stances becomes the cause of a form of insanity resembling the hysterical.

(1) For example, C. Mayer (*Jahrbücher für Psychiatrie*, xi, p. 37), who has collected three years' material from the Vienna General Hospital, states that those affected in this way after intoxication—which, after Meynert, he names a half dreamy condition—only bear a small proportion to the other alcoholics.—(2) Mach, in his *Analyse der Empfindungen*, 2nd edition, p. 133, says that the mere missing of inhibiting associations may lead to delusions of grandeur.—(3) Griesinger (*Pathologie und Therapie der psychischen Krankheiten*, 2 *Auflage*, 1861) has already pointed out how often the last conceptions before the outbreak of insanity give a character to the delirium.

Kinds of Insanity. By CHAS. MERCIER.

In the last number of this JOURNAL, I gave reasons for concluding that the table of forms of insanity, suggested by the Statistical Committee, was unsatisfactory, and suggested a new classification of cases of insanity to be substituted for their arrangement. Certain objections that are likely to be taken to the classification that I have proposed are worth considering, and would have prolonged the previous communication to an unwieldy length if embodied therein; I propose, therefore, to consider them now.

The arrangement that I have suggested divides, first, the congenital from the non-congenital cases. This division is eminently natural, and has been adopted in every classification with which I am acquainted. I think, therefore, that it needs no formal defence. The non-congenital cases were divided, it will be remembered, primarily with regard to the degree of intensity of their symptoms; secondarily with respect to the predominant symptom that they display; and the cases of general paralysis were separated throughout from cases of non-paralytic insanity. The question that I now propose to discuss is whether a further classification of the latter kind is not desirable; in other words, whether there are not, included within the group of non-paralytic insanity, diseases sufficiently distinct to merit the same separation that is given to general paralysis. Is it not, it may be objected, as important to know the number of cases of adolescent insanity, of puerperal, climacteric, senile, alcoholic, phthisical, epileptic, and other named varieties of insanity, as to know the

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number of cases of general paralysis of the insane? How are we to hold up our heads before our Continental and American brethren if we omit from a table of forms of insanity such distinct diseases as paranoia and dementia præcox?

These questions can be answered best by taking each of the varieties of insanity alleged to be distinct, and investigating whether, in the first place, it is in fact a distinct disease, and in the second, how far it is left undistinguished in the tables that I have suggested. Before entering on this investigation, however, it is necessary to come to some understanding as to what is meant by "a disease." As far as I know, there is no definition, no satisfactory definition, in existence of disease, beyond that it is a departure from health. But it is clear that we mean something more than this when we speak of general paralysis as a disease, and deny the title to palsy, or jaundice, or mania. All of these are departures from health, but the first is entitled, we feel and know, to be considered "a disease," while the others are not. The statement is often made that the only perfect classification to insanity would be a pathological classification, by which I understand a classification founded upon morbid structural alterations; and those who hold this view would, I suppose, base the claim of general paralysis to be considered "a disease" upon its specific morbid appearances. I doubt whether this view is tenable. If the anatomical change found in general paralysis had been discovered after death, but no corresponding disability had existed during life, I do not think the anatomical change alone would have been called, or would have been entitled to be called, "a disease." The connotation of the word "disease" includes, I think, as an integral and necessary part, the existence of specific symptoms during life. When the patient is dead, it is inappropriate to speak of disease as existing in the cadaver. What is left is not disease, but morbid structure. We may speak of a diseased kidney, a diseased liver, or brain, but what we mean is a structure showing alterations from the normal structure. Disease is departure from health. Health is the efficient performance of function. Disease includes, therefore, of necessity, inefficiency of function; and structural alteration, at any rate, recognisable alteration of structure, does not of necessity enter into our concept of disease. There are plenty of "functional"

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diseases in which no structural alteration has been found, and this is especially true of insanity. And, granting that, as our knowledge extends, more and more "functional" diseases are taken out of that category, and found to have a recognisable structural basis; yet there still remain many in which the translation has not been made; and we cannot wait to classify disease until we know in every case the anatomical change, even supposing that in every case such change exists. A clinical picture is, then, essential to the concept of disease. Disease was recognised, individual diseases were recognised and named, long before the structural changes on which they depend were known. And individual diseases are still recognised and named, and admitted to be distinct diseases, to which no structural change can be assigned. There are few, I think, who would deny the term disease to asthma, to angina pectoris, or to tic-douloureux. Specific anatomical change is not, therefore, essential to our notion of disease. What is essential is a specific clinical picture.

