A Note on Psychiatric Terminology and Classification.[1]

By THOMAS DRAPES, M.B., District Asylum, Enniscorthy.

IN any department of knowledge worthy of the name of science I think it will be admitted that one of the most important elements is terminology. The accurate (and adequate) expression of facts by appropriate words is a prime essential in the advancement of knowledge; the absence or imperfection of such is one of the greatest hindrances to progress. And perhaps no more forcible example of this can be adduced than the case of psychiatry, that sphere of knowledge in which all who are members of this Association are supposed to be more or less expert students. I doubt if any branch of science has suffered more than our own from the disability of an imperfect terminology, a point which it is hardly necessary to argue. I may, however, by way of illustration remind you of the numerous schemes of classification of insanity which have from time to time appeared, a matter with respect to which every writer on the subject seems to have done that which was right in his own eyes. But what would be thought of any science—say botany, chemistry, or zoology—if a new system of classification, and even new terms for genera and species, were to be brought out with the same frequency, or anything like the same frequency, as in the case of insanity? Can anything be more bewildering to anyone commencing the study of insanity than to take up book after book and find each writer adopting a different classification, and grouping cases under one heading or category which the next authority he takes up places under another and quite different one? Surely there ought to be, in the first place, agreement amongst authorities as to the meanings of terms, and in the next place at least some permanent basis of classification which all can accept, capable, no doubt, of expansion and modification with the advance of knowledge, but not liable to continual changes, not to say upheavals, in its fundamental structure.

The fact that so many abortive attempts have been made to evolve a classification of insanity which shall obtain general acceptance, that there has been such a signal failure in constructing a satisfactory working basis for the study of that condition, is indicative of one of two things: either that our

information on the subject is so imperfect that the data requisite for a proper scientific classification are wanting, or that there is such an essential difference between insanity and all other departments of knowledge, that the construction of a system of classification on the usual broad principles which obtain in the case of all other branches of science is impracticable. Probably each of these factors forms an element of difficulty in greater or less degree. Our knowledge of mental action is as yet very imperfect, and as regards a great deal of it merely conjectural; and, again, mental functions differ so radically from all other functions of the body, our methods of investigation of them are so totally dissimilar in the one case and in the other, that attempts at classification of mental disorders by similar methods to those adopted in the case of other bodily diseases have up to this spelt failure. Is the unravelling of these causes to be regarded as impossible? Until they are discovered it is to be feared that their effects, from which we have been so long suffering, must be looked on as irremediable. I am fully conscious that anyone who enters upon the thorny path of the subject of classification is as likely as not to be pointed at with the finger of scorn as a case of "fools rushing in." At the risk of meeting with this fate, however, I venture some considerations on the subject which must be regarded in the light of suggestions only.

Disease or disorder of any bodily organ is recognised by symptoms which are mainly referable to the functions of the organ affected. They are the outward expression of the internal disturbance; and they may be objective or subjective, patent to an outside observer, or only appreciable by the patient himself. Cough, vomiting, paralysis are evident to any outsider; pain, giddiness, or nausea are only cognisable by the person who is the subject of them. But disease is also revealed by physical signs, and these are wholly objective. I need hardly say to which class a physician attaches most importance. The physical signs of disease and the objective symptoms are what he mainly relies on as helping him to a diagnosis. The subjective symptoms have a certain value, but in many instances, and notably in the case of functional nervous disorders, they have to be largely discounted.

Insanity from a clinical and diagnostic standpoint presents some special difficulties. Except in the case of general paralysis

there cannot be said to be any specific pathological conditions corresponding to any of the forms or varieties of insanity; so that pathology, which forms the basis of classification of so many diseases of other organs than the brain, is inapplicable to that of mental derangements. This is one, and it is to be feared an insurmountable, difficulty. Their clinical features are, then, almost the only available basis. And these differ so in character and in course and progress as to present another great difficulty to the would-be classificator. Insanity, taken in its widest sense—that is to say, insanity in the abstract—is an aggregate of symptoms, comprising all abnormal mental phenomena referable to the intellectual, emotional, and volitional departments of mind; and for the production of any individual case of insanity we could almost imagine that all these symptoms were thrown into a hat, well shuffled, and a certain number drawn out at hap-hazard by some invisible hand, so as to form a group or so-called "variety" of insanity. No two cases of mania, no two of melancholia, or of dementia, follow a similar course—that is, in the sense that two, or for that matter a dozen, cases of pneumonia, typhus fever, or Bright's disease can be said to follow the same or a similar course. In diseases of organs other than the brain well-defined and discoverable pathological conditions give rise to very similar symptoms, which run on the whole a very similar course, and the personality of the individual is but slightly, if at all, affected. But in the case of mental disorders in the large majority the pathological conditions are very indefinite, if at all discoverable, while the character and personality are profoundly altered. And while stomach, heart, liver, etc., functionate in an almost identical fashion in any number of individuals, their minds, which represent the functioning of their highest cerebral centres, are wholly and entirely different in their action.

