

UNIFORM STATISTICAL REPORTS ON INSANITY NOW
ASSURED. AN OFFICIAL CLASSIFICATION
OF PSYCHOSES¹

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Psychiatric progress has been seriously hampered by an unfortunate absence of accurate scientific information which would warrant definite conclusions regarding many matters of far-reaching importance. In our search for knowledge we naturally turn to the published works of recognized authorities whose observations are based presumably upon a wide experience with the subject under discussion. We soon find ourselves overwhelmed with theories and confronted with a startling absence of established facts. Widely heralded writers, in some instances without any actual experience in the care or observation of the insane in any considerable numbers, discuss psychiatric topics voluminously, often reflecting views generally entertained a generation ago, but long since discarded. At best, we are likely to find personal opinions advanced as accepted facts. The textbooks are filled with unsubstantiated statements regarding the frequency of various forms of insanity and the recovery rate of certain psychoses. These are usually based upon the personal observations of the author in question or upon the statistical data available from his own hospital. It is only by accurate statistical studies that we can arrive at conclusions of any great value regarding matters upon which our fundamental conceptions of psychiatry largely depend.

The etiology of insanity has long been a favorite topic of discussion. A brief reference to the publications of some of our well-known authors will, I think, be sufficient to show that further information on this important subject is very essential. Heredity is usually looked upon as one of the most important factors in the production of mental disease, and it unquestionably is. To what extent is it responsible for dementia præcox or manic depressive insanity as compared with the various forms of mental deficiency or epilepsy? Are the Mendelian theories relating to heredity sufficiently estab-

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lished to warrant a complete revision of our views on this subject? These questions can be answered only by a careful analysis of the facts.

The importance of mental defects and insanity as related to criminality, prostitution, alcoholism and pauperism is now quite generally accepted. Further statistical studies, however, are absolutely necessary if conclusions of any value are to be reached. The infrequency of clear-cut psychoses due to the use of any single drug is surprising. Statistics of nearly forty thousand committed cases of insanity show that psychoses due to cocaine alone, for instance, are exceedingly unusual, morphine or some other factor almost always complicating the situation.

Our knowledge of epileptic psychoses is perhaps one of the most discouraging features of psychiatry. We know that nervous and mental diseases, feeble-mindedness and alcoholism are prominent in the family history of epileptics. Attention has been called recently by L. Pierce Clark and others to the so-called "epileptic constitution." If we are to determine whether or not there is such a thing as an epileptic constitution and what its relation to that disease really is, we must know definitely what percentage of cases show the characteristics of that mental makeup. There is, unfortunately, no satisfactory classification of epileptic psychoses. We know, of course, that a large majority of epileptics ultimately reach an advanced state of mental deterioration. We do not, however, know just what this percentage is. We know that many epileptics show pre-paroxysmal states; others are subject to post-paroxysmal conditions; while some exhibit only inter-paroxysmal episodes. In many cases there are associated psychoses, such as manic depressive insanity, which, however, have no definite relation to the epilepsy. There are also other conditions which are probably purely epileptic in character. These matters require considerable discussion, careful analysis and much further consideration, which should be based upon trustworthy statistical information.

We are certainly in need of definite data relating to the psychoneuroses. The necessity of this has, I think, been emphasized by the examination of recruits at the beginning of the war and subsequent developments overseas.

Constitutional psychopathic inferiority is now recognized by the federal government as an adequate reason for rejecting immigrants. The relation of this condition to the various psychoses is also worthy of much more careful study.

The frequency of different forms of insanity has long been a

topic of discussion, as has the recovery rate. Our information on these subjects is, however, practically useless, as it has not been based on the analysis of a large number of carefully studied cases. We can only determine the relative frequency of the various forms of dementia præcox by going over carefully the material available in our large hospitals.