The problem with which we are dealing is now better defined. It may now be stated thus: Are there, within the disease insanity, disorders so distinct in their symptoms and course as to be separable from one another, and each entitled to be considered a distinct disease? As to general paralysis, the question must undoubtedly be answered in the affirmative. Its symptoms are so distinct that it is recognisable at every stage in its progress. It has a definite history, runs a definite course, and forms a complete clinical picture, separable from that of any other case of insanity. It is undoubtedly entitled to be called a disease. Let us now take the other varieties of insanity, ordinarily dealt with and described as distinct, and examine their titles to be called diseases.

Acute delirious mania affords a distinct clinical picture, both in its symptoms at any one time, and in its course; a picture which prevents it from being confused with any other case of insanity, and therefore may truly and properly be called a disease. In any scheme of classification of forms, or of cases, of insanity, it is entitled to a separate position; and a separate position is assigned to it in the table that I have proposed. There is no such position in the Table proposed by the Statistical Committee, nor is there any in the Table at present in use.

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Taking next the group of insanities of Reproduction, so called, I think it will be admitted that Puerperal Insanity presents us with no distinct clinical picture. The very fact that it has been divided into puerperal mania and puerperal melancholia is proof of what I say. Puerperal insanity is acute insanity occurring within an uncertain time of child-birth; and, if the antecedent of child-birth is unknown, or is disregarded, there is nothing whatever in the clinical picture of the disease that is different from other cases of acute insanity that have no connection with the puerperium, or even from acute insanity occurring in men. If acute insanity following child-birth is to be regarded as a disease distinct from acute insanity that does not follow child-birth, then acute rheumatism which follows a wetting must be regarded as a disease distinct from acute rheumatism that does not follow a wetting. Even if it be regarded as a distinct disease, however, the number of cases of puerperal insanity can be extracted, without risk of error, from the causation table, if that table is properly constructed.

The insanity of Pregnancy has a much better right to be considered a disease, for here the fact of the pregnancy is a continuing feature in the clinical picture, a feature which at once marks off the case from all other cases of insanity. But two things should be had in remembrance with respect to insanity in pregnant women. First, although the insanity is associated with pregnancy, and post-dates the pregnancy, yet the pregnancy is not necessarily the only nor the chief cause of insanity; and it may not be a cause at all. Pregnant women are not exempt from the causes that produce insanity in non-pregnant women and in men, and the insanity of a pregnant woman is not necessarily an insanity of pregnancy. It is notorious that the cessation of the pregnancy, whether produced by natural or by artificial means, is by no means always followed by the cessation of the insanity. Second, there is nothing in the insanity of a pregnant woman, except the pregnancy, which differentiates the case from other cases of acute insanity. Lastly the number of cases in which insanity occurs in association with pregnancy can be gathered, if required, from the Causation Table, and need not be indicated again in Table IV.

What is true of the insanity of pregnancy is even more

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emphatically true of the insanity of Lactation. It is an insanity of exhaustion—of innutrition—and differs in no respect in its clinical features from other cases of insanity of similar origin. It, also, is provided for in the Causation Table.

The next variety of insanity commonly distinguished is that of the climacteric, and this is open to the same objections as apply to the insanity of pregnancy. At present, every case of insanity occurring in a woman between the ages of 40 and 55 is called climacteric insanity; and yet it is quite possible that many of them have nothing to do with the menopause. Many of the same causes, that produce insanity at other ages, may operate upon women about the climacteric period, and may be as competent to produce insanity at that as at other ages. And when the menopause does act as the efficient cause, or as one of the efficient causes, of insanity, it does not follow that it will impress upon the insanity such a specific character, such a peculiar facies, as to entitle it to be considered a distinct kind of insanity. Granting, however, that, in some cases of insanity occurring at this period, there are specific features, I think such cases are sufficiently distinguished by separate indication in Table VI.

