidentally we may notice that Dr. Turner has already changed his definition of insane person. It was one whose conduct is out of harmony with his environment. Now it is one who is himself out of harmony with his environment. According to this new definition, Daniel was insane as long as he was in the lion's den. A miner in an escape of choke damp is insane. A man overboard at sea is insane. An Orangeman among Irish Nationalists, or a Nationalist among Orangemen, is insane.

Dr. Turner's want of appreciation of law is as great as his want of appreciation of definition. He says "An individual" (again he means a person) "may be the subject of chronic insane delusions, but so long as he is not a source of danger to himself or to others, nor an annoyance to the community, the law has no right to control his liberty." What does Dr. Turner mean by "the law has no right"? Law, being neither a person nor a corporation, can have no rights. What Dr. Turner must be presumed to mean is "the law gives no right" to anyone to control the liberty of such a person; and if this is his meaning, he is utterly and totally wrong. The law confers upon every maker of an urgency order the right to place a lunatic forthwith under control if it is "expedient for the welfare" of the lunatic to do so; and *à fortiori* the law confers upon every judicial authority right to place a lunatic under control for the same reason. The lunatic need not be a source of danger to himself or to others, or an annoyance to the community; but if it is ex-

pedient for his own welfare that he should be detained under care and treatment, the law confers upon a proper authority the right to place him under care, and to detain him under care, in order that he may, for his own welfare, undergo treatment.

Dr. Turner adds to his definition of certifiable insanity that the conduct of the lunatic must be "owing to disease." This would shut out and prevent us from certifying not only every congenital idiot and imbecile, but every lunatic whose lunacy was partly or wholly due to inherited predisposition, or it would need a modification of the meaning of "disease."

The definitions of insanity and of certifiable insanity are so utterly and hopelessly wrong, that our anticipations of the classification that is to be founded on them are not very high, but before he enters on classification Dr. Turner has further general observations to make.

"All physiological observations and experiments tend to show that each of the highest nervous centres represents every part of the organism, some parts in greater, some in less, degree, some more directly, others more indirectly." If there are, in fact, any physiological observations or experiments that tend to show the truth of this doctrine I should be glad to hear of them. Dr. Turner states it as if it were his own discovery, but I first learnt the doctrine forty years ago from Hughlings-Jackson, and have often referred to it since, but I never heard him claim that it rested on physiological observations or experiments. He taught it as a pure speculation.

Dr. Turner states that when nerve-cells are discharged—he should rather say discharge—their molecular constitution is disturbed and a more stable nervous substance is formed, which requires a stronger stimulus for its discharge. And the converse —Dr. Turner means the obverse—of this is also true, that the longer the nerve-cells have been left undischarged the slighter is the stimulus required to discharge them. All very true, and first taught in my *Nervous System and the Mind* some five and twenty years ago, but it has not the slightest bearing on Dr. Turner's classification.

Dr. Turner endorses Dr. Bolton's assertion that the lunatic is born and not made, in the sense that it is not possible for a person to become insane in default of a certain amount of structural deficiency in the manufacture of his brain. It is news

to me that brains are manufactured. No doubt Dr. Turner can tell us where the factory is situated and how many hands are employed in the manufacture. In all cases in which insanity is produced by poison, the mental disorder—it will be noticed that the definition of insanity is again altered and is now given in terms of mind—disappears as soon as the noxious agent is got rid of. Does it? Does "persistent" insanity never follow influenza or typhoid fever?

Now for Dr. Turner's classification. He has already, as far as I can make out, excluded from insanity all cases of "gross lesions, as injuries, tumours, or such like," yet one of his two primary classes is the "traumatic or accidental."

The other of his primary classes consists of "the idiopathic, or those hereditarily predisposed," and is divided into three sub-classes.

The first sub-class consists of the imbeciles, in whom the structural defect is of such a degree that the nervous system is incapable, at the outset of life, of performing its functions in an efficient or normal manner. So that insanity, which was first to be estimated by conduct, and then by mind, is now to be estimated by the manner in which the nervous system performs its functions—by the state of the reflexes, *inter alia*, I suppose.

"The second class is formed of those whose structural defect is of such a degree that, although their brain is capable up to a certain point of performing its functions efficiently, yet it is incapable of withstanding the physiological and inevitable stresses of life." As this second class is composed of those whose brain is capable up to a certain point of performing its functions efficiently, two consequences follow. In the first place these unfortunate people have only one brain between them. I know not how many they are, but since they include all the cases of dementia præcox in the world, they must be very numerous. Is it any wonder that these unfortunate beings, with only a small fraction of a brain a-piece, are unable to withstand the physiological and inevitable stresses of life?

