

**The 'Table of the Forms of Insanity': The History of the  
Psychiatric Nosology of the Medico-Psychological  
Association of the United Kingdom and the British Isles**

Kevin Matthew Jones

Submitted in accordance with the requirements for the degree of  
Doctor of Philosophy

The University of Leeds  
School of Philosophy, Religion and History of Science

November 2019

The candidate confirms that the work submitted is his/her own and that appropriate credit has been given where reference has been made to the work of others.

This copy has been supplied on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

The right of Kevin Matthew Jones to be identified as Author of this work has been asserted by him in accordance with the Copyright, Designs and Patents Act 1988.

© 2019 The University of Leeds and Kevin Matthew Jones

## Acknowledgements

First off, I would like to thank Michael Finn and Adrian Wilson for their support for this project from the very outset: if they had not helped me to develop my initial research project for funding applications then I certainly wouldn't be writing these acknowledgements. They have provided intellectual and emotional support of a kind that I am very lucky to have had, have given me the freedom to pursue lines of research that have not always been apparent in their worth, and an intellectual freedom. Their guidance at crucial points during the development of this project was key to its completion. I would like to thank the School of Philosophy, Religion and History of Science, and the Centre for the History and Philosophy of Science for the funding which allowed this research to happen. I would like to thank Nicholas Jones for his support as director of teaching in the department and all the module leaders and tutoring colleagues I have had the pleasure to work with: I have the strong conviction that teaching is a key component of one's development as an academic, and being granted the opportunity to teach on such a wide-variety of modules from the history of science and the many different branches of philosophy has helped me to develop professionally and personally. I would like to thank the organisers of the conferences I have been lucky enough to present at and receive feedback on my work, including the British Society for the History of Science, the Committee for the Integrated History and Philosophy of Science, and the History, Science, Technology and Medicine Network of Ireland. I would like to thank the people who have been kind enough to take the time to read my work. First off, I would like to thank Åsa Jansson, who was kind enough to give detailed feedback on a draft of the second chapter of this thesis. I would like to thank Jennifer Wallis, whose work has been a continual source of inspiration and has been kind enough to provide critical feedback on my work. I would like to thank Sean Dyde and Konstantin Kiprijanov, who in addition to being kind and supportive friends, provided detailed and constructive feedback on early drafts of the first chapters. Finally, I would like to thank Chris Millard for leads on post-war psychiatry that proved very fruitful during the final phases of the write up, Jonathan Topham for leads on Pinel's reception in the British Isles, and Polina Merkulova for pointers on Thomas Laycock's work. I would like to thank Gregory Radick, Rhodri Haywood and Jonathan Hodge for their generosity with their time. Finally, I would like to thank Emily Herring and Laura Sellers for their strong collaborative spirit on the projects we have worked on over the years. Last but not least, I would like to thank my brother, who has been a rock during these last four years, and I would like to dedicate this thesis to my father Roy.





## Abstract

The most appropriate means of classifying mental health disorders has attracted the interest of philosophers of psychiatry since at least the 1970s, with much discussion being centred around successive incarnations of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, a document which overwhelmingly contributed to the standardisation of concepts of psychopathology across the world today. This thesis seeks to provide an historical contribution to these debates by presenting a case study that has been overlooked by historians of psychiatry: attempts made to standardise the concepts of psychopathology that were used by British alienists during the mid-late nineteenth century. The somatic turn in the conceptualisation of mental disorders that was seen across Europe from around the 1850s onwards led to growing concern amongst British alienists about the worth of Pinel's symptom based classification of mental disorders. British mental scientists offered new classifications that attempted to offer aetiological and biological concepts of psychopathology informed by research undertaken in the fifty years since Pinel. This led to series of failed attempts to standardise concepts of psychopathology during the 1870s to the 1880s, and culminated in a fierce debate that took place at the turn of the twentieth century about what a standardised psychiatric nomenclature for use by alienists British Isles should look like. The objects of these debates, the Table of the Forms, would be used by doctors in the United Kingdom up until the 1950s, the beginning of the era of global psychiatric nomenclature in the form of the *DSM* and the *ICD*.

# Table of Contents

Acknowledgements.....	3
Abstract .....	5
Table of Contents .....	6
List of Figures.....	9
<b>Introduction</b> .....	11
Section 1: What is a Mental Disorder? Historiographical and Philosophical Approaches to Mental Disorder and Classification .....	14
Section 2: The Role of Diagnosis and Classification of Mental Disorder in the Formulation of Psychiatric Knowledge .....	22
Section 3: The Table of the Forms of Insanity and Mental Disorder.....	28
Section 4: Methodology and Outline of the Thesis .....	32
<b>Chapter 1: The Rise of Pinel’s Classification in the British Isles and the Aspirations to a Scientific Classification: 1800 – 1860</b> .....	44
Introduction .....	44
Section 1: Pinel’s Forms of Insanity.....	49
1.1: British Influences on Pinel’s Work.....	50
1.2: The Forms of Mental Alienation in Pinel’s <i>Traité médico-philosophique sur l’aliénation mentale</i> and their English (Mis)Translation.....	54
Section 2: James Cowles Prichard and the origins of a standard psychiatric nomenclature ...	62
2.1: Prichard’s Textbooks and the Introduction of the Pinelean system to the British Isles..	63
2.2: The Origins of the Table of the Forms of Insanity: Prichard and the Lunacy Commission .....	71
Section 3: Skae and the Aspirations to a Scientific Classification.....	79
Conclusion.....	87
<b>Chapter 2: Statistics, Causal Explanations of Insanity and Revisions to the Table of the Forms: Medico-Psychological Association Debates 1860 – 1882</b> .....	89
Introduction .....	89
Section 1: The First Revisions to the Statistical Tables: 1840 – 1882.....	93
1.1: The Beginnings of the Statistical Tables 1840 - 1868 .....	94
1.2: Skae’s First Set of Revisions and the Aftermath: 1868 – 1882.....	100
Conclusion .....	115
Section 2: The Second Revision to the Statistical Tables: 1880 - 1882.....	115
Conclusion.....	126
<b>Chapter 3: A Higgledy Piggledy Conglomeration: Prognosis and the 1906 ‘Proto- Kraepelinian’ Classification of the Medico-Psychological Association</b> .....	129
Introduction .....	129
Section 1: The Development of an ‘Official Classification of the Forms of Insanity’ 1902 - 1906 .....	133

1.1 Discussions on Prognosis and the First Set of Revisions to the Statistical Tables: 1902 – 1905 .....	135
1.2 The First Revisions to the Tables and the Introduction of Prognosis to the Table of the Forms .....	139
1.3 Mercier’s Classification: .....	149
Section 2: The Classification of the Forms of Insanity .....	154
2.1 The Debates Between July 1904 and July 1906 .....	155
2.2: The Final Report and the Final Classification .....	158
2.3: The Reception .....	162
2.4 The Aftermath.....	165
Conclusion.....	167
<b>Chapter 4: Heterogeneity in Classification and the (Failed) Second Revision to the Table of the Forms of Mental Disorder.....</b>	<b>171</b>
Section 1: Why was a revisions committee established in 1929? .....	176
Introduction .....	176
1.2 Focal Infection Theory .....	178
1.3 Psychoanalysis .....	181
1.4 The Borderland .....	189
Section 2: The Classification Committee.....	191
2.1 The Deliberations and Reports of the Classification Committee .....	193
2.2 Oligophrenia.....	199
2.3 Neurosis and Psychoneurosis .....	201
2.4 Schizophrenic Psychosis .....	203
2.5 Psychopathic Constitution .....	206
2.6 Affective Psychosis.....	208
2.7 Toxic Psychosis.....	208
Section 3: Reactions .....	208
Conclusion.....	216
<b>Chapter 5: The ‘Mesozoic’ Table of the Forms: An Epilogue.....</b>	<b>218</b>
Introduction .....	218
Section 1: War Time Debates Surrounding Classification.....	222
Section 2: The Amalgamation of Services in the Post-War Period and the Adoption of the ICD.....	230
Conclusion.....	244
<b>Conclusion.....</b>	<b>245</b>
Bibliography.....	253
Primary Sources .....	253
Archives Consulted.....	253
Reports and Minutes.....	253

Academic Papers, Textbooks, Treatise, Nosologies.....	257
Addresses and Lectures.....	262
Laws and Acts of Parliament.....	262
Obituaries .....	263
Secondary Sources .....	263

## List of Figures

Figure 1: The Periods of the Table of the Forms .....	39
Figure 2 William Cullen’s nosology of Neurosis (Nervous Diseases). .....	52
Figure 3 Thomas Arnold, ‘A Table of Species of Insanity’ .....	53
Figure 4 Pinel’s forms of insanity. ....	56
Figure 5: ‘To these heads may perhaps be added ‘Delirium Tremens’ since it is mentioned, as a form of Insanity, in the Reports of some Lunatic Asylums.’ .....	76
Figure 6: Skae’s Classification included in his lecture Of the Classification of the Various Forms of Insanity .....	85
Figure 7: Forms of Mental Disorder Presented in John Thurnam’s <i>Observations and Essays in the Statistics of Insanity</i> . ....	95
Figure 8: Forms of Mental Disorder presented in Lockhart’s ‘Suggestions Towards an Uniform System of Asylum Statistics and Hospitals for the Insane’. ....	97
Figure 9: Skae’s Classification as presented to the Association of Asylum Medical Officers in 1863. ....	101
Figure 10: Classification Proposed by the MPA Statistical Revisions Committee in 1870. ....	101
Figure 11: The classification presented by John Batty Tuke in ‘A Pathological Classification of Mental Diseases. ....	105
Figure 12: Recommended Changes to the Table of the Forms of Mental Disorder Presented to the Annual General Meeting of the MPA in 1882. ....	119
Figure 13: Recommended Changes to the Aetiological Table of the MPA Presented by The Statistical Committee and presented at the 1882 Annual General Meeting of the Association. ....	124
Figure 15: Proposed Medical Register submitted in the report of the Statistical Revisions Committee. ....	141
Figure 16: Table of the Forms of Mental Disorder Presented to the Annual General Meeting of the MPA in 1882. ....	143
Figure 17: The Forms of Mental Disorder Included in the Report of the Statistical Committee presented to the 1904 AGM of the MPA. ....	144
Figure 18: Charles Mercier’s classification of the forms of non-congenital insanity. ....	153
Figure 19: Table of the Forms Presented to the 1906 Annual General Meeting of the MPA .	160
Figure 20: Provisional Classification Presented in July 1931. ....	196
Figure 21: Final Classification approved by the RMPA. ....	198
Figure 22: Henderson and Gillespie’s Classification of Mental Diseases. ....	214
Figure 23 Mental Health Section, <i>ICD-6</i> . ....	239

Figure 24: Draft Classification of the Medical Research Council put forward by Penrose.....	241
Figure 25: Mental Illness and Mental Deficiency Index cards .....	243

# Introduction

This thesis seeks to add to our understanding of where the concepts of mental health that we are familiar with today came from by looking at a document that had a huge impact on standardising the terms used in British mental health care: The Table of the Forms of Insanity, a document used by the Medico-Psychological Association (MPA), the principle representative group of psychiatrists and the precursor to the Royal College of Psychiatrists.<sup>1</sup> This thesis provides a comprehensive history of how this important document was used by professional organisations associated with the treatment of madness in the United Kingdom between 1845 and 1948. In doing so, the thesis looks at how British psychiatrists understood, categorised, and classified mental disorder in the United Kingdom from the middle of the nineteenth century, though the era of the asylum, the Great War, during the interwar years and ending at the beginning of the National Health Service after the Second World War, when the document would fall out of use. This document demonstrates how people with insanity and mental disorder were diagnosed before their admittance to asylums, mental hospitals, and psychiatric wards during this important period in the history of psychiatry.<sup>2</sup>

The Table of the Forms began life as a guide to doctors on what concepts should be used to diagnose those who were to be admitted to an asylum, but it would become the official psychiatric classification of the MPA, and many hoped that adopting a standardised set of diagnostic concepts would improve the statistics returned on asylum admissions and improve the quality of data that were used in psychiatric epidemiology. The Table of the Forms was included in statistical tables that were sent out to asylum medical-superintendents by the Lunacy Commission and the MPA and were filled in yearly with numbers representing the forms of insanity that were suffered by pauper lunatics admitted to county asylums. The

---

<sup>1</sup> The document in question was known as the Table of the Forms of Insanity until the second round of revisions were undertaken by the MPA in 1932, when it became known as the Table of the Forms of Mental Disorder. For brevity's sake, I will refer to it generally as the 'Table of the Forms', but when I am specifically referring to the document that was used from 1845 until the beginning of the twentieth century, I will refer to it as the 'Table of the Forms of Insanity'. In the fourth chapter onwards, which covers the period between 1932 and 1948, I will refer to the document as 'the Table of the Forms of Mental Disorder'. There are part of the thesis when the Table of the Forms reads awkwardly, and saying 'classification' would make it read more elegantly, but I have decided to continue using 'Table of the Forms' because it expresses the unclear epistemological status of the document, with some believing that it described symptom-based forms of insanity, and others regarding it as describing different natural kinds of insanity.

<sup>2</sup> Another note on terminology: the Medico-Psychological Association has existed under four different names since its establishment: the Association of Medical Officers of Asylums and Hospitals for the Insane between 1841 and 1865, the Medico-Psychological Association from then until it received its Royal Charter in 1926, making it the Royal Medico-Psychological Association until it became the Royal College of Psychiatrists in 1971. This thesis uses the historically correct moniker where appropriate, but the Medical-Psychological Association, or simply 'the Association' have been used as the defaults when discussing a period that straddles any of these periods in its existence. For some details on the history of the Association, see the official history of the Royal College of Psychiatrists, though as Gerald Grob notes, this is by no means an authoritative history: Thomas Bewley, *From Madness to Mental Disorder. A History of the Royal College of Psychiatrists*, (RCPsych Publications, 2008); and Gerald N. Grob, 'Review: *Madness to Mental Illness: A History of the Royal College of Psychiatrists*', in *Journal of the History of Medicine and Allied Sciences*, Vol. 67, No.3, July 2012, pp.509 – 510

debates surrounding which concepts should be used in these tables led to it becoming the standard psychiatric classification of the MPA at the turn of the century in the hope that this document would be a modern clinical classification that represented the consensus view of which concepts of insanity were important for use in diagnosis and research. The document would be revised again in the 1930s with the aim of capturing the most advanced psychiatric concepts in use during the interwar period, before falling out of use immediately after the Second World War.

This thesis looks in detail at the creation and development of this document, as well as the revisions that were made to it during its century long existence, from the passing of the 1845 Lunacy act until the 1948 National Health Service Act. This study looks at the procedures that helped to formulate the document, and the discussions undertaken by British psychiatrists during revisions that were made to it during its century long existence. In doing so, this thesis confronts historical and philosophical questions about what it meant to categorise cases of mental disorder, and how attitudes held by psychiatrists towards classification helped shape the document. These attitudes were diverse, and sometimes came into conflict with one another; far from being an homogenous thought collective who held narrow ideas on psychiatric classification, debates surrounding the revisions that were made to the Table of the Forms were sometimes heated and demonstrate divergences on what diagnostic concepts should be included in a standard classification used in British psychiatry.<sup>3</sup> These debates on classification touched on grander questions about what it meant to classify a mental disorder, whether such an enterprise was desirable, or indeed, whether such an enterprise was even possible. The naming of diseases plays an important social role – in the communication between medical professionals, in the development of administration surrounding public health, and the categories that are developed by medicine become used within wider culture.<sup>4</sup> The practicalities and greater metaphysical questions on what constituted insanity and mental disorder surfaced during the discussions on the Table of the Forms in a way that is difficult to see from the analysis of textbooks and research papers alone, and this thesis attempts to outline the discursive culture that existed within British psychiatry.

To understand how the concepts employed in this document became the standard, it has been necessary to go beyond the debates undertaken by psychiatrists which are recorded in the archives of the Royal College of Psychiatrists, and understand the legal and social developments surrounding psychiatric care that took place during this period. For instance, during the first phases of the existence of the document, psychiatry was itself in its very earliest

---

<sup>3</sup> A thought collective (*Denkkollektiv*) was according to Ludwik Fleck the collection of

<sup>4</sup> Charles E. Rosenberg, 'The Tyranny of Diagnosis: Specific Entities and Individual Experience' in *the Milbank Quarterly*, Vol.80, No.2, June 2002, pp.237 – 260.



stages as a profession and as a medical discipline, with much of what we came to know as psychiatric care being undertaken by lunacy administration and general medicine.<sup>5</sup> This is reflected in the history of the Table of the Forms: it was first drawn up by the administrative body set up by the passing of the 1845 Lunacy Act, the Lunacy Commission, which was the regulatory authority for British asylums until 1913, when it was renamed the Board of Control and would finally be abolished in 1959.<sup>6</sup> The Lunacy Commission recommended a set of concepts of insanity included in the table because the 1845 act made it a legal requirement for asylums to record the psychological diagnosis of a patient and the physical cause of their illness. This was a crucial development that had huge impact on the standardisation of concepts of insanity, functioning as a catalyst for discussions on classification carried out by psychiatrists; the terms they recommended became the standard terms used in British psychiatric diagnosis until the end of the nineteenth century, and they would become the terms invoked in the discussions surrounding classification that the Table of the Forms functioned as a catalyst for. In short, these terms constituted the shared language of psychiatric discourse from the 1860s until at least the 1900s.

The revisions that were made to the tables triggered debates amongst British psychiatrists on classification, and these are the focus of this thesis. The thesis looks at the discussions that surrounded these tables, looking at the justifications that were made for including and excluding certain disease concepts from the list of the different forms of insanity and mental disorder that were recognised by the MPA. In doing so, it will look at how psychiatric concepts were formulated from the concepts used in these statistical tables, and how these same tables triggered debates about the clinical classification of mental disorder. In looking at debates that surrounded the table, this thesis provides an archaeology of thought on psychiatric classification, and looks at the broader issues that arose during these debates.<sup>7</sup> In being used as standard concepts to record the diagnoses of the people who entered asylums across the United Kingdom, the concepts of mental disease used in the Table of the Forms were arrived at by consensus by committees established by the MPA, the principle representative body of asylum doctors and psychiatrists in the United Kingdom. The concepts included therefore are a record of what forms of mental disorder doctors thought they would need to accurately record the diagnosis the patients that they received, be it into the asylums of the nineteenth century, or the psychiatric out-patient clinics that were becoming more widespread throughout the interwar years. The context in which treatment was given to patients then was an important consideration in the demands placed upon the Table of the

---

<sup>5</sup> Kathleen Jones, *Mental Health and Social Policy, 1845 – 1959*, Routledge, 1960

<sup>6</sup> Charles Webster, *The Health Services Since the War vol.1*, HMSO, 1988.

<sup>7</sup> Michel Foucault articulated in *The Archaeology of Knowledge* the methodological approach that he had taken in his earlier phase of works, including *The Birth of the Clinic*, *The Order of Things*, and *Discipline and Punish*.

Forms, and this is just one of the examples of how context helped to define the concepts that were used within the document, and the discussions that took place surrounding the document which this thesis will explore.

## Section 1: What is a Mental Disorder? Historiographical and Philosophical Approaches to Mental Disorder and Classification

Current scholarly views on what mental disorder constitutes vary greatly, and it is useful at this point to provide a brief overview of the main positions taken by scholars from the history and philosophy of psychiatry before I explore them in more detail below, and establish links between these perspectives and how they inform the research undertaken in this thesis. There are some who believe that mental disorders are natural, and exist objectively in the world in some form, either as biomarkers or as biological signs that are detectable with the right techniques and equipment, or in the form of a breakdown in biological and evolutionary functions such as decreased chances of survival or procreation. There are those who counter these views by saying that all forms of mental illness, and our recognition of them, are to some extent influenced by society and culture.<sup>8</sup> The strength of these claims can vary: we can claim that mental disorders are a construct of society and culture, and so are radically variable as societies and culture change; or we can say that they are natural entities that are understood through epistemic frameworks that vary across societies, and the way that they are understood under. Those who take a very strong position in this way gesture towards mental disorders that appear to have been limited to certain cultures and historical periods.<sup>9</sup> In addition, the number of people suffering from mental disorder can vary depending on social and cultural factors, such as the recognition of disorders and cultural elements that give rise to certain behaviours. The cultural and social elements of mental disorders are perhaps at first glance more apparent than in other diseases such as ebola or cholera: mental diseases are dependent and shaped by the fact that they apply to the human mind, humans who are capable of suppressing or playing up to the symptoms described by these disorders, and humans who live in societies and reside within cultures.

Classification within general medicine and more specifically in psychiatry has attracted the attention of historians, sociologists, clinicians and philosophers, amongst many others.<sup>10</sup>

---

<sup>8</sup> The medical anthropologist Margaret Lock places medical nosologies, and in particular the DSM, within a culturally bound, epistemic tradition: 'DSM III as a Culture-bound Construct: Commentary on Culture-bound Syndromes and International Disease Classifications' in *Culture, Medicine and Society*, Vol.11, 1987, pp.35 – 42.

<sup>9</sup> For instance, Ian Hacking *Mad Travellers*, Harvard University Press, 2002.

<sup>10</sup> Martyn Pickersgill, 'Debating DSM-5: Diagnosis and the Sociology of Critique' in *Journal of Medical Ethics*, No.40, 2014, pp.521 – 525; Ian Hacking, 'Lost in the Forest: A Review of the DSM-5' in *LRB*, Vol.35, No.15, 8<sup>th</sup> August 2013, pp.7 – 8; Edward Shorter, 'The History of Nosology and the Rise of the *Diagnostic and Statistical Manual of Mental Disorder*' in *Dialogues in Clinical Neuroscience*, Vol. 17, No.1, pp. 59 – 67; Rachel Cooper, *Classifying Madness: A Philosophical Examination of the Diagnostic and Statistical Manual of Mental Disorders*, Springer, 2005.

Broadly speaking, we can see that philosophical perspectives on classification tend to the normative, offering critiques and views on what the best form of psychiatric classification should be; historical accounts generally try to understand the purposes that classification has served in the past; and sociologists try to understand the social functions of that classification. Yet, this disciplinary distinction is not always so clear in the literature because clinicians frequently use historical arguments in their research, historians make philosophical assumptions about the existence or not of mental disorders, and philosophers and sociologists use case studies from the history of psychiatry to investigate the social function of classification. This section will review the positions taken by such scholars, but because of the porous nature of the disciplinary backgrounds of those offering perspectives on the history of mental disorder, it is difficult to neatly separate these perspectives. In light of this, I will not impose firm disciplinary boundaries when reviewing these scholarly accounts of mental disorder and classification, and instead attempt to articulate the exchange that has taken place between clinicians, philosophers, historians and sociologists through the history of psychiatry and, more specifically, the history of classification.

The first historical accounts of psychiatric classification that arose in the middle decades of the twentieth century sought to demonstrate how they had developed and had become more advanced as psychiatric knowledge developed throughout history. The most famous of these include works by Richard Hunter and Ida MacAlpine, and Gregory Zilboorg, who emphasised *developments* in clinical classification in their histories of psychiatry.<sup>11</sup> This is partly explained by the clinical background of these authors, with them presenting valuable resources which provide in depth analysis of the development of psychiatric ideas that were informed by clinical knowledge and are still useful to historians today. At the same time, the limitations of focusing entirely on *developments* can be that it quickly becomes ‘Whiggish’, with the assumption underlying these histories being that less advanced concepts of insanity and mental illness were replaced with more advanced ones as the disciplines became more well formulated. Classification has advanced through history according to these authors through scientific and clinical discoveries that have increased our understanding of mental disorder, narrowing history to the charting of some important but limited considerations from the history of clinical knowledge. Whilst building on these works, this thesis adopts a more pluralist approach, presenting the discussions and context that surrounded the revisions of the Table of the Forms in order to understand how considerations other than scientific discoveries gave rise to concepts that were included in the Table of the Forms.

More recent historians who present a narrative of development include Edward Shorter, yet his account is not so linear: for him there have been bumps in the road of

---

<sup>11</sup> Richard Hunter and Ida MacAlpine, *Three Hundred Years of Psychiatry 1535 – 1860: A History Presented in Selected English Texts*, LLC, 2013; Gregory Zilboorg, *A History of Medical Psychology*, W.W. Norton and Company, 1967.

psychiatric development, with periods of discovery and periods of stagnation. For Shorter, the first wave of biological psychiatry that emerged from Germany in the second half of the nineteenth century saw breakthroughs in psychiatric research that culminated in the classification system of Emil Kraepelin at the dawn of the twentieth century.<sup>12</sup> According to his view, what he terms the ‘first biological psychiatry’ was the era of the great European nosologists, but this era of progress was cut short by the dominance of psychoanalysis in the United States after the Second World War. Shorter also judges British psychiatry by its scientific contributions to psychiatric knowledge, dismissing the ‘English’ as ‘never [having been] big systematisers’, who made little in the way of progress or impact in terms of the classification of mental disorders.<sup>13</sup> This he seems to explain partly with an anti-theoretical empiricism that left British alienists stumbling in the dark in comparison to the work of German psychiatrists, whose systematic spirit allowed them to collect and sort evidence with more effectiveness.<sup>14</sup> Aside from taking issue with Shorter for in most part overlooking the contributions of psychiatrists working in the Edinburgh medical school, most notably Skae and Clouston, which this thesis presents in depth, this stance is also at risk of overlooking how ideas from psychiatry in the British Isles helped to shape the era of global psychiatric nosologies that was seen in the second half of the twentieth century.<sup>15</sup> The United Kingdom and Ireland enjoyed greater social and political stability than France, Italy and Germany, the other main centres of psychiatric development during the late nineteenth and early twentieth century, and with the centralisation of the profession and narrow biological conception of insanity generally adopted in Britain, it was able to preserve the ideas of Kraepelin whilst the US was turned over to Adolf Meyer’s Freudian ideas, at least as Shorter views it.<sup>16</sup> British psychiatry would go on play a key role in ushering in the era of neo-Kraepelinian classification from the publication of the third edition of the *DSM*: this thesis will argue through its presentation of the Table of the Forms that the continuity in British psychiatry between the nineteenth century and the interwar period was an

---

<sup>12</sup> Edward Shorter, ‘The History of Nosology and the Rise of the *Diagnostic and Statistical Manual of Mental Disorder*’ in *Dialogues in Clinical Neuroscience*, Vol. 17, No.1, pp. 59 – 67.

<sup>13</sup> *Ibid.*, p.60

<sup>14</sup> *Ibid.*, p.61

<sup>15</sup> Historians have pointed out the contributions to psychiatric knowledge that were made by the Edinburgh school, including: Allan Beveridge, ‘Thomas Clouston and the Edinburgh School of Psychiatry’ in G.E. Berrios and Hugh Freeman eds., *150 Years of British Psychiatry 1841 – 1991*, Gaskell, 1991, pp.359 – 388; Douglas Guthrie, *The Medical School of Edinburgh*, Oliver and Boyd, 1964; Michael Barfoot, ‘To ask the Suffrages of the Patrons’: Thomas Laycock and the Edinburgh Chair of Medicine’ in *Medical History*, Supplement No. 15, pp.1 – 226.

<sup>16</sup> Edward Shorter, ‘The History of Nosology and the Rise of the *Diagnostic and Statistical Manual of Mental Disorder*’ in *Dialogues in Clinical Neuroscience*, Vol. 17, No.1, pp. 59 – 67; and *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*, John Wiley and Sons, 1997.

important factor in bringing about the era of so-called neo-Kraepelinian psychiatric classification.<sup>17</sup>

Looking at philosophical approaches to classification, the philosopher of psychiatry Rachel Cooper presents a realist view of what mental disorders are, but one which acknowledges that social values and scientific cultures influence what we understand them to be.<sup>18</sup> She argues that mental disorders objectively exist as natural kinds, that is to say, entities independent of human reasoning or knowledge, but the values that we ascribe to them are crucial in shaping how these naturally occurring phenomena are conceived. A concept like schizophrenia for instance represents a structure that exists objectively in nature, like the molecular structure of water being H<sub>2</sub>O.<sup>19</sup> Yet, according to Cooper, some natural kinds are valued more than others: what makes a plant a weed is that it is considered a nuisance by the gardener, and interferes with cultivated plants; there is no shared property that makes a weed a weed aside from the judgment of the person who keeps the garden according to Cooper. She then applies this same principle to mental disorder, stating that what makes schizophrenia a mental *illness* is partly a value judgement placed upon objective structures in the world. There are then naturally occurring phenomena in the form of biomarkers that make one person have a disorder and another not to have one, but the structures we label *disorders* are the results of value judgements carried out by human beings. For Cooper therefore, the structures that cause mental disorders have always been there in the world waiting for our discovery. Yet, this would almost allow us to think that as our knowledge has become more advanced, then we have made more discoveries about these natural kinds. Cooper warns against this, stating that epistemology in the form of how mental disorders are conceptualised and how they are classified can prevent scientists from making the right investigations to find out the structures of these natural kinds. Science then is not always on a course to find out the structures of the world as it becomes more advanced, and many of Cooper's own criticisms of the *DSM V* consider institutional,

---

<sup>17</sup> The UK-US diagnostic project is noted by historians of psychiatry as being one of the main triggers which led to the revision of the DSM from Adolf Meyer's Freudian informed classification to the Neo-Kraepelinian document it is today. The project, which compared the rate of diagnoses of schizophrenia and manic-depression in geriatric patients, found large discrepancies between psychiatrists working at Bethlem and the Maudsley in London, and those working at St Francis Hospital in New York. The findings were that American psychiatrists diagnosed patients more frequently with schizophrenia than their British counterparts, with the research group concluding that the American concept of schizophrenia was much broader. Alongside the second edition of the DSM, the diagnostic framework that was used by the research group was the ICD-8, which was based on the British Glossary of Mental Disorders, which was found to be reliable in the diagnosis of patients. The DSM was brought into line with the ICD in its third revision. For more on the project, see J.R.M. Copeland, 'Classification and the British Glossary of Mental Disorders' in *British Journal of Psychiatry*, Vol.119, No.551, Oct. 1971, pp.413 – 418; R.E. Kendell et al., 'Diagnostic Criteria of American and British Psychiatrists' in *Archives of General Psychiatry*, Vol.5, No., 1971, pp.123 – 130; and for the unique history of schizophrenia and dementia praecox in the USA, see Richard Noll, *American Madness: The Rise and Fall of Dementia Praecox*, Harvard University Press, 2011.

<sup>18</sup> Rachel Cooper, *Classifying Madness: A Philosophical Examination of the Diagnostic and Statistical Manual of Mental Disorders*, Springer, 2005.

<sup>19</sup> *Ibid.*, (p.4).

economic and political developments that prevent it from being, in her view, a useful classification of mental disorders.<sup>20</sup>

Cooper's view contrasts with that of Ian Hacking, who claims that mental disorders are not natural kinds which society bestows values upon, but instead states that society plays a role in constituting them. For Hacking, mental disorders are not independent of human knowledge or reasoning, but are defined to some degree by them, and this leads him to make his distinction between the *natural kinds* studied by natural scientists, and the *human kinds* studied by human scientists such as psychologists and psychiatrists.<sup>21</sup> Hacking points towards examples from the history of mental disorder to make this claim. He describes a historically and culturally specific form of mental disorder that led people to walk for days, months and sometimes years on end in a state of catatonic stupor.<sup>22</sup> This *fuge*, or *mad travel* only existed in a certain culture, namely late nineteenth century Europe, and spread from France across to Germany, Italy and Russia, in what Hacking describes as a *looping effect*, when mental disorders are emulated by others.<sup>23</sup> He claims that mental disorders are subject to a *looping effect*, or a *semantic* kind of contagion that functions differently from the laws of nature. Further backing up this argument about the cultural and social specificity of certain mental disorders, he claims that conditions in the British Isles during this period meant that the disease did not spread there. Mental disorders like *mad travel* are what Hacking calls *human kinds*. Hacking's view has proven controversial because it is understood by some to be denying the reality of mental disorders. but this somewhat misses the point that he is trying to make: that human sciences *make up* people in their interactive investigations into the mind, and that these interactions to some degree affect and change the object of their research.<sup>24</sup> The act of classifying mental disorders is an interactive endeavour that does not merely describe and represent its object but also *makes up* human kinds, or kinds of people, in the very act of naming and labelling.<sup>25</sup> Hacking's human kinds then questions the extent to which psychiatrists represent nature as they name and classify kinds of mental disease, and how the act of classification helps to define the kind of

---

<sup>20</sup> Rachel Cooper, 'Understanding the DSM-5: Stasis and Change' in *History of Psychiatry*, Vol.29, No.1, pp.49 – 65.

<sup>21</sup> Rachel Cooper has questioned the distinction made by Hacking, claiming that the natural kinds that he points towards as examples are party to the same reflexivity as the *human kinds* that he cites. See: Rachel Cooper, 'Why Hacking is Wrong About Human Kinds' in *British Journal for the Philosophy of Science*, Vol.55, 2004, pp.73 – 85.

<sup>22</sup> Ian Hacking, *Mad Travellers: Mad Travelers: Reflections on the Reality of Transient Mental Illnesses*, Harvard University Press, 2002.

<sup>23</sup> Hacking also points to the reported rise of dissociative identity disorder as an example of this effect; Ian Hacking, *Rewriting the Soul: Multiple Personality and the Sciences of Memory*, Harvard University Press, 1998.

<sup>24</sup> He makes this point clearly and succinctly by stating that naming is a form of nominalism, but the acts of naming that arose during the nineteenth century when freewill began to be studied by human scientists was an interactive form of nominalism that made up people: see Ian Hacking, 'Making Up People' in *LRB*, Vol. 28, No.16, 17<sup>th</sup> Aug 2006.

<sup>25</sup> *Ibid.*

human that is being described, be they *maniacs, melancholics, schizophrenics, manic-depressives*, or any one of the terms that were employed in the Table of the Forms in its 100 year history.

Hacking and Cooper – representing two main strands of philosophical thinking about classification – disagree about the fundamental nature of mental disorders, yet they agree that the clinical view of mental disorders in the form of the current edition of the *DSM* is highly problematic.<sup>26</sup> Clinical conceptualisations of mental disorder typically emphasise how effective an understanding of mental disorder is for the treatment of patients, and are less concerned with the ‘nature’ or the ‘reality’ of what mental disorders are.<sup>27</sup> This is also sometimes called ‘the medical model’ of mental disorder, and it frames disorder as being a problem that is treated with medicine primarily.<sup>28</sup> This is now the dominant way that mental disorder is conceptualised, with the public often taking the view that if one has a mental disorder, then they need to be seen by a medical doctor. The most influential incarnation of the clinical conceptualisation of mental disorder is included in the *DSM*: this is a lengthy definition that seeks to account for socially acceptable reactions to life events and culture-bound behaviours, to avoid pathologising emotional responses such as grief for the death of a loved one or certain religious practices, whilst understanding mental disorder as biological, psychological or behavioural dysfunction which is deemed to be significant by a clinician.<sup>29</sup> This definition was introduced in the third edition of the *DSM* published in 1980, and has remained largely unchanged in the most recent fifth edition published in 2013, despite challenges from philosophers who have expressed concern about its failing to not pathologise behaviour such as grief and have offered alternative accounts.<sup>30</sup>

Different forms of the clinical or medical view of mental disorder have been adopted by certain historians, who seek to retrospectively diagnose historical figures with mental disorders: this long-standing tendency reflects an assumption about the stability of disease

---

<sup>26</sup> See Ian Hacking ‘Lost in the Woods’ in *LRB*, Vol.35, No.15, 8<sup>th</sup> Aug. 2013; Rachel Cooper ‘What is Wrong with the DSM?’ in *History of Psychiatry*, Vol.15, No.1, Mar. 2004, pp.5 – 25.

<sup>27</sup> A particularly striking summary of this was offered in an op-ed that sought to build on the *DSM V*’s approach to classification: ‘In their day-to-day work, clinicians will continue to use the fuzzy constructs operationally defined and narratively depicted in DSM-5 and ICD-11.’; Dan Stein et al. ‘Classification systems in psychiatry: diagnosis and global mental health in the era of DSM-5 and ICD-11’ in *Current opinion in psychiatry*, Vol. 26, No.5, 2013, pp.493 – 7.

<sup>28</sup> K. Black, ‘Psychiatry and the Medical Model,’ in E. Rubin & C. Zorumski (eds.), *Adult Psychiatry*, 2<sup>nd</sup> edition, Blackwell, 2005 pp.3–15.

<sup>29</sup> See Dan J. Stein, Katharine A. Phillips, Derek Bolton, K.W.M Fulford, John Z. Sadler, and Kenneth S. Kendler, ‘What is a Mental/Psychiatric Disorder? From DSM-IV to DSM-V’, in *Psychological Medicine*, Vol.40, No.11, November 2010, pp.1759 – 1765.

<sup>30</sup> Jerome C. Wakefield’s definition of mental disorder as ‘harmful dysfunction’ is one of the most influential alternatives, in which he attempts to bring together cultural concerns with ‘harmful’, which he interprets as a value judgement, and ‘dysfunction’ which he understands to be a ‘scientific’ term, with the modern science of human behaviour being evolutionary behavioural psychology. See: Jerome C. Wakefield, ‘The concept of mental disorder: diagnostic implications of the harmful dysfunction analysis’ in *World Psychiatry*, Vol.36, No.3, pp.149 – 156, Oct. 2007; *Diagnostic and Statistical Manual of Mental Disorders*, 4<sup>th</sup> edition, textual revision, American Psychiatric Association, 2000.

concepts throughout history which other historians of medicine have questioned.<sup>31</sup> In his analysis of the way disease concepts have been written in the past, Adrian Wilson outlines the dialectic that has taken place between two different approaches: one that can be ascribed to earlier historians, which I identify with Zilboorg and more recent scholars like Berrios who use the current concept of a disease to understand the past; and one that Wilson identifies with the work of Ludwik Fleck, which emphasises the development of scientific and clinical knowledge as a social process.<sup>32</sup> When the history of disease concepts is written from the perspective of current understandings, or ‘when they are identified with their *modern* names-and-concepts’, this constructs ‘a conceptual space in which the historicity of all disease-concepts, whether past or present, has been obliterated’.<sup>33</sup> Wilson, again drawing on Fleck, views this as a problem specific to science, with triumphant celebration of its discoveries serving to bury the ideas of those who were ultimately proven to have held theories which were not in line with the progression of knowledge.<sup>34</sup> If we link Wilson’s ideas to Foucault methodological terminology, unearthing these ideas ultimately becomes the task of an archaeologist of knowledge.

Partly in response to Wilson, Andrew Cunningham suggests that to recover the historicity of disease concepts, we must look at how diagnosis occurred.<sup>35</sup> When practitioners diagnose, they make a diagnosis by selecting from what Cunningham calls an ‘array of available diseases’ in any given historic or modern society.<sup>36</sup> Cunningham discusses and analyses statistical records which list the array of diseases which would have been available to coroners making a diagnosis on the causes of death in the seventeenth, nineteenth, and the late twentieth centuries.<sup>37</sup> He chooses to look at causes of death because he understands the concept ‘disease’ as being *causal*, but not simply biological: in discussing the death of his father from cancer, Cunningham attempts to show that the biological element of the disease is just one component of the factors that a historian needs to pay attention to, and that the diagnosis of cancer that was given to his father was shrouded in cultural elements that helped to define the disease.<sup>38</sup>

---

<sup>31</sup> A particularly striking example of this is Henry Maudsley being diagnosed with clinical depression in response to the dementia suffered by his wife: ‘It is my belief that Ann [Maudsley’s] dementia was a drawn out affliction and that Maudsley voluntary withdrew from society in order to look after and act as companion to his stricken wife. It is likely that he became depressed as result of looking after a loved one, and that he reacted to her eventual death [...] with manifest clinical depression.’ Henry R. Rollin, in *150 Years of British Psychiatry: 1841 – 1991*, German Berrios and Freeman eds., Gaskell, 1991.

<sup>32</sup> Adrian Wilson, ‘On the History of Disease Concepts: The Case of Pleurisy’, in *History of Science*, Vol.38, No.3, 2000 pp.271 – 319.

<sup>33</sup> *Ibid.*, p.273

<sup>34</sup> *Ibid.*

<sup>35</sup> Andrew Cunningham, ‘Identifying Disease in the Past: Cutting the Gordian Knot’ in *Asclepio*, vol.54, 2002 pp.13 – 34.

<sup>36</sup> *Ibid.*, p.21

<sup>37</sup> *Ibid.*, p.30

<sup>38</sup> Cunningham describes how in the 1980s cancer had such a social stigma attached to it that it was described as the ‘disease which dare not speak its name’ which he attributes to the nature of the disease: cancer comes with ‘overtone of dirt and shame, and of blame and punishment, which few other diseases have’, and that since it attacks



The identity of a disease is made up ‘of a compound of elements’ according to Cunningham, and the biological and medical for him are just two of these: indeed, sometimes the least important for a historian to consider.<sup>39</sup> In other words, a person’s death may be *caused* by the disease to which the concept refers, but the disease concept cannot be reduced to the biomedical element. This comes close to Hacking’s notion of *looping kinds*, emphasising the social and cultural influences on the naming of diseases, but there is a key difference: the attitude of Cunningham and Wilson is that they do not seek to find the fact of the matter, and merely seek to chart the concept of disease through history: they question the historiography of disease concepts, whereas Hacking seeks to offer a positive and ontological thesis about the constitution of disease concepts, which for him is historical.<sup>40</sup>

Whereas Cunningham focuses on the *causes* of death and links this to diagnoses in writing about disease concepts in the past, writing about mental disorder in the past is somewhat different. There are certain mental disorders that would frequently be used as causes of death in asylum log books, a clear example being *general paralysis of the insane* (GPI), which was frequently recorded as a cause of death by asylum superintendents.<sup>41</sup> Many others however, such as *melancholia*, which was one of the concepts of psychopathology that would be used in the classification system that is the focus of this thesis, would often be coupled with a bodily condition.<sup>42</sup> For a great deal of the time that is covered by this thesis, the diagnosis of the disease would have been made by a general practitioner on a medical certificate, and a mental disorder would have *caused* a person to be admitted to an institution.<sup>43</sup>

Sociologists and social historians tend to emphasise the social function of psychiatry and the classifications that they use to diagnose mental disorder. Jan Goldstein claims that the act of classification was carried out by alienists in order to justify their activity as medical men, whereas in reality, their ‘treatment’ was no more advanced than the consolation provided by

---

individuals one at a time, there is viewed to be some sort of responsibility the person feels for having brought it upon themselves. *Ibid.*, Pp. 18 - 20

<sup>39</sup> *Ibid.*

<sup>40</sup> Chris Millard provides a historical meta-critique of the use of Hacking’s *looping kinds* that asks if it is legitimate to apply concepts formed by current scholarship, such as Hacking’s, to pre-modern thought on the formation of disease identity: Chris Millard, ‘Concepts, Diagnosis and the History of Medicine: Historicising Ian Hacking and Munchausen Syndrome’ in *Social History of Medicine*, Vol.30, No.3, Aug. 2017, pp.567 – 589.

<sup>41</sup> Jennifer Wallis, *Investigating the Body in the Victorian Asylum Doctors, Patients, and Practices*, Palgrave Macmillan, 2017.

<sup>42</sup> For examples of the connection between suicide and melancholia, Åsa Jansson, ‘From Statistics to Diagnostics: Medical Certificates, Melancholia, and ‘Suicidal Propensities’ in Victorian Psychiatry in *Journal of Social History*, Vol.46, No.3, Spring 2013, pp.716 – 731.

<sup>43</sup> Although it is important to note that not all ‘insane’ people were admitted to asylums and there was still a tradition of care at home for the mentally ill even during the height of the asylum era. Yet these would not be professionally treated and often would not receive a diagnosis. See Akhito Suzuki, *Madness at Home: the Psychiatrist, the Patient, and the Family in England, 1820 – 1860*, University of California Press, 2006; and Peter Bartlett and David Wright eds., *Outside the Walls of the Asylum: the History of Care in the Community 1750 – 2000*, Athlone Press, 1999.

religious orders before the French Revolution.<sup>44</sup> Georges Canguilhem claimed that the boundary between what is deemed normal and what is considered pathological in biology and medicine is historically contingent, with it arising during the early nineteenth century due not only to scientific discoveries but also due to a complex set of technological, political, and social changes.<sup>45</sup> His student Michel Foucault offered the view that psychiatry was a form of social control, and that the moral treatment that emerged from the Quaker Retreat in York replaced the physical chains that had hitherto confined the insane.<sup>46</sup> Foucault's work, hugely significant in stimulating scholarly interest in the history of psychiatry over the last 50 years, has influenced many later writers, including Andrew Scull and Nikolas Rose, who both place clinical classification in its wider social context, attempting to understand how the dominance of the medical model of mental disorder has helped to shape wider society, and even help to constitute psychological subjects.<sup>47</sup> In *The Female Malady*, Elaine Showalter claims that madness was a social construct which was identified with women during the Victorian period, and the diagnoses of it served gender political purposes.<sup>48</sup> In her response to Showalter's thesis, Joan Busfield uses a realist conception of mental disorder reminiscent of Cooper's, along with asylum admissions statistics, to state that Showalter overemphasised the identification of madness with women.<sup>49</sup> The debate between Showalter and Busfield also represent different responses to Foucaultian post-structuralism, with the former taking the strong social construction perspective on mental disorder, and the latter attempting to demonstrate that mental disorders do have some kind of independent existence, but these are viewed through society and culture.

## Section 2: The Role of Diagnosis and Classification of Mental Disorder in the Formulation of Psychiatric Knowledge

The Table of the Forms of Insanity that was used in British asylums between the 1840s and 1948 would record the diagnosis of the patient that was admitted to the asylum, with the

---

<sup>44</sup> Jan Goldstein in *Console and Classify: the French psychiatric profession in the nineteenth century*, Cambridge University Press, 1988.

<sup>45</sup> George Canguilhem, *The Normal and the Pathological*, trans. Carolyn R. Fawcett, MIT Press, 1991.

<sup>46</sup> Michel Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason*, trans. Richard Howard, Routledge, 1989.

<sup>47</sup> Nikolas Rose, *Governing the Soul: Shaping of the Private Self*, Free Association Books, 1999; Andrew Scull, 'The Social History of Psychiatry in the Victorian Era' in Andrew Scull ed., *Mad Houses, Mad Doctors and Madmen: The Social History of Psychiatry in the Victorian Era*, Athlone, 1981.

<sup>48</sup> Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830 – 1980*, Virago, 1987.

<sup>49</sup> Joan Busfield, 'The Female Malady? Men, Women and Madness in Nineteenth Century Britain' in *Medical Sociology*, Vol.28, No.1, Feb. 1994, pp.259 – 277.

diagnosis then serving as the cause that led to the person being admitted for treatment.<sup>50</sup> This is how the Table of the Forms started its life, and it would develop from here to be used for the purposes of diagnosis in the out-patient clinics that started to become established at the beginning of the twentieth century but became more widespread under the terms of the 1930 Mental Treatment Act. This made it much easier for people to be treated as voluntary patients within in and out-patient wards in general hospitals, as well as in the ‘mental hospitals’ as they were referred to under the terms of the act. During the period this thesis covers, it would be revised twice: what Cunningham would term the *array* of disorders would change and expand, once in 1906 and once again in 1932.

Diagnosis played a key role in the formation of medical knowledge, and the Table of the Forms played a crucial role in standardising diagnostic concepts used in asylums. Patient histories that were tied to diagnostic concepts helped to create associations between those same concepts and the physical symptoms noticed by doctors, and the social background of the patient, be they relating to the occupation or marital status of the patient prior to their admittance, or what was deemed to be their hereditary constitution, or their physical condition.<sup>51</sup> Paper technologies in the form of admissions books and statistical returns helped to collect and collate diagnoses. In doing so, generalisations could be formulated from the collections of individual patient histories, with the development of the printing press being one of the key drivers that enabled the assembly of large amounts of data which in turn helped to formulate concepts that described cases that displayed similar symptoms, and how certain bodily conditions and behaviour began to be strongly identified with these concepts. Collected patient histories formed ‘the stable centre’ of medical knowledge, and this was reflected in the case study that this thesis presents: in lieu of evidence to provide a strong pathological understanding of mental disorder, medical psychologists resorted to the collection of statistical data that might provide some key to understanding the pathology and aetiology of mental disorder. In her work, Åsa Jansson charts how suicidal tendencies became increasingly associated with melancholia during the first half of the nineteenth century chiefly through the diagnoses that were recorded in asylum admissions books from 1845.<sup>52</sup>

The strategies and techniques that were adopted by medical psychologists and alienists are further explored in detail in Ted Porter’s recent book *Genetics in the Madhouse*.<sup>53</sup> Porter looks

---

<sup>50</sup> As we will see below, the Table of the Forms was not an official requirement after 1919, but it was still held as the official nomenclature of the MPA after this period, and attempts were made by the Association in the nineteen-thirties to have it reinstated as the standard nomenclature used in admissions to mental hospitals.

<sup>51</sup> Volker Hess and J. Andrew Mendelsohn, ‘Case and Series: Medical Knowledge and Paper Technology, 1600 – 1900’, in *History of Science*, Vol.48, No.3, pp.287 – 314.

<sup>52</sup> Åsa Jansson, ‘From Statistics to Diagnostics: Medical Certificates, Melancholia, and “Suicidal Propensities” in Victorian Psychiatry’, in *Journal of Social History*, Vol.43, No.3, Spring 2013, pp.716 – 731; ‘Mood Disorders and the Brain: Depression, Melancholia, and the Historiography of Psychiatry’ in *Medical History*, Vol.55, No.3, July 2011, pp.393 – 399.

<sup>53</sup> Ted Porter, *Genetics in the Madhouse: The Unknown History of Human Heredity*, Princeton University Press, 2018.

at the statistics that were collected by asylum medical superintendents before statisticians and eugenicists became interested in the role of heredity in the causation of mental disorders. Porter claims that in collecting and ordering data about those admitted to the asylum, doctors were proto-geneticists who sought to explain the inheritance of mental disorders in their patients. Porter's book looks at the work of individual doctors such as John Thurnam – who worked at the Retreat and whom we encounter in chapter two of this thesis – and how he compiled exhaustive lists of data relating to the conditions of the patients admitted to the institution. Porter's account also looks in depth at the paper technologies that allowed statistical data to be recorded in asylums. These take the form of tables that were either devised by individual asylum superintendents like Thurnam, or issued by central authorities including medical associations and administrative bodies. Missing from Porter's account is an analysis of the concepts of psychopathology that were used within the tables that were published by the Medico-Psychological Association, and the first two chapters of this thesis will look in detail at the emergence of the different forms of mental disorder from the attempts of large organisations to collect data from asylums across the United Kingdom.

Historians of psychiatry have established certain foundational truths about the development of psychiatric knowledge that occurred first in France, then in Germany, and finally in the United States and which were reflected in the Table of the Forms. In France, post-revolutionary secular ideals and the materialistic turn in science have been credited as being the reasons why diagnostic categories emerged in early nineteenth century France with the work of Philippe Pinel (1745 – 1826).<sup>54</sup> Pinel's foundational work would establish a nosology of medical psychology that would influence psychiatric classification in the nineteenth century: it is a defining feature of thought on classification throughout this period that it was seen by those involved as a response to Pinel's work. The terms he adopted to classify symptoms would be used throughout Europe by alienists working in asylums; these included *melancholia*, *mania*, *mania without delusion*, *dementia*, and *idiocy*. Students of Pinel, principally Jean Étienne Dominique Esquirol (1772 – 1840) and Jean-Pierre Falret (1794 – 1870), would further develop the symptom-based approach to formulating concepts of mental disorder. They had a huge influence on British alienism, by formulating disease concepts that were based upon the description of symptoms, or clusters of symptoms. *Monomania* and *circular insanity* would, in addition to the concepts developed by Pinel, become popular with British psychiatrists. In addition, the work of Bénédict Morel (1809 – 1873), went on to become very popular amongst alienists based in the United Kingdom, and his work on degeneration informed many of the debates surrounding the classification of mental disorders taking place in the second half of the

---

<sup>54</sup> Jan Goldstein, *Console and Classify: the French psychiatric profession in the nineteenth century*, Cambridge University Press, 1988.

nineteenth century.<sup>55</sup> Morel's work, along with Darwinian evolution and the ideas of Herbert Spencer (1820 – 1903), were an influence on Henry Maudsley (1835 – 1918): in the estimation of Trevor Turner, 'the scepticism that [Maudsley] was to ally to the degenerationist theories of Morel accompanied a dreadful paralysis in the profession as a whole' at the end of the nineteenth century.<sup>56</sup> This lack of a breakthrough in the mental sciences and the ever-burgeoning asylum population were partly behind the call to carry out the 1906 revisions to the classifications, though such therapeutic nihilism was in the first half of the 1920s alleviated by the involvement of psychiatrists in the Great War, in both the German and the British military.<sup>57</sup> This involvement led to certain developments in treatment and the theories surrounding mental disease, would instil a new optimism in the profession after the war and throughout the first half of the 1920s. This thesis will demonstrate how this initial post-war optimism about psychiatry's curative potential would start to wane, and by the late 1920s would prove a factor in MPA members putting pressure on the council of the Association to establish a committee to revise the 1906 Table of the Forms.

Morel's degeneration theory then had a lasting legacy on British psychiatry, but after him there were fewer influences on British psychiatry that came from France, and by the middle of the nineteenth century, medical psychology was starting to look at the ideas coming from newly established German research institutes.<sup>58</sup> British psychiatrists valued the research being published by Karl Ludwig Kahlbaum (1828 – 1899), Ewald Hecker (1843 – 1909) and Wilhelm Griesinger (1817 – 1868), who would all make attempts to connect physiology and the concepts developed by Pinel in technical and ambitious clinical classifications.<sup>59</sup> Although these were respected by certain members of the MPA, others would criticise them for being too technical for practice. The work of Emil Kraepelin (1856 – 1926) that would emerge at the end of the nineteenth century became hugely popular in Britain and the US, principally because the concepts of *dementia praecox* and *manic depressive insanity* were viewed as incorporating prognosis

---

<sup>55</sup> As Daniel Pick makes clear, 'degeneration' is a problematic term whose meaning is context dependent. In the usage here, I mean ideas about psychiatric diagnosis that are informed by the theories of Morel which understand insanity to be hereditary and atavistic. See: Daniel Pick, *Faces of Degeneration: A European Disorder c.1848 – 1918*, Cambridge University Press, 1993.

<sup>56</sup> Trevor Turner, 'Henry Maudsley: Psychiatrist, philosopher and entrepreneur', in *Psychological Medicine*, Vol.18, No.3, Aug. 1988, pp.551 – 574.

<sup>57</sup> Stefanie Caroline Linden and Edgar Jones, 'German Battle Casualties: The Treatment of Functional Somatic Disorders during World War 1' in *Journal of the History of Medicine*, Vol.68, No.4, Oct. 2013, pp.627 – 58; Ben Shepherd, *A War of Nerves: Soldiers and Psychiatrists, 1914 – 1994*, Jonathan Cape, 2000; Paul Lerner, *Hysterical Men: War, Psychiatry and the Politics of Trauma in Germany, 1890 – 1930*, Cornell University Press, 2009; Peter Lees, *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War*, Palgrave MacMillan, 2002.

<sup>58</sup> Excluding Pierre Janet and Alfred Binet, who were influential amongst the emerging psychological movement but did not receive the same kind of popularity amongst the mainstream of asylum psychiatry.

<sup>59</sup> Ewald Hecker, 'Classic Text No.55: Cyclothymia, a Circular Mood Disorder' in *History of Psychiatry*, Vol.14, No.3, pp.377 – 399; Karl Wilmanns, 'Ewald Hecker (1843 – 1909)' in *History of Psychiatry*, Vol.13, No.52, 2002; Juan Goldar et al., 'Karl Ludwig Kahlbaum's Concept of Catatonia' in *History of Psychiatry*, Vol.6, No.22, 1995; Otto Marx, 'Wilhelm Griesinger and the History of Psychiatry: A Reassessment' in *Bulletin for the History of Medicine*, Vol.46, No.5, 1972.

into the classification. Eugen Bleuler (1857 – 1939) would provide the term *schizophrenia* that eventually replaced Kraepelin's *dementia praecox* in much clinical literature, and his combination of Kraepelinian ideas with those of Sigmund Freud and Josef Breuer (1842 – 1925) would become very popular in the US.<sup>60</sup> During the Weimar period (1918 - 1933), the new science of phenomenology developed by the philosopher Edmund Husserl (1859 – 1938) would have an influence on German ideas of psychopathology, most notably through the work of Karl Jaspers (1883 – 1969). The innovations that would come out of the German clinics started to wane as the Nazi regime began to use medicine to pursue eugenic and euthanasia policies. In addition, anti-Semitic policies would see prominent German psychiatrists emigrate to the United Kingdom and the US, bringing with them a more nuanced understanding of Kraepelin and psychopathology influenced by Husserlian phenomenology, which would have an impact upon the intellectual landscape of inter-war British psychiatry.<sup>61</sup>

Histories of British psychiatry that have touched upon the history of diagnosis and classification have tended to emphasise the preoccupation with somatic explanations for mental disorders.<sup>62</sup> The judgement on British psychiatry is that it made fewer contributions to psychiatric progress than France and Germany, and like psychiatrists in the US, the British for the most part synthesised the symptom-based ideas from France with the more technical work emerging from Germany: as Michael Finn notes, asylums in the British Isles were 'backwaters', and although research was undertaken in places like the West Riding Lunatic Asylum, researchers often had to balance their investigations into the nature of insanity with practical pressures.<sup>63</sup> David Wright notes in his analysis of admissions to the Buckinghamshire County Asylum that the concepts of Pinel and Esquirol were the 'standard classifications in the mid-Victorian period', as does Michael J. Clarke in his assessment of intellectual cultures in Victorian psychiatry.<sup>64</sup>

---

<sup>60</sup> Richard Noll, *American Madness: The Rise and Fall of Dementia Praecox*, Harvard University Press, 2011.

<sup>61</sup> These would include figures who would have a dramatic impact on psychiatric pedagogy and classification, including Wilhelm Mayer-Gross and Erwin Stengel: the latter would have a pivotal role at the World Health Organisation after the war. For more on the impact of German émigrés on British psychiatry during the inter-war period, see Rhodri Hayward, 'Germany and the Making of 'English' Psychiatry: The Maudsley Hospital 1908 – 1939' in Volker Roelcke, Paul J. Weindling and Louise Westwood eds., *International Relations in Psychiatry: Britain, Germany and the United States to World War II*, University of Rochester Press, 2013, pp.67 – 90.

<sup>62</sup> Michael J. Clarke, 'The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth Century British Psychiatry' in Andrew Scull ed., *Mad Houses, Mad Doctors and Madmen: The Social History of Psychiatry in the Victorian Era*, Athlone, 1981.

<sup>63</sup> Michael Anthony Finn, *The West Riding Lunatic Asylum and the Making of the Modern Brain Sciences in the Nineteenth Century*, PhD Thesis, University of Leeds, 2012.

<sup>64</sup> David Wright, 'Delusions of Gender?: Lay Identifications and Clinical Diagnosis of Insanity in Victorian England' in *Sex and Seclusion, Class and Custody: Perspectives on Class and Gender in the History of British and Irish Psychiatry*, Jonathan Andrews and Anne Digby eds., Rodopi, 2004, pp.149 – 171; and Michael J. Clarke, 'The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth Century British Psychiatry' in *Mad Houses, Mad Doctors and Madmen: The Social History of Psychiatry in the Victorian Era*, Andrew Scull ed., Athlone, 1981.

The most comprehensive treatment of notions of psychopathology coming from the British Isles during the latter half of the nineteenth century comes in the form of William Bynum's analysis of Daniel Hack Tuke's (1827 – 1895) *A Dictionary of Psychological Medicine*.<sup>65</sup> The dictionary was a compendium of research from neurologists, psychiatrists, psychologists, surgeons, pathologists, physicians and obstetricians, and was designed to provide a snapshot of the cutting edge of research into the mental sciences.<sup>66</sup> Bynum focused upon this seminal work because it was, like the Table of the Forms, a consensus based classification of insanity: the ideas in it were formulated by contributions from asylum superintendents working in larger institutions in the British Isles, like James Crichton-Browne, who established his own research centre at the West Yorkshire Lunatic Asylum.<sup>67</sup> The key difference between these histories and the history of the Table of the Forms which is presented in this thesis is that the emphasis is on the discussions that led to the formulation of an *array*, (again to borrow Cunningham's term) of diagnosis concepts.

During the first part of the thesis, the discussions on classification carried out by British medical psychologists centre around the somatic pathology, or bodily causes of, mental diseases. This fits into the wider wave of thought in the United Kingdom, with the last four decades of the nineteenth century being characterised by the growth to near dominance of physiological explanations for mental disorder.<sup>68</sup> This led to major figures within the MPA like David Skae, George Blandford, J. Batty Tuke, and Thomas Clouston to call for insanity to be classified according to physiological considerations, in the form of aetiology or pathology.<sup>69</sup> During the second half of the thesis, developments are charted which pressured to loosen this adherence to a narrow physical view of mental disorders, emblematic in the second set of revisions that were made to the Table of the Forms used by the MPA in the 1930s. Psychiatry and indeed the world had changed after the Great War, and the interwar years saw changes in the British Isles which began to make psychiatry look like the profession that it is today: voluntary treatment in out-patient wards; alignment with social work and the establishment of out-patient clinics; legal changes that renamed asylums as *mental hospitals*; the establishment in the British Isles of the kind of research institutes long seen in the German lands; and the growing influence of the British Psychological Society and the British Psychoanalytic

---

<sup>65</sup> William F. Bynum, 'Tuke's *Dictionary* and psychiatry at the turn of the century' in *150 Years of British Psychiatry: 1841 – 1991*, Berrios and Freeman eds., Gaskell, 1991, pp.163 – 179.

<sup>66</sup> *Ibid.*, p.165.

<sup>67</sup> Michael Anthony Finn, *The West Riding Lunatic Asylum and the Making of the Modern Brain Sciences in the Nineteenth Century*, PhD Thesis, University of Leeds, 2012.

<sup>68</sup> Michael J. Clarke, 'The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth Century British Psychiatry' in Andrew Scull ed., *Mad Houses, Mad Doctors and Madmen: The Social History of Psychiatry in the Victorian Era*, Athlone, 1981.

<sup>69</sup> *Ibid.* p.271

Association, both of which challenged the adherence to the narrow physiological view of mental disorder that had dominated much of the asylum era.

### Section 3: The Table of the Forms of Insanity and Mental Disorder

The Table of the Forms was used, in four different guises – two versions as a mere statistical table and two versions as a classification – during a period which saw huge changes in how mental disorder was conceptualised, and treated. These changes include: the development of the psychiatric profession itself, with the Table of the Forms being used during the massive expansion of the asylum system in the British Isles under the terms of the 1845 County Asylums Act; the increasing professionalization of asylum medical officers and the development of the mental sciences during the second half of the nineteenth century; the greater restrictions placed upon the practice of psychiatry under the terms of the 1890 Lunacy Act; the therapeutic nihilism that accompanied degenerationist explanations of mental disorder and the filling of asylums at the end of the nineteenth century; the development of out-patient psychiatric wards in hospitals and voluntary treatment during the interwar era that saw psychiatry becoming a part of the mental hygiene movement; and the closer alignment to general medicine that psychiatry saw immediately after the Second World War when the National Health Service was established.<sup>70</sup> All these developments had an impact upon the Table of the Forms, and on the eventual decision to replace it with an international general medical nosology in the form of the *ICD*. To put it another way, the period this thesis considers a set of developments that culminated in the dedicated psychiatric nosology that had been drawn up by a British psychiatric organisation being made redundant, in turn leading to the beginning of the era of international psychiatric classification that would be dominated by the different incarnations of the World Health Organisation's *ICD* and the American Psychiatric Association's *DSM*.

To begin with, however, we need to be careful about using the term 'classification' too strongly and literally when we refer to the Table of the Forms: I argue in this thesis that too firmly identifying the Table of the Forms with modern classifications runs the risk of overlooking important historical considerations that can help us to understand precisely the different purposes of this document in its different guises during its one hundred year history, and understanding these functions helps to reveal exactly why psychiatrists designed the

---

<sup>70</sup> Charles Webster, 'Psychiatry and the early National Health Service: the role of the Mental Health Standing Advisory Committee' in Berrios and Freeman eds., *150 Years of British Psychiatry*, Gaskell, 1991, pp.103 – 106.



documents the way that they did, as well as what the demands they placed upon it were.<sup>71</sup> As will become clear, this is not a century long history of a classification of mental disorders, but is the century long history of a document that served as both a statistical table and a classification. This is a crucial distinction to bear in mind, because it was from the statistical tables of the Association that this classification arose. The different functions of the Table of the Forms would also have an impact upon the debates carried out over the revisions because they would shape the demands that psychiatrists made from this document; this thesis demonstrates how this is vital to properly understanding the history of this document.

Current understandings of what a classification of mental disorders is might point towards the various incarnations of the American Psychological Association's *Diagnostic and Statistical Manual*, which was introduced in the years immediately following the period covered by this thesis. This is a document which in addition to providing the general definition of mental disorder discussed above, provides a list of definitions of specific ones, such as personality disorders and genetic disorders. Yet this was not what the Table of the Forms started out as being, and it played a very different role from modern classifications like the *DSM*. This is most strikingly seen in its name: it was called the Table of the Forms of Mental Disorder, and within this title is a key ambiguity about what the table was referring to. The most obvious explanation from our understanding of psychopathologies in the present day would be that the concepts included in the Table of the Forms were referring to natural kinds that were ontologically distinct disease entities. Yet whilst this was a popular view, it was by no means the standard: many also believed that insanity was one disease, but that it took different manifestations, or took on different *forms* in different people. This was the notion of unitary psychosis that had been put forward by the Belgian Joseph Guislan (1797 – 1860) who believed that at the basis of all mental diseases was a fundamental *phrenalgia*, or pain of the mind, that gave rise to different forms of insanity, ranging from *melancholia* to *mania*.<sup>72</sup> Given the right conditions, this mental pain could change its constitution, which would lead to a different *form* of insanity manifesting in the individual. From the 1850s, Morel's hereditary classification and the theory of degeneration would inform unitary psychosis, with the constitution of the

---

<sup>71</sup> This thesis seeks to in part to identify how just as Cooter and Stein identify how disease concepts have become essentialised in the history of medicine, and Canguilhem warns of the danger of essentialising the boundary between the normal and pathological, this thesis seeks to tackle how classification itself has become essentialised by certain writers. Examples include Kendler who in presenting Skae's classification system makes no mention of notion of unitary psychosis, which was subscribed to by one its most fervent promoters, Thomas Clouston; Kenneth Kendler, 'David Skae and his nineteenth century etiologic psychiatric diagnostic system: looking forward by looking back' in *Molecular Psychiatry*, Vol.22, pp.802 – 807: see also AH Mack et al, 'A Brief History of Psychiatric Classification: From the Ancients to DSM-IV' in *Psychiatric Clinics of North America*, Vol.17, No.3, Sept. 1994, pp. 515 – 523; Roger Cooter and Claudia Stein, *Writing History in the Age of Biomedicine*, Yale University Press, 2013.

<sup>72</sup> G.E. Berrios and D. Beer, 'The Notion of Unitary Psychosis: A Conceptual History' in *History of Psychiatry*, Vol. 5, 1994, pp.13 – 36. (p.27)

individual and their heredity shaping the manifestation of this unitary psychosis in the form of physical stigmata and symptoms of mental disorder such as delusions.<sup>73</sup>

The Table of the Forms only became a classification in the sense of the word that we are now familiar with in 1906, and prior to this it is not legitimate to call neither it nor Skae's proposed revisions that are discussed in chapter 1, a classification of different kinds of mental illness.<sup>74</sup> Furthermore, due to definitions of terms not being offered by the 1906 revision, it was not until the 1932 revision that the Table of the Forms began to resemble classifications that we have today like the *DSM*, but even then only very minimal definitions of the disorders included in the table were offered. In outlining the debates that took place over whether the Table of the Forms should include definitions, I will confront philosophical debates about the nature of insanity, and about whether a definition-based and highly technical form of classification is best for treatment: these discussions were undertaken by psychiatrists involved with the revisions that took place in 1906. Past compendia of mental disorders played a different role from that of modern classifications.

The Table of the Forms was the consensus-based classification of British psychiatry, around which discussions about the nature of mental disorder were focussed. Unsurprisingly perhaps, many medical psychologists held the philosophical assumption that mental disorders, or the different *forms* of insanity as they were referred to in the late nineteenth century, were real entities that existed independently of human knowledge, society and culture. They viewed the purpose of their discussion to be finding and developing the most appropriate and precise terminology that would describe insanity and its different manifestations. Due to the medical background of asylum superintendents, the assumption held by a great deal of members was that this language would be 'scientific', in that it would carve insanity at the joints and would lead to an understanding of it which would resemble nosologies of general medicine. To put this philosophical assumption in more technical philosophical terms, the best concepts describe the reality of insanity, with medical psychologists hoping that the terms used in the Table of the Forms would be in a relationship of correspondence to insanity's reality, and thereby there is a dualism deeply embedded in late-nineteenth century attitudes to mental disorder.

The Table of the Forms was not merely a list of mental disorders that were recognised by the MPA, but it also constitutes for the historian a series of snapshots of the theories of insanity that informed the practice of British psychiatry over a hundred-year period. Built into each of the diagnostic concepts that were included in each version of the Table of the Forms was a theory about the nature of mental disorder. Effective diagnoses were also viewed to be connected to research into the nature of insanity by members of the MPA: one of the

---

<sup>73</sup> Ibid.

<sup>74</sup> Kenneth Kendler, 'David Skae and his nineteenth century etiologic psychiatric diagnostic system: looking forward by looking back' in *Molecular Psychiatry*, Vol.22, pp.802 – 807.

requirements of the 1845 Lunacy Act was that the form of insanity that a patient had been diagnosed with would be recorded in a logbook held by the asylum. Asylums would submit the numbers recorded in their logbooks to the MPA and the Lunacy Commission, constituting a powerful resource of data. How the MPA then sought to harness this powerful resource, debating the concepts that would be used in the statistical tables, reflected conflicting assumption about the nature of mental disorder. In lieu of pathologies of mental disorder which would satisfy the physiological conceptualisation of insanity that was held by members of the Association, it was hoped that statistical analysis of data relating to admissions to asylums could begin to provide insights which would improve the 'scientific' understanding of mental disorder.

The connection between research and practice was a defining feature of British psychiatry, and this thesis makes the argument that the practical pressures placed upon members of the MPA frequently came to be the deciding factor in how the Table of the Forms was formulated. British psychiatry consistently sought concise and practically useful descriptions of the forms of insanity and mental disorder which were able to account for all the phenomena presented within the clinic. The tensions between the ideal of a scientific classification and the practical concerns were, this thesis argues, a defining feature of British psychiatry. As we will see during the course of this study, when it comes down to it, classification committees erred on the side of caution, opting to create classifications that they thought would ensure the clinical efficiency of the documents that they would produce: despite knowing that the lists of psychopathologies that they produced were far away from the scientific ideal, the quotidian demands of the practice of psychiatry meant that a compromise was needed.<sup>75</sup> In contrast to many of the histories of classification that are structured around discovery, this thesis argues that these practical considerations were not ancillary to these

---

<sup>75</sup> The issue of efficiency comes up again and again during the discussions surrounding the classifications that are covered in this thesis. It was mostly used to refer to the speed that it took to use the classification to make a diagnosis and to collect statistics. This would then include the time it would take to learn the concepts in the system so that they could be used in practice, how fast they allowed for the diagnosis to take place, and the clear distinctions they made between different cases which would allow for appropriate treatment to be given. In the asylum system, *treatment* would often refer to where and with whom they would be housed, with some asylum superintendents preferring to keep different disorders in separate parts of the institution, and others wanting to mix the patients up for therapeutic reasons. As treatments started to develop after the Great War, there would be different treatments for different disorders, but aside from specific treatments for GPI, ECT, insulin coma therapy and the first psychopharmaceuticals were often prescribed at the judgement of the psychiatrist, so there was no rule which connected certain diagnoses with certain treatments. For more on the physical treatments of mental disorder during the period, see: Edward Shorter, *A History of Psychiatry: From the Age of the Asylum to the Age of Prozac* (Wiley and Sons, 1997); A.W. Beveridge & E.B. Renvoize, 'Electricity: A History of its use in the Treatment of Mental Illness in Britain during the Second half of the 19th Century', *British Journal of Psychiatry*, 153 (1988), pp. 157-162; D. Blythe Doroslow, 'Performing a Cure for Schizophrenia" Insulin Coma Therapy on the Wards', *Journal of the History of Medicine and Allied Sciences*, Vol.62, 2007, pp. 213-243; D. Crossley, 'The introduction of leucotomy: A British case history', *History of Psychiatry*, Vol.4, 1993, pp. 553-564; and G. Berrios, 'Early Electroconvulsive Therapy in Britain, France and Germany: A Conceptual History', in Berrios & Freeman eds., *150 years of British psychiatry. Vol. 2, The aftermath*, Athlone, 1996, pp. 3-15.

scientific developments in classification, but in fact were central to how British classifications of the forms of insanity were developed and shaped over one hundred years.

## Section 4: Methodology and Outline of the Thesis

The focus of this thesis is the Table of the Forms of Insanity and the debates that surrounded the revisions that were carried out to it. Recent work emerging in Anglophone scholarship from the French school of historical epistemology offered me a way of handling many of these debates and problems addressed by Wilson and Cunningham above. Historical epistemology offered a methodology that would enable me to focus on what I was principally interested in: the debates and discussions surrounding classification that were undertaken by psychiatrists who worked on the Table of the Forms, and the role these played in the formulation of psychiatric classification. In short, historical epistemology offers a methodology that enables a focus on the discussions surrounding classification, and the identification of predominant themes and concepts that structure this discourse.

The Table of the Forms functioned as a catalyst for debates over the very nature of mental disorder and how it should be classified. These were invariably tied to their social context, yet were not defined by them alone, and followed a logic that was shaped by the knowledge of their time. The historical epistemology carried out by figures like George Canguilhem, Michel Foucault and more recently Lorraine Daston, Ian Hacking, and Alain Desrosières provides an effective way of investigating the discussions that are the object of this study.<sup>76</sup> Broadly speaking, their work advocates the combination of the concerns of social history and history of philosophy to study the contingent practices that create knowledge. These attempts to understand how past conditions of knowledge in turn structured discourse and practices amongst what Ludwik Fleck called 'thought collectives', or a community of scientists mutually exchanging ideas and maintaining intellectual interaction.<sup>77</sup> The agreed assumptions of these thought collectives ultimately helped to formulate the shared horizon of beliefs and theories which would be used to comprehend empirical research, and structure communication between researchers. The members of the MPA that discussed the Table of the Forms and the revisions that were made to it would constitute a Fleckian thought collective, with the discourse undertaken within this collective governed by sets of scientific and professional concerns that changed during the period under investigation.

---

<sup>76</sup> Alain Desrosières, *The Politics of Large Numbers: A History of Statistical Reasoning*, Harvard University Press, 1998; George Canguilhem, *The Normal and the Pathological*, trans. Carolyn R. Fawcett, MIT Press, 1991; Ian Hacking, *The Taming of Chance*, Palgrave, 1990; Michel Foucault, *The Order of Things: An Archaeology of the Human Sciences*, trans. Alan Sheridan, Routledge, 2002; Lorraine Daston, *The Empire of Chance: How Probability Changed Science and Everyday Life*, Cambridge University Press, 1989

<sup>77</sup> Ludwik Fleck, *Genesis and Development of a Scientific Fact*, trans. Fred Bradley, Robert K. Merton and Thaddeus J. Trenn, University of Chicago Press, 2008.

Historical epistemology has provided me with the delicate conceptual tools that have allowed me to dissect the relationship between the historically contingent circumstances in which these debates took place, and the knowledge produced in the form of the revisions that were recommended to the table. A perspective informed by these thinkers has allowed me to identify four broad trends in the conceptualisation of mental disorder that existed in the discussions surrounding the Table of the Forms that are the object of this study. The first was an emphasis on the observation of symptoms that were visible in a patient and which were used to formulate disease concepts. The popularity of this approach began in France at the beginning the nineteenth century with work of Philippe Pinel, and gained popularity in the British Isles in the work of James Cowles Prichard. From 1845 onwards, Prichard's translation of Pinel's work would be adopted by the Lunacy Commissions as their official nomenclature, and they would become the most widely used diagnostic concepts during the latter half of the nineteenth century. They were the shared terminology that constituted an important element of the knowledge that was used for psychiatric diagnosis, and as we will see during the course of this thesis, although they were not universally accepted as scientifically rigorous, many considered them the best available heuristics to make sense of the different forms of insanity.

During the second trend, some perceived these concepts to be vague and ill defined, and sought to replace them with concepts that were built on the aetiology, or causes, of mental disorder. Causal explanations of mental phenomena were familiar and desirable to asylum superintendents because of their medical training, and they looked to the processes and conditions of the body for these causes. Pinel did not need to find causes for his forms of mental alienation because he described behaviours and psychological features, so they did not run into the problems faced by the aetiological concepts provided by David Skae and which were pushed to be the standard concepts of the MPA by students of his, most prominently Thomas Clouston. Skae's system received a hostile reception from some, most notably James Crichton-Browne, because it determined psychological illnesses too narrowly through physical conditions. Ultimately, the behaviours and the thoughts of patients defied the neat causal forms of insanity offered by Skae, and so individuals like Crichton-Browne took the view that the causes of insanity were relatively unknown, and Skae's system was too crude in the way that it connected psychological disorders to bodily causes.

The third trend saw an increased interest in prognosis as a means to understand the different forms of insanity and this occurred at the very end of the nineteenth century. The rise of prognosis as a factor in psychiatric classification is down to many psychiatrists regarding asylum psychiatry to have failed to find the definitive causes of the different forms of

insanity.<sup>78</sup> Statistics that many hoped would be useful in research were still considered to be far away from informing the different forms of insanity – psychiatric epidemiology was criticised for using ‘insanity’ as a general term and not dividing it into separate forms. This led to a push to revise the statistical tables in 1902, and the way of collecting data from asylums was massively overhauled during these discussions. As will be detailed in a little more detail below, this third trend was characterised by the inclusion in the Table of the Forms of concepts of disease that gave some indication of the prognosis of the form of insanity. This marks the beginning of prognosis being used as a means to differentiate the different forms of insanity from one another. As we enter the third phase of the Table of the Forms, the period surrounding the revisions that took place between 1902 and 1906 which produced the first classification of the Association, we see how British psychiatrists became interested in the possibilities of treating mental disorders beyond the asylum walls. This was a crucial shift in the history of the table because it helped to push the Association towards considering forms of insanity that would not necessarily lead one to being admitted to an asylum – prior to this, the Table of Forms was a document that was solely for use in asylum admissions, but in drawing up the 1906 classification, members of the MPA considered disorders that may never be admitted to an asylum, or those that could be detected prior to entry and prevent an admission altogether. By this time, British psychiatrists were becoming interested in the *borderland* between sanity and insanity, and since the asylums by the turn of the century were crowded partly due to low discharge rates, measures that would prevent someone reaching the asylum doors were starting to capture the attention of psychiatrists. Accordingly, the Table of the Forms began to reflect these wider developments, with the disorders that were included representing illnesses that may not need to be admitted to an asylum, and which gave some indications of the prognosis of the disease. Despite there being some attention to the illnesses suffered by the general population, the concepts that populated this first classification were products of the asylum era. The eager acceptance of Kraepelin’s work amongst British psychiatrists fit into this context, and his concepts of dementia praecox and manic depressive insanity were represented in some manner, yet they took the form of terminology that was more familiar to British psychiatrists, namely alternating insanity and primary dementia.

This would continue into the fourth phase that is covered by the thesis, and one which occurred after the Great War, and which found its expression in the revisions to the Table of the Forms were published in 1932. Due to the changes in the treatment of insanity, including the establishment of outpatient clinics, the beginnings of psychiatric social work, legal developments making voluntary admissions possible, the popularity of psychoanalysis and the

---

<sup>78</sup> E. Chamberlin & S. Gilman eds., *Degeneration: the dark side of progress*, Columbia University Press, 1985; Janet Saunders, ‘Quarantining the weak-minded: psychiatric definitions of degeneracy and the late-Victorian asylum’, in W.F. Bynum, R. Porter & M. Shepherd eds., *The Anatomy of Madness: Essays in the History of Psychiatry: Vol.3, The Asylum and its Psychiatry*, Tavistock, 1988, pp. 273 – 296.

expansion of the British Psychological Society during the interwar era, the kinds of illnesses that psychiatrists treated were not just the acute kinds that were admitted to asylums. These developments also meant that the approaches to the classification of mental disorder widened, and the narrow approach of the asylum, which tended to conceptualise insanity predominantly through the naturalistic causal concepts of aetiology, hereditary, and physiological pathology that reflected the medical training of asylum superintendents were being challenged by psychiatrists informed by psychodynamic theory and psychoanalysis. These led to a questioning of what a psychiatric classification should seek to achieve, and whether it could do more than simply represent empirically the concepts that were admitted into asylums. Certain figures, that will be discussed in the fourth chapter of this thesis, thought that classification should incorporate more in terms of theory about the psychological factors involved in the development of mental disorders. This final phase of the Table of the Forms was not governed by the same rules of discourse of that allowed the previous three phases to be conceptualised through one predominant concern.

I have labelled this phase 'pluralistic', but the term 'heterogeneous' could equally be applied, because it was a stage in the history of psychiatry when ideas on classification that had existed during the era of the asylum were being phased out, and were being replaced by Meyer's Freudian concepts, the ideas of Kraepelin and emerging ideas on psychotherapy. In attempting to bring these heterogeneous ideas together whilst still satisfying the old guard of asylum superintendents that constituted the elder members of the Association, the classification of the 1932 committee attracted criticism for both being out of date and for employing new concepts that would not be familiar or useful to many members of the Association. The fourth and final phase of the Table of the Forms reflects then to some extent the developments in psychiatric care that took place after the Great War, and the changes in the context of psychiatric care: the MPA had put pressure on the government to allow voluntary rate aided patients to be admitted to asylums during a Royal Commission into psychiatric care that had sat from 1924 and which published its report in 1926. The 1930 Mental Treatment Act, which took up many of the recommendations included in the report of the commission, allowed for voluntary rate aided patients, and made it easier for a person to be admitted into a mental hospital, or to one of the new generation of psychiatric wards that were beginning to be established. On top of this, developments in the wider culture of psychiatric treatment such as the advent of psychoanalysis, the growth of the British Psychological Society and the establishment of clinics like the Tavistock provided alternatives to the asylum centred approach to psychiatric treatment that had developed from general medicine because asylum

superintendents were medically trained men.<sup>79</sup> These developments made it harder for the committees appointed at the end of the 1920s to make the revisions to the classification they had inherited, one that was mainly a product of the asylum era: instead of being limited to the concepts that had developed within asylum psychiatry, concepts that had come from Viennese clinics and had been developed in clinics devoted to psychodynamic treatment, industrial psychology and even in psychiatric social work were being used in mental health treatment by the middle of the interwar period. This made the task of the revisions committee which sat between 1929 and 1932 much more difficult, and led to a classification that: was heterogeneous in character; which attempted to include concepts that were in use by differing approaches to treatment and theoretical views on mental disorder; and the different contexts in which treatment would be delivered.

The sources that I have consulted for this research reflect the aims of this thesis: to represent the discursive cultures and the practices that helped to formulate standardised concepts of mental disorder that were included in the Table of the Forms. The debates that surrounded the Table of the Forms in each of its incarnations are recorded in issues of the Association's *Journal of Mental Science*.<sup>80</sup> These were the starting points for the research in this thesis, and which are presented in four of its five chapters. Deliberations of the committees appointed by the MPA are available in the archives of the Royal College of Psychiatrists, and these have proven useful for details needed in chapter three and four, but unfortunately the minutes available in the archives of the Royal College of Psychiatrist rarely document anything beyond the cursory and official details of attendees, dates and agendas. When looking at the debates that have surrounded the Table of the Forms, I have also consulted textbooks from some of the principle figures involved in the revisions to understand their ideas on classification. The reader will notice that the first chapter of this study is much more reliant on textbooks, and this is because it covers a topic and a period that predated the establishment of specialised psychiatric journals, and the existence of the MPA itself.