Insanity of times of life offers fewer difficulties. For my own part, I doubt whether insanity at the period of adolescence has any better title to be called adolescent insanity, than broncho-pneumonia in the adult has to be called adult broncho-pneumonia. There are, in both cases, unimportant differences in the clinical pictures, due to the different constitutions of individuals at different ages; but these differences are not, in my opinion, of sufficient gravity to constitute distinct diseases. In any case, the number of cases of insanity at the period of adolescence can be obtained from the Age Table.

With respect to the claim of senile insanity to be considered a distinct disease, in virtue of the uniform and specific clinical picture that it presents, I had some doubt until I referred to Dr. Clouston's account of the malady. "I confess," he says, "I was myself astonished at the immense variety of symptoms present" [in different cases]. This dictum at once abolishes the right of senile insanity to a distinct place in nosology. The term means, it appears, insanity, not assigned to any distinct category except by its occurrence in advanced life. It would, in my opinion, be unreasonable to base the differentia

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of a disease upon so slender a foundation; and, besides, the number of cases will be shown by the Age Table.

The insanity of epilepsy has a good title to the denomination of a disease. Not only is it accompanied throughout by the periodic attacks of epilepsy, but it is marked, with some approach to distinctness, by its turbulence and aggressiveness, and by its periodic fluctuations in connection with the fits. The clinical picture is, therefore, fairly distinct, and accordingly a separate place is provided for it in the Table IV which I propose.

Cases of insanity associated with different forms of bodily disease, whether the bodily disease may justly be regarded as a cause or not, in no case present a clinical picture of sufficient distinctness to entitle them to separate rank as diseases. Stupor is already provided for in the table; paranoia, recurrent and alternating insanity also are provided for. Dementia, that convenient rubbish-heap, is sifted, and its several constituents apportioned into their proper places. The only cases of insanity which remain to be considered are dementia præcox, hebephrenia, katatonia, fixed delusion, and alcoholic insanity.

Dementia præcox does not require much consideration. No form of insanity that cannot be, or that has not been, specifically defined or described is entitled to be considered a distinct disease; and this stage of distinction has not yet been attained by dementia præcox. There is not yet in existence any definition or description of dementia præcox on which its votaries are agreed; nor is there one which enables it to be distinguished from the residue of insanity which remains when the other distinct forms are eliminated. It need not therefore detain us longer.

Hebephrenia and katatonia are in a somewhat different position, for these are fairly distinguishable forms of insanity in the very few cases in which these characteristics are well marked. Their individuality is, however, destroyed for purposes of classification by the fact that they shade off by insensible degrees into the mass of insanity that is not hebephrenia nor katatonia. To insert them into a table of classification would therefore be to leave that table completely at the mercy of the personal equation of the individuals who severally contribute to its compilation. It is quite true that the same may be said of stupor, but it cannot be said of stupor with the same emphasis

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and weight. There are many cases of acute, and some of sub-acute insanity in which traces of stupor may be discovered by the attentive observer; but the improper classification of such cases is provided against by the condition that classification is to go by the *predominant* symptom; and the predominance of a symptom, as of stupor, is much more easily decided upon than the existence or non-existence of the group of qualities that go to make up katatonia or hebephrenia.

I am inclined to think that fixed delusion merits a separate place in a table of classification. If we keep the term paranoia for those cases of fixed delusion in which the delusion is persecutory in character, there is a considerable remnant of cases characterised by enduring, unchanging delusion, extending over many years, and not accompanied by conduct to match. The character of the delusion is either a glorious exaltation, or it refers to change of part of the personality, as that there is a weasel in the stomach, or that the brain has been removed, etc. The symptoms are well characterised, sharply cut, distinct from those of any other malady, and the course also is characteristic. The symptoms endure for many years without material change, and never disappear. The clinical picture is complete. I think that so well characterised a variety of insanity deserves a separate place in a nosology, and a place can be provided for it in the table that I have suggested, by dividing the delusion column into two, entitled respectively Variable Delusion and Fixed Delusion. The latter column would be re-divided into three, headed respectively Persecutory, Exalted, and Personal. By this small addition to the table, not only would fixed delusion find the separate place to which it is entitled, but the cases of paranoia also would appear in a single column, and the total would be given at the foot of the column. This is a useful addition to the table, easily made, and does not increase materially the labour of compilation.