The functions of the nervous system, taken as a whole, are, as we know, mainly three—sensory, motor, and mental. Derangements of the sensory and motor functions are comparatively easily recognised and located. The departures from the normal are but three: the function may be in excess, or in defect, or perverted. Thus, hyperæsthesia, anæsthesia, and paræsthesia on the sensory side, spasm or convulsion, and paralysis on the motor side, sum up the symptomatic phenomena presented by these "lower centres." But it is far otherwise

with mental symptoms; they are as diverse and as complex as the operations of the healthy mind itself. Still, we find types of mental derangement corresponding broadly with those of motor or sensory character. We have in the excitement of mania an example of excess or over-action in some highest centres, in the condition of apathy and stupor we have defect, and in delusion we have perversion of these centres. And it is a question whether in any classification of insanity it might not be well to start with some such division as this, so bringing its symptomology into line with that of the disorders of the lower centres. In old days an impassable gulf was made to separate mental from all other functions of the body, but the less the functions of mind are divorced from those of other parts of the same nervous system, whether they are in normal or abnormal operation, the better for the progress of mental science.

In derangements of the lower centres physical signs, and very significant ones, can be elicited which are of high value in determining the seat and nature of the disease which produces them. In mental disorders, on the other hand, such signs are almost wholly wanting. We cannot palpate or auscultate the brain. We cannot locate a delusion or a focus of mental excitation as we can a lesion of sensory or motor centres. The nearest approach to physical examination that we have in such is inspection of the condition of the fundus oculi with the ophthalmoscope, and it is only rarely that any help in diagnosis is obtained in this way. We are therefore debarred from one of the principal methods of investigation in the case of "bodily" disease.

It would seem, then, that anything like a complete or satisfactory classification of insanity in the present state of our knowledge is an impossibility. The most we can do is to classify our cases on some basis on which all or the great majority of psychologists can agree. There are different considerations, each of which might serve to form a basis of classification. For instance, all cases of insanity could be grouped according to the duration of the disease, or according to the degree of intensity, or according to the period of life at which they occur, or to the predominant mental condition, such as excitement, depression, stupor, etc. Any of these expresses facts, and facts upon which everyone would be in agreement. No one would be at a loss to understand what was

meant by saying that a patient was the subject of recent melancholia, or of acute adolescent insanity. Each term expresses a fact about which there can be no dispute. But when in a few cases a certain grouping of symptoms, and that by no means identical in any two cases, occurs, and a special name is given to such casual combinations, it does not in the least assist in the better understanding of insanity; rather the contrary, it makes confusion worse confounded. I ask anyone to read with an unbiassed mind the descriptions given by different authorities of the so-called "varieties" of insanity designated by the terms "katatonia" and "dementia præcox," and say in all honesty whether he has found any mental enlightenment therein, or whether he has not rather found himself reduced to a condition of intellectual bewilderment, more or less. Possibly the discovery, or quasi-discovery, of a new variety of insanity has a special attraction for some minds, as the discovery of a new species of plant gladdens the heart of the enthusiastic botanist, who hopes his reputation will be enhanced by the transfer of his own cognomen to the new discovery, as Smithii, Jonesii, or Robinsoniani.

But no matter what basis of classification is adopted, there should be an absolute agreement as to the precise meaning of terms. This is far from being the case at present. As an instance of the ambiguity of terms which is, unfortunately, so marked a feature in psychiatric literature, let us take the very simple word "chronic." It would seem scarcely possible, scarcely credible, that there should be any difference of opinion as to the exact significance of a word with apparently so obvious a meaning, and in constant every-day use. Yet so it is. For the term is used with reference to (1) duration of the disease, *i.e.*, chronicity in the proper sense of the word; (2) intensity; (3) incurability. Can we not come to some agreement to have, if it must be so, even an accepted technical meaning attached to the word "chronic"? Some cases of mania and melancholia are just as acute in their symptoms six, nine, and even twelve months after their inception; and if "chronic" is used to imply a certain degree of intensity below what is regarded as acute, then a case may be as acute after twelve months as after three. But if duration is to be taken as the meaning of chronicity, in such a case we have—it sounds uncommonly like a bull—a chronic state of acute insanity, which *appears* a contradiction