It has long been customary to state in textbooks that certain mental diseases were peculiar to given races, or that they were prevalent in certain communities, or limited largely to various stages of life. These are all questions which can be definitely settled in time, when more facts are available. It will, I think, be conceded that this information must be obtained from institutions, where extended observation is possible and where the insane are under constant supervision. It can be obtained in no other way. The fact that there were over 200,000 insane in the institutions of the United States in 1917 is sufficient evidence that there is no lack of material for such studies. Reports on occasional cases are practically of no value. The official publications of various institutions and the annual reports of a few state departments contain statistical information which can be subjected to intelligent study and analysis. Any effort to make a comparative study of conditions prevailing in different communities or to make statistical studies of psychoses on any elaborate scale has, however, been difficult, if not impossible.

The cost of the care and maintenance of the insane is in itself a question of the utmost importance. There are quite frequent legislative investigations along this line. Unfortunately, it is very difficult to get at the facts. Some states include the cost of repairs and extraordinary improvements in the cost of maintenance. A few state departments in computing the cost of care deduct all receipts for reimbursing patients. Others take into consideration the value of articles produced in the manufacturing departments and the value of the farm products raised. There is no uniformity. A superficial comparison of annual reports would convey the impression that the per capita cost of maintenance in Massachusetts is double that of some of the other states, whereas the real difference consists merely in the method of bookkeeping. It is, of course, equally important to know the cost of construction, the number of employees authorized by the various institutions, etc.

The correlation of statistics regarding the insane in various states has been difficult owing to the multiplicity of methods of administration. Six states have no central administrative control of the insane whatever. In Massachusetts the insane, feeble-minded,

epileptics, inebriates and drug habitues are under the general supervision of a Commission on Mental Diseases. In New York there is a State Hospital Commission; in Maryland, a State Lunacy Commission. In Illinois the institutions for the insane are under the executive control of a Department of Public Welfare, succeeding a former Board of Administration. In Utah there is a State Board of Insanity. In twelve states there are Boards of Control.

In seventeen states the institutions for the insane are under the supervision of State Boards of Charity. In one state only, New Hampshire, they are under the State Board of Health. In forty-two states they are under some form of central control. No two of these states in compiling statistical reports has used the same classification of insanity. As a matter of fact, very few states have consistently used any classification at all, usually leaving the method of reporting psychoses to the individual hospital. The reports of the last few years show everything from dementia to chronic delusional insanity, and have embraced practically every psychiatric term coined during the last century.

Repeated efforts have been made to remedy this unfortunate condition of affairs. The Association of Medical Superintendents of American Institutions for the Insane in 1869 prepared a set of statistical tables which were used more or less for some years but never officially adopted. At the annual meeting of the American Medico-Psychological Association at Niagara Falls in June, 1913, a committee was appointed for the purpose of formulating a plan for the compilation of statistical data on the insane in the hospitals of the United States and Canada. At the annual meeting of the Association in New York in 1917, the committee submitted a report recommending the adoption of a set of statistical tables and a classification of mental diseases to be used by all institutions.

The conclusions reached by the committee are well illustrated by a quotation from their report to the Association:

"That the statistical data annually compiled by the various institutions for the insane throughout the country should be uniform in plan and scope is no longer open to question. The lack of such uniformity makes it absolutely impossible at the present time to collect comparative statistics concerning mental diseases in different states and countries, and extremely difficult to secure comparative data relative to movement of patients, administration, and cost of maintenance and additions. The importance and need of some system whereby uniformity in reports would be secured have been repeatedly emphasized by officers and members of this Association, by statisticians of the United States Census

Bureau, by editors of psychiatric journals, and by administrative officials in various states. We should know accurately the forms of mental disease occurring in all parts of the country; we should know the movement of patients in every hospital for the insane; we should know the cost of maintenance of patients and the amounts spent for additions and improvements in every state hospital; we should be able to compile annually complete data concerning these and other matters, and compute rates and draw comparisons therefrom. Such data would serve as the basis for constructive work in raising the standard of care of the insane, as a guide for preventive effort, and as an aid to the progress of psychiatry.