I now come to alcoholic insanity. Around this variety of insanity there are special interests and special difficulties. Perhaps there is no subject connected with insanity in which the general public is so much interested, or to which it will turn so eagerly to these tables for information, as that of the production of insanity by alcohol. The statistics of causation must be obtained from the causation table; but it is obvious that the statistics of alcoholic insanity have a special interest

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of their own apart from those of the causation table. There are many cases of insanity which are wanting in the specific features of alcoholic insanity, but into whose causation alcohol enters, and all these would be apportioned to the causation of alcohol in the causation table, while they would be excluded from the statistics of alcoholic insanity in the Tables of Forms.

First must be discussed the preliminary question whether alcoholic insanity presents such a specific clinical picture as to entitle it to be considered a distinct form or variety of insanity; and here, at the outset of the inquiry, we are met with the difficulty that "alcoholic insanity" may mean one of several things that are quite distinct. We can distinguish three several clinical pictures comprised or comprisable without this single term. First, there are those cases in which ordinary drunkenness, that is to say, the effect of a single debauch, exhibits itself, not as maudlin, or quarrelsome, or hilarious, or stupid conduct, with thickness of speech, and defect of gait, and so forth, but as furious mania or other well-characterised insanity. These are the cases to which the term *mania a potu* should, I think, be restricted; and these are the cases which enable some institutions to show such remarkably high recovery rates. The second group consists of delirium tremens, the result of repeated gross debauch. The clinical picture is remarkably uniform and distinct; and, although the duration is a little more prolonged than in the group previously described, the cases do not so often find their way into lunatic asylums. The third group comprises cases of alcoholic insanity ordinarily so termed, the result of years of excessive indulgence in alcohol. In these cases also the clinical picture is specific; the mnemonic defect, the insane suspicions, the moral deterioration, and the physical symptoms usually rendering the malady unmistakable, apart from knowledge of its causation. Each of the three groups of cases of insanity due to drink constitutes such a specific clinical picture of disease as fairly entitles it to separate tabulation as a distinct variety of insanity, even apart from its manifest causation; and, although cases of each group can be ranked and filed in due and proper positions in the table that I have proposed, yet, when so allocated, they are mingled with other cases which they generally resemble, are lost in the crowd, and are not afforded that separate and distinctive position to which they seem to be entitled, as well by their peculiar combination

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of symptoms as by their assignable causation. The most obvious means of erecting them into such a distinctive position would be by inserting a new column, headed Alcoholic Insanity, and dividing it into three, distinguished respectively as *mania a potu*, delirium tremens, and alcoholic insanity proper; but there is a manifest objection to such a course. It would introduce into the table of Forms of Insanity an ingredient of causation which would render it logically difficult to exclude other ingredients of the same class, and so would open the door to the very confusion and cross-classification which characterises the table now in use, and which it is so important to avoid. No course that I can devise is wholly free from objection, but, upon the whole, I think the wisest plan would be to introduce a new table, devoted to alcoholic insanity alone, distinguishing the three varieties that I have described above. The great importance of the matter, and the great interest that it excites among the public at large, seem to constitute a sufficient warrant for devoting to its consideration a separate table, in which, moreover, a great deal more information might be embodied than could be inserted in such a general table as Table IV. The following scheme is suggested as a model:

Insanity ascertained to be due to Alcohol.

	Duration of attack before admission.	Ordinal number of attack.	Duration of habit.	Mode of inhibition.		Name of customary stimulant.
				Constant.	Paroxysmal.	
Acute (mania a potu) . . .						
Subacute (delirium tremens) . .						
Chronic (alcoholic insanity) . .						