in terms. But it need not be. For, on the whole, having regard to the etymology of the word, it would be better to use the term "chronic" exclusively with reference to duration than in either of the other senses, as thereby there would be no doubt as to its application in any particular case, and facility of application is the great *desideratum* either in terminology or in classification. But some one meaning should be selected and adhered to by all. The complementary term to "chronic" should be "recent," not "acute," recent referring to occurrence in point of time, while acute denotes intensity. And in this way to say that a case, although of chronic duration, was acute in character would not be the contradiction in terms which, at first sight, it might seem to imply. We might adopt, as regards the duration of an attack, a scale of three degrees—recent, sub-chronic, and chronic, meaning cases of, say, three, six, and twelve months' duration respectively; and as regards intensity we might also have three degrees—acute, subacute, and mild. The use of these terms would at least give definiteness to our ideas, and, what is equally important, they would be generally understood.

Take now the word "dementia." By most alienists, and up till recently by all, this term was held to denote a general failure of all mental faculties, such as occurs so frequently in old age. Here the mind fails in all departments—intellect, emotion, volition, conduct. The process may be slow or rapid, and of various degrees, from mere impairment to, in advanced cases, total abolition of the mental functions, of which memory is generally the first, or one of the first, to become affected. It is a condition which is found under long-acknowledged and well-recognised circumstances, *viz.*, as the terminal stage of all forms of insanity, as a result of organic disease of the brain, and as the effect of senility, and therefore the old classification of dementia into secondary, organic, and senile has a sound basis of fact underlying it; and, again, it is easy of application to any particular case, and probably on this point the vast majority of alienists will be found in absolute agreement. The form "primary dementia" was, of course, also included in this classification, but I venture to think that it would have been wiser if such a term had never been employed. The term "dementia" is associated in our minds for the most part with an incurable condition, the privative particle *de* denoting the loss of something once possessed, and, in my opinion, it would be

well to limit the term to incurable break-down, the destruction of function, and not such phases of insanity as those included in "primary dementia," from which recovery not infrequently takes place."

If the use of the term "dementia" is not altogether satisfactory, what are we to say of that unfortunate modern discovery "dementia præcox"? No doubt it has been ushered into existence, at any rate brought into prominence, by a very distinguished authority, with respect to whose writings I am sure no one here would wish to utter one word of even seeming depreciation. In the sphere of psychiatry Kraepelin holds a well-earned reputation which nothing that I may say can either injure or enhance. But I am inclined to think that a good many alienists in this instance find themselves unable to see eye to eye with the master. At the annual meeting of the British Medical Association at Oxford last year Dr. Conolly Norman read an exhaustive and well-reasoned paper on "Dementia Præcox"; and his conclusion, after a most careful consideration of the subject, was that the facts did not justify the adoption of such a designation for any combination, or grouping, or course of symptoms at present known to us—"The existence, either as a distinct entity (which Kraepelin does not affirm), or as a practically useful homogeneous group, of any condition which can be called by the name 'dementia præcox,' does not in my opinion admit of proof." (I may add that another example of divergence of opinion on an apparently simple matter is to be found in the same paper, in which Dr. Norman characterises judgment as the most adult of all the mental functions, whereas Tichener speaks of it in his *Outlines of Psychology* as "the most elementary form of intellect"; and again, in his *Primer of Psychology*, he says, "The simplest thought process, the unit of thinking, is the judgment." Can it be the same faculty which these writers allude to in such apparently contradictory language, or does the word "judgment" convey a different meaning and content to each?)

To return to dementia præcox, Kraepelin, in his recently published *Lectures on Clinical Psychiatry*, says that "the peculiar and fundamental want of any strong feeling of the impressions of life, ***with unimpaired ability to understand and to remember***, is really the diagnostic symptom of the disease." Does it not seem rather strange to apply the term "dementia" to a mental con-

dition where there is unimpaired ability to understand and to remember? Surely this is a misapplication of terms. If comprehension and memory are unimpaired, what is dementia? (I refer to the dementia with which we are all familiar, or think we are familiar.) Let us hear Kraepelin himself on a case of senile dementia in the same work: "The most prominent feature of the case is the almost complete failure of the power to retain impressions, which far exceeds anything we have observed in other forms of disease. . . . . Absolutely no connected chain of ideas ever comes into existence . . . . clear impressions are far more slowly arrived at than is the case with healthy people. Hence many of our patient's ideas vanish before they have really become clear. It is easy to understand how the united effect of these two disturbances may produce the condition presented by her, which we will call 'senile bewilderment.'" It would be difficult to discover by what process of reasoning these two forms of mental derangement are classed together as varieties of the same genus dementia. To call by the same name groups of cases in which on the one hand one of the diagnostic symptoms is unimpaired ability to understand and remember, and on the other mental distraction and bewilderment, with very slow comprehension, and complete failure to retain impressions, is not this to take an unwarrantable liberty with language, and to give a latitude of meaning to a term outside the limits of reason and common sense? As long as psychiatry permits such totally different, even contradictory, significations to be given to the same term, it seems hopeless to expect that we shall ever arrive at anything like a scientific classification of insanity.