"Your Committee feels that the first essential of a uniform system of statistics in hospitals for the insane is a generally recognized nomenclature of mental diseases. The present condition with respect to the classification of mental diseases is chaotic. Some states use no well-defined classification. In others the classifications used are similar in many respects, but differ enough to prevent accurate comparisons. Some states have adopted a uniform system, while others leave the matter entirely to the individual hospitals. This condition of affairs discredits the science of psychiatry and reflects unfavorably upon our Association, which should serve as a correlating and standardizing agency for the whole country.

"The large task of your Committee therefore has been the formulation of a classification which it could unanimously recommend for adoption by the Association. The task was accomplished only after several prolonged conferences at which classifications now in use in various states and countries, and the recommendations of leading psychiatrists were considered. The classification finally adopted is simple, comprehensive and complete; it copies no other classification but includes the strong features of many others; it meets the demands of the best modern psychiatry, but does not slavishly follow any single system. In short, your Committee has endeavored to formulate a classification that could be easily used in every hospital for the insane in this country and that would meet the scientific demands of the present day."

The following classification of mental diseases was recommended and adopted by the Association:

1. Traumatic psychoses:

- (a) Traumatic delirium.
- (b) Traumatic constitution.
- (c) Post-traumatic mental enfeeblement (dementia).

2. Senile psychoses:

- (a) Simple deterioration.
- (b) Presbyophrenic type.
- (c) Delirious and confused types.

- (d) Depressed and agitated states in addition to deterioration.
- (e) Paranoid types.
- (f) Pre-senile types.
- 3. Psychoses with cerebral arteriosclerosis.
- 4. General paralysis.
- 5. Psychoses with cerebral syphilis.
- 6. Psychoses with Huntington's chorea.
- 7. Psychoses with brain tumor.
- 8. Psychoses with other brain or nervous diseases. The following are the more frequent affections and should be specified in the diagnosis:
 - Cerebral embolism.
 - Paralysis agitans.
 - Meningitis, tuberculous or other forms (to be specified).
 - Multiple sclerosis.
 - Tabes.
 - Acute chorea.
 - Other conditions (to be specified).
- 9. Alcoholic psychoses:
 - (a) Pathological intoxication.
 - (b) Delirium tremens.
 - (c) Korsakow's psychosis.
 - (d) Acute hallucinations.
 - (e) Chronic hallucinations.
 - (f) Acute paranoid type.
 - (g) Chronic paranoid type.
 - (h) Alcoholic deterioration.
 - (i) Other types, acute or chronic.
- 10. Psychoses due to drugs and other exogenous toxins:
 - (a) Opium (and derivatives), cocaine, bromides, chloral, etc., alone or combined (to be specified).
 - (b) Metals, as lead, arsenic, etc. (to be specified).
 - (c) Gases (to be specified).
 - (d) Other exogenous toxins (to be specified).
- 11. Psychoses with pellagra:
- 12. Psychoses with other somatic diseases:
 - (a) Delirium with infectious diseases.
 - (b) Post-infectious psychosis.
 - (c) Exhaustion-delirium.
 - (d) Delirium of unknown origin.
 - (e) Cardio-renal diseases.

- (f) Diseases of the ductless glands.
- (g) Other diseases or conditions (to be specified).
- 13. Manic-depressive psychoses :
 - (a) Manic type.
 - (b) Depressive type.
 - (c) Stupor.
 - (d) Mixed type.
 - (e) Circular type.
- 14. Involution melancholia.
- 15. Dementia præcox :
 - (a) Paranoid type.
 - (b) Catatonic type.
 - (c) Hebephrenic type.
 - (d) Simple type.
- 16. Paranoia or paranoic conditions.
- 17. Epileptic psychoses :
 - (a) Deterioration.
 - (b) Clouded states.
 - (c) Other conditions (to be specified).
- 18. Psychoneuroses and neuroses :
 - (a) Hysterical type.
 - (b) Psychasthenic type.
 - (c) Neurasthenic type.
 - (d) Anxiety neuroses.
- 19. Psychoses with constitutional psychopathic inferiority.
- 20. Psychoses with mental deficiency.
- 21. Undiagnosed psychoses.
- 22. Not insane :
 - (a) Epilepsy without psychosis.
 - (b) Alcoholism without psychosis.
 - (c) Drug addiction without psychosis.
 - (d) Constitutional psychopathic inferiority without psychosis.
 - (e) Mental deficiency without psychosis.
 - (f) Others (to be specified).

