STATISTICAL MANUAL

FOR THE USE OF

INSTITUTIONS FOR THE INSANE

PUBLISHED BY BUREAU OF STATISTICS
THE NATIONAL COMMITTEE FOR MENTAL HYGIENE
50 UNION SQUARE, NEW YORK CITY
1918

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PREPARED BY THE

COMMITTEE ON STATISTICS

OF THE

AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION

IN COLLABORATION WITH THE

BUREAU OF STATISTICS

OF THE

NATIONAL COMMITTEE FOR MENTAL HYGIENE

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FOREWORD

The American Medico-Psychological Association at its meeting held in New York, in May 1917, adopted the report of its Committee on Statistics which provided for a system of uniform statistics in institutions for mental diseases, and appointed a standing Committee on Statistics to promote the introduction of the system throughout the country. This committee met in New York City on February 7, 1918, and in cooperation with the National Committee for Mental Hygiene outlined a plan of procedure.

The National Committee has established a Bureau of Uniform Statistics and has received a special gift to defray the initial expenses of the work of collecting statistics from institutions for the insane. As close relationships have always existed between the American Medico-Psychological Association and the National Committee, it was thought wise for the Committee on Statistics to become an advisory committee to the Bureau of Uniform Statistics of the National Committee and to have the work of introducing the new system and of collecting statistics from the institutions carried out by the Bureau.

In accordance with this arrangement the Bureau, with the assistance of the Committee on Statistics of the American Medico-Psychological Association, has prepared this manual to assist the institutions in compiling their annual statistics and has printed a series of forms to be used in preparing statistical reports. The manual and duplicate forms will be furnished free to all cooperating institutions, and it is earnestly hoped that they will be generally adopted, so that a national system of statistics of mental diseases may become an actuality.

It is recommended that the standardized tables be used in the annual reports of the institutions so far as possible and that a duplicate copy of the tables be sent to the Bureau of Uniform Statistics of the National Committee for Mental Hygiene as soon as possible after the end of the fiscal year of the institution.

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STATISTICAL MANUAL FOR THE USE OF INSTITUTIONS FOR THE INSANE

SUGGESTIONS FOR THE PREPARATION OF STATISTICS IN A STATE HOSPITAL FOR THE INSANE

Statistics of mental disease, to be trustworthy, must be based on accurate original data. If the facts first ascertained concerning the patients are recorded in a haphazard way without a clear understanding of the purposes to be attained, the statistics compiled therefrom will probably be very defective, if not absolutely worthless.

As a first step in preparing statistics of patients in an institution for the insane it is necessary to formulate statistical data cards with the essential captions arranged in convenient form. Such cards call for the same items of information concerning every patient, and if properly designed and filled out, will furnish data that may be classified in various ways and tabulated so as to give clear summaries of important facts concerning the patients and their diseases and the results of treatment.

To facilitate tabulation and filing, it is recommended that four distinct statistical cards be used, viz.:

1. A **first admission card,** to be filled out for every insane patient admitted for the first time to any hospital for the treatment of mental diseases, except institutions for temporary care only.

2. A **readmission card,** to be filled out for every insane patient admitted who has been previously under treatment in a hospital for mental diseases, excepting transfers and those who have received treatment only in institutions for temporary care.

3. A **discharge card,** to be filled out for every insane patient discharged, except transfers.

4. A **death card,** to be filled out for every insane patient who dies in the hospital.

It is suggested that first admission cards be printed on *white* cardboard, readmission cards on *yellow,* discharge

cards on *salmon,* and death cards on *blue,* and that in each instance cards for male patients be printed with *black* ink and cards for female patients with *red.*

Sample forms for the cards are submitted herewith:

FIRST ADMISSION MALE (or female)

..... **State Hospital**

Committed

Name **Identification No.** **Legal status**—Voluntary

Psychosis—No. Group Type

Nativity (state or country) of patient of father of mother **Date of arrival in U. S.**

Citizenship of patient—American foreign of father—American foreign

Race **Marital condition**—Single married widowed divorced separated

Education—None reads only reads and writes common school high school collegiate

Occupation **Religion** (Denomination)

Environment—Urban rural **Economic condition**—Dependent marginal comfortable

Actual residence—County P. O.

Time in state

Etiological factors other than heredity

Mental make-up { Temperamentally normal, abnormal (specify)
Intellectually normal, abnormal (specify)

Family history of mental diseases

Family history of nervous diseases

Family history of mental deficiency

Family history of inebriety (alcohol or drugs) (specify)

Alcoholic habits of patient { Abstinent
Moderate (specify)
Intemperate (specify)

Accompanying physical diseases not an integral part of the psychosis

Duration of present attack before admission yrs. mos. das.

Number of previous attacks

Date of admission 19 **Age on admission** yrs.