Towards the end of the 1890s and in the third chapter of the thesis, I have referred to back issues of the *Lancet* and the *British Medical Journal* in addition to the Association's *JMS*.<sup>81</sup> The British Medical Association had a psychological section in which ideas on classification were presented and discussed. In addition, I have consulted articles published in these journals,

---

<sup>79</sup> For more on the early history of the British Psychological Society, and its rapid expansion during the 1920s, see A.D. Lovie, 'Three Steps to Heaven: How the British Psychological Society Found its Place in the Sun', in *Psychology in Britain: Historical Essays and Personal Reflections* G.C. Bunn, A.D. Lovie, & G.D. Richards ed., BPS Books, 2004.

<sup>80</sup> Transactions of meetings were usually included in the minutes of regional and annual general meeting of the Association.

<sup>81</sup> A great deal of the resources that I have drawn upon are from the archives of the *JMS*, which played not only a crucial role in knowledge transfer, but was also a means of communication between asylum medical superintendents, and which, like the AAMO helped to foster a sense of community and camaraderie amongst this nascent profession; Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England with Special Emphasis on Leicestershire and Rutland*, PhD thesis, UCL, 1993. (p.172).



and other Victorian periodicals where necessary. A similar set of materials was drawn upon in the fourth chapter of this thesis, with the goal, once again, to analyse the debates and discussions that helped to formulate standardised clinical concepts in a consensus based psychiatric classification designed to be a compromise between the members of the MPA. The fifth chapter of this thesis will offer some reasons why the Table of the Forms ceased to be used to classify the admissions to psychiatric hospitals after the Second World War. It looks at the conceptual developments in classification that took place in research presented in the *BMJ* during the war which questioned classifications of mental disorder. In addition, it looks at the projects that were carried out to reform the recording of admissions data that were carried out by leading figures in British public health. I have consulted the National Archives and material from the Ministry of Health that document the planning that was undertaken during the final phases of the Second World War, in order to understand the reasons why the Table of the Forms ceased to be used.

This thesis then is not an attempt to provide an exhaustive account of British psychiatric classification. Such a project is out of the remit of this work. This is important to note, because there are some omissions in this thesis that may be unexpected to the reader expecting a comprehensive history of British classification between 1845 and 1948. For instance, the work of Henry Maudsley, as well as John Charles Bucknill and Daniel Hack Tuke's are not given extensive treatment here, yet are invoked in relation to the discussions carried out by members of the Association. Similarly, with the work of Kraepelin, Darwinian biology and Freud, which I have not discussed in depth but have invoked when they have informed the ideas that have surfaced during the debates that are the focus of this study.

The central concern of this thesis is the formation of clinical knowledge and a psychiatric classification that was used for diagnostic purposes in asylums and psychiatric hospitals. As such, it has placed a great emphasis on clinical discussions of mental disorder. I have appealed to wider social developments and how they have had an impact upon the formation of clinical knowledge, and to the development of psychiatric epidemiology where relevant, because one of the arguments that runs through this thesis is that developments beyond medicine and the mental sciences were instrumental in starting and continuing debates on psychiatric classification. For instance, the legal requirement in the 1845 Lunacy Act to keep a record of the diagnosis of all *pauper lunatic* admissions, and the suspected cause of their disorder upon their admission to an asylum was pivotal in establishing the Table of the Forms, and for making it an obligation for a doctor to make one firm diagnosis. Asylum superintendents would frequently change their diagnosis during the course of a patient's illness, and whilst this practice may have been more responsive to the condition of the patient, it made the task of collecting statistics on diagnosis very difficult. The passing of this law was vital in allowing debates surrounding classification to take place because the collection of the statistics

on admissions triggered debates on what the standard forms of insanity used in the MPA's statistical tables should be. Further legal developments that had an impact upon diagnosis and treatment that are referred to in this thesis include the 1890 Lunacy Act, which expanded the legal requirement for the recording of data at the point of admission to *private patients*; the 1930 Mental Treatment Act, which made it possible to admit voluntary, non-private, patients; and the 1948 National Health Service Act, which played a role in ending the functional existence of the Table of the Forms.

For the sake of brevity, I have decided not to include lengthy discussions on criminal lunacy and responsibility in the concepts included in the Table of the Forms. These topics are certainly relevant to some extent because the document included concepts of forensic psychology. Put briefly, 'moral insanity' was included in Prichard's Table of the Forms that was introduced by the Lunacy Commission's report in 1845, yet it was reclassified as a congenital deficiency in the 1906 classification, and in 1932 was reformulated as psychopathic constitution. However, the statistical tables that were used in returns from criminal lunatic asylums were not the same as those used in County asylums, with, predictably perhaps, these returns including much more information on the nature of the crime committed by the person admitted to the institution.<sup>82</sup> In addition, there is little evidence to suggest issues of criminal responsibility were thought to be relevant by those engaging in the discussions surrounding the Table of the Forms, presumably once again because this document was not designed to be used in criminal lunatic asylums. As such, I have decided to concentrate on how the Table of the Forms was relevant to diagnosis in County asylums.

---

<sup>82</sup> The tables for Broadmoor for instance were more extensive than those normally submitted by County Asylums, see the tables included in David Nicolson et al., *Reports Upon Broadmoor Criminal Lunatic Asylum with Statistical Tables for the year 1889*, HMSO, 1890, pp.18 – 49. For more information on the statistics collected by Criminal Lunatic Asylums, see Laura Mary Sellers, *Managing Convicts, Understanding Criminals: Medicine and the Development of English Convict Prisons, c.1837 – 1886*, PhD thesis, University of Leeds, July 2017, in particular the fourth chapter 'Brains and Scientific Medicine: Henry Clarke's Research in Wakefield Prison 1876 – 1888' pp.169 - 215.

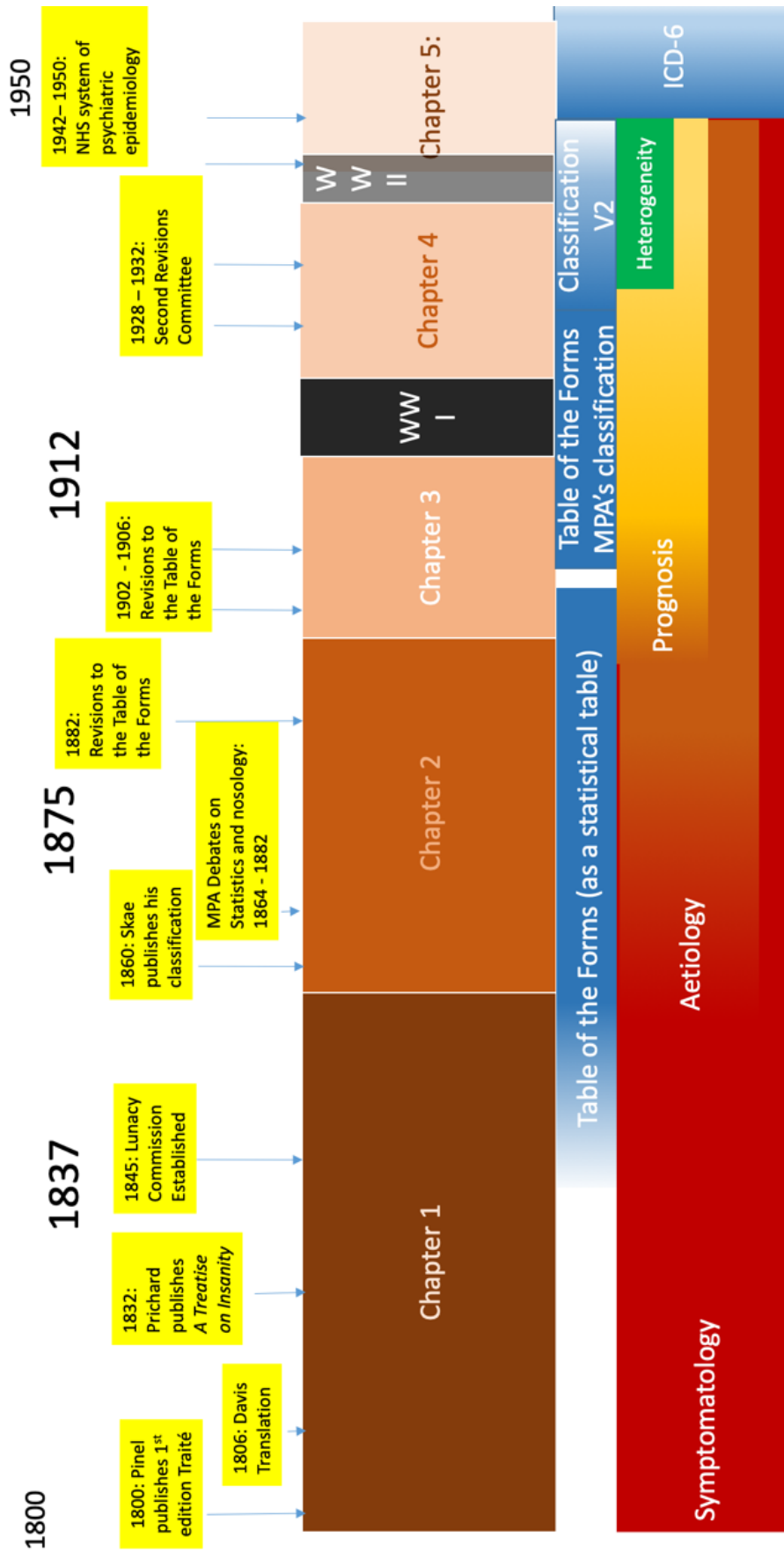


Figure 1: The Periods of the Table of the Forms

Chapter one (1800 – 1845) contextualises the Table of the Forms of Insanity by looking at how and why the concepts developed by Philippe Pinel became the shared terminology of British psychiatrists during the latter half of the nineteenth century. It draws upon the medical textbooks of William Cullen, Alexander Crichton and Pinel himself to demonstrate how the concepts of Pinel became the most popular descriptions of the forms of insanity. It traces the ways in which Pinel's ideas found their way into the United Kingdom, through initial reviews and translations. The initial reception of Pinel's work was unfavourable, and it was through the work of James Cowles Prichard (1786 – 1848) that Pinel's ideas became popular in the United Kingdom. Prichard was a crucial figure in the establishment of Pinel's concepts as the standard that were used in the psychiatric discourse analysed in later chapters due to his involvement in the early years of the Lunacy Commission, the body established under the Lunacy Act of 1845 to regulate county asylums. In addition, I argue that the popularity of Pinel's concepts of melancholia, mania, dementia and idiotism can also be explained by their simplicity, practicality and effectiveness in managing the treatment of a patient: psychiatry was not yet a medical specialisation, and the lack of formal training meant that medical men wanted a classification that was easy to learn and easy to use. Yet, despite its clinical value, as mental science developed, the hopes for a scientific classification grew based upon the model of a mechanical, somatic and causal explanation for mental disorders, dissatisfaction began to be directed towards the Table of the Forms. The first chapter will end by focusing on one classification that would provoke debate from its publication in 1853; that of the founder of the Edinburgh school of psychiatry David Skae, whose work sought to explain the different forms of insanity through bodily processes and conditions, and sparked interest in how the aetiology of insanity could be incorporated into a standard Table of the Forms that was to be used by British psychiatrists.

Chapter two (1845 – 1880) discusses how the Table of the Forms was used to gather statistics by the Lunacy Commission and the MPA. It looks at debates that are recorded in the archives of the *Journal of Mental Science (JMS)* between members of the Association about what forms of insanity should be used in statistical tables that were filled in by asylum superintendents and returned to the Lunacy Commission and the MPA – these would provide data on admissions to asylums from across the country to both organisations. In reaction to the Pinelean system which was employed in these annual statistical returns, a new Table of the Forms was offered by the Edinburgh physician David Skae in 1862. Skae sought to describe the natural progression of symptoms with his concepts of insanity by describing what he termed the *natural history* of the disease. This chapter looks at disagreements between those who wanted Skae's work to become the new standard, and those who acknowledged the 'scientific' shortfalls of the existing Table of the Forms but valued its clinical effectiveness and efficiency.

This chapter argues that these debates signal the start of divergences between scientific views of psychology, which hold a realist perspective on the relationship between the concepts of medical knowledge and the diseases that they describe, and a clinical view, which is more concerned with the practical and pragmatic dimension of classification. This chapter will also show that in the case of British psychiatry, practicalities coupled with fear of implementing Skae's system – a system that was deemed by peers to be overly complicated, overly speculative and conceptually incoherent – proved to be the decisive factor that led to the retention of Prichard's long used Table of the Forms as the official one of the MPA and the Lunacy Commission until the end of the nineteenth century.

Chapter three (1880 – 1912) examines how the Table of the Forms used in the collection of statistics became the official classification of the Table of the Forms of Insanity during a series of revisions that took place between 1902 and 1906: what became an exercise to revise the concepts used in the statistical tables led to discussions taking place about what an official classification of the forms of insanity recognised by the MPA should look like. This was in the hope of improving medical data and using more 'modern' concepts to understand the kinds of insanity that were being admitted to asylums, but what began as an exercise in improving data would lead to a series of crucial questions posed about the role of psychiatric classification: what function should it serve, and what should it look like? The chapter's first section will outline the series of events and the debates that led to the appointment of the revisions committee and the ideas which informed the debates that occurred. It will focus on the principal figures who contributed to the debate, and on what attitudes they held towards how insanity should be classified. The second section will look in detail at the debates that occurred at the annual general meetings of the MPA, providing explanations for the rejection of the first version of the revisions committee's report in 1904, and why the second version was accepted in 1906. I argue in this chapter that although the Table of the Forms published in 1906 did not settle many of the questions that were posed about psychiatric classification, it should be considered 'proto-Kraepelinian' because it included concepts that resembled the German psychiatrists' dementia praecox and manic depressive insanity, which reflects the increased attention given to prognosis by British psychiatrists.

Chapter four (1912 – 1938) then discusses the further revisions that were made to the now Royal Medico-Psychological Association's (RMPA) classification in the early thirties. These were the second set of major revisions to the classification system employed by the Association, and this chapter argues that the revisions that were made were the result of broader changes surrounding psychiatric treatment. It will look at the 'progress' that had occurred in psychiatry since the 1906 publication of the Table of the Forms of Insanity to explore the reasons why in 1929 the RMPA appointed a classification committee to revise the tables again. These changes had a direct impact on what kind of revisions were made by the

clinical-psychiatry sub-committee on behalf of the RMPA between 1929 and when it published its final reports in 1932. The chapter will then provide a detailed breakdown of these changes and how they had an impact on the revisions to the Table of the Forms. It will focus on the forms of neurosis, schizophrenic psychosis, psychopathic constitution, and emotional and affective psychoses that were included in the revisions. It will then finish by discussing the hostile reception that these changes received from prominent members of the British psychiatric community as expressed in textbooks and pages of medical journals.

The fifth chapter of the thesis (1942 – 1948) argues that the end of the Table of the Forms was due to psychiatry moving closer to general medicine on conceptual and institutional levels, and the war functioned as a catalyst for this move. To demonstrate this, I look at a series of debates that were undertaken by those serving in the Emergency Medical Services during the conflict on psychological classification, often by those who were not trained psychiatrists and who were attempting to understand the trauma, neuroses and psychoses that were suffered by civilians on the home front. On the institutional level, I look at the planning that went into the National Health Service, and how this provided an opportunity for the prominent eugenicist Carlos Patton Blacker and the statistician Lionel Penrose to carry out reform of the admissions system which would improve the collection of mental health statistics. The diagnostic system they decided to use was the *International Classification of Diseases* (ICD). Ultimately, this spelled the end of the troubled history of the Table of the Forms that was drafted by the MPA, and would usher in a new, global era of mental health classification. Since the main goal of this thesis is to understand the role of the discussions surrounding the document, this chapter will be brief and will not exhaustively explore these reasons, but it will present research on the admissions system and the importance these figures held in getting the admissions system correct, and how this could reveal insights about mental disorder amongst the general population and beyond the confines of the psychiatric hospital.

Being a document that existed for just over a century in its different guises, The Table of the Forms provides a unique opportunity to look at a set of concepts of mental disorder in relation to one another over an extended historical period. If we understand the Table of the Forms as a model of sorts, an interesting question arises about what exactly this array of concepts sought to represent. The answer to this is connected to the function it performed during its existence. Initially it functioned as an heuristic for data collection, and the challenges that came in the form of Skae's aetiology informed classification was down to those who were dissatisfied with the vagueness of the symptomatic concepts, and wanted it to be a more precise representation of the forms of insanity. Vitaly, this document primarily functioned from its founding in 1845 to its revision in 1906 as a *representation of the forms of insanity that would see one admitted to an asylum*. Whether or not it sought to represent *all known* forms of insanity is a matter of debate. The evidence, in the form principally of minutes from the annual general

meetings, would seem to indicate that matters concerning insanity within the population were beyond the concern of members during the early years of the Table of the Form's existence; rather, the central concern was how best to classify admissions, and represent them within a standard set of diagnostic criteria. Whilst people who were admitted to asylums came from the general population, the function of the Table of the Forms was not to capture illnesses that would be suffered by those who could live without being interred in an asylum. Furthermore, the legal requirement made in the 1845 Lunacy Act to record a diagnosis for all patients at the point of admission was initially limited to pauper lunatics, and there was no need to provide a diagnosis for private and voluntary patients until the passing of the 1890 Lunacy Act.<sup>83</sup> This would have an impact upon the demands placed upon the system, with those who would be admitted as rate-aided pauper lunatics coming from lower classes and poorer backgrounds. This then shaped the demands placed upon the Table of the Forms in its initial stages, and it would mainly describe acute cases. As the context and goals of psychiatry changed, so did the demands it placed upon the Table of the Forms, which this thesis will explore through the debates that were carried out amongst psychiatrists and those in charge of Lunacy administration.

# Chapter 1: The Rise of Pinel's Classification in the British Isles and the Aspirations to a Scientific Classification: 1800 – 1860

## Introduction

The terms employed by the French physician Phillippe Pinel (1745 – 1826) in his 1801 *Traité médico-philosophique sur l'aliénation mentale; ou la manie* were used as the standard language to describe the different forms of insanity used by psychiatrists working in the United Kingdom in the second half of the nineteenth century. *Dementia*, *Idiocy*, *Melancholia* and *Mania*: these became the common currency of psychiatric discourse in the latter half of the nineteenth century, and although many did not think that they were the most accurate or useful to use to describe different cases of insanity, they were terms that structured Victorian discourse on psychiatric classification. Furthermore, the sub-class of *moral insanity* that had its root in Pinel's work became central to discussions surrounding criminal responsibility during this same period. These concepts were formulated by describing groups of observable psychological symptoms in the form of behaviours and emotions, and this way of classifying mental disorders would become the norm during the age of the asylum.

Yet, despite Pinel's symptom based concepts of the different forms of insanity becoming dominant in British psychiatry for over a hundred years, a hostile welcome was initially given to his work in the form of a scathing review that dismissed Pinel's contribution to medicine.<sup>1</sup> The reviewer, Henry Reeve, deemed Pinel's work to be self-satisfied and intellectually bankrupt plagiarism, which had failed to offer any novel insight into madness and its causes. It began by claiming that:

...to medical readers in this country, many of our author's remarks will appear neither new nor profound, and to no-one will his work appear complete. It is a general view of madness, under all its deplorable forms, not a minute and philosophical investigation of any particular species. It may be considered as a sketch of what has already been done[...]; though [Pinel] seems frequently to wonder, with a smile of self-approbation, at what he thinks [of] his own discoveries.<sup>2</sup>

According to Reeve, Pinel's imprecision was apparent in the Frenchman's tendency to name drop, with the reviewer doubting whether he had really understood the works that he cited by John Locke and the French philosopher of mind Étienne Bonnot de Condillac. Reeve instead

---

<sup>1</sup> Henry Reeve, 'Phillippe Pinel's *Traité Médico-Philosophique sur l'Aliénation Mentale ou la Manie*' in *The Edinburgh Review*, Vol.2, April – July 1803, pp.160 – 172.

<sup>2</sup> *Ibid.*, p.161



speculated that Pinel had only included these names to appear more erudite to the dilettante reader since they did nothing to further his vision of mental disorder, which Reeve thought that any real medical man would see as being a superficial investigation that sacrificed detail for generality.<sup>3</sup> Reeve thought that this generality manifested itself in vague forms of insanity that were not distinct, but rather ‘only varieties of the same affection’: Reeve held that the symptoms the Frenchman used to distinguish between the different forms of insanity were often encountered in the same patient.<sup>4</sup> This crossover between the forms was unacceptable for Reeve, because:

At different times [the patient] passes through all the gradations, from furious phrensy [sic] to complete fatuity. The four species [of insanity], as [...] defined by our author, [are] so very general, that it would include a great part of the authors quoted [elsewhere] in our *Review*; every transitory excels of passion, and every eccentricity or peculiarity of conduct in society.<sup>5</sup>

The forms offered by Pinel were too broad for Reeve, and their lack of precision made them unbecoming of medicine. Opining this looseness, Reeve thought that two of Pinel’s disorders, *manie sans delire* and *dementia*, should be removed from the classification system because ‘the only valid distinctions which can be made, appear to be between *melancholia*, *mania*, and *idiotism*’.<sup>6</sup>

Furthermore, Pinel’s ‘little sagacity and precision’ was ‘unremarkable for its clearness and accuracy’, with ‘many of the distinctions [between disorders] seem[ing] absurd’, and others failing because they simply were ‘not well founded’.<sup>7</sup> What Reeve meant by this is uncertain, but his background provides some clues: Reeve was an alumnus of the University of Edinburgh’s prestigious medical school, and this may explain why he attacked Pinel for not making any notable advances on the work of fellow Edinburgh men William Cullen and Alexander Crichton. Reeve thought that Pinel had stolen terminology from the pair yet had not built upon their work in any way whatsoever. This accusation was accompanied by an objection to Pinel’s view that insanity was not always caused by brain lesions, and the looser connection that Pinel made between mental disorders and physical lesions led Reeve to dismiss the Frenchman’s

---

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.,

<sup>5</sup> Ibid., pp.168 – 169.

<sup>6</sup> Ibid., p.169.

<sup>7</sup> Ibid.

work as being too ‘Cartesian’ to be taken seriously.<sup>89</sup> As a follower of *Naturphilosophie*, the anti-Cartesian idealist movement which rejected substance dualism in favour of viewing mind and matter as part of one natural whole, Pinel’s dualism was unacceptable to Reeve, leaving a work too imprecise for practical use.<sup>10</sup> Reeve’s idealist convictions made it necessary to explain mental and physiological phenomena in the same manner, and not to disassociate mental phenomena from their physical causes; Reeve characterised Pinel as thinking that insanity had no physical basis, was not caused by brain lesions and were purely caused by mental faculties, or thought processes. Pinel had in fact claimed that no lesion may accompany certain cases of insanity, and the loose connection he made between physical and psychological conditions had offended Reeve to the extent that he warned his readers that Pinel’s work was useless, with the forms that he had presented in it having no practical role in British medicine.<sup>11</sup>

Reeve’s reaction to Pinel’s work neatly articulates tensions between the symptom based and physiological approaches to psychiatric classification that are explored throughout this thesis. At the root, then, of Reeve’s criticisms of Pinel was a physicalism that was informed by natural philosophy that took issue with the lack of natural explanations in Pinel’s presentation of the forms of insanity, deeming their absence to be unworthy of the standard required for medicine. A subtle clue in the review also indicated that Reeve had not properly understood what Pinel was doing in his work when he complained that the ‘want of an accurate history of the several *kinds* of insanity, has often been felt and acknowledged’;<sup>12</sup> Reeve was asking for an account of *natural kinds* of insanity, yet Pinel was presenting the *forms*, or appearances of insanity in his work. Pinel’s *Traité medico-philosophique sur l’aliénation mentale ou la manie* described forms of insanity that he had experienced in practice, and which were based on the description of symptoms that were commonly associated with each other in certain clinical cases. Reeve however thought that only diseases that were tied to physiological damage in the form of brain lesions would be a useful way of describing the different kinds of insanity. Pinel’s goal was to provide a practical table of the different forms of insanity that presented themselves within asylums, yet Reeve demanded from Pinel something that the French physician had not aimed to provide: a description of the *natural kinds* of insanity that would be drawn along the lines of pathology, prognosis and causation. Pinel grouped together

---

<sup>8</sup> Ibid.

<sup>9</sup> Trev Lynn Broughton, ‘Henry Reeve (1813 – 1895), translator and magazine editor’ in *Oxford Dictionary of National Biography*, January 3<sup>rd</sup>, 2008.

<sup>10</sup> Michael Heidberger, ‘Naturphilosophie’ in *The Routledge Dictionary of Philosophy*, Taylor and Francis, 1998.

<sup>11</sup> Phillippe Pinel, ‘Traité Medico-Philosophique sur l’Aliénation Mentale ou la Manie’ in *The Edinburgh Review*, Vol.2, April – July 1803, pp.160 – 172. (p.164)

<sup>12</sup> Ibid., p.160.

symptoms commonly associated with one another to formulate the concepts of *mania*, *melancholy*, *idiotism* and *dementia*, but did not attempt to explain them through natural processes: instead providing accounts which spoke of the damage to the *mental faculties*, or different parts of the mind.

Despite Reeve's criticisms, Philippe Pinel's forms of insanity were to become hugely popular in the British Isles. This chapter will account for this popularity, and how Pinel's symptomatology would become the standard concepts used to describe and diagnose the different forms of insanity in the United Kingdom. Understanding how the concepts of Pinel's symptomatology came to be adopted in the British Isles is vitally important to making sense of the debates that took place amongst members of the Medico-Psychological Association (MPA) that will be explored in the second, third, and fourth chapters of this thesis. Although the literature on the influence of Pinel's moral treatment is extensive, relatively little work has been carried out on how his ideas came to the United Kingdom, and in particular, how Pinel's classification came to be used for administrative and clinical purposes.<sup>13</sup> The first section will argue that despite the critical reception from Reeve, part of the reason Pinel's work became popular in the United Kingdom because he used terminology that was already familiar to English physicians familiar with Cullen and Crichton's work, and because it was empirical and practical, so held an intuitive appeal to those who worked in asylums.

The second section will look at how Pinel's ideas came to the United Kingdom via the textbooks of James Cowles Prichard, who adapted and translated Pinel's work for English audiences, whose role as the psychiatric expert on the first Lunacy Commission was pivotal in the forms being recommended for use in asylums. Prichard's role in the Lunacy Commission, which was established after the passing of the Lunacy Act in 1845, would be one of the reasons why the Pinelean forms of insanity became established as the standard used for diagnosis in asylums across the United Kingdom. The third section will briefly look at the challenges that were mounted against the Pinelean system, again from Edinburgh, namely through the work of David Skae, who offered a Table of the Forms of Insanity which sought to provide disease concepts instead of mere forms of insanity, and did so by attempting to implement aetiology and the *natural history*, or the natural progression, of the symptoms of the different forms of insanity.<sup>14</sup> This chapter will then tell a broader story of a tension between psychological

---

<sup>13</sup> Michel Foucault, *Madness and Civilization: A History of Insanity in the Age Reason*, trans. Richard Howard, Routledge, 2001; Roy Porter *Mind Forged Manacles*, Athlone Press, 1987; Andrew Scull, 'Moral Treatment Reconsidered: Some Sociological Comments on an Episode in the History of British Psychiatry' in Andrew Scull ed., *Madhouses, Mad-doctors and Madmen*, pp.105 – 120.

<sup>14</sup> *Natural history* was Skae's own term, and he thought that charting this natural course of the disease was the best way of drawing lines between the different forms of insanity. Skae's use of this term will be outlined in full in section three of this chapter.

explanations for the mind, and the natural, physical and somatic explanations that were favoured by British medicine. Both were different manifestations of what Foucault termed the *medical gaze*: on the one hand the aetiology approach to the classification of the insanities sought to look into the patient's body to find the hidden, internal processes that caused insanity, but symptomatology would predominantly remain at the surface level, describing behaviours of the patient and clustering these together to formulate disease concepts.<sup>15</sup> These differing approaches to classification also signalled the beginning of the difference between clinical views that prioritised the pragmatic value of a classification for the purposes of treatment and medical practice, which ordered *forms* of insanity according to symptoms, and the aspirations for scientific classifications of the *kinds* of insanity that were ordered according to pathology, aetiology and prognosis. On the one hand, clinical views like Pinel's described symptoms and clustered them together to create forms of insanity which were designed to be useful for the purposes of diagnosis. This was an empirical approach that did not need to offer a theory about the causes of insanity, and by not being restricted by the relatively limited knowledge of insanity's aetiology, pathology and prognosis, Pinel was able to provide a representation of the different manifestations of madness that were seen in the clinic.<sup>16</sup>

This chapter argues that the adoption of Pinel's concepts of the mental alienations was not a certainty and was the result of a contingent set of complex historical factors encompassing elements of the transmission of ideas from France, and how they were received by medical men in the United Kingdom. One appeal of Pinel's symptom based classification lay in it not being encumbered by a speculative theory of the development of madness, with its proponents stating that it returned to the symptoms as they were witnessed in the bodies of the patient. On the other hand, those who aspired for a scientific classification hoped that discovering insanity's underlying processes would allow for its different kinds to be discovered, thereby allowing it to be ordered along naturally occurring boundaries. As we will see in the third section of this chapter, those who were in favour of this approach believed that the classification Pinel offered was arbitrary, and often led to patients being misdiagnosed because they demonstrated different symptoms during the course of their disease: the diagnosis of a patient could vary depending upon the condition of the patient at any given time. For example, during a period of stupor, a patient could be diagnosed with melancholia, but if they were examined and admitted during a period of agitation, then they could be diagnosed with mania. For

---

<sup>15</sup> Michel Foucault discusses the reorganisation of discourse that surrounded the medical patient, and which led to a change in how the patient was conceptualised, a development that was fundamental to clinical knowledge: *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A.M. Sheridan, Routledge, 1989.

<sup>16</sup> Pinel in fact used the term 'nosography' to describe his clinical classification. See Philippe Pinel, *Nosographie philosophique ou La méthode de l'analyse appliquée à la médecine*, Paris, 1797

many, reliable diagnoses would only be made once madness was classified according to its pathology, prognosis and aetiology, yet the limitations of psychiatric knowledge meant that the aspiration for this sort of classification would never be fully realised in the period covered by this thesis. By the second half of the nineteenth century, many began to view the dominance of the classification offered by Pinel as an obstruction to their ideal of a natural, scientific classification. Questioning the symptom based approach was one of the ways in which this aspiration acted as a catalyst for discussions surrounding classification of insanity amongst the thought collective of British psychiatrists.<sup>17</sup> As we will see in the coming chapters, the toing and froing between symptomology, and the scientific aspirations for classification that were based in aetiology, pathology and prognosis would do much to define the debates that surrounded psychiatric classification, and in lieu of the knowledge that would allow pathology, aetiology or prognosis to be the grounds of classification, a Pinelean symptom based classification of the forms would be employed by asylum medical superintendents working throughout the United Kingdom.

## Section 1: Pinel's Forms of Insanity

Philippe Pinel's (1745 – 1826) background combined the man of letters and the clinician, and this was vital to shaping his medical writings on general nosology and his work on the classification of mental disorder. He was prevented from practicing in Paris due to his training in Toulouse, which was deemed to be unfit for the elite medical schools in the capital. Pinel relied on income from translations and reviews, rendering works by both Cullen and Crichton into French.<sup>18</sup> Before the French revolution, he had considered emigrating to North America for the sake of his career, but shortly after the overthrow of the Ancien Régime in 1789 he was placed in charge of the Bicêtre asylum, later going on to stewardship of the prestigious Salpêtrière. He drew upon this experience when formulating his classification of the forms of insanity included in *Traité médico-philosophique sur l'aliénation mentale; ou la manie* (henceforth referred to as Pinel's *Traité* when referring to the French, and Pinel's *Treatise* when referring to the English). Prior to publishing this foundational work for the mental sciences, Pinel had

---

<sup>17</sup> Ludwik Fleck, *Genesis and Development of a Scientific Fact*, trans. Fred Bradley, Robert K. Merton and Thaddeus J. Trenn, University of Chicago Press, 2008.

<sup>18</sup> Dora Weiner, 'Mind and Body in the Clinic: Philippe Pinel, Alexander Crichton, Dominique Esquirol, and the Birth of Psychiatry' in G.S. Rousseau ed., *The Languages of Psyche: Mind and Body in Enlightenment Thought*, UC Berkeley Press, 1990, pp.331 – 403. (p.334).

published an encyclopaedia of medical nosology, or nosography as he termed it.<sup>19</sup> In line with the empirical aspect of works on general medical nosology, Pinel classified mental disorders on the basis of the symptoms that presented themselves to the physician, and conceived mental alienation as having four broad forms: *la simple melancholie* (melancholia), *la manie* (mania), *la demence* (dementia), and *l'idiotisme* (idiotism).<sup>20</sup> These four disorders comprised a spectrum of acuteness or severity of mental disorder: melancholia was *délire partiel* (translated as partial insanity), manias were *délire généralisé* (general insanity), dementia was *affaiblissement intellectuel généralisé* (generalised intellectual weakening), and idiotism meant *abolition totale des fonctions de l'entendement* (total obliteration of the functions of the understanding).

### 1.1: British Influences on Pinel's Work

Due to his background as a translator and reviewer, Pinel could read English, and in the *Traité* he responded to the works of British physicians who had previously made attempts to classify mental diseases.<sup>21</sup> These included Thomas Sydenham, William Cullen, Thomas Arnold, and Alexander Crichton. Pinel had translated work by Cullen into French, as well as a set of papers from the *Philosophical Transactions of the Royal Society*.<sup>22</sup> Cullen's 1769 *Synopsis Nosologie Methodicae* was an important influence on Pinel, and this is apparent from the way the French physician, like Cullen, classified illnesses on the basis of symptoms. Many of the details included in Cullen's nosological work were also based on his twenty-five-years' worth of experience working in teaching hospitals in Glasgow and Edinburgh. Cullen was amongst the first to place nervous disorders into a category of their own, and he did this by conceptualising them as forms of neurosis (*versanie*). This was because Cullen thought that psychological pathologies were generated when an imbalance occurred in the brain's 'nervous power', and imbalances in this power were the starting point for disorders of the nervous system.<sup>23</sup> As such, Cullen's theory of nervous power was the aetiology he used to separate mental disorders: for example disorders caused by lesion on organs, and fevers due to diseases that were contracted from the miasmas. Cullen used the notion of imbalances of nervous power to explain a great number of

---

<sup>19</sup> Phillippe Pinel, *Nosographie philosophique ou La méthode de l'analyse appliquée à la médecine*, Paris, 1797.

<sup>20</sup> The term 'forms' will be used throughout this thesis as it was the prevailing terminology employed by those who attempted to classify insanity for a great deal of the nineteenth century. Berrios claims that the distinction between the 'form' and 'content' of insanity informed much of Western knowledge on mental disorders, and traces this back to Aristotle's notion that objects had a common essence, or character, their 'eidos'. See G. Berrios, *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century*, Cambridge University Press, 1996.

<sup>21</sup> Dora Weiner, 'Mind and Body in the Clinic: Philippe Pinel, Alexander Crichton, Dominique Esquirol, and the Birth of Psychiatry' in G.S. Rousseau ed., *The Languages of Psyche: Mind and Body in Enlightenment Thought*, UC Berkeley Press, 1990, pp.331 – 403. (p.334).

<sup>22</sup> Aubrey Lewis, 'British Psychiatry in the First Half of the Nineteenth Century: Philippe Pinel and the English' in *Proceedings of the Royal Society of Medicine*, Vol.48, Feb 1955, pp.581 – 586. (p.582).

<sup>23</sup> F. Clifford Rose, 'William Cullen' in *History of British Neurology*, Imperial College Press, 2011, pp.67 – 68.

pathologies, and the specific nature of the illness depended on which part of the nervous system was affected. The important role that Cullen believed the nervous system played was evident from the fact that two-thirds of his lectures on general pathology were devoted to the nervous system. Furthermore, Cullen included a great number of illnesses in the ‘Neurosis’ section of his general nosology:

<b>Order I</b>	
Comata	Sophtose Diseases
Apoplexia	Apoplexy
Paralysis	Palsy
<b>Order II</b>	
Adynamie	Defect of Vital Power
Syncope	Fainting
Dyspepsia	Indigestion
Hypocondriasis	Low Spirits
Chlorosis	Green Sickness
<b>Order III</b>	
Tetanus	Universal Cramp, or lockjaw
Convulsio	Convulsion
Chorea	St Vitus’s Disease
Raphania	Spasms of the Joint
Epilepsia	Epilepsy
Palpitatio	Palpitation of the Heart
Asthma	Asthma
Dyspnoea	Difficult Breathing
Pertussis	Hooping Cough
Pyrosis	Water Brash
Colica	Colick
Cholera	Vomiting and Purging
Diarrhoea	Purging
Diabetes	Excessive, discharge of urine
Hysteria	Hysterics
Hydrophobia	Canine Madness
<b>Order IV</b>	
Versaniae	Mental Diseases
Amentia	Idiotism
Melancholia	Melancholy

Mania	Madness
Oneirodynia	Night Mare

Figure 2 William Cullen’s nosology of Neurosis (Nervous Diseases).<sup>24</sup>

As we can see in Figure 2, within the class of the neuroses Cullen created a specific sub-class to differentiate mental disorders, or the *versaniae*, from other kinds of nervous disorders. Cullen understood mental disorders to be problems with the mind that were not accompanied by any type of fever or delirium.<sup>25</sup> The theoretical backing to this was the theory of ‘sympathy’ that Cullen had developed from Robert Whytt’s work, a function which animated and co-ordinated the body, transmitting sensation from target organs to the brain. Cullen used a theory of the function of the nerves to group the disorders within his classification, yet when it came to differentiating the different forms of *versanie* Cullen relied upon the symptoms observed in a sufferer.

Cullen’s student Thomas Arnold published *Observations on the Nature, Kinds, Causes, and Prevention of Insanity, Lunacy, or Madness* in 1782, and like Cullen he used symptoms drawn from clinical observation to formulate a classification of nervous diseases. Arnold drew upon his long experience with patients at the Leicester Asylum to develop his classification, although Arnold’s work differed from Cullen’s in one important respect: he did not provide a theory of psychogenesis, but rather stressed that his work attempted to efficiently and practically classify madness based upon the observation of clinical symptoms.<sup>26</sup> Figure 3 shows how Arnold divided insanity into two classes:

---

<sup>24</sup> William Cullen, *Synopsis Nosologiae Methodicae*, trans. William Jackson, W. Jackson (publisher), 1827, pp.11 – 12.

<sup>25</sup> German Berrios, *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century*, Cambridge University Press, 1996. (p.174).

<sup>26</sup> Peter K. Carpenter, ‘Thomas Arnold: A Provincial Psychiatrist in Georgian Britain’ in *Medical History*, 1989, Vol.33, pp.199 – 216.



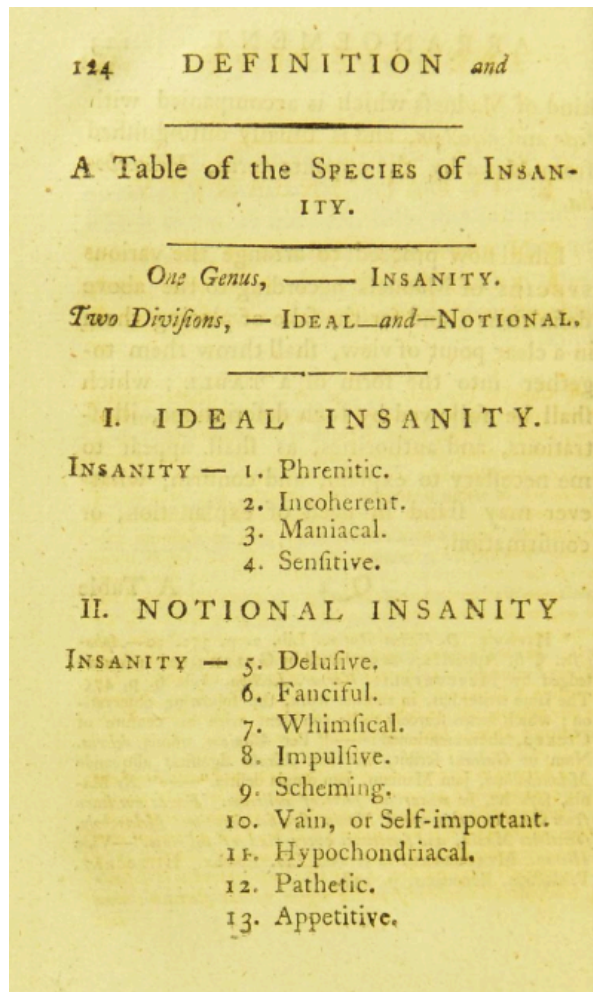


Figure 3 Thomas Arnold, 'A Table of Species of Insanity'<sup>27</sup>

Arnold's notion of *ideal insanity* described conditions which affected the thought processes of the patient and interfered with their ability to reason. Arnold divided the second class of *notional insanities* according to the psychological states, such as excessive *vanity* or *impulsiveness*. Notional insanities were also distinct from ideal insanities because they affected the person's emotions, and accordingly, their capacity to act morally. Arnold's division of diseases according to the faculty of the mind that was affected is perhaps due to his education at the University of Edinburgh; although he had aspired to publish a practical nosology of mental disease that he hoped would provide an empirical description of psychological symptoms he associated with the different forms of insanity Arnold described, the result firmly bears the stamp of the faculty psychology that had developed in the Athens of the North. This application of faculty

---

<sup>27</sup> Thomas Arnold, *Observations on the Nature, Kinds, Causes, and Prevention of Insanity, Lunacy, or Madness*, (G. Ireland: Leicester, 1782), p.124

psychology to the classification of mental disorders foreshadowed a similar strategy that was adopted by Pinel in classification, published nearly twenty years later: the limited set of diagnostic concepts used by Arnold made his classification practical, which helped to make it popular amongst doctors working in asylums in the British Isles.<sup>28</sup>

The rate of breakthroughs in medicine during the late eighteenth century made Arnold's work look dated by the dawn of the new century, and it drew criticism from a new wave of classifiers of mental disease, most prominently from the English physician Alexander Crichton.<sup>29</sup> Crichton attacked Arnold in the preface to his 1797 *Inquiry into the Nature and Origin of Mental Derangement* because he classified insanity according to its psychological content.<sup>30</sup> Crichton thought that this strategy had led to confusions in Arnold's work, such as Arnold's principle of differentiating disorder by psychological content such as *scheming* or *whimsy* risked creating an endless list of the forms of insanity which was incoherent. Crichton believed that a much more accurate classification could be derived from basing disease concepts upon the somatic symptoms that were presented, such as tics, states of catatonia and excitement. He also focussed his attention on thought processes, something more abstract than the psychological contents such as *scheming* and *vanity*, which had been employed by Arnold in his classification.

## 1.2: The Forms of Mental Alienation in Pinel's *Traité médico-philosophique sur l'aliénation mentale* and their English (Mis)Translation

Pinel's *Treatise* was first published in 1800, and it utilised some of the concepts that Cullen used in his classification of the *versanies*.<sup>31</sup> Pinel replaced Cullen's Latin-derived term *amentia* with the French *la demence*. Although the symptoms that Pinel described and associated with *dementia* very closely resembled Cullen's description of *amentia*, it is unclear why he chose *dementia* for his nosology. Berrios argues that it was because the term *la demence* had a long tradition in the French language, whereas the term *amentia* was typically used in English clinical literature due to William Battie's employment of the term in his celebrated 1758 *Treatise on Madness*.<sup>32</sup> The replacing of the term would lead to *dementia* being used in the 1806 translation and by Prichard

---

<sup>28</sup> Peter K. Carpenter, 'Thomas Arnold: A Provincial Psychiatrist in Georgian Britain' in *Medical History*, 1989, No.33, pp.199 – 216.

<sup>29</sup> Alexander Crichton, *An inquiry into the nature and origin of mental derangement: comprehending a concise system of the physiology and pathology of the human mind and a history of the passions and their effects*, Cadell Jr. & Davies, 1798) (p.5)

<sup>30</sup> Ibid.

<sup>31</sup> Pinel, Phillipe. *Traité médico-philosophique sur l'aliénation mentale*. Chez J. Ant. Brosson, 1800. (p.130)

<sup>32</sup> German Berrios, 'Dementia during the Seventeenth and Eighteenth Century' in *Psychological Medicine*, Vol.7, No.4, Nov. 1987, pp.829 – 837. (p.834)

in his own *Treatise on Insanity*, which was heavily influenced by Pinel and Esquirol.<sup>33</sup> As a result Pinel's term *dementia* gradually came to replace *amentia* in the English language, although Thomas Laycock and David Skae, influential thinkers whose work would prove to be influential in Britain in the second half of the nineteenth century, would continue to use *amentia* during the 1860s and 1870s.

Pinel employed the term *melancholia* yet the symptoms to which it referred were different to Cullen's: he made it a broader category than the Scotsman's, and as we will see, included a broader spectrum of symptoms within it.<sup>34</sup> For Pinel it included emotional disorders, like the feeling of sadness and despair that Cullen understood it to be, but he also included certain manias and delusions, and chronic psychotic states.<sup>35</sup> In the case of melancholia, Pinel did not determine it as either an emotional disorder or as an intellectual disorder, and so included certain intellectual behaviours and emotional behaviours within its diagnostic boundaries. Thus it is important to remember that the melancholia that Pinel drew upon was not limited to 'sadness' as such, but included a number of other behaviours including delusions and obsessive behaviours.<sup>36</sup> Jean Etienne Esquirol, his student and protégé, whose work is discussed in more detail below, would attempt to distinguish melancholia as a form of depression of the emotions from disorders that affected the intellectual capacities by developing the concepts *hypomania* and *monomania* in his own work.

Pinel's work divided insanity into four forms based upon the clinical symptoms that he observed during his time in practice at the Salpêtrière. He did not think that these forms were mutually exclusive, and – this is a crucial point – he was not classifying natural kinds, but he was producing a set of forms, or manifestations, of insanity that would be useful in the asylum.<sup>37</sup> Cullen's concept *onierodynia* was replaced entirely by Pinel with *idiotism*. Instead, Pinel included idiotism as a distinct class, which would have been included under Cullen's concept of *amentia*. In essence then, Pinel divided Cullen's concept of *amentia* into *dementia* and *idiotism* in order to differentiate between gradual degenerative intellectual degradation and what would then have been called mental deficiency caused by constitutive factors. Pinel's *Traité* was a move away from previous classifications of mental disorders due to the way that he cordoned off the

---

<sup>33</sup> Hannah Franziska Augstein, 'JC Prichard's Concept of Moral Insanity – A Medical Theory of the Corruption of Human Nature' in *Medical History*, Vol. 40, 1996, pp.311 – 343, (p.314).

<sup>34</sup> German Berrios, 'Mood Disorders: Clinical Section' in *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders*, Berrios and Porter eds., London, 1995, pp.384 – 408 (p.389).

<sup>35</sup> Judith Misbach and Henderikus J. Stam, 'Medicalizing Melancholia: Exploring Profiles of Psychiatric Professionalization' in *Journal of the History of the Human Sciences*, Vol.42, No. 1, pp.41 – 59. (p.45)

<sup>36</sup> German Berrios, 'Mood Disorders: Clinical Section' in *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders*, Berrios and Porter ed., Athlone, 1995, pp.384 – 408. (p.384).

<sup>37</sup> Evelyn A. Woods, and Eric T. Carlson. 'The Psychiatry of Philippe Pinel' in *Bulletin of the History of Medicine*, Vol.35, No.14, 1961, pp.14 – 25.

mental alienations of *melancholia*, *dementia*, the *manias* and *idiotism* from other nervous diseases, which, as figures 2 demonstrates, were included in the same category in Cullen’s work. This departure was demonstrated within Pinel’s own work: in his nosography, he followed Cullen by including forms of neurosis in the same category as these mental disorders, but he did not do the same in the *Treatise*, with hysteria and hypochondriasis not being included in his nosography of mental alienation. Woods and Carlson claim that Pinel’s work signalled a division in the study of cognitive and mental disorders due to neurosis not being recognised by Pinel as a form of mental alienation.<sup>38</sup>

La simple mélancolie (délire partiel)
La manie (délire généralisé)
La demence (affaiblissement intellectuel généralisé)
L’idiotisme (abolition totale des fonctions de l’entendement)

Figure 4 Pinel’s forms of insanity.<sup>39</sup>

In the *Traité* then, Pinel abandoned the aetiological theory of nervous power that was presented by Cullen, yet he retained many of the forms of mental disorder that were included in the Scottish physician’s section on mental diseases, or *versaniae* (neuroses) as Cullen labelled them.<sup>40</sup> To put it another way, Pinel provided a classification of mental disorder that adopted disease concepts that were influenced by Cullen, but he separated his mental alienations from nervous disorders because he did not follow Cullen’s view that these forms of mental disorder were simply caused by disorders of the nervous system.<sup>41</sup> Pinel did not offer an alternative aetiology of mental diseases - that is to say, an alternative theory of the genesis of mental pathology - to underpin his classification. Like Cullen, Pinel formulated the concepts in his classification on the basis of the symptoms that were observed to be associated with each disorder, but he did not attempt to explain their causation, instead providing remarks in the *Traité* that criticise an aetiology of mental disorder which was couched in narrowly physiological

---

<sup>38</sup> Ibid., (p.22)

<sup>39</sup> Phillippe Pinel, *Traité médico-philosophique sur l’aliénation mentale*. Second edition, Chez J. Ant. Brosson, 1809.

<sup>40</sup> Ibid.

<sup>41</sup> Ibid.

terms: he explicitly rejected the view that brain lesions were always the cause of mental alienation.<sup>42</sup> Pinel's work then adopted a purely symptomatic approach to the classification of mental disorders, an approach which did not attempt to provide a comprehensive aetiology into the disease concepts that comprised the work. Pinel would also employ terms that, although not coined by Cullen, were used by the Scotsman to describe certain forms of nervous disorders: *mania*, *melancholia*, and *amentia*. Crichton's faculty psychology was also an influence on Pinel, and provided the basis of his concept of *manie sans delire*: a disorder which affected the emotional, but not the intellectual, faculties of the mind. In the preface to his *Traité* he praised Crichton's work and agreed with his criticisms of Arnold: that a classification of mental disorders should be based according to the bodily and behavioural symptoms as they presented themselves, as opposed to Arnold's belief that the content of the psychological symptom, such as nightmares, should be used to differentiate diseases from one another.<sup>43</sup> For the purposes of this chapter, then, it is possible to draw two conclusions from this summary of Pinel's ideas. First, the concepts in the *Traité*, although modified, firmly bear the stamp of Cullen's concepts that were included in his section on mental diseases. Second, Pinel employed a purely empirical, symptomatic approach to the classification of mental disorders.

The initial reception of Pinel's *Traité* amongst British physicians was slow, and there is little to suggest his ideas caught on amongst British physicians upon their initial publication.<sup>44</sup> This may have been due to complications in the transmission of French scientific thought due to Napoleon's continental blockade, and the prohibition of printed material entering the United Kingdom from France.<sup>45</sup> Whatever may have been the case, Reeve's response is the longest and fullest review recorded in a British journal, but other reviews criticised his division of insanity:

With regard to the practical utility of his division, (which, it is to be remarked, by no means entirely belongs to the present author) it may be doubted to what extent it may reach. The distinctions are far from being constant, even in the same

---

<sup>42</sup> *Ibid.*, (p.156).

<sup>43</sup> Dora Weiner, 'The Madman in the Light of Reason. Enlightenment Psychiatry: Part II. Alienists, Treatises, and the Psychologic Approach in the Era of Pinel' in *History of Psychiatry and Medical Psychology: With an Epilogue on Psychiatry and the Mind-Body Relation*, Edwin R. Wallace and John Gach eds., pp.281 – 304. (p.294).

<sup>44</sup> Aside from the lack of reviews lauding Pinel's work, a remark made by Victorian social campaigner Ellice Hopkins wrote in *Fraser's Magazine* also suggests that Pinel's influence in the United Kingdom was slow to take hold: 'Not only was the spread of Pinel's principles extremely slow, so that as late as 1836, when, as we shall afterwards see, Charlesworth and Hill, in England, were abolishing the last vestige of mechanical treatment...' Hopkins, (1877). 'The Moral Treatment of Insanity' in *Fraser's Magazine*, Vol.15, No.88, pp.444 – 459. (p.449).

<sup>45</sup> Jonathan Topham 'Science, Print, and Crossing Borders: Importing French Science Books into Britain, 1789-1815' in *Geographies of Nineteenth-Century Science*, ed. DN Livingstone and CWJ Withers, University of Chicago Press, 2011, pp.311 – 344.

individual; nor are the means of cure always dependent on the particular place which may be allotted in nosology to the combination of existing symptoms.<sup>46</sup>

The impression the reviewer had that the forms of mental diseases were not constant, or particularly steadfast, may not have been helped with *la demence* being translated as simply ‘madness’ by the reviewer.<sup>47</sup>

The unenthusiastic response to Pinel’s division of insanity seen in these initial reviews was confounded by the poor quality of the English translation of the work, carried out in 1806 by the Sheffield-based physiologist David Daniel Davis.<sup>48</sup> The title given to the translation itself demonstrated a major divergence from Pinel’s original: Davis opted for *A Treatise on Insanity in Which are Contained the Principles of a New and More Practical Nosology of Manical Disorder*, which is very different to Pinel’s original, a faithful translation being *A Medical Philosophical Treatise on the Mental Alienations, or the Manias*. The differences in the titles is no small point, because it reflected Davis’s tendency to translate ‘manie’ as ‘insanity’ throughout the 1806 translation, which introduced a number of key ambiguities, such as ‘Manie intermittente’ (intermittent mania) being translated as ‘periodical insanity’, ‘le traitement de la Mânie’ (the treatment of mania) being rendered by Davis as ‘treatment of insanity’, and ‘Les accès de Manie’ (outbursts of mania) being rendered as ‘paroxysms of insanity’.<sup>49</sup> Most serious of all was Davis’s rendering of *manie sans délires* as *mania without delirium*: with the original French *délires* being a clinical term that described delusions, hallucinations, false beliefs and distortions in chains of reasoning. *Mania without delirium* suggested none of these, with the English *delirium* suggesting the kind of transitory hallucinations and delusion seen in fevers and intoxication. Further inconsistencies included: Thomas Arnold being lauded in the translation, despite Pinel having criticised him in the original;<sup>50</sup> the style of writing employed by Davis being florid and complicated, whereas Pinel’s French was clinical and austere.<sup>51</sup> The quality of the translation could be explained by Davis’s lack of experience working in an asylum,<sup>52</sup> and the parochial nature of the translation

---

<sup>46</sup> It is important to note that this review did hold respect for Pinel’s moral treatment and the observations from his case notes. ‘Book review’ in *Monthly Review, Or, Literary Journal*, 1803, Vol.42, 526 – 532, (p.530).

<sup>47</sup> Ibid.

<sup>48</sup> In addition, a second expanded edition published by Pinel in 1809 was not translated until 2018, leaving a rather shoddy and inaccurate translation of the earlier edition of his work as the only one available to English readers. Dora Weiner suggests that this has had a profound impact upon the understanding of Pinel amongst Anglophone scholars; Dora Weiner, ‘Betrayal! The 1806 Translation of Pinel’s *Traité medico-philosophique sur l’Aliénation mentale, ou la manie*’ in *Generus*, Vol.57, 2000, pp.42–50.

<sup>49</sup> Philippe Pinel, *A Treatise on Insanity, in which are contained the principles of a new and more practical nosology of maniacal disorders*, trans. D.D. Davis, W.Todd, 1806, p.43 and p.25.

<sup>50</sup> Ibid.

<sup>51</sup> Ibid.

<sup>52</sup> Ibid.

could equally be explained by rising international tensions between Napoleon's France and the United Kingdom.<sup>53</sup>

Although the basic forms of insanity presented in Pinel's original *Traité* were preserved, the quality of the prose in Davis's translation of Pinel's articulation of the foundational principles which he used to distinguish between the disorders in his classification suffered. This created ambiguities which would have resulted in the work appearing unclear, far away from the more precise clinical style that characterised Pinel's own writing.<sup>54</sup> For instance, 'les diverses lésions des facultés intellectuelles ou affectives' was rendered by Davis as the 'the various lesions of the intellectual and active faculties'.<sup>55</sup> It is unclear why Davis opted for 'active' instead of 'affective' or 'emotional' which would have been a more salient translation, or how he understood Pinel's use of this crucial term in this key section which provided the rationale for the differentiation of the disorders he presented in his nosology. It may have been that Davis viewed intellectual faculties as being a passive feature of the mind, and emotional faculties as being active, or, as a trained physician he may have been using the term to describe the stage of a disease which produced pathological changes or symptoms.<sup>56</sup> Whatever may have been the case, this fundamental distinction of Pinel's psychological classification was obscured by this mistranslation: Davis's translation went on to infer this distinction when he wrote that 'the powers of perception and imagination are frequently disturbed without any excitement of the passions' and that 'the functions of the understanding are [...] often perfectly sound, while the man is driven by his passions to acts of turbulence and outrage'.<sup>57</sup> However, the use of passions lacked the abstraction and neutrality that emotions offered; from Davis's translation it appeared that Pinel was narrowing this to furious passions., with the distinction between affective faculties and intellectual faculties again becoming obscured in Davis's confused translation.

A further peculiar move taken by Davis was in the section of the work that discussed the terminology that the Frenchman had decided to use to describe each of the forms of the mental alienations. Pinel wrote that Ancient Greek, although rich and expressive, had only

---

<sup>53</sup> Sarah Chaney, 'The Action of the Imagination: Daniel Hack-Tuke and Late Victorian Psycho-Therapeutics' in *History of the Human Sciences*, Vol.30, No. 2, pp.17 – 33.

<sup>54</sup> Dora Weiner, 'Betrayal! The 1806 Translation of Pinel's *Traité' medico-philosophique sur l'Aliénation mentale, ou la manie*' in *Genesis*, Vol.57, 2000, pp.42–50. (p.45).

<sup>55</sup> Davis, see opp. cit. 48 p.135, and Pinel, opp cit. p.136.

<sup>56</sup> "active, adj. and n." *OED Online*, Oxford University Press, September 2019, oed.com/view/Entry/1953. Accessed 15 October 2019.

<sup>57</sup> Davis, p.135.

offered terms for acute forms of delirium that were seen in severe illnesses, but lacked a language which described the human understanding.<sup>58</sup> Pinel then stated:

Il fallut donc revenir sur mes pas, et faire entrer dans l'ordre de mes études les écrits de nos Psychologistes modernes, Locke, Harris, Condillac, Smith, Stewart, etc., pour saisir et tracer toutes les variétés comprises dans la dénomination générique d'aliénation de l'esprit.<sup>59</sup>

Pinel here was saying that it was necessary to retrace his steps in his studies, and return to reassess the work of our modern psychologists to find, apprehend, collect and trace all the varieties of alienation of the mind that had been described by these writers. Pinel's aim for research was much more blandly and vaguely put by Davis in his translation:

But the history of insanity, being inseparable from that of the human understanding, is necessarily found in a very imperfect state in the writings of the ancients. I have, therefore, felt the necessity of commencing my studies with examining the numerous and important facts which have been discovered and detailed by modern pneumatologists.<sup>60</sup>

Aside from not even including the names of the thinkers that Pinel invoked and thought were important to cite in his study, adding to the vagueness of the claims made in the English translation, Davis's substitution of psychology for pneumatology placed the work firmly in the previous century, and although this term was gradually becoming used to describe the functioning of the human mind and as a precursor to *psychology*, it still held supernatural connotations.<sup>61</sup> Pinel's footnotes to this section are completely omitted from the English version, yet they provide lengthy and illustrative elaborations in the form of nuanced descriptions of the details of each of the alienations, and often invoked specific cases to further highlight them. These ambiguities and the problems with the prose in Davis's translation may have been an additional factor in leading a reviewer in Reeve, who was theoretically hostile to Pinel's approach, to dismiss the work as imprecise and thus unbecoming of British medicine.

Despite the imprecision of Davis's translation, and the omission of a great deal of the notes which were intended to inform the description of each of the alienations, the main forms of the mental alienations were preserved. *Melancholia*'s different forms are preserved: *Melancholia with delirium* is given the two forms that Pinel gave it, with those that are characterised by symptoms of despair and other forms which are accompanied by exalted delusions of

---

<sup>58</sup> Pinel., p.136

<sup>59</sup> Ibid.

<sup>60</sup> Davis., p.135

<sup>61</sup> "Pneumatology, n." OED Online, Oxford University Press, September 2019, [oed.com/view/Entry/146322](http://oed.com/view/Entry/146322). Accessed 15 October 2019.



grandeur.<sup>62</sup> Intellectual forms of melancholia Pinel described as patients building obsessions but without any accompanying delusions, which he considered to be a form of *versanie*, or neurosis. In addition, forms of melancholia that were connected to suicide are described by Davis, but again in less precise terms. *Mania without delirium* and *with delirium* were also included in Davis's translation, in addition to *periodical mania*, and *dementia, the abolition of the thinking faculty*, and *dementia, marked by ideas unconnected amongst themselves, and without relation to external objects*.<sup>63</sup> The forms of mental alienation that Pinel presented in the first edition of his *Traité* were preserved in the English translation, but Davis lost much of the nuance, which contributed to his ideas receiving an unenthusiastic initial reception in the United Kingdom.

Pinel's influence was huge, with the concepts and the principles that he used to formulate them setting the paradigm for French psychiatry during the first half of the nineteenth century. Students of his based in the Salpêtrière, most notably Esquirol, came to dominate French classification of the mental alienations. For instance, in 1810, Esquirol published *De la monomanie*, which built upon Pinel's classification by developing the forms of *melancholia* that his master described by formulating the concepts *monomania* and *lypomania*.<sup>64</sup> Esquirol was not a system builder like Cullen, Pinel, Arnold or Crichton, and unlike Pinel, his oeuvre does not contain a magnum opus which neatly contains his ideas on psychiatric classification. Rather, he operated on a more piecemeal basis, with his work on mental alienation being contained in shorter monographs and entries in medical dictionaries that he himself often edited. Esquirol was a major figure in medical discourse in France, serving as an editor of the *Dictionnaire des Sciences Médicales*, writing the entry on *monomania* for the 1819 edition.<sup>65</sup> One of Esquirol's goals in dividing Pinel's melancholia into lypomania and monomania was to more clearly demarcate emotional disorders from intellectual disorders: lypomania was an attempt to distinguish the emotional form of melancholia from *monomania*, which was an intellectual disorder, a division that was not so clearly articulated in Pinel's work on melancholia.<sup>66</sup> Researchers associated with the large Parisian asylums sought to divide *monomania* and *lypomania* into a further sub-types on the basis of the symptoms presented and differentiating between emotional and intellectual disorders.<sup>67</sup>

---

<sup>62</sup> Phillippe Pinel, *Traité médico-philosophique sur l'aliénation mentale*. Second edition, Chez J. Ant. Brosson, 1809, (p.142).

<sup>63</sup> Ibid., pp.140 – 165.

<sup>64</sup> Roy Porter, 'Psychiatry' in *the Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present*, Harper Collins, 1997, pp.493 – 524. (p.502).

<sup>65</sup> Rafeal Huertas, 'Esquirol: Between Doctrine and Clinical Practice' in *History of Psychiatry*, Vol.19, No.2, 2008, pp.123 – 140.

<sup>66</sup> DB Weiner, 'Betrayal! The 1806 Translation of Pinel's *Traité médico-philosophique sur l'Aliénation mentale, ou la manie*' in *Generus*, 2000, Vol.57, pp.42–50. (p.45).

<sup>67</sup> German Berrios, 'Mood Disorders: Clinical Section' in *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders*, Berrios and Porter eds., Athlone, 1995, pp.384 – 408 (p.389).

Although popular in France, Pinel's ideas would not receive the kind of reception they enjoyed across the Channel. As Reeve's hostile review which opened this chapter suggests, Pinel's views were too speculative, and the loose connection he drew between certain mental alienations and physical lesions was a sign of an unacceptable Cartesian world view. A hostile intellectual climate could not be won over by a poor translation of his work which failed to capture both the clinical tone of Pinel's language and the nuances of the forms of mental disorder that were described in his work. In addition, it is possible that the popularity of phrenology eclipsed Pinel's work in the British Isles, and debates that surrounded material and medical explanations of the mind and linked them to the French revolution may also have contributed to Pinel's ideas not becoming popular in the British Isles. Pinel's lack of adherence to a strictly causal and physical explanation of insanity would, as we will see especially in chapter two, continue to reverberate throughout Victorian psychiatry and the age of the asylum.

## Section 2: James Cowles Prichard and the origins of a standard psychiatric nomenclature

The Victorian polymath James Cowles Prichard (1786 – 1848) published work which helped to popularise Pinel's concepts in the United Kingdom, and would use his influence to ensure that the concepts developed by Pinel and Esquirol would become the standard language of psychopathology during the second half of the nineteenth century. Prichard was a prominent figure in British psychiatry and lunacy administration, as well as an influential anthropologist and legal theorist.<sup>68</sup> Textbooks published under his name from 1835 onwards helped to popularise the concepts of psychopathology that had been developed in France in reaction to Pinel's work. Prichard had first-hand experience of how Pinel's concepts were used in diagnosis due to his time spent working in Paris with Esquirol at the Salpêtrière. Due to Prichard's ability to understand French as well as having met and worked with Pinel's student Esquirol, his work functioned for the Anglophone world as a summary of the classifications of the forms of insanity that were emerging from Paris during the first half of the nineteenth century.

Prichard's work would help to establish the standard Table of the Forms of Insanity in the United Kingdom until the end of the nineteenth century. This section will explore how Prichard more faithfully captured the spirit of the ideas of French psychiatry. In addition, it will consider the reasons why the concepts included in his textbook became the standard terminology used in the debates that are the focus of the second chapter: those surrounding the

---

<sup>68</sup> H.F. Augstein, *James Cowles Prichard's Anthropology: Remaking the Science of Man in Early Nineteenth Century Britain*, *Clio Medica*, Vol.52, 2016.

Table of the Forms of Insanity. The context in which Prichard published his work, the 1830s and 1840s, was one that saw a wane both an interest in phrenology, and hostility from the English clergy who viewed work from figures such as William Lawrence, who promoted thought as an organ of the brain, as challenging the notion of an immaterial soul.<sup>69</sup> Paranoia surrounding the French revolution dying down to an extent, along with anti-French sentiment against Napoleon may also have made conditions more receptive to Pinel's ideas than when it was initially released. Furthermore, the influence that Prichard would come to exercise as the mental health specialist on the first Lunacy Commission, the regulatory body established in 1845 to oversee asylum management was also an important factor. The prominent position he held provided him with a great deal of influence in a period that was vital for shaping the rules and regulations that asylum psychiatry would need to abide by for the rest of the nineteenth century, including the diagnostic concepts used for asylum admissions. Prichard's contribution would have a dramatic impact, and would lead to the widespread use of Pinel and Esquirol's diagnostic criteria by medical officers working in asylums across the British Isles: these concepts would as a result become foundational to the official Table of the Forms that was used by British psychiatry during the latter half of the nineteenth century. As will be explored below, the terms used by French psychiatry after Pinel were brought to the British Isles in Prichard's work, and would come to be used in most asylums across the United Kingdom to describe and diagnose the different forms insanity that would pass through their doors. This language of diagnosis would form the common shared terminology of psychiatrists for the remainder of the nineteenth century, and would be the common currency that were used in debates surrounding classification of the forms of insanity that will be explored in the second and third chapters of this thesis.

## 2.1: Prichard's Textbooks and the Introduction of the Pinelean system to the British Isles

A brief look at Prichard's own intellectual development can help to shed further light on how Pinel's ideas were introduced to the United Kingdom: he went from dismissing the Frenchman's ideas to fully embracing his classification of insanity in his mature works. Prichard's first textbook on mental disorder, *A Treatise on Diseases of the Nervous System* was published in 1822, and this work was influenced by Cullen's explanation for the cause of

---

<sup>69</sup> Elfed Huw Price, 'Do Brains Think? Comparative Anatomy and the End of the Great Chain of Being in 19<sup>th</sup>-century Britain' in *History of the Human Sciences*, Vol.25, No.3, pp.32 – 50.

insanity and Arnold's descriptions of psychological symptoms.<sup>70</sup> It included a chapter on the different forms of insanity, and in this Prichard claims that it was one disease which had different manifestations depending on a person's constitution and at what point they were in the course of the disease.<sup>71</sup> He claimed that the essence of insanity was when the mind was not able to determine reality from illusion, and damage to the faculties of memory and imagination, or what he termed *reverie*.<sup>72</sup> Prichard thought that insanity was characterised by confusing recollection and fantasy, following Arnold in his use of *reverie* when he wrote how a person 'mist[ook] the [intellectual] ideas of *reverie* for the impressions of memory and reflection.'<sup>73</sup> The capacity to confuse memory and self-reflection for reality was what Prichard understood to be the essence of insanity: it was upon this foundation that he built a theory of the genesis of madness:

To sum up this account in a few words, the character of madness seems to consist in the circumstance that the impressions of reverie are so modified by the disease as to be no longer distinguishable from those of attentive and active reflection.<sup>74</sup>

Prichard used this theory of insanity to explain all of its forms. These included *melancholia*, *dementia*, and *mania*, but not *monomania* or *mania without delusions*. His account of *mania* bore the influence of Arnold, for he divided this form of insanity along the lines of the symptoms that were presented, using the terms *maniacal hallucination* and *daemonomania*, the latter describing symptoms that saw patients talking to imaginary beings. In this way, then, Prichard's early ideas on madness pay tribute to the work of both Cullen and Arnold.<sup>75</sup>

In this early work, Prichard rejected Pinel's notion of *manie sans delire* and explained manic symptoms in patients who seemed to be in full possession of their intellectual faculties:

...such a phenomena [sic] as that of a man rushing with eagerness to commit the most atrocious of murders, under the influence of ungovernable fury, without any impression on his mind that is calculated to excite anger, even without any fancied ground of offence against his unfortunate victim, cannot be imagined to result from the operation of *any natural causes*. Such a maniac must be literally possessed by a daemon: his action is not *that of a human being*, however insane. Yet M. Pinel

---

<sup>70</sup> James Cowles Prichard, *A Treatise on Diseases of the Nervous System*, Thomas and George Underwood, 1822.

<sup>71</sup> For more information on the development of Prichard's ideas on mental illness, see Denis Leigh, 'James Cowles Prichard' in *Proceedings of the Royal Society of Medicine: Section of Psychiatry with Section of the History of Medicine*, 1955, pp.586 – 590; James Cowles Prichard, 'Chapter IV: A General Description of Madness' in *A Treatise on Diseases of the Nervous System*, Thomas and George Underwood, 1822, pp.113 – 116. (p.113).

<sup>72</sup> James Cowles Prichard, see opp. cit. 70.

<sup>73</sup> Ibid., p.122

<sup>74</sup> Ibid, p.126

<sup>75</sup> Ibid, p.132.

describes this as the proceeding of a man who, in the common sense of words, must be called *sane*, as being in full possession of his intellectual faculties.<sup>76</sup>

Prichard misinterpreted Pinel as claiming that those who suffered from manic symptoms with no seeming intellectual impairment had no damage to their mind because they were in full possession of their intellectual faculties. Yet as we have seen in section one, Pinel in fact claimed that patients could be in full possession of their intellectual faculties yet still be considered insane because *manie sans delusions* saw damage to the emotional faculties of the mind but not the intellectual faculties. Pinel's distinction between emotional and intellectual forms of mental alienation seems to have eluded Prichard, and he offered an alternative explanation that was in line with his own theory of the essence of insanity: that the individual could appear to be in full possession of their intellectual faculties 'free from any maniacal illusion, and are hence supposed to have an undisturbed possession of their intellectual faculties', yet they could 'fall at certain periods under the influence of some sudden hallucination, which excites their rage to a vehement degree'.<sup>77</sup> Those suffering from the form of insanity that Pinel described as *manie sans delire*, which led to emotional disturbances that explained violent behaviour in those who seemed intellectually competent, were instead according to Prichard actually suffering from intermittent delusions that led them to commit violent acts. Prichard's misapprehension of Pinel could again be due to his reliance on Davis's poor translation: the sole footnote citing Pinel's work Prichard's *A Treatise on Nervous Diseases* was made to the English translation, and not the original French which Prichard would cite in his later works on insanity.<sup>78</sup>

By the time it came to writing *A Treatise on Insanity* (henceforth referred to as Prichard's *Treatise*) in 1835, he had spent time in Paris working with Esquirol and could read French: in this later work he referred to the second French edition of Pinel's *Traité* that had not been translated into English, as well as articles by Esquirol that also were yet to be translated.<sup>79</sup> Prichard's *Treatise* provide an argument for why insanity needed to be divided into different forms, but still conformed to his earlier position that it was one illness with different manifestations:

...the practical advantages of a definition [of insanity] can, in this instance, only be attained by stating what are in reality those disturbances which the mental

---

<sup>76</sup> Ibid, p.136 [Italics added for emphasis].

<sup>77</sup> Ibid., p.137.

<sup>78</sup> Ibid., p.140

<sup>79</sup> James Cowles Prichard, *A Treatise on Insanity and Other Disorders Affecting the Mind*, Sherwood, Gilbert, and Piper, 1835. (p.14).

operations sustain in cases of insanity, [but] these disturbances [...] present very different phenomena in different forms of the disease.<sup>80</sup>

Prichard thought that insanity was one disease, but strangely he thought that it had many different causes and took on different forms in different cases. He devoted a lengthy section of the *Treatise* to listing them.<sup>81</sup> He would also refer in this text to different *kinds* of mental disorder, introducing further ambiguity about what he was describing: it is unclear whether he thought that these were different natural kinds or not.<sup>82</sup> Prichard was not alone in possessing this apparent tension between referring to insanity as one disease, yet describing different causes and its different forms: this tension would run through nineteenth century classification, and is explored in the first three chapters of this thesis.

Prichard also incorporated the ideas of Esquirol into his nosography of insanity with his addition of *monomania*, as we can see from the four main categories of Prichard's nosology below:

1. moral insanity;
2. monomania or 'partial derangement of the understanding';
3. *mania*, or raving insanity
4. *dementia*, or 'incoherence'.<sup>83</sup>

*Idiocy* was not included in the nosography because Prichard believed it was unnecessary as a separate disease category and including it would make the classification overly complicated: he thought instead that patients suffering from idiocy should be classified under the diagnostic term *dementia*. We see then that Prichard sacrificed nuance in his classification for concision, which was in the service of pragmatism – he wanted his nosography to be practical and useful in clinical diagnosis, and he viewed brevity as achieving this end. Prichard's numerical ordering of these disorders correlated to the severity of the disorder: he believed that moral insanity was the least acute because it was a disorder of the 'feelings' and not the intellect<sup>84</sup>; that monomania was a partial form of intellectual derangement that only affected the understanding when the mind was engaged in harmful thought patterns; mania was a 'general', or complete intellectual

---

<sup>80</sup> Ibid.

<sup>81</sup> Prichard would discuss different forms of insanity as they appeared in different 'cases' – he steers clear of calling them kinds. See Ibid.

<sup>82</sup> Ibid., p.6.

<sup>83</sup> James Cowles Prichard, 'Nosography of the Four Forms of Insanity' in *A Treatise on Insanity and Other Disorders Affecting the Mind*, Sherwood, Gilbert, and Piper : London, 1835. pp.6 – 7.

<sup>84</sup> Ibid.

derangement that affected the rational capacities of the sufferer; and dementia/incoherence was the most severe form of insanity because in this condition, the associations between ideas were completely broken down leading to the complete obliteration of the patients' intellectual capacities. It was within this concise nosography of mental illnesses that Prichard believed 'all varieties of madness may find their place.'<sup>85</sup>

Prichard's *Treatise* introduced the term *moral insanity* into the Anglophone world, which was an interpretation of Pinel's *manie sans delire*, and defined by Prichard as a 'perversion of moral disposition'.<sup>86</sup> Due to his time spent in Paris, Prichard had gained an understanding of 'delire' which was close to Pinel's original French: not simply as 'delusions', as mistranslated by Davis, but referring to a degradation of the powers of reasoning and the cognitive faculties. Prichard wrote of moral insanity:

'...[it is] madness consisting in a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions, and natural impulses, without any remarkable disorder or defect of the intellect or knowing and reasoning faculties, and particularly without any insane illusion or hallucination.'

Prichard then followed Pinel's understanding of *manie sans delire* in writing that moral insanity was accompanied by symptoms which demonstrated a distortion of the emotions, whilst intellectual faculties remained intact. This form of madness was distinctly important for Prichard because the other forms of insanity in his nosography all involved a degree of damage to the intellectual capacities of the mind.<sup>87</sup>

One notable absence from Prichard's classification was *melancholia*. This is because he replaced it with Esquirol's concept of *monomania*, but he chose not use the concept of *hypomania* that Esquirol employed to describe the sadness that was associated with melancholia by French psychiatry. Instead, Prichard included the symptoms of Pinel's *melancholia* and Esquirol's *hypomania* with *monomania*, because he believed that the thought processes associated with *monomania* gave rise to the symptoms that had been associated with *melancholia* in Cullen and Pinel's work, as he described:

Monomania, or partial insanity, in which the understanding is partially disordered or under the influence of some particular illusion, referring to one subject, and

---

<sup>85</sup> Ibid, (p.7).

<sup>86</sup> Ibid., and German Berrios, 'Introduction to J.C. Prichard and the Concept of 'Moral Insanity'' in *History of Psychiatry*, No. 10, 1999, pp.111 – 126, (p.111)

<sup>87</sup> It is also important to note here that Prichard followed Pinel in employing the term 'nosography' instead of 'nosology': this demonstrates that he intended his diagnostic criteria to be an empirical representation of the behavioural symptoms of mental disorders, and not to be a theory based nosology. See James Cowles Prichard, *A Treatise on Insanity and Other Disorders Affecting the Mind*, Sherwood, Gilbert, and Piper, 1835. (p. 131).

involving one train of ideas, while the intellectual powers appear, when exercised on other subjects, to be in a great measure unimpaired.<sup>88</sup>

Prichard had thus eventually come to employ the descriptions of disorders from Pinel and Esquirol, but varied from their work by continuing his earlier emphasis on the links between perception, memory and madness in his description of monomania. The thought processes that Esquirol associated with *monomania* then, for Prichard, also explained *hypomania/melancholia*, and as a result, he viewed Esquirol's concept of *hypomania/melancholia* as redundant and unnecessary to include in his own nosography. Prichard's description of mania or 'raving madness' drew further upon the work of Pinel in that it necessitated:

...the understanding [being] generally deranged; the reasoning faculty, if not lost, is confused and disturbed in its exercise; the mind is in a state of morbid excitement, and the individual talks absurdly on every subject to which his thoughts are momentarily directed.<sup>89</sup>

Here, then, it is possible to see another departure from his early work in the acknowledgement that the intellectual and reasoning faculties of the mind are damaged in those who suffered from *mania*. *Mania* was thought of as a general state of insanity and should be understood in contrast to *monomania*, which was understood as being a partial insanity by Prichard because the patient would only experience spells of insanity that would accompany certain 'thought patterns'.<sup>90</sup> The severest form of insanity then was *dementia*, although Prichard frequently used Thomas Arnold's term *incoherent insanity*, which he seemed to prefer using in his *Treatise*. Although using Arnold's term, Prichard still quoted Pinel's description of *dementia* as:

Rapid succession or uninterrupted alternation of insulated ideas and evanescent and unconnected emotions; continually repeated acts of extravagance; complete forgetfulness of every previous state; diminished sensibility to external impressions; abolition of the faculty of judgement; perpetual activity.<sup>91</sup>

Prichard placed great emphasis on the need for a classification system to be concise for it to be of practical use. It is important to point out that in following Pinel by calling his classification of mental disorders a nosography, Prichard assumed a realist and empirical position in how his classification represented mental disorders. In his own words, Prichard attempted to provide:

an accurate and tolerably complete description of the phenomena of insanity [...and] in this description, while I avail myself of the aid afforded by the best

---

<sup>88</sup> Ibid.

<sup>89</sup> Ibid, (p.6)

<sup>90</sup> Ibid., (p.6).

<sup>91</sup> Pinel quoted and translated by Prichard in Ibid.(p.6).



practical writers of different countries, it will be my aim to avoid the admission of any circumstance or feature of disease which I have not in more or fewer instances actually observed.<sup>92</sup>

In addition to its practical utility, Prichard wanted the forms that were presented in his nosology to be anchored to empirical observations of symptoms in patients suffering from insanity.

Concepts of insanity based upon the description of symptoms allowed a great deal of freedom and practicality. They could be used widely because they were not associated with a certain theory on the pathology or aetiology of insanity. They described symptoms that most asylum superintendents were familiar with, so they appealed to intuition, and a person using them did not need to learn a complicated pathological or aetiological theory to diagnose the patient. Despite those who wrote about these forms of insanity indeed offering theories of pathology and aetiology, as in the case of Prichard, terminology would not usually be modified to include aspects of aetiology or pathology. This is one of the principle reasons why they became so widely used – readers of textbooks and medical journals would easily understand what sort of symptoms were being described, even if theories were being offered on how they were caused or how they were linked to lesions or other physical symptoms. They played a huge role in the communication of research into the insanities amongst mental scientists from the 1840s onwards, and this was linked to their practical nature and intuitive appeal.

In order to make the case for the practical nature of the nosography he presented, Prichard contrasted it with that of the German physician Johann Christian Heinroth (1773 – 1843).<sup>93</sup> Heinroth had divided the drives of the human into the basic ones of the body, and the higher ones of the ego, and disorders in the latter were caused by behaviours that are considered by many religions to be sins. The mind communicated with the body through the soul, and so the sins of the mind could lead to illnesses in the body, leading to some considering Heinroth's work to be the inventor of the concept of psychosomatic illnesses.<sup>94</sup> Like Prichard, Heinroth's views of mental disorder was informed by his research in anthropology, and by his vision of the development of human civilisation. This indicated to Heinroth humanity's telos, albeit one which was based upon a form of Christian morality. Despite these affinities, Prichard described Heinroth's classification as 'singular and absurd in

---

<sup>92</sup> Ibid.

<sup>93</sup> Ibid., (p.18).

<sup>94</sup> Holger Steinberg, 'The Sin in the Aetiological Concept of Johann Christian Heinroth' in *History of Psychiatry*, Vol.5, No.4, Dec. 2004, pp.299 – 344.

some of its fundamental principles', and criticised it for being too complex for use in practice.<sup>95</sup> He distinguished it from his own as being 'theoretical and speculative [rather] than the result of actual observation and experience'.<sup>96</sup> This is because although the theory that Heinroth used to deduce the existence of the disorders in his classification system resembled a form of faculty psychology, the disorders that were included were over-determined by the theory that he subscribed to, at least according to Prichard. Although finding some worth in the theoretical aspect of Heinroth's work for research into the causes of insanity, Prichard ultimately thought his work was thin on the ground in terms of empirical observations in the form of case notes.<sup>97</sup> Prichard seems to value the work as having some value for having provided 'the most elaborate and comprehensive' of the classifications of mental disorders that had so far been published.<sup>98</sup> Prichard was a subtle thinker, who did not seek to promote his own nosography as the ideal classification, but he did consider French psychiatry to be providing the most practical description of the forms of insanity for use in the clinic, preferring this practical element to the theoretical approach of Heinroth.<sup>99</sup>

Partly due to its empirical and practical nature, Prichard's new classification of mental disorder saw immediate popularity, with the concepts in them quickly becoming used by asylum medical superintendents for the purposes of classification. In 1839, only four years after the publication of the first edition of the *Treatise on Insanity*, the most popular diagnosis for patients at Ticehurst House was moral insanity, and by the 1860s it became a common diagnosis in asylums across the British Isles.<sup>100</sup> The adoption of Prichard's classification as opposed to any of the other classifications of mental disorder that were available at that time indicates that the emerging psychiatric community valued a nosology that was of simple and practical use, over and above the scientific value of the concepts that were presented. Instead of a complex classification such as that of Heinroth's that sought to make subtle distinctions between the forms of insanity, the classification offered by Prichard included broad groups which could be easily learnt and quickly used in practice – this was also before psychiatry had become an

---

<sup>95</sup> James Cowles Prichard, *A Treatise on Insanity and Other Disorders Affecting the Mind*, Sherwood, Gilbert, and Piper : London, 1835. p.18

<sup>96</sup> Ibid.