In the second place, since they are distinguished from the first class by the fact that their brain is capable up to a certain point of performing its functions efficiently, it follows that the brain or brains of those in the first class is, or are, not capable up to a certain point of performing its, or their, functions

efficiently. In other words, the brain or brains of the persons in the first class cannot perform any functions at all. They are practically without brains. They are, as far as function goes, acephalous monsters. This is not the usual concept of an imbecile.

The third class comprises all those who are able to withstand the ordinary physiological stresses, but break down when opposed to the influence of adventitious unfavourable circumstances, or with advanced age. It is clear, therefore, that in Dr. Turner's opinion, old age is not a physiological or inevitable stress. Inevitable, in one sense, it is not; for any one can avoid it by committing suicide in youth; but that old age is a pathological stress is new to me.

Dr. Turner then goes on to lay stress upon the importance of recognising both the internal factor and the external factor, or, as he calls them, the intrinsic factor and the extrinsic factor, in the causation of insanity, and says that they are in inverse proportion. This relative interdependence of intrinsic and extrinsic factors is, he says, a fundamental point in the schemes of classification of Tansi and J. S. Bolton. He might have added, if his reading had extended so far, that it was a fundamental feature in the scheme of causation of insanity formulated by C. A. Mercier when Tansi and J. S. Bolton were boys at school.

Dr. Turner's second class is composed entirely of cases of dementia præcox. I am always interested in this mysterious disease, which no one has yet been able to define or to describe in such terms as to distinguish it from other forms of insanity, and therefore I turned to Dr. Turner's description with attention; but I have so often been disappointed in my hope of hearing something definite or tangible about it that my anticipation was not pitched very high, and it was well it was not, for I should only have been disappointed again.

It appears from Dr. Turner's description that insanity of his first class—imbecility—"may simulate dementia præcox in all its forms." It appears also that cases of insanity of his third class—acquired insanity—may resemble cases of dementia præcox so closely that it is "impossible to differentiate them clinically." *Primâ facie*, a classification whose classes cannot be distinguished from one another is not a very serviceable classification, and it appears that Dr. Turner's three classes

cannot be clinically distinguished from one another, a peculiarity that I anticipated as soon as I found that one of the classes was dementia præcox. To do Dr. Turner justice, however, he does not leave us entirely without guidance. Although cases of "acquired insanity" resemble cases of dementia præcox so closely that "very often it may be impossible to differentiate them clinically," yet the cases of mimetic "acquired insanity" have "much better prospects" of "making a serviceable recovery" than they would have if they were cases of dementia præcox. Dr. Turner does not say that the cases of acquired insanity recover and the cases of dementia præcox do not. If this were so, we could sometimes make a diagnosis, if only on the *post-mortem* table. No. Cases of acquired insanity have a much better chance of making a serviceable recovery than cases of dementia præcox. Dr. Turner does not say that no case of dementia præcox ever recovers; on the contrary, on p. 18, he says that there are a number which improve and make serviceable recoveries. Nor does he say that every case of acquired insanity recovers, but only that they have a better chance of making a serviceable recovery. So that we are arrived at this conclusion—that the only means of distinguishing between dementia præcox and acquired insanity is that in acquired insanity some recover but others do not, while in dementia præcox some do not recover but others do; truly an exquisite piece of fooling.

Imbeciles also may, according to Dr. Turner, simulate the symptoms of dementia præcox. How are we to distinguish the one from the other? Dr. Turner does not tell us. Whether imbeciles also include, in Dr. Turner's estimation, recoverable cases, he does not tell us. If they do, they are in this respect indistinguishable from both dementia præcox and acquired insanity. If they don't, we may know with certainty that a case that recovers is not a case of imbecility, and thus we arrive at the first instance in which we can discover a rudiment of use or value in the classification. But our satisfaction, small as it is, is short lived. When we refer to the definition, we find that insanity is not insanity unless it persists. But if the patient recovers, his insanity does not persist, and therefore he never was insane at all.

I wish to be quite fair to Dr. Turner and the Kraepelinites, and therefore I must point out that while the transient insanity

that he does not regard as insanity is that in which the patient "returns to a normal frame of mind," the recovery from acquired insanity and from dementia præcox is "serviceable recovery." Whether Dr. Turner means to make a distinction between the two, whether return to a normal frame of mind is an unserviceable recovery, what the difference is between a serviceable and an unserviceable recovery, and what the nature of an unserviceable recovery is, I do not know, and Dr. Turner does not enlighten us.