Presented at staff meeting 19 By Dr.

Hospital number for the year

Note—This card for First Admission to any hospital for the insane.

[Size of card 5 in. x 8 in.]

READMISSION CARD MALE (or female)

..... **State Hospital**

Name **Identification No.** **Committed** **Legal status**—Voluntary

Psychosis—No. Group Type

Nativity (state or country) of patient of father of mother **Date of arrival in U. S.**

Citizenship of patient—American foreign of father—American foreign

Race **Marital condition**—Single married widowed divorced separated

Education—None reads only reads and writes common school high school collegiate

Occupation **Religion** (denomination)

Environment—Urban rural **Economic condition**—Dependent marginal comfortable

Actual residence—County P. O.

Time in state

Etiological factors other than heredity

Mental make-up { Temperamentally normal, abnormal (specify)
Intellectually normal, abnormal (specify)

Family history of mental diseases

Family history of nervous diseases

Family history of mental deficiency

Family history of inebriety (alcohol or drugs) (specify)

Alcoholic habits of patient { Abstinent
Moderate (specify)
Intemperate (specify)

Accompanying physical diseases not an integral part of the psychosis

Duration of present attack before admission yrs. mos. das.

Number of previous attacks

No. of previous admissions **Date and duration of each previous hospital residence** (exclusive of parole)

Condition at last discharge **Date** **Hosp.**

Date of readmission 19 **Age on readmission** yrs.

Presented at staff meeting 19 By Dr.

Hospital number for the year

Note—This card for cases previously admitted to any hospital for the insane.

[Size of card 5 in. x 8 in.]

DISCHARGE CARD MALE (or female)

..... **State Hospital**

Committed

Name **Identification No.** **Legal status**—Voluntary

Psychosis—No. Group Type

Nativity (state or country) of patient of father of mother

Citizenship of patient—American foreign of father—American foreign

Age on discharge years

Residence when admitted—County P. O.

No. of previous attacks

No. of previous admissions **Date of last admission**

Date and duration of each previous hospital residence (exclusive of parole)

Duration of last psychosis before admission years months days

Duration of last hospital residence (exclusive of parole) years months days

Total duration of hospital life (all admissions, exclusive of paroles) years months days

Condition on discharge—Recovered much improved improved unimproved

Not insane: Epilepsy alcholism drug addiction constitutional inferiority mental deficiency dotage others (specify)

Date of parole 19

Date of discharge 19

Patient was discharged to the custody of

Address

Hospital discharge number for the year

[Size of card 5 in. x 8 in.]

DEATH CARD MALE (or female)

..... **State Hospital**

Committed

Name **Identification No.** **Legal status**—Voluntary

Psychosis—No. Group Type

Nativity (state or country) of patient of father of mother

Citizenship of patient—American foreign of father—American foreign

Age at death years

No. of previous attacks **No. of previous admissions**

Date and duration of each previous hospital residence (exclusive of parole)

Duration of last psychosis before admission years months days

Date of last admission

Period of last hospital residence years months days

Total duration of hospital life (all admissions. exclusive of paroles) years months days

Cause of death (Follow international list of causes and underline principal lesion)

Autopsy No yes **Findings of autopsy**

Residence when admitted—County city or village

Date of death 19

Hospital discharge number for the year

[Size of card 5 in. x 8 in.]

The facts needed to fill out the admission cards are obtained from (a) the relatives and friends of the patient, (b) the patient himself, (c) the commitment papers, (d) the family physician, (e) official documents and records, and (f) the mental and physical examination of the patient.

The nurse or attendant sent from the hospital to bring in a patient should be provided with a *history* blank and should note thereon all of the important facts concerning the patient and his family history that can be obtained from relatives and friends. Additional data should be secured when friends come to the hospital to visit the patient.

The data required to fill out the discharge and death cards are obtained from the hospital records. These cards should always be consistent with the admission cards.

It is advisable to have a statistical data sheet, similar to the first admission card, filled out and incorporated in the case record of the patient.

At the close of the fiscal year when all the cards are filled out and checked up, the statistical tables should be made therefrom. The tabulation can be easily and accurately done by sorting the cards into groups corresponding to the table headings and then counting the several groups. The totals should be made after each count is completed, and mistakes rectified before the cards are regrouped.

When the tables for the year are finished, the cards should be systematically filed according to patients' identification numbers, all of the cards relating to one patient being brought together.

Filling in Cards

Fill in every caption on each card; if full or accurate information can not possibly be obtained, enter " U " (symbol for "facts unascertained").

If the information is negative, enter " none " or " no ".

Do not use the interrogation point (?).

Do not use the dash (—) for " unascertained " or for " negative ".