The following statistical tables were adopted by the Association on the recommendation of the committee :

1. General information.
2. Financial statement for the year.
3. Movement of population.
4. Nativity of first admissions and of parents of first admissions.

5. Citizenship of first admissions.
6. Psychoses of first admissions.
7. Races of first admissions classified by psychoses.
8. Age of first admissions classified by psychoses.
9. Education of first admissions classified by psychoses.
10. Environment of first admissions classified by psychoses.
11. Economic condition of first admissions classified by psychoses.
12. Use of alcohol by first admissions classified by psychoses.
13. Marital condition of first admissions classified by psychoses.
14. Psychoses of readmissions.
15. Discharges classified by psychoses.
16. Cause of death classified by psychoses.
17. Age at death classified by psychoses.
18. Duration of hospital life classified by psychoses.

Since the official adoption of these statistical tables, the Association's committee has prepared an elaborate statistical manual explaining their use. This includes explanatory notes intended to answer any questions which may arise in connection with either the classification or the statistical tables.

The report of the committee represented a consideration of the entire subject extending over a period of about four years, during which time practically every psychiatrist of note in the country was consulted. To use the phraseology of the committee, quoting again from their report, it is well worth while to emphasize the fact that the classification adopted "copies no other classification, but includes the strong features of many others; it meets the demands of the best modern psychiatry, but does not slavishly follow any single system." All debated points were carefully avoided as far as possible. Only generally recognized entities were included. There is no reason why it should meet with any opposition. As a matter of fact, it has not. The Association now has a standing committee on statistics which will make such modifications and amendments in the statistical scheme as may be found necessary from time to time. The committee in 1918 as designated by Dr. E. E. Southard, President of the Association, consists of the following: Dr. A. M. Barrett, professor of psychiatry and neurology, University of Michigan, chairman; Dr. Adolf Meyer, professor of psychiatry, Johns Hopkins University; Maj. E. Stanley Abbot, McLean Hospital; Dr. James V. May, superintendent Boston State Hospital; Dr. George H. Kirby, director of the Psychiatric Institute, Manhattan State

Hospital, New York City; Dr. Owen Copp, superintendent Pennsylvania Hospital, Department for Nervous and Mental Diseases; and Dr. Samuel T. Orton, clinical director and pathologist, Pennsylvania Hospital, Department for Nervous and Mental Diseases. Lt. Col. Thomas W. Salmon, medical director, Maj. Frankwood E. Williams, associate medical director, and Dr. Horatio M. Pollock, consulting statistician, were designated by the National Committee for Mental Hygiene to represent that organization on the committee.

The practical operation of this plan for obtaining statistical reports from institutions of the country has been assured by the establishment of a Bureau of Statistics of the National Committee for Mental Hygiene at its office at 50 Union Square, New York City. The work of this bureau is officially coördinated with the Committee on Statistics of the American Medico-Psychological Association. Since this work was undertaken, the Association's classification has been adopted officially by the commissions and various central boards of control in the following states: Arizona, California, Illinois, Kentucky, Maryland, Massachusetts, Missouri, Nebraska, New York, Ohio, Pennsylvania, Tennessee and Wyoming. Its official recognition by other states is merely a matter of time. It has already been adopted by 145 of the 156 state hospitals for the insane in the country, including all of the institutions in forty different states.

The Bureau of Statistics has furnished all of the public institutions with complete sets of forms for the statistical reports. The success of this important movement would appear to be definitely assured at last and it unquestionably constitutes one of the greatest developments of modern psychiatry. The adoption of the classification of psychoses throughout the United States will alone do more towards raising the standards of hospital care in this country than anything attempted or proposed heretofore.

In conclusion, I wish to appeal to all who are interested in the progress of modern psychiatry to spare no efforts towards making this undertaking an unqualified success.