But the position may be defended in this way. The term "dementia," as used in dementia præcox, does not imply that there is a condition of dementia present from the first, but that sooner or later the train of symptoms described under that designation will end in dementia, premature in its onset. If that be the essential inwardness of dementia præcox, then it differs not at all from all other forms of insanity, which also, sooner or later, if the patient is not cut off by intercurrent illness, end in dementia. In fact, to follow the precedent of Mark Twain in connection with the claims of Michael Angelo, why not lump all insanity together and call it dementia præcox? Which would seem the most satisfactory way of

settling the question. As other writers as well as Dr. Norman have taken strong exception to the use of this term, and have no belief in the existence of such a distinct form, I should not have referred to the matter were it not that in the first draft scheme of classification of insanity drawn up by the Statistical Committee the variety dementia præcox was included with primary dementia. The Committee evidently considered that opinion in these countries was too much against the employment of such a debatable term, and have, wisely, dropped it in their amended scheme. But we have escaped the adoption of this exotic, as it were, by the skin of our teeth.

The terms "hallucination" and "illusion" are even still occasionally used promiscuously, but more in the case of general practitioners than by psychiatrists. But it would be well if a definite meaning were attached to each, the meaning which almost all authorities support—that is, that an hallucination is a false perception without an object, and an illusion a false perception with an object, a misinterpreted perception. It is unfortunate that the French have no word "delusion," and use the term "illusion" to denote what we mean by delusion. If we are ever to have, as is the dream of some, an international terminology and classification, it would be well if our neighbours could see their way to incorporate the English word "delusion" in their language, which could be so readily done without any difficulty except an alteration in pronunciation, and so find another opportunity of showing the *entente cordiale*.

I would suggest that any classification of insanity which may ultimately be adopted should be preceded by definitions of those terms upon which there is general agreement amongst psychologists, leaving those of doubtful meaning to take care of themselves until a stage of greater preciseness and accuracy in terminology is reached.

I have called the foregoing observations a "note." They do not claim to be anything more, and being of a fragmentary character, are not deserving of any more dignified title. If they serve a suggestive purpose, which is all they are expected to do, the object with which they were written will have been attained.

Note.—At the time this paper was written I had not seen Dr. Easterbrook's able contribution on "Statistics in Insanity: a Universal Scheme," in which he takes exception, as I have

done, to the ambiguous sense in which the terms "acute" and "chronic" are used. But, while hesitating to differ from him, I can hardly think that he has suggested the best way out of the difficulty, although he quotes high authorities in support of it. Dr. Easterbrook is inclined to discontinue the use of the terms "acute," "sub-acute," and "chronic," and to substitute for them "recent," "sub-recent," and "persistent." I venture to submit that the terms "acute" and "sub-acute" are not properly correlated with "chronic" at all, but should be used to express degrees of intensity alone, which, as I have suggested in my paper, might be three in number—"acute," "sub-acute," and "mild," and that there should also be terms available for expressing three degrees of duration, such as those which Dr. Easterbrook suggests: "recent," "sub-recent," and "persistent," or, preferably as I think, "recent," "sub-chronic," and "chronic." Dr. Easterbrook asks: "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." But, nevertheless, it is a fact that there are patients whose insanity is of considerable duration, say over a year or longer, and who are as acutely maniacal as they were twelve months previously. Here the illness is surely chronic in duration, but acute in intensity; and we should have terms to express these facts clearly. It does not matter much whether we call such cases "persistent acute" mania, or "chronic severe" mania. But what I do urge is that, in any scheme of classification, degrees of intensity and degrees of duration should be kept perfectly distinct, and that appropriate terms admitting of easy application should be employed to denote them.—T. D.

(1) Read at a meeting of the Irish Division of the Medico-Psychological Association held in Dublin on November 22nd, 1905.

The David Lewis Manchester Epileptic Colony. By Alan McDougall, M.D.

The David Lewis Colony is one of the latest results of the sympathy for the epileptic spread, if not originated, by Pastor von Bodelschwingh, of Bielefeld.