So much for the distinction between dementia præcox on the one hand and acquired insanity and imbecility on the other. Now for the varieties of dementia præcox. The state in which the classification of these varieties is can only be adequately described as a state of mush. No one authority agrees with any other as to what the varieties are, how they are characterised, or what are their boundaries. Dr. Turner gives Kraepelin's division into the katatonic, the hebephrenic, and the paranoidal groups, and as far as one can make out, it appears that he adopts them. Katatonia, he says, is a well-marked group, but all cases are apt to take on katatonic characteristics at some time or other in their course, and, "as Tansi remarks, 'In all cases of dementia præcox, whatever the clinical variety to which they belong, absurdity of behaviour spreads a shadow of katatonia beyond the limit of the katatonic variety.'" This is Dr. Turner's notion of "a well-marked group." The hebephrenic variety, in Dr. Turner's opinion, "at present seems very much in the nature of a rubbish-heap, wherein to throw cases that do not readily conform to the two other types." This, then, is, I suppose, also "a well-marked group." The paranoidal group consists of those who have unsystematised delusions. Since the characteristic feature of paranoia is the existence of systematised delusion, the attachment of the name paranoidal to those whose delusions are unsystematised strikes one as so peculiarly inappropriate that it needed a Kraepelin to hit upon it. Moreover, since unsystematised delusions are pretty frequent in combination with katatonia, and since any case, whether with unsystematised delusions or not, may be called hebephrenia, I should agree with Dr. Turner when he says, "It will be gathered that the subdivisions of dementia præcox are not very satisfactory." Yes, I think it will. Indeed, I would go further, and suggest that "it will be

gathered" that the divisions among the forms of dementia præcox are in a state of mush; that the concept of dementia præcox itself is in a state of mush; that the whole notion of dementia præcox has all the definiteness of outline and architectonic precision of a par-boiled batter pudding.

Dr. Turner says that the opponents of Kraepelin are a rapidly decreasing minority. They may be, but I trust Dr. Turner will allow that they have some kick left in them; and the fact, if it be a fact, that they are in a minority is evidence, as far as it goes, that they are right, for it is a maxim whose truth is proved by long and universal experience that the majority is always wrong. Dr. Turner says that Sir Thos. Clouston, in his account of adolescent insanity, comes very near to Kraepelin. There is only one word that will properly characterise this statement — it is impudent. Sir Thos. Clouston described adolescent insanity, and described it admirably and for the first time, if not before Kraepelin was born, yet long years before Kraepelin described anything. Kraepelin took Sir Thos. Clouston's description; muddled it; spoilt it by the addition of cases foreign to adolescent insanity; gave a new name to it; and posed as the discoverer of a new disease; and men like Dr. Turner, whose capacity of thinking clearly, and the value of whose opinion can be gathered from this analysis of his classification, fall down and worship the plagiarist, and speak with patronising superiority of Sir Thos. Clouston, the latchet of whose shoes they are not worthy to unloose. Dr. Turner writes vaguely about "the essential identity between this phase and the various other phases of this protean disorder," about "their significance and inter-relationship"—empty words, which he does not explain, and which I venture to say he cannot explain.

Dr. Turner's third group consists of the "acquired insanities." He admits that these, or some of them, cannot be distinguished by their symptoms from cases of dementia præcox. The only difference between them and dementia præcox is that in them the prognosis is more favourable. Prognosis is not a thing that can be observed. It is a pure guess; and the distinction between acquired insanity and dementia præcox is pure guesswork. It is not even as if the prognosis in dementia præcox was uniformly bad, and that in acquired insanity uniformly good. If it were so the distinction would be worthless. But

it is not even worth as much as this. The distinction is that in the one the prognosis is better than in the other. What does this mean? Is it better in every case, or good in a larger proportion of cases? And who is the arbiter? If one observer gives to a case a good prognosis and another a bad prognosis, is that case "acquired insanity," or is it dementia præcox? It seems to me that Dr. Turner would have an equally good criterion if he called those cases acquired insanity that have a good chance of going to heaven, and those cases dementia præcox that have a good chance of going to hell.

Among acquired insanities Dr. Turner includes morbid obsessions. (Why morbid? Is there a normal obsession?) In fact, the victims of obsession are very rarely insane. "They may have delusive ideas which they recognise as such." Then they are not delusive, for they do not delude. "And they may even take steps (often, however, ludicrously inadequate) to prevent their impulses from taking effect." Victims of obsession and impulse very rarely need to take any steps to prevent themselves from acting on their obsessions or impulses. In the great majority of cases such persons have enough self-control to render such steps needless. But when they do take steps they usually take very effectual steps. They give themselves up to the police, or they go into asylums, or they mechanically restrain themselves.