<sup>97</sup> Ibid.

<sup>98</sup> Ibid.

<sup>99</sup> Ibid., (pp10 – 23).

<sup>100</sup> Charlotte Mackenzie, *A Family Asylum: A History of the Private Madhouse at Ticehurst in Sussex, 1792 – 1917*, PhD thesis, UCL, 1986. (p.139); For a wider considerations on moral insanity, see David W. Jones, 'Moral Insanity and Psychological Disorder: the Hybrid Roots of Psychiatry' in *History of Psychiatry*, Vol.28, No.3, pp.263 – 279.

established discipline with specialist education, and many physicians who found themselves in asylums would need to learn how to diagnose with little prior training or experience.<sup>101</sup>

These practical considerations were especially important to those working in asylums in the 1830s and 1840s, who at this point were without professional representation in the form of an official body that would represent their interests, and were often overworked and practicing their profession in poor conditions. The 1840s was a crucial decade in the development of asylum psychiatry, with the rules and regulations that would define practice for a great proportion of the era of the asylum being enshrined in the Lunacy Act and the County Asylums Act, both passed in 1845. The concepts that were used in the diagnosis of those admitted to asylums would be caught up in this context of reform, and Prichard's classification of the forms of insanity would be established as the foundation of asylum classification of the forms of insanity for the next half of the nineteenth century.

## 2.2: The Origins of the Table of the Forms of Insanity: Prichard and the Lunacy Commission

The concepts developed by Pinel and Esquirol, and channelled through the work of Prichard were recommended for use by the Lunacy Commission for the purposes of diagnosis upon its establishment through the Lunacy Act and the County Asylums Act in 1845.<sup>102</sup> These landmark pieces of legislation made it a requirement that every county in the United Kingdom of Great Britain establish an asylum and established the Lunacy Commission to oversee their administration. The provisions included in this pair of acts established the foundation for Victorian asylum treatment, with the requirements of the County Asylums Act leading to a new wave of asylums being built: the sturdy design of these buildings meant that many would be in use until the mass post-war closure of mental hospitals in the United Kingdom.<sup>103</sup>

A record of the diagnosis of a patient upon admission was a legal requirement placed upon all asylums in the United Kingdom, and by the 1860s, numbers based upon the diagnoses that were kept in asylum admissions books were submitted to the Lunacy Commission in annual reports from asylums, but were not published in Lunacy Commission annual reports until much later in the century.<sup>104</sup> Åsa Jansson has highlighted the importance of statistics

---

<sup>101</sup> John Walton, 'The Treatment of Pauper Lunatics in Victorian England: The Case of Lancaster Asylum, 1816 – 1870' in Andrew Scull ed., *Madhouses, Mad-doctors and Madmen*, pp.166 – 200.

<sup>102</sup> Earl of Shaftesbury et al., 'Forms of Disease, Medical Treatment, Diet, and Classification' in *The Report of the Metropolitan Commissioners of Lunacy*, Bradbury and Evans Printers, 1844, pp.102 – 128.

<sup>103</sup> Kathleen Jones, *Mental Health and Social Policy, 1845 – 1959*, Routledge, 1960. (p.153).

<sup>104</sup> Simon A Hill, and Richard Laugharne 'Mania dementia and melancholia in the 1870s: Admissions to a Cornwall asylum' in *Journal of the Royal Society of Medicine*, Vol.96, No.7, 2003

gathered from these diagnoses in the formation of concepts of psychopathology, by arguing that melancholia became increasingly associated with suicidal propensities in medical certificates.<sup>105</sup> Medical certificates and admissions books constituted the data of statistical research during the asylum era. More broadly speaking, medical statistics were a growing concern for public health administration from the 1830s onwards. The General Record Office (GRO) was established in 1837, and its work for a great period was characterised by the involvement of William Farr (1807 – 1883), who acted as Superintendent of Statistics from 1842 – 1879. The GRO played an important role in the establishment of demography, and the development of epidemiology – this and founding of the Statistical Society were two vital developments in statistical understanding of public health issues. The GRO and Farr in particular had been involved with the accumulation of statistics relating to insanity before the establishment of the Lunacy Commission.<sup>106</sup> The collection of statistics relating to insanity would fall under the jurisdiction of the Lunacy Commission upon its establishment in 1845, and this would mark a separation between the collection of statistics relating to lunacy and general medical statistics that would last nearly a century, until these were placed back in the hands of the GRO at the establishment of the National Health Service after the Second World War.<sup>107</sup>

Prichard was central to the operations of the first Lunacy Commission due to his role as the one of the psychiatric experts appointed to the regulatory body and the only one who had written a textbook on insanity. He used this position to promote the classification that he had offered based upon the diagnostic concepts that had been developed by Pinel and Esquirol.<sup>108</sup> This was not an easy task for there was much disagreement on the concepts that should be used in diagnosis: senior colleagues, such as John Charles Bucknill, often disagreed with the diagnoses given by the Poor Law medical officers, who frequently used the categories developed by Prichard;<sup>109</sup> whilst Thomas Clouston, working at the Morningside asylum in Edinburgh, kept two logs of diagnosis for patients: one that was recommended by the Lunacy Commission, and the other that was based upon David Skae's classification, which will be

---

<sup>105</sup> Åsa Jansson, 'From Statistics to Diagnostics: Medical Certificates, Melancholia, and 'Suicidal Propensities' in Victorian Psychiatry' in *Journal of Social History*, Vol.46, No.3, Spring 2013, pp.716 – 731

<sup>106</sup> William Farr, 'Report upon the Mortality of Lunatics' in *Journal of the Statistical Society of London*, Vol.4, No.1 April 1841, pp.17 – 33.

<sup>107</sup> See chapter five.

<sup>108</sup> D.J. Mellett, 'Bureaucracy and Mental Illness: The Commissioners in Lunacy 1845 – 1890' in *Medical History*, Vol.21, pp.221 – 250.

<sup>109</sup> Bill Forsythe and Joseph Melling, *The Politics of Madness*, Routledge, 2006, (p.51).

discussed later in this chapter.<sup>110</sup> Medical superintendents of asylums were bound to use the diagnostic categories that were promoted by the Lunacy Commission because of the admittance procedures that has been set in place, yet prominent psychiatrists like Clouston and Bucknill frequently questioned the diagnosis given to those admitted to their asylums.

Lunacy reform fitted into a broader context of the expansion of the bureaucratic state in Victorian Britain from at least the Great Reform Act of 1832, as well as the state providing greater provisions to contain the public health crisis that had emerged in many British towns and cities.<sup>111</sup> As Dorothy Porter notes, the expansion of public health in the British Isles can be interpreted as displaying the tensions between liberal, laissez faire politics that favoured a minimal-state, Malthusean-style population control, and the emerging utilitarian values which called for greater state intervention in order to increase the general happiness of society.<sup>112</sup> Following the passing of the Lunacy Act in 1845, a national Lunacy Commission was established which would function as a regulatory body, appointing commissioners who would carry out visits to oversee conditions in asylums throughout the British Isles. The first Lunacy Commission had the same membership as that of the Metropolitan Lunacy Commission, and this included Prichard.

Internment in an asylum was a sensitive issue, and this was one of the motivating factors for the establishment of the powerful nationwide Lunacy Commission to enforce regulations on the asylums that operated in the British Isles.<sup>113</sup> Recommendations for stricter regulation on asylum admittances were published in the Inquiry's report in 1844. One of the ways that this would be enacted would be through the stringent admissions procedure that included the recording of a patient's data in an admittance book, which, if not adhered to within certain timeframes, would lead to fines being imposed on the asylum and its chief medical officer.<sup>114</sup> Amongst the various provisions established by the 1845 Act, key for the purposes of this thesis was the requirement that the grounds for patient admittance to an asylum needed to be recorded in a log book, and that this took the form of writing down which form of insanity the person had suffered. Such records would then be observed by members of the Lunacy Commission, in their regular visits. The passing of legislation in 1845 requiring that

---

<sup>110</sup> James Wilkes, W.G. Campbell, T.S. Clouston et al., *Eighth Annual Report of the Cumberland and Westmorland Lunatic Asylum*, 1869, (p.23).

<sup>111</sup> Dorothy Porter, 'Public Health and Centralisation: the Victorian British State' in *Health, Civilisation and the State: A History of Public Health from Ancient to Modern Times*, pp.117 – 127.

<sup>112</sup> Ibid.

<sup>113</sup> Kathleen Jones, 'Law and Mental Health: Sticks or Carrots' in Berrios and Freeman eds. *150 Years of British Psychiatry*, Gaskell, 1991, pp.89 – 102.

<sup>114</sup> Ibid., (p.93).

the diagnosis of a patient be recorded on admission, is an example of how the law surrounding mental health did not merely constrain, but in fact had a role in formulating, the modern psychiatric profession.<sup>115</sup>

Recording the form of insanity suffered by an individual, and cross-referencing this to additional information such as the occupation, gender and marital status of the person, provided huge potentials for the epidemiology of mental disorders. From the 1850s until the end of the century, the pages of the *Journal of Mental Science*, the key publication of asylum doctors, became more and more populated with studies that aimed to draw correlations between social background and the prevalence of insanity. The availability of the data was not the only reason for this: there were concerns with the perceived increase that rates of insanity were on the increase, and this was associated with the industrialisation of major towns and cities in the British Isles, the rapid expansion of urban spaces, and the alarmist view that European society had advanced to such a degree that it was experiencing a fall, or degeneration, of which the rise in madness was an early sign.<sup>116</sup> Epidemiological studies of insanity based upon the admission and discharge data from asylums was one way that medical researchers sought to prove or disprove these theories. The chairman of the Metropolitan Lunacy Commission, the progenitor of the Lunacy Commission established in 1845, remarked in 1840 that:

the most ample means exist in the records of the commission for determining the age and previous occupations of the lunatics, with a view of ascertaining whether any particular time of life, or any one occupation more than another, be characterised by mental affections; but I have been utterly debarred from embarking in such a minute and laborious enquiry by the want of leisure; but the day may come when a paper on the statistics of the Lunacy Commission, more worthy than the present, may be presented to the notice of the Society.<sup>117</sup>

However, the chairman's remarks were limited to drawing broad connections between insanity construed as a unitary concept, and the social background of the person who suffered it: no mention was made of the usefulness of differentiating it into discrete concepts of psychopathology along the lines of Pinel, or any other. The formation of the Association of Medical Officers for Asylums and Hospitals for the Insane (henceforth referred to as 'the Association') in 1841, forerunner to the MPA, had also been founded in part to facilitate the

---

<sup>115</sup> Roger Smith, 'Legal Frameworks for Psychiatry' in Berrios and Freeman eds. *150 Years of British Psychiatry*, Gaskell, 1991, pp.137 – 151.

<sup>116</sup> Daniel Pick, *Faces of Degeneration: A European Disorder c.1848 – c.1918*, Cambridge University Press, 1993.

<sup>117</sup> Lieut.-Col. Sykes, 'Statistics of the Metropolitan Commission in Lunacy' in *Journal of the Statistical Society of London*, Vol.3, No.2, July, 1840, pp.143 – 160

exchange of statistical information, and an early meeting of the Association in 1843, which had Prichard in attendance, discussed the various forms of insanity that would be admitted to the asylum system.<sup>118</sup> For the most part during this period, when it came to statistics, insanity was treated as a unified condition: at best differentiations were made between idiots and lunatics for the purposes of interpreting the data on the people who populated British asylums.<sup>119</sup> In the 1844 Report of the Metropolitan Lunacy Commission, statistics were produced which classified patients according to whether they were private or pauper patients, and the data that was available on asylum admissions in the British Isles to classify patients as Epileptics, Idiots, Homicidal Patients, and Suicidal Patients.<sup>120</sup>

The classification of insanity that was promoted by the Lunacy Commission for the purposes of recording the forms of insanity adopted the terminology devised by Pinel at the beginning of the century:

- I. Mania
  - 1. Acute Mania, or Raving Madness
  - 2. Ordinary Mania, or Chronic Madness of a less acute form
  - 3. Periodical, or Remittent Mania, with comparatively lucid intervals
- II. Dementia, or decay and obliteration of the intellectual faculties
- III. Melancholia
- IV. Monomania
- V. Moral Insanity

Form II, IV and V sometimes being comprehended under the term Partial Insanity.

- VI. Congenital Idiocy
- VII. Congenital Imbecility
- VIII. General Paralysis of the Insane
- IX. Epilepsy

To these heads may perhaps be added 'Delirium Tremens' since it is mentioned, as a form of Insanity, in the Reports of some Lunatic Asylums.'

---

<sup>118</sup> T. Outterson Wood, 'The Early History of the Medico-Psychological Association' in *JMS*, Vol.42, No.177, 1896. pp.241 – 260

<sup>119</sup> John Webster, 'Statistics of Bethlem Hospital with Remarks on Insanity' in *Medico-chirurgical transactions*, Vol.26, 1843, p.374–416

<sup>120</sup> John Thurnam, *Essays on the Statistics of Insanity: including an inquiry into the Causes influencing the Results of Treatment in Establishments for the Insane. To which are added, the Statistics of the Retreat, near York*. London: Simpkin and Co., 1845.

Figure 5: Forms of Disease, Medical Treatment, Diet, and Classification' recommended by Metropolitan Commissioners in Lunacy.<sup>121</sup>

The Lunacy Commission played a fundamental role in establishing the forms of insanity outlined in figure 5 as the standard psychiatric categories. As well as these recommended set of diagnostic categories, the report also included a detailed description of each disorder, which were based upon the descriptions included in Prichard's *Treatise*: it followed the differentiation between *acute* forms of *mania* and *melancholia*, *partial insanities*, which included *melancholia*, *monomania* and *moral insanity*. This classification offered by the Metropolitan Lunacy Commission was that based on that offered by Prichard, which would appear to be because he was one of the specialists in mental alienation serving on the Lunacy Commission, until his death in 1848 from an infection contracted whilst carrying out an inspection on an asylum.<sup>122</sup> In making it a legal requirement for patients to be given a diagnosis upon admittance to the asylum, and for this to be recorded in an admissions book, lunacy legislation and administration heightened the importance of diagnoses:

... every Physician, Surgeon, or Apothecary signing such Certificate shall specify therein any Fact or Facts (whether arising from his own Observation or from the Information of any other Person) upon which he has formed his Opinion that the Person to whom such Certificate relates is a Lunatic or Insane Person, or an Idiot, or a Person of Unsound Mind.<sup>123</sup>

Asylum registers from the period immediately after the passing of the Act demonstrate that medical superintendents used the concepts that were recommended by the Lunacy Commission. During the 1870s, the Cornwall County Asylum diagnosed the vast majority of patients with mania (38%), dementia (35%), or melancholia (26%).<sup>124</sup> From 1845 to 1880, the Devon County Asylum also diagnosed the vast majority of patients entering the asylum according to the classification concepts of mania, dementia, melancholia and idiotism.<sup>125</sup> The Buckinghamshire Asylum also employed Prichard's classification for admissions, with all but a very few patients that passed through its doors being classified as suffering from mania, dementia, idiocy and imbecility, melancholia.<sup>126</sup> Although many asylums used the basic

---

<sup>121</sup> 'Forms of Disease, Medical Treatment, Diet, and Classification' in *The Report of the Metropolitan Commissioners of Lunacy*, Bradbury and Evans Printers, 1844, pp.102 – 128.

<sup>122</sup> H.F. Augstein, 'Prichard, James Cowles (1786 – 1848), physician and ethnologist' in *Oxford Dictionary of National Biography*, September 23<sup>rd</sup>, 2004. OUP.

<sup>123</sup> Section 46, Lunacy Act, 1845.

<sup>124</sup> Simon A Hill, and Richard Laugharne 'Mania dementia and melancholia in the 1870: admissions to a Cornwall asylum' in *Journal of the Royal Society of Medicine*, Vol.96, No.7, 2003

<sup>125</sup> Bill Forsythe and Joseph Melling, *The Politics of Madness* (Routledge, London, 2006) p.62

<sup>126</sup> David Wright, 'Delusions of Gender?: Lay Identifications and Clinical Diagnosis of Insanity in Victorian England' in *Sex and Seclusion, Class and Custody*, *Clio Medica*, 2003, pp.149 – 176. (p.161).



concepts of the classification that were proposed by the Lunacy Commission, and it can be thought of as the first standardised psychiatric diagnostic criteria that was used in British psychiatry, many medical officers used their own classifications in their clinical notes, thereby creating a diversity in the number of classifications that were used. Nevertheless, attempts were made by physicians to draw up statistics based upon the new data available from admittance books now kept by asylums.

In John Charles Bucknill and Daniel Hack Tuke's *A Manual of Psychological Medicine* (1858), which in the third quarter of the nineteenth century would become the most widely referenced and authoritative textbook amongst psychiatrists, terminology used by Pinel and Esquirol was employed in their chapter on diagnosis:

Idiocy, Cretinism and Imbecility  
Dementia  
Melancholia  
Emotional Insanity (Moral, Homicidal, Suicidal, Kleptomania, Erotomania,  
Pyromania, Dipsomania)  
Mania.<sup>127</sup>

In the preface to what would become one of the seminal texts in the history of psychiatry, the authors stated their intention to provide 'a systematic treatise on insanity' which would serve as a definitive guide to the diagnosis and treatment of mental health disorders.<sup>128</sup> As well as employing the work of Pinel and Esquirol, they also pointed to Prichard's work, but noted that the latter's *Treatise on Insanity* was at the time of their writing out of print, and was over a quarter of a century old. Bucknill's chapter on diagnosis was also published in the *Journal of Mental Science*, so would have certainly been circulated to all members of the Medico-Psychological Association; in it he wrote that the purposes of diagnosis were to distinguish a state of mental pathology from a state of healthiness, and to distinguish one form of mental disease from another. A clear set of concepts which distinguished diseases from one another was therefore crucial for the correct diagnosis of mental disorder, and the concepts that were employed were again the ones that Prichard, Pinel and Esquirol had used. Bucknill stated that complications could arise with the misidentification of certain disorders for one another, acute melancholia and acute mania being the most commonly confused because:

Between acute mania and acute melancholia, no distinct line of demarcation can be drawn. The domains of the two diseases overlap so much, that in practice, cases

---

<sup>127</sup> John Charles Bucknill and Daniel H. Tuke, *A Manual of Psychological Medicine*, Blanchard and Lea, 1858.

<sup>128</sup> Ibid.

not unfrequently present themselves, which may with equal propriety be referred to the one or to the other; cases which we may call acute mania with melancholic depression, or acute mania with maniacal excitement. The typical forms of the two diseases are however sufficiently distinct.<sup>129</sup>

Diagnosis might become confused in extreme cases because, Bucknill claimed, of the overlap in symptoms in acute cases. In typical cases of both *melancholia* and *mania*, the forms of the diseases were distinct from one another. Bucknill then thought that both *mania* and *melancholia* were distinct diseases, but there were symptoms that were common to acute forms of the disease.

We can clearly see, then, the importance of the concepts introduced by Pinel, Esquirol and Prichard to the practice of psychiatry in the British Isles up until at least the middle of the nineteenth century. Pinel's work was important because it separated the disorders that would be treated by psychiatrists working within asylums from general medicine: previously *dementia*, *idiotcy*, *melancholia* and the *manias*, were included in general nosologies of medicine, like Cullen's. In addition, he created the notion of moral, or emotional, insanity, and this would become both very influential and controversial because some viewed it as medicalising immorality. Prichard provided the first work which reliably translated the concepts developed by Pinel and Esquirol into English psychiatry, and his position as a prominent member of the Lunacy Commission contributed to Pinel's and Esquirol's concepts becoming embedded into the practice of asylum medical officers after 1845. The diagnostic concepts employed by Pinel and Esquirol thus came to be central to the practice of psychiatry in the British Isles, and the system that they developed was valued by alienists and medical psychologists for its efficiency, ease of use and practical utility.

The works of James Cowles Prichard served a pivotal role in bringing French ways of classifying insanity to the British Isles during the 1830s. As we have seen in the first section, the ideas in Pinel's *Traité* failed to gain traction upon their initial publication partly because of a poor translation, and due to his time spent working with Pinel's students in Paris, Prichard's work would serve a crucial role in bringing the spirit of French classification to the British Isles. Furthermore, Prichard's influence as a psychiatric authority on the Lunacy Commission helped to make these concepts the dominant ones in the United Kingdom, and the Commission's recommendation that these concepts be used to record the form of insanity of admissions would prove a decisive factor in making them the standard terms used in psychiatric discourse during from the 1840s onwards. The complex set of factors presented in

---

<sup>129</sup> John Charles Bucknill, 'The Diagnosis of Insanity' in *The Asylum Journal of Mental Science*, Vol.3, No.20, May 1857, pp.141 – 185.

this section demonstrate that it was far from a certainty that Pinel's means of classification would become the most dominant, and instead a contingent set of historical considerations that included legal and administrative factors, as well as clinical developments, helped to ensure that melancholia, dementia, idiocy, moral insanity and mania would become the most commonly used terms employed within psychiatric discourse surrounding classification during the second half of the nineteenth century.

### Section 3: Skae and the Aspirations to a Scientific Classification

Over time, however, criticisms were increasingly directed towards the symptom based concepts developed by French psychiatry, and interest began circulating around developing a classification that aspired to be more scientifically rigorous than the forms of insanity that were used in asylums. The work carried out in the emerging research clinics of the German speaking lands in the middle decades of the century had inspired British psychiatrists in this endeavour, and especially David Skae and Thomas Laycock, colleagues at the University of Edinburgh's medical school. Both would publish work that would testify to the strength of the research conducted by Griesinger, who attempted to connect the forms of insanity that were coined by Pinel to aetiology and somatic pathology.<sup>130</sup> Skae would go on produce a classification of the forms of insanity that he designed to be more accurate than Pinel's, and this would become a contender to replace the forms of insanity that had been introduced by Prichard.

Wilhelm Greisinger presented a detailed nosology of mental diseases he hoped would provide a greater level of accuracy than the dominant forms.<sup>131</sup> The nosology he presented in this textbook was split into three parts: the first were states of depression, which included forms of melancholia including those associated with stupor, self-harm, and hypochondria.<sup>132</sup> The second class of Griesinger's nosology, comprised states of 'exaltation', that included mania and monomania; the final class were forms of 'mental weakness', which included dementia and idiocy. Despite using terms that had been employed by Pinel, Greisinger rejected the notion of *moral insanity*, claiming that it lacked real evidence and even went as far as to say that Pinel's establishment of the term was detrimental to the mental sciences.<sup>133</sup> Greisinger's basis for this damning judgement was that he thought it impossible for the intellectual faculties to remain intact in acute disorders, and that damage to the emotional faculties would inevitably be linked

---

<sup>130</sup> Roy Porter, 'Psychiatry' in *The Greatest Benefit to Mankind*, Harper Collins, 1997. (p.507)

<sup>131</sup> Wilhelm Griesinger, *Mental Pathology and Therapeutics*, trans C. Lockhart Robinson and James Rutherford, The New Sydenham Society, 1867.

<sup>132</sup> Ibid., p.301.

<sup>133</sup> Ibid., pp.301 – 302

to damage in the intellectual faculties, a division which was fundamental to Pinel's formulation of moral insanity, and arguably served as the foundations to his psychiatric classification. Greisinger believed that this had led Pinel into coining a non-existent category of mental disorder that confused two different 'morbid mental states'; what he termed 'on the one hand actual periodic attacks of fury with very little delirium, and on the other hand and principally, to those moderate states of mental exaltation [...] in which the patient performs foolish actions and shows perversity of demeanour, but [is] also in a position to justify and explain their conduct [with] coherent reasoning which lies within the bounds of possibility.'<sup>134</sup> He went on to attack 'disciples of Pinel' in France, who, like Prichard, had mistakenly categorised many other conditions, such as the 'moderate degree[s] of melancholia with violence' seen in moral insanity.<sup>135</sup> Greisinger's rejection of the existence of moral insanity led him to develop a number of new disorders which had hitherto been conceptualised as forms of moral insanity.<sup>136</sup> Griesinger, then, thought that the intellectual faculties could not remain unaffected and 'perfectly free from any disorder' and that 'in *all* attacks of fury, clear, calm, healthy thought is quite impossible': whilst he rejected moral insanity, or *manie sans delire*, he still structured much of his nosology around the other diagnostic concepts developed by Pinel.<sup>137</sup> His followers, including Karl Kahlbaum (1828 – 1899) and Ewald Hecker (1843 – 1909) would further criticise the Pinelean forms of insanity, claiming that such terms described temporary and transient conditions as opposed to referring to natural diseases.<sup>138</sup>

French psychiatrists also began to question the concepts of their countrymen as the century progressed. In 1853 Jules Baillarger published his 'Essay on a Classification of Different Genera of Insanity' in which he claimed that the forms of Pinel and Esquirol needed to be reformulated to improve the accuracy of diagnosis of insanity.<sup>139</sup> Baillarger, a defender of phrenology, resorted to the language of physical lesions to argue that the division between the partial and general insanities described by Pinel needed to be understood instead as 'partial and general lesions' of the intellectual and moral, or emotional, faculties.<sup>140</sup> These lesions resulted in delusions, hallucinations, unusual impulses, excitation of the intellect, and depression of the

---

<sup>134</sup> Ibid

<sup>135</sup> Ibid.

<sup>136</sup> Ibid.

<sup>137</sup> Ibid.

<sup>138</sup> Ewald Hecker, cited in Kenneth Kendler and Eric Engstrom, 'Kahlbaum, Hecker, and Kraepelin and the Transition From Psychaitry Symptom Complexes to Empirical Disease Forms' in *American Journal of Psychiatry*, 1<sup>st</sup> February 2017, Vol.174, No.2, pp.102 – 109.

<sup>139</sup> German Berrios and Jules Baillarger, 'Classic Text No.75: Essay on a classification of different genera of insanity' in *History of Psychiatry*, vol.9, No.3, pp.358 – 373.

<sup>140</sup> Ibid.

moral and intellectual faculties.<sup>141</sup> Baillarger's criticisms were different from Greisinger's because he still agreed with Pinel that emotional disorders could exist without the intellectual capacities being affected, but argued for a stronger connection between physical lesions and insanity. He further argued that a classification of mental disorder should be structured according to which faculty of the mind had a lesion. For instance, melancholia was understood by Baillarger as a 'paralysis of the moral and intellectual faculties that abolishes strength and will', and correctly identifying as such would prevent instances of monomania and certain forms of mania, which were caused by lesions of the intellectual and emotional faculties respectively, being confused for melancholia.<sup>142</sup> Establishing which faculties of the mind were affected by which identified lesion would help in the diagnosis of the mental disorder, and thus for Baillarger, the nosology should be structured accordingly.

One year later, fellow French psychiatrist Jean Pierre Falret published an essay that sought to argue against the existence of *monomania*.<sup>143</sup> Falret, who did not subscribe to faculty psychology, had argued against the existence of *manie sans delire* since writing his medical thesis, and his 1854 essay also argued against the idea that the mind was divided into discrete faculties. As a result, according to his work, any diagnostic concept which presumed what he deemed to be the empty abstractions of intellect and emotion was not of clinical use. Although Falret's target was monomania in this instance, he was concerned with the theoretical basis of the prevalent symptom-based classification system because he did not think that this provided a scientific basis to the formulation of disease concepts. Falret's criticisms of *monomania* spelled the beginning of the end of it being taken seriously as a disease category. To add to these critical voices, when Morel published his 1860 *Treatise on Mental Diseases*, he did not consider *melancholia* and *mania* as 'essential forms' since 'depression and excitation are but symptoms which can be found in any form of madness'.<sup>144</sup> Like Falret, Morel rejected formulating mental disease concepts solely on the basis of observed symptoms, and instead sought to base his own classification on pathology.<sup>145</sup>

In 1861 the *Edinburgh Medical Journal* reported that the 'The German Society of Psychiatrie and Juridical Psychology' was holding a competition that offered a prize of 100

---

<sup>141</sup> Ibid.

<sup>142</sup> Ibid.

<sup>143</sup> "De la non-existence de la monomania" by Jean-Pierre Falret', trans Thomas Lepoutre & Tom Denning, in *History of Psychiatry*, Vol.23, No.3, pp.356 – 370.

<sup>144</sup> John C. O'Neal, Understanding and Interpreting Confusion: Philippe Pinel and the Invention of Psychiatry' in *Lumen*, No.26, 2007, pp.243 – 258.

<sup>145</sup> Pierre Pichot, 'Nosological Models in Psychiatry', in *British Journal of Psychiatry*, Vol.164, No.2, February 1994, pp. 232 – 240.

thalers for the best essay to answer the question: “What is the Classification of Mental Disturbances which is likely to prove the Most Serviceable in Regard to Practical Medicine?”<sup>146</sup> This shows the attempts that were being made to build collaborations between researchers based in France, Germany, Italy and the United Kingdom by the 1860s, and that the classification of mental health disorders was becoming a concern for researchers across Europe, who were in a transnational and transcultural dialogue. Morel’s system was also split into four categories, however these were aetiological: heredity, toxins, other nervous disorders, and what the review called ‘morbid conditions of some other part of the body than the brain’.<sup>147</sup> Although favouring the classification system offered by Morel, the review criticised his approach for being overly reliant on biological aetiology in the form of heredity, and for not taking into account the moral [psychological] aspects of mental illness, such as anger, grief, shame, love or jealousy.

Some practitioners acknowledged the practical value of the symptom-based nosology whilst believing that a scientific classification of mental diseases was needed. Henry Monroe, writing in the *Asylum Journal of Mental Science* in 1856, thought that the symptom-based classification provided a useful description of behaviours associated with insanity, without being overly theoretical, therefore being of use to lay as well as medical men.<sup>148</sup> Yet for Monroe, these strengths also led to its weakness, in that the terms employed by the nosology were inaccurate and superficial. This often led, he argued in line with others, to the misidentification of cases of monomania with cases of mania and melancholia. Monomania was doubted by Monroe on the grounds that the symptoms were inaccurate, and indeed he claimed that instead of being fixated on one notion or idea, monomaniacs’ ‘characteristic is rather an invincible and generally melancholic persistence in the erroneous notions’.<sup>149</sup> As such, Monroe thought that the term *monomelancholia* would be a more suitable description of the condition. Monroe offered some suggestions to make the terminology more accurate in symptom-based classification, but he thought that even if these adjustments were made, the classification of Pinel and Esquirol was doomed to failure because it relied upon the claim that there were ‘intellectual’ and ‘moral’ faculties to the mind. These were for Monroe, like his French

---

<sup>146</sup> ‘Reports of Societies: Royal Medical and Chirurgical Society, Tuesday, May 14, 1861’, in *Medical Times & Gazette*, May 25th, 1861, pp. 562 – 565, (p.565).

<sup>147</sup> Ibid.

<sup>148</sup> Henry Monroe, ‘On the Nomenclature of the Various Forms of Insanity’ in *The Asylum Journal of Mental Science*, vol.2, No.17, April 1856, pp.286 – 305.

<sup>149</sup> Ibid.

counterpart Falret, redundant metaphysical categories, and future classifications needed to be based upon harder empirical evidence in the form of physiological aetiology.

Stepping into this Europe-wide project to develop a new system of psychiatric classification, in 1863 the Scottish physician David Skae delivered his address as President of the Association of Medical Officers of Asylums (AAMO) which repeated the attacks on diagnostic concepts based upon clinical descriptions of mental symptoms.<sup>150</sup> He criticised Pinel's notion of mania and Esquirol's concept of monomania, claiming that without a physiological basis, they were doomed to be so vague as to be of no clinical use. Because of this, he argued that a reliable classification system based upon aetiology was needed. Skae drew upon his experience to stress the importance of an aetiological system: he claimed that patients admitted to asylums were being misdiagnosed due to the concepts in the symptom-based nosography being too broad, and thus such a system was, contrary to the widely-held view, never of practical utility. Those diagnosed with monomania, dementia and the various other forms of mania could also be diagnosed with moral insanity, and he used this observation to underline the ineffectiveness of the widely-used forms of insanity that were based solely upon the description of symptoms.<sup>151</sup> Beginning the address by recounting his experience training medical students to make psychological diagnoses to demonstrate that the diagnostic criteria included in textbooks were not fit for purpose, he noted:

... it has always struck me, that the moment [that these students] came into contact with the insane, all their preconceived notions of Insanity derived from our systematic works were found to be vague, misty, and purely conventional descriptions of what they actually saw.<sup>152</sup>

He went on to describe how categories based upon clinical descriptions of symptoms had proven ineffective in the clinical experience of the people that he had trained. His address focused upon acute mania, describing it as a 'transient and babbling excitement of a harmless and frightened, but dirty, nudifying, and destructive patient'.<sup>153</sup> According to Skae, the transient nature of the disorder made it very hard to differentiate between acute mania and mania, and its chronic forms as well as dementia.<sup>154</sup> The gradual differences between the forms also made

---

<sup>150</sup> For a biography of Skae see Michael Barfoot, 'David Skae: Resident Asylum Physician; Scientific General Practitioner of Insanity', in *Medical History*, 2009, No.53, pp.469 – 488.

<sup>151</sup> David Skae, *Of the classification of the various forms of insanity on a rational and practical basis: being an address delivered at the Royal College of Physicians, London, at the annual meeting of the Association of Medical Officers of Asylums on 9th July, 1863*, Royal College of Physicians, 1863

<sup>152</sup> *Ibid.*, (p.6)

<sup>153</sup> *Ibid.*

<sup>154</sup> *Ibid.*, (p.8)

it difficult to differentiate between them, and it were only the habits of the asylum officer that directed them to make a diagnosis of one over the other. Skae then discussed idiots and those who suffered dementia, and claimed that every degree of mental impairment could be found amongst these classes of patients, ‘from simple loss of memory and slight childishness, to total fatuity, and obliteration of all the mental faculties’.<sup>155</sup> Esquirol’s category of monomania was the next category to attract Skae’s attention, with him questioning the main criteria for this category, namely a patient being obsessed with one thing, but otherwise having a sane mind:

Among the so-called Monomaniacs, they found very few who were Monomaniacs at all: most of them were insane on several subjects, although presenting some more salient feature, such as the fear of poison, hanging, or eternal damnation, or the belief of exalted rank or enormous wealth or power.<sup>156</sup>

Skae argued that the predominant symptom based diagnostic concepts were vague, and that most patients admitted to asylums, including those with *monomania*, *dementia* and forms of *mania*, could just as easily be diagnosed with *moral insanity*.<sup>157</sup> Skae deemed the forms of insanity to be based upon a limited set of clinical observations, which were inadequate because ‘the form of Insanity [sic] varies within very short periods of time [...] [and] [w]hat was a few days ago a case of *mania*, is now one of *monomania* or *dementia*, in any of their forms or degrees’.<sup>158</sup>

---

<sup>155</sup> Ibid., (p.7)

<sup>156</sup> Ibid., (p.6)

<sup>157</sup> David Skae, *Of the classification of the various forms of insanity on a rational and practical basis: being an address delivered at the Royal College of Physicians, London, at the annual meeting of the Association of Medical Officers of Asylums on 9th July, 1863*, (Royal College of Physicians : London, 1863. (p.8)

<sup>158</sup> Ibid.



For facility of reference, I sum up the various natural orders I have thus sketched out in the following tabular form :—

Idiocy,	} Moral and Intel- lectual.	Senile Mania.
Imbecility,		Phthisical Mania.
Insanity, with Epilepsy.		Metastatic Mania.
Insanity of Masturbation.		Traumatic Mania.
Insanity of Pubescence.		Syphilitic Mania.
Satyriasis.		Delirium Tremens.
Nymphomania.		Dipsomania.
Hysterical Mania.		Mania of Alcoholism.
Amenorrhœal Mania.		Post-Febrile Mania.
Post-Connubial Mania.		Mania of Oxaluria and Phospha- turia.
Puerperal Mania.		General Paralysis, with Insanity.
Mania of Pregnancy.		Epidemic Mania.
Mania of Lactation.		
Climacteric Mania.		Idiopathic Mania, } Sthenic.
Ovario-Mania (Utero-Mania.)		} Asthenic.

Figure 6: Skae's Classification included in his lecture *Of the Classification of the Various Forms of Insanity*<sup>159</sup>

The alternative classification shown in figure 5, that Skae presented at this lecture fitted into this context of challenging the Pinelean approach. He was also a critic of phrenology, and looked to provide a system that was materialist, but did not subscribe to Spuzheim's ideas.<sup>160</sup> To avoid confusing one disease for another, Skae thought that what he termed 'the Natural History of the disease' should be traced, by observing the symptoms and physiology of a patient during the course of an illness. The term 'natural history' was borrowed from Alexander Crichton, who in his 1797 text employed the terms 'natural history of the mind' and 'morbid history of the mind' to describe mental diseases.<sup>161</sup> This notion of a disease having a natural history was a foundational concept for Skae's proposed classification, because he believed that it was possible to determine the pre-history of the disorder from questioning the patient, as well as his family and friends, and to make reliable prognoses based upon the data that had been recorded. Skae proposed that this data be used to draw up the categories that would populate any worthwhile

<sup>159</sup> Ibid., p.15.

<sup>160</sup> Michael Anthony Finn. *The West Riding Lunatic Asylum and the Making of the Modern Brain Sciences in the Nineteenth Century*, PhD Thesis, University of Leeds, 2012. (p.98).

<sup>161</sup> Alexander Crichton, *An inquiry into the nature and origin of mental derangement: comprehending a concise system of the physiology and pathology of the human mind and a history of the passions and their effects*, Cadell Jr. & Davies, 1798)

clinical classification of mental disorders. He drew comparisons between bodily disorders such as typhus and typhoid fevers, asking the question:

‘Why should we attempt to group and classify the varieties of Insanity by the mental symptoms, and not, as we do in other diseases, by the bodily disease, of which those mental perversions are but the signs?’

The historian Michael Barfoot explains Skae’s adoption of the term ‘natural history’ as being due to his attempt to use language that would strike a chord with medical physicians, a profession that due to his training he found more affinity with than with the alienists practicing in asylums.<sup>162</sup> Whilst this may perhaps partly be the case, the term natural history has a rich heritage, and Skae’s use of it cannot be reduced to mere window dressing: the term had its origin in the *naturphilosophie* of German romantic philosophy which was an attempt to dispel the dualism inherent in post-Cartesian thought. Skae’s use of the term signals that he thought it possible to explain the ailments of the human mind through natural laws, and was an attempt to combat the dualism inherent in Pinelean psychiatric classification.

Fellow Edinburgh physician Thomas Laycock also attempted to provide an aetiological classification of mental disorder in his *Principles and Methods of Medical Observation and Research*, which was published in 1863. Like Skae, he thought that an aetiological classification of mental disorder would satisfy the requirements of medicine and provide more accurate diagnosis than the symptom-based classifications that were the norm. Laycock attempted to provide an exhaustive nosology of medical disorders of the body and mind that included a section on mental diseases, which he regarded as having the same kind of causation as other nervous and bodily diseases. Laycock’s system of classification was lengthy and elaborate, and was interested in finding ways to differentiate between forms of insanity by focusing on causes, or aetiology. In a section devoted to ‘The Naming and Classifications of Diseases’, Laycock wrote that the ‘the development of any department of science may be measured by the copiousness and precision of its terminology’.<sup>163</sup> This placed him in contrast to some practitioners, who supported the Pinelean system because it was an efficient classification procedure that would be of practical use. He criticised the English language as having ‘so degenerated in its inflexions as to become unpliant’ for the purposes of scientific classification, and argued that it was the German language that needed to be adopted when attempting to classify the objects of scientific study, especially in a developing science like psychology. This was because according

---

<sup>162</sup> Michael Barfoot, ‘David Skae: Resident Asylum Physician; Scientific General Practitioner of Insanity’, in *Medical History*, 2009, No.53, pp.469 – 488. (p.482)

<sup>163</sup> Thomas Laycock, *The Principles and Methods of Medical Observation and Research*, 1863, MacLachlan & Stewart, Edinburgh. (p.219).

to Laycock, the fixed structure of the English language meant that the references of terms would be too wide, and the terms could not be modified in order to adjust for slight differences in the manifestation of diseases.

Laycock also posed the philosophical question of what constituted a disease, with his answer being that diseases caused irregularity and the hindrance of function. To classify these irregularities of function, Laycock argued that the focus for classification is the observation of a connection between tissues and symptoms, but that it was ultimately useless to classify diseases by symptoms alone. With Laycock's classification, we see a return to the spirit of Cullen's work: like his Edinburgh predecessor, he employed the Latin *versaries* to describe mental disorders, and thought that they were caused almost exclusively by problems in the nervous system, arguing that they should be included in a nosology of general medicine. By appealing to the concepts of Cullen, Laycock and Skae sought to overturn the dominance of the symptom-based classification system established by Pinel and which had become the standard terminology used in discourse surrounding psychiatric classification by the 1860s.

## Conclusion

This chapter has argued that the forms of insanity developed by Pinel and Esquirol were introduced to the British Isles via the work of Prichard, and this was how it became established as the standard classification used by British psychiatrists during the latter half of the nineteenth century. The fundamental diseases concepts that Pinel coined, namely melancholia, mania, dementia, and idiotism, established the realm of diseases that alienists would treat in asylums. In doing so, Pinel's work drew upon the work of Cullen, Arnold and Crichton, and this partly explains why his diagnostic concepts were so popular. They were also empirical in character since they had been based upon the observation of symptoms, and his Table of the Forms was concise and practical, which appealed to British alienists often working in underfunded and increasingly overcrowded asylums. What was vital about Pinel's classification was that, unlike Cullen, he did not provide a theory on the causation of the forms of mental alienation that he described. These qualities of the Table of the Forms made it possible for them to become popular in the United Kingdom, however, the important and contingent historical reason for it becoming popular was the promotion carried out Prichard. After Prichard had published his *Treatise on Insanity*, the concepts of Pinel, with the addition of Esquirol's monomania, began to be employed by the Lunacy Commission, who recommended that the symptom-based classifications as formulated by Prichard be used to record the form of mental disorder that every person admitted to an asylum suffered, and because of this, they

were viewed as standard diagnostic concepts for mid-nineteenth century asylum medical officers.

During the 1850s, these symptom-based concepts attracted criticism from Greisinger, Baillarger, and Falret, whose work would have been read by British psychiatrists, and who thought that the forms were not scientific, and quibbled over the veracity of certain concepts within the nosology. They also held that Pinelean concepts, although not of a scientific standard, held some practical utility. By the 1860s, classifications from Skae and Laycock, who had taken notice of developments in the German lands, were presented in Britain and sought to establish what they hoped were more scientific grounds to the classification of insanity than the Table of the Forms, and these grounds were causal explanations of insanity. These Edinburgh physicians questioned the basis of Pinel's forms, adopting new terminology. We see then how the terminology that was used to refer to mental illnesses became pluralistic and varied during the nineteenth century. There were, by the middle of the century, many different ways of conceptualising mental disorders, and although a form of official classification had been adopted due to Prichard's connection with the Lunacy Commission, many asylum superintendents developed their own classifications which were either variants of Pinel's classification, one of the many crude systems that did not even aspire to use clinical terminology, or were influenced by the new wave of aetiological classifications offered by individuals like Skae and Laycock. It is with this contested and critical state of psychiatric classification that we turn to debates undertaken by members of the MPA over the admissions concepts used within British asylums that took place from the 1860s onwards.

## Chapter 2: Statistics, Causal Explanations of Insanity and Revisions to the Table of the Forms: Medico-Psychological Association Debates 1860 - 1882

### Introduction

In October 1875 and in the face of the challenges to the Forms of Insanity promoted by the Lunacy Commission and adopted by the Medico-Psychological Association, James Crichton-Browne (1840 – 1938) made a spirited defence of them in the pages of the *Journal of Mental Science* (JMS).<sup>1</sup> The classification of the forms of insanity offered by the Edinburgh physician David Skae (1814 – 1873), first published in 1853, sought to replace the Forms of Insanity that had become the standard used for diagnosis in the United Kingdom, and which were used in statistics collected by the MPA. Many found Skae's work appealing because it provided clearer differentiation between the insanities due to it seeking to incorporate aetiology by drawing causal links between bodily conditions. Crichton-Browne attacked this enterprise because he feared that it would be adopted as the new standard of the Lunacy Commission and the MPA, and would be used to classify asylum admittances. For Crichton-Browne, Skae's system was conceptually incoherent and lacked the scientific credentials it aspired towards, and using them in statistical tables would render a potentially powerful resource useless: the numbers returned from asylums on the forms of insanity suffered by admittances. Although Crichton-Browne thought the concepts of French psychiatry used in the Table of the Forms – dementia, melancholia, mania, moral insanity and idiocy were unscientific, they were useful and efficient for the purposes of diagnosis and for the collection of statistics.

Skae's system offered no benefits according to Crichton-Browne because it neither offered a way out of the impasse that mental science found itself in by the 1870s in not being able to explain insanity and provide effective treatment that would lead to greater discharges from asylums, and it was too complicated for efficient diagnosis.<sup>2</sup> Crichton-Browne thus defended the existing Table of the Forms because he thought it captured the changing nature of mental disorder.<sup>3</sup> Crichton-Browne here was taking issue with Skae's contention that continuity between disease concepts is unacceptable for the classification of mental disorders. He provided the damning judgment on those who trained under Skae, principally Thomas Clouston (1840 – 1915), who pushed for their master's system to be implemented as the new

---

<sup>1</sup> James Crichton-Browne, 'Skae's Classification of Mental Diseases: A Critique', in *JMS*, Vol. 21, No.95, Oct. 1875, pp.339 – 365.

<sup>2</sup> This is partly because Crichton-Browne thought that it would take too long for Skae's classification to be learnt by doctors posted to asylums. *Ibid.*, (p.340).

<sup>3</sup> *Ibid.*

British standard, describing them unkindly as disciples whose ‘bungling’ and ‘divergent opinions’ proved a risk to the quality of research undertaken by the MPA.<sup>4</sup>

We will return to the debates that took place between Victorian alienists on whether the *forms* of insanity that were described by Pinel and his students, or the *kinds* of insanity that were described by Skae, should be used in the Table of the Forms of Insanity. These discussions show how statistics from admissions procedures triggered debates on classification, and how they played an important role in the formulation of diagnostic categories. They demonstrate how the mental sciences needed to invent categories ‘into which people could conveniently fall in order to be counted’.<sup>5</sup> These categories were modelled on the static classification of natural objects that characterised the eighteenth century botanical classifications, and nosologies of general medicine like that offered by Cullen and discussed in the first chapter of this thesis.<sup>6</sup> The task of classification became complicated and elusive when attempting to classify human subjects capable of free will. The lack of an ability to classify can be seen from the sorts of explanation which were offered by Victorian classifiers such as Skae, who attempted to provide mechanistic, causal explanations of the kind that characterised the classical era, and have them implemented into the Table of the Forms. In contrast, figures like Crichton-Browne wanted to keep the forms as they were in the hope that statistics and epidemiology, the sciences of chance, would explain insanity.<sup>7</sup>

The debates that were conducted on the statistical Table of the Forms from the 1860s onwards were crucial in the formulation of psychiatric knowledge. Roger Smith points out that part of the project of the human sciences that emerged from the mid-nineteenth century onwards was the study of freewill and the attempt to explain it.<sup>8</sup> The discussions outlined in this chapter, on the classification of insanity, were carried out by asylum medical superintendents who were trained in the causal, mechanistic and bodily explanations for illnesses that were seen in medicine. Physicians like Skae attempted to apply these kinds of medical explanations to insanity in their classifications, but these were unsuccessful because those like Crichton-Browne thought that these were too deterministic and did not provide a

---

<sup>4</sup> Ibid., (p.350)

<sup>5</sup> Ian Hacking, *The Taming of Chance*, Palgrave, 1990. (p.15)

<sup>6</sup> On botanical classifications see Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A.M. Sheridan, Routledge, 1989; and for the development of the human sciences, or sciences of freewill, see Roger Smith, *Between Mind and Nature: A History of Psychology*, Reaktion Books, 2013.

<sup>7</sup> Lorraine Daston, *The Empire of Chance: How Probability Changed Science and Everyday Life*, Cambridge University Press, 1989; Ian Hacking, *The Taming of Chance*, Palgrave, 1990.

<sup>8</sup> Roger Smith, *Free Will and the Human Sciences in Britain, 1870 – 1910*, University of Pittsburgh Press, 2016.

satisfactory explanation of the illnesses that they came across during their time spent in asylums. As psychiatrists had more practical experience of the freewill seen in their patients, the neat causal explanations of a system builder like Skae became less convincing, especially to the practical inclinations of asylum psychiatrists, who at this time were often based in underfunded and overcrowded asylums.<sup>9</sup> Instead, as Crichton-Browne argued, Pinel's classifications were useful for differentiating forms of insanity because they described symptoms that were often associated with one another, such as the morose behaviour and obsessions seen in Pinel's description of melancholia.

Åsa Jansson identifies how the legally required practices of recording the form and cause of insanity played a role in the construction of diagnostic categories and psychiatric knowledge; admissions procedures helped to forge connections between suicidal thoughts and melancholia.<sup>10</sup> Under the terms of the 1845 Lunacy Act, asylums were required by law to keep an admissions book, and in it list the diagnosis that the patient had received on admittance to the asylum as well as the suspected cause of their insanity. Numbers relating to these details of patients were included in annual statistical returns that were completed and returned to both the MPA and the Lunacy Commission. The Table of the Forms of Insanity was a part of the yearly returns that also provided details on the deaths, injuries and finances of the asylum. Discussions on the standardisation of statistical tables took place from the formulation of the MPA in 1841, and during the early years of the Association more attention was placed on the standardisation of financial tables, deaths and procedures on transferring patients between asylums. As these began to be resolved, and greater standardisation was achieved in the day to day running of British asylums, attention turned towards the Table of the Forms from the 1860s onwards. As Jansson's work demonstrates, the numbers that were returned on the causes and the forms of insanity played an important role in the development of psychiatric knowledge, and members of the Association thought that having a standard set of diagnostic concepts would improve the quality of the data, and could provide insights into the causes of insanity.

This is why the members of the MPA placed so much importance on the diagnostic concepts that would be the standard used in the statistical tables of the Association. The diagnostic concepts that were included in the statistical tables were tantamount to being the official diagnostic classification of the MPA: they embodied the forms of insanity that were

---

<sup>9</sup> John Walton, 'The Treatment of Pauper Lunatics in Victorian England: The Case of Lancaster Asylum, 1816 – 1870' in Andrew Scull ed., *Madhouses, Mad-doctors and Madmen*, pp.166 – 200.

<sup>10</sup> Åsa Jansson, 'From Statistics to Diagnostics: Medical Certificates, Melancholia, and "Suicidal Propensities" in Victorian Psychiatry', in *Journal of Social History*, Vol.43, No.3, Spring 2013, pp.716 – 731.

recognised and used by all members of the Association when compiling statistical data that they would submit in their annual reports. The debates they engaged in were essentially between two broad schools, both of which were dissatisfied with the symptomatic classification of Pinel, but one which viewed sought to be remedy in a system that provided causal explanations in order to divide insanity into different forms, and the other who wanted to continue using the symptom-based classification in the hope that statistics from asylums would allow connections to be made between bodily causes and psychological disorders such as monomania and moral insanity.

The Table of the Forms constituted the shared terminology that was used to communicate between lunacy administration and clinical treatment of the different forms of insanity, and as such was the theatre in which psychiatrists held debates on the correct classification of insanity. Although a melange of German, French, Latin and Greek derived terms were employed within the research papers that populated the pages of the MPA's *Journal of Mental Science*, the terms used in official documents, diagnosis and statistics were the Pinelean terms included in the Table of the Forms. Many who viewed the aetiological concepts offered by Skae as being flawed, it was hoped by many members of the MPA and the Lunacy Commission that data on diagnosis returned from asylums across the British Isles would establish causal links between the forms of insanity and the causes that were recorded in asylum admittance books. This demonstrates that aetiology during this period constituted the *historical a priori* that determined what statements were admissible within this discourse.<sup>11</sup> To put it another way, the grounding assumption to this discourse was that insanity could be given a causal explanation, and the notion that there could be another form of explanation for insanity other than that of the physical and mechanistic was not admissible to those who engaged in these debates surrounding classification. They did not think that statistical explanations were a different kind of explanation, but rather that the statistics would eventually reveal causal explanations, be they in the form of the natural history of the disease of Skae, or pathological explanations. In short, the discovery of such bodily causes was seen by many as an eventuality and remained undoubted, and thus formed the historically constituted *a priori* conditions that allowed these debates to take place.

The data that was returned by asylums was then viewed as a crucial resource, and great importance was placed on getting the concepts correct in the Table of the Forms that would be included in the statistical tables. Doing so could have a dramatic influence upon the direction of psychiatric research and could lead to new treatments being developed. Crichton-Browne was

---

<sup>11</sup> Michel Foucault. *The Order of Things : An Archaeology of the Human Sciences*. Routledge, 2002.



spurred into writing his rebuke of Skae's work due to his concerns about how real a possibility it was that Skae's classification would be introduced as the standard in the statistical tables: only two years previously John Archibald Campbell, a former student of Clouston, recommended that Skae's aetiological classification be used as the standard in the MPA's statistical tables.<sup>12</sup> As such, these debates constitute a crucial chapter in the history of the classifications used by the fledgling British psychiatric profession, one which has been overlooked by historians of psychiatry and which had left a significant gap in scholarship on the history of classification. This chapter will then look in detail at the debates surrounding psychiatric classification triggered by the establishment of committees between 1860 and 1882 that were appointed to revise the statistical tables used in asylums, and will analyse the reactions to the forms that these committees proposed.

## Section 1: The First Revisions to the Statistical Tables: 1840 – 1882

Lunacy statistics found themselves at the centre of a complex set of links between asylum administration, public health and psychiatry. Clinical ideas that informed the debates over the forms of insanity to be used in the collection of statistics came from the works of notable British figures such as David Skae, Thomas Laycock, and James Crichton-Browne, and from across the channel in the work of Jean-Pierre Falret (1794 – 1870), Wilhelm Griesinger (1817 – 1868), Joseph Guislain (1797 – 1860) and Karl Ludwig Kahlbaum (1829 – 1899) amongst many others. Phrenology had also had a considerable impact on these discussions, with some attempting to link the location of certain lesions in the brain to characteristics of the mind.<sup>13</sup> Degenerationist thought, that was initially inspired by Bénédict Morel and Jean-Baptiste Lamarck's ideas on heritability, also informed discussion about what forms of insanity should be used in the statistical tables.<sup>14</sup>

The growth in admittances to asylums in the larger cities during this period was a vital issue that alienists thought quality statistical data could provide insights into. Some argued that these numbers provided proof that the conditions in these new industrial centres contributed to

---

<sup>12</sup> J.A. Campbell and J. Todd, 'Uniformity in Public Asylum Reports', in *JMS*, Vol.19, No. 85, April 1873, pp.67 – 78. (p.69).

<sup>13</sup> Cooter, Roger. 'Phrenology and British Alienists c.1825 – 1845: Part II: Doctrine and Practice', in *Medical History*, Vol.20, No.2, April 1976, pp.135 – 151.

<sup>14</sup> Henry Maudsley, 'On Some of the Causes of Insanity' in *JMS*, Jan. 1867, Vol.1, No.60.

the increased prevalence of certain forms of insanity, and so alienists needed to consider the social circumstances of an individual when attempting to explain their illness. Others dismissed these statistics, arguing that they showed no such connection, but instead the increase in numbers was proportional to the burgeoning populations of these towns.<sup>15</sup> For instance, a regional variation of the forms of insanity that were recorded in asylum admittances was pointed out in a review of the *1873 Report of the Commissioners of Lunacy* in the *JMS*:

It has often been suggested that there is a great difference between the forms of insanity received into urban asylums and those admitted into rural establishments. But, granting that to a certain extent this is the case, we are not inclined to attribute the difference in the condition of the patients in urban and rural asylums nearly so much to the former being drawn from a more excitable and degraded class of the population, as to the latter being generally grouped together in smaller number.<sup>16</sup>

Concerns like these demonstrate that by the 1870s, admittance statistics were sought after to make sense of the rates of insanity amongst the population, and what kinds of insanity were suffered by whom and where. Statistics were beginning to structure the questions formulated by those involved in the administration and treatment of insanity. The debates surrounding the Table of the Forms of Insanity, a document that played a central role in the collection of these statistics, was the beginning then of a debate surrounding the correct ways to classify insanity, and a series of debates that are covered in this chapter would take place until 1882, when the final table of statistics would be settled upon, at least until discussions were reopened at the dawn of the twentieth century.

### 1.1: The Beginnings of the Statistical Tables 1840 - 1868

Forms of insanity were included in statistical tables that were introduced at the very establishment of the MPA in 1841, its first incarnation being the Association of Asylum Medical Officers (AAMO). During its second meeting in 1842 a classification of the forms of insanity was approved for the purposes of statistics, and due to this preceding the establishment of the Association's journal, the *Journal of Mental Science*, it saw itself published in the form of John Thurnam's 1845 textbook, *Observations and Essays in the Statistics of Insanity*.<sup>17</sup> The forms of insanity presented in this work did not diverge much from the forms of insanity which had

---

<sup>15</sup> P. Maury Deas, 'Five Years of Statistics' in *JMS*, Vol. 25, No. 109, April 1879, pp.8 – 19.

<sup>16</sup> 'Reviews: The Lunacy Blue Books' in *JMS*, Vol. 19, No.85, Apr. 1873, pp.409 – 433, (p.426).

<sup>17</sup> John Thurnam, *Observations and Essays in the Statistics of Insanity: Including an Inquiry into the Causes Influencing the Results of Treatment in Establishments for the Insane; To Which are Added the Statistics of the Retreat, Near York*, (London : Simpkin Marshall, 1845), pp.39 – 40.

been recommended by the Lunacy Commission and which are outlined in the previous chapter, but Thurnam's included a number of sub-classes:

Partial Insanity

- i. Moral Insanity
- ii. Monomania
- iii. Melancholia

General Insanity

I. Mania

1. Acute Mania (raving madness)
2. Ordinary Mania (chronic madness of a less acute form).
3. Periodical or Remittent Mania (with comprehensively lucid intervals)

II. Dementia (decay and obliteration of the intellectual faculties)

1. Imbecility (acquired)
2. Fatuity (confirmed dementia)

III. Amentia

1. Idiocy (congenital)
2. Imbecility (congenital)

IV. Delirium Tremens (when, as in the United States, this is regarded as a form of insanity, and is treated in hospitals for the insane)<sup>18</sup>

Figure 7: Forms of Mental Disorder Presented in John Thurnam's *Observations and Essays in the Statistics of Insanity*.<sup>19</sup>

As discussed in the previous chapter, the Lunacy Commission used a very basic statistical table to collect data about admissions. Thurnam followed the plans of the earlier Metropolitan Lunacy Commission in the sub-division of the forms of mania, but made the rather audacious statement that the one presented to the AAMO in 1842 was 'perhaps as complete and as

---

<sup>18</sup> John Thurnam, *Observations and Essays in the Statistics of Insanity: Including an Inquiry into the Causes Influencing the Results of Treatment in Establishments for the Insane; To Which are Added the Statistics of the Retreat, Near York*, (London : Simpkin Marshall, 1845), pp.39 – 40.

<sup>19</sup> Ibid.

scientifically accurate as any which is ever likely to be adopted in classifying the cases of mental disorder admitted into asylums'.<sup>20</sup>

The Lunacy Commission did not use the table that was adopted by the AAMO, and which was published in Thurnam's textbook: although both the Lunacy Commission and the AAMO used the same main classes of *dementia*, *mania*, *melancholia*, *moral insanity* and *idiocy*, there were important divergences, with the one that was devised by Thurnam including both *dementia* and *amentia*, a distinction which served to differentiate between degenerative disorders that were considered to only exist in old age and congenital disorders respectively.<sup>21</sup> It also did not include *General Paralysis of the Insane* (GPI).<sup>22</sup> The AAMO did not have a journal until 1853, when the *Asylum Medical Journal* was established, and thus Thurnam's medical textbook was the sole means via which the nosology was circulated. This had a smaller circulation than the reports of the Lunacy Commission, which may explain why the concepts approved by the Lunacy Commission were more widely used and came to be adopted as the standard set.<sup>23</sup> Since the Lunacy Commission led the way during the 1850s on the collection of statistics, very little occurred in the development of asylums statistics within the MPA until Lockhart Robertson published an 1860 report that recommended the following concepts to be used for the diagnosis of those admitted to asylums, with the aim of strengthening the consistency of data by establishing a standard set of diagnostic concepts:

1. Mania
2. Melancholia
3. Monomania
4. Moral Insanity
5. Dementia – Under the two heads of imbecility and fatuity.
6. Congenital Idiocy

---

<sup>20</sup> Ibid., (p.39)

<sup>21</sup> Ibid.

<sup>22</sup> C. Lockhart Robertson, superintendent of the Sussex asylum and secretary of the by now renamed AAMO to the Medico-Psychological Association, in an 1860 report concepts that were recommended for use by the Lunacy Commission replacing by the ones proposed by Thurnam and adopted as the classification of the MPA; C. Lockhart Robertson, 'Suggestions Towards an Uniform System of Asylum Statistics (with Tabular Forms)' in *JMS*, Vol. 7, No. 36, January 1861, pp.195 – 211 (p.195).

<sup>23</sup> Worth reminding ourselves here that whilst the Lunacy Commission recommended that concepts of the forms of insanity were employed to be used in asylum admissions, they did not force them to be used. It seems for the most part that superintendents complied with their recommendations.

Criminal Lunatics should be further distinguished as such

Figure 8: Forms of Mental Disorder presented in Lockhart's 'Suggestions Towards an Uniform System of Asylum Statistics and Hospitals for the Insane'.<sup>24</sup>

Lockhart Robertson proposed a simpler classification of the forms of insanity than that presented in Thurnam's textbook, which was at that point the classification that had been adopted as the standard by the MPA. His goal was to bring about greater uniformity, and one of the strategies he adopted was to make the classification simpler by following the Lunacy Commission's classification, which had removed sub-classes of disorders. In addition, Thurnam's sub-class of amentia, was merged it into dementia. Unlike Thurnam, Lockhart Robertson's concern was to standardise data as opposed to presenting an exhaustive classification of the forms of insanity: Lockhart Robertson wanted to create a concise set of diagnostic concepts that were easier to standardise and would help to improve the integrity of the statistical data that was collected by the MPA and the Lunacy Commission. Lockhart Robertson did not provide much to accompany these diagnostic concepts because the report that he drew up was not restricted to the forms of insanity: he proposed huge revisions to all sets of data that were collected within asylums, including information relating to personnel, finances, dietary information, and clinical sets such as recovery rates, discharge data, and the duration of the disorder prior to a person's admittance to an asylum.<sup>25</sup> Lockhart Robertson suggested great changes to the statistical tables that were filled in yearly by asylum superintendents and returned to the MPA and the Lunacy Commission in order to streamline asylum statistics. The sheer number of changes that were proposed to the statistical tables, everything from finances to deaths, discharges and transfer statistics, meant that the Table of the Forms of Insanity were lost in the details, not gathering much attention from members of the MPA; during the 1860 annual meeting, members of the Association were more concerned with discussing Lockhart Robertson's recommendations to standardise the financial data than discussing the proposed changes to the Table of the Forms of Insanity.<sup>26</sup>

At the 1864 AGM, the MPA appointed a Committee on Asylum Statistics to further consider how the association could bring about uniformity in the recording of asylum data.<sup>27</sup> At

---

<sup>24</sup> C. Lockhart Robertson, 'Suggestions Towards an Uniform System of Asylum Statistics (with Tabular Forms)' in *JMS*, Vol. 7, No.36, January 1861, (p195 – 211) (p.199)

<sup>25</sup> *Ibid.*

<sup>26</sup> 'Association of Medical Officers for the Asylums and Hospitals for the Insane: Official Report of Proceedings at the Annual Meeting held at the Freemasons' Tavern, Thursday, July 5<sup>th</sup>, 1860' in *JMS*, Vo. 7, No.35, pp.23 – 49.

<sup>27</sup> 'Annual Meeting of the Association of Medical Officers of Asylum and Hospitals for the Insane' in *JMS* Vol. 10, No.51, Oct. 1864, pp.448 – 469. p.468.

this stage, the MPA relied on the Lunacy Commission for data on how asylums were ran and what happened within them. Amongst the membership of the MPA, there was a growing desire for detailed data on pathology, mortality and how these were linked to the different forms of insanity diagnosed in their patients. One member, Dr. Wood, complained that the ‘statistics present[ly] rendered were of very little value’ and Thurnam himself expressed the concern about the paucity of data collected about admissions, stating ‘that the [data] returned in some of the tables were so incomplete that even the distinction of sex was not marked’.<sup>28</sup> Lockhart Robertson, following up on Thurnam’s earlier call for uniformity, introduced a bill which called for a committee to be appointed that would consider how data collected from different asylums could be compared and contrasted, allowing inefficiencies to be identified and addressed, in turn providing clues for how to improve asylum management. He himself cites a discovery that he had made towards this end, albeit after a great deal of work:

In one case he had discovered that a great element of economy was the marvellously small cost of the beer consumed, so that instead of spending £1000 a year, as asylums of similar size did, on beer, the establishment in question expended only £400, making a difference of fourpence on the rate.<sup>29</sup>

This was no small saving considering the stretched resources of asylums during this period. Despite discoveries such as these offered by the streamlining of statistics, Wood voiced concerns that some superintendents may be unwilling to adopt any plan to increase uniformity; a concern borne out of a fear of an increased workload, and suspicion of possible interference from the Lunacy Commission in daily matters.<sup>30</sup> Irrespective, Wood acknowledged the importance of statistical uniformity, and the discussion at the 1864 annual meeting finished with the appointment of a committee of three who were put in charge of drawing up a set of tables which would allow for the uniform recording of data from county asylums.<sup>31</sup>

It took the committee one year to return their report, and they recommended that the collection of financial data relating to the day to day running of the asylum be left as it was, and that if any adjustments be made, they should be carried out by the Lunacy Commission and via changes in legislation relating to asylum administration.<sup>32</sup> Instead, the committee paid more

---

<sup>28</sup> Annual Meeting of the Association of Medical Officers of Asylum and Hospitals for the Insane’ in *JMS*, Vol.10, No.51, Oct. 1864, pp.448 – 469. (pp.467 – 468)

<sup>29</sup> *Ibid.*

<sup>30</sup> *Ibid.*

<sup>31</sup> *Ibid.*

<sup>32</sup> ‘The Medico-Psychological Association Proceedings at the Annual Meeting of the Association, held at the Royal College of Physicians, on Thursday, July 13<sup>th</sup>, 1865’ in *JMS*, Vol. 11, No.55, Oct. 1865, pp.383 – 427. (p.403)

attention to how medical data was collected, and recommended that a new set of tables be introduced which would provide more information on admissions, re-admissions, discharges, and deaths. At this point, it did not recommend that any differentiation between the forms of insanity suffered by patients admitted to asylums be implemented into these statistical tables, although they recommended that ‘maniacal and melancholic exhaustion or decay’ and ‘general paresis’ were included as causes of death.<sup>33</sup> It also erred to the judgement of the Royal College of Physicians when it came to the forms of insanity, writing that ‘that the concepts may be subject to revision in light of the publication of the Report of the College of Physicians on “Medical Nomenclature”’.<sup>34</sup> This was not followed up, and this marks the moment when the six forms of insanity from the 1860 report were introduced into statistical collection, and would provide the foundation for medical statistics that were collected by the MPA for the next forty years.

In 1866, only one year later, a motion was proposed by Lockhart Robertson to act on a recommendation made in the *1865 Annual Report of the Lunacy Commission* to reappoint the Committee on Asylum Statistics so that the tables could be revised to allow more nuanced data on admissions to be gathered and returned, including the form of insanity suffered by a patient.<sup>35</sup> In the Lunacy Commission’s report cited by Lockhart Robertson, a call was made for ‘[u]niformity in recording the ages of patients on admission, the duration of the existing attack, and the form of mental disorder under which they labour’, and ‘hoped that the medical officers of asylums may see great importance of coming to some agreement on these points’.<sup>36</sup> This was the crucial point when the forms of insanity shifted from being a predominantly administrative and legal concern to becoming regarded as a matter of important clinical value to members of the MPA: prior to this point, the forms of insanity that were recorded in the admissions book of an asylum served primarily as a legal justification for admitting an individual into an asylum.<sup>37</sup> Hitherto, it was the Lunacy Commission that led the MPA in standardising the forms of insanity that were used for diagnosis, and collecting these numbers for publication in their annual reports, but from this point, it would be the MPA and its members who would take control of what concepts would be employed in the Table of the Forms of Insanity that were used in statistical returns.

---

<sup>33</sup> Ibid., (p.410).

<sup>34</sup> Ibid.

<sup>35</sup> ‘The Medico-Psychological Association: Proceedings at the Annual Meeting of the Association, held at the Rooms of the Royal Society, Edinburgh, on Tuesday, July 31<sup>st</sup>, 1866’ in JMS, Vol. 12, No.59, Oct. 1866, (p.425)

<sup>36</sup> ‘The Medico-Psychological Association: Proceedings at the Annual Meeting of the Association, held at the Rooms of the Royal Society, Edinburgh, on Tuesday, July 31<sup>st</sup>, 1866’ in JMS, Vol. 12, No.59, Oct. 1866, pp.415 – 437.

<sup>37</sup> Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England* (with special Emphasis on Leicestershire and Rutland), PhD Thesis, UCL, 1993, pp.221 – 222.

## 1.2: Skae's First Set of Revisions and the Aftermath: 1868 – 1882

In 1869 another committee was appointed to revise the statistical tables, with the Table of the Forms of Insanity taking centre stage. The classification they produced was heavily influenced by David Skae's classification, which is evident from a brief comparison of Skae's tables as included in his lectures, and the classification produced by the committee (see next page). Also, the revised Table of the Forms was founded upon Skae's principle that the natural history of the *kinds* of insanity should be the defining feature of each of the forms. As explored in chapter 1, Skae meant by natural history the course of each of the kinds of insanity, which incorporated both the cause and the prognosis of a disease, but the emphasis in his system was on the causes as these were, as far as Skae was concerned, more intelligible, and increased understanding of aetiology would lead to knowledge of the prognosis of the disease. Skae thought that the current Table of the Forms, that defined conditions based upon observable phenomena in the form of behaviours, was too vague and needed to be revised with one that stood on the firmer foundation of the natural history of the disease. Skae and his former students Thomas Clouston and John Batty-Tuke sat on this committee, with Robert Smith, James Howden, and John Sibbald, comprising the rest of the members.

It returned its report in January 1870, and proposed a complex and intricate classification system, seeking to combine Skae's aetiological classification, which provided the core to the committee's elaborate system, with mania and melancholia being used as sub-classes to the forms of insanity that had been lifted from Skae's table (see next page):



For facility of reference, I sum up the various natural orders I have thus sketched out in the following tabular form:—

Idiocy, } Moral and Intel-	Senile Mania.
Imbecility, } lectual.	Phthisical Mania.
Insanity, with Epilepsy.	Metastatic Mania.
Insanity of Masturbation.	Traumatic Mania.
Insanity of Pubescence.	Syphilitic Mania.
Satyriasis.	Delirium Tremens.
Nymphomania.	Dipsomania.
Hysterical Mania.	Mania of Alcoholism.
Amenorrhœal Mania.	Post-Febrile Mania.
Post-Connubial Mania.	Mania of Oxaluria and Phosphaturia.
Puerperal Mania.	General Paralysis, with Insanity.
Mania of Pregnancy.	Epidemic Mania.
Mania of Lactation.	
Climacteric Mania.	Idiopathic Mania, } Sthenic.
Ovario-Mania (Utero-Mania.)	} Asthenic.

Figure 9: Skae's Classification as presented to the Association of Asylum Medical Officers in 1863.<sup>38</sup>

		PREDOMINANT FEATURES.									
		Acute delirium and incoherence.	Simple Excitement.	Simple Depression.	Stupor.	Hypochondria.	Strong suicidal impulses.	Remittency or intermittency.	Chorea.	Hallucinations.	Embecement.
		a	b	c	d	e	f	g	h	i	k
* e.g. A case could be quoted as being in class 1 (a, b, i).	<b>CURABLE.</b>										
	1.	Insanity of Pregnancy*	1	1				1			
	2.	"			1	1					
	3.	Insanity of Childbirth	1	1							
	4.	"			1	1		1			
	5.	Insanity of Lactation	1	1							1
	6.	"			1	1		1			1
	7.	Climacteric Insanity	1	1					1		1
	8.	"			1	1	1	1	1		1
	9.	Insanity from Uterine Disorder	1	1					1		1
	10.	"			1	1	1	1	1		1
	11.	Insanity from Tuberculosis	1	1							1
	12.	"			1	1	1				1
	13.	Insanity from Masturbation	1	1			1				1
	14.	"			1	1	1	1			1
	15.	Insanity from Alcoholism	1	1							1
	16.	"			1	1	1	1			1
	17.	Delirium Tremens	1			1		1			1
	18.	Post Febrile Insanity	1	1					1	1	1
	19.	"			1	1	1	1	1	1	1
20.	Hysterical Insanity	1	1					1		1	
<b>INCURABLE.</b>											
1.	General Paralysis	1	1	1	1	1	1	1		1	1
2.	Epileptic Insanity	1	1	1	1		1	1	1	1	1
3.	Senile Insanity			1	1	1	1			1	1
4.	Paralytic Insanity			1	1					1	1

Figure 10: Classification Proposed by the MPA Statistical Revisions Committee in 1870.<sup>39</sup>

<sup>38</sup> David Skae, 'A Rational and Practical Classification of Insanity', in *JMS*, Vol.9, No.47, Oct. 1863, pp.309 – 319.

<sup>39</sup> David, Skae, et al. 'Report of the Committee Appointed at a Meeting of Member of the Medico-Psychological Association, Held at the College of Physicians, Edinburgh, on 25<sup>th</sup> November, 1869, for the Purpose of Taking

The report produced a classification (see figure nine above) that employed fifteen forms, most of them Skae's, with main classes defined by what he believed to be the different causes of insanity, and then split into sub-classes according to the predominant psychological disorder of mania or melancholia, which the committee understood to be symptoms of brain diseases or bodily conditions. The bodily causes were the primary distinguishing feature of each of the insanities in this table, with the psychological being placed secondary as sub-classes in this system. Placing the forms in this order was done with the goal of providing greater distinctions between the forms of insanity:

In regard to classification, [the committee is] of opinion [sic] that the chief point to be attended to in adopting any system is to secure accuracy and definiteness of terms, so that each case may with certainty be placed in its class by different observers, and that by the same terms different observers may mean the same thing. They are of the opinion that none of the ordinary systems of classification used alone is sufficient for this purpose.<sup>40</sup>

The committee believed that they were providing a state of the art classification system that would synthesise Skae's natural history defined forms with the forms of insanity that were currently in use. The report also claimed that these different forms of insanity were natural kinds that could be the object of a precise form of scientific research, which in turn would allow reliable observations to be made.<sup>41</sup> The committee then attempted to change The Table of the Forms from being a classification that divided of insanity according to observable phenomena in its different forms, or appearances, to being a representation of what the committee believed to be natural kinds of insanity that were defined by their aetiology. It was this vital change that triggered debates surrounding the nature of insanity, and reactions like that we saw in the introduction from Crichton-Browne who thought that the knowledge available at that juncture would mean that any classification formulated on these principles would merely be speculative.

John Batty Tuke had misgivings about this classification being the authoritative one of the MPA, and in April of the same year, he published a paper which offered a pathological

---

Certain Questions Relating to the Uniform Recording of Cases of Insanity and to Medical Treatment of Insanity into Consideration' in *JMS*, Vol.16, No.74, July 1870, pp.223 – 232.

<sup>40</sup> David, Skae, et. al. 'Report of the Committee Appointed at a Meeting of Member of the Medico-Psychological Association, Held at the College of Physicians, Edinburgh, on 25<sup>th</sup> November, 1869, for the Purpose of Taking Certain Questions Relating to the Uniform Recording of Cases of Insanity and to Medical Treatment of Insanity into Consideration' in *JMS*, Vol.16, No.74, July 1870, pp.223 – 232, (p.224).

<sup>41</sup> *Ibid.* p.224

means of classifying insanity.<sup>42</sup> This was also partly in response to the Royal College of Physicians publishing a nomenclature of general medicine that included a classification of the insanities.<sup>43</sup> Batty Tuke complained that whilst this listed over nine hundred somatic disorders, only six forms of insanity were included.<sup>44</sup> The classification produced by the Royal College was identical to the one recommended by the Lunacy Commission.<sup>45</sup> Like Skae, Batty Tuke challenged the Table of the Forms that was in use, but he argued that Skae would have found firmer ground if he had used pathology instead of the natural history and causes of the insanities as the basis for his classification.<sup>46</sup> In fact, Batty-Tuke claimed that Skae was classifying insanity along pathological and not aetiological grounds in his work.<sup>47</sup> Like Crichton-Browne then, Batty Tuke claimed that Skae's classification rested on a shaky conceptual basis, employing murky and unclear concepts that he thought confused pathology and aetiology in an attempt to make natural distinctions between different diseases. Batty Tuke narrowed his sights on Skae's *mania of oxaluria* to demonstrate how he confused the symptom for the cause: this was believed by Skae to be a family of insanities which were characterised by the existence of an excess of calcium oxalate in the sufferer's urine.<sup>48</sup> Batty Tuke went on to claim that *manias of oxaluria* 'can hardly be regarded as a natural family from the mere fact of the occurrence of the salt in certain cases, as its presence must be regarded as a consequence, not a cause, of such diseases as *Climacteric* or *Idiopathic Insanity*'.<sup>49</sup> For Batty Tuke then, Skae had been too hasty in his claim that the presence of calcium oxalate formed a natural family of insane diseases because he had made the confusion between regarding a symptom as a cause. He also contested his empirical findings, claiming that oxalation was 'generally found in cases where *melancholy* (not *mania*) is the leading mental symptom'.<sup>50</sup> Most serious of Batty Tuke's criticisms was that *idiopathic insanity* functioned as a junk category, or in his terms a Gahenna: comparing this category to the biblical valley in Jerusalem where kings sacrificed their children to fire, he was deeming patients given this diagnosis to being the damned, as the untreatable and the

---

<sup>42</sup> J. Batty Tuke, 'A Pathological Classification of Mental Disease' in JMS, July, 1870, Vol.16, No.74, pp.195 – 210.

<sup>43</sup> Ibid.

<sup>44</sup> Ibid.

<sup>45</sup> Ibid

<sup>46</sup> Ibid., (p.204)

<sup>47</sup> Ibid.

<sup>48</sup> Although *Oxaluria* was not explicitly reproduced in the revisions to the Table of the Forms produced by the committee, it was included under the broader category of Insanity from Uterine Disorder that was included in their report.

<sup>49</sup> Ibid.

<sup>50</sup> Ibid., (p.205)

hopeless.<sup>51</sup> According to Batty Tuke, this hardly allowed for the classification to be called one that divided insanity according to natural kinds, although he tried to save the face of his former teacher by making the conciliatory description of him as being ‘the Cullen of Psychiatric Medicine’ albeit after savaging the conceptual bases of his nosology.<sup>52</sup>

Batty Tuke thought that Skae’s work was a false departure: his aetiological classification was simply the emperor’s new clothes because it was dressing up in the language of natural kinds the Pinelean symptom-based concepts of psychopathology, and tied these to unproven causes. In his own pathological classification (see next page), Batty Tuke eschewed all the forms of Pinel. Instead of aetiology, which he thought to be an unrealistic way of formulating disease concepts due to the limited knowledge of insanity’s causes, Batty Tuke called for ‘[p]athology [to be adopted] as the fundamental principle, without any regard to mental symptoms; that the causating pathological influence which induces the symptoms ought to be accepted as the ground-work of nomenclature’.<sup>53</sup> Psychological disorders were symptoms of physical disorder according to Batty Tuke. This is clear from Batty Tuke’s description of ‘insanity’ as a not being a disease, and he instead described it as a symptom. As such, insanity became a symptom ‘of a disease either of the brain plasm primarily, or of a disease of the brain dependent on exoteric influences’.<sup>54</sup> The physicalist stance of Batty Tuke shows that he thought there were many forms of insanity, but these were natural kinds and no consideration of mental symptoms or causes for that matter, were of relevance.

---

<sup>51</sup> Ibid.; Skae’s Idiopathic insanity seems to be what Star calls a ‘garbage’ category, and although her works focused on functional categories such as neurasthenia and hysteria, idiopathic insanity would seem to fulfil the model that she sets up for these categories – that garbage categories like this function to classify cases that do not fit other categories in a classification; S.L. Star, *Regions of the Mind: Brain Research and the Quest for Scientific Certainty*, Stanford University Press, 1989.

<sup>52</sup> Ibid., (p.205)

<sup>53</sup> Ibid.

<sup>54</sup> Ibid., (p.206)

SUB-CLASSES.	
Class I.—Insanity resulting from arrested or impaired development of the brain.	{ Idiocy, congenital and acquired.
Class II.—Idiophrenic Insanity.	{ Sthenic and Asthenic Idiopathic Insanity. Phrenitic Insanity (Inflammatory) General Paresis. Paralysis with Insanity. Traumatic Insanity. Senile Insanity Epileptic Insanity.
Class III.—Sympathetic Insanity.	{ Epileptic Insanity. Insanity of Masturbation. Insanity of Pubescence. Climacteric Insanity. Ovarian and Uterine Insanity. Insanity of Pregnancy. Puerperal Insanity. Post-connubial Insanity. Hysterical Insanity. Enteric Insanity.
Class IV.—Anemic Insanity.	{ Limopsoitos (from starvation). Post-febrile Insanity. Insanity of Lactation.
Class V.—Diathetic Insanity.	{ Insanity of Tuberculosis. Syphilitic Insanity.
Class VI.—Toxic Insanity.	{ Cretinism. Delirium Tremens. Insanity of Alcoholism. Insanity from Opium-eating.
Class VII.—Metastatic Insanity.	{ Rheumatic Insanity. Pellagrous Insanity. Metastatic Insanity (from healing of long-established issues).

Figure 11: The classification presented by John Batty Tuke in 'A Pathological Classification of Mental Diseases'.<sup>55</sup>

Batty Tuke proposed seven main classes in his classification: *insanity from arrested development*, which incorporated acquired and congenital idiocy; *idiophrenic insanity*, caused by brain defects and organic problems, which included *traumatic insanity*, the traumas in these cases being impacts to the skull; *sthenic* and *asthenic* insanity, which were abundances and deficiencies in nervous energy, respectively, conceived by the Edinburgh physician John Brown, private tutor of Cullen<sup>56</sup>; *sympathetic insanity*, a vague class which included bodily processes such as *enteric* (relating

<sup>55</sup> Ibid., (pp.206 – 207).

<sup>56</sup> Sean Dyde, 'Cullen, a Cautionary Tale' in *Medical History*, Vol.59 No.2, 2015, pp.222 – 240.

to the digestive system) and emotional imbalances *post-connubial* (consummation), or *hysterical insanity*.<sup>57</sup> The final four main classes were: *anoemic insanity*, caused by deficiency in nutrients; *diathetic*, caused by weaknesses in physical constitution; *toxic*, caused by drugs, pollution and alcohol; and the final class, *metastatic insanity*, sets of insanity that were caused by a seemingly distant or unconnected condition, such as rheumatism or *pellagra*, a malnutrition caused by diets including an over reliance on maize. Batty Tuke's table was even more radical than Skae's system, and the revisions proposed by the committee – there was no language of psychological disorders in Batty Tuke's classification, and he had completely removed any trace of Pinel's symptom based forms of insanity.