A collateral advantage of such a table would be that it would exclude all cases in which alcohol was not the main actuating cause of the malady. Of cases of insanity, said to be due to alcohol, there is, between the percentages of different observers, a very wide discrepancy, which cannot be explained by the

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different habits of localities, nor by the different classes to which the statistics refer. It seems that this discrepancy must arise largely from the restriction of the figures, by one observer, to such cases only as could be included in such a table as the foregoing—cases in which the symptoms bear the characteristic stamp of causation by alcohol; while another observer may include, in his cases caused by alcohol, all cases of insanity, whatever the clinical picture they present, in which excessive indulgence in alcohol, habitual or occasional, can be discovered among the antecedents. It is important, no doubt, that, when the abuse of alcohol is discovered among the antecedents of an outbreak of insanity, it should be recorded among the facts of possible causation; but it is more important to distinguish the cases in which the insanity can certainly, from the nature of its symptoms, be mainly ascribed to alcoholic excess, from those in which the alcoholic excess acts as a contributory cause, among others, in bringing about a form of insanity which is not characteristic of causation by alcohol alone. Cases of the latter class would still be recorded, by the method that I propose, in the general causation table; and their number could be ascertained by deducting, from the total of alcoholic causation, the total recorded in the new table.

From the foregoing examination it appears that the only varieties of insanity that have any claim, from the distinctness of their symptoms and course, or from what I have termed the distinctness of the clinical picture that they present, to the title of distinct diseases, are general paralysis, acute delirious mania, some cases of insanity in pregnant women, some cases of insanity at the climacteric, insanity associated with epilepsy, fixed delusion, including paranoia, and alcoholic insanity. All other cases must be lumped together under the heading of insanity *simpliciter*.

With respect to the varieties that have sufficient distinctness to be regarded as separate disorders, the question arises, whether it is desirable and practicable so to arrange the tables as to collect separate statistics bearing upon each or any of them. To determine this question it will be necessary to consider each variety in turn.

A momentary consideration of general paralysis enables us to answer the first part of the question in the affirmative. In

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the light of recent research, it is manifestly desirable to collect statistics of the number of cases of this disease in which syphilis is, and in which it is not, a discoverable antecedent. Here we are concerned no longer with Table IV, but with Table VI, and it is apparent that in this respect the Table proposed by the Statistical Committee is superior to that which I have suggested, for the former does, while the latter does not, afford the means of tabulating this information. Other particulars with respect to general paralysis, which it is desirable to tabulate, are the nature of the stress, other than syphilitic infection, which precedes the disease, the character or type that the disease displays, and its duration. These, I think, are the minimum requirements, though others, such as the occurrence and character of crises in the course of the disease, might be usefully inserted. Confining ourselves, however, to the irreducible minimum, the first and second can be met by abolishing, in the Table of Stress, the vertical division into principal and contributory causes, which is, after all, of doubtful advantage, and substituting, for the first column, a column headed General Paralysis. All the facts of causation with respect to this disease would then be separated from those relating to other cases of insanity. The third requirement—the indication of the type of the malady—is provided for in Table IV as I have drafted it; while the statistics of the duration of the malady must be specified by a modification of Death Group Table III, separating deaths from general paralysis from deaths from other causes.

Of acute delirious mania, any peculiar antecedent should be specified, but beyond this, and the duration of fatal cases, I know of no particulars that are useful to collect. The method is obvious.

I am unable to suggest any statistical facts that could be set forth in these tables with regard to insanity associated with epilepsy.

As to fixed delusion, and its variety paranoia, it is desirable to know whether the malady is primary, or secondary to acute insanity; but this is often difficult or impossible to ascertain, and if separate columns were provided for the purpose in Table IV, some nine of them would be needed, a complication out of proportion to the benefit obtained. The causation should, however, be set forth separately, and this would need

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a separate column in the Causation Table. It may seem that, as fixed delusion, including paranoia, is often secondary to an attack of acute insanity, the latter may logically be regarded as the cause of the former; and that, consequently, if the causation of paranoia is to be separately set forth in the Causation Table, a new rank should be added to that table, entitled "previous acute insanity." Such an addition would, I think, imply a misconception of the object of the Causation Table. As I understand it, the object of the table is to indicate the antecedents of insanity generally, not to indicate the order in which one form of insanity succeeds another. The purposes of this table are satisfied when we have indicated the antecedents of the original attack of insanity, in this case, of the attack of acute insanity. Whatever changes may thereafter take place in the type of the insanity, must all be regarded as results of the original causes by which the patient became insane.