Dr. Turner's second great class is called by him Traumatic insanity, and he says it does not need extended discussion. I am not so sure about that. "It includes all cases of insanity arising from gross lesions of the brain." Dr. Turner does not seem to know what is meant by a gross lesion of the brain. The term was invented by Hughlings-Jackson to characterise macroscopic lesions, such as tumour, hæmorrhage and laceration, and to distinguish them from microscopic lesions. Dr. Turner applies it to excessive proliferation of the neuroglia, which is a microscopic lesion. Nor does Dr. Turner seem to know the meaning of "traumatic." It is derived from *trauma*, and has always hitherto been used in medicine to mean the product of a wound, or of the application of violence from without. Dr. Turner includes in his traumatic insanity, tumour, amaurotic idiocy, and gliosis, for whose traumatic origin there is not a vestige of evidence.

A good many years ago I suggested that the terms "idiocy'

and "imbecility," which were then used rather at haphazard, but generally to mean a greater and a less degree respectively of intellectual defect, should be more strictly defined, and that idiocy should be applied to persons who, by reason of mental defect existing from birth or from an early age, were incapable of acquiring those direct self-conservative activities, the want of which in young children prevents us from leaving them alone; while imbecility should be applied to those who are capable of exercising these activities, but are unable, from congenital mental defect, to earn their own living. These definitions were accepted by the Royal College of Physicians, and, at the instance of the College, by the Royal Commission on the Care and Control of the Feeble-minded. I have always taught that both idiocy and imbecility might have one of two origins. They might be due to sheer lack of developmental impetus, so that the process of development ceased prematurely before the brain was complete; or they might be due to some quasi-accidental agency, such as injury to the head, or meningitis, acting in early youth on a brain that, but for such accident, would have developed normally. Now it appears that Tansi makes the primary division according to the mode of origin, and the secondary division according to the degree of the defect, instead of *vice-versâ*. This trumpery alteration, if it does no good, does no harm; but as it is an innovation, and as it is made by a foreigner, Dr. Turner, of course, in his anxiety to be up-to-date, adopts it. Unfortunately the innovation does not stop here. The soaring ambition of the modern alienist is never content until he has altered the names of things. Not until he has given a new name to an old thing, as in the case of dementia præcox and manic-depressive insanity, or until he has shifted about the familiar names of familiar things, is he hailed as a great discoverer; but when this is done his fame is secure. Therefore the genetous idiot and imbecile of Bucknill and Tuke are dubbed imbecile, and the accidental idiot and imbecile are called idiots, and the claim of Tansi to be a great discoverer is secure, at least among the logolaters, of whom the rising generation of alienists in this country appears mainly to consist.

I have dealt with Dr. Turner's paper at greater length than it deserved, not because it is itself important, but because it fairly represents a class. A large proportion, perhaps a

majority, of the younger alienists in this country—the country of the Tukes and of Conolly, of Locke and Berkeley and Hume, of Hughlings-Jackson and Clouston and Savage—are so bitten with the anti-patriotic bias, that they can see no merit in the most momentous discoveries of their own countrymen, of whose achievements they are for the most part ignorant, and whose books they do not trouble to read; and they hail every twopenny-halfpenny innovation, even though it is only a change of name, that comes from the Continent, as a discovery to which the discovery of gravitation, of combining proportion, of natural selection, or of aseptic surgery is a bagatelle, and of no importance. When I looked back on the splendid roll of eminent Englishmen, I used to feel proud of my country; but now when I look around me and see a shoal of small fry engaged in belittling their compatriots and belauding the foreigner with fulsome and undeserved adulation, I take shame to myself to belong to such a crew. Perhaps this exposure of the utter confusion of thought that underlies this attitude, a confusion that cannot be paralleled except in the slipshod character of the English in which it is expressed, may induce those of this school that are capable of thought to consider whether after all a change of name is necessarily a great discovery, and whether it is not worth while to pay attention to things as well as to the names of things.

Comments on Dr. Mercier's Criticisms of Dr. John Turner's Paper on Classification. By JOHN TURNER, M.B.

THROUGH the kindness of the Editors I have been given the opportunity of reading Dr. Mercier's diatribe on a paper I published in the last number of the Journal.

He points out in that courteous and temperate manner so characteristic of him, and which has served to render him so justly popular in debate, what he considers to be slips in grammar, illogical and contradictory statements, acts of plagiarism, and other offences against good sense and good taste, of which latter he should be a good judge.

Why all this bother and unbottling of spleen on a paper so unworthy of his notice? He says it is because it is representa-