Batty Tuke's paper was read at the quarterly meeting of the association in Edinburgh, with Laycock as chairman and Skae and Clouston in attendance.<sup>58</sup> It gave rise to one of the longest discussions yet amongst members of the MPA about how to properly classify the forms of insanity. Laycock questioned the grounding principle of both Batty Tuke and Skae's classifications by claiming that it was not possible to come up with one singular cause or pathology for insanity, and this it was a composite of psychological and bodily disorders. Furthermore, Laycock criticised the basis of *insanity of alcoholism*:

alcoholism was not a sufficiently discriminating classification. It was not a scientific term. Nobody drank alcohol, but alcohol mixed in some way – in beer for instance. [...] He was mentioning this because they were adopting the popular phraseology, when they should deal with these matters with strict attention to the facts. Of late there had been great adulteration of fermented drinks, and he thought that he had tended to insanity more than the alcohol in these liquors. Beer was a wholesome drink, let the teetotallers say what they would.<sup>59</sup>

Laycock claimed then that the ordinary language term 'alcoholic' had no place in a clinical classification of insanity because it lacked the scientific precision that Batty Tuke and Skae were aspiring to. Laycock thought that Batty Tuke's diathetic class of mental disorder, had a stable pathology, and even if the rest of the classification was disputable, Batty Tuke's exploratory and speculative classification could be excused if it included at least one valid category.<sup>60</sup>

Even for Clouston, a strong advocate of Skae's classification, Batty Tuke's eschewing of all language of symptoms was a step too far. He took issue with a fundamental feature of

---

<sup>57</sup> German Berrios and J.H. Pons, 'J.H. Pons on "Sympathetic Insanity": With an Introduction by G.E. Berrios' in *History of Psychiatry*, Vol.25, No.3, September 2014, pp.364 – 76.

<sup>58</sup> 'Report of a Meeting of Members of the Medico-Psychological Association, held at Glasgow, April 27<sup>th</sup>, 1870' in *JMS*, July, 1870, Vol.16, No.74, (p.300)

<sup>59</sup> Thomas Laycock, remarks in 'Report of a Meeting of Members of the Medico-Psychological Association, held at Glasgow, April 27<sup>th</sup>, 1870' in *JMS*, July, 1870, Vol.16, No.74, (p.304)

<sup>60</sup> *Ibid.*

Batty Tuke's classification: the move to call insanity a symptom, which he thought was symptom of brain states.<sup>61</sup> Clouston called this a fallacy because Batty Tuke's assumption was out of sync, he thought, with the reality of being an alienist – insanity was a composite of physical states and mental states, and both were treated in asylums, and not merely the pathologies of insanity that Batty Tuke described in his classification. Batty Tuke's hope that alienists would treat the underlying physical causes was attacked by Clouston, accusing him of eradicating the years of knowledge of psychological forms of insanity. Clouston thought that the established forms of insanity corresponded to physical states when he argued that 'certain French observers had the good luck to find out that in certain cases of insanity they could lay their finger on a particular portion of the brain as the diseased part'.<sup>62</sup> Clouston then claimed that the forms originally described by Pinel had seen some success amongst alienists such as Jean-Pierre Falret, Jean-Martin Charcot and, Georges Gilles de la Tourette. These were a set of physicians who were centred around the Salpêtrière in Paris, where a series of discoveries had been made since the 1860s which had made breakthroughs in linking observable symptoms such as facial tics and disordered speech, to disorders of the nervous system and disruptions to certain areas of the brain. This tradition had been characterised by a dualism between physical and mental symptoms, but physicians sought to resolve these two different spheres with research into pathologies. Clouston's argued that Pinel's forms of insanity needed to be retained, although these were only part of the story, because he thought that relying on mental symptoms alone could lead to misdiagnosis.<sup>63</sup> Yet, the kind of radical departure from the accumulated knowledge that Batty Tuke was calling for meant placing the future course of British psychiatric research on uncertain and untested foundations.

In addition to Clouston's criticisms, Skae himself waded in and turned Batty Tuke's criticism of his system on him by claiming that Batty Tuke was in fact doing aetiology and not pathology, although his own remarks were generally genial and contrite in their tone.<sup>64</sup> Skae conducted himself with the air of someone who relished disagreement and discussion on scientific physiology, even if his own work was the target of critique. He thought then that it was important to recognise that Batty Tuke's pathologies were in fact aetiologies because the natural groups that he had developed and which were criticised by Batty Tuke were the descriptions of collections of symptoms that occurred during certain points in the natural course of the disease. These were some of the last contributions Skae would make to research

---

<sup>61</sup> Ibid., (p.305)

<sup>62</sup> Ibid.

<sup>63</sup> Thomas Clouston, *Clinical Lectures on Mental Diseases*, Third Edition, J & A Churchill, 1892. (p.20)

<sup>64</sup> David Skae, remarks in opp. cit. 55.

into insanity: he would die less than three years later. Cited at length below, his last recorded remarks in these debates reveal insights into the very final ideas on classification from such an enigmatic and crucial figure in the history of classification in the British Isles:

What [Batty Tuke] sought in his paper was to point at natural groups. They were founded on causation, but not on that alone. He described climacteric mania. He did not say that that was the cause of insanity; but that at that particular period of the life of the female, insanity occurred which ran its natural course, and they had just to look for the symptoms [psychological phenomena]. It was the same with many other causes of insanity. He could tell a case of puerperal mania the moment he saw it. He did not mean to say what caused puerperal insanity, but where it occurred there must be *predisposition*. He believed that predisposition existed in every case of insanity. No remarks occurred to him with regards to Dr. Tuke's re-arrangement of his classification. It would require consideration but it seemed to be very good. He agreed with Dr. Clouston that they could only arrange those forms of insanity he had mentioned in certain groups or natural families. He did not think that they would gain much by dividing them into seven different classes.<sup>65</sup>

Skae's remarks indicate here that he had moved away from thinking that his concepts simply mapped causes, but the kinds of insanity he described were co-current with certain bodily conditions such as pregnancy. This would seem to make his classification redundant. John Sibbald, by this time assistant superintendent at Morningside asylum under Skae,<sup>66</sup> joined Clouston in defending Skae's classification, calling it the 'the only one that came anything near to the truth', and that whilst even 'Dr Skae, he believed, did not consider it good himself; [...] he thought it was the most practicable classification we had yet'.<sup>67</sup> Clouston thought that it was vital to differentiate the forms of insanity because this would allow alienists to isolate them from the 'general mass of unclassified insanity' and give a clearer understanding of the kinds of insanity that were being admitted into asylums across the British Isles.<sup>68</sup> However, despite these goals and the defence of the revisions that had been proposed by Clouston, Sibbald and Skae, the blows had landed and the revisions were not made to the Table of the Forms.

Despite the controversy surrounding his forms of insanity, Skae remained influential, and his disciples, led by Clouston, would continue to press for a Skae-inspired classification to replace the Table of the Forms. Crichton-Browne's attack on Skae's classification was motivated by fears that they would get their own way. In his attempt to thwart the aims of these disciples, Crichton-Browne criticised the conceptual basis of the forms Skae proposed. As outlined in the previous chapter, Skae thought that the natural history of the disease should

---

<sup>65</sup> Skae, remarks in *Ibid*.

<sup>66</sup> 'Obituary: John Sibbald' in *JMS*, July 1905, Vol.51, No.214, pp.636 – 637.

<sup>67</sup> John Sibbald, remarks in 'Report of a Meeting of Members of the Medico-Psychological Association, held at Glasgow, April 27<sup>th</sup>, 1870' in *JMS*, July, 1870, Vol.16, No.74, pp.295 – 306. (p.305).

<sup>68</sup> *Ibid*.



determine how it was classified in the hope that causes of insanity could be combined within his Table of the Forms of Insanity. Crichton-Browne's judgement was that Skae's ambitious task was conceptually confused, and that the current state of the data available to asylum superintendents could only make this a speculative endeavour. Skae had made a critical mistake according to Crichton-Browne because his aspiration for an aetiological system was wrong-headed, and he had in fact produced a pathological system. The judgment that he reached was harsh:

[Skae's pupils] will resent the indictment of the many counts brought against it – but the sooner they realise the justice of that indictment the better will it be for British Medical Psychology. The verdict sooner or later will be that this so-called classification is no classification, for it involves no act of comparison or judgement, but trusts to hearsay testimony, and is founded on conditions numerous, venial, and inextricably entangled. Griesinger says, with true wisdom, "Our classification [...] proceeds upon the symptomological method, and by such a method alone can any classification be effected."<sup>69</sup>

He went on to address the details of the concepts within Skae's system, the primary target being *idiopathic insanity*, a concept Crichton-Browne thought served no other purpose than being a junk category:

...there is the objection which has been before advanced by Dr. Maudsley and others, that at the tail of the classification there is a miscellaneous lot – *idiopathic insanity*, a refractory ward into which are forced all the recalcitrant cases that will not submit to the discipline of classification. Into this limbo march all cases that cannot be identified as belonging to any of the other thirty-four circles of madness, and in it we may suppose there is a strange and motley mob. We are told by Dr. Clouston that only one-tenth or one-twelfth of the whole number of the insane require to be placed in this group, but a medical friend of mine who tried on a small scale to apply Skae's system, and surviving the attempt, has assured me that about thirty per cent. of the asylum patients ought to be included within it.<sup>70</sup>

Ultimately, Crichton-Browne dismissed the classification offered by Skae as being a logically incoherent attempt to provide a firmer basis for psychiatric classification, and he went as far as to say that Skae could not decide whether to base his work on pathology or aetiology. If this was not enough, most serious of all was his judgement that it was impractical, and this was a potentially fatal blow because practical utility was one of the main appeals to overworked asylum medical superintendents. Crichton-Browne then could see no convincing arguments for the usefulness of Skae's classification system, and he used the pages of the *JMS* to launch his sustained attack against it.

---

<sup>69</sup> Ibid., (p.365)

<sup>70</sup> Ibid., (p.362)

Crichton-Browne sought to dispel the appeal Skae's classification had as an attractive alternative to certain members of the MPA, and why there was such a strong reaction against its adoption as the MPA's Table of the Forms of Insanity. Crichton-Browne's was one of the most vocal opponents of the tendency in Victorian psychiatry to reduce insanity in its various forms to being entirely a symptom of brain pathology, even as he established a research school dedicated to investigating insanity's physical treatments and its pathological causes.<sup>71</sup> Crichton-Browne was also a student of Thomas Laycock (1812 – 1876), another Edinburgh physician who unlike Skae attempted to synthesise psychological factors into his own classification system.<sup>72</sup> In contrast, the system proposed by Skae sought to explain all mental disorders through physical aetiology, and in doing so omitted psychological considerations, and the role that they played in the genesis of insanity.

Skae had formed a career long hostility towards phrenology, with his Royal Medical Society dissertation arguing against the existence of phrenological classification, in favour of the Kantian division of the mind into faculties.<sup>73</sup> He associated the symptomatic approach to the ties it had had to phrenology, which had enjoyed widespread popularity during his training: influential members of the MPA such as W.A.F. Browne (1805 – 1885), Crichton-Browne's father, subscribed for a time to phrenology, enthusiastically promoting the potential contributions it held towards advancing the newly established moral treatment.<sup>74</sup> Up until the 1850s, many mental scientists had hoped that phrenology may provide clues for the aetiology of disorders such as melancholia and monomania, and so attempted to establish links between brain physiology, the localisation of the characteristics described by phrenology, and the symptoms associated with the different forms of insanity.<sup>75</sup> According to Cooter, physicalists like Skae were motivated to eliminate psychological considerations in reaction to the influence of phrenology.<sup>76</sup> Whatever may be the case – filial defence may also have played a part – this over-reduction irked Crichton-Browne and he viewed the classification of Skae as being

---

<sup>71</sup> Michael J. Clarke, 'The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth Century British Psychiatry' in Andrew Scull ed., *Mad Houses, Mad Doctors and Madmen: The Social History of Psychiatry in the Victorian Era*, Athlone, 1981, pp.271 – 312.

<sup>72</sup> Joseph Melling and Bill Forsythe, *The Politics of Madness: the State, Insanity and Society in England, 1845 – 1914*, Routledge, 2006. (p.21)

<sup>73</sup> Michael Barfoot, 'David Skae: Resident Asylum Physician; Scientific General Practitioner of Insanity' in *Medical History*, Vol.53, No.4, Oct 2009, pp.469 – 488

<sup>74</sup> R.J. Cooter, 'Phrenology and British Alienists c.1825 – 1845: Part II: Doctrine and Practice', in *Medical History*, Vol.20 No.2, April 1976, pp.135 – 151

<sup>75</sup> *Ibid.* p.148

<sup>76</sup> *Ibid.*

emblematic of the somatic dogma that had gripped medical psychology during the second half of the nineteenth century.

Crichton-Browne held that psychological considerations should guide research into the nature of insanity in lieu of a major breakthrough into its aetiology, and that the symptom-based approach to insanity's classification had long-served well for clinical purposes. He also viewed this to be a nascent period in the development of the mental sciences, so although he thought that the six disease concepts that had been adopted by the Lunacy Commission and the MPA were far from perfect, they still functioned as useful heuristics for research because they served to group together the most common symptoms in practically useful diagnostic categories.<sup>77</sup> His fear was that Skae's system was conceptually incoherent so it did not even offer the benefit of being useful, and it could derail the progress of the mental sciences for a very long time to come. The coherency of the symptom-based approach to the classification of the forms of insanity allowed for the return of statistics that would be of some use in research because they at least mapped onto symptoms that were phenomenally apparent to clinicians, even if their causes were still a mystery. The same could not be said of Skae's system, so this battle was for Crichton-Browne about much more than a simple disagreement on what terms should be adopted within asylum admittance registers: the very future of the mental sciences was at stake, because a faulty conceptual basis to such a powerful resource as the statistics these registers would produce could set back research into the nature of insanity for decades to come.

Clouston in turn provided a rebuke to this attack on Skae's classification system in the next issue of the *JMS*.<sup>78</sup> Whilst Skae was good-humoured when discussion was directed towards his work, Clouston got personal, describing Crichton-Browne's reasoning as that of the 'uneducated', accusing him of 'childish sophistry' and claiming that the attacks levelled at Skae's system demonstrated 'the unwisdom [sic] of its author'.<sup>79</sup> He also rejected Crichton-Browne's claim that Skae had rejected Pinel and Esquirol's work, and argued that Skae's system could be made compatible with established the forms of insanity. He warned that to think of them as the 'true forms of mental disease was a scientific blunder', and investigations like Skae's were needed to connect the symptom based diseases identified by French clinicians to their natural histories.<sup>80</sup> Clouston then went on to argue that general paralysis, with manifestations of melancholia, mania and dementia, did not fit into the symptom based Pinelean system because

---

<sup>77</sup> As covered in the previous chapter, these concepts were: melancholia, mania, moral insanity, idiocy, and general paralysis of the insane.

<sup>78</sup> Thomas Clouston, 'Skae's Classification of Mental Disorder' in *JMS*, January, 1876, Vol. 21, No. 96, pp.532 – 500.

<sup>79</sup> *Ibid.* (p.534)

<sup>80</sup> *Ibid.* (p.536)

they were physical and not psychological diseases, and that they had merely been added to the established classification for convenience purposes.

At the Association's 1876 annual meeting, Clouston tabled a motion to appoint a new committee that would be responsible for the revision of the tables of statistics, and this was seconded by Joseph Lalor, another Edinburgh-educated asylum superintendent. Clouston's address concentrated on the tables that were compiled which recorded the form of mental disorder that a patient was suffering from when they were admitted to an asylum. As outlined, the AAMO and the Lunacy Board of England and Wales had harmonised the forms of mental disorder that they each used for the collection of data from asylums.<sup>81</sup> These were the basic forms developed by Pinel and Esquirol, yet some asylum superintendents used two diagnostic systems: one to fill out the admittance register that would be submitted to the Lunacy Board and the MPA, and another for their own use in the guidance of treatment. Clouston believed that the concepts that had until then been used for statistical purposes were out of date, and that since they had been established, there had been advances in the understanding of the link between psychological disorders and brain pathology. Clouston linked this to the increase in the number of patients residing within asylums, with the autopsies that were carried out upon them providing a rich source of data that he thought should be implemented into the collection of statistics.<sup>82</sup>

Clouston then thought that new statistical tables could incorporate the data that had been gathered within asylums since their mass expansion under the 1845 Lunacy Act. These would form new statistical tables, in particular, with the forms of insanity that were employed to diagnose patients, and that the existing diagnostic concepts of Pinel and Esquirol could be developed into, or replaced with, ones which captured the current state of the art in British psychiatric research.<sup>83</sup> Ultimately, Clouston argued that the forms of disorder that were used to classify patients in the collection of statistics would improve the quality of the numbers that were submitted, because if updated they would be describing disorders that were closer to the natural kinds that were discovered through physiological research. He pointed towards Germany and France as using more advanced statistical tables than the UK, and this was because they incorporated and collected more information due to the more cutting edge

---

<sup>81</sup> This was not the same for Scottish superintendents, with Clouston having used two forms of classification at Morningside asylum: one of his devising that was informed by the ideas of Skae, and another that was in line with the five-point classification that was being employed by the Lunacy Commission of England and Wales and the MPA.

<sup>82</sup> Thomas Clouston, 'Skae's Classification of Mental Disorder' in *JMS*, January, 1876, Vol.21, No.96, pp.532 – 500.

<sup>83</sup> Thomas Clouston, remarks in 'Annual General Meeting of the Medico-Psychological Association' in *JMS*, Vol.22, No.99, Oct. 1876, pp. 487 – 503.

concepts of psychopathology employed by them. Clouston urged any potential committee to scrutinise these statistical tables because the lessons that could be learned from them could help to provide the kinds of breakthroughs in research that the mental sciences needed at a time when asylums throughout the British Isles were seeing fewer discharges than hoped for, and were becoming more and more crowded.

Clouston thought that there were standout examples of model collections of statistics from British Isles, and he cited the work of Robert Boyd, superintendent of Somerset asylum and another Edinburgh trained physician. Boyd's annual reports provided a number of findings that Clouston thought the committee should consider; this is especially important when we consider that in his 1867 report Boyd dismissed the work 'of metaphysicians of emotion' and instead argued for a physicalist position which reduced all mental disorders to being fevers induced in stages of physical disease.<sup>84</sup> Boyd used this philosophy of insanity to argue for greater welfare and healthcare for the poor: if you could administer preventative medicine for bodily conditions, then asylums may cease to be clogged up with those who were in such a pitiful mental state that was caused by advanced physical illnesses.<sup>85</sup> In citing such a figure as Boyd then, it is clear that Clouston wanted to shift away from the symptom-based forms of insanity that had hitherto been used for diagnosis towards new concepts that incorporated observations on the relationship between psychological and somatic disease. Statistics collated in light of these considerations would guide the future research of the MPA, and would, in Clouston's mind, be one step towards achieving the kind of aetiological classification system that his teacher Skae had aspired, but had failed, to achieve. However, despite a great deal of preparatory work conducted by Clouston, the committee that was appointed to review the tables in 1876 never met,<sup>86</sup> and the Pinelean classification of mental disorder would continue to provide statistics that were used by the MPA as before.<sup>87</sup>

Momentum continued to grow behind the movement to change the ways in which patients suffering from insanity were classified, with many increasingly linking the concepts that were used to diagnose a patient as being linked to the treatment that they would receive. This was not entirely new in the final quarter of the century, with John Conolly as far back as the 1840s delivering lectures that linked the housing of patients to the form of insanity that they were suffering from. Conolly claimed that there were therapeutic benefits to patients with

---

<sup>84</sup> Boyd, 16<sup>th</sup> Annual Review

<sup>85</sup> Boyd, 16<sup>th</sup> Annual Review

<sup>86</sup> Ibid.

<sup>87</sup> D.G. Thompson, 'The Prognosis in Insanity', in *JMS*, Vol. 29, No.126, July 1883, pp.188 – 205.

melancholia and those with mania being housed with one another.<sup>88</sup> On the other hand, Conolly thought that grouping patients according to the form of insanity that they suffered risked accentuating and heightening their symptoms. He backed up these claims with observations on the benefits he had seen at his own Middlesex County Asylum when he placed together melancholic and manic patients.<sup>89</sup> Yet, despite this early interest, links between the kinds of insanity and treatment offered was not so widespread, with the difference being for the most part established between curable and incurable patients. Although forms of insanity such as dementia, idiocy and GPI were increasingly associated with incurable patients, asylum superintendents would not have specific treatments for these patients, so the diagnosis that they received on admittance was, as argued so far, primarily an administrative matter.

A key break from this was the argument made by Dr Monroe that some forms of insanity did not even require admittance to an asylum, and would be far better treated in private clinics.<sup>90</sup> This is a key development, because Monroe would be one of the first to state that insanity did not automatically require someone to be admitted to an asylum. His words predated the formal development amongst psychiatrists of the concept of the borderlands between sanity and insanity, and they also contested the degenerationist assumption that once the rot of madness set in it was a downward spiral towards the complete loss of the mental faculties. Monroe's argument stated the case for the importance of developing the forms of insanity so that diagnosis might be made which would prevent asylum treatment for those who did not need it, due to the specific needs of the form of insanity that they were suffering. He thought, in other words, that some of the milder forms of mania and melancholia did not need incarceration, demonstrating an understanding amongst some alienists of the need to differentiate between acute forms of insanity and their milder forms, and which of these required asylum treatment. This was the beginnings of the understanding that the asylum was not the one size fits all treatment for insanity, and that some forms of disorder could be spared the asylum. As such, it now required greater work on the correct diagnostic concepts to differentiate precisely those different kinds of mental disorder.

Renewed calls for the improvement of tables used to collect data from asylums were published in the *JMS* during the second half of the 1870s,<sup>91</sup> and attempts to revise them would

---

<sup>88</sup> John Conolly, *The Treatment of the Insane without Mechanical Restraints*, Smith, Elder and Co, 1856. (pp.94 – 95)

<sup>89</sup> *Ibid.*

<sup>90</sup> 'Proceedings of the Twenty-sixth Annual General Meeting of the Medico-Psychological Association, held at the Royal College of Physicians of London (by permission of the President and Fellows), on Thursday, August 3rd, 1871, under the Presidency of Henry Maudsley' in *JMS*, Vol. 17, No.79, Oct. 1871, pp.438 – 468. (p.460)

<sup>91</sup> Major, 'Dr. Major on Statistical Tables of the Causes of Insanity' in *JMS*, Vol. 23, No.104, January 1878, pp.573 – 575; P. Maury Deas, 'Five Years of Statistics', in *JMS*, Vol. 25, No.109, April 1879, pp. 8 – 9.

commence once again at the beginning of the next decade with the reappointment of the statistical committee. This would give rise to further debates concerning the most appropriate way to classify the different forms of insanity that were treated by asylum medical officers.

## Conclusion

Thus we can see how the Table of the Forms of Insanity increasingly became the focus of members of the MPA during the first wave of revisions of the statistical tables. In the attempts to increase the amount of data that was gathered by the MPA from asylums across the country, the forms of insanity that were employed by the Lunacy Commission were viewed as not gathering enough information on the conditions suffered by patients who were being admitted to asylums. It was hoped that revisions to the tables would provide information from across the United Kingdom's asylums that would bring about better understandings of the aetiology, pathology and treatment of insanity. Although the extra work required to fill in these tables was not welcomed by all, it ultimately was well received by the majority of members of the MPA.<sup>92</sup> The standardised data pooled from all institutions across England and Wales allowed complex cross-sectional analysis that held enormous potentials for the development of psychiatric knowledge. As the statistical tables began to include data relating to the different forms of insanity that were suffered by those admitted to asylums, this led to debates about what forms of insanity were to be included. During this early period of asylum data, the forms of insanity that were adopted were simply those that had been recommended by the Lunacy Commission from its establishment in 1845. In the next set of revisions, we begin to see attempts by the MPA to include forms of insanity that included aetiological considerations in the statistical tables, and will see how this triggered another set of debates about what the most appropriate kinds of concepts were to be employed in the classification of the different forms of insanity.

## Section 2: The Second Revision to the Statistical Tables: 1880 - 1882

Growing interest in the recovery rates from the different forms of insanity partly led to calls to revise the statistical tables once again in 1880.<sup>93</sup> The hope was that if the tables were revised correctly, then they would provide better data which would lead to useful findings about how

---

<sup>92</sup> See Sir John Charles Bucknill, *The Care of the Insane and their Legal Control*, London, Macmillan, 1880, p.51.

<sup>93</sup> Daniel Hack Tuke, 'On the Best Mode of Tabulating Recoveries from Insanity in Asylums Reports', Vol 26, No.115, Oct. 1880, pp.375 – 383; Campbell, remarks in 'Report of the Thirty-fifth Annual Meeting of the Medico-psychological Association' in JMS, Vol.26, No.115, Oct. 1880, pp.444 – 460. (p.449)

long those who suffered from each of the different forms of insanity tended to stay in asylums, and whether they were at any point discharged.<sup>94</sup> Asylum superintendents suspected that a diagnosis of dementia would not provide a very good prognosis, with the admission likely to remain in the asylum until their death. Those diagnosed with a mania would also, in all likelihood, have a very long stay, and perhaps would never be released, yet hope remained for those diagnosed with a form of melancholia, who tended to see the best recovery rates. Those classified as idiots would often find themselves in different institutions entirely, especially since the passing of the 1866 Idiocy Act, which made different provisions for those diagnosed with forms of insanity that were considered either congenital, or had existed from birth.<sup>95</sup>

The debates that occurred from July 1880 would lead to a new Table of the Forms being published in 1882. The revisions committee attempted to make a compromise between the disciples of Skae and those who wanted to retain the existing symptom based concepts of mental disorder. In order to placate conservatives like Crichton-Browne who wanted to retain a tried and tested classification system and whom were fearful of Skae's system, which they regarded as being highly speculative and experimental in nature, the main classes from the old Table of the Forms were retained. To satisfy those who demanded aetiological classification concepts, sub-classes of each of the main classes of the existing Table of the Forms were introduced. The crucial element of this compromise however was that filling in these sub-classes was deemed optional, and this undermined the attempt to have Skae's classification introduced as the new standard. This compromise then meant that the question of the MPA's standard forms of insanity would not be settled at the end of these debates, leaving this issue unresolved at the end of the nineteenth century.

This second phase in the revision of the statistical tables commenced with the reappointment of the committee in July 1880. Thomas W. McDowell, who had served as a pathologist under Crichton-Browne at the Wakefield asylum, put forward this motion,<sup>96</sup> and it was seconded by Henry Sutherland who had also spent time with Crichton-Browne during his training years spent in Wakefield.<sup>97</sup> McDowell did not have the kind of lofty aspirations Clouston had when Skae's disciple had proposed the first motion to revise the statistical tables in 1876. Instead, this re-appointment of the committee was an historical fluke due to McDowell

---

<sup>94</sup> Ibid.

<sup>95</sup> Bartlett, Peter. *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England (with special Emphasis on Leicestershire and Rutland)*, PhD Thesis, UCL, 1993.

<sup>96</sup> Michael Anthony Finn, *The West Riding Lunatic Asylum and the Making of the Modern Brain Sciences in the Nineteenth Century*, PhD Thesis, Leeds, September 2012, (p.77)

<sup>97</sup> 'Obituary: Henry Sutherland' in *JMS*, Vol. 48, No.200, January 1902, pp.208 – 209.



querying the progress of revisions that he believed were taking place.<sup>98</sup> Upon hearing that the committee in charge of them had not sat, McDowell called for its reappointment to consider how the MPA could improve the quality of the data being collected on the forms of insanity that were admitted to asylums.<sup>99</sup> To achieve this, the committee was given the task of revising the tables once again in order to ensure uniformity of the data that were submitted by asylum superintendents across the country in their annual reports.

The committee presented their proposed statistical tables the following year at the 1881 AGM.<sup>100</sup> The secretary for the committee, Henry Rayner, took the floor and proposed that the statistical tables be approved without discussion, and that instead of discussing them there and then, feedback should be mailed directly to the committee by members of the association and the regional divisions. He appealed for power to be granted to the revisions committee to implement the revised statistical tables once any minor adjustments were made based upon members contacting the committee with their suggestions. Rayner stated that this move would allow the committee to implement the revisions as soon as possible, but this was met with disapproval, with prominent members of the Association also raising their voices in protest, including Thomas Clouston. The revisions were considered to be a matter of such importance that they needed to be discussed at the annual general meeting of the Association, one of the most elite public forums for British alienists. It was suggested instead that the tables be sent for discussion to the regional divisions of the Association for further discussion before the next year's annual meeting, where they would be discussed in light of feedback gathered from members across the British Isles.<sup>101</sup> Whether this was a political move or not is difficult to tell: it may be the case that Rayner was sincere with his desire to not take up precious time during the annual meetings to discuss the minutiae of the statistical tables, as this was after all the only opportunity for members from across the British Isles to meet, with some of the most eminent names in British alienism attending, including John Charles Bucknill, Henry Maudsley, Crichton-Browne, and Daniel Hack Tuke. Rayner may also have wanted to prevent a repeat of the kind of bombastic debates that surrounded previous revisions of the statistical tables: MPA annual general meetings were becoming more and more prestigious events, with increasing membership seeing bigger audiences. Even the learned members of the Association may at

---

<sup>98</sup> Dr Blandford, remarks recorded in 'Report of the Thirty-fifth Annual Meeting of the Medico-Psychological Association', in *JMS*, Oct. 1880, pp.444 – 460. (p.447).

<sup>99</sup> *Ibid.*

<sup>100</sup> Henry Rayner, remarks recorded in 'Report of the Thirty-Sixth Annual General Meeting of the Medico-Psychological Association' in *JMS*, Vol.27, No.119, pp.434 – 444. (p.440)

<sup>101</sup> *Ibid.*

times let the occasion go to their heads, and Rayner's proposal to switch the discussion to the *JMS* may have been a strategy to elicit a clearer headed discussion of the Table of the Forms of Insanity proposed by his statistical committee. Either way, Rayner's plan was emphatically rejected by the president of the MPA Dr. G.W. Mould, superintendent of the Cheadle Lunatic asylum, and a motion was passed to present the revisions to the regions before they would be discussed at the next annual general meeting.<sup>102</sup>

Prior to this, J.A. Campbell complained that the table proposed by the committee divided the forms of insanity into 'curable' and 'incurable' forms:

Table XI. subdivides the patients in a valueless mode. The first division into curable and incurable is clearly antagonistic to what should be, from a physician's point of view, and some of the other subdivisions are unworkable.<sup>103</sup>

This is the beginning of a concern that what Skae had done with aetiology was now being carried out with prognosis, in that unproven assumptions were being made about the future course of a disease, and the potential to cure patients. Campbell's fear was that curable and incurable being such a prominent feature of classification would over-determine the treatment that was provided to a patient. There was limited knowledge about the prognosis of each of the forms of insanity during this period, and Campbell is giving voice to fears that mistaken assumptions about how to classify patients along these lines may have a detrimental impact upon the treatment that they receive. Matters relating to prognosis were beginning to gather more and more attention from members of the MPA, but they would come to prominence in the round of revisions that would take place between 1902 and 1906 and which will be explored in the next chapter.

---

<sup>102</sup> G.W. Mould, remarks recorded in *Ibid.*

<sup>103</sup> J.A. Campbell, 'Proposed Statistical Tables' in *JMS*, Vol. 28, No.122, July 1882, pp.318 – 319.

**TABLE XI.**  
*Showing the form of Mental Disorder in the Admissions, Recoveries, and Deaths of the Year 18 , and of Inmates on 31st December, 18 .*

FORM OF MENTAL DISORDER.	ADMISSIONS.			RECOVERIES.			DEATHS.			REMAINING IN ASYLUM.		
	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.
Congenital or Infantile Mental Deficiency...												
" $\alpha$ with Epilepsy ...												
" $\beta$ without Epilepsy ...												
Epilepsy acquired ...												
General Paralysis of the Insane ...												
<b>Mania—</b>												
" Acute ...												
" Chronic ...												
" Recurrent ...												
" A Potu ...												
" Puerperal ...												
" Senile ...												
<b>Melancholia—</b>												
" Acute ...												
" Chronic ...												
" Recurrent ...												
" Puerperal ...												
" Senile... ...												
<b>Dementia—</b>												
" Primary ...												
" Secondary ...												
" Senile ...												
" Organic (i.e., from Tumours, } Coarse Brain Disease, &c.) }												

Figure 12: Recommended Changes to the Table of the Forms of Mental Disorder Presented to the Annual General Meeting of the MPA in 1882.<sup>104</sup>

Upon the reconvening of the discussions surrounding the Table of the Forms at the 1882 meeting, Clouston stated that the tables were ‘like everything else in this country [...] a compromise between the views of a great many members of this Association’.<sup>105</sup> Although this address was delivered with ostensible congeniality, Clouston may well have been making a subtle slant at the failure of the Association to deliver anything that lived up to hopes for tables that he originally had had: that they would be informed by the latest in pathological research and that there would be radical changes that would be in-line with what he considered to be the state of the art. For him, all compromise had achieved was to retain a classification that very strongly resembled the one that was originally used, but with optional classes that related to bodily causes.<sup>106</sup> Hack Tuke’s response to Clouston’s criticism was that:

When Dr. Clouston proposed the Committee, he said that such was the advance of cerebral pathology that he hoped some of our tables could be improved in accordance with it, but he was sorry to say the Committee found that to attempt to construct any tables based upon our advance in cerebral pathology could not be carried out. The Table of the Forms of mental disease agreed upon was, he

<sup>104</sup> ‘Report of the Thirty-Seventh Annual General Meeting of the Medico-Psychological Association’ in *JMS*, Vol. 28, No.123, Oct. 1882, pp.437 – 462. (p.460)

<sup>105</sup> *Ibid.*

<sup>106</sup> Thomas Clouston. Remarks recorded in ‘Medico-Psychological Association: Quarterly Meeting January 1882’ in *JMS*, Vol. 28, No.121, April 1882, pp.136 – 146.

thought, a workable one. It was not absolutely necessary to fill up the sub classes. The table would be practically complete if any superintendent preferred filling up only the major and omitting the minor or sub-classes.<sup>107</sup>

Campbell also objected that the statistical tables did not collect enough information about the physical condition of the patient upon admission, and claimed that findings were increasingly suggesting 'physical causes to be more and more the cause of mental disease.'<sup>108</sup> He also expressed concern at the disruption caused by the introduction of a flawed system for only one year.<sup>109</sup> Despite his criticisms, Clouston suggested that the tables be adopted for one year in a trial form, and that the committee be reappointed so that it could receive feedback from members of the Association. He successfully appealed to Daniel Hack Tuke, the chair at that meeting, for them to be passed without discussion. Hack Tuke then addressed the meeting, and stated that the Table of the Forms was the most contentious out of the statistical tables.<sup>110</sup> According to Hack Tuke, this demonstrated that the main contention amongst psychiatrists at this point were the causes of insanity, and this needed more research before the kind of certainties that Skae had offered in his classification system could be confirmed. Resistance to a system that resembled Skae's being adopted as the standard classification, which integrated the causes of insanity into its disease concepts, arose because of fears that in implementing them into the classification, the causes would become difficult to change in light of future research. To put it another way, in standardising causation, the Table of the Forms of Skae could be in danger of settling the debate on the aetiology with speculative causes which would inhibit the development of psychiatric knowledge. Like Crichton-Browne, Skae's detractors held that the knowledge on the physical causes of mental disorder was still crude, and the aetiology presented in his system did not account or explain variations in behaviour and other symptoms observed in patients.

A large committee of eighteen members was appointed in response to these calls to revise the statistical tables. Hack Tuke was nominated as chairman of this revisions committee due to his prominent role within the association, and Henry Rayner, due to his previous work and expertise on statistics, was appointed as secretary. Prominent members included John Sibbald, who was at that time the Commissioner in Lunacy for Scotland who had worked under Skae at the Edinburgh Royal Asylum, and had been a colleague of Clouston, who also served

---

<sup>107</sup> Ibid.

<sup>108</sup> J.A. Campbell, remarks recorded in 'Medico-Psychological Association: Quarterly Meeting January 1882' in *JMS*, Vol.28, No.121, April 1882, pp.136 – 146.

<sup>109</sup> Ibid.

<sup>110</sup> Daniel Hack Tuke, remarks recorded in Ibid.

on the committee.<sup>111</sup> Herbert Major was also appointed, who had succeeded Crichton-Brown as medical superintendent at the West Riding Lunatic Asylum. Major had previously expressed hopes in the pages of the *JMS* that carefully compiled statistical tables would yield more reliable details and numbers on the admissions to asylums, and this would in turn allow for more reliable deductions to be made on treatment, prognosis and the causes of insanity.<sup>112</sup> Other members of the committee included Campbell, who due to having previously worked on statistics, including a call for uniformity of statistics published in the *JMS* in 1873, and a defence of the use of Skae's classification as the standard;<sup>113</sup> William Henry Parsey, who served as president of the MPA in 1876 and was London trained;<sup>114</sup> Isaac Ashe, steward to Bethlem, who had published research in the *Journal of Mental Science* on general paralysis;<sup>115</sup> Robert Boyd who as discussed, had made a number of contributions to the debates concerning statistics that occurred in 1869 – 70; Hayes Newington, who would rise to become a prominent member of the society during the early part of the twentieth century, was a part of the Newington dynasty that had established the Ticehurst asylum and had trained in London and at Morningside Asylum in Edinburgh under the stewardship of David Skae;<sup>116</sup> James Murray Lindsey, another Edinburgh trained alienist who worked with Sankey at Hanwell County Asylum;<sup>117</sup> William Chapman Begley, who had worked with John Connolly again at the Hanwell Asylum;<sup>118</sup> and TW McDowall.

The tables produced by this large elected committee retained the separation between causations of mental disease and the forms of insanity. Aetiological considerations had still not been incorporated into the core concepts of this committee's classification. Instead, it was recommended that data relating to apparent causes and the form of mental disorder suffered by a patient be kept separate, in the hope that these could be cross referenced to arrive at findings concerning the aetiology of mental disorders. Although it presented a series of causes that it hoped would be used by asylum superintendents, the committee recommended that new causes that were not already in there be included at the discretion of the superintendent. Importantly, it stressed the need for superintendents to provide only one cause of mental illness for a

---

<sup>111</sup> 'Obituary: John Sibbald' in *JMS*, Vol.51, No. 214, July 1905, pp.636 – 637.

<sup>112</sup> Hebert C. Major, 'Remarks on the Results of the Collective Record of the Causation of Insanity' in *JMS*, Vol.30, No.129, pp.1 – 7.

<sup>113</sup> J.A. Campbell and J. Todd, 'Uniformity in Public Asylum Reports', Vol.19, No.85, April 1873, pp.67 – 78. (p.69)

<sup>114</sup> 'Obituary: William Henry Parsey' in *JMS*, Vol. 30, No.129, April 1884, pp.166 – 167.

<sup>115</sup> Isaac Ashe, 'Some Observations on General Paralysis' in *JMS*, Vol. 22, No.97, April 1876, pp.82 – 91.

<sup>116</sup> 'Obituary: Herbert Francis Hayes Newington', in *JMS*, Vol. 63, No.263, Oct. 1917, pp.461 – 467.

<sup>117</sup> 'Dr James Murray Lindsay' in *JMS*, Vol. 58, No.240, January 1912, p.197.

<sup>118</sup> 'Obituary: William Chapman Begley' in *JMS*, Vol. 33, No.142, July 1887, pp.337 – 339.

patient, but information relating to heredity and previous attacks could be included alongside because the committee thought that information relating to the heredity, or family background, of a patient was an important and valuable line of research. The committee encouraged superintendents to add supplementary data that would allow for other ‘predisposing and exciting’ factors to be included, which could be clustered together in the analysis of asylum statistics.<sup>119</sup> Yet, the attempt to derive statistics which would be structured around one primary cause signalled a desire by the committee to arrive at statistics that would benefit efforts to understand the aetiology of mental disorders.

Statistics relating to aetiology were to be cross referenced with those pertaining to the form of mental disorder suffered upon admittance to the asylum. The concepts recommended were still not much changed from the symptom-based division of insanity that had been adopted before by the Lunacy Commission. The exception to this was the addition of GPI and epilepsy as primary classes of the forms of insanity, along with the four classes developed by Pinel and Esquirol (mania, melancholia, idiocy, and dementia). This had frustrated Clouston’s aim to bring them more into line with research into brain pathology and realise Skae’s hopes of a classification of insanity that was based upon an aetiology of mental health disorders. This had been frustrated due to the lack of any clear breakthrough in research tying physiological states to psychological conditions. Furthermore, with asylums filling up and placing increased professional demands upon asylum superintendents, of which the committee was undoubtedly aware due to many of the members being practicing medical superintendents, an emphasis was placed on making ‘the [recording of the] forms of mental disorder in those admitted in as practical a manner as possible’.<sup>120</sup> As the table below demonstrates, certain sub-classes were included which included aetiological factors, such as pregnancy and alcoholism, and this was because alienists of the time believed there to be a strong connection between certain forms of mania and these so-called exciting factors.<sup>121</sup> The committee recommended that these sub-classes be used at the discretion of the superintendent, and they were free to not use them at all, as long as they conformed to the main forms of mental disease that were included in the statistical table.

The product then was a classification that conformed to the bureaucracy surrounding asylum governance, but with the causation table there was the hope that data on admittance,

---

<sup>119</sup> Daniel Hack Tuke et al., ‘Report of Committee on the Statistical Tables of the Medical-Psychological Association’, in *JMS*, Oct. 1882, pp.463 – 464.

<sup>120</sup> *Ibid.*

<sup>121</sup> For a full treatment of puerperal insanity see Hilary Marland, ‘Destined to be a perfect recovery’: the confinement of puerperal insanity in the nineteenth century’ in Melling and Forsythe eds., *Insanity, Institutions and Society, 1800 – 1914: A Social History of Madness in Comparative Perspective*, Routledge, 1999, pp.137 – 156.

discharge, occupation, marriage and duration recorded in other tables issued by the MPA could be cross referenced to provide more insight into lunacy. In this way then, the statistical committee functioned as a committee addressing matters related to classification of mental disorders. It stated that the primary forms of classification were included in 'the Lunacy Blue book', slang for the Commissioner's Annual Report. The statistical report was penned by Henry Rayner and Daniel Hack Take, the president at the time.

NUMBERS OF INSTANCES IN WHICH EACH CAUSE WAS ASSIGNED.						
CAUSES OF INSANITY.	Admissions {		No. of Cases.		T.	
	M.		F.		Total.	
	As predisposing cause.*		As exciting cause.		As predisposing or exciting (where these could not be distinguished).	
	Male.	Female.	Male.	Female.	Male.	Female.
	Total.	Total.	Total.	Total.	Total.	Total.
MORAL: Domestic trouble (including loss of relatives and friends) ...						
Adverse circumstances (including business anxieties and pecuniary difficulties) ...						
Mental anxiety and worry (not included under the above two heads), and overwork ...						
Religious excitement ...						
Love affairs (including seduction) ...						
Fright and nervous shock ...						
PHYSICAL: Intemperance in drink... sexual...						
Veneral disease ...						
Self-abuse (sexual) ...						
Over-exertion ...						
Sunstroke ...						
Accident or injury ...						
Pregnancy ...						
Parturition and the puerperal state ...						
Lactation ...						
Uterine and Ovarian disorders ...						
Puberty... ..						
Change of life... ..						
Fevers ... ..						
Privation and starvation ... ..						
Old age ... ..						
Other bodily diseases or disorders ... ..						
Previous attacks ... ..						
Hereditary influences ascertained (direct and collateral)... ..						
Congenital defect ascertained ... ..						
Other ascertained causes ... ..						
Unknown ... ..						

NOTE.—\* With reference to the distinction between "predisposing" and "exciting" causes, it must be understood that no single cause is enumerated as both predisposing and exciting in the case of any individual patient.  
 † The figures in the Total column represent the entire number of instances in which the several causes (either alone or in combination with others) were stated to have produced the mental disorder. The excess of the aggregate of such causes over the number of patients admitted is owing to combinations of causes.

Figure 13: Recommended Changes to the Aetiological Table of the MPA Presented by The Statistical Committee and presented at the 1882 Annual General Meeting of the Association.<sup>122</sup>

<sup>122</sup> 'Report of the Thirty-Seventh Annual General Meeting of the Medico-Psychological Association' in *JMS*, Vol. 28, No.123, Oct. 1882, (pp.437 – 462) (p.459).



The Table of the Forms that was produced by this committee preserved the four classes that were used by the Lunacy Commission, but added ‘Acquired Epilepsy’, and ‘General Paralysis of the Insane’ to make six primary categories. It added sub categories to each of the original four classes: congenital deficiency was divided into two classes of with and without epilepsy; mania was divided into acute, chronic, recurrent, *a potu*, puerperal and senile forms; melancholia was divided into acute, chronic, recurrent, puerperal and senile types; and finally dementia was divided into primary, secondary, senile and ‘organic’ (ie. From tumours, coarse brain disease, etc)’. The classification did not include in-depth descriptions of the disorders that were included in the classification, and it mixed terms which were symptomatic with aetiological terms, such as ‘organic dementia’. We can see then that there is a desire to expand upon the symptom-based classification system used by the Lunacy Commission on the behalf of the committee by including aetiological, and biological factors that were thought to contribute to the development of mental disorder. This is seen most clearly in the differentiation in the Table of the Forms between two sorts of epilepsy: ‘acquired’ and ‘congenital’. It also could be the case that the committee chose to make additions rather than make wholesale revisions because it was still being used by the Lunacy Commission. The problem with this however was that the concepts of Pinel and Esquirol were still being employed in diagnosis within asylums and data collections of admittances, so it is possible to see how these concepts, although they were beginning to be questioned by members of the Association, were ‘locked in’ by a complex set of institutional factors. Although there was little belief that these were the best concepts to be employed in diagnosis, they would continue to be used after these recommendations were made. Administrative and legal factors meant they were too deeply ingrained into the practice of medical psychology. An announcement of the approval of the Statistical Tables was published in January 1883 in the *JMS*, and it called for members to use the tables in their annual reports; and whilst they were not limited to recording the statistics that were required to fill in the tables, they were requested to fulfil the basic requirements of them. Members of the MPA were also requested to send any problems they had experienced with them during their year’s trial to Rayner as the secretary of the committee.<sup>123</sup>

The Table of the Forms of Insanity included in the statistical tables that were approved by the 1882 statistical committee were left mostly unchanged, apart from the addition of

---

<sup>123</sup> Anon, ‘The Statistical Tables’ in *JMS*, Vol. 28, No.124, January 1883, (p.653).

*delusional insanity* as a main class and *moral insanity* as an optional class. These were added to the statistical tables in 1883, when the call was made to members of the MPA for feedback on the statistical tables, when the tables appeared in a version of the classification that was included in a statement, drafted by Rayner on behalf of the council of the MPA, and presented in September 1885 to the International Congress of Psychiatry in Antwerp.<sup>124</sup> This was part of a discussion set to pave the way for an international classification, and associations from the main centres for psychiatric treatment were asked to submit their official classifications for consideration. Writing in the *JMS* the following year, Rayner stated that the MPA had decided to submit the forms of insanity that were included in the statistical tables that came from the last round of revisions.<sup>125</sup>

The statement was clear that the council would, in its submission to the International Congress of Psychiatry, stress ‘that a classification intended for international adoption [...] be extremely simple’ and that such a classification allow ‘individual alienists to add supplementary sub-divisions’ where they deem necessary.<sup>126</sup> This statement by the MPA demonstrates the dominant attitude to the classification of insanity that existed in the period: practical efficiency over theoretical complexity, and a pragmatist attitude to psychiatric classification over a form of scientific that wanted the forms of insanity to correspond to natural kinds. This attitude would continue to dominate the proceedings of the next set of revisions, although there were notable individuals who, like Skae, would resist this pragmatism and push for a classification that would be tied either to aetiology, or like Batty Tuke, would be tied to pathology. In doing so, the hopes were that that psychiatry could either tie-in the symptom-based concepts that had been developed since Pinel, or eschew them completely in favour of diagnostic concepts that included aetiological or pathological factors within them. This is where we turn to the next set of major revisions, that would explicitly discuss the role of psychiatric classification, instead of it being an adjunct to statistical data garnered from asylums.

## Conclusion

The discussions surrounding the statistical tables explored in this chapter demonstrate the tables functioned as a catalyst or trigger for discussions on what a standardised classification should look like. Growing dissatisfaction with the symptom based classification that was used in admissions led to a clash between aetiologists influenced by Skae and those who did not think his concepts captured the causes of mental disorder. Attempts to revise the statistical

---

<sup>124</sup> Henry Rayner, ‘Classification of Insanity’ in *JMS*, Vol. 32, No.138, July 1886.

<sup>125</sup> *Ibid.*

<sup>126</sup> *Ibid.*, (p.234)

tables along aetiological or pathological grounds, as we saw with Batty Tuke, were unsuccessful because in opposition to these radical attempts to revise the forms of insanity, a number of other alienists favoured sticking with the Pinelean concepts, despite the growing questioning of their relevance and validity. These oppositions were fuelled by two concerns: first, exemplified by Crichton-Browne, who thought that Skae's system was conceptually flawed and inconsistent, and would place the future course of research into the causes and treatment of insanity on a misguided path; and second, exemplified by the Lunacy Commission and many members of the MPA, who wanted a simple set of diagnostic concepts that would not complicate the submission and collection of statistics relating to asylum admittances.

This reflects changes in the role of the asylum superintendent from that of a skilled practitioner, who used loose diagnostic concepts to make a skilled judgement on the condition suffered by a patient, to that of a professional who must make diagnosis according to a set of uniform concepts prescribed by a central administrative body. This development is an often over-looked feature of the history of psychiatry, but the episode in the history of psychiatric classification in the British Isles considered in this chapter allows a greater understanding of how the history of clinical thought has been shaped by developments in asylum administration and expansion. The drastic increase in the number of patients led to a call for accurate statistical data that would help with research.

To achieve this the MPA needed to have uniformity of the concepts of mental disorder that were used to collect data, and to some extent, a uniformity of the recognised causes of insanity. It would be an easy story to tell if it were as simple as a centralised and bureaucratic MPA imposing a set of diagnostic criteria that many of its members objected to, wanting to retain their autonomy yet forced to change due to classifications promoted by a few; but this is not the case. Rather, from reading the records of the MPA, it is clear that there was a recognition of the dilemma: either embrace new but potentially faulty diagnostic concepts that incorporated aetiology into a more complex Table of the Forms that made more differentiations based upon the known or speculated causes of insanity, or retain the tried and tested forms that included fewer concepts that allowed greater discretion to medical superintendents when it came to diagnosis. Whilst the MPA did not want to impose upon its members something that was not uniformly accepted, it needed to progress in terms of research, and improving the quality of statistics concerning activities in asylums was viewed as being the best way to achieving the breakthroughs that the discipline was so desperately in need of: by the 1860s, the new generation of county asylums were beginning to become crowded with patients due to relatively low discharge rates, and cures for insanity were desperately needed.

The hope that these revisions would lead to statistics that could be used for research was the driving factor behind the changes, but the fear of completely replacing a symptom based forms of insanity that was viewed to have functioned well enough led to a compromise: the introduction of a table of causes and the addition of aetiological sub-classes to the Table of the Forms. This, combined with the daily and practical demands placed upon asylum superintendents, led to the MPA adopting a uniform classification of mental disorders. Because of these everyday pressures, it was thought that it would be easier to solve two problems at once by adopting and slightly modifying the classification that was already being used by the lunacy commission. In a lot of ways then, the development of the statistical tables, and the way that it led the MPA into reluctantly revising the forms of insanity, reflects the changing role of the asylum superintendent from being a figure of intellectual authority with much control over the running of their institution, to being one that was becoming increasingly subordinate to regulatory bodies and wider bodies of research in the British Isles and across Europe.

The classification that was produced in 1882 signalled a compromise between Skae's followers and those who wanted to stick with the classification concepts that had been introduced by Pinel and which had been used for around half a century. They had proven to be effective, even if vague and potentially leading to misdiagnosis. The concern with Skae's system were so severe that some thought their adoption could lead to the corruption of asylum statistics, putting into jeopardy the future of psychiatric research. Ultimately, the diagnostic concepts that were established attempted to compromise by including categories that were along the Pinealean lines, yet introduced sub-classes picked from Skae's aetiology, although the use of these sub-classes was optional. This compromise signals wider cracks that were appearing in the aspirations for a scientific psychiatry, one which would provide mechanistic, somatic explanations for the different forms of insanity. The increased importance placed upon statistics during this period and during these discussions reflects the lack of pathological breakthroughs in the study of madness, and statistics garnered from asylum admittances were increasingly being viewed as the horizon on which future discoveries would be made.

# Chapter 3: A Higgledy Piggledy Conglomeration: Prognosis and the 1906 ‘Proto-Kraepelinian’ Classification of the Medico-Psychological Association

## Introduction

By the late 1880s, concern over psychiatric diagnosis was no longer just a professional concern, with fears growing amongst the public about wrongful confinement in lunatic asylums, and trust in the judgement of psychiatrists being questioned. Whilst there had long been criticisms of asylums and nefarious doctors willing to admit sane individuals, psychiatrists now increasingly felt the need to defend their practice and their status. In August 1888, Daniel Hack Tuke engaged in correspondence with the editors of *The Times* disputing a pair of claims that had been made in a review of the latest *Report of the Commissioners of Lunacy* concerning psychiatric diagnosis in the British Isles: the first, that insanity on was on the increase and the second, that it was more frequently diagnosed in women than in men.<sup>1</sup> Tuke, one of the most prominent psychiatrists in the United Kingdom, insisted that neither of the interpretations of the statistics included in the report were correct: he dismissed as a fallacy the claim that there was an increase in the rate of insanity, and he dismissed the possibility that there could be any differences in the diagnosis of insanity between genders.

Tuke dismissed both of the reviewer’s claims, deigning that any difference in gender be unworthy of comment, and explaining away the increase in insanity by accusing the reviewer of conflating an increase in the diagnoses of insanity with the actual rate of insanity amongst the population. Instead, he claimed that the rate of insanity had been constant during this period, and the increase in numbers could be explained by the expansion of asylum treatment which meant that the increase in diagnoses of insanity was inevitable.<sup>2</sup> Right or wrong, the review demonstrates the prevailing public attitude: that to be diagnosed insane meant passing through the doors of an asylum, and growing asylum numbers meant growing insanity.<sup>3</sup> As historian of

---

<sup>1</sup> The reviewer had compared the numbers published that year to ones to ones that were published in the 1859 version. The conclusion was that insanity had risen, with there being ‘one known lunatic to every 535 of the population [whereas] [o]n the 1<sup>st</sup> January in the present year there was one known lunatic to every 346 of the population, or a total of 82,643’; the he second claim was that ‘male lunatics were one to every 370 of the population, while female lunatics were one to every 326’: Daniel Hack Tuke, ‘Lunacy Statistics: To the Editor of the Times’ in *JMS*, Vol. 34, No.147, Oct. 1888; *The Times* (London, England), August 30, 1888, No.32478, p.6

<sup>2</sup> Ibid.

<sup>3</sup> The historiography on the debate over the increase in insanity during this period is extensive and whether there was an actual increase in the rate of insanity is debatable. Hare gives an assessment of the historical debate, claiming that there was in fact an increase in the rate of insanity, which he interprets as being a schizophrenia-like disorder, and points towards dietary and viral factors as explanations. Social historians like Scull take the view that the rise in the rate of insanity can be explained as part of a wider political project of ‘social control’ of the mad, and the removal of their potentially disruptive force from a means of production was in the interests of workhouse owners: mad doctors were in cahoots with this plan because of professional interests tied to treating more people. Others

psychiatry Andrew Scull notes, the ‘institution was, of course, the almost exclusive arena in which the new profession plied its trade’ observing that the ‘asylum was itself a major weapon [...] in the struggle to cure the insane’.<sup>4</sup> Although historians such as Akhito Suzuki have questioned this view by looking at home care during this period, it remains the case that for the most part, those receiving a diagnosis of one of the forms of insanity would have been admitted to an asylum.<sup>5</sup> For the most part, insanity was still being used as a catch all term in statistical investigation to designate a wide variety of mental disorders. The assistant to William Farr at the General Registry Office (GRO), Noel Humphreys, in his 1890 paper on statistics on insanity wrote that:<sup>6</sup>

It should moreover be explained that the word insanity is used in this paper as a generic term, signifying all forms of mental unsoundness, and includes all degrees and all varieties of mental unsoundness, which is classed, by the various authorities called upon to deal with the insane, as lunacy, idiocy, or imbecility. In the Census Report for 1881, it was pointed out that no accurate line of demarcation can be drawn between the general conditions indicated by the terms lunatic, idiot and imbecile; although generally speaking, the term lunatic is used to describe persons suffering from the more acute forms of mental disease; idiot to describe those suffering from congenital mental deficiency; and imbecile, to describe persons suffering later in life from chronic dementia.<sup>7</sup>

In response, George Savage observed that the lack of any kind of differentiation of the forms of insanity in Humphrey’s paper made it difficult to draw firm conclusions about the diagnosis of insanity, and whether it was on the increase:

[...] he felt the futility of collecting statistics, for it might be that though there was no great increase of insanity as [qua] insanity, the form of mental disorder was changing for the worse. Insanity being, as Dr. Tuke had said, a relative term, there

---

such as Kathleen Jones also take the view that the increase is artificial, but that the humanitarian desire to care for the insane was behind the increase in admittances. See: Edward Hare, ‘Was Insanity on the Increase?’ in *BJP*, Vol.142, No.5, May 1983, pp.439 – 455, (p.451); Andrew Scull, ‘Was Insanity Increasing? A Response to Edward Hare’ in *BJP*, Vol.144, No.4, Apr. 1984, pp.432 – 436; ‘The Rise of the Asylum’ in *The Most Solitary of Afflictions: Madness and Society in Britain 1700 – 1900*, Yale University Press, 1993, pp.3 – 45; Kathleen Jones, *Mental Health and Social Policy, 1845 – 1959*, Routledge, 1960. (p.22).

<sup>4</sup> Andrew Scull, ‘The Social History of Psychiatry in the Victorian Era’ in Andrew Scull ed., *Madhouses, Mad-doctors and Madmen*, pp.5 – 33. (p.9).

<sup>5</sup> Akhito Suzuki’s work on the social history of madness from the perspective of the family is important to mention here, because although insanity was mainly treated in the asylum, there was some sort of home care tradition. Suzuki also highlights the importance expressed by Bucknill on the importance of families in the diagnostic procedure. Yet the provisions by 1903 were still opined by psychiatrists as being almost very limited in England, yet more progress had been in Scotland: Akhito Suzuki, *Madness at Home: The Psychiatrists, the Patient and the Family in England 1820 – 1860*, University of California Press, 2006, (p.62); Editorial, ‘The Home Care of the Insane Poor in England’ in *JMS*, Vol.49, No.207, pp.708 – 711.

<sup>6</sup> Simon Szreter, *Fertility, Class and Gender in Britain, 1860 – 1940*, Cambridge, 1996. (p.79)

<sup>7</sup> Noel A., Humphreys ‘Statistics of Insanity in England, with Special Reference to its Alleged Increasing Prevalence’ in *Journal of the Royal Statistical Society*, June 1890, Vol.53, No.2 pp.201 – 252.

are a large number of persons who are on the borderland, who are or are not lunatics according to the convenience or affluence of their friends. The statistics with regards to the persons found lunatics and recognised as such by the Commissioners' report are of importance; but it is of still greater importance to remember that the forms of insanity differed greatly in their gravity. If, for instance, there were no increase in the number of the insane, but if the form of insanity was getting worse, then there would be cause for very much greater alarm than if the numbers were not increased and the form of insanity was worse, but unfortunately he was not in a position to back it up with statistics. The addition of new statistical tables was endless, and each new one suggested others.<sup>8</sup>

The *borderland* was the realm that existed between sanity and insanity which psychiatrists were taking an interest in towards the end of the nineteenth century, and which referred to the indeterminate zone between the diseased and the healthy, and between medical and social deviance.<sup>9</sup> Henry Maudsley wrote of a borderland between crime and insanity, and the need to identify the early signs of insanity in order to recognise 'peculiar' lineages to identify individuals who 'do sometimes inherit a positive tendency to a particular nervous disease'.<sup>10</sup> William Lloyd Andriezen, a wunderkind who had attempted to reconcile neurology, evolutionary biology and psychology in his work, understood what lay in the borderland to be a combination of pathological changes triggered by environmental causes and underlying hereditary predisposition.<sup>11</sup> These cases may never need treatment, but some thought that the early identification of the different forms of insanity may allow treatment that would prevent further admissions to the crowded asylums, of which entrance was often for life.

The rise of Kraepelinian diagnoses advocated the close attention to symptoms to make judgements on the outcomes of patients usurped the work of the great Victorian anatomists who attempted to establish causal connections between the forms of insanity and physical conditions.<sup>12</sup> This turn towards prognosis characterised the discussions of mental disorder that

---

<sup>8</sup> George Savage, remarks recorded in discussion in response to Noel A., Humphreys 'Statistics of Insanity in England, with Special Reference to its Alleged Increasing Prevalence' in *Journal of the Royal Statistical Society*, June 1890, Vol.53, No.2 pp.201 – 252. (p.248).

<sup>9</sup> Mark Jackson, *The Borderland of Imbecility: Medicine, Society and the Fabrication of the Feeble Mind in Late Victorian England*. Manchester University Press, 2000, pp.10-15.

<sup>10</sup> Henry Maudsley, *Responsibility in Mental Disease*, D. Appleton & Company, 1895. (pp.34 – 40).

<sup>11</sup> This work demonstrated the biological and evolutionary basis of Andriezen's ideas, and he praised Henry Maudsley, Charles Darwin and Herbert Spencer as being responsible for some of mental science's most crucial advances. He was also a physicalist, citing the work carried out in the clinical and neurological schools of Meynert, Golgi, Sergio Ramon y Cajal and Ludwig Flechsig, as well as that carried out in the British Isles by Mercier and Bevan Lewis. He also drew upon the work of the psychometric school of Gustav Fechner and Wilhelm Wundt when advancing his ideal principles of classification. See William Lloyd Andriezen, 'On the Bases and Possibilities of a Scientific Psychology and Classification in Mental Disease' in *JMS*, Vol.45, No.189, Apr. 1899, pp.257 – 290.

<sup>12</sup> See Michael Finn's discussion of William Bevan-Lewis's work as pathologist at the West Yorkshire Lunatic Asylum, which is described by Finn as being 'the final flourish' of pathologically based accounts of mental illness; Michael Anthony Finn, *The West Riding Lunatic Asylum and the Making of the Modern Brain Sciences in the Nineteenth Century*, PhD Thesis, University of Leeds, 2012. (p.175).

occurred during this third period of the Table of the Forms, and this commenced with revisions to the table that occurred between 1902 and 1906, which will be the focus of this chapter. The debates surrounding psychiatric disorders confronted huge questions about the very nature of insanity, and how it should be best categorised. It also marked a significant move away from a statistical Table of the Forms of Insanity towards the MPA adopting a *classification* of insanity. This classification was viewed to be a tool that could be employed in the diagnosis of insanity, which would in turn allow for more reliable prognoses to be made. It was becoming increasingly recognised that the different forms of insanity differed in their prognosis, and wider developments that will be explored in this chapter put pressure on psychiatrists to make diagnosis that were based upon reliable prognosis.

The shift from the Association's table being a set of forms in the statistical returns to being a classification of the forms of insanity was an important philosophical change. It marked a shift in the status of the concepts that the document included, and this change was recognised and discussed by psychiatrists taking part in the debates surrounding this set of revisions. For many, keeping the name 'forms of insanity' allowed generalisations and distinctions to be made between cases that displayed similar symptoms, but it did not commit one to saying that these differences necessarily reflected natural kinds, pathologies, or disease entities. Such a commitment was viewed with caution because of an awareness of the relative ignorance surrounding the causes and pathologies of insanity and its different forms. This attitude was held by the first committee placed in charge of revising the forms of insanity used in statistical tables, who favoured conservatism in their approach by recommending only minor adjustments to the concepts that were used, and to continue the tradition that no definitions of the terms employed in the Table of the Forms should be included in the document.

The omission of definitions was challenged by a sizeable membership of the Association, led by Charles Mercier, who believed that the time was ripe for a standard classification that would include precise definitions of the forms of insanity. In doing so, Mercier believed that this would help British medical psychology to seize the opportunity to provide a world leading standardised classification of insanity that would be adopted as by French, Italian, German and American national psychiatric associations – the major centres for psychiatric research during the final phases of the nineteenth century. Providing definitions would aid arriving at a gold standard classification: one that would be based on clear conceptual grounds, would represent the insanity's natural kinds, and which was informed by the latest research from the mental sciences. This would provide a veridical table of the kinds of insanity



that were encountered by asylum medical superintendents, improving statistical data not just in the British Isles, but in psychiatric practice across the world.

The lack of definitions in versions of the Table of the Forms hitherto adopted by the association created ambiguities surrounding . Despite the ambiguity surrounding the terms included in the table, the Table of the Forms was still a description of the symptoms seen in different cases, or the *forms* of insanity that were encountered in the clinic. For better or worse, these deliberations would lead to the Table of the Forms that was published in 1906 being a classification of *kinds* of insanity, although there was no consensus whether these were understood to be *natural kinds* of separate disease entities, forms of one mental disease that was known as insanity, or a compromise between two conflicting attitudes to classification. This is a complex question, the answer to which will be found between the symptom based concepts employed in the Table of the Forms of Insanity, and those used in a separate Table of the Causes of Insanity which was designed to allow asylum superintendents to separately record the form of insanity and the suspected cause of a case that had led to a person's admittance. The 1906 statistical tables saw the formal separation of the aetiology and symptomology of insanity, leading to a classification system that signalled an attempt by the committees in charge of revisions to draw a compromise between what they viewed as two dominant forces within the MPA: those who wanted a 'scientific classification' that was informed by Skae's work, and those that wanted to retain the long-used Table of the Forms that they regarded as being of practical and clinical use.

However, it is important to note that there was not a clear divide between these factions, with many members of the MPA having quite unique positions that crossed these boundaries. The first section will then look in detail at the debates that occurred at the annual general meetings of the MPA between 1902 and 1906, and the second section will look at the final report of the committee and the classification presented within it. The chapter will end with some conclusions on the classification that emerged from these discussions and conclude that the classification was considered out of date almost as soon as it was published.

## Section 1: The Development of an 'Official Classification of the Forms of Insanity' 1902 - 1906

The attempt to revise the forms of insanity recognised by the MPA commenced as an exercise in the long history of improving statistical tables, a story that spanned four decades and was charted in the previous chapter. The initial goal was to revise the Table of the Forms that would be used for the purposes of statistical collection, but reaction to the conservative changes

recommended by the first committee that were presented in 1904 led to the establishment of a dedicated classification committee that same year. Furthermore, growing suspicion from the public also led indirectly to an increase in administration for asylum doctors after the passing of the 1890 Lunacy Act.<sup>13</sup> From this point, all private patients were brought under asylum administration, meaning in practical terms that their admissions now had to be recorded in admissions books so that they could be monitored by the Lunacy Commission. In addition, a reception order was required to legally certify all private patients into the asylum, and this needed to be ratified by a justice of the peace or a judge. As Takabayashi notes, many saw these measures as the first stage of closing the private system, with some prominent figures wanting to see the eradication of private institutions altogether, with a plan for managed closure: sudden closure of the private patient system would lead to additional pressures being placed on an already overstretched public system.<sup>14</sup>

The grand task of revising the statistical tables and producing the first classification of the MPA saw the collision of different conceptions of insanity held by the Association's members. Clear boundaries were drawn on whether the classification should attempt to keep psychological and physiological facts separate; whether they should be integrated, as Skae's followers had long attempted; whether to take a revolutionary approach informed by Darwinian biology; or whether to adhere to approaches that sought to retain a kind of symptom based classification, yet sought to implement considerations on the prognosis of disease and which were informed by the work of Emil Kraepelin; British psychiatrists had taken heed of his call to 'distinguish the manifold states [of *dementia praecox*] from a whole series of diseases which outwardly are similar but which are totally different in their course' in diagnosis, and these concerns found their way into the discussions surrounding classification that took place at the beginning of the twentieth century.<sup>15</sup>

To complicate these divisions, there was an influential and sizeable number of members of the Association who still subscribed to the notion of unitary psychosis. This was the view that *melancholia*, *mania*, and *dementia* were different extremes or manifestations of one disease, one insanity. Some thought that these were different stages of one disease, and that although an individual may not see a complete degradation of the mental faculties seen in *dementia*, the forms

---

<sup>13</sup> Peter McCandless, 'Liberty and lunacy: the Victorians and wrongful confinement', in Andrew Scull (ed.), *Madhouses, Mad-doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, University of Pennsylvania Press, 1981, pp.339–62.

<sup>14</sup> Akinobu Takabayashi, 'Surviving the Lunacy Act of 1890: English Psychiatrists and Professional Development During the Early Twentieth Century' in *Medical History*, Vol.61, No.2, pp.246 – 269.

<sup>15</sup> Emil Kraepelin, *Dementia Praecox and Paraphrenia*, trans. R. Mary Barclay, ed George Robertson, Chicago Medical Book Co., 1916. (p.258).

of mental disorder that had been described by Pinel signalled different stages and extremities of one disease. As such, according to those who subscribed to unitary psychosis, it made no sense whatsoever to speak of there being different forms of mental disorder, so the very task of classifying different forms of insanity was misguided. Instead, individuals like Clouston who subscribed to this idea thought that the task that faced the committee was to classify different forms of the one disease that was known as insanity. This ultimately meant that the task was to classify the different kinds of behaviour, the different kinds of symptoms, and the different aetiology of the different manifestations of insanity, as opposed to arriving at a conception of different disease entities of the kind that underpins modern diagnostic frameworks.

The task that faced the committee was complex and daunting. They needed to negotiate a complex set of pressures, imposed by these differing approaches to classification, and practical anxieties about the increased work that would come with the introduction of a new system of classification, which had long directed the MPA's attempts at revisions<sup>16</sup>

### 1.1 Discussions on Prognosis and the First Set of Revisions to the Statistical Tables: 1902 – 1905

Discussions on prognosis began to gain momentum from the 1890s onwards, with a number of lectures, papers and addresses to both the MPA and the British Medical Association (BMA) confronting the difficulties that faced psychiatrists when attempting to make a diagnosis with a reliable prediction on the future course of the disease.<sup>17</sup> Attention was being paid to Kraepelin's division of insanity on the basis of the differing prognosis of each of its forms.<sup>18</sup> Kraepelin's work was based upon the diligent record keeping of patient data and this had allowed him to track the course of insanity in his patients.<sup>19</sup> The MPA had attempted to standardise their record keeping and Skae had raised issues related to prognosis in his concept of the natural history of the insanities, but these had not led to the kind of breakthrough enjoyed by the German

---

<sup>16</sup> See chapter two of this thesis for a lengthy discussion.

<sup>17</sup> See: Robert Armstrong-Jones, 'Prognosis in Mental Diseases' in *BMJ*, December 16<sup>th</sup>, 1905, pp.1578 – 1582; Sir William R. Gowers, 'A Lecture on the Prognosis and Treatment of Syphilitic Disease of the Nervous System' in *JMS*, April 4<sup>th</sup>, 1903, pp.773 – 778; Judson S. Bury, 'Prognosis in Relation to Disease of the Nervous System' in *BMJ*, November 9<sup>th</sup>, 1901, pp. 1389 – 1396; W.R. Gowers, 'The Lettsomian Lectures on Syphilis and the Nervous System' in *BMJ*, February 9<sup>th</sup> 1889, pp.283 – 285; G. Fielding Blandford, 'The Lumleian Lectures on the Diagnosis, Prognosis and Prophylaxis of Insanity' in *BMJ*, April 6<sup>th</sup>, 1895, pp.741 – 747; George Green, 'The Prognosis in Dementia Paralytica' in *JMS*, No.52, No. 217, pp.84 – 305; A.R. Urquhart, 'The Morison Lectures on Insanity, with Special Reference to Heredity and Prognosis' in *JMS*, Vol.52, No.217, April 1907, pp.233 – 321.

<sup>18</sup> See: Thomas Drapes, 'On the Maniacal-Depressive Insanity of Kraepelin' in *JMS*, Vol.55, No.228, January 1909, pp.58 – 64.

<sup>19</sup> Edward Shorter, 'The History of Nosology and the Rise of the Diagnostic and Statistical Manual of Mental Disorders' in *Dialogues of Neuroscience*, Vol.17, No.1, March 2015, pp.59 – 67.

psychiatrist. Robert Armstrong-Jones, who would sit on the revisions committee established by the MPA, gave a lengthy address to the psychological section of the BMA which addressed the issue of prognosis in psychiatric diagnosis in the different forms of insanity.<sup>20</sup> He claimed that:

Insanity is a genetic term, having many species and varieties, some of these differing widely as to prospects of recovery, and also, as to the occurrence in their course, of life and death.<sup>21</sup>

Although the different forms of insanity had different prognosis, the form did not define the prognosis according to Armstrong-Jones, with the particularities of the patient having to be considered by the psychiatrist before they could make a judgment. Armstrong-Jones thought that making these judgments as accurately and as early as possible was critical, because it could lead to a family's social ruin and cast a stigma upon them. For the patient, it could lead to a lengthy stay in an asylum, with perhaps no prospect of recovery and discharge. Making the right diagnosis as soon as possible was vital for Armstrong-Jones because:

[It is] absolutely essential to obtain early treatment for insanity and that the chances of recovery dwindle out of all proportion by delay. [...] insanity is curable in inverse ratio to its duration, and that if actively and skilfully treated within the first month, more than 70 percent of the recoveries are sent out cured [...] whereas after the first year only about 10 percent recover, after the second year 3 percent, and the third up to the fifth 2.3 percent, and after the fifth recovery is exceptional.

The different forms of insanity carried with them different likelihoods of a recovery and discharge. Generally speaking, the statistics he presented from his Claybury asylum indicated that melancholic patients had the best prognosis, with there being a higher number of discharges than patients diagnosed with mania; delusional insanity and monomanias he deemed to be incurable, and similarly with acute forms of mania, yet there were still chances for recovery for those diagnosed with even acute forms of melancholia.<sup>22</sup> Furthermore, the cause of insanity was also deemed by Armstrong-Jones to indicate clues about its prognosis, with him stating that when alcoholism was present, or any other 'single and powerful cause be operative – such as disappointment in love to a sensitive woman – the prognosis is better than if several causes, such as poverty, anxiety, and domestic bereavement acted in conjunction'.<sup>23</sup> Yet, despite these optimistic notes, Armstrong-Jones thought that even if there was a recovery, this would

---

<sup>20</sup> Robert Armstrong-Jones, 'Prognosis in Mental Diseases' in *BMJ*, December 16<sup>th</sup>, 1905, pp.1578 – 1582

<sup>21</sup> *Ibid.*, p.1578.

<sup>22</sup> *Ibid.*, p.1582.

<sup>23</sup> *Ibid.*

never be a full one, and there would always remain a weakness that could lead to a patient to being readmitted.<sup>24</sup>

The first two years of the sitting of the revisions committee were devoted to revising the statistical tables of the MPA that were passed in 1882 which are discussed in the previous chapter. This was triggered by a paper calling for the modernisation of the statistical framework used by the Association to the annual general meeting of the Association in 1902.<sup>25</sup> Poor Law Commissioner Charles Hubert Bond voiced concerns about the present tables, and that they could lead to confusion of symptoms with aetiological factors since the main symptomological classes employed in them included sub-classes relating to aetiology.<sup>26</sup> Instead, Bond proposed that they be kept separate to preserve the quality of data. Bond suggested that the classification be split into two parts, one describing symptoms in definitions of the terms used in the classification, and the other being a list of causes of insanity. He argued that keeping the two separate would help with research into the causes of mental diseases, primarily because if they were kept separate, statistics based upon symptoms could be correlated to statistics based upon aetiological factors. This would not conflate the two, addressing the methodological issues about concepts of insanity that incorporated suspected, but not known, causes being adopted as standard. In response to Bond's paper, a motion was passed at the annual general meeting of the association held in July 1902 to appoint a committee charged with revising the Table of the Forms. The Scottish psychiatrist and former colleague of Skae, David Yellowlees, was appointed chairman, and Bond was appointed Honorary Secretary. Other prominent members included Henry Rayner, who was discussed in the last chapter and was a member of the committee responsible for the 1882 revisions, and Bedford Pierce, medical superintendent of the Retreat in York.<sup>27</sup>

From the outset, the committee sought to alleviate concerns of any possible increase in workload by emphasising that one of their guiding principles was to reduce the time it took members to fill in medical data relating to admissions on their yearly returns, including numbers

---

<sup>24</sup> This point was hotly debated by Thomas Clouston in his response to Armstrong-Jones's paper in *ibid.*

<sup>25</sup> Charles Hubert Bond, 'Medico-Psychological Statistics: the Desirability of Definition and Correlation, with a View to Collective Study' to the annual general meeting of the association in 1902 (check this); R. Lord and G.W.T.H. Fleming, 'The Revision of the Classification of Mental Disorders: Report by the Clinical Psychiatry Sub-Committee of the Research and Clinical Committee' in *JMS*, Volume 78, No.320, January 1932, (pp.177 – 201) (p.181)

<sup>26</sup> See chapter Two for a full discussion.

<sup>27</sup> 'Minutes of the Annual Meeting of the Medico-Psychological Association of Great Britain and Ireland, July 1902' in *JMS*, Vol.48, No.203, Oct. 1902, pp.795 – 805.

relating to the forms of insanity diagnosed in patients.<sup>28</sup> They sought to combine this efficiency with increased diagnostic accuracy of the data in the returns, by updating the concepts that were used and following up on Bond's recommendations to separate aetiology from symptomology in the tables. Bond's recommendations would be vital in the decisions made by the committee, and would determine the final format of the Table of the Forms from these discussions. In October of the same year, these intentions were included in an announcement of the committee's appointment which was placed in the *JMS*, along with a call for suggestions about how to best carry out these revisions.<sup>29</sup> Stating their aim to retain 'simplicity of form as far as is consistent with accuracy' the committee made it clear that practical considerations would be the priority in their deliberations.<sup>30</sup> This announcement demonstrated the committee's intention to alleviate any concerns about an increased workload, and practical concerns like these were often what would prove to be the decisive factor over the four years the revisions were made. At the same time, they expressed a desire to improve the scientific accuracy of the medical data that was collected by the Association. They thought that Bond's proposal to separate aetiology and symptoms into two tables would help with this goal, and allow data relating to causes to be cross referenced to diagnosis based on concepts that described symptoms: this would open the possibility for an increased understanding of insanity by drawing upon aetiological data that asylum superintendents already collected in their case notes.<sup>31</sup>

The work of the statistical committee was eagerly anticipated over the next two years. It met four times between February and June 1903. At the annual general meeting in July that year, an interim report was presented where the revisions to the statistical tables were deemed to be the 'most important matter that the Association now has on hand'.<sup>32</sup> They reiterated their aim to introduce a streamlined set of statistical tables that would 'save an enormous amount of clerical work' and increase their 'value and accuracy', and criticised the existing forms as being too complicated for practical use, although conceding that they may have some scientific value.<sup>33</sup> They proposed in their interim report that the tables be used across the United Kingdom,

---

<sup>28</sup> David Yellowlees and Charles Hubert Bond, 'Committee for the Revision of the Statistical Tables of the Medico-Psychological Association', in *JMS*, Vol.48, No.203, Oct. 1902, pp.812 – 813.

<sup>29</sup> *Ibid.*

<sup>30</sup> *Ibid.*, (p.812)

<sup>31</sup> *Ibid.*, (p.813).

<sup>32</sup> 'Occasional Notes: The Annual Meeting of the Medico-Psychological Association' in *The Journal of Mental Science*, Volume 49, No.207 Oct. 1903, pp. 703 – 705, (p.704).

<sup>33</sup> Charles Hubert Bond, remarks recorded in 'Part IV: Notes and News: Medico-Psychological Association of Great Britain and Ireland: Annual Meeting 1903' in *JMS*, Vol.49, No.207, Oct. 1903 pp.749 – 774, (pp.770 – 771).

having had the agreement of the Scottish and Irish boards that the tables produced by the MPA would be uniform ‘across all three kingdoms’.<sup>34</sup> The committee hoped that this work would lead to a valuable and powerful new source of data on the different forms of insanity, and cross referencing these statistics relating to causes included in a separate table would provide new insights into the causes of the different forms of insanity that had long been recognised by the MPA.

## 1.2 The First Revisions to the Tables and the Introduction of Prognosis to the Table of the Forms

During the first set of revisions, tensions arose between those who desired changes that would increase the scientific credentials of the classification, and those who prioritised the need for a practical and efficient diagnostic framework. David Yellowlees delivered the first full report to the annual general meeting of the association in July 1904, and this emphasised the practical implications of the introduction of any new classification: ‘we felt that an asylum physician had something more important in his life than statistics, that he is already burdened far too greatly with statistical labour’.<sup>35</sup> The report also sought to remove ambiguity from the concepts used in the statistical tables to reduce as far as possible subjective judgement in diagnosis, and they sought to achieve this by eliminating all superfluous information relating to aetiology in the sub-classes which would help for clearer distinctions between different cases of insanity: many had complained about the risk that puerperal mania would be confused with puerperal melancholia, or confuse instances of general paralysis of the insane for cases of organic dementia because they had similar physical causes.<sup>36</sup> According to the committee, the combination of causes and symptoms introduced an unacceptable level of complexity to the diagnostic concepts which served to increase their ambiguity and reduce the precision of their application.

The changes they proposed to the structure of the tables involved grouping together data relating to admissions, deaths, transfers and discharges.<sup>37</sup> To further assist efficiency in the completion of the tables, the committee suggested that a new medical register be introduced which would be separate from the civil register which collected data on the social background and legal status of the patient, a legal requirement under the terms of the Lunacy Act. The

---

<sup>34</sup> Ibid.

<sup>35</sup> David Yellowlees, Report of the Statistical Committee, Appointed at the Annual Meeting Held at Liverpool in 1902, Presented to the Annual Meeting of the Association, July 21st, 1904, in *JMS*, Vol.51, No.215, Oct. 1905, pp.799 – 826. (p.800).

<sup>36</sup> Ibid.

<sup>37</sup> Ibid.

proposed medical register kept by the asylum would record all the data needed for admittances and discharges in one place.





As figure 15 demonstrates, this would collect all the data that was required for the statistical forms, including the form of insanity as well as the main suspected cause. One mark was to be made alongside the relevant diagnosis of the form of insanity, and one primary cause was to be recorded, although superintendents could record as many secondary causes as they wished. Medical superintendents complained that they often needed to sift through case notes to find the medical data that was needed for the then current statistical tables.<sup>39</sup> Instead, the report proposed that if kept accurately throughout the year, the medical register would speed up completing the returns on admissions because it would collect all the information necessary to complete the tables, and would prevent the need for a medical superintendent to sift through case notes for this information.<sup>40</sup> The report announced that the English Commissioners in Lunacy were in favour of the changes, and had granted their approval for the separation of a medical and civil register, something that was undoubtedly helped by Bond and Pierce being appointed to the committee, who were at the same time serving on the board of the Lunacy Commission. As discussed in the previous chapter, collecting this information at the point of admission was a legal requirement for asylum superintendents, but they were becoming increasingly recognised as a potential source of data that could provide the kinds of insights into the nature of insanity that had thus far eluded psychiatrists.

The committee had spent much of its time developing these medical registers, and so had only made minor revisions to the Table of the Forms. These removed aetiology from the concepts used in the tables from 1882. The list of causes that were used in the statistical tables were the same as the ones produced by the 1882 committee, mainly because it did not think that producing a new set of causes was part of its remit; it instead viewed its primary duty to be the improvement of the efficiency and accuracy of the statistics collected by the MPA and the Lunacy Commission.<sup>41</sup> In their revisions, the committee had retained the main classes of mania, melancholia, dementia, epileptic insanity and GPI from the 1882 table, but had removed the aetiological sub-classes from its revisions to the Table of the Forms, as can be seen from a comparison of the existing table and their proposed revision (see figures 16 and 17):

---

<sup>39</sup> David Yellowlees, Report of the Statistical Committee, Appointed at the Annual Meeting Held at Liverpool in 1902, Presented to the Annual Meeting of the Association, July 21st, 1904, in *JMS*, Vol.51, No.215, Oct. 1905, (pp.799 – 826).