I regard it as certain that many cases of insanity that take place about the climacteric age, and are commonly classed as climacteric insanity, have very little connection with the menopause, and, while I agree that there is a form of insanity that is so connected, and that does present a clinical picture of some little distinctness, yet I am quite sure that in practice this clinical picture would in future be, as it now is, disregarded, and that all cases of insanity in women between forty and fifty-five will continue to be called climacteric insanity. I am of opinion that it would be less misleading, for scientific purposes, to lump cases of true climacteric insanity with the residue, rather than to collect statistics of a so-called climacteric insanity, based upon insufficient discrimination.

The same reasoning applies to the insanity of pregnancy; and applies even more cogently, for insanity associated with pregnancy is not distinguishable, save by the co-existing pregnancy, from insanity in the non-pregnant. I think, therefore, that it would serve no useful purpose to collect separate statistics of insanity occurring either about the climacteric period, or during pregnancy.

Alcoholic insanity, the only remaining variety that has a claim for separate treatment, has already been dealt with.

After the proposed alterations are made, the new headings of Table IV will be as as follows:

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	Non-paralytic.							Associated conditions.												
		Secondary.						Mental.						Bodily.						
									Delusion.											
										Fixed.										
General paralytic.	Primary.	Recurrent.	Alternate.	Exacerbate.	Continuing.	Summary.	Total.	Hallucination.	Temporary or fluctuating.	Persecutory.	Exalted.	Personal.	Mnemonic defect.	Epilepsy.	Fever.	Myxœdema.	Phthisis.			

EXPLANATIONS.

Primary means that the case is admitted for the first attack of insanity.

Recurrent means an attack after recovery from one or more previous attacks.

Alternate means a stage in circular insanity.

Exacerbate means a chronic case subject to acute exacerbations.

Continuing means a chronic case which does not fluctuate decidedly in severity.

Temporary or fluctuating delusion is used in contradistinction to fixed delusion.

Fixed exalted delusion does not include the exalted delusion of general paralysis, even if continuing moderately uniform.

Personal delusion means delusion of alteration of part of the personality.

Mnemonic defect is not to be entered unless it is pronounced.

Epilepsy means idiopathic epilepsy, and excludes, *inter alia*, the fits of general paralysis.

Fever means fever which cannot be attributed to intercurrent disease.

Bodily associated conditions mean bodily diseases believed to be organically connected with the insanity, and not accidental accompaniments. For instance, it includes phthisis associated with the phthisical insanity of Clouston, but excludes phthisis not so associated.

It will be observed that I have not dealt with, as separate varieties of insanity, those cases which are associated with bodily disease. For this there are sufficient reasons. In the first place, if, and in as far as, they really are distinct varieties of insanity, in the sense distinguished in this paper, they are

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sufficiently provided for in the last columns of the Table IV that I submit. While it must be admitted that the insanity of myxœdema, and it may be admitted that the phthisical insanity of Clouston, present clinical pictures sufficiently distinct to entitle them to separate consideration as specific diseases, yet for the great majority of cases of insanity, to which the name of some bodily disease is adjectivally connected, there is no such justification for a specific title. If there is a gouty insanity, apart from insanity which is associated, causally or otherwise, with gout, then assuredly there is a plumbic gout, apart from the gout which is associated, causally or otherwise, with lead poisoning. If there is an anæmic insanity, recognisably different from other insanity, then there is a traumatic anæmia, recognisably different from, say, the anæmia of lactation. There appears to be a confusion in the minds—there certainly is in the nomenclature—of alienists, by reason of which they convey the notion that, if the cause of insanity can be recognised or surmised in any given case, that cause impresses upon the insanity itself a recognisable peculiarity, which may be nominally fixed and indicated by attaching the name of the cause, or surmised cause, adjectivally to insanity. This is not the practice in other departments of medicine. A surgeon speaks, it is true, of syphilitic iritis and rheumatic iritis, but he does so, not merely to indicate the cause of the inflammation of the iris, but because the cause so impresses itself upon the character of the inflammation as to afford a clinical picture of disease distinct from that produced by any other cause. In cases in which no such clinical picture is impressed by the cause, the practice is not followed in any department of medicine except alienism. No physician, I believe, speaks of spinal lardaceous disease and empyematous lardaceous disease; or of emotional diabetes and traumatic diabetes; or of sexual syphilis, and gynæcological syphilis. No surgeon, as far as I know, divides fractures into machinery fractures, fall fractures, and run-over-by-a-cart fractures; or wounds into intentional wounds, unintentional wounds, and wounds from putting the hand through the window glass. It is true that he divides wounds inflicted in battle into bayonet wounds, bullet wounds and shell wounds, in each case employing an adjectival word connoting the cause; but he does so, not to classify the wounds by their causes, but because the cause dominates the character of the wound, and