<sup>40</sup> *Ibid.*

<sup>41</sup> *Ibid.*, (p.804)

**TABLE XI.**  
*Showing the form of Mental Disorder in the Admissions, Recoveries, and Deaths of the Year 18... and of Inmates on 31st December, 18...*

FORM OF MENTAL DISORDER.	ADMISSIONS.		RECOVERIES.		DEATHS.		REMAINING IN ASYLUM.	
	Male.	Female.	Male.	Female.	Male.	Female.	Male.	Female.
Congenital or Infantile Mental Deficiency...								
" $\alpha$ with Epilepsy ...								
" $\beta$ without Epilepsy ...								
Epilepsy acquired ...								
General Paralysis of the Insane ...								
Mania—								
"  Acute ...								
"  Chronic ...								
"  Recurrent ...								
"  A Potu ...								
"  Puerperal ...								
"  Senile ...								
Melancholia—								
"  Acute ...								
"  Chronic ...								
"  Recurrent ...								
"  Puerperal ...								
"  Senile...								
Dementia—								
"  Primary ...								
"  Secondary ...								
"  Senile ...								
"  Organic (i.e., from Tumours, Coarse Brain Disease, &c.)								

Figure 15: Table of the Forms of Mental Disorder Presented to the Annual General Meeting of the MPA in 1882.<sup>42</sup>

<sup>42</sup> 'Report of the Thirty-Seventh Annual General Meeting of the Medico-Psychological Association' in *JMS*, Vol. 28, No.123, Oct. 1882, pp.437 – 462. (p.460)

ADMISSION GROUP, TABLE IV.—*Showing the Form of Mental Disorder on admission in the Direct Admissions during the year 19... (Voluntary Boarders excluded).*

Forms of mental disorder.	M.	F.	T.
<b>Congenital or infantile mental deficiency:</b>			
(a) Without epilepsy . . . . .			
(b) With epilepsy . . . . .			
Epileptic insanity . . . . .			
General progressive paralysis . . . . .			
Mania { Recent* . . . . .			
{ Chronic . . . . .			
Melancholia { Recent* . . . . .			
{ Chronic . . . . .			
Alternating insanity . . . . .			
Volitional and moral insanities . . . . .			
Delusional insanity . . . . .			
Stupor and states of confusion . . . . .			
Dementia { Primary (including Dementia præcox) . . . . .			
{ Senile . . . . .			
{ Organic and paralytic. . . . .			
{ Secondary . . . . .			
<b>Total . . . . .</b>			

\* The period of one year is taken as the limit of the term recent.

Figure 16: The Forms of Mental Disorder Included in the Report of the Statistical Committee presented to the 1904 AGM of the MPA.<sup>43</sup>

The committee had decided to retain organic forms of dementia, an apparent aetiological sub class, as a disease sub-category because they thought that it was a distinct clinical entity which had symptoms that were distinct from the other sub-types of dementia, and distinct from cases of GPI. Aside from this, all other terminology associated with causes were removed from the Table of the Forms of Insanity.

The new additions to the Table of the Forms proposed by the committee signalled a move towards incorporating concepts that included prognosis. This can be seen most starkly with the inclusion of Emil Krapelin’s *dementia præcox*. This would be a relatively unfamiliar term to some members of the MPA, the only mention of it appearing in British clinical literature prior to the report of the committee in reviews of the sixth edition of Kraepelin’s *Ein Lehrbuch der Psychiatrie*.<sup>44</sup> The committee’s use of the term was one of the earliest in the United Kingdom, and the turn of the century proving a decisive moment in the spread in popularity of Kraepelin’s

<sup>43</sup> Hubert Bond and Henry Yellowlees, ‘Report of the Statistical Committee, Appointed at the Annual Meeting Held at Liverpool in 1902, Presented to the Annual Meeting of the Association, July 21st, 1904’, in *JMS*, Vol.51, No.215, Oct. 1905, (pp.799 – 826).

<sup>44</sup> Anon., ‘Review: *Psychiatrie: ein Lehrbuch für Studierende und Aerzte* (Psychiatry: A Manual for Students and Physicians). Von Dr. Emil Kraepelin’ in *JMS*, Vol.45, No.190, Jul. 1899, pp.581 – 583.

ideas throughout the British Isles.<sup>45</sup> In addition to dementia praecox, the inclusion of alternating insanity, whose symptoms were remarkably close to those described by Kraepelin in cases of manic depressive insanity, it's hard not to interpret the first revision of the Table of the Forms as being an early kind of Kraepelinian document. Alternating insanity or circular madness found its origins in the work of Falret and Baillarger, the symptoms of which were 'the opposite conditions of mania and melancholia or of excitement and depression [that] succeeded each other with a certain amount of regularity'.<sup>46</sup> Partial insanities in the form of *moral and volitional* insanities were included, possibly as a response to calls to treat these forms of insanity preemptively. *Delusional insanity* was also added: this concept had enjoyed popularity towards the end of the nineteenth because it accounted for cases where the patient suffered from delusions, either as hallucinations or distorted ideas of reality, which were not accompanied by the emotional disturbances seen in either mania or melancholia.<sup>47</sup>

The committee anticipated criticism of their concise table by announcing that they did not think it was the right time to offer radical changes or a new classification, nor was it their duty to carry out either of these tasks as a statistical committee.<sup>48</sup> As a result, the table they suggested only saw minor changes to the categories that were already in use, and these mainly included the removal of sub-categories relating to causation. Although they acknowledged that these were far from perfect and that members 'would perhaps feel disappointed that more of the terms used in modern classifications have not been used', it anticipated this criticism by answering that it 'did not feel either that the time for this was ripe, or that the suggesting of a new classification really formed part of the task imposed upon them'.<sup>49</sup>

It is possible that the members of the committee thought that the new classification concepts offered by Kraepelin would be further developed, or that new discoveries were on the horizon which would realise the much-valued classification of mental diseases according to pathology. Change was in the air, and the beginning of the century was a transition period between the classifications that were used in Victorian asylums and the beginning of the

---

<sup>45</sup> German Berrios, 'Mood Disorders: Clinical Section' in *A History of Clinical Psychiatry*, Berrios and Porter eds., Athlone, 1995, p.396.

<sup>46</sup> Edward B. Lane, 'Some Cases of Alternating Insanity with One Case of Recovery' in *Boston Medical and Surgical Journal*, Vol.116, Jan. 20<sup>th</sup>, 1887, pp.52 – 56.

<sup>47</sup> Maurice Craig, 'Delusional Insanity' in *Hospital*, Vol.22, No.549, Apr. 3<sup>rd</sup>, 1897, pp.9 – 10.

<sup>48</sup> Hubert Bond and Henry Yellowlees, 'Report of the Statistical Committee, Appointed at the Annual Meeting Held at Liverpool in 1902, Presented to the Annual Meeting of the Association, July 21st, 1904', in *JMS*, Vol.51, No.215, Oct. 1905, pp.799 – 826.

<sup>49</sup> *Ibid.*

dominance of Kraepelinian concepts of psychopathology that would come to be enthusiastically received by psychiatrists working across Europe and the United States during the inter-war period. Although refraining from suggesting comprehensive revisions, the report hoped that the concepts it introduced would include ‘so many cases occurred for whom without them there seems no suitable niche’.<sup>50</sup> One of the members of the committee, Henry Rayner, stated that the forms of insanity that were recommended by the committee represented a move to formulate the ‘highest and latest views of insanity that were held in this country’.<sup>51</sup> To some extent this was reflected in the concepts included in figure 17: Kraepelin’s dementia praecox, which was beginning to gather more and more attention from British psychiatrists, had been included in the classification as a sub-form.<sup>52</sup>

The report of the committee was eagerly anticipated by members of the MPA, with a *JMS* editorial predicting that the results of the committee ‘must stand for the guidance of the profession for many years to come’.<sup>53</sup> The responsibilities placed upon the committee and the revisions that it was tasked to carry out were by no means a mere administrative task: many members viewed the future of research on insanity resting on the committee getting the concepts used in the statistical returns right. It had been over twenty years since a revision to the statistical tables had been carried out, and even then, the 1882 revisions had seen very little advancement on the forms of insanity that had been in use since the establishment of the organisation. For many, the concepts had not been properly changed or modernised for over fifty years, and there were big expectations from a great deal of members of the association that a brand-new classification would be produced that would incorporate elements from the complex clinical classifications offered by Skae, Greisinger, and Kahlbaum, and ideas that had been introduced by evolutionary biology.<sup>54</sup>

The committee were right to anticipate criticism, with the reception to their recommendations being far from enthusiastic; many took the view that the revisions committee

---

<sup>50</sup> Ibid.

<sup>51</sup> Ibid.

<sup>52</sup> More and more case studies and research was appearing in the *JMS* after 1900: for instance: Henry M. Eustace, ‘A Case of “Dementia Praecox”’, *JMS*, Vol.50, No.210, July 1904, pp.516 – 521.

<sup>53</sup> ‘Occasional Notes: The Annual Meeting’ in *Journal of Mental Science*, Volume 50, No.11, Oct. 1904, pp.750 – 751. (p.751)

<sup>54</sup> One striking example of a psychiatrist who attempted to unify anatomical, pathological, psychological and biological models of the mind was William Lloyd Andriezen. His oeuvre was marked by attempts to draw connections between the activities of the brain on the very fundamental levels through to complex mental phenomena, though an analysis of the structures of the brain, language and observations on the development of the mind. ‘On the Bases and Possibilities of a Scientific Psychology and Classification in Mental Disease’ in *JMS*, Vol.45, No.189, Apr. 1899, pp.257 – 290.

had not made enough in the way of changes to the 1882 Table of the Forms.<sup>55</sup> Despite the committee's lofty aims, their revisions were too conservative and a sizeable proportion of the membership thought that this displayed a reluctance for change. Certain members of the MPA criticised the committee's report, with the most prominent of these being Mercier. He disagreed with the report's claim that these were embodiments of the most advanced clinical concepts available to psychiatrists, and felt that the committee's over reliance on symptom based concepts that had, with the exception of *dementia praecox*, been in existence for a very long time and signalled a wasted opportunity for British psychiatry to create a modern Table of the Forms that would be based on novel conceptual grounds. He thought that with more work, the MPA could produce a global contribution to the field by providing a gold standard classification of the forms of insanity:

I think we have the chance of getting this scheme adopted generally, not only by the administration of this great country, but by the subordinate and inferior administrations of the Isle of man [sic], Berwick-upon-Tweed, Scotland (laughter), and Ireland; and also that we may set such an example by which the statistics of insanity of all countries may be comparable with one another.<sup>56</sup>

This was part of a lengthy outburst conducted by Mercier against the revisions suggested by the statistical committee.<sup>57</sup> He contested the committee's claim that it was not a part of their task to provide a new set of concepts for the purposes of the collection of statistics, and their insistence that the changes that they had made were necessary for the effective revision of the statistical tables.<sup>58</sup> He also attacked the draft classification's conceptual grounds, for many of the categories that had been included in the causation table presented by the committee. *Inheritance* and *heredity* he considered too vague to be used in mental science, and he regarded *previous attacks* as a tautologous concept of causation, that was categorically incompatible with other concepts included in the table including *old age* and *venereal disease*.<sup>59</sup>

---

<sup>55</sup> Hubert Bond and Henry Yellowlees, 'Report of the Statistical Committee, Appointed at the Annual Meeting Held at Liverpool in 1902, Presented to the Annual Meeting of the Association, July 21st, 1904', in *JMS*, Vol.51, No.215, Oct. 1905, pp.799 – 826.

<sup>56</sup> 'Medico-Psychological Association of Great Britain and Ireland: Annual Meeting July 21<sup>st</sup> 1904', in *The Journal of Mental Science*, Volume 50, No.211, Oct. 1904, pp.784 – 805. (p.799)

<sup>57</sup> *Ibid.*, (pp. 798 – 799)

<sup>58</sup> *Ibid.*, (p.799)

<sup>59</sup> Mercier railed against the proposed sterilisation of 'degenerates' in a *BMJ* letter in 1904, asking for those calling for this policy to explain and provide a precise definition of a 'degenerate'; Charles Mercier, 'Correspondence: Proposed Sterilisation of Certain Degenerates', in *BMJ*, Apr. 2<sup>nd</sup> 1904, pp.808; He also

The waspish tone of Mercier's comment provides an insight into the general tone of ill feeling that was exchanged over the revisions of the statistical tables. Mercier appealed for the deliberations on the Table of the Forms to be conducted in open between the members of the MPA, and not behind closed doors as had been the recent trend with MPA committees.<sup>60</sup> As a man who thrived on intellectual debate and disagreement, he took exception, along with the medical superintendent of Murray Royal Asylum in Perth, Alexander Reid Urquhart, to a motion submitted by Carlyle Johnstone to conduct further discussions on the revisions in regional meetings that would take place later that year and in early 1905 before the Association reconvened at the next annual meeting in July that same year. Relenting, the chair gave Mercier additional time to further outline his objections. In another lengthy address, he stated three conditions for a good classification:

A classification, to be good, must include all the things to be classified and nothing else. In the second place, it should separate things which are different, and associate things which are alike. In the third place, it should not include the same thing under more than one class of the same rank.<sup>61</sup>

Mercier was calling here for logical clarity for the classification. He stated that the system needed to have some order and not to confusedly include concepts of different classes. The sources of his criticisms were the inclusion of 'organic' as a sub-class of dementia, which he thought was an aetiological category, and the omission of psychological symptoms in the table:

But I regret to say that all those canons of classification have been violated [by the table]. It does not include all the things which have to be classified. I see in it no place for suspicion, no place for illusion, or hallucination; I see no place in it for suicide, nor for the various phobias and manias; and such very distinct forms or varieties of insanity as acute delirious mania and paranoia have no place in it at all. It associates things which are unlike; it puts together under the same heading [melancholia] such diverse things as morbid hesitation and kleptomania; it puts together under the same heading stupor, which is an anomaly of conduct, and confusion, which is an anomaly of thought...<sup>62</sup>

Mercier's view was that the fundamental to any useful classification was logical clarity which placed disorders in a coherent hierarchy, yet according to him, the classification offered by the committee had none of these qualities. For example, he thought it was absurd to make *general progressive paralysis* (GPP) a main category that was on the same level as *mania* and *melancholia*: these were symptoms that he considered to be a part of GPP, so for Mercier it did not make

---

<sup>60</sup> 'Medico-Psychological Association of Great Britain and Ireland: Annual Meeting July 21<sup>st</sup> 1904', in *JMS*, Volume 50, No.211, Oct. 1904, pp.784 – 805. (p.799)

<sup>61</sup> Ibid.

<sup>62</sup> Ibid.



sense to make them distinct disease entities. Mercier considered the classification absurd because it allowed for a person be diagnosed as having a disease which is also only a symptom seen in cases of another disease.

Mercier's criticisms of the logical structure of the forms was the beginning of his criticism of the symptomatic approach to classifying illnesses. He thought that GPP was a natural kind, mainly because he suspected that it had an underlying pathology which defined it as a disease entity, albeit one that was yet to be discovered. For Mercier, this was not the case with *mania* and *melancholia*: he thought that they could not have a separate underlying pathology because symptoms of each could be observed in most of the other diseases in the Table of the Forms, most clearly in *alternating insanity*. Placing them in the same class alongside GPP reified them according to Mercier, and only served to mistakenly turn symptoms into disease entities.<sup>63</sup> Finally, Mercier thought the terms *mania*, *melancholia* and *dementia*, had long passed their shelf life, and should be replaced with more modern clinical terms: again, this was more than a cosmetic issue for Mercier: he thought that by continuing to use terms that conflated symptoms with natural kind disease entities, investigations into the nature of insanity would be forever hindered by the faulty concepts that were used in the diagnosis of the forms of insanity.

Mercier's lengthy speeches dominated the proceedings at the 1904 meeting. Proposals were put forward to garner opinion on the proposed table of forms from local divisional meetings, but due to protests from Mercier and Urquhart, this was suspended: both thought that the general assembly at the annual meetings was the venue to discuss the Table of the Forms, and it should only be presented to regional meetings once the main details of the classification had been agreed upon.<sup>64</sup> In light of these protests, the annual general meeting of the association was adjourned until November 1904 to allow a special assembly to be held which would continue the debates on the forms of insanity.

### 1.3 Mercier's Classification

Mercier was an eccentric and well liked member of the MPA.<sup>65</sup> He was regarded as having enjoyed 'more than most men, the actual glory of mental conflict' and having seized 'on opportunities to crush what he deemed to be important errors of fact or thought', he proved to

---

<sup>63</sup> Ibid.

<sup>64</sup> Ibid.

<sup>65</sup> Paul Bowden and R.V. Chetwynd, 'Pioneers in forensic psychiatry. Charles Arthur Mercier (1852–1919): 'Wit without understanding' in *Journal of Forensic Psychiatry*, Vol.5, No.2, 1994, pp.321 – 353, (p.324).

be a formidable intellectual opponent, especially when it came to the classification of the forms of insanity.<sup>66</sup> Despite this he was respected as a polymath, well versed in logic as well as physiology and psychology. His views on classification were unique and his strong objections to the conservative changes that were made by the first sitting of the revisions committee shaped the debate about the purposes of the tables: whether they should record the forms of insanity or its natural kinds.<sup>67</sup> According to Mercier, psychological forms were the disorders that had populated the Table of the Forms of Insanity, and were the symptoms demonstrated by a patient, which were different to the natural kinds that were connected to physical pathologies. Mercier would, during the discussions surrounding classification, argue passionately that the two must be kept separate, and contributed to the voices which had led to the separation of the forms and aetiologies in the tables that were established as an outcome of these meetings.

In formulating his ideas on classification, Mercier drew from his textbook, published in 1902, which sought to provide a concise and practical system that was not overly theoretical in character and could be quickly learnt by medical students.<sup>68</sup> Compared to Tuke's two volume *Dictionary of Insanity*, Mercier's was a slim single volume that sought to prioritise logical clarity and concision over lengthy case notes and clinical observations.<sup>69</sup> Earlier on in his career, Mercier had written a textbook which employed the core diagnostic concepts of Pinel, using his term 'exaltation' instead of mania, but including *dementia*, *melancholia* and *idiocy*.<sup>70</sup> Yet at the same time, Mercier had subscribed to unitary psychosis: in his 1890 book *Sanity and Insanity*, he devoted a whole section attempting to provide a definition of insanity, which he referred to as a singular entity, with different forms.<sup>71</sup> These forms of insanity were for him the different stages in the onset of madness, ultimately ending with dementia. Mercier's views shifted during the course of these debates from seeing the forms of insanity as being caused by one disease, to viewing them as being caused by different diseases, or natural kinds.<sup>72</sup>

---

<sup>66</sup> 'The Late C.A. Mercier' in *JMS*, Vol.67, No.276, Jan. 1921, p.146.

<sup>67</sup> In a paper on classification presented to the British Medical Association in 1903, Mercier made a distinction between 'psychological forms' and the 'true varieties or types of insanity': 'Charles Mercier, 'Kinds of Insanity', delivered to the British Medical Association: Swansea 1903: Section of Psychological Medicine' in *JMS*, Volume 49, No.207, Oct. 1903, pp. 776-780. (p.776).

<sup>68</sup> Charles Mercier, *A Text-Book of Insanity*, Macmillan, 1902.

<sup>69</sup> Daniel Hack-Tuke, *A Dictionary of Insanity*, P. Blakiston, 1892.

<sup>70</sup> Charles Mercier, *Sanity and Insanity*, Scott, 1890, pp.102 – 103.

<sup>71</sup> Charles Mercier, 'What Insanity Is' in *Sanity and Insanity*, Scott, 1890, pp.97 – 139.

<sup>72</sup> It is important to stress here that Mercier did not think that the symptom based forms were natural kinds, but he did think it were possible to discover different natural kinds of insanity.

Describing his attacks on the tables at the 1904 meeting as being ‘purely destructive’ Mercier would in the meantime publish an article in the *JMS* that offered his own proposal for a classification.<sup>73</sup> Mercier’s paper signalled a turning point in the deliberations, because in his lengthy response to the committee’s proposed Table of the Forms, he shifted the debate towards a classification of insanity, not a table of its forms as it had hitherto been understood. Yet Mercier’s view was nuanced: he began his paper by stating that he did not think that there were different *natural kinds* of insanity, and instead believed all the forms of insanity to have one underlying pathological cause, what he termed disorders of ‘the highest nervous regions’ due to ‘their original constitution [being] imperfect, or their working is vitiated by some interference’.<sup>74</sup> According to Mercier there was no other kind of pathology for insanity, and although he thought that some of the causes may contribute to the development of disorders of these highest nervous regions, he thought that *natural kinds* must be defined by pathology, with his view being that insanity was one disease:

My own opinion is clear and strong that there are no such divisions within the disorder that we call insanity, but that it is one and indivisible; but it is quite unnecessary to discuss this matter, since it is indisputable that the purpose of these tables is to enable a classification to be made, not of kinds, but of *cases* of insanity; and it is to the classification of cases of insanity that my endeavours will be limited. It will be understood, of course, that a classification of cases of insanity is very different from a classification of insane persons.<sup>75</sup>

In contrast, he repeated his criticism that the committee had ‘erected “mania”, or excited conduct, which is a *manifestation* of insanity, into a *kind* of insanity, and placed it on a level with general paralysis, or *folie circulaire*, which include mania among their manifestations’.<sup>76</sup> He emphasised that understanding mania as a natural kind was to make a dangerous category error, with mania being a symptom, whereas general paralysis was a ‘morbid change’ which would lead to disruption of the nervous regions. He applied this criticism to many other concepts in the Table of the Forms and the table of causation that had been presented by the committee:

Look down the list [in the Table of the Forms], and you will find one kind distinguished by its causation (alcoholic insanity); another by its underlying morbid change (general paralysis); another by [an associated condition]: (epileptic insanity); another by the course of the disease (*folie circulaire*) [or *alternating insanity* in the Table of the Forms]; another by its predominant system (fixed delusion) [in cases

---

<sup>73</sup> Charles Mercier, ‘The Statistical Tables’ in *JMS*, Volume 50, No.211, Oct. 1904, pp.672 – 697.

<sup>74</sup> *Ibid.*, (p.688).

<sup>75</sup> *Ibid.*, (p.674).

<sup>76</sup> *Ibid.*

of *delusional insanity*]; another by the time of its origin (congenital imbecility); and another by the intensity of the disease (acute delirious mania).<sup>77</sup>

These inconsistencies led Mercier to dismiss the Table of the Forms that was offered in 1904 as a ‘higgledy piggledy conglomeration’ that was disorderly and chaotic.<sup>78</sup> He acknowledged that the means of classification embodied in each of these concepts, such as classification according to the course and prognosis of the disease in *alternating insanity*, or according to its predominant system, as in *delusional insanity*, were in themselves legitimate means of classification. Mercier though took issue with what he viewed to be the incompatibility of the concepts employed in the proposed Table of the Forms, which he deemed to have been thrown together into a classification that he attacked for being conceptually incoherent.

Which of these principles would Mercier choose as the grounding for his classification of the kinds of insanity? Deeming mental science to still be in a ‘primitive’ stage in its development, he appealed to ignorance of the causes and pathology of insanity to claim that ‘the predominant symptom was still the best grounds for classification’.<sup>79</sup> However, he did not think that this was the end of the story, and that the whole classification should be structured along these lines: he thought that the main classes should be divided according to the intensity of the insanity, and he used the following categories in his own classification: *fulminant*, that is to say, severe or sudden in its onset; *acute*; *sub-acute*; *chronic*. The main classes would be drawn along lines that described the intensity of the symptoms, with the predominant symptom, such as *depression*, *exaltation* or *obsession*, being used to differentiate cases within the main classes. Upon these principles, Mercier proposed a complex, multi-axial classification system that sought to cross reference what he thought were different classes of predominant symptoms with behaviours and intensity of the disorder:

---

<sup>77</sup> Information in square brackets I have inserted in order to make clearer the links between Mercier’s criticisms and the terms he is referring to in the Table of the Forms: Mercier is inconsistent with his terminology, favouring at times Falret’s terminology of *folie circulaire* to *alternating insanity* as employed in the table proposed by the committee; Ibid., (p.675)

<sup>78</sup> Ibid.

<sup>79</sup> Ibid., (p.679).

TABLE IV.—Forms of Non-congenital Insanity.

	General paralytic.	Non-paralytic.						Associated conditions.															
		Primary.	Recurrent.	Secondary.			Summary.	Total.	Mental.			Bodily.											
				Alternate.	Exacerbate.	Continuing.			Hallucination.	Delusion.	Mnemonic defect. <sup>a</sup>	Epilepsy.	Fever. <sup>b</sup>	Myxœdema.	Phthisis. <sup>c</sup>	e	e						
																		1	2	3	4	5	6
Fulminant (ac. delirious mania)	1	—	1	—	—	—	1	1 <sup>d</sup>	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—
Acute	Stuporose . . . . .	2	—	2	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	Resistive . . . . .	3	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	Depressed . . . . .	4	12	11	2	—	—	13	2	18	—	—	—	—	—	—	—	—	—	—	—	—	—
	Excited . . . . .	5	5	8	—	2	—	10	4	10	—	2	—	—	—	—	—	—	—	—	—	—	—
	Exalted . . . . .	6	—	—	1	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
		7	—	—	—	—	—	—	26 <sup>e</sup>	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Sub-acute	Neurasthenic . . . . .	8	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	Exalted . . . . .	9	6	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	Excited . . . . .	10	—	—	—	1	23	7	6	15	—	5	—	—	—	—	—	—	—	—	—	—	—
	Depressed . . . . .	11	4	—	3	—	10	3	15	16	—	—	—	—	—	—	—	—	—	—	—	—	—
	Suspicious . . . . .	12	—	1	—	—	—	1	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—
	Persecuted . . . . .	13	—	2	—	—	—	14	15	16	—	—	—	—	—	—	—	—	—	—	—	—	—
	Obsessed . . . . .	14	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	Perverted . . . . .	15	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	16	—	—	—	—	—	—	54 <sup>f</sup>	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Chronic	Defective . . . . .	17	5	—	—	2	230	54	—	—	5	32	—	—	—	—	—	—	—	—	—	—	—
	Exalted . . . . .	18	2	—	—	—	5	8	—	13	—	—	—	—	—	—	—	—	—	—	—	—	—
	Excited . . . . .	19	—	—	—	—	13	2	8	30	—	7	—	—	—	—	—	—	—	—	—	—	—
	Depressed . . . . .	20	1	—	—	—	—	18	—	18	—	—	—	—	—	—	—	—	—	—	—	—	—
	Suspicious . . . . .	21	—	—	—	—	—	2	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—
	Persecuted . . . . .	22	—	—	—	—	—	48	—	48	—	—	—	—	—	—	—	—	—	—	—	—	—
	Obsessed . . . . .	23	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	Perverted . . . . .	24	—	—	—	—	—	5	—	5	—	—	—	—	—	—	—	—	—	—	—	—	—
Totals . . . . .	26	25	6	3	281	171	—	407 <sup>g</sup>	76	222	7	46	1	—	2	—	—	—	—	—	—	—	
	486	—	—	—	—	—	—	486 <sup>h</sup>	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
Grand total insanity .	512	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	

a. Defect of memory so great as to be unmistakably morbid. b. Fever is not to be registered when it can be attributed to intercurrent disease. c. Other associated bodily conditions, being not intercurrent disease, but organically connected with the insanity. d. Total acute delirious mania. e. Total acute insanity (non-paralytic). f. Total sub-acute insanity (non-paralytic). g. Total chronic insanity (non-paralytic). h. Total non-paralytic insanity.

Figure 17: Charles Mercier's classification of the forms of non-congenital insanity.<sup>80</sup>

<sup>80</sup> Ibid., (p.685)

By the end of his paper, Mercier proudly accompanied the presentation of this complex system by stating it had presented a map of the forms of insanity that satisfied J.S. Mill's notion of natural kinds.<sup>81</sup> This seems at odds with his claim that there were no different kinds of insanity, and that insanity was in fact one thing. Yet Mercier's classification was an elaborate attempt to map the natural progression of mental disorder by representing what he thought was the typical onset of symptoms. He thought the concepts in his classification were natural kinds of symptomatic forms of insanity. He described *fulminant insanity* as a 'true *natural kind*', which was distinct from acute insanity, which he also regarded as a 'very natural kind' of insanity. Mercier used *form* and *kind* interchangeably in the paper in which he presented his classification, and this tension in Mercier's ideas would be exploited by critics of his classification system.

## Section 2: The Classification of the Forms of Insanity

The debates conducted over the next two years were lengthy, acrimonious, and drawn out over a series of adjourned general meetings of the association, and regional meetings that took place across Scotland, Ireland, England and Wales. The adjourned annual meeting would be held in November 1904, and adjourned again until July 1905, the day before the regular yearly meeting of the association. The revisions were also put to the regional meetings during this time, allowing psychiatrists from across the country to be involved in some way in the discussions surrounding the Table of the Forms. External authorities in biology and statistics were consulted by the committee, as well as experts on data collection from the General Records Office (GRO) at Somerset House. Although the committee went to great lengths to reach compromises, it could not avoid impasse at certain points, and the debates would become more and more heated as the process became drawn out. The members of the committee received very little in terms of recompense for the time that they had sacrificed, and many had not envisaged that an apparently simple task of carrying out statistical revisions would take-up so much of their time and take over two years. The committee's reactions to quibbles over details and resistance to their proposals became increasingly bad tempered and irritable as the discussions went on, with barbs also being traded in the association's *JMS* in letters, articles and editorials. Since the debates were so extensive, this section will provide an overview of the developments that took place in the lead up to the 1906 annual general meeting, where the classification was finally approved, and will focus on notable flashpoints within these discussions. It will then look at the deliberations that surrounded its final approval at the 1906 meeting and provide an analysis of the final classification.

---

<sup>81</sup> Ibid.

## 2.1 The Debates Between July 1904 and July 1906

Henry Rayner responded on behalf of the committee to Mercier, dismissing his criticisms of the revisions that they had presented and the classification that he proposed.<sup>82</sup> He defended the tables published by the committee as representing ‘the highest and latest views of insanity held in this country’, and accused Mercier of not living up to his own logical standards with his classification.<sup>83</sup> Rayner described it as impractical, unwieldy and conceptually confused, and dismissed Mercier’s claim that the committee had reified melancholia and mania into kinds of insanity out of hand.<sup>84</sup> Instead of providing a full response to Mercier’s criticism, he went on the attack, deriding Mercier for not having exacted the kind of precision that he demanded from the committee: ‘a philologist should recognise that “form” refers to contour and outward appearance as distinguished from structure’.<sup>85</sup> Rayner meant by this that the committee had not, during its sitting, considered that its task was to describe natural kinds, or the structure of pathological disease entities: instead their task was merely to develop concepts that were of clinical significance, and not of scientific validity.

Rayner thought that ignorance of the causation of insanity meant that the forms of insanity could only be just that: a description of the symptoms, of insanity’s forms and not its natural kinds. The forms proposed were a temporary measure until advances, which he speculated may not be far away, could provide insights that would allow for either an aetiological or pathological classification of insanity.<sup>86</sup> He emphasised the point that the primary divisions presented by the committee of emotional, volitional, intellectual and general insanities were valid because those were the main appearances that insanity presented within the clinic. He rubbished Mercier’s claim that the intensity of the disorder should be the basis of the main classes of the forms, instead defending the decision to sub-divide based on the temporal considerations of *recent* and *chronic*, which would, he thought provide clues on the prognosis of the disorder. He repeated Bond and Urquhart’s call to split the forms into two parts: the first to include all conditions where the pathology was not known, and the second for those that were. Rayner considered the changes that had been made temporary, and argued that

---

<sup>82</sup> Henry Rayner, ‘The Classification of Insane States in Revised Statistical Tables’ in *JMS*, Vol.51, No.212, Jan. 1905, pp.140 – 143.

<sup>83</sup> *Ibid.*, (p.140).

<sup>84</sup> *Ibid.*, (p.141).

<sup>85</sup> *Ibid.*

<sup>86</sup> *Ibid.*

being conservative with changes would have the advantage of allowing the table to be adaptable to new developments in research. Rayner suggested that this provided a much more satisfactory approach than Mercier's, which he deemed to be overly complex and impractical: 'in the face of his table I fear that any sort of alienist would be in the condition of a man finding his way through a maze ending in a morass'.<sup>87</sup>

The annual meeting was adjourned until July 1905 to debate the statistical tables, where during a series of tense discussions, both the Table of the Forms and the table of causes took centre stage.<sup>88</sup> That same year, the statistician Karl Pearson had published in the *BMJ* a paper on biostatistics and insanity.<sup>89</sup> In it, he called for the better understanding of the hereditary factors, and how these could provide insights into the causation of insanity. Also, and perhaps more importantly, this line of research could, Pearson argued, provide clues on what was becoming the holy grail for psychiatrists – its prognosis; Pearson's article called for the collection of 'reliable family records for the solution of the inheritance of pathological character', and claimed that admissions data from asylums had a role to play in solving this puzzle, but these needed to be correlated to family records because clinicians often did not know the family history of a patient going back more than one generation. The committee informed the assembly that they had been in contact with Pearson over the revisions to the statistical tables, and that Francis Galton had also taken an interest in the deliberations undertaken by the MPA on the revisions to the statistical tables. The committee were asked if they were able to gain external consultation from either of these world leading statisticians, and although Pearson did offer informal advice, he was not, due to other commitments, able to work with the committee extensively on the revisions to the tables.<sup>90</sup>

As in Rayner's response to Mercier, the committee held the attitude that the state of psychiatric knowledge did not allow for a pathological classification to be drawn up at this juncture.<sup>91</sup> Although they felt that the time was not ripe, the committee were hopeful that discoveries which would enable a classification that would describe natural kinds of insanity and not be restricted to symptomatic forms might be as close as ten years away.<sup>92</sup> The committee's frequent announcements that the classification they had produced was a

---

<sup>87</sup> Ibid., (p.143).

<sup>88</sup> Percy Smith, 'Adjourned Annual Meeting of 1904' in *JMS*, Vol.51, No.215, Oct. 1905, pp733 – 772.

<sup>89</sup> Karl Pearson, 'On the Inheritance of Insanity' in *BMJ*, May 7<sup>th</sup> 1905, pp. 1175 - 1176

<sup>90</sup> Percy Smith, 'Adjourned Annual Meeting of 1904' in *JMS*, Vol.51, No.215, Oct. 1905, pp733 – 772.

<sup>91</sup> Ibid.

<sup>92</sup> Ibid.



temporary measure demonstrates the uncertainty that existed over the then current state of psychiatric knowledge, and what was known about insanity's pathology and aetiology.<sup>93</sup> The medical training of the committee members informed the epistemological and metaphysical notions of classification that were present in these debates: the ideal held was to understand insanity in a causal manner, and pathology and aetiology were for many the routes to what was considered the ideal aspirations for a gold standard of scientific psychiatry. Yet, the cracks were beginning to appear in this aspiration with the gradual shift in emphasis towards prognosis: with lack of a major breakthrough in the pathology of insanity, some held the view that the best thing to do was to predict the course of insanity in order to carry out preventative treatment, rather than understand the causes and pathology of insanity to work out cures that would lead to an increased discharge from asylums.

Despite the furore caused by the proposed revision in 1904 and the revision passed in 1905, radical changes were not made to the final classification that would eventually be presented the following year: one category was added, with the debate at the 1905 AGM centred around disagreements on what sub-categories of mania were to be included. On the one hand, there were members of the association who thought that the classification was too conservative: for example, Thomas Drapes, who would later go on to write a seminal introduction of Kraepelin to readers of the *JMS*, rejected the notion that the forms presented by the committee would be a temporary measure, and instead gestured that it might be a hundred years before a scientifically informed classification could be possible if the Association continued to produce classifications like the one offered by the committee.<sup>94</sup> On the other hand there were those like D.G. Thomson who claimed that the categories of *alternating*, *delusional*, *volitional* and *moral insanity* were 'new fangled' and fashionable terms for existing forms of insanity: in his view the committee should have kept with familiar terminology and described them as forms of mania instead of differentiating them as distinct disease entities.<sup>95</sup> In the face of these objections and differences of opinion, members of the revisions committee reiterated its belief that it was not its job to carry out a wholesale revision of the system that was in use, but stated that it also wanted to conservatively introduce new concepts to British psychiatry.<sup>96</sup>

---

<sup>93</sup> Ibid.

<sup>94</sup> Ibid.

<sup>95</sup> D.G. Thompson, remarks recorded in Ibid.

<sup>96</sup> Ibid.

Mercier, who had been unable to attend the adjourned session from November 1904 held the day before annual meeting, attempted to raise problems with the tables at the 1905 annual meeting of the association.<sup>97</sup> By this point however, the council and many members of the MPA had the previous day sat through eight hours' worth of deliberation over the tables, and their patience was beginning to wane. Mercier was unhappy with the Table of the Forms that the committee has presented, pointing out that despite the lengthy exchanges, it had undergone no significant changes.<sup>98</sup> He then proposed that a new and separate classification committee be set up alongside the statistics committee that was devoted entirely to drawing up a classification of the forms of insanity that were recognised by the association, offering to serve on it himself. The committee eagerly seconded this motion, for it was the troublesome Table of the Forms that had taken up most of their time over the last two years, and they were more than willing to pass on the task to Mercier. The new classification committee, which Mercier was appointed to, would sit for one year and deliver its final version of the classification at the next annual meeting in July 1906.<sup>99</sup> This was the point at which the MPA devoted energy specifically to drawing up a classification of the forms of insanity: prior to this it had been a statistical table that had contained forms, or clinical appearances, of insanity in the statistical returns submitted by asylums across the country. This was an important turning point, and the beginning of the process for an official classification of the kinds of insanity to be drawn up by the MPA.

## 2.2: The Final Report and the Final Classification

Knowing that the classification committee would be delivering their final version of the forms of insanity that year, the president of the MPA, Robert Armstrong Jones, delivered an address at the annual general meeting on July 26<sup>th</sup> 1906 that sought to give a definitive picture of 'the evolution of insanity'.<sup>100</sup> In an ambitious narrative that spanned four millennia, and mentioned some of the figures discussed in the first chapter, namely Alexander Crichton, Thomas Arnold, David Davis, Philippe Pinel and Jean-Étienne Esquirol, Armstrong Jones projected across cultures and into the past the notion that there had been different forms of insanity, with the

---

<sup>97</sup> 'Medico-Psychological Association of Great Britain and Ireland: Annual Meeting of the Association, July 20<sup>th</sup>, 1905' in *JMS*, Vol.51, No.215, Oct. 1905, pp.773 – 789.

<sup>98</sup> Mercier, remarks recorded in *Ibid*.

<sup>99</sup> *Ibid*.

<sup>100</sup> Robert Armstrong Jones, 'Medico-Psychological Association of Great Britain and Ireland: Presidential Address on the Evolution of Insanity, delivered July 26<sup>th</sup>, 1906' in *JMS*, Vol.51, No.215, Oct. 1905, pp.629 – 661.

‘milder forms of mental disorder [being] treated by pilgrimages to the shrines of certain saints’ who were reputed to be skilled at exorcism of evil spirits, and that even in ‘the most barbarous and least civilised of races there occur two forms of psychic anomalies, viz., the congenital and the toxic, the latter due to some poison, such as occurs from alcohol in our own country.’<sup>101</sup> This discussion of the past of the insanity in its different forms allowed him to discuss its prevalence, with ‘the spread of venereal disease being responsible for increasing certain forms of insanity’, whilst ‘the congenital varieties of mental deficiency show but little increase, according to asylum statistics.’<sup>102</sup> This historical framing of the nature of the different forms of insanity, as well as the potentials held for treatment by understanding its various guises, was a fitting way to introduce the presentation of the final version of the Table of the Forms.

The classification committee of which Robert Armstrong Jones was himself a member along with Charles Mercier, George Savage and Edwin Goodall, submitted its final report separately to the statistical committee’s. It had sat five times since July 1905, and lengthy deliberations had led it to make adjustments to the classification that had been offered by the statistical committee in July 1904:

**Forms of Insanity (as presented to the 1906 Annual Meeting of the  
Medico-Psychological Society and included in the Report of the Classification  
Committee of 1906).<sup>103</sup>**

- I. Congenital or infantile mental deficiency (idiocy or imbecility), occurring as early in life as it can be observed –
  1. Intellectual
    - a. With Epilepsy
    - b. Without Epilepsy
  2. Moral
- II. Insanity occurring later in life
  1. Insanity with epilepsy
  2. General paralysis of the insane
  3. Insanity with the grosser brain lesions
  4. Acute delirium (acute delirious mania)
  5. Confusional Insanity
  6. Stupor
  7. Primary Dementia

[the committee intended a note to be entered here which indicated that 4, 5, 6, and 7 were grouped together by the committee because they constituted a ‘natural group’<sup>104</sup>]

---

<sup>101</sup> Ibid., (p.644 & 652).

<sup>102</sup> Ibid., (p.652).

<sup>103</sup> ‘Medico-Psychological Association of Great Britain and Ireland’ in *JMS*, Oct. 1906, pp.809 – 838 (p.820).

<sup>104</sup> Ibid., p.821

8. Mania
  - a. Recent
  - b. Chronic
  - c. Recurrent
9. Melancholia
  - a. Recent
  - b. Chronic
  - c. Recurrent
10. Alternating Insanity
11. Delusional Insanity
  - a. Systematised
  - b. Non-systematised
12. Volitional Insanity
  - a. Impulse
  - b. Obsession
  - c. Doubt
13. Moral Insanity
14. Dementia
  - a. Senile
  - b. Secondary or Terminal<sup>105</sup>

Figure 18: Table of the Forms Presented to the 1906 Annual General Meeting of the MPA

The committee had mainly charged itself primarily with rearranging the classes of insanity that were included in the initial Table of the Forms offered in 1904. The diseases were separated into two main classes: the first relating to congenital illnesses and the second to ‘Insanity occurring later in life’.<sup>106</sup> The classification judged moral insanity to be a congenital disorder that was in the same class as intellectual insanity, but moral dementia was included in the second class of insanities that were considered to develop from beyond birth. Many of the diseases included in this category had appeared on the 1904 table, but some had been rephrased: the committee had favoured the more well-known *general paralysis of the insane* to the general progressive paralysis that had been employed by the last committee. In a similar vein and fearful that the term would be unfamiliar to psychiatrists practicing in the British Isles, *dementia praecox* was replaced with *primary dementia*: during the regional meetings, certain members of the MPA had expressed disfavour with the use of a non-English term and demanded that it be replaced with one was not so awkward to the British tongue. *Primary dementia*, as it was now known, was promoted to a main class, further enhancing the Kraepelinian character of this classification. To incorporate an element of Mercier’s classification, *acute delirium* was introduced to make a distinction between extreme cases of delusional insanity and milder forms which would still be classed as *delusional insanity*, which

---

<sup>105</sup> Ibid.

<sup>106</sup> Ibid.

itself had been granted two sub-classes – *systematised* and *non-systematised* – and referred respectively to cases of what were considered perpetual and continuous states of delusion, which had a poor prognosis, and transitory cases which had a better chance of recovery.

This revision then was marked by two things. Firstly, it restricted itself to symptom-based disease entities, removing any terminology that implied causation or bodily states by removing organic as a sub category of dementia, and rephrasing epileptic insanity to insanity with epilepsy. This second revision was a subtle difference – the committee thought that epileptic insanity inferred that the insanity was caused by epilepsy, and instead made the change so that it was clear it referred to cases of insanity that were *accompanied* by epilepsy. The committee then presented a classification that had abstracted symptoms from the body, and not tying them to conditions such as puerperal or climacteric, or lesions or observable structural changes of the brain. The second important thing to note about these changes was that by removing the last remaining talk of bodily causes, this final version of the table had restricted itself to listing forms of insanity that were based upon observable symptoms. What marked a departure though from earlier versions of the table was that differentiations between the forms was not based on symptomology alone. The differentiations were also made on predictions about the course of the disease. As mentioned above, delusional insanity was thought by members of the committee, in particular Armstrong-Jones, to have a very poor prognosis.<sup>107</sup> Similarly, alternating insanity which was characterised by fluctuations between mania and melancholia, was thought to have a poor outlook, with gradual decline spanning over a long period.<sup>108</sup> Uncertainty existed over the differences in the prognosis of mania and melancholia, but it was agreed that recent forms, which referred to manias in their earliest stages were thought to have a better chance of recovery if mild in their intensity because they were observed in younger patients. Chronic forms typically affected middle aged patients and were less hopeful of recovery, whereas hopeful reports were given for those with recurrent forms of mania and melancholia.<sup>109</sup> Again, uncertainty surrounded the prognosis of primary dementia, but it was generally viewed as better than that of dementia and melancholia due to it often afflicting younger patients.

---

<sup>107</sup> Robert Armstrong-Jones, 'Prognosis in Mental Diseases' in *BMJ*, December 16th, 1905, pp.1578 – 1582.

<sup>108</sup> G. Fielding Blandford, 'The Lumleian Lectures on the Diagnosis, Prognosis and Prophylaxis of Insanity: Lecture II' in *BMJ*, April 13<sup>th</sup>, 1895, pp.797 – 800. (p.799).

<sup>109</sup> John G. Havelock, 'A Case of Recurrent Mania' in *JMS*, Vol.4, No.179, October 1896, pp.817 – 81.

## 2.3: The Reception

The classification committee faced resistance to their recommendations from three fronts. The first was from those who perceived the classification to be a backwards step in the classification of the insanities. Lewis Campbell Bruce, who had trained under Clouston at Morningside asylum, remarked:

...the speciality had advanced a good deal farther than the proposed classification indicated. The committee was a very strong one, and if they considered that no further progress had been made, it would, he thought, be better to leave it entirely, than to print and publish to the world that the present effort was all that the British Medico-Psychological Association could do.<sup>110</sup>

Armstrong Jones responded to Bruce's criticism that the symptom based classification of mental disorders was retained due to the lack of any major breakthrough in the aetiology or pathology of mental disorders.<sup>111</sup> Psychiatry would have a long wait for its aetiological classification. Tied to the hopes that this system would promote the international status of British psychiatry, there was some hostility expressed during the meeting to so-called 'continental' ideas about classification.<sup>112</sup> There were two main manifestations of this hostility. The first was a perception on the part of those – especially those who were disciples of Skae – dissatisfied with the dropping of all aetiological factors. Clouston for one wanted to keep with an aetiological approach to insanity, and rejected what he regarded as diagnostic concepts whose prognostic value was vague and imprecise.<sup>113</sup> Furthermore, according to some members, the then mainstream symptom based approach had been imposed upon British psychiatry from France, and it was time to break free from this and draw up a more 'scientifically' valid aetiological approach.<sup>114</sup>

Mercier defended the exclusion of aetiological factors on the basis that the classification that they had drawn up was designed to be used by psychiatrists who did not have information available to them at the point of diagnosis about the person's history.<sup>115</sup> The designers of the classification system presented in 1906 intended it to be used by physicians to

---

<sup>110</sup> Lewis Campbell Bruce, remarks recorded in 'Medico-Psychological Association of Great Britain and Ireland' in *JMS*, Oct. 1906, pp.809 – 838, (p.822).

<sup>111</sup> *Ibid.*, (p.823)

<sup>112</sup> *Ibid.*

<sup>113</sup> Clouston would criticise primary dementia in his lectures, describing it as a form of melancholia, and saying that stupor should replace this term. See; Thomas Clouston, *Clinical Lectures on Mental Diseases*, J&A Churchill, 1892, p.302.

<sup>114</sup> 'Medico-Psychological Association of Great Britain and Ireland' in *JMS*, Oct. 1906, pp.809 – 838

<sup>115</sup> *Ibid.*

make an ahistorical diagnosis based purely upon the symptoms that presented themselves to the clinician at the point of entry to an asylum, and what the future course of the condition would be. Although this was perhaps a legitimate pragmatic measure, this eradicated Skae's belief that diagnostic concepts should, when mapping the natural history of a disorder, place their emphasis on the somatic cause of the illness. Mercier pointed out in response to these criticisms that it would not be possible to include aetiological and symptom based concepts in the same diagnostic system because it would make the classification confused and logically incoherent. The importance that Mercier held on logical consistence was due to the influence of Herbert Spencer, considering himself as 'more Spencerian than Mr. Spencer himself'.<sup>116</sup> He considered Spencer to be a doggedly rigorous classifier, yet in his response to his classification of the cognitions, Mercier thought that this work could be improved upon by following through on some of the principles that Spencer had established, yet had failed to follow to their logical conclusions. This attention to logical detail was behind the classification committee's attempts to create a logically consistent table that would not, in his own words, become another higgledy piggedly compendium of the insanities.

The second line of criticism was the call for the adoption of ideas that were more in line with British psychiatry.<sup>117</sup> For instance, Urquhart was 'very glad the English name 'delusional insanity' had been adhered to'.<sup>118</sup> Responding to this issue, one of the members of the committee, Connolly Norman, stated that 'the [members] could not have their bread buttered on both sides, any more than could others, and no one could blame the committee for having been Germanic and non-Germanic at the same time'.<sup>119</sup> It was clear then that with the haphazard translation of a German clinical term, the committee had resolutely decided to be non-Germanic. This was seen at its starkest articulation with the rendering of the Kraepelinian concept of 'dementia praecox', into primary dementia. Although towards the end of the proceedings Urquhart stood up to laud Greisinger as being the greatest classifier that had so far lived, his was the sole voice that was raised in favour of non-British psychiatry. It is possible that the general ill feeling of the British towards the aggressive foreign policy undertaken by the Kaiser and the Iron Chancellor had seeped into the halls of the Medical Society of London where the annual general meeting was being held that July afternoon. Whatever may be the case. these kinds of parochial attitudes towards the terminology and concepts employed in the

---

<sup>116</sup> Charles Mercier, 'Mr. H Spencer's Classifications of Cognitions' in *Mind*, Vol.8, No.30, April 1883, pp.260 – 267. (p.260)

<sup>117</sup> Ibid.

<sup>118</sup> Ibid.

<sup>119</sup> Ibid., (p.826).

1906 classification were in direct contrast to the calls by some members of the Association in various annual meetings previously to seek to unify the many classification systems that had been published by psychiatrists from across the world.

The lack of any attempt to include definitions in the Table of the Forms of Insanity was the third line of criticism, and was a particularly contentious issue. The aforementioned Campbell Bruce, called for some of the terms employed in the diagnostic criteria to be defined, with the claim that ‘all medical terminology ought to be definable’.<sup>120</sup> Maurice Craig, who supported Bruce, ‘thought the committee were simply adhering to the old division on a symptomatic basis’, that the lack of definitions allowed the committee to get away with presenting an old form of classification in a new guise, and ‘if that was all that could be done he thought it better to do nothing’.<sup>121</sup> Another speaker took a dim view of ‘practically all aetiological terminology [being] separated from mania’ and that melancholia should have headed the section on the insanities because it was the nearest divergence from sanity.<sup>122</sup> Surprisingly, considering his earlier opposition to the report published by the 1904 statistical committee, Mercier responded that it was not their job to provide definitions of psychopathologies since it ‘was a classification committee, not a defining committee’, and he directed members to look to textbooks for definitions of clinical terms.<sup>123</sup> This lack of an attempt to include definitions was because Mercier took the view it was the task of medical textbooks to provide research that would allow definitions to be formulated, and not the task of a classifications committee like the one he chaired.

The lack of any attempt to provide definitions puzzled many members of the Association, given that the committee was tasked with bringing about a standardised classification of psychiatric diagnosis. This deliberate move to not define disorders was indicative of a change in attitudes about the role that classification systems should adopt, and that instead of providing formal definitions of the symptoms associated with a mental disorder, the classification serves to provide a simple, operational schematic of the known disorders that were recognised by the profession. In fact, the lack of any attempt to define the disorders included in this classification system was viewed by some as undermining the effectiveness of the document. By presenting a stripped-down classification without definitions, a number of

---

<sup>120</sup> ‘Medico-Psychological Association of Great Britain and Ireland’ in *The Journal of Mental Science*, Volume 52, No.219, Oct. 1906, pp.809 – 838. (p.822).

<sup>121</sup> Ibid.

<sup>122</sup> Ibid.

<sup>123</sup> Ibid., (pp.823 – 824)



ambiguities had arisen surrounding the terms employed in the Table of the Forms of Insanity. For instance, some delegates did not know what *confusional insanity* or *primary dementia* meant, and it harder to deduce what these meant because they were not tied to causes, which was an effective way of communicating the substance of a concept of mental disease to medically trained doctors.<sup>124</sup> Towards the end of the proceedings, Henry Yellowlees supported Mercier's defence of the omission of causal factors, stating that at that time, an aetiologically based classification system was not possible, and in order to improve asylum statistics, it was necessary to separate aetiology from symptoms.

## 2.4 The Aftermath

The classification that was devised by the 1906 committee would the following year be adopted by the Commissioners in Lunacy. At the quarterly meeting in November 1906, Dr Hayes Newington announced that the statistical tables had been formerly adopted and members would be sent them to use in the 1907 statistical returns.<sup>125</sup> Asylum medical superintendents would also be sent the medical registers that had been devised by the first revisions committee to standardise and streamline the recording of data on admissions, and this included the Table of the Forms, and the Schedule of Causes and Associated Factors of Insanity. The diagnostic concepts published by the MPA would be the official classification of the Association until they were revised in 1932, but the Board of Control would cease to make it compulsory for asylums to complete the medical registers after the Great War, and the table of the causes and the Table of the Forms would cease to be used by many institutions after 1919.<sup>126</sup>

The Table of the Forms of Insanity was considered outdated almost as soon as it was published. Research devoted to Kraepelinian concepts of psychopathology increased dramatically after 1906, with the January 1909 issue of the *JMS* deserving special mention: aside from an essay penned by Maudsley on the relationship between mind and body, the entirety of the papers in this issue employed Kraepelinian concepts in empirical research, or analysed the German psychiatrists concepts. Two papers that served as introductions to English medical psychologists were amongst the papers included in this volume: Thomas Johnstone's 'The Case

---

<sup>124</sup> Ibid.

<sup>125</sup> Dr Hayes Newington, remarks recorded in 'The Medico-Psychological Association of Great Britain and Ireland: Quarterly Meeting November 15<sup>th</sup> 1906' in *JMS*, Vol.53, No.220, Jan. 1907, pp.214 – 217. (p.215).

<sup>126</sup> This was mainly because the Board of Control saw the task of collecting asylum statistics as dispensable in the face of the disruption caused by many asylums being repurposed as war hospitals during the conflict; Anon, 'Statistical Intermission' in *JMS*, Vol.6, No.56, Jan. 1916, pp.182 – 183.

for Dementia Praecox' and Thomas Drapes's 'On the Maniacal-Depressive Insanity of Kraepelin'.<sup>127</sup> Although *primary dementia* had been included in the classification, it also had been used in Anglophone psychiatry prior to Kraepelin to describe a variety of disorders, and in their work Johnstone and Drapes opted to use *dementia praecox* instead of primary dementia in order to make it clear that they were referring to the German's work.

The revisions committee was successful in their original aim of keeping the causes of insanity and the symptom derived concepts of mental disorder separate by removing all mention of aetiology from the classification they published. As a point of comparison, that same year, the Royal College of Physicians (RCP) would publish the third edition of their nomenclature, which included a sub-section on mental diseases.<sup>128</sup> It closely resembled the Table of the Forms presented by the revisions committee, with two of the members of the revisions committee appointed by the MPA, George Savage and Percy Smith, acting as the psychiatric consultants.<sup>129</sup> Like the MPA's classification, the RCP's mental diseases sub-section was split in two, including a section on 'Errors of Development', and a section titled 'Disorders of Function' which corresponded to the MPA's distinction between 'Congenital and Infant Deficiency' and 'Insanity Occurring Later in Life'.<sup>130</sup> These two sections contained disease concepts that were very similar to the ones included in the Table of the Forms, but it included aetiological sub-categories to the main disorders. Melancholia and mania for instance both had puerperal sub-classes, with the former having climacteric forms, and the latter having alcoholic and epileptic forms.<sup>131</sup> Crucially, there were two additional classes which had not found their way into the MPA's classification: these were insanities which were the 'Result of Infective, Toxic, and Other General Conditions' and, most importantly, a section on the 'Degenerations'.<sup>132</sup> Degenerations included general paralysis of the insane, and dementia with six different forms: developmental; senile; epileptic; syphilitic; organic; and those 'From other acute or chronic disease, or from injury'.<sup>133</sup> The college's nomenclature attempted to combine functional mental disorders with their suspected causes, be they in the form of bodily

---

<sup>127</sup> Thomas Drapes, 'On the Maniacal-Depressive Insanity of Kraepelin' in *JMS*, Vol.55, No.228, January 1909, pp.58 – 64.

<sup>128</sup> William S. Church, E. Liveing et al., *The Nomenclature of Diseases: Drawn up by a Joint Committee appointed by the Royal College of Physicians of London*, fourth edition, HMSO, 1906.

<sup>129</sup> *Ibid.*, (p.vii).

<sup>130</sup> *Ibid.* (p.35)

<sup>131</sup> *Ibid.* (p.36)

<sup>132</sup> *Ibid.* (pp.37 – 39).

<sup>133</sup> *Ibid.*

conditions such as pregnancy, habits such as alcoholism, lesions or other degenerative disorders that had an observable impact on brain physiology, or hereditary theories of causation in the form of degeneration. This is in stark contrast to the MPA's classification, which attempted to provide a descriptive classification that included no elements of the aetiology of the disorders it included.

Although some perceived this to be a strength, others thought this to be a shortfall of the document. John Turner, the medical superintendent of Essex County Mental Hospital in Brentwood offered an ambitious classification of insanity drawn along an anatomical basis.<sup>134</sup> Like the 1906 classification approved by the MPA, this was divided into two sections: the first dealing with 'the idiopathic or those hereditarily predisposed, embracing by far the larger number of individuals' and the second 'the traumatic or accidental'.<sup>135</sup> Turner also stated that the 'relative interdependence of intrinsic and extrinsic factors is a fundamental point' to his classification system – the intrinsic referred to the hereditarily predisposed, the extrinsic to the traumatic or accidental. The first section was divided 'into three classes according to the degree of anatomical change or developmental defect in the cortex'.<sup>136</sup> The first class were 'imbeciles' whose 'structural defect' was to such a degree 'that the nervous system is incapable, at the outset of life, of performing its functions in an efficient or normal manner'.<sup>137</sup> The second class is based upon a similar principle of structural defect, but was accompanied by efficient function but is 'incapable of withstanding the physiological and inevitable stresses of life', and the third class comprising those who can withstand 'the ordinary physiological stresses, but break down when exposed to the influence of adventitious unfavourable circumstances, or with advanced age'.<sup>138</sup> Turner's system was presented to a meeting of the South Division of the MPA in 1912, but it drew a lot of criticism, perhaps predictably, by Mercier, who attacked it on the basis that it had not separated aetiological, pathological and symptomatic notions and that Turner's work again, was a complicated compendium of the insanities.

## Conclusion

The turn of the century was a transition period between the classifications that were used in Victorian asylums and the beginning of the dominance of Kraepelinian concepts of

---

<sup>134</sup> John Turner, 'The Classification of Insanity' in *JMS*, Vol.58, No.40, January 1912, pp.9 – 25.

<sup>135</sup> *Ibid.*, (p.14).

<sup>136</sup> *Ibid.*

<sup>137</sup> *Ibid.*

<sup>138</sup> *Ibid.*, (p.15).

psychopathology that would be enthusiastically received by psychiatrists working across Europe and the United States during the inter-war period. Aspect of prognosis, seen primarily with the inclusion of Kraepelin's primary dementia, and the concept of alternating insanity, began to surface at these discussions. Commenting on the revisions, a review published in the *JMS* in 1923 expresses sympathy towards the committee exercising caution on developing and implementing the relatively new and untested diagnostic category of primary dementia.<sup>139</sup> It acknowledged that it may have not been the right time for a completely new classification, it does express regret that 'some definition of the scheduled forms of mental disorder was not attempted', adding that 'names are immaterial so long as we have some idea of the type of case they refer to'.<sup>140</sup> The report claims that had this been done, the 're-classification in accordance with advancing knowledge of cases now recorded in our statistics would not have been impossible'. According to the review, British psychiatry should try to emulate the American Psychiatric Association's success in providing 'workable definitions of the main types of mental disorder in its statistical manual' because these had given some indication of the future course of each form of insanity.<sup>141</sup> The report emphasised that the lack of definitions was an important oversight that hindered communication between psychiatrists, and that whilst there 'was disagreement on whether they work well or not, at least [definitions] functioned well enough to allow communication to occur amongst the community'.<sup>142</sup>

But should we judge the Table of the Forms so harshly? With the introduction of the medical register, it was possible to calculate admissions and discharges on the basis of the each form of insanity. Furthermore, it acted as an important catalyst for discussion on classification, and it enabled the whole of the membership of the MPA to contribute to these debates which confronted issues about the nature of insanity and mental illness. As Henry Rayner, one of the members of the revisions committee stated:

The utmost consideration, therefore, should be given to insure the adoption of a table that shall be clear and stand the test criticism and experience. The committee that has given such careful thought to it will welcome discussion on this point as a recognition of the importance and the difficulty of the task which they have so zealously attacked and so admirably overcome. This table, however, is worthy of the vigorous discussion that it has excited, since it may be described, without

---

<sup>139</sup> M. Hamblin Smith, 'Review: *The Seventh and Eighth Annual Report of the Board of Control for the years 1920 and 1921*' in *JMS*, January 1923, pp.99 – 108.

<sup>140</sup> *Ibid.*

<sup>141</sup> *Ibid.*, (p.103).

<sup>142</sup> *Ibid.*

undue exaggeration, as the hub around which the other [statistical tables] revolve.<sup>143</sup>

The Table of the Forms served as an important catalyst for discussions on how best to classify insanity, and this helped to develop clinical ideas on psychiatric classification amongst British alienists. The medical and civil registers were used by the Board of Control until the Great war, but the chaos caused by the conflict meant that the Board of Control did not make it a requirement during and after the war for medical statistics to be collected.<sup>144</sup> Statistics after the war on admittances based upon the form of insanity were not published by the Board of Control after 1914, and although certain asylum medical officers would use the table for their own purposes, the official classification would fulfil some of the premonitions made by in the debates about it only being in operation for ten years.

It is also important to understand the practical pressures that were placed upon the committee, which led to the minor revisions to the Table of the Forms that were deemed so unsatisfactory by many of the members. Members that partook in statistical and classification committees carried out their work on a voluntary basis, and had to spend many hours in meetings and consultations with members of the association, needing to draft reports, papers and announcements. This all took time, and the grand visions of a lone wolf like Mercier, who wanted to completely reinvent classification and proposed elaborate work in response to the committee's work, were tamed by the everyday realities of committee procedures once they were appointed to carry out revisions. These realities had a huge impact upon the shaping of the psychiatric classification produced by the committee. The symptomatic classification that they produced was partly because symptom based concepts had functioned as useful heuristics, and many took the view that these that would do the job of classifying admittances until reliable pathologies could be found. The terms included within the 1906 classification drew upon the experience of the medical superintendent and their familiarity with textbooks and research that described the symptoms associated with each of the disorders that were included in the table. Put simply: symptom based concepts worked and were familiar, and in light of the practicalities of the research committee, they were resorted to in lieu of pathological classifications that would allow medical men to classify along the lines that they aspired to: those of the causal, somatic and mechanistic model of insanity.

---

<sup>143</sup> Henry Rayner, 'The Classification of Insane States in Revised Statistical Tables' in *JMS*, Vol.51, No.212, Jan. 1905, pp.140 – 143.

<sup>144</sup> Anon, 'Statistical Intermission' in *JMS*, Vol.6, No.56, Jan. 1916, pp.182 – 183.

What may have been the biggest 1906 classification's biggest flaw was its reformulation of Kraepelin's *dementia praecox* as *primary dementia*. This may seem like a small point, but this made the classification *seem* parochial and out of touch once Kraepelin's original term had become the standard after the Great War. The term became the standard used in research, and no apparent inclusion of manic depressive insanity also sealed the fate of the MPA classification. To stop at this conclusion however would be hasty. As discussed above, *alternating insanity* to some extent captured the symptoms that were described by Kraepelin's manic depressive insanity, and the 1906 classification did indeed include *dementia praecox*, but in failing to provide definitions of the terms, the actual meaning of these terms was ambiguous to those who were supposed to use the classification in practice. This chapter has presented proof that the committee included *dementia praecox* in at least one of the revisions to this document. If we understand alternating insanity to function as a prototype of manic depressive insanity, the 1906 revision can be understood in turn as a proto-Kraepelinian classification because it was carried out just before his ideas would become hugely popular in Europe and America. Whilst the classification was ultimately deemed to have massive failings, and did not live up to the aspirations to devise and adopt a world leading classification that would raise the profile of medical psychology in the British Isles, the MPA's Table of the Forms anticipated that there was change in the air, and anticipated the popularity of Kraepelinian psychopathology. Ultimately, the classification and the debates surrounding its genesis remains a crucial documentary record of the ideas that surrounded the conceptualisation of insanity at a crucial period in British psychiatry.

## Chapter 4: Heterogeneity in Classification and the (Failed) Second Revision to the Table of the Forms of Mental Disorder

On 8th July 1931, and in the face of growing despair about the prospects of psychiatric research, Richard Leeper, the president of the Royal Medico-Psychological Association (RMPA), gave an impassioned defence of the kind of hereditarian theories of mental disorder that had once dominated conceptions of mental disease in the British Isles since the 1870s, yet were now becoming increasingly unpopular. His presidential address posed the question: had mental science failed in its quest to treat the insane?<sup>1</sup> Answering his own question allowed Leeper to provide his vision of what he thought the future of mental science should be: one that was firmly rooted in the understandings of insanity that were seen during the era of the asylum. It is striking therefore that during that same year, a committee had been established by the Association to reform the existing classification of the MPA, with the goal of making revisions so that the table would represent the state of the art of psychiatric classification.

The problem was that the state of the art of psychiatric classification was divided, with new developments in psychoanalysis and psychology vying for position with the remaining dogmas of asylum psychiatry. Leeper, a representative of the latter, titled his speech 'Progress in Psychiatry', yet his vision of psychiatric classification and aetiology showed its retrospection when he claimed that 'nine out of ten forms of mental disease are due to the ever-varying vagaries of hereditary defect'.<sup>2</sup> Leeper adopted dramatic language to describe the dangers these products of hereditary defect held for wider society: 'neurotics breed neurotics, and unstable people breed insane people', and he blamed marriages between the mentally ill for producing offspring who in turn clogged up asylums.<sup>3</sup> Leeper thought that the danger posed by these 'terrible and disastrous unions' should be prevented at all costs, especially because the 'persecuted paranoiac [was] much more dangerous to the public than a man with a smallpox rash'.<sup>4</sup> He dramatically invoked the murder of the famous English actor William Terriss to drive home this point: Terriss had enjoyed fame in the 1880s, making acquaintance with George Bernard Shaw and Thomas William Robertson, before being stabbed to death in 1897

---

<sup>1</sup> Richard Robert Leeper, 'Some Reflections on the Progress of Psychiatry: The Presidential Address at the Ninetieth Annual Meeting of the Royal Medico-Psychological Association Held in Dublin' in the *JMS*, Vol.77, No.319, Oct. 1931, pp.683 – 691.

<sup>2</sup> *Ibid.*, (p.683)

<sup>3</sup> *Ibid.*, (p.684)

<sup>4</sup> *Ibid.*

by fellow actor, Richard Archer Prince.<sup>5</sup> Prince was found guilty but not responsible for his actions on the grounds of insanity, and when Leeper was speaking, would have been whiling away the rest of his days in Broadmoor mental hospital.<sup>6</sup>

The danger posed by ‘constitutionally psychotic’ people like Terriss, could only be combatted by what Leeper regarded to be the one true form of ‘scientific psychiatry’, one that understood the causation and classification of mental disorder through hereditary. This kind of psychiatry was deeply entrenched in the degeneration theory of Bénédict Augustin Morel and had informed British psychiatry since the second half of the nineteenth century: it had informed Henry Maudsley’s ideas and his legacy had been preserved during the interwar period in the research carried out at the hospital in Denmark Hill that bore his name.<sup>7</sup> Leeper thought that these two psychiatric false idols had arisen since the turn of the century: the now forgotten focal infection theory and psychoanalytic theory. which had been developed since the last set of revisions were made to the Table of the Forms. The first he identified as focal infection theory, a line of research that had become popular during the 1920s and claimed that mental disorders were caused by infections of the body. Infections of the gums were considered to be the source of insanity by one of the theory’s most enthusiastic and evangelical popularisers, the American physician Henry Cotton, and this had led him to forcefully and painfully remove the teeth of inmates in the asylum he ran.<sup>8</sup> Cotton’s ideas had been greeted with initial enthusiasm in the United Kingdom, yet by the time of Leeper’s address, their popularity was beginning to wane as the ethics of the procedures employed by the American were beginning to attract the attention of the federal authorities.<sup>9</sup> Leeper was not concerned about the welfare of patients when he dismissed focal infection theory, but instead questioned its scientific credentials. He thought that it may possibly lead to a short-term improvement in the bodily condition of the patient, but the forcible removal of teeth and the treatment of infection would not necessarily provide a cure for mental illness.

The therapeutic intervention of treating infections that was advocated by focal infection theory was nothing new: medical superintendents had long treated bodily infections in asylums, and although Leeper accepted that anti-septic measures were a good thing, he

---

<sup>5</sup> Richard Foulkes, ‘William Terriss [real name William Charles James Lewin] (1847–1897), actor.’ in *Oxford Dictionary of National Biography*, OUP.

<sup>6</sup> Ibid.

<sup>7</sup> Daniel Pick, *Faces of Degeneration: A European Disorder c.1848 – 1918*, Cambridge University Press, 1993.

<sup>8</sup> Andrew Scull, *Madhouse: A Tragic Tale of Megalomania and Modern Medicine*, Yale University Press, 2005.

<sup>9</sup> Ibid., (p.16)



thought that the science of focal infection was groundless. Ultimately, the resources directed towards developing focal infection treatments were wasted and could be directed towards a more efficient solution: the sterilisation of the insane, and their segregation from wider society. Leeper's appeal was successful: two years later a motion was presented to members of the RMPA for a formal union to be made with the Eugenics Society which would lobby parliament to introduce 'voluntary' sterilisation of the mentally ill.<sup>10</sup> Leeper's case was that measures such as these were necessary because the mental hygiene movement had failed in its task to 'educate the public to the danger of persons suffering from delusions of persecution'.<sup>11</sup> He expressed regret towards the end of his address that the Mental Deficiency Act, which in 1913 legislated for the creation of colonies to segregate the mentally deficient from society, was never extended to Ireland.<sup>12</sup> It was only by sterilising and removing from society 'feeble-minded psychopath[s]' like Terriss' killer that the future mental health of the nation could be guaranteed.<sup>13</sup>

If focal infection was merely a distraction from the ideal that Leeper held for psychiatric treatment and classification, he viewed the spread of psychoanalytic ideas as insidious, themselves proving to be an active public health danger. He described it as 'utterly fantastic and repulsive to a sane, disciplined mind', and that its exponents were 'latter-day apostles of astrology and necromancy'.<sup>14</sup> Leeper thought that the methods psychoanalysts adopted were 'frequently disastrous in [their] application to the psychoses', and he argued that 'melancholic' patients could be made even worse by the kind of self-deprecation that he thought were inherent to psychoanalytical principles and methods.<sup>15</sup> Unlike focal infection theory, which Leeper viewed as having some therapeutic benefit even if he questioned its scientific credentials, psychoanalysis' use of hypnosis was an occult and magical practice that could only bring harm to the people it professed to treat. In short, for Leeper, this modern

---

<sup>10</sup> See discussions conducted in the MPA's minutes for their 1933 Annual General Meeting; Minutes from The Medico-Psychological Association of Great Britain and Ireland: Ninety-Second Annual General Meeting of the Association. *JMS*, Vol.79, No.327, Oct. 1933, pp.800–817.

<sup>11</sup> Richard Robert Leeper, 'Some Reflections on the Progress of Psychiatry: The Presidential Address at the Ninetieth Annual Meeting of the Royal Medico-Psychological Association Held in Dublin' in the *JMS*, Vol.77, No.319, Oct. 1931, pp.683 – 691; extensive discussion was carried out by the RMPA to bring in voluntary sterilisation, see the Annual General Meeting Minutes of the Association c.1930 – 1933; 'Minutes from The Medico-Psychological Association of Great Britain and Ireland: Ninetieth Annual General Meeting of the Association' in *JMS*, Vol.77, No.319, pp.862–901; 'Minutes from The Medico-Psychological Association of Great Britain and Ireland: Ninety-First Annual General Meeting of the Association' in *JMS*, Vol.78, No.323, pp.973–999.

<sup>12</sup> *Ibid.*

<sup>13</sup> *Ibid.*

<sup>14</sup> *Ibid.*

<sup>15</sup> *Ibid.*

witchcraft had nothing to offer the modern mental sciences, neither in terms of the treatment, or the understanding, of the different forms of mental disorder.

Leeper then posed the rhetorical question: had the MPA ‘a really satisfactory classification of insanity, or should not all mental abnormality be ascribed to one fact – hereditary mental aberration?’.<sup>16</sup> Leeper’s call to understand mental abnormality simply through heredity is a heavy-handed solution to the problems of classification that had been encountered thus far by committees established by the Association to derive a standardised Table of the Forms of Mental Disorder. The attempts that are outlined in this chapter to revise the document in this chapter faced different problems than those faced in the previous episode, in the form of differing approaches to the theory and treatment of mental health. Leeper’s solution was to dismiss by two of these differing approaches, psychoanalysis and focal infection theory, two of the most popular approaches to mental illness in Europe since the turn of the century. Leeper had not even mentioned the psychopathology of Emil Kraepelin, whose disease entities of dementia praecox and manic depression were fast becoming standard concepts to classify psychosis. In fact, Leeper even seemed to air suspicion towards the very notion of a disease entity in psychiatry with him believing that melancholia, neurosis, psychopathic constitutions, and mental deficiency were for the most part a result of what he termed ‘insane inheritance’.<sup>17</sup>

This chapter will, then, look in detail at some of the topics addressed in Leeper’s lecture – how remnants of the old guard of asylum psychiatry like himself stoked the fires of conflict with those who diverged from the hereditarian theories of mental disorder that had characterised classifications of mental disorder. These included those like Cotton, who sought a pathological basis for all forms of insanity; those informed by psychoanalysis who believed that even extreme forms of neurosis could be treated with the psychoanalytic method; the growing British psychology movement, that had massively expanded upon the stewardship of C.S. Myers, and a new generation of researchers who had not spent time in asylums and who saw the future of psychiatric classification as being one which would be closer aligned to medicine. These changes that had occurred in psychiatry since the Table of the Forms of Insanity was published in 1906 led to pressure being placed on the Association to revise the classification, and the eventual appointment of a revisions committee in July 1929.

Ultimately, these efforts were in vain, for the classification published in 1932 was a failure: it attracted much criticism, and would, unlike the 1906 classification, be ignored by the

---

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

Board of Control and thus never be implemented into practice. The changes that had occurred in psychiatric knowledge and the many different schools of psychiatry had encouraged the revisions committee to attempt a heterogeneous and pluralistic classification that could satisfy the old guard, younger generations and those who had been attracted by new ideas coming from psychology and psychoanalysis. It was this attempt to satisfy so many divisions within the MPA and mental science that ultimately led to the 1932 revisions receiving such a hostile reception from members of the MPA, mental hospital administration, and the wider medical profession.

The reasons for this hostile reception were manifold, and partly the culmination of issues that had surrounded the Table of the Forms from the 1860s onwards and which have been explored in the previous three chapters of this thesis. The first set of debates between the 1860s and 1880s were reactions against symptom based concepts that were used in the statistical tables, and this took the form of demands to implement aetiology of insanity into the Table of the Forms. In turn, during discussions surrounding the revisions at the turn of the century, prognosis became a growing concern as a reaction against the 1882 committee's attempts to combine aetiology and symptomology, and considerations of prognosis finding their way into the classification of 1906. Taking the lead from Hubert Bond and Charles Mercier, the committee sought to provide greater coherence to the table by separating aetiology from symptomology, and placing all concepts of causation into the Table of Causes. Yet, the classification had attempted to incorporate symptomatic concepts that had long dominated psychiatry in Britain with prognosis, and this quickly meant that although it satisfied the demands of some, who wanted a reliable and pragmatic Table of the Forms of Insanity, it also attracted criticism for placing dated concepts of symptomology alongside Kraepelinian concepts that incorporated prognosis.

The Table of the Forms inherited by the 1929 committee was then the result of a series of compromises since the 1860s that were made in pursuit of drawing up a classification that was based on consensus. In order to achieve this task, it needed to appeal to the preconceptions of members of the MPA, which were shaped by their experience of working in asylums. It also needed to appeal to those who wanted to incorporate the latest theories and research findings of mental disorder's aetiology, pathology, and prognosis. What changed during the interwar period and made the debates surrounding the 1932 classification particularly distinctive was the development after the Great War of alternative approaches to the diagnosis and treatment of mental illnesses; hitherto, asylum treatment was most common,

and although clinics existed which treated private patients, they only began being considered as public health solutions in the United Kingdom during the interwar period.

This then made the revision committee's task of formulating a consensus based classification that would satisfy those with very different ideas about how mental disorder should be diagnosed and treated even more difficult. There were members of the RMPA like Leeper, who understood mental disorder primarily as being a product of congenital weaknesses, the solution to which was prevention, containment and isolation from stronger members of society. As we have seen, Leeper had little time for other approaches to psychiatry, and although his dogmatic views are not representative of all members of the Association, they do indicate how incompatible certain approaches to mental disorder were during this period. Yet at the same time there were more open minded members of the profession who sought to create bridges between a mainstream version of psychiatry that had its roots in the asylum system and the new psychological approaches. There were practicing psychoanalysts who were members of the RMPA such as Edward Glover, who were involved with institutes such as the Tavistock Clinic, that were founded during the interwar period and where developments in psychodynamic therapy were taking place. There were also those who were members of the British Psychological Society (BPS) who, although not rejecting biological approaches entirely, thought that British psychiatry had for too long preoccupied itself with biological causes of mental disorder at the expense entirely of psychological theory.

To satisfy these diverse approaches to mental disorder, the classifications committee produced a heterogeneous document that attempted to bring together many diverse theories of psychopathology. Yet, in trying to have a heterogeneous classification the concepts were in conflict and in tension with each other. Ultimately, conflicting concepts of mental disorder were included in the 1932 classification, and this would contribute to the negative reception that it received.

## Section 1: Why was a revisions committee established in 1929?

### Introduction

By the 1920s, the Table of the Forms was viewed as not satisfying the demands of modern psychiatric treatment or psychiatric epidemiology. Those influenced by psychoanalysis thought that the disease concepts were too descriptive of behaviours, and that concepts of psychopathology included in a classification needed to be informed by theories of the development of the ego. And it did not satisfy those who, like David Skae, John Batty-Tuke

and Thomas Clouston before them, wanted biological considerations such as the aetiology or pathology of mental disorder to be incorporated into a system of psychiatric classification. As we saw in the last chapter, the 1906 revisions removed all aetiological factors from the Table of the Forms, and the period between the turn of the century and the interwar years had seen important developments in the understanding of the aetiology, prognosis and the pathology of mental disorder.

This section will outline some of the competing schools of thought surrounding mental disorder during the inter war era to demonstrate the enormity of the task that faced the revisions committee. The profession viewed itself as being divided between two broad schools of thought on the principles surrounding the causation of mental disorders.<sup>18</sup> Robert Armstrong Jones, who would become one of the most vocal critics of the 1932 revision, celebrated Frederick Mott as being the principle representative of the mainstream of British psychiatry, which was biological, organic and informed by eugenics. Mott was a protégé of Henry Maudsley, and he was a central figure in research attempting to make connections between hereditary conditions and certain forms of mental disease, primarily *dementia praecox* and neurasthenia.<sup>19</sup> Armstrong Jones was a senior member of the Association, and he had been involved in discussions surrounding classification that had taken place at the turn of the century.<sup>20</sup> He praised Mott's quest to find the material origin of mental diseases.<sup>21</sup> Mott described how he thought there to be a divide within the medical psychological community:

...on the one hand there was the organic or the material school; and on the other the psychogenetic or mental school, [the] latter has been very much in evidence during and since the war. The latter school believed, among other things, that dementia praecox was entirely due to mental causes, and that epilepsy also had a similar origin. It was held by many that the abnormal mental states were due to subconscious complexes causing repression, and that this repression gave rise to conflicts involving a dissociated personality and so resulting in *dementia praecox*.<sup>22</sup>

---

<sup>18</sup> Minutes from The Medico-Psychological Association of Great Britain and Ireland: Eightieth Annual General Meeting of the Association. *JMS*, Vol.67, No.279, Oct 1921 pp.511–556.

<sup>19</sup> Edgar Jones, 'An Atmosphere of Cure: Frederick Mott, Shell Shock and the Maudsley', *History of Psychology*, Vol.25, 2014, pp.412 – 421.

<sup>20</sup> See the discussions covered in the last chapter, and in particular Robert Armstrong Jones' contributions.

<sup>21</sup> Minutes from The Medico-Psychological Association of Great Britain and Ireland: Eightieth Annual General Meeting of the Association. *JMS*, Vol.67, No.279, Oct 1921 pp.511–556.

<sup>22</sup> Frederick W. Mott, 'The Genetic Origin of Dementia Praecox' in *JMS*, Vol.68, No.283, Oct. 1922, pp.333 – 347. (p.333)

Mott perhaps had in mind Jung's work on dementia praecox, with the Swiss psychoanalyst's ideas being very much the antithesis of his own hereditarian explanations for mental illness.<sup>23</sup> Mott was a disciple of Henry Maudsley, and was interested in the organic pathologies that gave rise to insanity: his view was that dementia praecox was a sign of congenital weakness.<sup>24</sup> He believed that research into the pathology of insanity that had been conducted by British psychiatrists since the Great War had placed a discovery of the biological causes of *dementia praecox* on the horizon. Mott's own work had looked for congenital weaknesses in the endocrine system, and carried out research upon patients diagnosed with dementia praecox, manic depressive psychoses, and the different forms of mania. Excitement about the possibilities for finding somatic cures for mental diseases were spurred by Julius Walter Juaregg's discovery of the syphilis spirochete which caused GPI, in 1917, less than one year prior to this meeting. The hope by many was that a similar discovery would occur with dementia praecox, and many hoped to raise the profile of the MPA by making sure this breakthrough came from British psychiatry. There was hope that new research institutes devoted to the mental sciences could help develop treatments which would treat the masses, helping to reduce the numbers of patients in mental hospitals, and creating greater opportunities for out-patient and home treatment. Mott, Armstrong Jones and many other members of the MPA thought that it was the biological and hereditarian kinds of psychiatry that held the promise for future treatment of mental diseases: the time and labour needed for psychoanalysis, as well as the sheer obscurity of the theory which informed it, in the opinion of many members of the MPA, made it fundamentally ill equipped for these public health goals.<sup>25</sup>

## 1.2 Focal Infection Theory

During the 1920s, researchers had attempted to establish a link between functional mental disorders and bodily infections, and this meant any pathological behaviour that could not be explained by either 'defectiveness' or 'deficiency' caused by hereditary or birth related 'defects', or by injury. In 1921 the Edinburgh based physician William Ford Robertson presented a paper

---

<sup>23</sup> Ibid.

<sup>24</sup> Ibid.

<sup>25</sup> The discussions contained in the minutes of the Annual General Meetings of the Association throughout the twenties demonstrate this clearly, and although there were prominent members like John Carswell and William McDougall who had some time for Freud's ideas, for the main they were dismissed as being a luxury that could only be afforded by the rich.

on 'Chronic Bacterial Infections in Dementia Praecox' to the annual meeting of the MPA.<sup>26</sup> The discussion following the paper explored the relationship between dementia praecox and bacterial infections, and called for more efforts to be put into research which could establish strong links between a 'multiplicity of mental [health] symptoms', 'bacterial growth, and [...] the toxins [that] they produce'.<sup>27</sup> Robertson's research was informed by the idea of unitary psychosis. Mania, melancholia and the other forms of insanity were in fact different manifestations of the same disease entity, but the constitution of the individual, amongst other factors, was responsible for *the form of insanity*. Construing mental disorder as one clinical entity made the possibility of connecting it to a certain set of somatic disorders, like bacterial infections, a much more plausible endeavour: portions of the profession hoped to find a one-size-fits all cure for a multitude of mental disorders in the form of the treatment for focal infections. The president in 1921 William Francis Menzies and Mott himself stressed the importance of focal infection in establishing a 'relation [between] psychological medicine [and] general medicine, as expressed by the link of bacteriology'.<sup>28</sup>

The 'focal infection theory' that had arisen in the United Kingdom at the beginning of the century became very popular during the 1920s, and was seen by many as a great hope for providing a biological basis to functional disorders. Cotton, its leading exponent, gave a speech to the MPA in 1923 outlining the research into focal sepsis that he had carried out during his time as the director of the New Jersey State asylum at Trenton, one of the largest institutions in the country. Cotton's address heralded the public health potential of focal infection, and how it held the prospect of a treatment for mental illness which could be administered quickly and efficiently. By 1927, a great deal of the discussion at the Association's annual meeting was devoted to research into focal sepsis, such was its popularity.<sup>29</sup> This excitement spilled over into the public sphere, with a 1929 article in *The Manchester Guardian* citing one practitioner's belief that 'it was beyond doubt [that] focal sepsis was a cause of depression and suicide'.<sup>30</sup> Despite this excitement, focal infection would go into sharp decline partly because Cotton's

---

<sup>26</sup> William Ford Robertson, 'Chronic Bacterial Infections in Dementia Praecox', lecture and responses recorded in Minutes from The Medico-Psychological Association of Great Britain and Ireland: Eightieth Annual General Meeting of the Association. *JMS*, Vol.67, No.279, Oct 1921 pp.511–556. (pp.543 – 546)

<sup>27</sup> *Ibid.*

<sup>28</sup> *Ibid.* (p.543)

<sup>29</sup> 'The Royal Medico-Psychological Association: The Eighty-Sixth Annual Meeting, July 19<sup>th</sup> – 22<sup>nd</sup>, 1927, in *JMS*, Vol.73, No.303, pp.691 – 728. (pp.723 – 726)

<sup>30</sup> Patrick Watson-Williams, remarks recorded in 'The Royal Medico-Psychological Association: The Eighty-Ninth Annual Meeting of the Association: July 1<sup>st</sup> – 4<sup>th</sup>', in *JMS*, Vol.76, No.315, Oct 1930, pp.860 – 894.

abuse of patients carried out during his research into focal infection became public knowledge, and partly because it led to no significant breakthrough in the cure of insanity. Cotton had forcibly removed the teeth of hundreds of patients in an attempt to prove his belief that there was a connection between oral infection and insanity. Cotton had noticed tooth decay in the patients of the asylum and had assumed that there was a connection between this condition and insanity. Yet, these infections were in fact iatrogenic, caused by conditions within the asylums themselves, and the painful removal of teeth, often without the patient or their family's consent, achieved little.<sup>31</sup> Cotton would die in disgrace after the extent of his crimes began to be uncovered from the mid-1930s, and Cotton, along with his focal infection theory, would quickly become associated with quackery and megalomania.<sup>32</sup>

Cotton's megalomania was spurred by a desire that had led to focal infection becoming popular in the United Kingdom: the prestige and honour that would accompany the discovery of a somatic cure for mental disorder, one which could be administered to the general public and which would alleviate the suffering of untold thousands of patients.<sup>33</sup> British psychiatrist William Hunter had helped to popularise focal infection theory in the British Isles, mainly because he too had carried out research into the connections between sepsis and insanity since the turn of the century. In the discussions following Cotton's 1923 address, Hunter expressed delight with the American's work, in particular the presentation of data on the lesions in the stomach of inmates from his asylum which he presented as evidence.<sup>34</sup> Hunter suggested that "focal infection" was not a suitable name, and he was in agreement with Cotton that the term "sepsis" should instead be used when discussing this phenomena.<sup>35</sup> Hunter's dissatisfaction with the use of the term 'focal infection' within the clinical literature published immediately

---

<sup>31</sup> Andrew Scull, *Madhouse: A Tragic Tale of Megalomania and Modern Medicine*, (Yale University Press, 2005)

<sup>32</sup> Ibid.

<sup>33</sup> It is very important to note that there were critical voices of focal infection theory: Yet there were less enthusiastic responses to Cotton's paper which questioned how much of a great new hope focal sepsis was for psychiatry. One speaker pointed out that work had been carried out by earlier bacteriologists in the clinics of Pasteur which had attempted to link intestinal toxæmia to mental disorder, but this research had yielded any significant findings. Another speaker pre-empted the disgrace that would end Cotton's career by voicing concern about the approach set out in his paper, that it could, and often did, lead to wasteful and harmful clinical procedures which imposed painful procedures on those who did not have the capacity to refuse it.

<sup>34</sup> William Hunter, remarks recorded in "The Medico-Psychological Association of Great Britain and Ireland: Eighty-Second Annual General Meeting of the Association". *JMS*, Vol.69, No.287, October 1925, pp.528–580., and Andrew Scull, *Madhouse: A Tragic Tale of Megalomania and Modern Medicine*, (Yale University Press, 2005).

<sup>35</sup> William Hunter, remarks recorded in "The Medico-Psychological Association of Great Britain and Ireland: Eighty-Second Annual General Meeting of the Association". *JMS*, Vol.69, No.287, October 1925, pp.528–580.



after the war was based on his belief that the term had been used too generally and imprecisely, which risked undermining its potential as a precise science.<sup>36</sup>

Despite the enthusiasm of many, there were murmurings of disapproval independent of the horrific realities of treatment. Members of the MPA pointed out in response to Cotton's paper that work had been carried out by earlier bacteriologists in the clinics of Pasteur which had attempted to link intestinal toxæmia to mental disorder, but this research had not yielded any significant findings. Another speaker voiced concern about that Cotton's approach could lead to wasteful, and more importantly, harmful clinical procedures which imposed painful procedures on those who did not have the capacity to refuse it. Further doubts were heaped on focal infection as the decade drew on. In response to a paper on focal sepsis given in at the 1925 annual general meeting of the Association by T.C. Graves, J.R. Lord argued that similar infections existed in patients who did not display any symptoms of insanity.<sup>37</sup> This backlash against sepsis and focal infection theory pointed to the growing dissatisfaction with biological research which had not helped to develop any useful new clinical treatments for insanity. Due to the failure of any significant breakthrough that built upon Julius Wagner-Jauregg's discovery of a cure for general paralysis of the insane, we see by the 1930s a return to the sort of pessimism which had characterised later Victorian thought on mental health, with some notable members of the profession voicing disillusion and concern with the MPA's over-reliance on a biological and scientific avenue of research into treatments for mental health disorders.<sup>38</sup>

### 1.3 Psychoanalysis

The biological character of mainstream British psychiatry that had welcomed focal infection theory with open arms was questioned by the rise of psychoanalysis, and the establishment of professional societies that were devoted to psychological treatment. For the main, British psychiatry had, since the latter half of the nineteenth century, played down psychological considerations in their research: what would be termed as *intentionality* by phenomenologists working in Germany such as Franz Brentano and his student Edmund Husserl. German

---

<sup>36</sup> Ibid.

<sup>37</sup> J.R. Lord, remarks recorded in 'The Medico-Psychological Association: The Eighty Fourth Annual General Meeting of the Association, July 7<sup>th</sup> – 10<sup>th</sup>' in *JMS*, Vol.7, No.295, Oct. 1925, pp.797 – 855. (p.840)

<sup>38</sup> The minutes of the RMPA's meetings from the early thirties demonstrate that focal infection theory was largely abandoned as a serious line of investigation, partly due to the lack of any real breakthrough, and partly because of the controversy surrounding Cotton's work.

phenomenology was somewhat unfamiliar to British psychiatrists, yet some of the more well-read members of the community would have been acquainted with its French counterpart: notable psychiatrists had cited Henri Bergson in their work, with one powerful example being Bernard Hart, who invoked the potential benefits of phenomenology to question the dogma of physicalism that existed within the mainstream of British psychiatry.<sup>39</sup> This dogma remained firm until Freud's work started attracting attention in the UK. In a somewhat grudging acknowledgement of the Austrian's contribution to the field, the Scottish psychiatrist John Carswell claimed that psychoanalysis had forced neurologists and physicians to pay more attention to the lived experiences of patients:

It had always occurred to the speaker that Freud was particularly fortunate in the time at which his theories were presented [...] Probably some were getting a little tired of looking into test tubes and into microscopes to find an explanation for human conduct, even of insane human conduct [...] it could be said at any rate that Freud had projected a new idea into our methods. So that, instead of looking into the nerve structures and the influence of the fluids of the body on the nerve tissues, to find the explanation of morbid feelings and ideas they ought to look at conduct itself as an explanation. And so *Freud sent the minds of the psychiatrists back to the experiences of life.*<sup>40</sup>

Carswell expressed a concern held by many that the over reliance on biological and scientific avenues of research was becoming a preoccupation that was distracting from the patient's psychological states and their lived experiences; experiences which had played some role in the development of mental disorder. With this growing concern that biological lines of enquiry

---

<sup>39</sup> Before WWI Dr Bernard Hart had written a provocative treatise which sought to overturn what he described as the physicalist dogma that prevailed in European psychiatry: Bernard Hart, 'A Philosophy of Psychiatry' in *JMS*, Vol. 54, No.226, July 1906, pp.473 – 490. Yet, Hart used a particular sense of the word dogma, which he stressed as Kantian. Instead then of just attacking the conservatism that resorted to physicalist understandings as being the only way of understanding insanity, Hart argued that dogmatism was inherently a part of scientific investigation. Psychology was different: it was focused on understanding human behaviour from the life-world, or the world of lived experience –this was a concept he had borrowed from William James. Hart invoked phenomenology to argue that the objects of investigation for the physicist and the alienist were irrevocably distinct. He made the somewhat controversial claim that insanity was not a scientific term, and that scientific investigation into 'a legal and sociological' concept that 'denotes individuals belonging to the anti-social group' was futile.<sup>39</sup> This pragmatist influence was also evident in Hart's views on classification: he did not see classification as an end, but rather as a means of investigation: effective classification would allow the 'us to handle our material in a convenient manner, and [that] which enables us to predict the future to any extent, has to that extent validity and utility.'<sup>39</sup> Similarly, his view on Kraepelin reflect this: 'the question at issue as regards Kraepelin's theories is not whether the diseases he described *really* exist or not, but whether his classification enables one to proceed more efficiently in the departments of prognosis and therapeutics.' Hart's view was that it was, and he compares the importance of his work to that of Kepler, but it was Janet and Freud that he compared to Newton. This, as well as his description of the 'melancholy and despairing' chapters on classification in textbooks that state 'the ideal, ultimate and perfect classification' as being anatomico-pathological, would hardly have endeared Hart to members of the physicalist RMPA. His contributions to the *JMS* trailed off after 1911 and helped found the rival *Journal of Neurology and Psychopathology* in 1920, becoming more aligned with the Medical Section of the BPS than the RMPA after the war.

<sup>40</sup> John Carswell, remarks recorded in 'Minutes from The Medico-Psychological Association of Great Britain and Ireland: Eightieth Annual General Meeting of the Association' in *JMS*, Vol.67, No.279, Oct 1921 pp.511–556.

were beginning to dry up, some members of the MPA became more receptive to psychoanalysis, or at least to considering the psychological experiences of the patient when attempting to understand the causes of mental disorders. This led some to question the prevailing orthodoxy in British psychiatry that overlooked psychological factors in the explanation of mental disease, and placed a great emphasis on hereditation theories and the physical constitution of patients when researching the causes of mental disorder.

This receptiveness to psychoanalysis was not primarily down to the open-mindedness of British psychiatrists. As we have seen with the example of Leeper's address, there was outright hostility towards psychoanalysis in the British Isles by prominent members of the MPA, and although calls had been made for psychiatrists to pay attention to psychological factors prior to psychoanalysis's reception in the British Isles, these went unheeded until the interwar period. What forced British psychiatry to take notice of psychological factors were the challenges it faced in setting the agenda for medical psychology. Briefly, these came from four fronts: one, the establishment of the British Psychoanalytic Association (BPA); two, the founding of the Medical Section of the British Psychological Society which quickly came to be the resort for Jungians who had been barred entry to the Freudian dominated BPA; three, the Royal Society of Medicine's psychology section; four, the British Medical Association, who also had a psychological section.<sup>41</sup>

Edward Glover, one of a generation of psychiatrists that emerged during the interwar years who sought to reconcile mainstream psychiatry with psychoanalysis, proposed a new classification of mental disorders that was informed by psychoanalytic theory. He thought that a classification which incorporated psychoanalytic ideas about the causation of mental disorder could become the starting point for psychoanalysis to come into an 'increasingly close alliance with psychiatry'.<sup>42</sup> He asked his audience, when speaking at the Royal Society, whether medical professionals should be satisfied classifying symptoms based upon a 'purely clinical and descriptive terminology'.<sup>43</sup> The warning he gave is that improper classification could lead to confusions in diagnosis: 'an apparently simple phobia may be a transient neurotic manifestation or the peak of a concealed paranoid construction.' A better means of classifying mental disorders could prevent a misdiagnosis because it will be able to recognise and differentiate

---

<sup>41</sup> In his presidential address, J.R. Lord described the RMPA as the 'guardian and cultivator in these [British] Isles of psychological medicine'; for more on the politics of the early years of the British Psychological Society and British Psychological Association, see Kevin Matthew Jones, 'REFERENCE!'

<sup>42</sup> Glover in fact uses the term 'pure psychiatry' but he is using this in the sense of the biologically informed psychiatry that this chapter has described as 'mainstream': Edward Glover 'A Psycho-analytic Approach to the Classification of Mental Disorders' in *JMS*, Vol.78, No.323, Oct. 1932, pp.819 – 842.

<sup>43</sup> *Ibid.*

between symptoms that demonstrated the early stages of psychosis, symptoms which appear identical, but were, according to Glover, manifestations of different underlying disorders. In the picture he offers, Glover questioned the disease model of mental health disorders that was held by mainstream psychiatry:

To call the delusions of paranoia a symptom of disease, is as complete a reversal of the psychological truths as to call granulation-tissue an abrasion' – granulation tissue is what we colloquially call the scab and is the first stage in the healing process of a wound.<sup>44</sup>

Glover deployed this metaphor to argue that by formulating disease categories from symptoms like delusions, Pinel, and those that had followed in his footsteps, were guilty of making a category error, and confusing the signs of a healing mind for the symptoms of a disease. Paranoia then was not a symptom of a disease but in fact the very contrary; it was the first sign of a mind healing from a trauma, and it was the role of the psychiatrist to assist with this healing process, as opposed to suppressing the symptoms.

Glover was calling into question the dominance of symptom-based models by invoking psychoanalytic theories of causation. To make a comparison with ground that has already been covered in this thesis, for Skae and Greisinger, rejecting the symptom-based disease entities involved replacing them with concepts of psychopathology that incorporated aetiology, but ones that were considered by their colleagues to be too speculative to be considered scientific. Yet these systems remained symptom-based, and diagnosis using them did not take much into account about the patient's past, apart from their social background, any recent attacks of the form of insanity and perhaps any similar attacks in the person's immediate family. For many in the mainstream of British psychiatry, psychoanalysis was too speculative and failed to live up to scientific standards, but attempts by medical men like Glover to combine psychoanalysis with mainstream psychiatry had some impact: as we will see later in the chapter, concepts of psychopathology that were compatible with psychoanalysis were included in the second major revision of the Table of the Forms of Mental Disorder that took place in 1932. Glover's speech outlined the internal psychological drives and complexes that psychoanalytic theory claimed were behind the development of mental disorder. To better understand these drives and complexes, psychiatrists needed to analyse the thoughts, feelings and testimonies of the patient, and spend the time required to search for the clues of a concealed trauma.

---

<sup>44</sup> Ibid.

Aware of his audience being comprised of RMPA members, who by this point were mainly hostile to Freud's work, Glover was not proposing the replacement of biological psychiatry with psychoanalysis: rather he wanted a streamlined and practical model of the development of the ego, which could be used by psychiatrists working in mental hospitals and out-patient clinics.<sup>45</sup> Glover argued that this classification system could be developed for use by psychiatrists that had had a minimal training in psychoanalytic theory, and who had not gone through the lengthy training required to be a practicing psychoanalyst.<sup>46</sup> Instead, a skeletal model of the ego could provide psychiatrists with a functional understanding of disorders that have arisen from ego development.<sup>47</sup> His proposal was a classification that would incorporate the aetiology proposed by psychoanalytic theory. The purely symptomatic concepts of psychopathology Glover called 'end-product' concepts for they described the fully formed disease in the adult, but did not provide indications of the development of the disorder. These forms of concepts of mental disorder were inadequate according to Glover, and must give way to a more 'functional' approach: instead of operating on a purely descriptive or representative model, the psychological reasons behind the manifestation of a certain disorder should be included in any classification of mental disorder. More sophisticated concepts of psychopathology would allow more sophisticated clinical interventions to be provided to clinicians. Before acknowledging that perhaps the descriptive element to classification may be needed as a 'temporary measure'<sup>48</sup>, Glover poses the question:

Can this descriptive factor be combined with criteria which will promote genetic understanding, aid differential diagnosis and prognosis, accentuate the essentially psychotic nature of the psychoses, and yet establish some intelligible relation between the phenomena of psychiatry and the psychological phenomena of everyday life?<sup>49</sup>

According to Glover, psychoanalysis had helped to return the eyes of the psychiatrist towards the psychopathologies of everyday life. Glover then provided a picture of the developmental factors he thought would contribute to the kinds of psychoses that were suffered by the many who until the 1920s would never have even been conceived of as having to need psychiatric treatment, due to the great deal of care in the British Isles being administered within the

---

<sup>45</sup> Ibid.

<sup>46</sup> Ibid., (p.821)

<sup>47</sup> Ibid.

<sup>48</sup> Ibid., (p.822).

<sup>49</sup> Ibid.

asylum. He went into depth on the psychoanalytic ideas of childhood development that informed this view, before concluding that any worthy psychiatric classification must understand how the psychoses were caused in developmental problems, and even what was considered then to be ‘normal development’<sup>50</sup>:

But to do this we must realize just how psychotic normal development is. Converted into systematic terms, a classification of psychoses must be built up in close relation to the historical modifications of ego-structure. And if we do not know all that is to be known of this structure, we must simply leave empty niches in this classification.<sup>51</sup>

What Glover was proposing was modest and echoed the final line of Ludwig Wittgenstein’s *Tractatus Logico-Philosophicus*, published almost exactly a decade earlier: whereof we cannot speak, thereof one must be silent. It was simply no use to make speculative and grand claims about the genesis of mental disorders, be they in the form of the sweeping statements made by Leeper, or even the speculative aetiology of Skae that were discussed in the first and second chapters of this thesis. The notable psychiatric classifiers of the previous century – Kahlbaum, Pinel, Skae, Greisinger, Hack Tuke, and the many that followed in their footsteps – these figures had sought to build comprehensive and exhaustive systems of psychopathology that would capture all the symptoms that an alienist would come across in the clinic. The aetiology of almost all the forms of insanity were not properly understood at the time they were writing, so they resorted to the language of symptomology to formulate disease concepts, and in order to facilitate communication between clinicians, they employed the terminology developed by Pinel. Just as Wittgenstein commented on the grand metaphysical visions provided by German idealism, Glover thought that in lieu of full understandings of the developmental stages that led to certain forms of psychosis, gaps must be left in a classification to allow research to fill them in – ignorance was then a virtue for him, and the classification committee would emulate this modesty; in the classification that they produced in 1932 they included a provisions that would allow superintendents to record disorders that could not be included under any of the existing categories.

Acknowledging ignorance was important because Glover thought the data available to those attempting to understand the development of psychosis was murky, since it was based upon the interpretation of subtle clues betrayed by the testimony of the patient. Psychoanalysis provided few clear cut behavioural hints which would allow one to differentiate simply and

---

<sup>50</sup> Ibid.

<sup>51</sup> Ibid.

efficiently one disorder from another: this is at odds with the demands that had proven the determining factor in the history of the Table of the Forms of Insanity produced by the mainstream of British psychiatry that this thesis has so far covered. One of the characteristic elements of psychosis is the patient's loss of touch with reality, and Glover drew on psychoanalytic theory when he described how people who suffer this disorder turn away from the world of objects and become caught in their own miserable world of 'frustrated instinct'.<sup>52</sup> The adult ego that suffers from psychosis is a construct of the first five years of development according to psychanalytic theory, and this period of attention was at odds with mainstream British psychiatry which instead placed an emphasis on an efficient clinical intervention that, as mentioned, only took into consideration the fully developed adult patient. The psychiatrist treated only the adult in front of him, only taking notice of the adult's recent past such as their occupation, marital status, and recent attacks of insanity, with perhaps only gathering cursory information on the background of insanity within the patient's family. This misses out childhood, the most important stage in the development of psychopathology according to the psychoanalyst.

Although Glover's speech did not turn British psychiatry suddenly towards psychoanalysis, his speech was a signal that there was some receptiveness to it. For the hostility of a Leeper, representative of a rather extreme version of the orthodoxy of British psychiatry there were lots of organisations beyond the RMPA who explored the public health applications of psychoanalysis: the medical section of the British Psychological Society, whose research was an eclectic mix of different psychological schools; and the work carried out by the Tavistock Clinic, which had been established in 1920 with the goal of providing psychotherapy to a public who could not afford the fees demanded by an analyst.<sup>53</sup> This came under the stewardship of Hugh Crichton-Miller, who established a 'New British Psychology', which sought to develop a form of child guidance that would see the principles of psychotherapy applied to social work and public hygiene measures.<sup>54</sup>

The biological mainstream of psychiatry had paid some attention to forms of insanity that would not see one admitted to an asylum. Interest had begun to grow in what was termed the 'borderland' between sanity and insanity, and moves were made by the RMPA to restructure psychiatric services so that they would avoid admitting patients to an asylum unless

---

<sup>52</sup> Ibid.

<sup>53</sup> H.V. Dicks, *Fifty Years of the Tavistock*, Routledge, 1970. (p.xiii)

<sup>54</sup> Hugh Crichton-Miller, *The New Psychology and the Parent*, Jarrolds, 1922.

necessary. This began immediately after the Great War, with the 1921 presidential address of the Association addressed structural and administrative issues on how psychiatric care was administered.<sup>55</sup> In response, Robert Armstrong-Jones stressed that 'the early treatment of borderland cases was most important and was a matter of urgent public importance'.<sup>56</sup> A lengthy discussion followed at that annual general meeting on measures to implement treatment into the everyday life of the general public during the 1920s, including the efficient administration of out-patient clinics, attempts to simplify the admissions of voluntary patients to asylums, and the introduction of mental hygiene into schools, universities, and industry.<sup>57</sup> The following year the Association would play a role in the National Council for Mental Hygiene., a movement established with the aim of developing mental health services that would detect 'the early symptoms of functional disorder' in order to administer treatment in out-patient clinics.<sup>58</sup>

The profession's aim to extend its remit beyond the walls of the asylum fitted into a wider context of social reform. The Dawson Report published in 1919 called for the development of a network of hospitals and health centres in which general practitioners, consultants, and municipal public health officers would collaborate to deliver health services. Although this plan was not implemented due to the onset of economic depression, the desire to develop state-funded health care in general medicine ran throughout the course of the interwar period, and British psychiatrists saw themselves as fitting in to this wider expansion of healthcare services. Psychiatrists began to discuss how they could treat mental health disorders that were not serious enough for institutionalisation, and how it could avoid patients experiencing the 'stigma' of certification to receive government-funded mental healthcare treatment.<sup>59</sup> This was a particularly thorny issue because it was still necessary for a person who

---

<sup>55</sup> Charles Hubert Bond, 'The Position of Psychological Medicine in Medical and Allied Services: The Presidential Address at the Annual Meeting of the Medico-Psychological Association of Great Britain and Ireland, held in London on July 11<sup>th</sup> – 15<sup>th</sup>, 1921' in *JMS*, Vol.67, No.27, Oct. 19221, pp.404 – 449.

<sup>56</sup> Robert Armstrong Jones, remarks recorded in 'Minutes from The Medico-Psychological Association of Great Britain and Ireland: Eightieth Annual General Meeting of the Association' in *JMS*, Vol.67, No.279, Oct. 1921 pp.511–556. (p.523).

<sup>57</sup> See discussion in response to A. Ninian Bruce, 'The Out-patient Treatment of Early Medical Disorder. The Neurological Clinic and Some of Its Function' recorded in (Anon 1922) (p.432) & discussion in response to G.A. Auden 'The School Medical Service in Relation to Mental Defect' recorded in (Anon 1921a) (p.538)

<sup>58</sup> Courtauld Thomson, 'Correspondence: A National Council for Mental Hygiene' in *BMJ*, April 1<sup>st</sup> 1922, 1(3196): 538

<sup>59</sup> G.M. Robertson, remarks recorded in Minutes from 'The Medico-Psychological Association of Great Britain and Ireland: Eightieth Annual General Meeting of the Association in *JMS*, Vol.67, No.279, Oct. 1921 pp.511–556. (p.527)



could not afford treatment to attend a magistrate's court to be certified insane under the 1890 Lunacy Act.<sup>60</sup>

## 1.4 The Borderland

By the start of the 1930s, psychiatric nursing was emerging from the out-patient clinics that had been established under the terms of the Mental Treatment Act.<sup>61</sup> Psychiatric social work, although in its infancy, was beginning to gain some influential supporters: Edward Mapother was an early contributor to the LSE's social work course, which had been established partly in 1927 with the aid of the Rockefeller Foundation to help emulate the sort of professionalization that social work enjoyed in the US.<sup>62</sup> This attempt to firmly establish psychiatric social work also saw philanthropic funds directed towards the voluntary organisations that were specialising in psychiatric support in the community: the psychiatric profession now needed to communicate clinical information like the patient's diagnosis to those who did not have the experience or training of the medical superintendent. Furthermore, the establishment of the Medical Research Council meant that non-practicing medical researchers needed to understand the concepts being used by psychiatrists to diagnose mental health disorders to be able to contribute meaningfully to research. Finally, and partly as a result of the advent of psychoanalysis, partly as a result of the trauma caused by the war and the growing interest in psychology within the work place, and partly as a result of the consolidation of psychology as a distinct discipline during the twenties, there was a slow but growing acceptance that mental health disorders were a part of everyday life – the dividing lines of the asylum walls were beginning to break down, and whilst deinstitutionalisation would not be carried out until after the Second World War, by the 1930s members of the RMPA were beginning to talk about care in the community, and charities were being established to treat the psychopathologies of everyday life.

The notion of the borderland was challenged by Glover because according to him it still inferred that there was something distinct about the insane which marked them as separated, and as distinct, from the sane. When taken at face value, the metaphor, 'borderland' inferred that there were two different realms, and between the blackness of insanity and the whiteness of sanity, there remained a zone of indeterminacy where the two became blurred.

---

<sup>60</sup> Ibid. (p.528)

<sup>61</sup> Ibid.

<sup>62</sup> Katherine Angel, Edgar Jones, and Michael Neve, 'European Psychiatry on the Eve of War : Aubrey Lewis, the Maudsley Hospital, and the Rockefeller Foundation in the 1930s' in *Medical History*, Vol.42, No.S22.

Glover instead emphasised that someone requiring treatment did not mean that one was closer to insanity, a concept that had stigmas of being a lost cause due to the influence of degeneration. Instead, Glover was trying to emphasise how psychological problems may result from socially-accepted lifestyles and conventional upbringing. They might afflict the ‘man in the street’, who could display behaviour that may have been regarded as ‘normal’, and that ‘only the consensus of social opinion entitles him to call his nursery and adult madness normality.’<sup>63</sup>

The understanding of insanity that gave rise to the concept of the borderland had provided much of the justification for the asylum system: that there was a big dividing border between the sane and the insane. The borderland simply served to modify this conception of mental disorder to capture the patients who could be prevented from entering the lost country of the insane. Glover’s concern was that the borderland simply served to extend this erroneous understanding into everyday treatment, and thus do nothing to tackle the social stigma that surrounded mental disorder. Glover’s idea was that a classification informed by psychoanalytic understandings development of the ego would provide a more nuanced understanding of the development of mental disorder, and which would allow psychiatrists to look for the subtle clues that would allow psychiatrists to diagnose mental health issues in functional members of society. Mental disorder then for Glover was experienced by many people who lived what were considered to be normal lives. He suggested that ‘all psycho-pathological states could be accurately named after specific disturbances in the function of the super-ego’, yet he appealed to ‘organic medicine’ in understanding the certain physical conditions, and that descriptive language that was used was important for the development of somatic pathology of mental disorder.<sup>64</sup>

In this first section I have outlined ways that British psychiatry changed during the interwar period, factors which would place pressure upon the RMPA to revise the 1906 Table of the Forms of Insanity, and how the mainstream of British psychiatry became interested in public health measures. The brief popularity of focal infection theory continued the biological preoccupations of the mainstream of British psychiatrists, but its ultimate failure to yield any effective results, as well as the emergence of alternative approaches to the treatment of mental disorder that were informed by psychoanalysis, led to questions beginning to be raised about

---

<sup>63</sup> Edward Glover ‘A Psycho-analytic Approach to the Classification of Mental Disorders’ in *JMS*, Vol.78, No.323, Oct. 1932, pp.819 – 842.

<sup>64</sup> *Ibid.*

the mainstream view. Pressure was placed on the RMPA to at least acknowledge psychological considerations in the development of mental disorder. Finally, the growing popularity and questioning of the concept of the borderland between sanity and insanity led the RMPA to take measures which would lead to psychiatric services moving beyond the walls of the asylum. These considerations shaped the environment which generated the second revisions of the Table of the Forms of Insanity, to which this chapter will now turn.

## Section 2: The Classification Committee

The spark to revise the Table of the Forms of Insanity was the presidential address made by J.R. Lord to the 1926 annual meeting of the Association.<sup>65</sup> As well as serving as president of the Royal Medico-Psychological Association, which had been granted Royal Charter that same year, Lord was also serving as honorary secretary of the National Council for Mental Hygiene. His address was a wide-ranging reflection on the state of the clinical study of mental disorders in the United Kingdom. He placed classification as a central problem inhibiting the development of useful clinical knowledge that would assist in the development of public health measures, that would in turn contribute to the mental hygiene movement.<sup>66</sup> He thought that the mental sciences needed to 'leave their static or descriptive stage of the observation and classification of phenomena and to become dynamic'.<sup>67</sup> Lord contrasted the descriptive, which he identified with the 'old order', that is to say, a neo-classical form of descriptive science, with a new modernist conception of knowledge that was utilitarian and interactive in spirit.<sup>68</sup> Lord considered the disease entities in the classification that were in use by the RMPA as being descriptive symptomologies that were 'confusing and meaningless', leading to an unacceptable degree of ambiguity that prevented effective communication between researchers:

On the broader issue, psychiatrists, not being able to understand each other, take their own lines, and hence the endless, confusing and seemingly contradictory psychological and clinical conceptions. The student, unable to make head or tail of

---

<sup>65</sup> J.R. Lord, 'The Clinical Study of Mental Disorders: The Presidential Address at the 85<sup>th</sup> Meeting of the Royal Medico-Psychological Association' in *JMS*, Vol. 72, No.(S)298, August 1926, pp.1 – 79.

<sup>66</sup> *Ibid.*

<sup>67</sup> *Ibid.*, (p.2)

<sup>68</sup> Gilbert Ryle would describe this as the difference between knowing that and knowing how, or to put it differently, propositional/factual knowledge, and practical knowledge: see Gerard Lum, 'Making Sense of Knowing-How and Knowing-That' in *Education and Expertise*, Christopher Winch and Mark Addis eds., Wiley, 2008, pp.117 – 137.

this melee of contradictions, makes the best shift he can, and his psychology as a rule is peculiar and individual to himself.<sup>69</sup>

To help prove this statement about the lack of communication amongst British researchers, Lord cited former president George Robertson's Maudsley lecture on psychiatric epidemiology, in which Robertson described how he needed to travel to the U.S.A. to see how an effective system for the collection of statistics had been implemented.<sup>70</sup> Like the RMPA, the APA had implemented a standard Table of the Forms of Insanity for the purposes of data collection, but the key difference was that this included definitions of the terminology included in the tables, unlike the 1906 classification. Lord lamented that effective data collection methods had been impaired by the lack of a well worked out classification system that included clearly defined concepts of mental disorders, and he blamed the classification committee's decision not to include definitions in the 1906 revision of the Table of the Forms: this not only hindered the streamlining of diagnosis, for Lord it also prevented the comparison of the data with older statistics – because at least if the current understandings were clarified, the data from the past could be interpreted according to a contemporary understanding.<sup>71</sup>

In response to Lord's critical statements, a committee to revise the Table of the Forms was appointed at the AGM of the RMPA in 1929. Lord was not alone in deeming this necessary: there was a growing perception amongst members that it was out of date and had not taken into account the advent of Kraepelin's ideas on psychopathology, which were coming to dominate the mainstream of British medical psychology; as well as those who doubted the symptomatic approach, calling for a classification system informed by aetiology, be it the hereditarian understandings of biological asylum psychiatry, or by psychoanalytical theories of the development of mental disorder. This section will commence by looking at some of the general considerations that were made by the classifications committee which reveal the philosophical attitudes that the committee held towards classification. I will then go on to analyse certain a selection of the concepts of psychopathology that were included in the 1932 classification. This is because the classification included a much greater number of categories than previous incarnations of the Table of the Forms, so for the sake of brevity I have chosen concepts that are representative of the main schools of interwar psychopathology and demonstrate how the classification that the committee produced was a heterogeneous one

---

<sup>69</sup> J.R. Lord, 'The Clinical Study of Mental Disorders: The Presidential Address at the 85<sup>th</sup> Meeting of the Royal Medico-Psychological Association' in *JMS*, Vol. 72, No.(S)298, August 1926, pp.1 – 79.

<sup>70</sup> Ibid.

<sup>71</sup> Ibid., (p.10).

that sought to incorporate concepts from across the broad church of interwar psychiatry in the British Isles.

## 2.1 The Deliberations and Reports of the Classification Committee

The allegiances of the classification committee are apparent from the review they conducted of the history of psychiatric classification, which emphasised the contribution of those like Skae who sought the aetiology of mental disorder, and downplays the influence of Pinel's and Prichard's symptom based classification that had dominated psychiatric classification during the second half of the nineteenth century.<sup>72</sup> This was dismissed by the committee as being part of the pre-history of psychiatry, and was of no relevance to the modern discipline.<sup>73</sup> Yet, as we have seen in the first part of the thesis, Pinel and Esquirol's concepts of psychopathology formulated the bedrock of psychiatric classification for much of the second half of the nineteenth century, with melancholia, dementia, idiocy, and the manias that they developed finding their ways into later classifications offered by Skae and Charles Mercier. The committee dismissed the symptom-based classification system that was devised by Pinel as only being relevant to those interested in 'the early history of psychiatry' despite the *terms* mania, melancholia and dementia being employed in the classification that they were set to revise.<sup>74</sup> The lack of a set of definitions in the 1906 classification makes it difficult to determine how close these *concepts* were to those of Pinel, Esquirol and Prichard, but the inclusion of Prichard's *moral insanity* in the form of *moral dementia* suggests that the understandings of the diseases held by the 1906 committee were different enough to make such a bold claim about the influence of Pinel.

Instead, the report emphasised the importance of Bénédict Morel, Thomas Laycock, John Charles Bucknill, Daniel Hack-Tuke, and Thomas Clouston, and on the concepts of psychopathology that had been used in previous iterations of the table of the forms. These were all figures who emphasised the biological causes of mental disorder at almost the total expense of psychological considerations. It also deemed the work of Skae and Griesinger to be of more relevance to modern psychiatric classification, the latter the committee members

---

<sup>72</sup> Adrian Wilson has recognised the importance of literature reviews in understanding science's conception of its own intellectual heritage: see Adrian Wilson, 'Viewpoint: Science's Imagined Pasts' in *ISIS*, Vol.108, No.4, Dec. 2017, pp.814 – 826.

<sup>73</sup> R. Lord and G.W.T.H. Fleming, 'The Revision of the Classification of Mental Disorders: Report by the Clinical Psychiatry Sub-Committee of the Research and Clinical Committee' in *JMS*, Volume 78, No.320, January 1932, pp.177 – 201. (pp.177 – 178).

<sup>74</sup> *Ibid.* (p.181)

considered as being the founder of modern clinical classification. The way in which the committee wrote the history of classification demonstrated their allegiances by celebrating the work of those who did attempted to classify mental disorder according to biological causation: be that the aetiology of Skae covered in chapters one and two of this thesis, or the hereditarian degeneration model of Morel.

The committee also considered other classifications that had been arrived at by consensus and were currently being used by psychiatric associations across the world. This demonstrates that they were not only interested in the cutting edge of research that had been published by individual researchers, and the scientific credentials of a classification system, but they were also interested in the ways that different national associations had synthesised ideas that had come from research to produce their own classification systems. The conclusion they reached was that many of the non-British classifications, including that drawn up by the APA were ‘too complicated’ for use by the RMPA.<sup>75</sup> Instead they used simplicity as a guiding principle, thus, as we have seen from the first half of this thesis, they took their place in a long tradition that favoured concision and pragmatism when it came to the classification of mental disorders.

The classification committee grouped the classifications that it had reviewed into four categories:

1. The psychological basis – claims that this would be the primary factor in ‘classifying mental states and their departure from normality’.
2. The symptomatological basis – the principle basis of the classifications used by the Association.
3. The aetiological basis – due to the number of factors offered by different psychiatrists for the manifestation of a particular case, this kind of classification ‘would be too cumbersome for construction, and difficult to use practically’.
4. The pathological basis – deemed the ideal scientific standard, ‘but that the factors for such a classification were meagre and failed entirely to illuminate symptomatology. Those anatomical and physiological data upon which a pathology could be founded were not yet sufficiently worked out.’<sup>76</sup>

---

<sup>75</sup> Ibid.

<sup>76</sup> Ibid. (p.180).

The Clinical Psychiatry Sub-Committee devoted most of its time in 1931 to discussing the revision of the classification of mental disorders, and it presented its provisional classification in July 1931 at the Annual General Meeting<sup>77</sup> (see next page):

---

<sup>77</sup> 'The Royal Medico-Psychological Association: The Ninetieth Annual General Meeting of the Association: July 8<sup>th</sup> – 11<sup>th</sup> 1931' in *JMS*, Vol.77, No.319, Oct. 1931, pp.862 – 901. (p.879)

PROVISIONAL CLASSIFICATION, 1931.

Part I: Amentia.

Part II: (1) Neuroses or psychoneuroses.

- (a) Mental inertia.
- (b) Anxiety states.
- (c) Hysteria.
- (d) Compulsions, obsessions and phobias.
- (e) Hallucinations.

(2) Schizophrenic psychoses.

- (a) Dementia præcox.
  - 1. Simple.
  - 2. Hebephrenic.
  - 3. Catatonic.
  - 4. Paranoid.
- (b) Paraphrenia.

(3) Affective and emotional psychoses.

- (a) Cyclothymic.
  - 1. Alternating.
  - 2. Non-alternating.
- (b) Involitional.

(4) Confusional or hallucinatory psychoses.

- (a) Toxic exhaustion.
  - 1. Acute.
  - 2. Chronic.
- (b) Psychogenic.

(5) Psychopathic constitution (including paranoia) or constitutional psychopathy.

(6) Epileptic psychoses.

(7) Organic brain disease psychoses.

- (a) General paresis.
  - 1. Acute.
  - 2. Chronic.
- (b) Arteriopathic psychoses.
  - 1. Presenile.
  - 2. Senile.

(8) Exogenous toxic psychoses.

- (a) Alcoholic psychoses.
  - 1. Delirium tremens.
  - 2. Subacute and chronic hallucinosis.
  - 3. Paranoia or delusional.
- (b) Other drug psychoses.

(9) Mental disorders not within the definitions of 1-8.

Figure 19: Provisional Classification Presented in July 1931.<sup>78</sup>

---

<sup>78</sup> Ibid.



At a meeting of the research and clinical committee on Monday November 23<sup>rd</sup>, 1931 it was reported that the Clinical Psychiatry Sub-Committee had decided to arrange a meeting between a sub-committee of the Royal College of Physicians appointed to deal with the classification of mental disorders, and a small sub-committee of the Clinical Psychiatry Sub-Committee.<sup>79</sup> At the next meeting on February 23<sup>rd</sup>, 1932 the draft report of the committee was presented to the council of the association. The Final Revisions that were passed in February 1932 were as follows (see next page):

---

<sup>79</sup> Fleming, G.W.T.H. 'The Revision of the Classification of Mental Disorders: Report by the Clinical Psychiatry Sub-Committee of the Research and Clinical Committee – Part II' in *JMS*, Vol.78, No.321, April 1932, pp.387 – 39. (p.389)

FINAL REVISION (FEBRUARY, 1932).

- Part I: Amentia (oligophrenia).
- (a) Idiocy.
  - (b) Imbecility.
  - (c) Feeble-mindedness.
    - i. Moral.
    - ii. Intellectual.
- Part II: 1. Neuroses and psychoneuroses.
- (a) Exhaustion neurosis.
  - (b) Anxiety states.
  - (c) Compulsions, obsessions and phobias.
  - (d) Hysteria.
2. Schizophrenic psychoses.
- (a) Dementia præcox.
    - i. Simple.
    - ii. Hebephrenic.
    - iii. Catatonic.
    - iv. Paranoid.
  - (b) Paraphrenia.
3. Psychopathic constitution (including paranoia).
4. Affective and emotional psychoses.
- (a) Manic-depressive insanity (cyclothymia).
    - i. Alternating.
    - ii. Non-alternating.
  - (b) Involitional melancholia.
5. Toxic psychoses.
- (a) Endogenous.
  - (b) Exogenous.
    - i. Alcoholic.
      - $\alpha$ . Delirium tremens.
      - $\beta$ . Mania *a potu*.
      - $\gamma$ . Chronic hallucinosis.
      - $\delta$ . Korsakov's polyneuritic psychosis.
    - ii. Other drug psychoses.
6. Epileptic psychoses.
7. Organic brain disease psychoses.
- (a) Syphilitic psychoses.
    - i. General paresis.
    - ii. Other types.
  - (b) Arteriopathic psychoses.
    - i. Presenile.
    - ii. Senile.
  - (c) Other types.
8. Other types of mental disorder not mentioned in 1-7:

Figure 20: Final Classification approved by the RMPA.<sup>80</sup>

---

<sup>80</sup> Ibid.

Two years after this official classification was published in 1932, a document was drafted by the clinical psychiatry sub-committee of the RMPA that provided more information on the terms of psychopathology that were employed within it.<sup>81</sup> Lord by now had passed away, but the committee honoured his recommendation that a definition of the terms employed in the classification be produced to accompany the tables. In light of the RMPA's involvement with the mental hygiene movement, it is likely that they thought that these terms would be used by non-medically trained staff, so guidance would have been needed for them to understand the concepts in the table. This shows how the world of psychiatry had moved on – the first Table of the Forms of Insanity was published around the height of the era of the asylum, where medical superintendents used a limited set of diagnostic criteria, but could use these loose terms because of their status as skilled and experienced medical professionals. A version of the classification, with codes for the purposes of filling in statistical returns was published in the *British Medical Journal* in 1934, with some adjustments to take into consideration the table of aetiological classification that was drafted between spring 1932 and spring 1934.<sup>82</sup>

## 2.2 Oligophrenia

The committee decided to use the term *oligophrenia* for a number of reasons. They pointed out that the term literally meant lack of mind, deficiency of mind, or small mind in Greek, with the committee favouring the latter translation in the report.<sup>83</sup> The committee stated that *oligophrenia* was a new term for the confusional insanity that had been employed in the 1906 Table of the Forms and was used during and after the Great War to describe troops with temporary and permanent states of severe incoherence. Confusional insanity had been coined by Meynert to describe incoherency of thought and speech<sup>84</sup>; and it had been described in the British clinical literature as displaying mental symptoms of 'an insane contrariness', 'a purposeless resistiveness, confusion, absence of emotion, and a facial expression which is perhaps best termed embarrassment', with physical symptoms including leucocytosis (increased white blood

---

<sup>81</sup> GWTH Fleming, 'The Revision of the Classification of Mental Disorders: Report by the Clinical Psychiatry Sub-Committee of the Research and Clinical Committee – Part II' in *JMS*, Vol.78, No.321, April 1932, pp.387 – 391. (p.389).

<sup>82</sup> GWTH Fleming, 'Classification of Mental Disorders' in *BMJ*, June 2<sup>nd</sup> 1934, p.991.

<sup>83</sup> GWTH Fleming, 'Definitions and Explanatory Notes on the Classification of Mental Disorders' in *JMS*, No.80, April 1934, pp. 409 – 410

<sup>84</sup> C Perris, Leonhard and Cycloid Psychosis: Clinical Section in Berrios and Porter eds., *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders*, Routledge, 1995, pp.421 – 430) (p.424)

cells associated with infection) and irregular blood vessel contraction.<sup>85</sup> Its aetiology was thought to be linked to toxins of the bodily constitution in the endocrine system or complications with lactation.<sup>86</sup> The committee decided to follow Bleuler in his use of the term oligophrenia instead of confusional insanity<sup>87</sup>, but the committee did provide a rationale for why they decided to use this term instead of the well-known and long used amentia: they felt that this was objectionable because they interpreted it literally as ‘absence of mind’ and felt that as such it was an inaccurate term.<sup>88</sup> They thought that a sizeable proportion of the members of the MPA would be more familiar with amentia so they included this as a substitute term, signalling an attempt to compromise the introduction of new ideas with those that were already familiar to practicing psychiatrists. The committee meanwhile recommended that dementia be completely removed from any revised classification because they thought the term was deceptive. This was based on their literal interpretation of it meaning ‘out of the mind’, and again deem the meaning of oligophrenia as being lack of, deficiency of, or small, mind, being more appropriate for clinical usage.<sup>89</sup>

Oligophrenia was included at the expense of congenital deficiency that had been used in the 1906 table, the then dominant term used in law, was not used and this is perhaps because the committee wanted to employ a term that did not have the negative political connotations that the legal and administrative term attracted: the 1913 Mental Deficiency Act had established deficiency colonies, and there was still a deep divide between the quality of hospitals that housed those considered mentally ill, and those considered mentally deficient, with the latter often enduring harsher conditions.<sup>90</sup> It may have been the case that the committee employed *oligophrenia* instead of *mental deficiency* partly in order to set an agenda of breaking down the institutional divide, although it is not possible to say this with certainty because of the paucity of the records kept in relation to the deliberations carried out during the revisions. In their report, the committee defined the condition as one of ‘arrested or incomplete development of mind, whether arising from inherent causes or induced by disease or injury’.<sup>91</sup> Presumably, their

---

<sup>85</sup> L.D.H. Baugh, ‘Some Observations On Confusional Insanity’ in the *BMJ*, Vol. 2, No.2337, Oct 14<sup>th</sup> 1905, (pp.949 – 951) (p.949)

<sup>86</sup> *Ibid.* (p.950)

<sup>87</sup> GTWH Fleming, ‘The Revision of the Classification of Mental Disorders: Report by the Clinical Psychiatry Sub-Committee of the Research and Clinical Committee – Part II’ in *JMS*, Vol.78, No.321, April 1932, (pp.387 – 391) (p.390)

<sup>88</sup> *Ibid.* (p.389 - 390)

<sup>89</sup> *Ibid.*

<sup>90</sup> See the 1913 Mental Deficiency Act S2 for details on the provisions for mentally deficient patients; for wider discussions of the implementation of the social policy on mental deficiency, see Matthew Thomson, *The Problem of Mental Deficiency*, OUP, 1998.

<sup>91</sup> *Ibid.*

use of 'idiocy' and 'imbecility' was designed to make the concepts intelligible to psychiatrists by employing terms that they would already be familiar with.

One of the three sub-categories of amentia/oligophrenia included by the committee was *feble-mindedness*, which was in turn split into *moral* and *intellectual* forms. It is difficult to determine why the concept of *intellectual feble-mindedness* was distinguished from *imbecility* and *idiocy*, again due to the paucity of the historical data available. The report of the committee provides no hints for why they decided to include feble-mindedness as a separate diagnostic category, but the term was used frequently by child guidance workers loosely to describe those with impaired cognitive facilities from birth, as well as those who struggled at school because of learning disabilities, and children with behavioural disorders. Those with underdeveloped intellectual faculties and learning disabilities would have been captured by *intellectual feble-mindedness*, whereas behavioural disorders would have been captured by *moral feble-minded*.

In summary then, the terms adopted in the first part of the classification followed the lead of the 1906 Table of the Forms of Insanity by placing those who had congenital mental disorders and, those who were deemed to be mental deficient, together. It simply updated the terms from *congenital or infant deficiency* that were adopted in the 1906 Table of the Forms of Insanity, and split them into *Intellectual* and *Moral* forms.

### 2.3 Neurosis and Psychoneurosis

The second class of the Table of the Forms of Mental Disorder included the sub classes of exhaustion neurosis, anxiety states, compulsions, obsessions and phobias, and hysteria. All of these disorders would be part of the broad term shell shock, and were discussed by the Royal Commission on War Neurosis.<sup>92</sup> The term was recognised as problematic by the authors of the war office's report. The vagueness of the term *shell-shock* was recognised, with the report stating that it referred to many conditions including hysteria, anxiety neurosis, insanities induced by the 'environment' or reactions to trauma, and 'congenital mental defect'.<sup>93</sup> The report stated that these different forms of insanity may be co-morbid but found it difficult to differentiate the forms of insanity from one another. The commission did not make any attempt to differentiate between *neurosis* and *psychoneurosis*, using the terms interchangeably in their classification. They split this into four sub-classes: *Exhaustion neurosis*, *Anxiety States*, *Compulsions*, *Obsessions and Phobias*, and *Hysteria*. *Exhaustion neurosis* meant 'abnormal mental states

---

<sup>92</sup> War Office 'Summary of Evidence of Witnesses Regarding the Influence of War Stress and 'Shell Shock' in the Production of Insanity' in *Royal Commission into Shell Shock*, HMSO, 1919.

<sup>93</sup> *Ibid.*, (p.6)

characterized essentially by mental or motor fragility; *Anxiety states* were characterised by symptoms of ‘generalised fear’; the third class included ‘phobia where the anxiety is attached to some definite object or situation’; and the fourth class of *hysteria* was ‘a faulty reaction to environment characterised by a variety of i. motor symptoms, ii. sensory symptoms, iii. mental symptoms.’<sup>94</sup> The committee notes of such patients that:

they are bound together by their dependence upon fundamental psychological laws, and that any one case may be found to exhibit the characteristics of two or more types of reaction. Thus a hysteric may show signs of anxiety neurosis and may also exhibit evidence of congenital mental defect, while his irresponsibility in any specific conduct may be due more to his degree of mental defect than to his hysteria.<sup>95</sup>

The committee decided not to use *neurasthenia* despite it being favoured by a great number of the RMPA’s members because it had, like *shell-shock*, been used too loosely during the war ‘as a dumping ground for all sorts and conditions of mental disorders’.<sup>96</sup> They also did not want to confuse it with the Freudian usage for masturbatory disorders, with the expression *exhaustion neurosis* to be much clearer and distinct. The committee considered *hysteria*’s clinical usage as an environmentally caused trauma to be clear enough and did not provide a justification for its use, despite it being so closely associated with psychoanalysis by the thirties. *Anxiety States* and *compulsions, obsessions and phobias* were based on clear and distinct clinical entities because they were based upon observable behaviours, so again no justification or rationale is offered for the use of these terms.

The definitions of these disorders then included psychological symptoms as well as behavioural ones and physical ones. Although the inclusion of descriptions of behaviour and physical symptoms like motor movements would satisfy physicalists, descriptions of psychological symptoms were the primary basis for the definitions provided by the committee, and that would prove too vague for some, as we will see in the final section of this chapter. For now it is important to note the receptiveness the committee had towards the psychological symptoms of mental disorder, and how concepts included in this section of the classification were defined in psychological terms.

---

<sup>94</sup> Ibid.

<sup>95</sup> GWH Fleming, ‘Definitions and Explanatory Notes on the Classification of Mental Disorders’ in *JMS*, Vol.80, No.329, April 1934, pp. 409 – 410.

<sup>96</sup> GWH Fleming, ‘The Revision of the Classification of Mental Disorders: Report by the Clinical Psychiatry Sub-Committee of the Research and Clinical Committee – Part II’ in *JMS*, Vol.78, No.321, April 1932, (pp.387 – 391) (p.390)

## 2.4 Schizophrenic Psychosis

The classification committee used *schizophrenic psychosis* as a main category stating that it had come to ‘occupy a permanent place in our vocabulary’.<sup>97</sup> They noted that ‘*This syndrome includes cases which show remissions and even recoveries in addition to cases which show progressive deterioration.*’<sup>98</sup> It was split into two sub-categories, using Kraepelin’s *dementia praecox* for the first, and *paraphrenia* for the second. The term that would eventually be entirely replaced in the clinical literature by *schizophrenia* was used so the more severe *dementia praecox* could be differentiated from the milder *paraphrenic* form. *Dementia praecox* was first introduced as a clinical concept in its modern forms in 1893 when Kraepelin used it in the fourth edition of his textbook;<sup>99</sup> *paraphrenia* had first been used by Kahlbaum to describe a form of insanity that would develop in adolescence and early adulthood.<sup>100</sup> By the 1930s, *paraphrenia* had become used in the UK as a sub type of *dementia praecox* due to Kraepelin having used *paraphrenia* to distinguish it as a less severe form of the disorder in the 1913 version of the *Lehrbuch der Psychiatrie*.<sup>101</sup> It followed Kraepelin’s understanding, describing patients whose ‘emotional and volitional disorder is slight’ with ‘[d]elusions and hallucinations generally grandiose and phantastic but with little effect on ordinary conduct’.<sup>102</sup>

The committee had followed Bleuler’s terminology in using *schizophrenia* as the main category name, but they retained *dementia praecox* so that it could be differentiated from the milder *paraphrenia* and split into the ‘time-honoured’ Kraepelinian sub-categories of i) *simple*, ii) *hebephrenic*, iii) *catatonic*, and iv) *paranoid*.<sup>103</sup> It provided the following definitions of each of these terms:

- (i) Simple - Cases characterized by defects of interest, gradual development of an apathetic state often with peculiar behaviour, but without expression of delusions or hallucinations.

---

<sup>97</sup> Ibid.

<sup>98</sup> GWTH Fleming, ‘Definitions and Explanatory Notes on the Classification of Mental Disorders’ in *JMS*, Vol.80, No.329 April 1934, pp. 409 – 410

<sup>99</sup> J. Hoenig, ‘Schizophrenia’ Hoenig, J. ‘Schizophrenia’ in Berrios and Porter eds., *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders*, Routledge, 1995, pp.336 – 348.

<sup>100</sup> Hecker, E. cited in Kendler, K. and Engstrom, E. ‘Kahlbaum, Hecker, and Kraepelin and the Transition From Psychiatry Symptom Complexes to Empirical Disease Forms’ in *American Journal of Psychiatry*, 1st February 2017, Vol.174, No.2, (pp.102 – 109)

<sup>101</sup> Hoff, P. ‘Kraepelin’ in Berrios and Porter eds., *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders*, Routledge, 1995, pp.261 – 279. (p.272).

<sup>102</sup> GWTH Fleming, ‘Definitions and Explanatory Notes on the Classification of Mental Disorders’, *JMS*, Vol.80, No.329, April 1934, pp. 409 – 410.

<sup>103</sup> Ibid.

(ii) Hebephrenic - Cases showing prominently a tendency to silly laughter, grimaces, mannerisms, together with grotesque ideas and erratic behaviour.

(iii) Katatonic - Cases in which there is a prominence of negativistic reaction or peculiarity of conduct, with phases of stupor or excitement, sometimes characterized by impulsive or stereotyped behaviour, and usually hallucinations.

(iv) Paranoid - Cases characterized by unsystematized delusions, usually of persecution or grandeur. Hallucinations in various fields and a tendency to early dementia.

After the Great War, *dementia praecox* had become widely used as a disease concept in the United Kingdom, and it was used in debates surrounding the aetiology of mental disorder amongst troops returning from the Great War. In 1919 The War Office set up a committee to scrutinise mental breakdown amongst troops: mindful of a burgeoning pension bill, the commission asked prominent British psychiatrists including Mott and his Maudsley colleague Edward Mapother whether it was the war that was solely responsible for the development of psychoses in troops. Mapother testified that:

His impression of the service patients seen by him since the war was that most of them would have been insane had there been no war. They suffered from insanity of the ordinary type; mostly from dementia praecox.<sup>104</sup>

Stanford Reade bolstered Mapother's view when he testified that:

Of the service patients [by 1919 who were now] in asylums, he thought the majority are suffering from dementia praecox. He thought the majority would have broken down under any slight strain.<sup>105</sup>

This was by no means a uniform view, however, with G. Roussy having stated before the committee that there may have been a certain number of cases of manic-depressive insanity, dementia praecox, and cases of mental confusion only occurring after shell-shock. Roussy contradicted Mapother and Reade when he claimed that instances of dementia praecox and manic depressions were in fact rare, but he agreed with them that the war had not been the sole cause of this spike in breakdown: when asked by the commission whether it was aggravated rather than produced by the war, he answered:

---

<sup>104</sup> War Office 'Summary of Evidence of Witnesses Regarding the Influence of War Stress and 'Shell Shock' in the Production of Insanity' in *Royal Commission into Shell Shock*, HMSO, 1919. (p.146)

<sup>105</sup> Dr. Stanford Read in Ibid.



I think the war created nothing in the way of the psychoses. It simply aggravated or revealed these manifestations in people who were predisposed to them.<sup>106</sup>

Dementia praecox was then invoked within deliberations concerning the awarding of war pensions to veterans, and it became the popular term to describe patients who would not recover from their condition. The expert testimonies above made their references in relation to dementia praecox and manic depression: both of these being concepts of psychopathology which had prognosis built into them. This is fundamentally different to mania and melancholia, diseases which could be seen amongst the young soldiers but provided no indication of the prognosis of the patient. Although sub types of these forms of insanity included in the 1906 classification, such as Recurrent Mania and Recent Melancholia, as well as other forms such as Volitional and Alternating Insanity, may provide some clues to aetiology, manic depression and dementia praecox proved to be powerful shorthand deployed often during these proceedings to refer to those destined for insanity, and those for whom the war had played a role in the development of mental disorder.<sup>107</sup>

Although Kraepelinian terms were popular, some doctors continued to employ the terms that were included in the 1906 Table of the Forms of Insanity. For instance, Geoffrey Clarke used the terms ‘temporary insanity’ and ‘confusional and exhaustion states.’<sup>108</sup> Likewise, Dr. W. Johnson described ‘numerous cases of acute confusional insanity’, the majority of whom recovered within a day of admission.<sup>109</sup> Clarke contrasted the cases he experienced on the Western Front – which were mainly instances of exhaustion psychosis – to the confusional insanity he came upon in ‘Mesopotamia and Gallipoli [which] were due to physical illness, such as malaria, typhoid fever, dysentery’.<sup>110</sup> Furthermore, neurasthenia, a nervous condition that was becoming firmly placed within the professional grasp of the neurologist, was also being employed by professionals testifying. Neurasthenia, like *confusional insanity*, was viewed as being a temporary condition caused by physical fatigue and shock to the body, whereas dementia praecox was still tied to heredity:

[Johnson] thought the psychoses were revealed rather than produced by the war. He did not get many cases who, having been diagnosed with neurasthenia, later developed mental symptoms. The 15 service patients [still] at present in his

---

<sup>106</sup> Ibid., (p.145).

<sup>107</sup> Ibid.

<sup>108</sup> Ibid., (p.146).

<sup>109</sup> Ibid., (p.145).

<sup>110</sup> Ibid.

hospital [in 1920] were all cases of dementia praecox. None of these cases was sent in as neurasthenic.<sup>111</sup>

To receive a diagnosis of dementia praecox as a veteran from the Great War meant facing a bleak future. The concept was wrapped in meaning from degeneration theory, which had seen its heyday before the war. As a result, patients could find themselves left without a veteran's pension, with the authorities deeming that the psychosis one suffered was not caused by the war, and was therefore not the responsibility of the state. As absurd as it sounds, the government held individuals responsible for their physical and mental constitution: if someone received a diagnosis of dementia praecox, they were viewed as being the kind of danger that Leeper would come to refer to in his presidential address nearly a decade after the shell shock committee sat.

## 2.5 Psychopathic Constitution

The committee introduced the concept of *psychopathic constitution* to differentiate 'paranoiac conditions which do not end in intellectual impairment should, it was thought, be sharply separated from the *schizophrenic psychoses*'.<sup>112</sup> This class included 'a large group of pathological personalities, such as may be found amongst criminals, tramps, sex perverts, drug addicts, mattoids, agitators, etc. The prison psychoses should be included in this group.'<sup>113</sup> There are three different strands of thought that are realised in the concept: Pinel's work on *manie sans delirei*, built upon by Prichard to formulate *moral insanity*, described as a disorder of emotion that saw no cognitive impairment;<sup>114</sup> Morel's work on degeneration and the increasing popularity of eugenics which made this a problem of constitution;<sup>115</sup> and finally, the German origins of the term itself, with J.L.A Koch first using psychopathy in his 1889 textbook *Leitfaden der Psychiatrie* to describe a state that existed between the normal and pathological, claiming that 'psychopathic inferiority did not corrupt personality [but] produced an isolated mental weakness of the faculties of intellect, emotions, or willpower'.<sup>116</sup>

---

<sup>111</sup> Ibid.,(p.147).

<sup>112</sup> GWTH Fleming, 'Definitions and Explanatory Notes on the Classification of Mental Disorders', *JMS*, No.80, April 1934, pp. 409 – 410

<sup>113</sup> Ibid.

<sup>114</sup> Greg Eghigian, 'A Drifting Concept for an Unruly Menace: A History of Psychopathy in Germany' in *ISIS*, No.2, vol.106, 2015, pp.283 – 309 (p.285)

<sup>115</sup> Henry Werlinder, 'Psychopathy: A History of Concepts', *Acta Universitatis Upsaliensis*, No. 6, Stockholm, Almqvist & Wiksell, 1978, 8vo, pp. 218 – 258)

<sup>116</sup> Greg Eghigian, 'A Drifting Concept for an Unruly Menace: A History of Psychopathy in Germany', *ISIS*, No.2, vol. 106, 2015, pp.283 – 309 (p.286)

Emil Kraepelin and Karl Birnbaum would, during the earlier decades of the 20<sup>th</sup> century, employ Koch's term to narrow their attention upon a category of patients whose mental illness led to disturbances in personality and in emotions, yet did not seem to have an impact upon cognitive abilities such as problem solving and or speech abilities, and rarely led to hallucinations. Furthermore, both Kraepelin and Birnbaum were influenced by Lombroso in this regard, and as a result sought to link the disorder to early criminology and its ideas about the psychological makeup of criminal types.<sup>117</sup> In his 1909 paper on degeneration, Kraepelin associated psychopathy with increased instances of depression, anxiety and neurosis, and he conceptualised it as a constitutive disorder.<sup>118</sup> He used the term degenerative psychosis (*Entartungsirresein*), which he grouped together with a set of disorders which could lead to:

The weakening drive for self-preservation [which] is shockingly evident in the continuous decline in the birth-rate, [and] has already begun to take the French people down the path towards extinction, and no less so in the prevalence and tolerance of all sorts of unnatural sexual aberrations.<sup>119</sup>

'Psychopathy' was used in clinical documents, and much research was carried out in British psychiatry into this disorder. There is evidence that it was used as a clinical term during the First World War by British psychiatrists. The largest sub-group of shell-shocked patients, Mott argued, were those servicemen who had 'an inborn timorous or neurotic disposition' or an 'acquired neuropathic or psychopathic taint'. The war had witnessed the recruitment of a mass army, drawing on individuals who would not normally have considered military service. Mott believed that they possessed an inherent vulnerability to mental strain.<sup>120</sup>

The term 'borderline psychopathic states' had been used as a diagnostic category in statistics collected by the War Office during the First World War.<sup>121</sup> The historian Ben Shepherd points out that by the time of the Second World War, psychiatric preparations under the lead of Francis Prideaux were being carried out which included provisions for those with borderline psychopathic states.<sup>122</sup> It is from the assorted language that surrounded psychopathy that the terms psychotic and psychopathic arose in the United Kingdom, and it is the term 'psychopathic' that would come to be used in the 1959 Mental Health Act.

---

<sup>117</sup> Ibid., (p.287).

<sup>118</sup> Emil Kraepelin, 'On the Question of Degeneration' in *History of Psychiatry*, vol.18, No.3, 2007, pp.399 – 404

<sup>119</sup> Ibid. (p.401)

<sup>120</sup> Edgar Jones, 'An Atmosphere of Cure: Frederick Mott, Shell Shock and the Maudsley', *History of Psychology*, vol.25, 2014, pp.412 – 421 (p.415)

<sup>121</sup> Ben Shepherd, 'Pitiless psychology': the role of prevention in British military psychiatry in the Second World War' in *History of Psychiatry*, Vol.10, Oct. 1999, pp.491 – 524.

<sup>122</sup> Ibid.

## 2.6 Affective Psychosis

The final noteworthy definition provided by the committee was *affective psychosis*, under which was included *manic depressive insanity*, also labelled *cyclothymia* because the committee felt that this term was more familiar to British psychiatrists. The term was used reluctantly by them, commenting that ‘it is in no way expressive of depression, but is much used by some clinicians’, and that its real meaning was ‘a fluctuation of the affective state’.<sup>123</sup> Due to the widespread acceptance of *manic depressive insanity* in British clinical circles, the committee did not provide a justification for having used this term, following its Kraepelinian understanding. Perhaps controversially amongst some of the more modern sections of the RMPA, the committee also decided to retain melancholia as a clinical concept but including *involutional melancholia* as a sub-category within the category of affective psychosis, including it to describe the ‘slowly developing depressions of middle and later years, characterized by worry, insomnia, uneasiness and agitation.’<sup>124</sup>

## 2.7 Toxic Psychosis

The clinical committee did not provide definitions for *toxic psychosis* and the extensive sub-categories that were included under this class of mental disorders. It was split into two parts: *endogenous* and *exogenous*. *Endogenous* was included in order to retain a place for the toxins that were thought to be caused by focal infections, and which although by this point not completely discredited, was on the decline. Investigations into the link between the endocrine system and psychoses was still thought to be a potentially fruitful line of research, and these would also be accommodated in the *endogenous* section. *Exogenous* would include alcoholism, which was removed by the 1906 tables, and the inclusion of Korsakov’s psychosis. This category would be removed in the final version of the classification, and moved to the list of aetiological factors that accompanied the Table of the Forms of Mental Disorder in June 1934.

## Section 3: Reactions

Did the revisions do anything to instil optimism amongst members of the RMPA? An address given by Henry Yellowlees, a prominent and influential member of the Association’s clinical

---

<sup>123</sup> Ibid.

<sup>124</sup> Ibid.

psychiatry sub-committee shortly after the publication of the committee's classification, suggests not:

It is simply the case that unfortunately research in psychiatry bears, on the whole, far less relation to clinical work with and for patients than in any other branch of medicine [...] the research aspect and the clinical aspect of present-day psychiatry are so far apart from each other that any amount of so-called research can be and is carried out far away from any mental hospital. Further, a very large number of the more junior research workers in our speciality, even though working in a mental hospital, have not, in spite of their undoubted talents, the slightest practical acquaintance with what most of us call clinical psychiatry.<sup>125</sup>

The address received a mixed reaction, with some practitioners agreeing to Yellowlees's general idea but disagreeing on specific details, and others taking exception to a proposal he put forward to separate those with severe mental illness from borderland cases. In fact, news that Yellowlees had resigned from his position on the clinical psychiatry sub-committee for research was announced the following year.<sup>126</sup> Yellowlees was not alone: the same year an address by that year's president, Reginald Worth, chief superintendent of Springfield Mental Hospital, also criticised the research coming from the Association, but in much stronger terms:

At the risk of bringing the whole of the elegant fabric of this learned society about my ears, I am going to make a bold statement. I maintain, whilst heartily deploring therapeutic nihilism, that we have advanced but little in the diagnosis and treatment of mental disorder: in fact, I am inclined to the view that some cases that have fallen within my purview have recovered in spite of, not because of, the treatment. We are plodding along, some of us desperately in earnest, experimenting with this and that in an empirical fashion, now a new drug and now a new electrical gadget, and so forth, and I express the view, again with all due humility, that I am after all this long time just as bewildered when confronted with a psychosis as I was at the outset of my career.<sup>127</sup>

These gloomy remarks articulated a return to the pessimism surrounding the profession's abilities to cure mental health disorder that was seen before the Great War. Yellowlees's proposal to create a kind of hospice for chronic patients can be interpreted as showing that certain practitioners within mental health care had abandoned some of their patients in light of the view that they were naturally doomed to their fate. Despite the humanitarian aspect of Yellowlees's proposal to improve the care of those with less severe mental health disorders by separating them from other extreme cases who were deemed incurable, the questioning of the

---

<sup>125</sup> Henry Yellowlees, 'Modern Psychiatry and Mental Hospitals', address recorded in (Anon 1934) (p.251)

<sup>126</sup> 'The Royal Medico-Psychological Association: Ninety Fourth Annual Meeting, July 3<sup>rd</sup> – 5<sup>th</sup>, 1935' in *JMS*, Vol.81, No.335, pp.970 – 991. (p.981)

<sup>127</sup> Reginald Worth, 'Four Decades of Psychiatry: The Presidential Address at the Ninety-Fourth Annual Meeting of the Royal Medico-Psychological Association', held in the Middlesex Guildhall, Westminster, July 3, 1935. In *JMS*, 81(335), pp.755–765. (p.757)

worth of the research into mental health disorders during this period are symptoms of a profession that was facing its own tensions in terms of how it perceived the effectiveness of its own practice, and the models of mental health disorders on which these practices rested.

The revised classification did nothing to cure these concerns and had little to no impact on psychiatric practice. On June 30<sup>th</sup> 1936, the Research and Clinical Committee of the RMPA made put forward a request to the Council of the Association to approach the Board of Control to adopt the classification of mental disorders.<sup>128</sup> It was reported at the 1938 meeting that the Board of Control was not entirely happy with the classification, and had criticised its potential for practical use on the basis that it was too complex.<sup>129</sup> The classification sub-committee pledged to make amendments in the hope of satisfying the requirements of the board, and sent through an amended classification for their certification. By 1940, the committee had not heard anything other than a formal acknowledgement of receipt from the Board of Control, and due to the emergency conditions imposed by warfare, the committee decided not to pursue the matter any further.<sup>130</sup>

The classification received criticism for being too Freudian from the old guard of British psychiatry. Robert Armstrong-Jones, by then in his late seventies and one of the last of the old generation of RMPA members who had been involved in drawing up the 1906 Table of the Forms of Insanity, criticised the table for not only having included Freudian ideas, but for being generally ‘continental’ in flavour.<sup>131</sup> Armstrong-Jones based this latter judgment on its inclusion of Eugen Bleuler’s term *schizophrenia*, which had by was starting to replace the Kraepelinian *dementia praecox* as the standard term to describe various psychotic and delusional disorders that had their onset in early adulthood.<sup>132</sup> He also took exception to the use of Latin and Greek terms, claiming that using oligophrenia and amentia complicated the classification unnecessarily. He wrote that ‘[apart from the uneasiness, and even fear, which many medical

---

<sup>128</sup> Royal Medico-Psychological Association, Minutes of the Meeting of the Research and Clinical Committee, June 30<sup>th</sup>, 1936, in RCPSYCH/L10 - Records of the Research and Clinical Section, 1927-1970, held by The Royal College of Psychiatrists, London.

<sup>129</sup> Royal Medico-Psychological Association, Minutes of the Meeting of the Research and Clinical Committee, 10th July 1938 in RCPSYCH/L10 - Records of the Research and Clinical Section, 1927-1970, held by The Royal College of Psychiatrists, London.

<sup>130</sup> Dr. Strom-Olsen, remarks recorded in Royal Medico-Psychological Association, Minutes of the Meeting of the Research and Clinical Committee, July 17<sup>th</sup>, 1941 in RCPSYCH/L10 - Records of the Research and Clinical Section, 1927-1970, held by The Royal College of Psychiatrists, London.

<sup>131</sup> Robert Armstrong-Jones, ‘Correspondence: Classification of Mental Disorders’ in *BMJ*, June 16<sup>th</sup>, 1934, pp.1091 – 1092, p.1091.

<sup>132</sup> The historical instability of *schizophrenia* is an area that needs further research, but Richard Noll’s work questions the conceived linear relationship between it and *dementia praecox*. See: Richard Noll, *American Madness: The Rise and Fall of Dementia Praecox*, 2011, Routledge.

men entertain about introducing the Greek Gods and other's into their patients, whether they be Oedipus, Electra, Narcissus or any other, I fail to see the necessity for complicating an English terminology with the use of classical names when the English equivalents can express the full meaning very well.<sup>133</sup> Underneath these terminological gripes, Armstrong-Jones was complaining about the loss of the 1906 Tables because they used simple and practical concepts, values which were of prime importance for alienists and medical psychologists in the British Isles. Armstrong-Jones thought that the new classification placed an unreasonable requirement upon medical students, asking them to make diagnoses using what he termed 'hieroglyphs', and appealed for the tables to be revised yet again to bring them closer to common English usage.<sup>134</sup> A reply signed by Fleming, the secretary of the clinical committee, was published two weeks later that engage with any of Armstrong-Jones' concerns, but rather curtly stated that the classification had been approved by the Association one year earlier.<sup>135</sup>

In contrast, the authors of one of the most influential and longest running textbooks of British psychiatry thought that RMPA's latest classification of mental disorder was retrospective and was not becoming of the state of the art of the profession. I.R.C. Gillespie and D.K. Henderson's damning verdict of the RMPA's classification instead recommended the classifications that were included in the sixth edition of the Royal College of Physicians' Nomenclature of Diseases', the committee that drew it up they sat upon.<sup>136</sup> Naming the RMPA's classification 'the British classification', they stated that:

This scheme can hardly be held to reflect modern psychiatric teaching as fully as might have been achieved. Confusional insanity is not a clinical entity on an equal footing with the other categories of part I; it is nearly always, if not always, a symptom of some of the other mental disorders. We have never seen a case which could not be more profitably designated as something else. In actual practice these have been grouped under this heading such diverse diseases as alcoholic, toxic and exhaustion states, senile confusion and dementia praecox. A given case will therefore sometime fall not only into a category of Part II, but into two categories of Part I. A similar criticism applied to the allocation of dementia to a separate category on an equal footing with, for example, schizophrenia, and the affective psychoses, of either of which type of dementia is a terminal state.<sup>137</sup>

Henderson and Gillespie were commenting on an early draft of the classification when they target 'confusional insanity', which was given a cosmetic change to 'confusional states' in the

---

<sup>133</sup> Ibid.

<sup>134</sup> *The Nomenclature of Diseases. Drawn Up by a Joint Committee Appointed by the Royal College of Physicians of London. Sixth Edition, Etc.* London, 1931.

<sup>135</sup> GWTH Fleming, 'Correspondence: Classification of Mental Disorders' in *BMJ*, June 30<sup>th</sup>, 1934, p.1187.

<sup>136</sup> Henderson, D.K. and Gillespie, R.D. *A Textbook of Psychiatry for Students and Practitioners*. 3<sup>rd</sup> ed., OUP, 1932, p.13.

<sup>137</sup> Ibid.

final classification. Confusional was used during the 1920s most notably in the War Office commission into shellshock, but it was also used by a generation of RMPA members who had experience training and working in asylums: Gillespie and Henderson however represented the new wave of psychiatrists who would see themselves as more internationalist in their approach, looking beyond the narrow parochialism of the country asylum (both Henderson and Gillespie had spent time abroad, working alongside Kraepelin and Adolf Meyer at the John Hopkins Hospital in Baltimore).<sup>138</sup> The alternative classification that they presented in their textbook bore the marks of these influences, with them being one of the central lines of communication for Meyer's psycho-biological approach to the theory and treatment of mental disorder.

Henderson and Gillespie questioned the category of 'psychopathic constitution' claiming that it was outdated, and that there was little justification for tying paranoia to hereditary factors.<sup>139</sup> They favoured the American Psychiatric Association's schema, which they judged to be Kraepelinian, albeit with modifications carried out by Meyer to the German's concepts. They provided a classification of their own, but stressed that they were not describing different kinds of mental disorders or diseases, but were instead describing what they termed 'different types of reaction'.<sup>140</sup> Their rationale for talking about 'reaction types' was that they were aiming to emphasise with their work how 'the individual as a psycho-biological individual [is] perpetually called upon to adapt to a social environment'.<sup>141</sup> Whilst promoting the psychological make-up of the individual in their view of what mental disorder was, however, the pair still conceded to the mainstream view that 'in many instances the constitutional element is the important factor [and] that the environmental influences in a number of cases are of relatively minor importance'.<sup>142</sup> What marks their work aside from the mainstream is that they acknowledged an internal psychological environment, and argued that 'what is regarded as a constitutional type of mental disorder may often be the reaction of the mind to inner-stimuli to which it finds difficulty in maintaining a healthy adjustment'.<sup>143</sup> Psychopathic constitution is the most obvious of the psychopathologies that were open to this criticism, and it is very likely that this was in fact the target of the authors: Henderson was conducting research on psychopathy, and produced a textbook in 1939 which listed different

---

<sup>138</sup> K. Loughlin, 'Henderson, Sir David Kennedy (1884–1965), psychiatrist' in *Oxford Dictionary of National Biography*, September 23<sup>rd</sup>, 2004.

<sup>139</sup> *Ibid.*, (p.16).

<sup>140</sup> *Ibid.* (p.21).

<sup>141</sup> *Ibid.*

<sup>142</sup> *Ibid.*

<sup>143</sup> *Ibid.*



types of the disorder, listing developmental and constitutional factors that played a role in developments of types of psychopathy. The different types of disorder also included different behavioural manifestations, with creative and passive or 'inadequate' forms of the disorder accompanying the aggressive forms that were commonly associated with psychopathy.

## Mental Diseases—continued

Functional psychoses.	Epileptic psychoses
Manic-depressive	Epileptic dementia.
Mania	Epileptic confusion
Hypomania.	Epileptic dream-state.
Acute mania	Epileptic automatism.
Acute delirious mania	Epileptic hallucinatory paranoid state.
Depression	
Simple retardation	Epileptic depression.
Acute depression	Epileptic excitement.
Depressive stupor	Psychopathic personality.
Hypochondriacal depression	Temperamental instability.
Stupor	Pathological lying.
Manic stupor	(Pseudologia phantastica)
Depressive stupor	Pathological swindling
Mixed type (e.g., agitated depression)	Kleptomania
	Contentious (litigious) type
	Sexual perversions
Circular type	Psychoneuroses
Alternating type.	Neurasthemia †
Recurrent type	Anxiety-neurosis
Cyclothymia	(Psychoneurotic anxiety-state)
Involution melancholia	Phobia
Hypochondriasis.	Agoraphobia
Paranoia	Claustrophobia.
Paranoid state.	Hysteria.
Hallucinatory paranoid state	Obsessive-compulsive psycho-
Paraphrenia.	neurosis (Psychasthenia)
Schizophrenia.	
	(Dementia praecox)
	Simple
	Hebephrenic
	Paranoid
	Catatonic
	Periodic.

† This term is used in various senses and should therefore be avoided.

## SECTION III

## Mental Diseases.

Mental deficiency (Amentia.)	Infection-exhaustion psychoses.
Simple	General
Mongolian	Prefebrile, febrile and post-febrile delirium
Microcephalic.	Exhaustion-psychoses
Anaurotic	Puerperal psychoses
Sclerotic	Psychoses associated with chronic organic disease.
Hydrocephalic	Local brain-infections.
Inflammatory	Syphilis
Syphilitic	Cerebral syphilis
Paralytic	General paralysis
Epileptic	(Dementia paralytica)
Cretinous	Encephalitis (including Epidemic encephalitis)
Due to sensory deprivation	Menigitis
Idiocy	Abscess.
Imbecility	Psychoses with Primary Degenerative Brain-changes
Feeble-mindedness	Senile dementia
Dulness and backwardness	Presenile sclerosis.
Moral deficiency	Arteriosclerotic brain-disease.
Psychoses accompanying Organic diseases	Huntington's chorea
Toxic	Psychoses with Brain-trauma
Endogenous (e.g., uremia, eclampsia, &c.)	Traumatic delirium
Exogenous	Traumatic constitution
Due to alcohol	(Explosive diathesis)
Mania a potu	Traumatic mental enfeeblement
Chronic alcoholism	Psychoses with Organic Brain-disease
Delirium tremens	(e.g., Tumour, Multiple sclerosis, Thrombosis, Embolism, &c.)
Alcoholic hallucinosis	Psychoses associated with Metabolic and Endocrine disorders
(acute and chronic)	
Alcoholic dementia	Pellagra
Korsakow's polynouritic psychosis	Myxoedema.
Due to Opium	Other metabolic disorders
Due to Lead	
Due to other poisons	

Figure 21: Henderson and Gillespie's Classification of Mental Diseases.<sup>144</sup><sup>144</sup> Ibid., (pp.13 – 14).

The pair also expressed regret that the RMPA isolated forms of exhaustion-based insanity from others, claiming in their textbook that exhaustion was a symptom ‘which on further analysis will be found to express either an anxiety or a hysterical psychoneurosis or some other form of mental illness’.<sup>145</sup> In other words, according to Gillespie and Henderson, the classification committee had made the grave error of confusing symptoms with disease types. As we see above, this was something that the pair sought to solve by referring to reaction types instead of disease entities.

The truth is that no attempt at classification is entirely satisfactory, and consequently that “diagnosis”, or the placing of the patient in the appropriate class, is on an unstable foundation. But, fortunately, it is not diagnosis that matters, but the understanding of the disorder, and of the patient who suffers from it - under what circumstances it arose, how it is related to the patient’s normal condition, what the disorder means, what light is shed on his problems, and what can be done to help towards a favourable outcome. In Adolf Meyer’s words, it is not the patients we are told to sort out, but the facts; and while in the following pages the case records will be arranged in groups for the sake of more or less systematic description, the disorders exhibited will be considered as the individual reactions of a specially endowed, and often constitutionally loaded, organism to the environment.

Nevertheless, classification is useful and even necessary; first for the student; that he may more readily grasp and arrange his cases; and second, for the compilation of a uniform set of statistics by institutions and administrative authorities, in order to make comparison possible. It seems to me that it would be a great help to British psychiatry if a uniform type of classification were adopted similar to that immediately above [i.e. the American one]. The Royal College of Physicians (England) has lately recognised this and has tried to adopt, in its Nomenclature of Diseases, a classification similar to that which follows [in this textbook].<sup>146</sup>

Bernard Hart and Eliot Slater were on the ‘mental diseases’ section of the revisions body for the Nomenclature of Diseases at the Royal College of Physicians, and were central in drawing up the society’s classification of mental diseases. They were not, however, involved with the RMPA’s revisions. Eliot Slater would also write a textbook with the German émigré Wilhelm Mayer Gross and Michael Roth that again would, like Henderson and Gillespie, call for attention to be paid to the psychological aspects in the treatment of mental health disorders.<sup>147</sup> Mayer Gross was an influential figure in British psychiatry since his arrival in the British Isles in 1933.<sup>148</sup> He would come to be regarded as the founder of ‘The British School of Psychiatry’, a

---

<sup>145</sup> Ibid.