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impresses upon the case a distinct, specific, clinical picture. It is not the cause that is uppermost in his mind, and that he wants to convey to his hearer, but the character of the wound inflicted. And this last element, the character of the malady, the clinical picture of the disease, is the only proper and valid reason for giving to a case of disease a distinctive title.

It is true that the public will have a name for every case. It is true that our professional brethren, outside our own specialty, consider a diagnosis very incomplete unless a title is given to the patient's malady; and by all means let them be satisfied. If a patient has a delusion, tell his friends that it is a case of delusional insanity. If he is a good deal excited, say that it is a case of acute maniacal delusional insanity. If he is suicidal and destructive, you can add these words as well, and the more elaborate your title, the better pleased will they be, and the more highly will they think of you. It is true that you are merely telling them what they already know, but this renders them the better able to appreciate the accuracy of your diagnosis. Truth is adhered to, and no harm is done. But say that a woman has "puerperal" insanity, and, however carefully we may safeguard ourselves against misconception, we cannot avoid conveying to the friends, and to the practitioner in charge, that the insanity from which the patient suffers is different from "ordinary" insanity. I do not say that any harm is done, either to the friends or to the general practitioner, but I am very sure that we shall not ourselves attain to any true concept of insanity until we have cleared our minds of these foggy confusions. Deep down in human nature is implanted the craving for names. The very first act of the very first man was to give a name to every beast of the field and every fowl of the air. As far as we are advised, he waited neither to eat nor to drink, neither to find shelter for his body nor shade for his head, before he started to give a name to every living creature. If I were to say that even marriage was postponed to this more urgent desire, I should not violate the literal interpretation of the text; but in this matter our first parent had little option, for his spouse did not come into the world until it was prepared for her by the attachment of names to the objects in which she was most likely to be interested. The deep-rooted craving for the attachment of names to objects, thus so strikingly exhibited by our earliest progenitor, has been inherited in undiminished in-

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tensity by all his descendants; and this appears to be a crushing refutation of the doctrine of Professor Weismann, that no qualities are inherited save those which are in-born. For it is indisputable that Adam was not born, and therefore could have had no in-born qualities. However that may be, it appears, from the account of his proceedings, that when he had attached a name to every object presented to him, he took no further interest in them. There can be no doubt, judging from the attitude of his descendants in similar case, that the attachment of a name to a thing gave him all the information about that thing that he considered desirable, and that thenceforth his interest in the thing was at an end. We see precisely the same attitude in every child that finds an unfamiliar flower, or beetle, or stone, by the roadside. He runs with it to his father, and asks what it *is*. The father, if he is able, tells his son the *name* of the thing, and both are satisfied. The object is now flung away. It is of no further interest. Is our own mode of dealing with forms of insanity much better? Are we not a little too anxious to give names to things, whether they deserve separate titles or no? And are we not apt to rest content when a name has been given, and to think that then all is known that need be known? Five-and-twenty years ago I protested against the exaggerated importance that seemed to me to be attached to the nerve-cell, and the neglect to study and appreciate the nerve-fibre; and I besought neurologists to repudiate their *cytolatry*. Must I now protest against an *onomolatry*? It is convenient, no doubt, that things, if they be distinct things, should have names. It would be inconvenient to be obliged to refer to the Chairman of the Statistical Committee as "the benevolent-looking gentleman with the beard of a patriarch and the tongue of a Chrysostom," but it would be attaching exaggerated importance to a name if I were to suppose that, by merely naming Dr. Yellowlees to a person to whom he was a stranger, I could convey a notion of the wisdom and eloquence of the nominee, or of his skill in piloting through this Association statistical tables that are indefensible. If Adam, when it came to the turn of the sea-serpent to receive a name, had given a different title to each coil that appeared above water, would he not have set a precise example to those alienists who designate puerperal insanity and dementia præcox as distinct diseases?

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