<sup>146</sup> Ibid. (p.16)

<sup>147</sup> William Meyer-Gross, Eliot Slater and Martin Roth, *Clinical Psychiatry*, Cassell, 1954.

<sup>148</sup> Rhodri Hayward, ‘Germany and the Making of ‘English’ Psychiatry: The Maudsley Hospital 1908 – 1939 in Volker Roelcke, Paul J. Weindling and Louise Westwood eds., *International Relations in Psychiatry: Britain, Germany and the United States to World War II*, University of Rochester Press, 2013, pp.67 – 90.

form of psychiatric inquiry that was informed by the phenomenology of Henri Bergson, Edmund Husserl, Max Scheler and Karl Jaspers.

## Conclusion

The timing of the second set of revisions to the Table of the Forms signalled a crossroads between the last vestiges of the diagnostic categories commonly used in the Victorian asylum, and the ultimate dominance of Kraepelinian approaches to psychiatric disorder that were combined, as in the work of Adolf Meyer, with Freudian notions of the psychological development of neurosis and psychosis. At the same time as there were those like Leeper who had spent their professional careers in underfunded and overcrowded asylums whose views firmly bore the stamp of later Victorian attitudes to the classification of insanity, there were those who were working in modern research institutes or out-patient clinics, and researchers who had no experience of treating patients in asylum.

The research and the practice of psychiatry had changed massively since the last set of revisions in 1906, with the RMPA no longer setting the agenda for medical research into mental health disorders. The concepts included in the 1932 revisions were an attempt at a compromise with the popularity of Kraepelinian concepts of dementia praecox, schizophrenia and manic depressive insanity, with Freudian concepts of hysteria and neurosis, and all whilst still retaining the last remnant of nineteenth century symptomology. Mindful of the changes in psychiatry since the last set of revisions, and the rapid development of research, the committee also attempted to create a system which could account for future findings. Although admirable, this attempt to incorporate these different approaches and satisfy conflicting attitudes severely weakened the coherence of the system that they produced, and as such it failed to convince prominent members of the British psychiatric profession and the Board of Control that it would serve as a useful document for diagnostic purposes.

The effectiveness of the biological, eugenic and hereditarian orthodoxy of the mainstream of psychiatry was beginning to be questioned by psychoanalysis, as well as the failure of focal infection theory to yield firm findings which could be translated to treatment. Ultimately, the biological orthodoxy was strengthened by a mental hygiene movement which played up to fears that the mentally ill could prove a public danger was too strong, and led to the inclusion of psychopathic as a constitutional and hereditary form of mental illness. These third set of revisions to the Table of the Forms failed to gain traction, and it had little influence beyond the RMPA, with influential members of the Royal Society of Medicine criticising it for

not representing modern psychiatric thought, and the the Board of Control disregarded these revisions. The classifications committee had kept with the dogmas of the asylum, and had failed to incorporate fully either the psychological considerations that had been called for by figures like Glover, or the closer alignment to general medicine. It was the last set of revisions that would be made to the Table of Forms: during planning for the new nationalised health system that took place from 1942 onwards, it was decided to adopt the diagnostic concepts included in the forthcoming *International Classification of Diseases* as the classification to be used to record the disorder suffered by admissions to mental hospital.

## Chapter 5: The ‘Mesozoic’ Table of the Forms: An Epilogue

### Introduction

By November 1944, the balance of power in the Second World War had tipped towards the allies, and peace, although not certain, was becoming an ever-closer prospect. The huge reforms to health and social care that had been proposed in Beveridge’s 1942 report were by this point in full motion, with special commissions appointed by the war-cabinet to look at ways to realise care from cradle to grave.<sup>1</sup> Psychiatrists and members of the wider medical profession were beginning to turn their attention to the rebuilding that needed to occur, and what role it would play in a post-war social security system.<sup>2</sup> The destruction that had been wrought by the bombardment of major British cities had destroyed infrastructure, and general hospitals had been emptied of their in-patients and were by now being used as war hospitals.<sup>3</sup> It was hoped that with the right planning, out of this chaos would come a new and better society, that would provide new standards for treatment and social care for the people that had fought in the war.<sup>4</sup>

Given the unclear professional status of psychiatrists during the interwar period, with them still for the most part being defined by their roles as the superintendents of mental hospitals, prominent members sought to establish their vision of post-war psychiatric care.<sup>5</sup> The president of the Royal Medico-Psychological Association (RMPA) in 1944, Lt Col. Andrew Petrie, who had served in the Royal Navy and was medical superintendent of Banstead Hospital is one prominent example.<sup>6</sup> His experiences during the war had, like many others, shaped his view that trauma and other environmental factors played a key role in the development of psychiatric conditions like neurosis and anxiety. This shaped his view that psychiatry needed to increase its sphere of influence into many areas of society, seizing opportunities it had not taken advantage of during the interwar period: education, industry, the church, advertising, the arts and even politics, proposing that every major political party appoint a psychiatric advisor in order to better understand the desires of the general population:

A psychological bureau attached to each of the great political parties is an obvious suggestion, and such parties would be more likely to guide their followers widely if influenced by sound psychological principles. With a given party in power such a

---

<sup>1</sup> Frank Honigsbaum, *Health, Happiness and Security: The Creation of the National Health Service*, Routledge, 1989.

<sup>2</sup> Kathleen Jones, *Asylums and after: a revised history of the mental health services: from the early 18th century to the 1990s*, Athlone Press, 1993. (p.143)

<sup>3</sup> Charles Webster, *The Health Services Since the War vol.1* (London : HMSO, 1988-1996) p.11-12

<sup>4</sup> A.A.W. Petrie, ‘Psychiatric Developments: The Presidential Address Delivered at the One Hundred and Third Annual Meeting of the Association on Wednesday November 29<sup>th</sup> 1944’, in *JMS*, Vol.91, No.384, July 1945.

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

bureaux [sic] would become advisors to the Cabinet, a position occupied by the soothsayers of the ancient world.<sup>7</sup>

Petrie went on – although these ancient soothsayers were superstitious, they had some psychological understanding of the masses, and their advice allowed politicians to be more effective leaders. Although Petrie’s grand plan did not come into fruition, there were massive expansions of psychiatric services beyond the grounds of the mental hospital after the Second World War.<sup>8</sup> The wider developments surrounding psychiatric care had an impact upon the Table of Forms, and it was deemed to not be useful for the aspirations many attached to laws passed that would establish universal health and social care. Some, most notably the prominent psychiatrist and eugenicist Carlos Patton Blacker, deemed the Table of the Forms that had been used by the Board of Control and developed by the Medico-Psychological Association (MPA) to be Mesozoic, and the relic of a bygone era.<sup>9</sup>

In 1948, the Table of the Forms would be officially replaced by the World Health Organisation’s *International Classifications of Diseases (ICD)* for the purposes of diagnosis and admissions.<sup>10</sup> This chapter will explore some of the reasons why an international nosology of general medicine replaced a devoted psychiatric nosology that had been devised by a body that had developed from asylum psychiatry. This chapter will argue that the change to the *ICD* signalled a wider alignment of psychiatry to general medicine seen most clearly with two major post-war developments: the formation of the National Health Service, and the publication by the newly formed World Health Organisation (WHO) of an internationally standardised document of diseases and causes of death. Broadly speaking, this pair of developments brought

---

<sup>7</sup> Ibid. p.269

<sup>8</sup> Webster, C. ‘Psychiatry and the early National Health Service: the role of the Mental Health Standing Advisory Committee’ in Berrios and Freeman eds., *150 Years of British Psychiatry*, Gaskell, 1991, pp.103 – 106.

<sup>9</sup> Carlos Patton Blacker ‘Mental Health Records: What we can learn from them?’, 27th February 1947, in Papers by Carlos Paton Blacker on Mental Health Records, Carlos Paton Blacker Collected Papers, held by The Wellcome Collection.

<sup>10</sup> The standard abbreviation of the 1948 International Classification of Diseases is the ICD-6, to demonstrate that it is the sixth edition of the international classification, but I will simply use (ICD) in this chapter. This is because I find calling the 1948 document confusing because it suggests that this is the sixth edition of one document, when it is in fact the product of a number of international collaborations since the late nineteenth century. It began life as a standard classification of causes of death, and it remained this way until 1948. Although there is a great deal of continuity in the concepts included in this nosology, the 1948 revision ceased to be a simple register of causes of death for use by coroners and medical professionals, and became a list of diseases that could be used for diagnostic purposes. This is the main reason why it *could* include mental disorders at this point – to include schizophrenia or any of the other concepts from the Table of the Forms in a classification of causes of death would not make sense to the prevailing orthodoxy of medical thought – to many, schizophrenia being a principle cause of death did not make sense, and would be caused by a somatic condition. Saying this, the 1932 (or 1928) International Classification of the Causes of Death did include mental conditions with a known aetiology, like GPI, and it did include a ‘junk’ or catch-all category ‘any other form of mental alienation’, a term which marks the central role that French medicine played in the development of this document.

psychiatry closer to general medicine, with the mental hospitals – no longer referred to as asylums – that were overseen by the Board of Control being brought into a unified health care system. The hope to bring psychiatry closer to general medicine was realised with the establishment of the NHS, and from 1942 a new admissions system was developed which would utilise the concepts used in the international document that was being developed by the World Health Organisation (WHO).<sup>11</sup> One of the easiest ways of achieving this was by replacing The Table of Forms with a document that included mental health disorders within a general nosology of all human medical conditions, one that embodied the aspirations for global disease and poverty prevention.

This document was based on the previous international classifications of the causes of death that were published first by the Office International d'Hygiène Publique upon its formation in 1907 and subsequently by the League of Nations' Health Organisation during the interwar period. Although these documents included neurological disorders and a select few concepts of mental disorder, they primarily functioned to standardise the recording of causes of death, and not diagnostic concepts. The change in 1948 to it being a classification of recognised diseases allowed the inclusion of concepts of mental disorder, and this brought them into a standard general medical nosology which aimed to be the product of a global medical consensus.

The wider changes in psychiatric practice took place on a national and international level, and according to Vivian Quirk and Jean-Paul Gaudillière the period immediately following the war was a pivotal moment in ushering in the era of global biomedicine, characterised by increasing links between the laboratory and the clinic.<sup>12</sup> In his analysis of psychiatric journals from 1950 onwards, John Burnham claims that the 'extreme national isolation of psychiatric communities' of the pre-war period 'gave way to a substantial transnationalisation' of psychiatric discourse.<sup>13</sup> Focusing on the *Journal of Mental Science* during this period, Burnham claims that this functioned as an important communication channel between the ideas in Europe and the Americas, and was also tied to Britain's former colonies of Australia, New Zealand and Canada. Burnham's view that there was extreme isolation prior

---

<sup>11</sup> For a full account of the initial steps to integrate psychiatry and general medicine, see Kathleen Jones, 'First Steps in Integration' in *Mental Health and Social Policy, 1845 – 1959*, Routledge, 1960, pp.135 – 147.

<sup>12</sup> Vivian Quirk and Jean-Paul Gaudillière, 'The Era of Biomedicine: Science, Medicine, and Public Health in Britain and France after the Second World War' in *Medical History*, Vol.52, pp.441 – 452.

<sup>13</sup> John C. Burnham, 'Transnational History of Medicine after 1950: Framing and Interrogation from Psychiatric Journals' in *Medical History*, Vol.55, No.1, pp.3 – 26.



to the war is to some extent questioned by the work of Rhodri Hayward, Paul J. Weindling and Mark Jackson, whose work identified the permeable boundaries between European, British and American psychiatry during the interwar years, and the period after the war would see greater degrees of international co-operation on psychiatric research, with those based in Britain being influential in attempts to realise this project.<sup>14</sup>

The period of international health following the war would contribute to bringing psychiatry, the ideas it used, the treatments it employed, and the spaces in which mental health care was carried out, closer to general medicine. This era would be precipitated by developments that occurred during the conflict, and these would include debates on psychiatric classification that would take place between doctors drafted into the military and wartime Emergency Medical Services. By 1942, plans were being made for a new welfare state of which a nationalised health service was a part. In the plans that were made to record admissions to psychiatric hospitals and psychiatric wards, prominent individuals, namely the aforementioned Blacker and his Eugenics Society colleague Lionel Penrose, argued for the importance of a well-designed admissions system that would record the diagnosis that had been given to a patient.<sup>15</sup> They viewed the lack of such a system as being part of the reason why there had been a lack of progress in psychiatric knowledge from British mental science. They viewed the opportunity provided by the new health service as a chance to redesign the admissions system to accurately record data in line with the *ICD*'s concepts of mental disorder, which were deemed by Blacker and Penrose to be the most modern available.

The events charted in this chapter signal the moves psychiatry made towards general medicine that would define its role in the post-war period. These occurred on a conceptual level and an institutional level. The conceptual shift was the move from a specialised psychiatric nosology in the form of the RMPA's Table of the Forms and towards a new international and general nosology in the form of the *ICD* that would include a section on mental disorders. This is in one way a return of mental disorder to general nosology as seen in the work of William Cullen that opened this thesis – like the *ICD*, the Scotsman provided a

---

<sup>14</sup> See Rhodri Hayward, 'Germany and the Making of 'English' Psychiatry: The Maudsley Hospital 1908 – 1939'; Mark Jackson, 'Permeating National Boundaries: European and American Influences on the emergence of Medico-Pedagogy in Late Victorian and Edwardian Britain'; Paul J. Weindling, 'Alien Psychiatrists: the British Assimilation of Psychiatric Refugees, 1930 – 1950' all in Volker Roelcke, Paul J. Weindling and Louise Westwood eds., *International Relations in Psychiatry: Britain, Germany and the United States to World War II*, University of Rochester Press, 2013, pp.67 – 90.

<sup>15</sup> Carlos Paton Blacker, 'Redhill Hospital – Notes on Visit Paid by Dr. Harris and Dr. Blacker on Monday, 16<sup>th</sup> December 1946 in Papers by Carlos Paton Blacker on Mental Health Records, Carlos Paton Blacker Collected Papers, held by The Wellcome Collection; Daniel Kevles provides a great deal of biographical information in his chapter on Penrose: 'Lionel Penrose and the Colchester Survey' in *In the Name of Eugenics: Genetics and the Uses of Human Heredity*, University of California Press, 1986, pp.148 – 163.

comprehensive list of all known human ailments that included a section on nervous disorders. On the institutional level, the post-war reforms re-unified the collection of psychiatric statistics with those relating to general medicine, since these duties were taken away from the specialised organisation of psychiatric administration, the Board of Control, and back to the General Records Office, where data on public health and general medical treatment had been collected since 1838.

## Section 1: War Time Debates Surrounding Classification

Debates surrounding psychiatric classification which took place during the Second World War signalled the beginning of British psychiatry's closer alignment with general medicine. These were mainly conducted in the pages of the *Lancet* and the *British Medical Journal*, in the form of research papers and responses from practicing medical services staff and took place from the 1940s onwards. This was not just confined to psychiatric classification, with the importance of adhering to terminology that had been set out in the general medical nosology that had been published by the Royal College of Physicians being emphasised in a 1940 editorial in the *BMJ*, which stated that 'although the *Manual [of the International List of Causes of Death]*, cannot be a medical practitioner's bedside book, it should be on his study bookshelf, to be consulted when the spirit moves him to write a paper – or even a letter to us – commenting on the rise and fall of a death rate'.<sup>16</sup> At the beginning of the war, the *Manual of the International List of Causes of Death* was adapted for use in England and Wales and was published in 1940 by Her Majesty's Stationary Office, and thus was an update of the manual of causes of death that had been adopted in 1928 which itself was an adaptation of the League of Nation's Health Organisation's *List of the Causes of Death*. Many hoped that this manual would improve mental hospital admittance statistics and these would lead to findings that could find their application within research into the psychiatric epidemiology amongst the general population. These changes were carried partly because the statistics from the Great War lacked diagnostic uniformity and lacked value.<sup>17</sup>

The Table of the Forms was not mentioned during these debates, with most doctors referring to *The Nomenclature of Diseases* published by the Royal College of Physicians.<sup>18</sup> This was

---

<sup>16</sup> Anon, 'The Classification of Causes of Death' in *BMJ*, April 20<sup>th</sup>, 1940, p.661.

<sup>17</sup> J.A. Hadfield, 'War Neurosis: A Year in a Neuropathic Hospital' in *BMJ*, February 28<sup>th</sup>, 1942, pp.281 – 285. (p.281).

<sup>18</sup> Ranyard West, 'Correspondence: War Neurosis: The "Awareness" of Fear' in *BMJ*, March 21<sup>st</sup>, 1942, p.395.

described as ‘very inadequate’, by one who complained that it did not provide definitions for the diseases included in the nosology.<sup>19</sup> This was perhaps due to the number of general medical professionals who were involved in these debates who drew from their experience treating mental disorders such as trauma in the emergency medical services. Since many of the people who worked in the emergency medical services were general doctors, they would have been more familiar with the general medical nosology that was promoted by the Royal College of Physicians. Whilst publishing research based upon the treatment of war casualties, practitioners questioned the diagnostic concepts that they had available to them, in particular, psychiatric concepts. Those working in the field sought to understand the new kinds of traumas and neuroses that they had to treat due to the technologies of warfare which brought new environmental pressures. For instance, the new generation of military aircraft placed new pressures on pilots, and allowed the theatre of war to be expanded to civilian locations. Medical staff struggled to understand the forms of trauma, anxiety and neurosis that were suffered by war veterans and the huge numbers of civilians injured during the bombings of major British cities.<sup>20</sup> As we will see below, work published by those working in military and civilian emergency medical services centred on the differential diagnosis of trauma, anxiety and anxiety states, and neurosis. In light of these new environmental pressures, many tried to understand the difference between what constituted a psychopathology and what was a typical response to warfare that did not require treatment, and this became especially pertinent when handling the cases of civilians injured during the bombing of British cities. These cases added an extra dimension to the trauma in warfare that had not been hitherto observed by medical doctors – whereas in the Great War, when there were relatively few civilian casualties from aerial bombardment, the advent of total warfare greatly increased the numbers of people admitted to wards who suffered from psychological disorders incurred by environmental pressures.

This section will argue firstly that these debates constitute a fascinating and hitherto overlooked discourse on the classifications of neurosis, functional neurological disorders, and anxiety disorders. They are a landmark because they demonstrate a real concern on the behalf of medical professionals to differentiate between forms of mental disorders, such as the concern some had about confusing psychopathic states with normal reactions to trauma. They are a key episode in the history of psychiatric knowledge formation and this attention to the line between the normal and the pathological would be amplified during the post war history and philosophy of psychiatric classification. These can be seen especially in debates that

---

<sup>19</sup> Anon, ‘The Classification of Causes of Death’ in *BMJ*, April 20<sup>th</sup>, 1940, p.661.

<sup>20</sup> C. P. Symonds, ‘The Human Response to Flying Stress’ in *BMJ*, December 4<sup>th</sup>, 1943, p.703 – 706.

occurred in the late sixties surrounding the shortfalls and unreliability of the DSM II's diagnostic categories as well as issues with the definition of mental disorders that were included in the DSM-III-R onwards.<sup>21</sup> The debates conducted during the war were serious discussions about how to best classify psychological disorder, and these were undertaken by general medical people. Instead of the discussions that were conducted by the RMPA, which for the main involved medical superintendents of asylums, these discussions during the war were conducted by a broad church of medically trained people.

Secondly, these are the first signs of the greater alignment with general medicine that the concepts of psychiatric classification would see after the Second World War and which would, I argue, lead to the end of the MPA's classification. It would essentially mark the end, an end that had been coming during the interwar era, and which had partly led to the failure of the second revision to gain any traction. This section will outline some of the main points that would lead to the replacement of a specific classification of mental disorders with a general medical nosology. Ultimately, the developments outlined show the twilight of the psychiatric concepts that informed admissions to asylums, and that despite two revisions, the Table of the Forms was never able to fully release itself of from terms like melancholia, mania, and idiocy.

The Emergency Medical Services were manned by a great number of doctors who were not specialised psychiatrists, and these would often treat civilians with trauma induced by air raids.<sup>22</sup> These professionals were suddenly confronted with forms of trauma, neurosis and anxiety that they had before seldom encountered. In their reports, many reported painful bodily injuries sustained by civilians who had been caught up in the aftermath of bombing, and who would experience trauma in association with their experiences, which may complicate treatment and lead to psychosomatic disorders.<sup>23</sup> Furthermore, long lasting anxiety was seen in those who had experienced multiple bombing raids, and those who had lost family members, businesses, houses and livelihoods.<sup>24</sup> Finally, many clinicians tried to understand whether these environmental factors had triggered and exacerbated pre-existing conditions, or if these environmental factors were the sole cause of mental and neurological disorders. This response

---

<sup>21</sup> Edward Shorter, 'The History of Nosology and the Rise of the *Diagnostic and Statistical Manual of Mental Disorder*' in *Dialogues in Clinical Neuroscience*, Vol. 17, No.1, pp. 59 – 67.

<sup>22</sup> Ben Shepherd, 'Pitiless psychology': the role of prevention in British military psychiatry in the Second World War' in *History of Psychiatry*, Vol.10, Oct. 1999, pp.491 – 524. (p.516)

<sup>23</sup> Hazel Croft, 'Rethinking Civilian Neurosis in the Second World War', in Peter Leese and Jason Couthamel eds, *Traumatic Memories of the Second World War*, pp.95 – 117. (p.102).

<sup>24</sup> Ibid.

to a study on anxiety and neurotic states in the Navy is a good example of work carried out to help answer this question:

We attach great importance to the necessity for regarding hysterical manifestations as but symptoms of the fundamental anxiety, and no attempt has been made [in this study] to separate those cases which showed hysterical phenomena from the general mass of anxiety states.<sup>25</sup>

Most frequently used diagnostic concepts during the war by the Emergency Medical Service were anxiety states: hysteria, depression, physical, schizophrenia, but diagnosis was mixed and was made based upon the primary or most 'important symptom'. Physical meant that the patient suffered from a clear physical disorder that was causing the trauma, or a mental disorder with a known physical aetiology, such as cerebral arteriosclerosis, Parkinsonism, or nerve injury.<sup>26</sup> Some studies only differentiated between psychotic and neurotic patients.<sup>27</sup>

It was in this way that general medical professionals beyond the psychiatric community and the membership of the RMPA became involved in the discussions surrounding the correct diagnostic labels to use because they came across the problems with these concepts in their day to day work, and the research they published that drew upon their experiences. They saw the shortfalls of the existing diagnostic labels, and some even tried to forge new ones that were based upon their wartime experiences. For instance, one physician proposed 'hyperphobesis' to differentiate excessive fear reaction from nervous states.<sup>28</sup> In addition, new forms of stress were witnessed: for instance 'flying stress', or functional nervous disorders seen in RAF pilots, with symptoms including insomnia, headaches, depression and 'being self-reproachful'.<sup>29</sup> Much of the research that was devoted to understanding the role of these new stressors in the causation of mental disorders weighed up environmental factors with predisposition.<sup>30</sup>

Complaints were also directed at the existing psychiatric diagnostic concepts on the grounds that they were vague, and not clear enough differences were evident between certain trauma states. In turn, the difference was also unclear on what constituted a state of psychopathology and a healthy, or non-pathological response to fear. Some thought that these could lead to normal responses to environmental stresses being confused with psychopathologies, and this made it difficult for doctors to determine whether a therapeutic

---

<sup>25</sup> Hugh Crichton Miller, 'Anxiety and Hysteria' in *BMJ*, November 27<sup>th</sup>, 1943, pp.687 – 688.

<sup>26</sup> W.S. Maclay and J. Whitby, 'In-patient Treatment of Civilian Neurotic Casualties' in *BMJ*, Oct. 1942, p.449 – 451.

<sup>27</sup> Dalton E. Sands, 'Treatment of Psychiatric Patients in General Hospitals: A Social Experiment' in *BMJ*, May 22<sup>nd</sup>, pp.628 – 630.

<sup>28</sup> Dr. S.W. Sutton, 'Letters, Notes, Etc.: Coined Medical Words' in *BMJ*, July 5<sup>th</sup>, 1941, p.38.

<sup>29</sup> C. P. Symonds, 'The Human Response to Flying Stress' in *BMJ*, December 4<sup>th</sup>, 1943, p.703 – 706.

<sup>30</sup> *Ibid.* Also: Curran and Mallinson 1940, Hadfield 1942, Love 1942, Cooper and Sinclair 1942 and Gillespie 1942.

intervention was needed, and if so, what kind. The boundaries for neurosis, anxiety and anxiety states were thought to be especially unclear and murky, with many expressing concern about the potential for confusing anxiety states for general anxiety, or overlooking functional neurological disorders. Furthermore, questions were raised about whether trauma states needed some form of psychological treatment to prevent it becoming anxiety or neurosis was another concern of those working in the medical services.

The bombardment of the United Kingdom and the condition of war veterans triggered these debates, and there were some concerns about whether, and to how to, medically classify psychological responses to bombings: should they be classified as ‘true neurosis’ or as ‘simple states of fear’, regardless of the predispositions of a patient?<sup>31</sup> Some sought to settle debates over the difference between anxiety and neurotic states by appealing to the patients’ own psychological awareness. For instance, this was used as the basis for the differentiation of anxiety states from conversion hysteria, the latter of which was considered to cause ‘cowardice’ because of a patient’s lack of awareness of fear.<sup>32</sup> The psychological understanding of fear was then deemed to be a crucial factor in the diagnosis of a disease.

Responses to treatment were thought by some to be a vital means of differentiating between certain forms of disorder. By 1944, electro-convulsive therapy (ECT), insulin treatments, sedation with barbiturates and continuous sleep treatment, were being used in mental and general hospital wards.<sup>33</sup> Doctors were trying to understand which physical treatments worked best for which disorders, and William Sargant claimed that depending on the intensity of the disorder, the ‘predisposition’ of the patient and whether it was a gradual or sudden breakdown, a different treatment was necessary for recovery; ECT worked best for ‘those with a good previous personality and genuine severe depression’ who had experienced a gradual breakdown over a period of years; acute panic states were being treated with ‘very heavy sedation, immediately applied to produce unconsciousness for some hours, [and] may stop the development of a neurosis’; if these develop into anxiety states of over a week or longer, then heavy sedatives in the form of paraldehyde or sodium amytal should be administered that would render the patient nonconscious for twenty out of twenty four hours for seven to ten days; and, according to Sargant, patients who were ‘the previous good

---

<sup>31</sup> William A. Brend, ‘Correspondence: War Neurosis’ in *BMJ*, March 21<sup>st</sup>, 1942, p.395.

<sup>32</sup> Ranyard West, ‘Correspondence: War Neurosis: The Awareness of Fear’ in *BMJ*, March 21<sup>st</sup>, 1942, p.395.

<sup>33</sup> William Sargant, ‘Physical Treatment of Acute War Neurosis: Some Clinical Observations’ in *BMJ*, November 14<sup>th</sup>, 1942, p.574 – 576.

personalities who break down over a long period of stress' and who experienced mild depression responded best to insulin coma therapy.<sup>34</sup> Sargant's neat view was complicated by Dalton Sand's observation of patients:

'[...]in whom psychotic and neurotic factors appear evenly balanced. [...] The decision on therapy may be difficult; hence my remarks on the therapeutic test. Generally speaking, the patients' response to E.C.T. was consistent with the accepted textbook symptomatic classifications.<sup>35</sup>

The therapeutic test was 'the dominant pattern or personality deviation responsible' for a patient's illness based upon the personality prior to breakdown, since 'the mere intensity of the symptoms is no reliable guide'.<sup>36</sup> Sands warned that careful observation of responses to treatment would demonstrate that a misdiagnosis had been made, when 'a few convulsions clarify the uncertain diagnosis all rather too drastically [and] instead of the usual remission there may be further depression, confusion, anxious or hysterical symptoms, or no demonstrable effect at all – not because the method is useless, but through the psychiatrist failing to perceive the mental pathology of his patient'.<sup>37</sup> For example, Sands claimed that the better results that ECT achieved in depression with anxiety than in anxiety neurosis were a better test than a diagnosis made by the clinician. Treatments like ECT were starting to be viewed as more reliable tests of correct diagnosis than the judgment of the psychiatrist, with 'the truth [being] that in this direction treatment has outstripped diagnosis and is likely to be more accurate than the clinician in doubtful cases'.<sup>38</sup> In addition, by the end of the conflict, psychiatrists were talking about the responses to psychosurgery, with one research paper co-authored by the American Walter Freeman and published in the *JMS*, claiming that this form of treatment was most effective on patients with schizophrenia and 'obsessive tension states', and less so on patients with depression.<sup>39</sup>

Debates on the ideal form of a psychiatric classification took place throughout the war and immediately afterwards. Work published during the war that debated the nature of psychological classification came to a head in a set of correspondence published in reaction to

---

<sup>34</sup> Ibid.

<sup>35</sup> D.E. Sands, 'Classification of Psychological Disorders' in *BMJ*, November 23<sup>rd</sup>, 194, pp. 793 – 794.

<sup>36</sup> D.E. Sands, 'Electro-convulsion Therapy in 301 Patients in a General Hospital: With Reference to Selection of Cases and Response to Treatment' in *BMJ*, August 31<sup>st</sup>, 1946, pp.289 – 293.

<sup>37</sup> Ibid.

<sup>38</sup> Ibid.

<sup>39</sup> Walter Freeman and James W. Watts, 'Psychosurgery: An Evaluation of Two Hundred Cases Over Seven Years' in *JMS*, Vol.90, No.379, pp.532 – 537. (p.535).

Sand's paper on using ECT as a means to make a differential diagnosis. Charles Symonds thought that Sand's research was misleading because he had not provided clear and precise definitions of the disorders that were the objects of his investigation:

...he produces figures to show that E.C.T. gives better results in depression with anxiety than in anxiety neurosis, but I find it difficult to discover from his paper what precisely is his distinction between the two. It is presumably not symptomatic because he states that anxiety and depression are to be found in both. If aetiological, the distinction is not clear.<sup>40</sup>

The issue was that the criteria for the definition of each disorder were not explicitly outlined, with Symonds rounding off his critique by saying that he found 'no objection to the classification of psychological disorders in terms either of symptoms, aetiology or response to specific treatment so long as each method of classification is clearly and separately defined.'<sup>41</sup>

Psychiatric research without stable and clear definitions was rendered useless according to Symonds and a number of other correspondents who wrote to the *BMJ* in response to Sand's article. Frederick Dillon wrote that the Sands's article was 'another illustration of the fact that statistical studies on psychiatric disorders [...] are very apt to be misleading unless it is made clear that the conclusions drawn merely indicate tendencies and do not constitute a positive addition to knowledge.'<sup>42</sup> Dillon thought that Sands's use of anxiety was too loose and 'not a simple unit factor' that could be quantified easily for the purposes of psychiatric epidemiology.<sup>43</sup> Instead, Dillon believed it to be a condition with a different psychological aetiology that was distinct from anxiety states and anxiety neurosis. Adding to Dillon's criticisms, A. Lionel Rowson agreed that psychological causes in the form of 'elements of guilt and tension from aggressive impulses may be quite wrongly interpreted by inexperienced psychiatrists when the anxiety is due to perfectly obvious and innocent reasons which they have not ascertained', and the chances for confusion in statistical research would further help to produce what he dramatically branded 'false knowledge'.<sup>44</sup>

Seeking to resolve the debate, Ian Atkin made an appeal to cease these quibbles on the definition of mental disorders.<sup>45</sup> For him, attempting to describe the ailments of the mind with narrow definitions was a futile task, and instead of trying to make patients fit into neat diagnostic

---

<sup>40</sup> Charles P. Symonds, 'Correspondence: Classification of Psychological Disorders' in *BMJ*, September, 1946, p.436.

<sup>41</sup> *Ibid.*

<sup>42</sup> Frederick Dillon, 'Classification of Psychological Disorders' in *BMJ*, October 19<sup>th</sup>, 194, p.588.

<sup>43</sup> *Ibid.*

<sup>44</sup> A. Lionel Rowson, 'Classification of Psychological Disorders' in *BMJ*, November 9<sup>th</sup>, 1946, p.709.

<sup>45</sup> I Atkin, 'Classification of Psychological Disorders' in *BMJ*, November 2<sup>nd</sup>, 1946, p.666.



categories, psychiatrists needed to accept that they were dealing with individuals who suffered disorders that defied clear demarcation. Instead of seeking firm grounds and clear boundaries for mental disorders, Atkin thought that Sands's detractors should recognise 'the complexity of human nature, which exhibits infinite variations.'<sup>46</sup> Atkin attempted to balance this nihilistic attitude towards psychiatric classification by acknowledging the practical use of classification in teaching and training, but that it was important also to 'insist that in a considerable number of cases we have to deal with "mixed reactions," because personalities are mixtures of many artificially separated types.'<sup>47</sup> Atkin, who came from a psychodynamic background, demonstrated his view of diagnosis, that should look at the complex biographical development of the individual, their professional and marital life as well as their childhood and adolescent experiences, instead of merely seeking to impose a clear diagnostic label on the patient. Ultimately, he agreed that the statistical work carried out by Sands was misleading, but that the problems for Atkin were much deeper than simple definitions and were inherent to the whole practice of psychiatry.

Answering his critics in November 1946, Sands appealed to consensus to settle the debate, claiming that although he did not provide a definition in his paper, his usage of the term during his research was in accordance with Royal College of Physician's classification and David Henderson and Ronald Gillespie's *Textbook of Psychiatry*.

[Henderson and Gillespie] refer to the special Freudian interpretation of anxiety neurosis, but many other parts of the text do not differentiate between 'neurosis' and 'state'. The same lack of differentiation is apparent in the numerous papers on psychotic breakdown in the war [...] It is obviously significant of the very nature of the problem that most textbooks describe but do not exactly define these conditions.<sup>48</sup>

The nature of mental illnesses prevented a clear definition, because there was a different aetiology depending on the unique biography of the patient. The diagnostic terms were guides for Sands in providing a diagnosis, and the diagnosis would guide treatment. However, as he argued in his original paper, these diagnoses were not fool proof and could be questioned by responses to treatment. The best available diagnostic categories were not the final measure of the patient:

---

<sup>46</sup> Ibid.

<sup>47</sup> Ibid.

<sup>48</sup> D.E. Sands, 'Classification of the Psychological Disorders' in *BMJ*, November 23<sup>rd</sup>, 1946, p.793 – 794.

Generally speaking, the patients' response to ECT was consistent with the accepted textbook symptomatic classifications, even if it did at times show up one's own diagnostic mistakes.<sup>49</sup>

The hope held by psychiatrists like Sands was that a new era of physical treatments for mental disorders would allow psychiatric diagnosis to be led by therapeutic technologies that would be superior to the judgement of the clinician. Diagnosis and treatment would draw closer to general medicine, and as we will see in the next section, so would the classifications that would be used to diagnose mental health disorders.

## Section 2: The Amalgamation of Services in the Post-War Period and the Adoption of the ICD

Towards the end of the war, talk and subsequent planning began of amalgamating general health services and psychiatric services.<sup>50</sup> Research published in the *BMJ* in 1943 argued that better recovery rates were seen in psychiatric patients admitted to general hospitals than in separate mental hospitals, and that the difference between the two streams of treatment needed to be eliminated.<sup>51</sup> Patients who suffered the kinds of transitory anxiety and neurotic states that had been seen throughout the war, and those demonstrating early signs of psychosis could have 'avoided prolongation of illness, subsequent certification, and economic loss' with early admission and treatment, but this would remain difficult to achieve given the association the public had of lengthy stays in asylums, and the many other stigmas associated with psychiatric treatment.<sup>52</sup> In addition, the advent of physical treatments discussed in the last section as a means of differentiating the forms of mental disorder also helped to draw psychiatry closer to general medicine.

The collection of psychiatric statistics would return to the General Records Office (GRO) after the Second World War, thus ending a century of division between the general medical statistics collected by the GRO and admissions data collected by the Lunacy Commission and the Board of Control. At the same time, it would end the era of The Table of the Forms, leading to its abandonment in favour of a general medical nosology that had a mental health section. This was the *ICD*, which would be published by the WHO in 1948, and would formally end the hundred-year history of the Table of the Forms that was published by

---

<sup>49</sup> Ibid.

<sup>50</sup> Kathleen Jones, 'First Steps in Integration' in *Mental Health and Social Policy, 1845 – 1959*, Routledge, 1960, pp.135 – 147.

<sup>51</sup> D.E. Sands, 'Treatment of Psychiatric Patients in General Hospitals: A Social Experiment' in *BMJ*, May 22<sup>nd</sup>, 1943, p.628.

<sup>52</sup> Ibid.

the Medico-Psychological Association (MPA). Members of the MPA would never again congregate or appoint committees to draw up new standard psychiatric classifications with such breadth and coverage as the Table of the Forms, with the era of a general and global medical nosology coming after the conflict.

After the Second World War, British human scientists enjoyed a period of international influence, with figures such as Julian Huxley heading UNESCO, the Scottish biologist, medical doctor and Nobel Prize winner John Boyd-Orr serving as the first Director-General of the United Nations Food and Agriculture Division, and the British-trained Canadian psychiatrist Brock Chisholm acting as the first head of the World Health Organisation (WHO).<sup>53</sup> The WHO was established in 1948, replacing the health bodies of the League of Nations, ushering in what Iris Borowy calls the ‘third phase’ of international health co-operation.<sup>54</sup> This third period was marked by an heightened interest in mental health care which, until this point, had been neglected on an international level: the League of Nations did not devote many of its resources to mental health, with the Rockefeller Organisation, and its mental health sub-committee, being largely responsible for the developing and funding of mental hygiene in Europe and any noteworthy attempts at establishing a global psychiatry.<sup>55</sup> Despite international conferences for other fields of medicine and science having continued to take place during the interwar period, there was an overriding sense amongst British psychiatrists that international organisations like the League of Nations and the Office International d’Hygiene Publique did not take much notice of mental health issues. From 1918 to 1939 there were only four items in League of Nations deliberations that addressed psychiatry, all of which related to mental hygiene and mental deficiency, and the League’s Hygiene Division had little in terms of psychiatric representation.<sup>56</sup>

This began to change after the war, with psychiatry attracting new interest, and mental health care being linked to wider political and social concerns. The rise of fascism was

---

<sup>53</sup> Allen Irving. *Brock Chisholm: Doctor to the World*. Fitzhenry & Whiteside, 1998.

<sup>54</sup> The first phase of international medical societies that arose during the nineteenth century was replaced by the League of Nations Health Organisation after the Great War; See Iris Borowy, *Coming to Terms with World Health: The League of Nations Health Organisation 1921-1946*, Peter Lang, 2009.

<sup>55</sup> The Rockefeller foundations, for instance, had helped to fund the first training course for psychiatric social workers in the United Kingdom and possibly in Europe; Noel Timms, *Psychiatric social work in Great Britain, 1939-1962*, Humanities Press, 1964.

<sup>56</sup> The priorities of the League of Nations Health Authority during the interwar period were ending child poverty, improving health in rural regions, and establishing health system in countries in Europe such as Greece that had not developed such infrastructure. See Iris Borowy, *Coming to Terms with World Health: The League of Nations Health Organisation 1921-1946*, Peter Lang, 2009.

understood by some as being a form of mass psychosis, and psychologists and psychiatrists in the Allied countries saw themselves as playing a role in preventing extremist political forces coming into power again.<sup>57</sup> The Sheffield-based German émigré Erwin Stengel, as well as the Tavistock-affiliated head of psychiatry for the British Army, T.P. Rees, were pivotal figures in these movements, with Stengel viewing a shared international terminology of mental disorders as being an important aim for global psychiatry.<sup>58</sup> Psychiatrists from the United Kingdom and the other Allied powers played a prominent role in the formulation of the international psychiatry that would come to define the post-war era, and were central to efforts to bring about greater standardisation of practice, treatment and classification.

In the United Kingdom, prominent psychiatrists and statisticians saw the establishment of the NHS as providing an opportunity for the improvement of the quality of admissions data which in turn would help develop understandings of mental health disorders. The RMPA's Table of Forms was not adopted in their new system. As we have seen in the second and third chapters, debates about what forms of insanity should be used in the statistical tables were the catalyst which led to the adoption of a set of concepts of psychopathology officially recognised by the MPA. Speaking at the first annual general meeting convened by the Royal Medico-Psychological Association (RMPA) after the Second World War, the geneticist, psychiatrist and member of the Eugenics Society Lionel Penrose presented his vision on how improvements could be made with the collection of medical statistics, which opened the potential to further understandings of mental health disorders.<sup>59</sup> Penrose focused upon what he called the social impact of mental illness: the burden placed upon families caring for relatives, associates within the workplace and the wider community.<sup>60</sup> Penrose called for improvement in the collection of statistics because it was only through these that the social

---

<sup>57</sup> F.A. Jenner, 'Erwin Stengel: A Personal Memoir' in German Berrios and Freeman eds. *150 Years of British Psychiatry: 1841 – 1991.*, Gaskell, 1991.

<sup>58</sup> Attempts to psychologise fascism and understand it as a mental disorder began with Wilhelm Reich's work, *The Mass Psychology of Fascism*, which was published in 1933, although it would not be translated into English until 1946. In this seminal work, Reich offered the theory that fascism was a product of a repressed sexual urge, and this was the key to understanding why it had come to triumph in Germany and not in other nations. Although Reich's view is highly questionable, this, and the large number of psychiatrists who emigrated from the Nazi regime, triggered attempts to by the human sciences to understand the psychology of fascism. Another highly problematic study, *The Authoritarian Personality*, which has become infamous for its association with the Frankfurt School philosopher Theodor Adorno, was also influential during the forties and fifties, and the work that these studies prompted influenced global health policies. See Wilhelm Reich, *The Mass Psychology of Fascism: translated from the German Manuscript*, trans. Mary Boyd Higgins, Orgone Institute Press, 1946; Theodor Adorno et al., *The Authoritarian Personality*, Harper and Row, 1950.

<sup>59</sup> L.S., Penrose, 'Social Aspects of Psychiatry: The Importance of Statistics' in *JMS*, Vol.9, No.389, Oct. 1946, pp.713 – 718.

<sup>60</sup> *Ibid.*

impact of mental health disorders could be understood. He thought that the figures could be garnered from, firstly, cases treated in both mental hospitals and psychiatric wards, and secondly from the general population, who were treated at home and in out-patient clinics. According to Penrose, in-patients were, or at least should be, predominantly psychotic and mentally deficient patients, with neurotic patients tending to be treated in out-patient wards and in the home.<sup>61</sup> He emphasised that at present, the figures garnered from the medical records of patients diagnosed by medical authorities were the best guide available to better understandings of mental illnesses and its impact upon the public.

Penrose made claims about the relationship between mental disorder and the larger community. He pointed out that British psychiatry had had a preoccupation with heredity, and named Frederick Mott as the most recent and prominent mouthpiece for that tendency amongst British psychiatrists.<sup>62</sup> Penrose thought that psychiatrists like Mott had misinterpreted their data, and instead thought that that social circumstances were responsible: parents with an undiagnosed mental health problem were likely to have caused developmental problems in their children.<sup>63</sup> Penrose viewed psychiatric social work as the solution, and thought that parents suffering themselves may never recognise that they need treatment, so an intervention would be needed from a third party. These interventions would lead to notes being drawn up by the psychiatric social workers in question, and this formed a key justification for Penrose of an advanced social care system: transmission of information of the mental health problems experienced in the general population by improving the social practice of medicine. Penrose thought that increased infrastructure and awareness of mental health disorders would lead to an increase in numbers of those seeking treatment, and he speculated that an increase in social services would bring about an increase in the diagnosis of mental disorders. That information would be transmitted to the medical community in the form of data that statisticians like himself could interpret in an expansive programme of psychiatric epidemiology.

Until the day came when psychiatric social services could be employed to collect data on mental disorders amongst the public, the data gathered from hospital admissions would have to suffice. Despite the limitations of this data, Penrose thought that if reforms were correctly made, then there was great potential to improve knowledge of the causes and the treatment of mental disorders with this information. Although Penrose acknowledged that

---

<sup>61</sup> Ibid.

<sup>62</sup> Ibid.

<sup>63</sup> Ibid.

these numbers had their limitations, even very basic information could be employed to provide insights into the mental disorders suffered by the population.<sup>64</sup> Penrose thought that it was possible to make prognostic predictions based just upon the age of a patient's first admission and their sex that would have a fair amount of reliability: a case certified below the age of twenty was, according to Penrose, most likely a defective; and as the age increased to twenty, it would become likely that they were a schizophrenic if they were a male, increasing to thirty five in females; whilst affective psychosis would see its peak at forty five for women and fifty five for men; and all those diagnosed for the first time after sixty five would most often be suffering with 'senile or organic' disorder.<sup>65</sup> Similarly to Penrose, fellow eugenicist and psychiatrist Carlos Patton Blacker, with whom Penrose would be involved in developing the new admissions system, had no love for the table of forms. In remarks to the Psychological Group of the British Medical Association, Blacker gave his view of the admissions system that had been in place since the establishment of the Board of Control in 1913. These used the Schedule of Aetiological Factors and the MPA's Table of Forms. He targeted the Schedule of Aetiological Factors' inclusion of masturbation in the causation of mental disorder, describing it as showing the ignorance of psychiatric knowledge from before the time that the cause of General Paralysis of the Insane was known. Blacker gave the damning judgment that the Table of the Forms of Insanity was a relic from 'the mesozoic age of psychiatry', and expressed distaste at its continued use.<sup>66</sup>

The clinical differences between the various forms of mental disorder 'though they may be of constant sources of irritation or of fascination to the psychiatrist according to his type of mind, are useless for the research worker', according to Penrose.<sup>67</sup> He called for an improvement in classification, stating that 'we cannot distinguish between schizophrenia and affective psychosis with any certainty'.<sup>68</sup> Penrose then is saying that a comprehensive collection of statistics, and their analysis by specialists who are not necessarily psychiatrists, will enable the data to be understood, and allow for patterns to be identified based upon the age and the diagnosis. This can in turn assist inquiries into aetiology, and ultimately this would allow the

---

<sup>64</sup> Ibid.

<sup>65</sup> Ibid.

<sup>66</sup> Carlos Patton Blacker 'Mental Health Records: What we can learn from them?', 27th February 1947, in Papers by Carlos Paton Blacker on Mental Health Records, Carlos Paton Blacker Collected Papers, held by The Wellcome Collection.

<sup>67</sup> L.S., Penrose, 'Social Aspects of Psychiatry: The Importance of Statistics' in *JMS*, Vol.9, No389, Oct. 1946, pp.713 – 718.

<sup>68</sup> Ibid., (p.715).

forms of mental disorder to be improved because clearer differences between disorders would be identified.

As we have seen throughout the course of this thesis, debates surrounding the concepts of psychopathology that were used by the Lunacy Commission or Board of Control and the MPA had taken place since the very birth of beginnings of mass psychiatric treatment in the British Isles in the mid-nineteenth century. These concepts were tied to statistical enquiry, with the concepts that were employed affecting the quality of the data returned. Penrose saw the potential this system offered for new and modernised epidemiological data to be produced by entries to the hospitals, but hoped that with broader application, it may provide insights into mental illnesses affecting those who would never be admitted to a hospital. This project relied upon an improvement in the quality of data that was produced by mental hospitals: by gaining better understandings of the acute disorders that were treated there, and by linking this data to genetics and aetiology, the prevalence of disorders amongst certain sectors of the population could be predicted and early treatment could prevent the onset of an acute disorder.

Although improvements had been made to the mental health statistics collected by members of the Association, they were still lacking, and the Table of the Forms of Mental Disorder that had been condemned as useless by Blacker, his colleagues at the Eugenics Society and the man that was placed in charge of reforming the admissions system to mental hospitals; almost as Penrose was speaking, Blacker was finalising plans to completely revolutionise the way in which data was collected from mental health patients. During the Second World War, plans were under way to reform the country, and establish a new kind of welfare state. The establishment of the welfare state and the NHS held enormous potential for reform of the mental health services immediately after the war,<sup>69</sup> so the time was now to restructure the

---

<sup>69</sup> Chris Renwick makes the argument that it is somewhat of a misnomer to talk about the *establishment* of the NHS and the welfare state, but rather social work agencies and health services that had been developed during the nineteenth and early twentieth century were standardised and brought together in post-war planning. There is a convincing case for this to be applied to psychiatric social work, by looking at the formation of the National Association for Mental Health (NAMH) (later Mind the Mental Health Charity) from organisations that were founded in the Edwardian period, including the Central Association for Mental Welfare, The National Council for Mental Hygiene, and the Child Guidance Council. They were initially brought together on the eve of the Second World War in the form of the Emergency Mental Health Services to assist Emergency Medical Services and billeting operations, but would be renamed the NAMH in 1946. See: Chris Renwick, *Bread For All*, Macmillan, 2017; and for more on the formation of the NAMH, see Kevin Matthew Jones, 'Mental Illness on the Home Front: The Emergency Medical Services and Psychiatric Social Work During World War Two' (forthcoming).

services.<sup>70</sup> Webster claims that the inclusion of mental health services was an ‘afterthought’<sup>71</sup> within the initial planning for the NHS included in the 1944 White Paper: this had resulted in mental health services being spread across a tripartite system that had sought to nationalise services, yet at the same time compromise with GPs and dentists by allowing them to continue private practice. For the most part, the mental health services, then, had to make the best out of the existing infrastructure in the form of the ageing Victorian asylum buildings.

Mental hospitals became included in the new NHS, and were given the same legal and administrative status as general hospitals. They were to come under the authority of the Ministry of Health, and were no longer overseen by the Board of Control.<sup>72</sup> Social services were covered by what the historian Kathleen Jones judged to be a ‘vague’ requirement placed upon local authorities within section 28 of the NHS Act.<sup>73</sup> In reality, no clear obligations were placed upon local authorities to provide mental health social care services, and although there existed areas, predominantly big cities, in which psychiatric social services had developed during the late 1940s, it still remained for most part the case that these services did not have the kind of state resources made available to the clinical care of those with mental disorders. This is most clearly outlined by the fact that medical superintendents of mental hospitals, as well as psychiatrists who served in out-patient units, were employed by hospital boards, whereas psychiatric social workers and other primary care professionals would usually work for a voluntary organisation such as the National Council for Mental Health, whose services were contracted by local authorities.

Having been low on the agenda for those leading health reforms, the inclusion of clinical services relating to mental health care within the NHS was perhaps only achieved so quickly due to it being a convenient and a rather straightforward matter: since clinical care for mental disorders was delivered primarily through mental hospitals or out-patient units in general hospitals, and since all general hospitals were set to be nationalised, it was not hard to include clinical psychiatric services within the measures of the 1946 National Health Service Act. Clinical mental health services, along with ophthalmic services and dentistry, however soon led to spiralling costs for the fledgling health service. Even with this spending, Aneurin

---

<sup>70</sup> Francis Pilkington, ‘Review: W.H.O. and Mental Health 1949–1961. W.H.O. Geneva 1962’ in *JMS*, Vol.109, No.458, Jan. 1963, p.154.

<sup>71</sup> Charles Webster, *The Health Services Since the War*, vol.1, HMSO, 1996, (p.55).

<sup>72</sup> M. Crowther, ‘From Workhouse to NHS Hospital in Britain 1929 - 1948.’ *The Poor Law and After*. Ed. Hiram and Bone. Liverpool: Liverpool Medical History Society, 1999. 38 – 49.

<sup>73</sup> Kathleen Jones, *Asylums and after: a revised history of the mental health services: from the early 18th century to the 1990s*, Athlone Press, 1993. (p.144)



Bevan acknowledged the overcrowding of beds in mental hospitals<sup>74</sup>, and had warned cabinet colleagues about the possibility of a scandal arising due to the poor conditions in mental hospitals: mental healthcare services were, as Klein remarks, ‘the slum of the NHS’.<sup>75</sup>

Attention was drawn to Bevan’s slums only after the dust had settled from the negotiations that had taken place between the Ministry of Health and professional bodies like the British Medical Association and RMPA during the formation of the NHS act.<sup>76</sup> The poor state of mental hospitals and the fragmented nature of social services led to calls for the kind of wholesale reforms in psychiatry that had been made to general medical services immediately after the war. Mental health services had been pushed to the back of the queue when it came to funding and available resources. Despite the enthusiasm from members of the medical profession to bring about reform, political will dwindled as soon as the costs of the NHS began to spiral out of control. This would lead to legal reform of mental services coming only after almost exactly a decade since the establishment of the NHS, in the form of the 1959 Mental Health Act.

Whilst these developments were ongoing, Penrose and Blacker, as prominent members of the British Eugenics Society, were working on research that could link psychiatric disorders to genetics and population numbers. The NHS act created a gap in legislation that Blacker and Penrose thought could be exploited to allow revisions to the admissions system, which would in turn allow the more comprehensive collection of mental health statistics that they desired. Blacker and Penrose thought that the *ICD* should be used instead of the RMPA’s troubled Table of the Forms of Mental Disorder. Ultimately, it spelled the end of the chequered history of the Table of the Forms that was drafted by the RMPA, and would be part of a new, global era of mental health classification. This chapter will assess some of the reasons for the changes and outline why the RMPA’s classification was abandoned before assessing its legacy within the new era of psychiatric classification.

A medical committee appointed by the United Kingdom’s General Registry Office [GRO], which had taken over the collection of general medical statistics during and after WWII.<sup>77</sup> The GRO had also taken over the duties of collecting data on admissions to mental

---

<sup>74</sup> Ibid., p.160

<sup>75</sup> Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention*, 3<sup>rd</sup> ed., Longman, 1995. p.59

<sup>76</sup> This was a lengthy process which took place between the initial white paper published in 1944, and the NHS amendment act made in 1949. For a full treatment; see Charles Webster, *The Health Services Since the War* vol.1, HMSO, 1996.

<sup>77</sup> Carlos Patton Blacker, ‘Redhill Hospital – Notes on Visit Paid by Dr. Harris and Dr. Blacker on Monday, 16<sup>th</sup> December 1946 in Papers by Carlos Paton Blacker on Mental Health Records, Carlos Paton Blacker Collected Papers, held by The Wellcome Collection

hospitals and in-patient units from the Board of Control. This was in line with statistics collected for general hospitals and other sorts of clinics, and what had started as a wartime measure, was made official under the NHS act. The NHS act did not make provisions for mental hospitals aside from bringing them directly under the control of the Minister of Health: they were not subject to the same kinds of inspections that general hospitals were by the local health authorities, and instead, the Board of Control was retained for these purposes until the passing of the 1959 Mental Health Act.

Mental hospitals then had a similar but distinct policy on collecting data relating to admissions. Work began on redesigning this during the war, with a committee being headed by Carlos Blacker. Blacker was serving in the Ministry of Health during the conflict, and he saw the opportunity to collect data relating to mental health disorders by coming up with a new system that would achieve this goal. He believed that research into the genetics of mental health disorders could be improved by coming up with an easy to use and comprehensive system that would record the data of those who entered all mental hospitals in the UNITED KINGDOM. A team led by Blacker conducted field trips to existing mental hospitals to review their admissions policies, making observations on how to improve the efficiency of the collection of data.<sup>78</sup> Meticulous planning to derive a system that would record patient data accurately was undertaken, including the way in which the index card should be stored, rotated and ordered. The committee that he directed came up with plans to produce index cards to record the data coming back from institutions. Two versions of the card were published: yellow for those classified as mental deficient and pink one for those diagnosed with a mental illness, and both had a small box in which the *ICD*'s code for the diagnosis of the patient would be entered. The codes and the psychopathologies included in the *ICD* were (see next page):

---

<sup>78</sup> Carlos Patton Blacker, 'Redhill Hospital – Notes on Visit Paid by Dr. Harris and Dr. Blacker on Monday, 16<sup>th</sup> December 1946 in Papers by Carlos Paton Blacker on Mental Health Records, Carlos Paton Blacker Collected Papers, held by The Wellcome Collection.

## Psychosis (300)

300 Schizophrenic disorders (dementia praecox)	317.2 Pruritus of psychogenic origin
300.0 Simple type	317.3 Other cutaneous neuroses
300.1 Hebephrenic type	317.4 Psychogenic reactions affecting musculoskeletal system
300.2 Catatonic type	317.5 Psychogenic reactions affecting other systems
300.3 Paranoid type	318 Psychoneurotic disorders, other, mixed and unspecified types
300.4 Acute schizophrenic reaction	318.0 Hypochondriacal reaction
300.5 Latent schizophrenia	318.1 Depersonalisation
300.6 Schizo-affective psychosis	318.2 Occupational neurosis
300.7 Other and unspecified	318.3 Asthenic reaction
301 Manic-depressive reaction	318.4 Mixed
301.0 Manic and circular	318.5 Of other and unspecified types
301.1 Depressive	(320-326) Disorders of character, behaviour, and intelligence
301.2 Other	320 Pathological personality
302 Involutional melancholia	320.0 Schizoid personality
303 Paranoia and paranoid states	320.1 Paranoid personality
304 Senile psychosis	320.2 Cyclothymic personality
305 Presenile psychosis	320.3 Inadequate personality
306 Psychosis with cerebral arteriosclerosis	320.4 Antisocial personality
307 Alcoholic psychosis	320.5 Asocial personality
308 Psychosis of other demonstrable aetiology	320.6 Sexual deviation
308.0 Resulting from brain tumour	320.7 Other and unspecified
308.1 Resulting from epilepsy and other convulsive disorders	321 Immature personality
308.2 Other	321.0 Emotional instability
309 Other and unspecified psychoses	321.1 Passive dependency
(310-318) Psychoneurotic disorders	321.2 Aggressiveness
310 Anxiety reaction w/out mention of somatic symptoms	321.3 Enuresis characterising immature personality
311 Hysterical reaction without mention of anxiety reaction	321.4 Other symptomatic habits except speech impediments
312 Phobic reaction	321.5 Other and unspecified
313 Obsessive-compulsive reaction	322 Alcoholism
314 Neurotic-depressive reaction	322.0 Acute
315 Psychoneurosis with somatic symptoms (somatisation reaction) affecting circulatory system	322.1 Chronic
315.0 Neurocirculatory asthenia	322.2 Unspecified
315.1 Other heart manifestations specified as of psychogenic origin	323 Other drug addiction
315.2 Other circulatory manifestations of psychogenic origin	324 Primary childhood behaviour disorders
316 Psychoneurosis with somatic symptoms (somatisation reaction) affecting digestive system	325 Mental deficiency
316.0 Mucous colitis specified as of psychogenic origin	325.0 Idiocy
316.1 Irritability of colon specified as of psychogenic origin	325.1 Imbecility
316.2 Gastric neuroses	325.2 Moron
316.3 Other digestive manifestations specified as of psychogenic origin	325.3 Borderline intelligence
317 Psychoneurosis with somatic symptoms (somatisation reaction) affecting other systems	325.4 Mongolism
317.0 Psychogenic reactions affecting respiratory system	325.5 Other and unspecified types
317.1 Psychogenic reactions affecting genito-urinary system	326 Other and unspecified character, behaviour and intelligence disorders
	326.0 Specific learning defects
	326.1 Stammering and stuttering of non-organic origin
	326.2 Other speech impediments of non-organic origin
	326.3 Acute situational maladjustment
	326.4 Other and unspecified.

Figure 22 Mental Health Section, ICD.<sup>79</sup>

<sup>79</sup> *Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death: 6th Rev. of the International Lists of Diseases and Causes of Death. Adopted 1948 [by the International Conference for the Sixth Decennial Revision of the International Lists of Diseases and Causes of Death].* Geneva, 1948.

Blacker thought that the correct logging of admissions statistics for mental health patients could help to answer four crucial questions: 1) Is the mental health of the country improving, remaining stationary, or deteriorating?; 2) What good are the mental health services doing?; 3) How do the mental health services vary throughout the country?; 4) Are specific forms of mental illness or defect becoming commoner or rarer? To help answer the first question, Blacker thought that mental health statistics needed to be collected which were of at least the same quality as existing epidemiological data that gave public health authorities clues on the physical health of the nation, namely: numbers relating to ‘deficiency diseases such as rickets’, infant mortality, and the weight of children.<sup>80</sup> Possible ‘finger-pointers’ included divorce rates, numbers of suicide, and ‘juvenile delinquency’.<sup>81</sup> The second question was one that had potential political capital – with the subsuming of mental health services into the NHS, Blacker made a prediction that the public wanted to know that the money being spent was worth it – were mental health services able to increase contentment as well as alleviating acute disorders.<sup>82</sup> When it came to his third question about how mental health services varied across the United Kingdom, Blacker viewed statistics as crucial for comparison and eventual improvement to standardise the levels of treatment.

To answer his fourth question concerning the different forms of mental disorder, Blacker again resorted to a comparison between mental health and known facts relating to somatic disorders:

The answer is available of many physical conditions. Typhoid is now a rarity. Plague, typhus and leprosy are now practically non-existent. Industrial diseases diminish as conditions of work improve [...] Tuberculosis and rheumatic disease fluctuate in incidence.<sup>83</sup>

Mental diseases associated with clearly discernible health conditions such as GPI, lead encephalopathies, pellagra, cretinism, myxoedema and alcoholic psychoses were less prevalent than they had been according to this report, making it harder to identify mental diseases. Again, it was hoped that the new mental health statistics would again provide the means to bring this about. Finally, Blacker’s fifth question could also be answered with diagnosis upon admission,

---

<sup>80</sup> Carlos Patton Blacker, ‘Redhill Hospital – Notes on Visit Paid by Dr. Harris and Dr. Blacker on Monday, 16<sup>th</sup> December 1946 in Papers by Carlos Paton Blacker on Mental Health Records, Carlos Paton Blacker Collected Papers, held by The Wellcome Collection.

<sup>81</sup> Ibid.

<sup>82</sup> Ibid.

<sup>83</sup> Ibid.

and keeping records on the kinds of treatment disorders would, he hoped, show which treatments worked, and which one were ineffective. In 1946, when planning of this new system was at an advanced stage, publication of the sixth edition of the ICD was on the horizon, and Blacker's committee decided that this was to be used for the purposes of admissions diagnosis in their new system.<sup>84</sup> This was after the Board of Control has been consulted by Lionel Penrose to discuss possible classifications that could be used.<sup>85</sup> There is no evidence to suggest that the Board considered the table of forms of mental disorder as an option; Penrose did bring up a rough classification used by the Medical Research Council but he acknowledged that it must be expanded to be useful<sup>86</sup>:

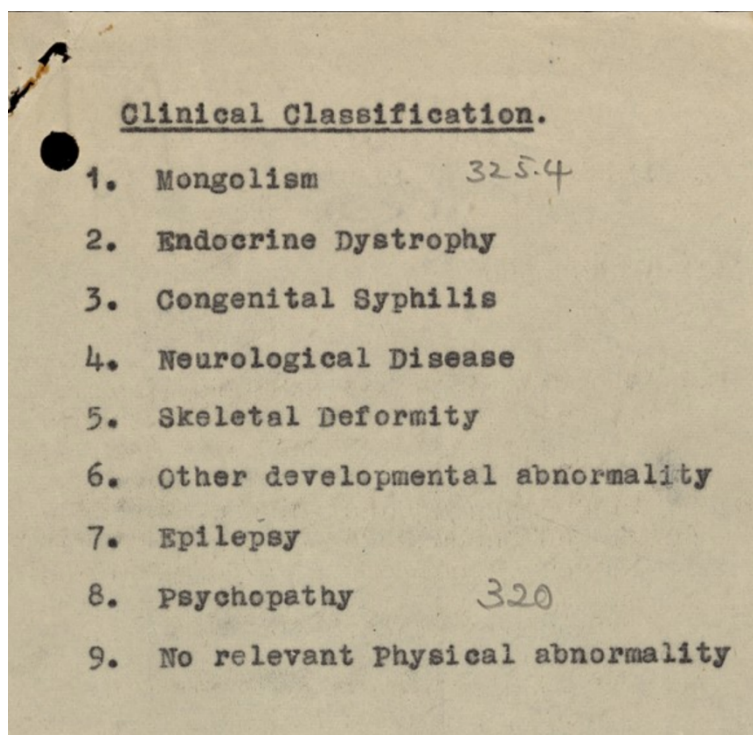


Figure 23: Draft Classification of the Medical Research Council proposed by Penrose.<sup>87</sup>

The numerical system of classification meant that plans could be made to use the latest in hole punch reading technology to speed up the gathering of this information, a responsibility which

---

<sup>84</sup> Ibid.

<sup>85</sup> Ibid.

<sup>86</sup> Lionel Penrose, Correspondence to R. Tomsett, the Board of Control, in Mr Corbett's proposals for revising the Index Cards. Diagnostic Lists, Carlos Paton Blacker, Collected Papers

<sup>87</sup> Ibid.

again rested with the GRO. The cards were introduced for service on January 1<sup>st</sup> 1949, and the booklet dispatched that accompanied the cards instructed them to be filled with the diagnostic codes that were contained in the ICD-6, pointing out that it would make it possible to correlate the returns with those from other countries.<sup>88</sup> The manual dismissed the MPA's Table of Forms as being out of date, and that the data returned from the Board of Control based upon this classification was 'too meagre to satisfy present day requirements'.<sup>89</sup> It stated that although the knowledge on admissions to mental hospitals collected by the Board of Control was satisfactory, one of the goals of the new system was to improve the dataset to include those who were in out-patient wings and the progress of long-stay patients. An early draft of the manual provided with the new patient index cards stated that the exact number of long-stay patients in mental homes was not known, but this was removed from the final version for fear that the Ministry of Health being ignorant of these figures would cause controversy. When it came to diagnosis, the manual instructed that the physical condition be given as the first diagnosis, with any accompanying mental condition being labelled as a secondary one.

---

<sup>88</sup> General Register Office, 'Mental Health Statistics', in RG 41/46, held by The National Archives.

<sup>89</sup> Ibid.

### MENTAL HEALTH SERVICE

#### Hospital Index Card 1 — Mental Disorder

PART A — continued										
20. Twin, Triplet, etc. Not a twin, etc. XX Not known VV If a twin, etc., has other twin, etc., been dealt with under L. & M. T. Acts? Yes No Not known Twin, same sex 21 22 23 Twin, different sex 34 35 36 Twin, sex unknown 47 48 49 Triplet, etc. 50 60 70			21. Parents related by blood Yes 1 No 2 Not known V		22. Patient related by blood to first spouse Yes 1 No 2 Not known V		23. First Spouse's Mental State Dealt with under L. & M. T. Acts Dealt with under M. D. Acts Not dealt with Not known			
24. Age of Mother at birth of patient Not known VV		25. No. of sibs and half-sibs born alive to patient's mother Not known VV		26. No. of Patient's children born alive Not known VV		27. (a) Age at first marriage Not known VV (b) Duration of first marriage Not known VV		28. Age of first wife at marriage to patient (Men only) Not known VV	29. Married more than once Yes 1 No 2 Not known V	
PART B. To be completed for all deaths, removals, transfers and discharges										
30. Date of — Leaving or dying ... Day Mth. Year Admission ... Day Mth. Year				32. Status on leaving or dying Voluntary 1 Temporary 2 Certified 3 Other 4		33. Outcome Recovered 1 Relieved 2 Not improved 3 Died 4		34. Disposal Died 1 Departed 2 Transferred 3		Discharged — Operation of Law 4 Not now insane 5 Petitioner 6 Appropriate relative 7 Other 8
31. Period of stay in this hospital Days Mths. Years				35. Diagnosis on leaving (if different from that on admission) (a) Principal Condition (b) Secondary Condition		36. Address to which patient left Coding		37. Causes of death as written on death certificate Ia Ib Ic II		38. Was P.M. performed Yes 1 No 2

### MENTAL HEALTH SERVICE

#### Hospital Index Card 2 — Mental Deficiency

PART A. continued										
20. Twin, Triplet, etc. Not a twin, triplet, etc. IX Twin, same sex 2 Twin, different sex 3 Twin, sex unknown 4 Triplet, etc. 5 Not known VX If a twin, triplet, etc., has other twin been dealt with under L. & M. T. Acts Yes 6 No 7 Not known V			21. Parents related by blood Yes 1 No 2 Not known V		22. Patient related by blood to first spouse Yes 1 No 2 Not known V		23. First Spouse's Mental State Dealt with under L. & M. T. Acts 1 Dealt with under M. D. Acts 2 Not dealt with 3 Not known V			
24. Age of Mother at birth of patient Not known VV		25. No. of sibs and half-sibs born alive to patient's mother Not known VV		26. No. of Patient's children born alive Not known VV		27. (a) Age at first marriage Not known VV (b) Duration of first marriage Not known VV		28. Age of first wife at marriage to patient (Men only) Not known VV	29. Married more than once Yes 1 No 2 Not known V	
PART B. To be completed for all deaths, removals, transfers and discharges										
30. Date of — Leaving or dying ... Day Mth. Year Admission ... Day Mth. Year				32. Period of licence prior to leaving or dying Not on licence X Under 1 year 0 1— 1 2— 2 3— 3 4— 4 5— 5		33. I.Q. or M.A. on leaving (Binet type)		34. Disposal Died 0 Removed by relative or guardian 1 Transferred to — Another Institn. 2 Mental Hospital 3 Guardianship 4		Discharged — By Bd. of Cont. S. R. & C. 5 Order lapsed while A.W.O.L. 7 Reaching age of 21 8 Other 9
31. Period of stay in this hospital Days Mths. Years				35.		36. Address to which patient left		37. Causes of death as written on death certificate Ia Ib Ic II		
37. Causes of death as written on death certificate Ia Ib Ic II				Code Number (Give blank)		38. Was P.M. performed Yes 1 No 2		39. Age on leaving or dying		

Figure 24: Mental Illness and Mental Deficiency Index cards

Improving this data would, it was hoped by Blacker, fulfil Penrose's goal to improve understandings of mental disorder through statistical analysis. As we can see from the cards above, detailed information concerning a patient's family background was included on the cards. A letter from 25<sup>th</sup> September 1953 dispatched from Penrose's office at the Galton institute would congratulate the GRO on the statistics they had gathered on mental health diagnosis and consanguinity, stating that the numbers would provide useful information for further research.<sup>90</sup> For so-called mental defectives, Blacker and the eminent statistician Percy Stocks took the decision to record the I.Q. of the patient.<sup>91</sup> I.Q. was key because aside from being used to diagnose mental deficient, it was used in education policy to detect mental and moral deficiency in children, and detect whether they should be sent to the increasing numbers of special schools, a measure to reduce juvenile delinquency. Classification would be done through the concepts of psychopathology that were used in the *ICD*.

## Conclusion

The abandonment of the Table of the Forms signals wider institutional and conceptual changes in psychiatry that would lead it closer to general medicine. The conceptual changes would begin to emerge during debates over classification that occurred during the war that were linked to the diagnosis and treatment of trauma states. These would question the classifications of mental disorder that were familiar to medical doctors. New treatment technologies and the vagueness of the diagnostic concepts that were in use meant that appeals were made to treatment to guide the hand of the clinician in making a diagnosis. The use of physical treatments, and the role that the psychiatric profession had played during the war were factors that along with the restructuring of the health services and the appointment of psychiatrists to prominent government roles, and the adoption of a general, international medical nosology: these were all factors that would spell the end of the RMPA carrying out discussions on what standardised concepts of mental disorder should be used to classify admissions. The categories of the *ICD* would be used to record the disorder suffered by a patient upon admission to the nationalised mental hospitals of the NHS, or into the psychiatric wards of general hospitals. The end of the Table of the Forms then reflected wider changes to psychiatric diagnosis and practice in the United Kingdom.

---

<sup>90</sup> Correspondence, L.S. Penrose to Ruth M. Loy, 25<sup>th</sup> September 1953 in MH RG 41/46 held by the National Archives, Kew Gardens.

<sup>91</sup> Mental Health Statistics, Minutes of Meeting, Wednesday February 18<sup>th</sup>, 1948 in MH RG 41/46, held by National Archives, Kew Gardens.



## Conclusion

This thesis has charted the century long journey of The Medico-Psychological Association's (MPA) Table of the Forms of Mental Disorder, a document which began its life in asylum statistical returns, but went on to cause three sets of drawn out and intense discussions on psychiatric classification. The debates that were waged over the revisions to the document ostensibly concerned how insanity and mental disorder ought to be categorised in admissions forms sent out to asylums, but they would confront huge questions about what exactly insanity was, and how it should be understood. To return to Andrew Cunningham's thoughts outlined in the introduction, the history that I have presented is of an array of classification concepts, as opposed to the history of each of the concepts that are used in this array.<sup>1</sup> This thesis has treated the Table of the Forms as an array which has been formulated from administrative developments and scientific discourse.

The debates that waged over this array, and the revisions that were made to it, saw conflicts over how insanity should be classified, but these led into discussions about how it should best be understood, be it through the observation of symptoms to make predictions, working out the aetiology and pathology of a disorder, statistical analysis of asylum returns, observing responses to treatment, studying a person's psychological illness, or a combination of these approaches. This thesis has attempted to represent these discussions, and how they developed during the century in which this table existed. In doing so, I have provided an account which provides a representation of the concerns about classification that were accepted by psychiatrists working within the British Isles over a hundred-year period. I have focused the attention of the thesis on each of the revisions that were made to the document because these each provide a snapshot of the concerns of the British psychiatric establishment at certain points in the document's history. I hope that this work can be used by scholars working on the history of medicine as a general guide to the concerns on classification and diagnosis that guided psychiatrists during this hundred-year period.

The history that has been presented in this study has attempted to provide a treatment that has encompassed both social and administrative events surrounding the table, as well as the clinical ideas that helped to shape it. However, how best can we understand this history? To return to some of the considerations outlined in the introduction to this thesis, we can first begin with an historiographical perspective informed by fundamental texts in the history of psychiatry.<sup>2</sup> Taking a perspective that focuses on the development clinical ideas and how they changed in response to breakthroughs would lead us to understand the history presented in this

---

<sup>1</sup> Andrew Cunningham, 'Identifying Disease in the Past: Cutting the Gordian Knot' in *Asclepio*, vol.54, 2002 pp.13 – 34.

<sup>2</sup> Richard Hunter and Ida McAlpine, *Three Hundred Years of Psychiatry 1535 – 1860: A History Presented in Selected English Texts*, LLC, 2013; Gregory Zilboorg, *A History of Medical Psychology*, W.W. Norton and Company, 1967.

thesis as a linear progression: from a symptom-based classification of Pinel that founded the very notion of a psychological classification; to the second phase in which this approach faced challenges from an aetiological understanding of insanity that sought to provide firmer grounds to psychiatric classification. A greater emphasis on prognosis was triggered by the *breakthroughs* made by Kraepelin in his work, which used the careful collection of data on patients to provide psychiatrists with concepts that would allow them to make more accurate prognoses, based upon the observation of symptoms.<sup>3</sup> The discussions that formulated the third phase covered in this study could then be understood as a response to these breakthroughs, and the final heterogeneous phase of the classification could be understood as the legitimate response to an asylum psychiatry that was facing challenges to its hereditarian and biological views of the nature of insanity.

I believe that this would be a coherent reading of the history presented: in fact I have myself made these judgments and conclusions during the course of this study. Yet, this is only part of the story, and it is possible to provide another reading of this study which does not conflict with what I have just outlined. This reading would be from the perspective of a social historian. Once again, to return to the ideas outlined in my introduction, Jan Goldstein takes the view that the classification undertaken by French psychiatrists during the nineteenth century was merely a performative task carried out to mask its therapeutic failures and to give it the appearance of a material science.<sup>4</sup> In addition, Charles Rosenberg discusses the social role of diagnosis, and how this fits with the functions of the administrative and bureaucratic state.<sup>5</sup> We have seen during the course of this study the impact that administrative and social developments have had upon the discussions surrounding the Table of the Forms, and how these have played some role in the formulation of each of the versions of the document. To briefly recap, the Table of the Forms emerged from lunacy administration due to the involvement of James Cowles Prichard with the first incarnations of the Lunacy Commission. Prichard's role in public office, coupled with the textbooks he wrote that helped bring the classifications of French psychiatry to the British Isles helped to establish the forms of insanity developed by Pinel as the standard classification that was widely used to record the diagnosis of any admission to an asylum.

---

<sup>3</sup> Edward Shorter, 'The History of Nosology and the Rise of the *Diagnostic and Statistical Manual of Mental Disorder*' in *Dialogues in Clinical Neuroscience*, Vol. 17, No.1, pp. 59 – 67.

<sup>4</sup> Jan Goldstein in *Console and Classify: the French psychiatric profession in the nineteenth century*, Cambridge University Press, 1988.

<sup>5</sup> Charles E. Rosenberg, 'The Tyranny of Diagnosis: Specific Entities and Individual Experience' in *the Milbank Quarterly*, Vol.80, No.2, June 2002, pp.237 – 260

Furthermore, as explored in the first chapter of this study, the requirement to make a diagnosis of pauper lunatics upon admission was a legal requirement of the 1845 Lunacy Act. This set of administrative developments commenced the history of the Table of the Forms, and established diagnosis on the point of admission as a legality which psychiatrists were required to provide and record. This legal development furnished the fledging psychiatric population with a potentially powerful source of data which, if harnessed with the proper classification concepts, could provide insights into the nature of insanity and its different forms. If it had not been for these administrative developments, admissions statistics may have taken longer to develop, and the debates that took place over classification that are presented in the second chapter of this thesis, and possibly the third, may never have taken place. The data provided by asylum admissions became the vital concern which fuelled these debates. Put simply, if we adopt this perspective, we can say that social developments beyond psychiatry caused the debates over classification that were conducted by members of the MPA during the latter half of the nineteenth century.

If we take this perspective further, we can see that the social developments that occurred during the *fin-de-siècle* of Victorian psychiatry had an impact upon the debates undertaken by members of the Association. The overcrowding of asylums, due to increased populations and poverty in major cities in the British Isles, combined with crowded and underfunded asylums, led to psychiatrists turning their attentions towards finding ways to prevent people being admitted to an asylum in the first place. As we saw from chapter three, which covers the second revisions to the Table of the Forms, psychiatrists argued for the early treatment of patients based upon research which they thought demonstrated that the later the insanity was treated, the harder it would be to cure the patient, which would in turn diminish the chances that they would have of ever being discharged from the institution. Furthermore, the widening of the requirements to provide a diagnosis upon admission to private patients meant that psychiatrists started not only talking of a person never being cured, but of the need to avoid the them and their family losing their livelihood and becoming stigmatised by the community. The concerns of psychiatrists then begin to shift as the demographic they needed to categorise also changed due to social and administrative developments. Developments during the inter-war era such as the establishment of out-patient clinics, legislation in the form of the 1930 Mental Treatment Act, and the post-war changes covered in the final chapter of this study had an impact upon the formulation of the classifications that were adopted by the RMPA and public health bodies. Finally, psychiatry's closer post-war alignment would be

reflected in the dropping of the RMPA's classification in favour of a general medical nosology in a global document that reflected the beginnings of transnational psychiatric classification.

Once again, I believe that such a social reading of the history would be acceptable, and I have indeed made these arguments during this study. Invoking these developments from beyond psychiatric discourse is vital to understanding the decisions made by scientists in the past, and the reasons why the object of this study was formulated in the way it was, during the different periods of its existence. However, and at risk of repeating myself, I do not believe that this captures the whole story, and a more delicate means of interpreting the history of the Table of the Forms is needed. At the outset, I appealed to the ideas of historical epistemology to provide this study with the conceptual and methodological tools necessary to navigate the delicate balance between social considerations and the clinical ideas relevant to this investigation. Principally, Michel Foucault's notion of the *historical a priori* is vital to understanding the conditions of a certain period that have allowed scientists to understand one another, and this notion will help us to make conclusions on this study from another perspective.<sup>6</sup> This view has informed the work of Ian Hacking, who like Lorraine Daston, seeks to understand the ways in which scientific explanations were shaped to some extent by the historical conditions in which they were formulated, yet scientific communities, or thought collectives, were also to some extent self-governing in that the disciplines themselves set the rules and the logic which admitted certain statements as legitimate knowledge claims, and others as inadmissible.<sup>7</sup>

It is clear from the debates that took place amongst psychiatrists in the second chapter of this thesis that certain conditions governed the kinds of considerations that could be invoked in discussions on classification. Members of the Association were agreed that 'symptom' was the term to use to describe the psychological aspects of a mental disorder. The term symptom was used by Pinel when describing phenomena to formulate the classification concepts in his *Traité médico-philosophique sur l'aliénation mentale*.<sup>8</sup> As we have seen from the second chapter, the term symptomology arose during the mid-nineteenth century to describe this approach to psychiatric classification, and psychiatrists engaged in these debates never doubted that psychological aspects of mental disorder were a symptom of an underlying

---

<sup>6</sup> Michel Foucault, *The Order of Things : An Archaeology of the Human Sciences*, trans. anonymous, Routledge, 2002.

<sup>7</sup> Historical epistemology has also helped this study to understand the debates that were conducted on their own terms. It has refrained as much as possible from using modern concepts of psychopathology to understand the debates that took place, and I have attempted to stay true to the knowledge and categories available to historical actors encountered during the course of this history.

<sup>8</sup> Phillipe Pinel, *Traité médico-philosophique sur l'aliénation mentale*. Chez J. Ant. Brosson, 1800.

physical cause. This was the *historical a priori* for British psychiatrists; it was the fundamental assumption upon which discussions and disagreements about classification rested. What brought the Association together was a rejection of the scientific value of Pinel's forms of insanity, with the only voices in defence appealing to their value as imperfect heuristics which had stood the test of time. As we saw, the aetiology of Skae was developed in response to what was viewed as their scientific imprecision, but this came into conflict with the reservations of other psychiatrists, who believed that the Scotsman was making hasty judgements when formulating the concepts in his classification: by tying them to certain bodily conditions, he was providing a form of deterministic theory for the genesis of insanity. Not one member of the Association questioned the ideal of providing causal, mechanistic and somatic explanations of insanity, with the debates that I have covered regularly voicing hopes, sometimes in despair, for classifications based on pathology or aetiology. Rather, as we saw in the stand out case of James Crichton-Browne, it was the way that Skae had formulated his concepts, and the concern that they may obstruct the development of knowledge that fuelled his criticisms. The ideal forms of classification for all those engaged in these debates were aetiological or drawn along the lines of pathology. The debates that took place were carried out based upon the fundamental assumption that insanity would be understood through its underlying physical processes.

The cracks began to appear in this fundamental assumption as insights into these underlying physical processes failed to materialise, and psychiatry began appealing to the very statistics that had triggered the debates on classification. These statistics were employed to make predictions about the future course of a disease, but they also signalled a departure from the anatomy driven research of the era of the asylum towards an interest in probabilities and tendencies, or what Ian Hacking describes as attempts to tame and harness chance.<sup>9</sup> These efforts would come to define psychological investigation during the twentieth century, yet because the fundamental assumption of psychiatric discourse was that physical and causal explanations were the ideal, attempts were made to pave over the cracks by tying these studies of chance to heredity.<sup>10</sup> The difference between the natural kinds of mental disorder that Rachel Cooper describes and the looping kinds of Hacking is that the former could potentially be discovered by pathology, yet the latter could never be.<sup>11</sup>

---

<sup>9</sup> Ian Hacking, *The Taming of Chance*, Palgrave, 1990.

<sup>10</sup> For instance, Stephen J. Gould provides a critique of the effort of psychological researchers such as Cyril Burt to provide deterministic arguments on the heredity of natural traits; see *The Mismeasure of Man*, W. Norton and Co., 1996.

<sup>11</sup> Cooper, Rachel. *Classifying Madness: A Philosophical Examination of the Diagnostic and Statistical Manual of Mental Disorders*, Springer, 2005.

Unlike Hacking I have not offered a thesis on the constitution of mental disorder, and thus I have not followed the approach of historical epistemology by line and letter. I have instead sought to stay adaptable to the object of this study, and present a scholarly treatment of this previously overlooked document. To put this a different way, what I have not sought to do is provide *a work* of historical epistemology with this thesis. The distinction between a work *of* historical epistemology and a study which *employs* historical epistemology can be best be understood as the difference between proving a thesis about the historical constitution of kinds of knowledge, and one that employs the tools and methods of this school to make sense of the history of science. This study is an exploratory project on a classification system that has been previously overlooked by historians of psychiatry, and I have sought to use the conceptual tools offered by historical epistemology to provide a comprehensive treatment of this fascinating document. The thesis that has arisen from this study stems from an historiographical perspective that has provided me with the necessary sensitivity to the object of research and the topics that it addresses. In employing the tools of this exciting approach to the history of science I have provided a treatment of this hitherto overlooked British classification that I hope will provide a conceptual map of the trends that have captured the attention of British psychiatrists over the course of a century.

Employing the concepts of historical epistemology has allowed me to identify four broad periods in the history of the table that would not have been possible by carrying out in isolation either a social history of the Table of the Forms, nor an analysis of the ideas of the thought collective that was made of the psychiatrists who engaged in these debates.<sup>12</sup> The four periods of the history of the Table of the Forms were not mutually exclusive, and they should be understood as heuristics to allow us to understand the general historical trends present in the debates; each period is labelled by the concern that raised themselves to the fore during the discussions. The movement that pressed for an aetiological classification indicates that psychiatrists believed it should best be understood and treated through the body, and this was reflected in the emphasis on mechanistic, causal classifications offered by figures like Skae. The reaction against Skae was not a rejection of this view, but was instead an indication that the evidence that was available did not allow for the crude deterministic classification concepts that he offered. Put simply, the contact with patients that figures like Crichton-Browne had did not conform to the narrow view that Skae took, but it did not mean that Crichton-Browne thought that the aetiological approach was not the way to go. Rather, it shows that Crichton-Browne

---

<sup>12</sup> Ludwik Fleck, *Genesis and Development of a Scientific Fact*, trans. Fred Bradley, Robert K. Merton and Thaddeus J. Trenn, University of Chicago Press, 2008.

thought that the state of knowledge did not allow for these causal explanations, although there is good evidence to suggest that he thought that such an explanation could be arrived at given further research. This research however failed to materialise, and as therapeutic nihilism began to set in due to the lack of breakthroughs and the lack of discharges from asylums, we find that attentions turn towards treatment that could prevent patients being admitted to an asylum based upon the observation of their symptoms, especially as Kraepelin's work began to gain favour. The turn to Freudian psychoanalysis, and the further development of statistical techniques by figures like Charles Spearman, the establishment of a Wundtian style laboratory by Charles Samuel Meyers and other efforts by the burgeoning movement in British psychology that took place after the Great War, meant that the foundations that had structured the discussions of asylum psychiatric classification were starting to crumble.

An attempt to revise the Table of the Forms at the beginning of the thirties again sparked debate amongst members of the MPA. When it was published in 1932, the revised classification was ignored by the Board of Control during the thirties, and it would be replaced entirely for the purposes of recording admissions to mental hospitals that were incorporated into the National Health Service. Due to a series of developments that took place in the 1920s which are reviewed at the beginning of chapter four, calls were made to revise The Table of the Forms once more. This would be the last set of revisions to the document. In 1929 a revisions committee was appointed, and their recommendations were published three years later, but the Table of the Forms would never be officially used again. During the interwar period, the classifications that dominated the asylum era were questioned by developments in psychology and, more specifically, by the influence of psychoanalysis.

The lasting impact of the Table of the Forms is difficult to determine and would be a fruitful avenue of further research. British psychiatrists embraced and then preserved Kraepelinian concepts of psychopathology during the interwar years, at a time when the USA, which is often viewed by many as setting the agenda for psychiatric classification, was heavily influenced by Freudian notions, imported through the ideas of Adolf Meyer.<sup>13</sup> Psychoanalytic ideas, although derided by many, were given heed by prominent British psychiatrists, as were the ideas of Kraepelin after the Great War and during the interwar years. After the Second World War, British psychiatry contributed to internationalising these Kraepelinian concepts through the involvement of British-trained psychiatrists with the WHO, and the ideas which had developed in here were implemented into the first editions of the *ICD*. Even the gospel of

---

<sup>13</sup> Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*, John Wiley, 1997.

American psychiatry the DSM, in its third edition revised in 1980 to move away from the Freudian ideas of Meyer, was partly inspired by British psychiatric thought through the US-UK diagnostic project of the early 1970s, which revealed disparities between how British and American psychiatrists understood and diagnosed schizophrenia and manic depressive disorder.<sup>14</sup> Although historians have recognised the importance of the project for the history of classification, and how it helped to usher in the age of neo-Kraepelinian psychiatry in which we now live, the role that British concepts of psychopathology that were included in the *ICD* has not been fully recognised.

This thesis has not been able to carry out a full transnational comparison of how different psychiatric cultures standardised nomenclature adopted by associations, and this would also be a fruitful direction of future research. I envisage this taking at least two directions. Firstly, the potential investigation into the impact that ideas in the British Table of the Forms had on the international scene in the era of transnational medicine after the Second World War. The second would be comparisons between the attempts undertaken by the British MPA, and other associations around the world in attempts to standardise psychiatric nosology. These investigations may look at the kind of local conditions that I have explored in this thesis which had an impact upon the demands and needs that were placed upon a psychiatric classification: as we have seen, these have taken the form of legal developments, developments in lunacy administration, institutional developments such as the establishment of outpatient clinics, intellectual factors such as the reliance of causal explanations for mental illnesses during the latter half of the nineteenth century.

---

<sup>14</sup> Ibid.



# Bibliography

## Primary Sources

### Archives Consulted

Archives and Manuscripts, Wellcome Library, London.

Archives of the Royal Society of Medicine, London.

Archives of the Royal College of Psychiatrists.

Parliamentary Archives, Hansard.

Manuscripts and Archives, The British Library.

Mass Observation Archives.

National Archives at Kew Gardens.

Explore York, Library and Archives.

Wakefield Collections, West Yorkshire Archives.

Special Collections, University of Leeds.

### Reports and Minutes

- 'Medico-Psychological Association: Quarterly Meeting January 1882'. *JMS*, Vol.28, No.121, April 1882, pp.136 – 146.
- 'Minutes from The Medico-Psychological Association of Great Britain and Ireland: Eightieth Annual General Meeting of the Association'. *JMS*, Vol.67, No.279, Oct. 1921 pp.511–556
- 'Statistical Intermission'. *JMS*, Vol.6, No.56, Jan. 1916, pp.182 – 183.
- 'The Medico-Psychological Association of Great Britain and Ireland: Quarterly Meeting November 15th 1906'. *JMS*, Vol.53, No.220, Jan. 1907, pp.214 – 217.
- 'Minutes from The Medico-Psychological Association of Great Britain and Ireland: Eightieth Annual General Meeting of the Association'. *JMS*, Vol.67, No.279, Oct 1921 pp.511–556.
- 'The Medico-Psychological Association of Great Britain and Ireland: Eighty-Second Annual General Meeting of the Association'. *JMS*, Vol.69, No.287, October 1925, pp.528–580.
- 'Annual Meeting of the Association of Medical Officers of Asylum and Hospitals for the Insane'. *JMS* Vol. 10, No.51, Oct. 1864, pp.448 – 469.
- 'Association of Medical Officers for the Asylums and Hospitals for the Insane: Official Report of Proceedings at the Annual Meeting held at the Freemasons' Tavern, Thursday, July 5th, 1860'. *JMS*, Vol.7, No.35, pp.23 – 49.

- 'British Medical Association Annual Meeting'. *JMS*, Volume 26, No.115, Oct. 1880, pp.460 – 471.
- 'Dr James Murray Lindsay'. *JMS*, Vol. 58, No.240, January 1912, p.197.
- 'Medico-Psychological Association of Great Britain and Ireland: Annual Meeting July 21st 1904'. *JMS*, Volume 50, No.211, Oct. 1904, pp.784 – 805.
- 'Medico-Psychological Association of Great Britain and Ireland: Annual Meeting of the Association, July 20th, 1905'. *JMS*, Vol.51, No.215, Oct. 1905, pp.773 – 789.
- 'Medico-Psychological Association of Great Britain and Ireland'. *JMS*, Oct. 1906, pp.809 – 838.
- 'Medico-Psychological Association of Great Britain and Ireland'. *JMS*, Vol.52, No.219, Oct. 1906, pp.809 – 838.
- 'Medico-Psychological Statistics: the Desirability of Definition and Correlation, with a View to Collective Study' to the annual general meeting of the association in 1902(check this)
- General Register Office, 'Mental Health Statistics'. MH 99/34, held by The National Archives.
- 'Minutes from The Medico-Psychological Association of Great Britain and Ireland: Ninetieth Annual General Meeting of the Association'. *JMS*, Vol.77, No.319, pp.862–901.
- 'Minutes from The Medico-Psychological Association of Great Britain and Ireland: Ninety-First Annual General Meeting of the Association'. *JMS*, Vol.78, No.323, pp.973–999.
- 'Minutes from The Medico-Psychological Association of Great Britain and Ireland: Eightieth Annual General Meeting of the Association. *JMS*, Vol.67, No.279, Oct 1921 pp.511– 556.
- 'Minutes of the Annual Meeting of the Medico-Psychological Association of Great Britain and Ireland, July 1902'. *JMS*, Vol.48, No.203, Oct. 1902, pp.795 – 805.
- 'Minutes of the Meeting of the Research and Clinical Committee', July 17th, 1941 in RCPSYCH/L10 - Records of the Research and Clinical Section, 1927-1970, held by The Royal College of Psychiatrists, London.
- 'Occasional Notes: The Annual Meeting of the Medico-Psychological Association' in *The Journal of Mental Science*, Vol.49, No. 207 Oct. 1903, pp. 703 – 705.
- 'Occasional Notes: The Annual Meeting'. *JMS*, Vol.50, No. 11, Oct. 1904, pp.750 – 751.
- 'Part IV: Notes and News: Medico-Psychological Association of Great Britain and Ireland: Annual Meeting 1903'. *JMS*, Vol.49, No.207, Oct. 1903 pp.749 – 774.
- 'Proceedings of the Twenty-sixth Annual General Meeting of the Medico-Psychological Association, held at the Royal College of Physicians of London (by permission of the President and Fellows), on Thursday, August 3rd, 1871, under the Presidency of Henry Maudsley'. *JMS*, Vol. 17, No.79, Oct. 1871, pp.438 – 468.
- 'Report of a Meeting of Members of the Medico-Psychological Association, held at Glasgow, April 27th, 1870'. *JMS*, July, 1870, Vol.16, No.74.
- 'Report of a Meeting of Members of the Medico-Psychological Association, held at Glasgow, April 27th, 1870'. *JMS*, July, 1870, Vol.16, No.74, p.304.

- 'Report of the Thirty-fifth Annual Meeting of the Medico-Psychological Association'. *JMS*, Oct. 1880, pp.444 – 460.
- 'Report of the Thirty-Seventh Annual General Meeting of the Medico-Psychological Association'. *JMS*, Vol. 28, No.123, Oct. 1882, pp.437 – 462.
- 'Reports of Societies: Royal Medical and Chirurgical Society, Tuesday, May 14, 1861', in *Medical Times & Gazette*, May 25th, 1861, pp. 562 – 565,
- 'Review: *Psychiatrie: ein Lehrbuch für Studierende und Aerzte* (Psychiatry: A Manual for Students and Physicians). Von Dr. Emil Kraepelin'. *JMS*, Vol.45, No.190, Jul. 1899, pp.581 – 583.
- 'Reviews: The Lunacy Blue Books'. *JMS*, Volume 25, No.112, January 1880, pp.557 – 574.
- 'Royal Medico-Psychological Association, Minutes of the Meeting of the Research and Clinical Committee, June 30th, 1936' in RCPSYCH/L10 - Records of the Research and Clinical Section, 1927-1970, held by The Royal College of Psychiatrists, London.
- 'Royal Medico-Psychological Association, Minutes of the Meeting of the Research and Clinical Committee, 01st Sept. 1938 in RCPSYCH/L10 - Records of the Research and Clinical Section, 1927-1970, held by The Royal College of Psychiatrists, London.
- 'Statistical Intermission'. *JMS*, Vol.6, No.56, Jan. 1916, pp.182 – 183.
- 'The Home Care of the Insane Poor in England'. *JMS*, Vol.49, No.207, pp.708 – 711.
- 'The Late C.A. Mercier'. *JMS*, Vol.67, No.276, Jan. 1921, p.146.
- 'The Medico-Psychological Association: Proceedings at the Annual Meeting of the Association, held at the Rooms of the Royal Society, Edinburgh, on Tuesday, July 31st, 1866'. *JMS*, Vol. 12, No.59, Oct. 1866, pp.415 – 437.
- 'The Medico-Psychological Association: The Eighty Fourth Annual General Meeting of the Association, July 7th – 10th'. *JMS*, Vol.7, No.295, Oct. 1925, pp.797 – 855.
- 'The Royal Medico-Psychological Association: The Eighty-Ninth Annual Meeting of the Association: July 1st – 4th'. *JMS*, Vol.76, No.315, Oct 1930, pp.860 – 894.
- 'The Royal Medico-Psychological Association: The Eighty-Sixth Annual Meeting, July 19th – 22nd, 1927. *JMS*, Vol.73, No.303, pp.691 – 728, (pp.723 – 726).
- 'The Statistical Tables'. *JMS*, Vol. 28, No.124, January 1883, (p.653).
- 'Mental Health Statistics, Minutes of Meeting, Wednesday February 18th, 1948'. MH 99/34, held by National Archives, Kew Gardens.
- Minutes from The Medico-Psychological Association of Great Britain and Ireland: Ninety-Second Annual General Meeting of the Association. *JMS*, Vol.79, No.327, Oct. 1933, pp.800–817.
- Minutes from The Medico-Psychological Association of Great Britain and Ireland: Eightieth Annual General Meeting of the Association. *JMS*, Vol.67, No.279, Oct 1921 pp.511–556.
- War Office 'Summary of Evidence of Witnesses Regarding the Influence of War Stress and 'Shell Shock' in the Production of Insanity'. *Royal Commission into Shell Shock*, HMSO, 1919.
- The Medico-Psychological Association Proceedings at the Annual Meeting of the Association, held at the Royal College of Psychiatrists.

- 'The report of the Commissioners in Lunacy' in *The Times* [London, England], August 16, 1888, No. 32466, p.7.

Armstrong-Jones, Robert. 'Correspondence: Classification of Mental Disorders' in *BMJ*, June 16th, 1934, pp.1091 – 1092, p.1091.

Blacker, Carlos Paton 'Mental Health Records: What we can learn from them?', 27th February 1947, in Papers by Carlos Paton Blacker on Mental Health Records, Carlos Paton Blacker Collected Papers, held by The Wellcome Collection.

Blacker, Carlos Paton. 'Redhill Hospital – Notes on Visit Paid by Dr. Harris and Dr. Blacker on Monday, 16th December 1946 in Papers by Carlos Paton Blacker on Mental Health Records, Carlos Paton Blacker Collected Papers, held by The Wellcome Collection.

Bond, Hubert, and Yellowlees, David. 'Report of the Statistical Committee, Appointed at the Annual Meeting Held at Liverpool in 1902, Presented to the Annual Meeting of the Association, July 21st, 1904'. *JMS*, Vol.51, No.215, Oct. 1905, pp.799 – 826.

Campbell J.A. and Todd, J. 'Uniformity in Public Asylum Reports'. *JMS*, Vol.19, No. 85, April 1873, pp.67 – 78 (p.69)

Campbell, J.A. 'Proposed Statistical Tables'. *JMS*, Vol. 28, No.122, July 1882, pp.318 – 319.

Campbell, J.A. and Todd, J. 'Uniformity in Public Asylum Reports'. *JMS*, Vol.19, No.85, April 1873, (pp.67 – 78).

Cooper, Anthony Ashley, Earl of Shaftesbury, et al. *The Report of the Metropolitan Commissioners of Lunacy*, Bradbury and Evans Printers, 1844

Farr, William. 'Report upon the Mortality of Lunatics' in *Journal of the Statistical Society of London*, Vol.4, No.1 April 1941, pp.17 – 33.

Fleming, G.W.T.H. 'The Revision of the Classification of Mental Disorders: Report by the Clinical Psychiatry Sub-Committee of the Research and Clinical Committee – Part II'. *JMS*, Vol.78, No.321, April 1932, (pp.387 – 391).

Fleming, G.W.T.H. 'Correspondence: Classification of Mental Disorders' in *BMJ*, June 30<sup>th</sup>, 1934, p.1187.

Fleming, G.W.T.H. 'Definitions and Explanatory Notes on the Classification of Mental Disorders'. *JMS*, No.80, April 1934, pp. 409 – 410.

Fleming, G.W.T.H. 'Classification of Mental Disorders'. *BMJ*, June 2nd 1934, p.991.

Hack Tuke, Daniel et al., 'Report of Committee on the Statistical Tables of the Medical-Psychological Association'. *JMS*, Oct. 1882, (pp.463 – 464).

Hack Tuke, Daniel. 'Lunacy Statistics: To the Editor of the Times'. *JMS*, Vol. 34, No.147, Oct. 1888; *The Times* [London, England], August 30, 1888, No.32478, p.6.

Mercier, Charles. 'Correspondence: Proposed Sterilisation of Certain Degenerates', in *BMJ*, Apr. 2nd 1904, pp.808

Yellowlees, David. 'Definitions of terms used in the Report and the Statistical Tables'. *JMS*, Vol.51, No.215, Oct. 1905, pp.834 – 856.

Yellowlees, David. Report of the Statistical Committee, Appointed at the Annual Meeting Held at Liverpool in 1902, Presented to the Annual Meeting of the Association, July 21st, 1904'. *JMS*, Vol.51, No.215, Oct. 1905, pp.799 – 826.

## Academic Papers, Textbooks, Treatise, Nosologies, Published

### Correspondence.

- 'The Classification of Causes of Death'. *BMJ*, April 20th, 1940, p.661.
- Adorno, Theodor Wiesengrund, Frenkel-Brunswik, Levinson, Daniel, Sanford, Nevitt.. *The Authoritarian Personality*, Harper and Row, 1950.
- Allen, Matthew. *Essay on the Classification of the Insane* John Taylor, 1837.
- Andriezen, William Lloyd. 'On the Bases and Possibilities of a Scientific Psychology and Classification in Mental Disease'. *JMS*, Vol.45, No.189, Apr. 1899, pp.257 – 290.
- Armstrong-Jones, Robert. 'Prognosis in Mental Diseases'. *BMJ*, December 16th, 1905, pp.1578 – 1582.
- Armstrong-Jones, Robert. 'Correspondence: Classification of Mental Disorders' in *BMJ*, June 16th, 1934, pp.1091 – 1092, p.1091.
- Arnold, Thomas. *Observations on the Nature, Kinds, Causes, and Prevention of Insanity, Lunacy, or Madness*, G. Ireland: Leicester, 1782.
- Ashe, Isaac. 'Some Observations on General Paralysis'. *JMS*, Vol. 22, No.97, April 1876, pp.82 – 91.
- Atkin, I. 'Classification of Psychological Disorders' in *BMJ*, November 2nd, 1946, p.666.
- Batty Tuke, John. 'A Pathological Classification of Mental Disease'. *JMS*, July, 1870, Vol.16, No.74, pp.195 – 210.
- Baugh, L.D.H. 'Some Observations On Confusional Insanity'. *BMJ*, Vol. 2, No. 2337, Oct 14th 1905, pp.949 – 951.
- Blandford, G. Fielding. 'The Lumleian Lectures on the Diagnosis, Prognosis and Prophylaxis of Insanity: Lecture I'. *BMJ*, April 6th, 1895, pp.741 – 747.
- Blandford, G. Fielding. 'The Lumleian Lectures on the Diagnosis, Prognosis and Prophylaxis of Insanity: Lecture II'. *BMJ*, April 13th, 1895, pp.797 – 800.
- Boyd, R. 'Statistics of Pauper Insanity'. *JMS*, Vol.17, 1871, pp. 221-225.
- Brend, William A. 'Correspondence: War Neurosis' in *BMJ*, March 21st, 1942, p.395.
- Browne, J.C. 'Skae's Classification of Mental Diseases: A Critique'. *JMS*, Vol. 21, No.95, Oct. 1875, pp.339 – 365.
- Bruce, A. Ninian. 'The Out-patient Treatment of Early Medical Disorder. The Neurological Clinic and Some of Its Function' recorded in 'Minutes from The Medico-Psychological Association of Great Britain and Ireland: Eightieth Annual General Meeting of the Association. *JMS*, Vol.67, No.279, Oct 1921 pp.511– 556.
- Bucknill, J.C. 'The Diagnosis of Insanity'. *The Asylum Journal of Mental Science*, Vol.3, No.20, May 1857, pp.141 – 185.
- Bucknill, J.C. and Tuke, Daniel H. *A Manual of Psychological Medicine*, Blanchard and Lea, 1858.
- Bucknill, J.C. *The Care of the Insane and their Legal Control*, London, Macmillan, 1880.
- Bury, Judson S. 'Prognosis in Relation to Disease of the Nervous System' in *BMJ*, November 9th, 1901, pp. 1389 – 1396

- Church, William S., Living E. et al., *The Nomenclature of Diseases: Drawn up by a Joint Committee appointed by the Royal College of Physicians of London*, fourth edition, HMSO, 1906.
- Clouston, Thomas. 'Skae's Classification of Mental Disorder'. *JMS*, January, 1876, Vol. 21, No.96, pp.532 – 500.
- Clouston, Thomas. 'Facts for the Teetotallers'. *JMS*, July 1870, Vol. 16, No.74 pp. 261 – 262.
- Clouston, Thomas. *Annual Report of the Royal Edinburgh Asylum for the Insane, 1877*, Royal Edinburgh Asylum, 1878.
- Clouston, Thomas. *Lectures on Mental Diseases*, fourth edition, J & A Churchill, 1904.
- Clouston, Thomas. *Lectures on Mental Diseases*, second edition, J & A Churchill, 1892.
- Craig, Maurice. 'Delusional Insanity' in *Hospital*, Vol.22, No.549, Apr. 3rd, 1897, pp.9 – 10.
- Crichton-Miller, Hugh. *The New Psychology and the Parent*, Jarrolds, 1922.
- Crichton Miller, 'Anxiety and Hysteria'. *BMJ*, November 27<sup>th</sup>, 1943, pp.687 – 688.
- Crichton, Alexander. *An inquiry into the nature and origin of mental derangement: comprehending a concise system of the physiology and pathology of the human mind and a history of the passions and their effects*, Cadell Jr. & Davies, 1798) (p.5)
- Cullen, William. *Synopsis Nosologiae Methodicae*, trans. William Jackson, W. Jackson, 1827, pp.11 – 12.
- Deas, P. Maury. 'Five Years of Statistics' *JMS*, Vol. 25, No.109, April 1879, pp.8 – 19.
- Dillon, F. 'Classification of Psychological Disorders' in *BMJ*, October 19<sup>th</sup>, 1946, p.588.
- Drapes, T. 'On the Maniacal-Depressive Insanity of Kraepelin' *JMS*, Vol.55, No.228, January 1909, pp.58 – 64.
- Walter Freeman and James W. Watts, 'Psychosurgery: An Evaluation of Two Hundred Cases Over Seven Years' in *JMS*, Vol.90, No.379, pp.532 – 537.
- Freud, S. *The Standard Edition of the Complete Psychological Works vol. 1 (1886 – 1899)*. trans James Strachey and Anna Freud, Hogarth Press, 1966.
- Fahet, M., "'On some of the Latent Causes of Insanity'", excerpts (translated) from *Leçons Cliniques de Médecine Mentale*, Paris, 1854'. *Journal of Psychological Medicine and Mental Pathology*, Vol.7, 1854.
- Glover, Edward. 'A Psycho-analytic Approach to the Classification of Mental Disorders'. *JMS*, Vol.78, No.323, Oct. 1932, pp.819 – 842.
- Gowers, William R. 'A Lecture on the Prognosis and Treatment of Syphilitic Disease of the Nervous System'. *JMS*, April, 1903, pp.773 – 778.
- Gowers, William R. 'The Lettsomian Lectures on Syphilis and the Nervous System' in *BMJ*, February 9<sup>th</sup> 1889, pp.283 – 285.
- Green, George. 'The Prognosis in Dementia Paralytica'. *JMS*, No.52, No. 217, 1906, pp.84 – 305.
- Griesinger, Wilhelm. *Mental Pathology and Therapeutics*, trans C. Lockhart Robinson and James Rutherford, The New Sydenham Society, 1867.
- Hack Tuke, D. 'On the Best Mode of Tabulating Recoveries from Insanity in Asylums Reports'. *JMS*, Vol 26, No.115, Oct. 1880, pp.375 – 382.

- Hack-Tuke, Daniel. *A Dictionary of Insanity*, P. Blakiston, 1892.
- Hadfield, J.A. 'War Neurosis: A Year in a Neuropathic Hospital'. *BMJ*, February 28<sup>th</sup>, 1942, pp.281 – 285.
- Havelock, John G. 'A Case of Recurrent Mania'. *JMS*, Vol.4, No.179, October 1896, pp.817 – 81.
- Hart, Bernard. 'A Philosophy of Psychiatry'. *JMS*, Vol. 54, No.226, July 1906, pp.473 – 490.
- Henderson, D.K. and Gillespie, R.D. *A Textbook of Psychiatry for Students and Practitioners*. 3<sup>rd</sup> ed., OUP, 1932.
- Henry, Eustace M. 'A Case of "Dementia Praecox"'. *JMS*, Vol.50, No.210, July 1904, pp.516 – 521.
- Hitchman, John. "The Pathology of Insanity: A Lecture, Delivered May 25<sup>th</sup>, 1850, in the Middlesex County Asylum, Hanwell". *Journal of Psychological Medicine and Mental Pathology*, Vol.3, 1850, pp.501 – 521.
- Hutchison, Robert et al., *The Nomenclature of Diseases: Drawn up by a Joint Committee Appointed by the Royal College of Physicians of London, 6<sup>th</sup> edition*. Her Majesty's Stationary Office, 1931.
- Hughlings Jackson, John. 'Remarks on the Diagnosis and Treatment of Diseases of the Brain'. *BMJ*, Vol.2, No.1438, July 1<sup>st</sup> 1888, pp.111 – 117.
- Humphreys, Noel A. 'Statistics of Insanity in England, with Special Reference to its Alleged Increasing Prevalence'. *Journal of the Royal Statistical Society*, June 1890, Vol.53, No.2 pp.201 – 252.
- Kraepelin, Emil. *Dementia Praecox and Paraphrenia*, trans. R. Mary Barclay, ed George Robertson, Chicago Medical Book Co., 1916.
- Kraepelin, Emil. 'On the Question of Degeneration' republished in *History of Psychiatry*, vol.18, No.3, 2007, pp.399 – 404.
- Lane, Edward B. 'Some Cases of Alternating Insanity with One Case of Recovery'. *Boston Medical and Surgical Journal*, Vol.116, Jan. 20<sup>th</sup>, 1887, pp.52 – 56.
- Laycock, Thomas. *The Principles and Methods of Medical Observation and Research*, Edinburgh University, 1863.
- Lord, J.R. 'The Clinical Study of Mental Disorders: The Presidential Address at the 85<sup>th</sup> Meeting of the Royal Medico-Psychological Association'. *JMS*, Vol.72, No.(S)298, August 1926, pp.1 – 79.
- Lord, J.R. and Fleming, G.W.T.H. 'The Revision of the Classification of Mental Disorders: Report by the Clinical Psychiatry Sub-Committee of the Research and Clinical Committee'. *JMS*, Vol.78, No.320, January 1932, pp.177 – 201.
- Maclay, W.S. Whitby, J. 'In-patient Treatment of Civilian Neurotic Casualties' in *BMJ*, Oct. 1942, p.449 – 451.
- Major, Herbert C. . 'Dr. Major on Statistical Tables of the Causes of Insanity'. *JMS*, Vol. 23, No.104, January 1878, pp.573 – 575.
- Major, Herbert C. 'Remarks on the Results of the Collective Record of the Causation of Insanity'. *JMS*, Vol.30, No.129, pp.1 – 7.
- Mapother, Henry. 'Emil Kraepelin'. *JMS*, Vol.73, No.303, 1927, pp.509 – 15.

- Maudsley, Henry. *Responsibility in Mental Disease*, D. Appleton & Company, 1895.
- Maudsley, Henry. 'On Some of the Causes of Insanity'. *JMS*, Jan. 1867, Vol.1, No.60.
- Meyer-Gross, William. Slater, Eliot. and Roth, Martin. *Clinical Psychiatry*, Cassell, 1954.
- Mercier, Charles. 'The Study of Insanity'. *JMS*, Vol. 27, No. 118, Oct 1882, pp.166 – 177.
- Mercier, Charles. 'Kinds of Insanity', delivered to the British Medical Association: Swansea 1903: Section of Psychological Medicine'. *JMS*, Volume 49, No.207, Oct. 1903, pp. 776-780. (p.776).
- Mercier, Charles. 'The Data of Alienism'. *JMS* Vol.28, No.123, Oct.1882, pp.333 – 343; Vol.28, No.124, Jan 1883, pp.496 – 510; Vol.9, No.125, Apr. 1883, pp.31 – 41; Vol.30, No.131, Oct 1884, pp.369 – 377, pp.369 – 377.
- Mercier, Charles. 'The Nature of Insanity'. *JMS*, Vol.27, No.120, January 1882, pp.512 – 527.
- Mercier, Charles. 'The Statistical Tables'. *JMS*, Vol.50, No.211, Oct. 1904, pp.672 – 697.
- Mercier, Charles. 'The Study of Insanity' in the *JMS*, Vol.27, No.118, July 1881, pp.166 – 177.
- Mercier, Charles. 'What Insanity Is' in *Sanity and Insanity*, Scott, 1890, pp.97 – 139.
- Mercier, Charles. *A Text-Book of Insanity*, Macmillan, 1902.
- Monroe, Henry 'One Nomenclature of the Various Forms of Insanity' in *The Asylum Journal of Mental Science*, vol.2, No.17, April 1856, pp.286 – 305.
- Mott, Frederick W. 'The Genetic Origin of Dementia Praecox'. *JMS*, Vol.68, No.283, Oct. 1922, pp.333 – 347.
- Nicolson, David. *Reports Upon Broadmoor Criminal Lunatic Asylum with Statistical Tables for the year 1889*, HMSO, 1890.
- Pearson, Karl. 'On the Inheritance of Insanity'. *BMJ*, May 7th 1905, pp. 1175 – 1176.
- Penrose, Lionel, S. 'Social Aspects of Psychiatry: The Importance of Statistics', *JMS*, Vol.9, No.389, Oct. 1946, pp.713 – 718.
- Penrose, Lionel, S. Correspondence to R. Tomsett, the Board of Control. Mr Corbett's proposals for revising the Index Cards. Diagnostic Lists, Carlos Paton Blacker, Collected Papers
- Penrose Lionel, S. 'Correspondence', 25th September 1953. MH 99/34 held by the National Archives, Kew Gardens.
- Pilkington, Francis. 'Review: W.H.O. and Mental Health 1949–1961. W.H.O. Geneva 1962'. *JMS*, Vol.109, No.458, Jan. 1963, p.154.
- Pinel, Phillippe *Nosographie philosophique ou La méthode de l'analyse appliquée à la médecine*, Paris, 1797.
- Pinel, Phillipe. *Traité médico-philosophique sur l'aliénation mentale*, Chez J. Ant. Brosson, 1800.
- Prichard, J.C. *A Treatise on Insanity and Other Disorders Affecting the Mind*, Sherwood, Gilbert, and Piper, 1835.
- Rayner, Henry. 'Classification of Insanity'. *JMS*, Vol. 32, No.138, July 1886.
- Rayner, Henry. 'The Classification of Insane States in Revised Statistical Tables'. *JMS*, Vol.51, No.212, Jan. 1905, pp.140 – 143.



- Rees, John Rawlings. *The Shaping of Psychiatry by War*. Chapman and Hall, 1945.
- Reeve, Henry. 'Phillippe Pinel, "Traité Medico-Philosophique sur l'Aliénation Mentale ou la Manie"'. *The Edinburgh Review*, Vol.2, April – July 1803, pp.160 – 172.
- Reich, Wilhelm. *The Mass Psychology of Fascism: translated from the German Manuscript*. trans. Mary Boyd Higgins, Orgone Institute Press, 1946.
- Revington, G.T. 'The Neuropathic Diathesis, or the Diathesis of the Degenerate'. *JMS*, Vol. 34, No.146, July 1888, pp.167 – 176.
- Richard Robert Leeper, 'Some Reflections on the Progress of Psychiatry: The Presidential Address at the Ninetieth Annual Meeting of the Royal Medico-Psychological Association Held in Dublin'. *JMS*, Vol.77, No.319, Oct. 1931, pp.683 – 691.
- Robertson, George. 'Obituary: Alexander Reid Urquhart'. *JMS*, Vol.63, No.263, Oct. 1917, pp.629 – 631.
- Robertson, William Ford. 'Chronic Bacterial Infections in Dementia Praecox', lecture and responses recorded in Minutes from The Medico-Psychological Association of Great Britain and Ireland: Eightieth Annual General Meeting of the Association. *JMS*, Vol.67, No.279, Oct 1921 pp.511–556. (pp.543 – 546)
- Robinson, Lockhart C. 'Suggestions Towards an Uniform System of Asylum Statistics (with Tabular Forms)' *JMS*, Vol. 7, No.36, January 1861, pp.195 – 211.
- Rowson, Lionel A. 'Classification of Psychological Disorders' in *BMJ*, November 9<sup>th</sup>, 1946, p.709.
- Sands, Dalton, E. 'Treatment of Psychiatric Patients in General Hospitals: A Social Experiment' in *BMJ*, May 22<sup>nd</sup>, pp.628 – 630.
- Sands, Dalton, E. 'Classification of Psychological Disorders'. *BMJ*, November 23<sup>rd</sup>, 194, pp. 793 – 794.
- Sands, Dalton, E. 'Electro-convulsion Therapy in 301 Patients in a General Hospital: With Reference to Selection of Cases and Response to Treatment'. *BMJ*, August 31<sup>st</sup>, 1946, pp.289 – 293.
- Sargant, W. 'Physical Treatment of Acute War Neurosis: Some Clinical Observations'. *BMJ*, November 14<sup>th</sup>, 1942, p.574 – 576.
- Skae, David, et. al. 'Report of the Committee Appointed at a Meeting of Member of the Medico-Psychological Association, Held at the College of Physicians, Edinburgh, on 25th November, 1869, for the Purpose of Taking Certain Questions Relating to the Uniform Recording of Cases of Insanity and to Medical Treatment of Insanity into Consideration'. *JMS*, Vol.16, No.74, July 1870, pp.223 – 232.
- Skae, David. 'A Rational and Practical Classification of Insanity'. *JMS*, Vol.9, No.47, Oct. 1863, pp.309 – 319.
- Skae, David. *Of the classification of the various forms of insanity on a rational and practical basis: being an address delivered at the Royal College of Physicians, London, at the annual meeting of the Association of Medical Officers of Asylums on 9th July, 1863*, Royal College of Physicians, 1863.
- Smith, Percy. 'Adjourned Annual Meeting of 1904'. *JMS*, Vol.51, No.215, Oct. 1905, pp.733 – 772.
- Smith, Percy. 'The International Committee for the Study of the Causes and Prophylaxis of Mental Disease'. *JMS*, Vol.56, No. 234, 1910, pp.389–405.

- Sutton, S.W. 'Letters, Notes, Etc.: Coined Medical Words'. *BMJ*, July 5<sup>th</sup>, 1941, p.38.
- Sykes, Lieut.-Col. 'Statistics of the Metropolitan Commission in Lunacy'. *Journal of the Statistical Society of London*, Vol.3, No.2, July, 1840, pp.143 – 160.
- Symonds, C. P. 'The Human Response to Flying Stress'. *BMJ*, December 4<sup>th</sup>, 1943, p.703 – 706.
- Symonds, C. P. 'Correspondence: Classification of Psychological Disorders'. *BMJ*, September, 1946, p.436.
- Thompson, D.G. 'The Prognosis in Insanity'. *JMS*, Vol. 29, No.126, July 1883, pp.188 – 205.
- Thomson, Courtauld. 'Correspondence: A National Council for Mental Hygiene'. *BMJ*, April 1<sup>st</sup> 1922, 1(3196): 538
- Thurnam, John. *Observations and Essays in the Statistics of Insanity: Including an Inquiry into the Causes Influencing the Results of Treatment in Establishments for the Insane; To Which are Added the Statistics of the Retreat, Near York*, Simpkin Marshall, 1845, pp.39 – 40.
- John Turner, 'The Classification of Insanity'. *JMS*, Vol.58, No.40, January 1912, pp.9 – 25.
- Urquhart, A.R. 'Nomenclature of Mental Diseases'. *JMS*, Vol.49, No.205, Apr. 1903, pp.236 – 245.
- Webster, John. 'Statistics of Bethlem Hospital with Remarks on Insanity' in *Medico-chirurgical Transactions*. Vol.26: 1843, p.374–416.
- West, Ranyard. 'Correspondence: War Neurosis: The "Awareness" of Fear'. *BMJ*, March 21<sup>st</sup>, 1942, p.395.
- Wood, T. Outterson. 'The Early History of the Medico-Psychological Association'. *JMS* Vol.42, No.177, 1896. pp.241 – 260.

## Addresses and Lectures

- Armstrong Jones, Robert. 'Medico-Psychological Association of Great Britain and Ireland: Presidential Address on the Evolution of Insanity, delivered July 26<sup>th</sup>, 1906'. *JMS*, Vol.51, No.215, Oct. 1905, pp.629 – 661.
- Leeper, Richard Robert. 'Some Reflections on the Progress of Psychiatry: The Presidential Address at the Ninetieth Annual Meeting of the Royal Medico-Psychological Association Held in Dublin. the *JMS*, Vol.77, No.319, Oct. 1931, pp.683 – 691.
- Urquhart, A.R. 'The Morison Lectures on Insanity, with Special Reference to Heredity and Prognosis. *JMS*, Vol.52, No.217, April 1907, pp.233 – 321.
- Urquhart, A.R. 'The Presidential Address delivered at the Fifty-Seventh Annual Meeting of the Medico-Psychological Association, held at the Royal College of Physicians, Edinburgh, on the 21<sup>st</sup> July, 1898. *JMS*, Vol.44, No.187, Oct. 1898, pp.673 – 693.
- Worth, R., 1935. Four Decades of Psychiatry: The Presidential Address at the Ninety-Fourth Annual Meeting of the Royal Medico-Psychological Association, held in the Middlesex Guildhall, Westminster, July 3, 1935. *JMS*, Vol.81, No.335, pp.755–765.

## Laws and Acts of Parliament

1845 County Asylums Act

1845 Lunacy Act  
1866 Idiots Act  
1890 Lunacy Act  
1913 Mental Deficiency Act  
1930 Mental Treatment Act  
1948 National Health Service Act

## Obituaries

- 'Obituary: Henry Sutherland'. *JMS*, Vol. 48, No.200, January 1902, (pp.208 – 209)
  - 'Obituary: Herbert Francis Hayes Newington'. *JMS*, Vol. 63, No.263, Oct. 1917, (pp.461 – 467).
  - 'Obituary: John Sibbald'. *JMS*, July 1905, Vol.51, No.214, pp.636 – 637.
  - 'Obituary: William Chapman Begley'. *JMS*, Vol. 33, No.142, July 1887, (pp.337 – 339).
  - 'Obituary: William Henry Parsey'. *JMS*, Vol. 30, No.129, April 1884, (pp.166 – 167).
  - 'The Late C.A. Mercier'. *JMS*, Vol.67, No.276, Jan. 1921, p.146.
- Donkin, H. Bryan. 'Obituary: Charles Arthur Mercier'. *JMS*, Vol. 66, No. 272, Jan. 1920, pp.1 – 10.

## Secondary Sources

- Ackerknecht, Erwin. 'Anticontagionism between 1821 and 1867'. *Bulletin for the History of Medicine*, 1948, Vol.22, pp.562 – 593.
- Andreasen, N.C. 'Linking Mind and Brain in the Study of Mental Illnesses: A Project for a Scientific Psychopathology'. *Science*, Vol.275, No.5306, pp.1586 – 1593.
- Andrew Scull, *Madhouse: A Tragic Tale of Megalomania and Modern Medicine*, Yale University Press, 2005.
- Andrews J. and Digby A. eds. *Perspectives on Class and Gender in the History of British and Irish Psychiatry*, Rodopi, 2004, pp.149 – 171.
- Angel, Katherine., Edgar Jones, and Neve, M. *European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital, and the Rockefeller Foundation in the 1930s*. Wellcome Centre for the History of Medicine, 2003.
- Ankeny, R.A. 'The Overlooked Role of asses in Causal Attribution in Medicine'. *Philosophy of Science*, Vol.81, No.5, Dec. 2014, pp. 999 – 1001.
- Augstein, H.F. *James Cowles Prichard's Anthropology: Remaking the Science of Man in Early Nineteenth Century Britain*, Clio Medica, Vol.52, 2016.
- Augstein, H.F. 'JC Prichard's Concept of Moral Insanity – A Medical Theory of the Corruption of Human Nature'. *Medical History*, Vol. 40, 1996, pp.311 – 343.
- Barfoot, M. 'David Skae: Resident Asylum Physician; Scientific General Practitioner of Insanity', in *Medical History*, No.53, 2009, pp.469 – 488.

- Barfoot, M. "‘To ask the Suffrages of the Patrons’: Thomas Laycock and the Edinburgh Chair of Medicine". *Medical History*, Supplement No. 15, pp.1 – 226.
- Bartlett Peter, and Wright David eds. *Outside the Walls of the Asylum: the History of Care in the Community 1750 – 2000*, Athlone Press, 1999.
- Bartlett, Peter. The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England (with special Emphasis on Leicestershire and Rutland), PhD Thesis, UCL, 1993.
- Bashford, Allison. "Global Biopolitics and the History of World Health." *History of the Human Sciences* Vol.19, No.1, 2006, 67–88.
- Bashford, Alison. *Global Population: History, Geopolitics, and Life on Earth*. Columbia University Press, 2014.
- Beer, D. Berrios, G. 'The Notion of Unitary Psychosis: A Conceptual History'. *History of Psychiatry*. Vol. 5, 1994, pp.13 – 36.
- Bentall, Richard P. *Madness Explained: Psychosis and Human Nature*. Penguin, 2003.
- Berrios, German. '19th Century Melancholia and Depression'. *British Journal of Psychiatry*, Vol.153, No.3, pp.298 – 304.
- Berrios, German. 'Dementia During the Seventeenth and Eighteenth Century'. *Psychological Medicine*, Vol.7, No.4, Nov. 1987, pp.829 – 837.
- Berrios, German. 'Early Electroconvulsive Therapy in Britain, France and Germany: A Conceptual History', in Berrios & Freeman eds., *150 years of British psychiatry. Vol. 2, The Aftermath*, Athlone, 1996, pp. 3-15.
- Berrios, German. 'Introduction to J.C. Prichard and the Concept of 'Moral Insanity''. *History of Psychiatry*, No.10, 1999, pp.111 – 126.
- Berrios, German. *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century*, Cambridge University Press, 1996.
- Berrios, German, and Roy Porter. *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders*. Athlone, 1995.
- Berrios, G. and Freeman H. eds. *150 Years of British Psychiatry: 1841 – 1991*, Gaskell, 1991.
- Berrios, German. 'Alzheimer's Disease: A Conceptual History.' *International Journal of Geriatric Psychiatry* 5.6 (1990): 355–365. Web.
- Beveridge, Allan. 'Thomas Clouston and the Edinburgh School of Psychiatry'. G.E. Berrios and Hugh Freeman eds., *150 Years of British Psychiatry 1841 – 1991*, Gaskell, 1991, pp.359 – 388.
- Beveridge A.W. & Renvoize, E.B. 'Electricity: A History of its use in the Treatment of Mental Illness in Britain during the Second half of the 19th Century', *British Journal of Psychiatry*., Vol.153, Jan. 1988, pp. 157-162.
- Bewley, Thomas. *From Madness to Mental Disorder. A History of the Royal College of Psychiatrists*, RCPsych Publications, 2008.
- Black, K. 'Psychiatry and the Medical Model'. Rubin, E. & Zorumski C. eds., *Adult Psychiatry*, 2nd edition, Blackwell, 2005 pp.3 – 15.
- Blashfield, Roger K. *The Classification of Psychopathology*. Springer US, 1984.

- Bolton, Derek, and Hill, J. *Mind, Meaning and Mental Disorder*. Oxford University Press, 2004.
- Boorse, Christopher. "Health as a Theoretical Concept." *Philosophy of Science* 44.4 (1977): 542–573. Web. 15 July 2016.
- Bowden P. & Chetwynd, R.V. 'Pioneers in forensic psychiatry. Charles Arthur Mercier (1852–1919): Wit without understanding'. *Journal of Forensic Psychiatry*, Vol.5, No.2, 1994, pp.321 – 353.
- Borowry, Iris. *Coming to Terms with World Health: The League of Nations Health Organisation 1921-1946*, Peter Lang, 2009.
- Broughton, Trev Lynn. 'Henry Reeve (1813 – 1895), translator and magazine editor'. *Oxford Dictionary of National Biography*, January 3<sup>rd</sup>, 2008.
- Burnham, John C. 'Transnational History of Medicine after 1950: Framing and Interrogation from Psychiatric Journals'. *Medical History*, Vol.55, No.1, pp.3 – 26.
- Busfield, J. 'The Female Malady? Men, Women and Madness in Nineteenth Century Britain'. *Medical Sociology*, Vol.28, No.1, Feb 1994, pp.259 – 277.
- Busfield, J. *Men, Women and Madness: Understanding Gender and Mental Disorder*. Macmillan, 1996.
- Bynum, W.F. Porter, R. Shepherd, M. *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. III: The Asylum and its Psychiatry*, Routledge, 1988.
- Bynum, W.F. 'Nosology'. *Companion Encyclopedia of the History of Medicine*. Bynum, W.F. and Porter, R. eds., pp. 335 – 355.
- Bynum, W.F. 'Tuke's *Dictionary* and psychiatry at the turn of the century'. *150 Years of British Psychiatry: 1841 – 1991*, Berrios and Freeman eds., Gaskell, 1991, pp.163 – 179.
- Bynum, W.F. 'Rationales for Therapy in British psychiatry 1780 – 1835'. *Medical History*, 18, 1974, pp.317 – 334.
- Canguilhem, George. *The Normal and the Pathological*, trans. Carolyn R. Fawcett, MIT Press, 1991.
- Carpenter, Peter K. 'Thomas Arnold: A Provincial Psychiatrist in Georgian Britain'. *Medical History*, 1989, Vol.33, pp.199 – 216.
- Casper, Stephen T. *The Neurologists: A History of a Medical Speciality in Modern Britain, c. 1789-2000*. Manchester University Press, 2014.
- Casper, Stephen T. and Jacyna, L. Stephen eds. *The Neurological Patient in History*. University of Rochester Press, 2012.
- Chamberlin, E. & Gilman, S. eds. *Degeneration: the dark side of progress*. Columbia University Press, 1985.
- Chaney, S. 'The Action of the Imagination: Daniel Hack-Tuke and Late Victorian Psycho-Therapeutics'. *History of the Human Sciences*, Vol.30, No. 2, pp.17 – 33.
- Cherry, Steven. *Mental Health Care in Modern England: The Norfolk Lunatic Asylum, St Andrew's Hospital, 1810-1998*. Boydell P., 2003.
- Clark, M.J. "'Morbid Introspection", unsoundness of mind, and British psychological Medicine c.1830 – 1900'. *The Anatomy of Madness: Essays in the History of Psychiatry: Vol.3, The Asylum and its Psychiatry*, Bynum, Porter and Shepherd eds., Tavistock, 1988, pp.71 – 101.

- Clarke, M.J. 'The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth Century British Psychiatry'. Andrew Scull ed., *Mad Houses, Mad Doctors and Madmen: The Social History of Psychiatry in the Victorian Era*, Athlone: 1981.
- Clifford Rose, F. 'William Cullen'. *History of British Neurology*, Imperial College Press, 2011,
- Compton, Wilson M., and Guze, Samuel B. "The Neo-Kraepelinian Revolution in Psychiatric Diagnosis." *European Archives of Psychiatry and Clinical Neuroscience* Vol.245, No.4-5, 1995, 196–201.
- Conrad, Peter. *The Medicalization of Society : On the Transformation of Human Conditions into Treatable Disorders*. Johns Hopkins University Press, 2007.
- Cooper, Rachel. 'What is Wrong with the DSM?'. *History of Psychiatry*, Vol.15, No.1, Mar. 2004, pp.5 – 25.
- Cooper, Rachel. 'Why Hacking Is Wrong about Human Kinds.' *The British Journal for the Philosophy of Science* Vol.55, No.1, 2004, 73–85.
- Cooper, Rachel. 'Understanding the DSM-5: Stasis and Change'. *History of Psychiatry*, Vol.29, No.1, pp.49 – 65.
- Cooper, Rachel. "Disease." *Studies in History and Philosophy of Science Part C: Studies in History and Philosophy of Biological and Biomedical Sciences* Vol.33, No.2, 2002, 263–282.
- Cooper, Rachel. *Classifying Madness: A Philosophical Examination of the Diagnostic and Statistical Manual of Mental Disorders*, Springer, 2005.
- Cooter, Roger. 'Phrenology and British Alienists c.1825 – 1845: Part II: Doctrine and Practice', in *Medical History*, Vol.20 No.2, April 1976, pp.135 – 151
- Cooter, Roger., and Claudia. Stein. *Writing History in the Age of Biomedicine*. New Haven: Yale University Press, 2013.
- Copeland, J.R.M. 'Classification and the British Glossary of Mental Disorders'. *British Journal of Psychiatry*, Vol.119, No.551, Oct. 1971, pp.413 – 418.
- Hazel Croft, 'Rethinking Civilian Neurosis in the Second World War', in Peter Leese and Jason Couthamel eds, *Traumatic Memories of the Second World War*, pp.95 – 117
- Crossley, D. 'The introduction of leucotomy: A British case history'. *History of Psychiatry*, Vol.4, 1993, pp. 553-564;
- Crowther, M. "From Workhouse to NHS Hospital in Britain 1929 - 1948." *The Poor Law and After*. Ed. Hillam and Bone. Liverpool: Liverpool Medical History Society, 1999. 38 – 49.
- Crowther, M. *Social Policy in Britain 1914-1939*. Macmillan Education, 1988.
- Crowther, M., 1999. From Workhouse to NHS Hospital in Britain 1929 - 1948. In Hillam & Bone, eds. *The Poor Law and After*. Liverpool: Liverpool Medical History Society, pp. 38 – 49.
- Crowther, M.A. *The Workhouse System 1834–1929: The History of an English Social Institution*, Methuen, 1983.
- Cunningham, Andrew. 'Identifying Disease in the Past: Cutting the Gordian Knot'. *Asclepio*, vol.54, 2002 pp.13 – 34.
- Daston, Lorraine. *The Empire of Chance: How Probability Changed Science and Everyday Life*. Cambridge University Press, 1989.

- Daston, Lorraine and Galison, Peter. *Objectivity*. Zone Books, 2007.
- Dawson, W.R. 'Notes on Two Cases illustrating the Difference between Katatonia and Melancholia Attonita'. *JMS*, Vol.49 No.207, 1903, pp.686 – 689.
- Decker, H. S. 'How Kraepelinian Was Kraepelin? How Kraepelinian Are the Neo-Kraepelinians? From Emil Kraepelin to DSM-III.' *History of Psychiatry* Vol.18, No.3, 2007, pp.337 – 360.
- Demazeux, Steeves. 'The Ideal of Scientific Progress and the DSM'. Steeves Demazeux and Patrick Singy eds., *The DSM-5 in Perspective: Philosophical Reflections on the Psychiatric Babel*, Springer, 2015. 3–24.
- Desrosières, Alain, *The Politics of Large Numbers: A History of Statistical Reasoning*, Harvard University Press, 1998.
- Dicks, H.V. *Fifty Years of the Tavistock Clinic*. Routledge & Kegan Paul, 1970.
- Digby, Anne, "The Changing Profile of a Nineteenth-Century Asylum: The York Retreat", *Psychological Medicine*, 14:4 (1984): 739-748.
- Digby, Anne, *Madness, Morality, and Medicine: A Study of the York Retreat, 1796- 1914*, Cambridge University Press, 1985.
- Dixon, Thomas, 'Patients and Passions: Languages of Medicine and Emotion, 1789- 1850', in *Medicine, Emotion, and Disease, 1700-1950*, ed. Fay Bound Alberti. Palgrave Macmillan, 2006.
- Dixon, Thomas. *From Passions to Emotions: The Creation of a Secular Physiological Category*, Cambridge University Press, 2003.
- Doroslow, D.B. 'Performing a Cure for Schizophrenia" Insulin Coma Therapy on the Wards', *Journal of the History of Medicine and Allied Sciences*, Vol.62, 2007, pp. 213-243.
- Dowbiggin, 'Delusional diagnosis? The History of Paranoia as a Disease Concept in the Modern Era'. *History of Psychiatry*, Vol.9, 2000, pp.37 – 69.
- Dyde, Sean. 'Cullen, a Cautionary Tale'. *Medical History*, Vol.59 No.2, 2015, pp.222 – 240.
- Eghigian, G. 'A Drifting Concept for an Unruly Menace: A History of Psychopathy in Germany'. *ISIS*, No.2, vol. 106, 2015, pp.283 – 309.
- Eghigian G. ed. *The Routledge History of Madness and Mental Health*. Routledge, 2017.
- Eldergill, Anselm. *Mental Health Review Tribunals: Law and Practice*. London: Sweet and Maxwell, 1998.
- Ellis, Robert, "The Asylum, the Poor law, and a Reassessment of the Four-Shilling Grant: Admissions to the County Asylums of Yorkshire in the Nineteenth Century". *Social History of Medicine*, Vol.19, No.1, 2006, pp.55 – 71.
- Engstrom, Eric J. *Clinical Psychiatry in Imperial Germany*. Cornell University Press, 2003.
- Engstrom, Eric J. 'Emil Kraepelin: Psychiatry and Public Affairs in Wilhelmine Germany'. *History of Psychiatry* Vol.2, No.6, 1991, pp.111 – 32.
- Engstrom, Eric J. "'On the Question of Degeneration" by Emil Kraepelin (1908)'. *History of Psychiatry* Vol.18, No.3, 2007, pp.389 – 98.
- Ewan, John H. *A Handbook of Psychiatry*. William Wood and Company, 1934.

- Fink, Max, and Taylor, Michael A. *Endocrine Psychiatry: Solving the Riddle of Melancholia*. Oxford University Press, 2010.
- Finn, Michael Anthony. *The West Riding Lunatic Asylum and the Making of the Modern Brain Sciences in the Nineteenth Century*, PhD Thesis, University of Leeds, 2012.
- Fleck, Ludwik. *Genesis and Development of a Scientific Fact*, trans. Fred Bradley, Robert K. Merton and Thaddeus J. Trenn, University of Chicago Press, 2008.
- Foucault, Michel. *Discipline and Punish: The Birth of the Prison*. Penguin, 1991.
- Foucault, Michel. *Madness and Civilisation: A History of Insanity in the Age of Reason*, trans. Richard Howard, Routledge, 1989.
- Foucault, Michel. *The Order of Things: An Archaeology of the Human Sciences*. trans. Alan Sheridan, Routledge, 2002.
- Foucault, Michel. *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A.M. Sheridan, Routledge, 1989.
- Freis, David. *Psycho-Politics Between the World Wars: Psychiatry and Society in Germany, Austria, and Switzerland*. Palgrave, 2019.
- Gadamer, Hans-Georg. *Truth and Method*. trans. Joel Weinshamer and Donald G. Marshall. London: Bloomsbury, 2013.
- Gaukroger, Stephen. *The Collapse of Mechanism and the Rise of Sensibility: Science and the Shaping of Modernity, 1680 – 1760*. Oxford University Press, 2010.
- Gaukroger, Stephen. *The Natural and the Human: Science and the Shaping of Modernity, 1739 – 1841*. Oxford University Press, 2016.
- Goffman, Erving. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Penguin, 1991.
- Goldstein, Jan. *Console and Classify: the French psychiatric profession in the nineteenth century*. Cambridge University Press, 1988.
- Graham Richards. "Psychology and the Churches in Britain 1919-39: Symptoms of Conversion." *History of the Human Sciences* Vol.13, No.2, 2000, pp.57 – 84.
- Greenberg, Gary. *The Book of Woe: The DSM and the Unmaking of Psychiatry*, Scribner, 2013.
- Grob, Gerald N. 'Review: *Madness to Mental Illness: A History of the Royal College of Psychiatrists*', in *Journal of the History of Medicine and Allied Sciences*, Vol. 67, No.3, July 2012, pp.509 – 510.
- Guthrie, Douglas. *The Medical School of Edinburgh*, Oliver and Boyd, 1964.
- Hacking, Ian. 'Lost in the Forest: A Review of the DSM-5'. *LRB*, Vol.35 No.15, 8<sup>th</sup> August, 2013, pp.7 – 8.
- Hacking, Ian. *Historical Ontology*. Harvard University Press, 2002.
- Hacking, Ian. *Mad Travelers: Reflections on the Reality of Transient Mental Illnesses*, Harvard University Press, 2002.
- Hacking, Ian. *Rewriting the Soul: Multiple Personality and the Sciences of Memory*, Harvard University Press, 1998.
- Hacking, Ian. *The Taming of Chance*, Palgrave, 1990.
- Hare, E. 'Was Insanity on the Increase?'. *BJP*, Vol.142, No.5, May 1983, pp.439 – 455.



- Hayward, Rhodri. 'Germany and the Making of 'English' Psychiatry: The Maudsley Hospital 1908 – 1939 in Volker Roelcke, Paul J. Weindling and Louise Westwood eds., *International Relations in Psychiatry: Britain, Germany and the United States to World War II*, University of Rochester Press, 2013, pp.67 – 90.
- Hayward, Rhodri. *The Transformation of the Psyche in British Primary Care 1880 – 1970*, Bloomsbury, 2014.
- Hecker, E. cited in Kendler, K. and Engstrom, E. 'Kahlbaum, Hecker, and Kraepelin and the Transition From Psychiatry Symptom Complexes to Empirical Disease Forms'. *American Journal of Psychiatry*, 1st February 2017, Vol.174, No.2, pp.102 – 109.
- Healy, David. *Mania: A Short History of Bipolar Disorder*, John Hopkins University Press, 2008.
- Heidberger, Michael. 'Naturphilosophie'. *The Routledge Dictionary of Philosophy*, Taylor and Francis, 1998.
- Henderson, David Kennedy. *The Evolution of Psychiatry in Scotland*, E. & S. Livingstone, 1964.
- Herring, Emily. "Great is Darwin and Bergson his poet": Julian Huxley's other evolutionary synthesis'. *Annals of Science*. Vol.75, No.1, 2008, pp. 40 – 54.
- Hess, Volker. Mendelsohn, Andrew J. 'Case and Series: Medical Knowledge and Paper Technology, 1600 – 1900', in *History of Science*, Vol.48, No.3, 2010, pp.287 – 314.
- Hide, Louise. 'In Plain Sight: Open Doors, Mixed-sex Wards and Sexual Abuse in English Psychiatric Hospitals, 1950s—Early 1990s'. *Social History of Medicine*, Vol. 31, No. 4, Nov. 2018, pp.732 – 753.
- Hill, S.A. 'Mania, Dementia and Melancholia in the 1870s: Admissions to a Cornwall Asylum'. *Journal of the Royal Society of Medicine*, July 2003, Vol.96, No.7, pp.361 – 363.
- Hirschmüller, Albrecht. "The Development of Psychiatry and Neurology in the Nineteenth Century", trans. Magda Whitrow, *History of Psychiatry*, 10 (1999): 395- 423.
- Hoenig, J. 'Schizophrenia'. Berrios and Porter eds., *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders*, Routledge, 1995, pp.336 – 348.
- Hoff, P. 'Kraepelin'. Berrios and Porter eds., *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders*, Routledge, 1995, pp.261 – 279.
- Honigsbaum, Frank. *Health, Happiness and Security*. London: Routledge, 1989.
- Huertas, R. 'Esquirol: Between Doctrine and Clinical Practice'. *History of Psychiatry*, Vol.19, No.2, 2008, pp.123 – 140.
- Hunter, Richard, McAlpine, Ida. *Three Hundred Years of Psychiatry 1535 – 1860: A History Presented in Selected English Texts*, LLC, 2013.
- Irving, Allen. *Brock Chisholm: Doctor to the World*. Fitzhenry & Whiteside, 1998.
- Jablensky, Assen. 'Living in a Kraepelinian World: Kraepelin's Impact on Modern Psychiatry'. *History of Psychiatry*, Vol.18, No.3, 2007, pp.381 –88.
- Jackson, Mark. *The Borderland of Imbecility: Medicine, Society and the Fabrication of the Feeble Mind in Late Victorian England*. Manchester University Press, 2000,
- Jacyna L.S. 'Somatic Theories of Mind and the Interests of Medicine in Britain, 1850-1879'. *Medical History*. Vol.26, No.233–258.

- Jacyna, L.S. 'Scientific Naturalism in Victorian Britain: an Essay in the Social History of Ideas', Unpublished Ph.D. Thesis, University of Edinburgh, 1980.
- Jacyna, L.S. 'The Physiology of Mind, the Unity of Nature, and the Moral Order in Victorian Thought'. *British Journal for the History of Science*, Vol.14, 1981, pp.109-132.
- Jansson, Åsa. "From Statistics to Diagnostics: Medical Certificates, Melancholia, and 'Suicidal Propensities'. Victorian Psychiatry", *Journal of Social History*, 46:3 (2013): 716-731.
- Jansson, Åsa, "Mood Disorders and the Brain: Depression, Melancholia, and the
- Jansson, Åsa. 'From Statistics to Diagnostics: Medical Certificates, Melancholia, and "Suicidal Propensities" in Victorian Psychiatry', in *Journal of Social History*, Vol.43, No.3, Spring 2013, pp.716 – 731.
- Jenner, F.A. 'Erwin Stengel: A Personal Memoir' in G. Berrios and H. Freeman eds. *150 Years of British Psychiatry: 1841 – 1991*, Gaskell, 1991.
- Jones, Kevin Matthew. 'The disappearance of "Medical Psychology" and the controversy over the Medical Section during the early 1950s'. *History and Philosophy of Psychology*, Vol.19, No.1, 2018.
- Jones, Kevin Matthew. 'Mental Illness on the Home Front: The Emergency Medical Services and Psychiatric Social Work During World War Two' (forthcoming).
- Jones, David. *Disordered Personalities and Crime: An analysis of the history of moral insanity*, Routledge, 2016.
- Jones, Edgar. 'An Atmosphere of Cure: Frederick Mott, Shell Shock and the Maudsley', *History of Psychology*, vol.25, 2014, pp.412 – 421 (p.415)
- Jones, Edgar. 2012. "The gut war": Functional somatic disorders in the UK During the Second World War. *History of the Human Sciences*, Vol.25, No.5, pp.30–48.
- Jones, Kathleen. *Asylums and after : a revised history of the mental health services : from the early 18th century to the 1990s*, Athlone Press, 1993.
- Jones, Kathleen. *Mental Health and Social Policy, 1845 – 1959*, Routledge, 1960.
- Jones, Kathleen. 'Law and Mental Health: Sticks or Carrots'. Berrios and Freeman eds. *150 Years of British Psychiatry*, Gaskell, 1991, pp.89 – 102.
- Kaufmann, Doris. 'Science as Cultural Practice: Psychiatry in the First World War and Weimar Germany'. *Journal of Contemporary History* Vol.34, No.1, 1999, pp.125 – 44.
- Kendell R.E. et al., 'Diagnostic Criteria of American and British Psychiatrists'. *Archives of General Psychiatry*, Vol.5, No., 1971, pp.123 – 130.
- Kendler, K. 'David Skae and his nineteenth century etiologic psychiatric diagnostic system: looking forward by looking back'. *Molecular Psychiatry*, Vol.22, pp.802 – 807.
- Kendig, Catherine ed. *Natural Kinds and Classification in Scientific Practice*. Routledge, 2016.
- Kevles, David. *In the Name of Eugenics: Genetics and the Uses of Human Heredity*. University of California Press, 1995.
- Kiprijanov, Konstantin S., 'Printing Lines and Letters: How Structural Formulae Became the Standard Notation of Organic Chemistry', doctoral thesis, University of Leeds, 2018.
- Klein, R. *The New Politics of the NHS: From Creation to Reinvention*, 3rd ed., Longman, 1995.

- Koselleck, Reinhart. *The Practice of Conceptual History: Timing History, Spacing Concepts*. trans. Todd Samuel Presner et al. Stanford University, 2002.
- Kuhn, Thomas S. *The Structure of Scientific Revolutions: 50<sup>th</sup> Anniversary Edition*, The University of Chicago Press, 2012.
- Kutchins, Herb. Kirk, Stuart A. *Making us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders*. Free Press, 1997.
- Laing, R.D. Easterton A. *Sanity, Madness and the Family: Families of Schizophrenics*, (Penguin, 1964).
- Lawlor, Clark. *From Melancholia to Prozac: A History of Depression*, Oxford University Press, 2012.
- Leff, Alex. 'Clean Round the Bend – the Etymology of Jargon and Slang Terms for Madness'. *History of Psychiatry*, Vol.9, 2000, pp.155 – 162.
- Leigh, Denis. 'James Cowles Prichard'. *Proceedings of the Royal Society of Medicine: Section of Psychiatry with Section of the History of Medicine*, 1955, pp.586 – 590.
- Leonhard, Perris C, 'Cycloid Psychosis: Clinical Section'. Berrios and Porter eds., *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders*, Routledge, 1995, pp.421 – 430.
- Lewis, Aubrey. 'British Psychiatry in the First Half of the Nineteenth Century: Philippe Pinel and the English'. *Proceedings of the Royal Society of Medicine*, Vol.48, February 1955, pp.581–586. (p.582).
- Linden, S. and Jones, E. 'German Battle Casualties: The Treatment of Functional Somatic Disorders during World War 1'. *Journal of the History of Medicine*, Vol.68, No.4, October 2013, pp.627 – 58.
- Lock, Margaret. 'DSM III as a Culture-bound Construct: Commentary on Culture-bound Syndromes and International Disease Classifications' in *Culture, Medicine and Society*, Vol.11, 1987, pp.35 – 42.
- Lovie, A.D. 'Three Steps to Heaven: How the British Psychological Society Found its Place in the Sun', in *Psychology in Britain: Historical Essays and Personal Reflections* G.C. Bunn, A.D. Lovie, & G.D. Richards ed., BPS Books, 2004.
- Löwy, Ilana. 'Labelled Bodies: Classification of Disease and the Medical Way of Knowing'. *History of Science*, Vol.49, No.3, 2011, pp.299 – 315.
- Lum, G. 'Making Sense of Knowing-How and Knowing-That'. *Education and Expertise*, Christopher Winch and Mark Addis eds., Wiley, 2008, pp.117 – 137.
- Mack, AH et al., 'A Brief History of Psychiatric Classification: From the Ancients to DSM-IV'. *Psychiatric Clinics of North America*, Vol.17, No.3, September 1994, pp. 515 – 523.
- Mackenzie, C. *A Family Asylum: A History of the Private Madhouse at Ticehurst in Sussex, 1792 – 1917*, PhD thesis, UCL, 1986.
- Magnello, Eileen and Hardy, Ann. eds., *The Road to Medical Statistics*, Rodopi, 2002.
- Marland, Hilary. 'Destined to be a perfect recovery': the confinement of puerperal insanity in the nineteenth century'. Melling and Forsythe eds., *Insanity, Institutions and Society, 1800 – 1914: A Social History of Madness in Comparative Perspective*, Routledge, 1999. pp.137 – 156.
- Marland, Hilary. *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain*. Palgrave, 2004.
- Marx, Otto. 'What is the History of Psychiatry?' *History of Psychiatry*, Vol.3, 1992, pp.279 – 292.

- McCandless, P. 'Liberty and lunacy: the Victorians and wrongful confinement'. Andrew Scull ed., *Madhouses, Mad-doctors, and Madmen*, 339 – 362.
- Melling, Joseph, and Forsythe, Bill. *The Politics of Madness: the State, Insanity and Society in England, 1845 – 1914*, Routledge, 2006.
- Mellettt, D.J. 'Bureaucracy and Mental Illness: The Commissioners in Lunacy 1845 – 1890'. *Medical History*, Vol.21, pp.221 – 250.
- Micale, Mark S. 'On the 'Disappearance' of Hysteria: A Study in the Clinical Deconstruction of a Diagnosis'. *Isis*, Vol.84, No.3, 1993, pp.496 – 526.
- Micale, Mark S. 'The Ten Most Important Changes in Psychiatry Since World War II'. *History of Psychiatry*, Vol.25, No.4, 2014, pp.485 – 91.
- Micale, Mark S. 'Hysteria and its Historiography: the Future Perspective'. *History of Psychiatry*, Vol.1, 1990, pp.33 – 124.
- Micale, Mark S., and Paul Lerner, eds. *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870–1930*. Cambridge University Press, 2001.
- Michael, P. *Care and treatment of the mentally ill in North Wales, 1800-2000*. University of Wales Press, 2003.
- Millard, Chris. 'Concepts, Diagnosis and the History of Medicine: Historicising Ian Hacking and Munchausen Syndrome'. *Social History of Medicine*, Vol.30, No.3, August 2017, pp.567 – 589.
- Misbach J. and Stam, Henderikus J. 'Medicalizing Melancholia: Exploring Profiles of Psychiatric Professionalization'. *Journal of the History of the Human Sciences*, Vol.42, No. 1, pp.41 – 59.
- Mol, Annmarie. *The Body Multiple: Ontology in Medical Practice*. Duke University Press, 2002.
- Moncrieff, Joanna. *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment*, Palgrave Macmillan, 2007.
- Murphy, Elaine "The Administration of Insanity in England 1800 to 1870", in *The Confinement of the Insane: International Perspectives, 1800-1965*, eds. Roy Porter and David Wright. Cambridge University Press, 2003.
- Murphy, Terrence D. "Medical Knowledge and Statistical Methods in Early Nineteenth-Century France", *Medical History*, Vol.25, 1981, 301 – 319.
- Noll, Richard. *American Madness: The Rise and Fall of Dementia Praecox*. Harvard University Press, 2011.
- O'Neal, John C. 'Understanding and Interpreting Confusion: Philippe Pinel and the Invention of Psychiatry'. *Lumen*, No.26, 2007, pp.243 – 258.
- Pichot, Pierre. 'Nosological Models in Psychiatry', in *British Journal of Psychiatry*, Vol.164, No.2, February 1994, pp. 232 – 240.
- Pick, Daniel. *Faces of Degeneration: A European Disorder c.1848 – 1918*, Cambridge University Press, 1993.
- Pickersgill, Martyn. 'Debating DSM-5: Diagnosis and the Sociology of Critique' in *Journal of Medical Ethics*, 2014, No.40, pp.521 – 525.

- Pickersgill, Martyn. 'From Psyche to Soma? Changing Accounts of Antisocial Personality Disorders in the *American Journal of Psychiatry*'. *History of Psychiatry*, Vol.21, No.3, pp.294 – 311.
- Pickren, W. & Fowler, R. Professional Organisations'. Freidheim & Weiner, eds. *Handbook of Psychiatry, Volume 1: History of Psychiatry*. Hoboken: John Wiley & Sons, 2003, pp. 535 – 554.
- Pomata, G. 'The Medical Case Narrative: Distant Reading of an Epistemic Genre'. *Literature and Medicine*, Vol.32, No.1, 2014, pp. 1 – 23.
- Pons, J.H. & Berrios G. 'J.H. Pons on "Sympathetic Insanity": With an Introduction by G.E. Berrios'. *History of Psychiatry*, Vol.25, No.3, September 2014, pp.364 – 76.
- Porter, D. 'Public Health and Centralisation: the Victorian British State'. *Health, Civilisation and the State: A History of Public Health from Ancient to Modern Times*. pp.117 – 127.
- Porter, Roy. 'The Patient's View: Doing Medical History from Below'. *Theory and Society*, Vol.14, No.2, 1985, pp.175 – 98.
- Porter R. Jones C. eds. *Reassessing Foucault: Power Medicine and the Body*, Routledge, 1994.
- Porter, R. 'Psychiatry'. *The Greatest Benefit to Mankind*. Harper Collins, 1997.
- Porter, R., 1999. *The greatest benefit to mankind: a medical history of humanity from Antiquity to the present*, FontanaPress, 1999.
- Porter, R., *Mind-forg'd manacles : a history of madness in England from the Restoration to the Regency*, Penguin, 1990.
- Porter, T. *Genetics in the Madhouse: The Unknown History of Human Heredity*, Princeton University Press, 2018.
- Porter, T. *Trust in Numbers: The Pursuit of Objectivity in Science and Public Life*, Princeton University Press, 1995.
- Price, Elfed Huw. 'Do Brains Think? Comparative Anatomy and the End of the Great Chain of Being in 19th-century Britain'. *History of the Human Sciences*, Vol.25, No.3, pp.32 – 50.
- Quirk, Vivian. Gaudillière, Jean-Paul, 'The Era of Biomedicine: Science, Medicine, and Public Health in Britain and France after the Second World War'. *Medical History*, Vol.52, pp.441 – 452.
- Renwick, C. *Bread for All*, Palgrave, 2017.
- Richard Foulkes, 'William Terriss'. *Oxford Dictionary of National Biography*, Oxford University Press.
- Roelcke, Volker. 'Biologizing Social Facts: An Early 20th Century Debate on Kraepelin's Concepts of Culture, Neurasthenia, and Degeneration'. *Culture, Medicine, and Psychiatry*, Vol.21, No.4, 1997, pp.383 – 403.
- Rogers, A. & Pilgrim, D., 2001. *Mental health policy in Britain*, Basingstoke: Palgrave.
- Rose, Clifford F. 'William Cullen'. *History of British Neurology*, Imperial College Press, 2011, pp.67 – 68.
- Rose, N. *Governing the Soul: Shaping of the Private Self*, Free Association Books, 1999.

- Rosenberg, Charles E. 'The Tyranny of Diagnosis: Specific Entities and Individual Experience'. *the Milbank Quarterly*, Vol.80, No.2, June 2002, pp.237 – 260
- Rosenberg, Charles E. "Contested Boundaries: Psychiatry, Disease, and Diagnosis", *Perspectives in Biology and Medicine*, Vol.49, No.3, 2006, pp.407 – 424.
- Rosenberg, Charles E. *Explaining Epidemics and Other Studies in the History of Medicine*. Cambridge University Press, 1992.
- Rousseau, George S., 'Depression's Forgotten Genealogy: Notes towards a History of Depression', *History of Psychiatry*, Vol.11, 2000, pp.71 – 106.
- Sapolsky, Robert. *Behave: The Biology of Humans at Our Best and Worst*, Penguin, 2017.
- Saunders, J. 'Quarantining the weak-minded: psychiatric definitions of degeneracy and the late-Victorian asylum'. W.F. Bynum, R. Porter & M. Shepherd eds., *The Anatomy of Madness: Essays in the History of Psychiatry: Vol.3, The Asylum and its Psychiatry*, Tavistock, 1988, pp. 273 – 296.
- Scull, A. 'The Social History of Psychiatry in the Victorian Era'. Andrew Scull ed., *Madhouses, Mad-doctors and Madmen*, pp.5 – 33.
- Scull, A. 'Was Insanity Increasing? A Response to Edward Hare'. *BJP*, Vol.144, No.4, Apr. 1984, pp.432 – 436;
- Scull, A. 'The Rise of the Asylum'. *The Most Solitary of Afflictions: Madness and Society in Britain 1700 – 1900*, Yale University Press, 1993, pp.3 – 45.
- Scull, A. *Decarceration: Community Treatment and the Deviant: A Radical View*, Polity, 1984.
- Scull, A. 'The Social History of Psychiatry in the Victorian Era'. Andrew Scull ed., *Mad Houses, Mad Doctors and Madmen: The Social History of Psychiatry in the Victorian Era*, Athlone, 1981.
- Sellers, Laura Mary. *Managing Convicts, Understanding Criminals: Medicine and the Development of English Convict Prisons, c.1837 – 1886*, PhD thesis, University of Leeds, July 2017.
- Shepherd, Ben. "Pitiless psychology": the role of prevention in British military psychiatry in the Second World War'. *History of Psychiatry*, Vol.10, Oct. 1999, pp.491 – 524.
- Shepherd, Ben. *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century: 1914 – 1994*. Harvard University Press, 2000.
- Shepherd, Michael, "Psychiatric Journals and the Evolution of Psychological Medicine", *Psychological Medicine*, Vol.22, 1992, pp.15 – 25.
- Shorter, Edward. 'The History of Nosology and the Rise of the *Diagnostic and Statistical Manual of Mental Disorder*'. *Dialogues in Clinical Neuroscience*, Vol. 17, No.1, pp. 59 – 67.
- Shorter, Edward. *A History of Psychiatry: From the Age of the Asylum to the Age of Prozac*, Wiley and Sons, 1997.
- Showalter, E. *The Female Malady: Women, Madness and English Culture, 1830 – 1980*, Virago, 1987.
- Smith, Roger, "The History of Psychological Categories", *Studies in History and Philosophy of Biological and Biomedical Sciences*, Vol. 36, 2004, p.55 – 95.
- Smith, Roger, *Between Mind and Nature: A History of Psychology*, Reaktion Books, 2013.

- Smith, Roger. 'The Boundary Between Insanity and Criminal Responsibility in Nineteenth-Century England' in Andrew Scull ed., *Mad Houses, Mad Doctors and Madmen: The Social History of Psychiatry in the Victorian Era*, Athlone, 1981, pp.363 – 377.
- Smith, Roger. 'Legal Frameworks for Psychiatry'. Berrios and Freeman eds. *150 Years of British Psychiatry*, Gaskell, 1991, pp.137 – 151.
- Star, S.L. *Regions of the Mind: Brain Research and the Quest for Scientific Certainty*, Stanford University Press, 1989.
- Stein, Dan J, Phillips, Katharine A., Bolton, Derek, Fulford, K.W.M., Sadler John Z., and Kendler, K. 'What is a Mental/Psychiatric Disorder? From DSM-IV to DSM-V', in *Psychological Medicine*, Vol.40, No.11, November 2010, pp.1759 – 1765.
- Steinberg, H. 'The Sin in the Aetiological Concept of Johann Christian Heinroth'. *History of Psychiatry*, Vol.5, No.4, Dec. 2004, pp.299 – 344.
- Suzuki, Akihito, "Framing Psychiatric Subjectivity: Doctor, Patient and Record- Keeping at Bethlem in the Nineteenth Century". *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective*, eds. Joseph Melling and Bill Forsythe, Routledge, 1999.
- Szasz, T. *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, Harper, 2010.
- Szasz, Thomas. 'The Myth of Mental Illness'. *American Psychologist*, Vol.15, No.2, pp. 113 – 118.
- Szreter, Simon. *Fertility, Class and Gender in Britain, 1860 – 1940*, Cambridge, 1996.
- Takabayashi, A. 'Surviving the Lunacy Act of 1890: English Psychiatrists and Professional Development During the Early Twentieth Century'. *Medical History*, Vol.61, No.2, pp.246 – 269.
- Taylor, Barbara. *The Last Asylum*, Penguin, 2014.
- Thomson, M. 'Mental Hygiene in Britain during the First Half of the Twentieth Century: The Limits of International Influence'. *International Relations in Psychiatry: Britain, Germany, and the United States to World War II*. Volker Roelcke, Paul Weindling, and Louise Westwood eds, University of Rochester Press, 2010, pp.134 – 55.
- Noel Timms, *Psychiatric social work in Great Britain, 1939-1962*, Humanities Press, 1964.
- Topham, Jonathan. 'Science, Print, and Crossing Borders: Importing French Science Books into Britain, 1789-1815'. *Geographies of Nineteenth-Century Science*, ed. Livingstone DN and Withers CWJ, University of Chicago Press, 2011, pp.311 – 344.
- Toms, Jonathan. *Mental Hygiene and Psychiatry in Modern Britain*. Palgrave, 2013.
- Toms, Jonathan. 'Political Dimensions of "the Psychosocial": The 1948 International Congress on Mental Health and the Mental Hygiene Movement'. *History of the Human Sciences*, Vol.25, No.5, 2012, pp.91–106.
- Tomes, Nancy. 'The Great Restraint Controversy: A Comparative Perspective on Anglo-American Psychiatry in the Nineteenth Century', *Anatomy of Madness vol.III*, pp. 190 – 225.
- Turner, Turner. 'Not Worth Power and Shot: the Public Profile of the Medico-Psychological Association c.1851 – 1914'. Berrios and Freeman eds. *150 Years of British Psychiatry*, Gaskell, 1991, pp.3 – 18.

- Turner, Trevor. *A Diagnostic Analysis of the Casebooks of Ticehurst House Asylum, 1845-1890*, Cambridge University Press, 1992.
- Turner, Trevor. 'Henry Maudsley: Psychiatrist, philosopher and entrepreneur', in *Psychological Medicine*, Vol.18, No.3, Aug. 1988, pp.551 – 574.
- Wakefield, Jerome C. 'The concept of mental disorder: diagnostic implications of the harmful dysfunction analysis'. *World Psychiatry*, Vol.36, No.3, Oct. 2007, pp.149 – 156.
- Wallace, Edwin R., and Gach, John, eds., *History of Psychiatry and Medical Psychology: with an Epilogue on Psychiatry and the Mind-Body Relation*, Springer, 2008.
- Wallis, Jennifer, 'The Bones of the Insane'. *History of Psychiatry*, Vol.24, No.2, 2013, 196- 211.
- Wallis, Jennifer. *Investigating the Body in the Victorian Asylum Doctors, Patients, and Practices*, Palgrave Macmillan, 2017.
- Webster, C. 'Psychiatry and the early National Health Service: the role of the Mental Health Standing Advisory Committee'. Berrios and Freeman eds., *150 Years of British Psychiatry*, Gaskell, 1991, pp.103 – 106.
- Webster, C. *The Health Services Since the War vol.1*, HMSO, 1996.
- Weiner, D.B. 'Betrayal! The 1806 Translation of Pinel's *Traité' medico- philosophique sur l'aliénation mentale, ou la manie'*. *Genus*, Vol.57, 2000, pp.42–50.
- Weiner, D.B. 'The Madman in the Light of Reason. Enlightenment Psychiatry: Part II. Alienists, Treatises, and the Psychologic Approach in the Era of Pinel'. *History of Psychiatry and Medical Psychology: With an Epilogue on Psychiatry and the Mind-Body Relation*, Edwin R. Wallace and John Gach eds., pp.281 – 304.
- Werlinger, H. 'Psychopathy: A History of Concepts'. *Series Acta Universitatis Upsaliensis*, No. 6, Almqvist & Wiksell, 1978, pp. 218 – 249.
- Wilson, A., 2000. On the History of Disease Concepts: The Case of Pleurisy. *History of Science*, 38(3), pp.271–319.
- Wilson, A. 'Viewpoint: Science's Imagined Pasts'. *ISIS*, Vol.108, No.4, Dec. 2017, pp.814 – 826.
- Woods, Angela. *The Sublime Object of Psychiatry: Schizophrenia in Clinical and Cultural Theory*. Oxford, 2011.
- Woods, Evelyn A. and Carlson, Eric T. 'The Psychiatry of Philippe Pinel'. *Bulletin of the History of Medicine*, vVol.35, No.14, 1961, pp.14 – 25.
- Wright, David. 'Delusions of Gender?: Lay Identifications and Clinical Diagnosis of Insanity in Victorian England'. *Sex and Seclusion, Class and Custody*, Clio Medica, 2003, pp.149 – 176.
- Wright, David. 'The Certification of Insanity in Nineteenth-Century England and Wales'. *History of Psychiatry*, Vol.9, No.35, 1998, pp.267 – 290.
- Zilboorg, Gregory. *A History of Medical Psychology*. W.W. Norton and Company, 1967.