Do not use the term " several "; as " several years "; enter rather " less than 1 yr.," " between 1 and 5 yrs.," or " over 10 yrs.," if exact figures can not be obtained.

Avoid round numbers; accept figures ending with 5 or with 0 with skepticism and only after close questioning. Avoid,

e. g., "1 yr." for 11 mos., 12½ mos., etc., and "1 mo." for 35 days, etc. Avoid "60 yrs." for 59 or 61 yrs.

Avoid ambiguous abbreviations; as "lob. pneu." (lobar or lobular?), "par." (paranoic or paralytic?), etc., and use only standard abbreviations.

If the place assigned to any caption of the schedule is too limited to enter all ascertained data, mark the blank "over", and enter the data on the back of the card.

Entries on all cards should be typewritten. Designate items on the cards, by underscoring; as, single. Do not cross out items or use check marks.

CLASSIFICATION OF MENTAL DISEASES

Explanatory notes of the various groups and clinical types follow the classification.

1. **Traumatic psychoses**
   - (a) Traumatic delirium
   - (b) Traumatic constitution
   - (c) Post-traumatic mental enfeeblement (dementia)
2. **Senile psychoses**
   - (a) Simple deterioration
   - (b) Presbyophrenic type
   - (c) Delirious and confused types
   - (d) Depressed and agitated states in addition to deterioration
   - (e) Paranoid types
   - (f) Pre-senile types
3. **Psychoses with cerebral arteriosclerosis**
4. **General paralysis**
5. **Psychoses with cerebral syphilis**
6. **Psychoses with Huntington's chorea**
7. **Psychoses with brain tumor**
8. **Psychoses with other brain or nervous diseases**

The following are the more frequent affections and should be specified in the diagnosis.

Cerebral embolism
Paralysis agitans
Meningitis, tubercular or other forms (to be specified)
Multiple sclerosis
Tabes
Acute chorea
Other conditions (to be specified)

9. **Alcoholic psychoses**
   - (a) Pathological intoxication
   - (b) Delirium tremens
   - (c) Korsakow's psychosis
   - (d) Acute hallucinosis
   - (e) Chronic hallucinosis
   - (f) Acute paranoid type
   - (g) Chronic paranoid type
   - (h) Alcoholic deterioration
   - (i) Other types, acute or chronic

10. **Psychoses due to drugs and other exogenous toxins**
   - (a) Opium (and derivatives), cocaine, bromides, chloral, etc., alone or combined (to be specified)
   - (b) Metals, as lead, arsenic, etc. (to be specified)
   - (c) Gases (to be specified)
   - (d) Other exogenous toxins (to be specified)

11. **Psychoses with pellagra**

12. **Psychoses with other somatic diseases**
   - (a) Delirium with infectious diseases
   - (b) Post-infectious psychosis
   - (c) Exhaustion-delirium
   - (d) Delirium of unknown origin
   - (e) Cardio-renal diseases
   - (f) Diseases of the ductless glands
   - (g) Other diseases or conditions (to be specified)

13. **Manic-depressive psychoses**
   - (a) Manic type
   - (b) Depressive type
   - (c) Stupor
   - (d) Mixed type
   - (e) Circular type

14. **Involution melancholia**

15. **Dementia praecox**
   - (a) Paranoid type
   - (b) Catatonic type
   - (c) Hebephrenic type
   - (d) Simple type

16. **Paranoia or paranoic conditions**

17. **Epileptic psychoses**
   - (a) Deterioration
   - (b) Clouded states
   - (c) Other conditions (to be specified)

18. **Psychoneuroses and neuroses**
    (a) Hysterical type
    (b) Psychasthenic type
    (c) Neurasthenic type
    (d) Anxiety neuroses
19. **Psychoses with constitutional psychopathic inferiority**
20. **Psychoses with mental deficiency**
21. **Undiagnosed psychoses**
22. **Not insane**
    (a) Epilepsy without psychosis
    (b) Alcoholism without psychosis
    (c) Drug addiction without psychosis
    (d) Constitutional psychopathic inferiority without psychosis
    (e) Mental deficiency without psychosis
    (f) Others (to be specified)

DEFINITIONS AND EXPLANATORY NOTES

The following explanatory notes and definitions of the various clinical groups were prepared for the Committee by Dr. George H. Kirby, Director, Psychiatric Institute, Ward's Island, New York City.

1. **Traumatic Psychoses**

The diagnosis should be restricted to mental disorders arising as a direct or obvious consequence of a brain (or head) injury producing psychotic symptoms of a fairly characteristic kind. The amount of damage to the brain may vary from an extensive destruction of tissue to simple concussion or physical shock with or without fracture of the skull.

Manic-depressive psychoses, general paralysis, dementia praecox, and other mental disorders in which trauma may act as a contributory or precipitating cause, should not be included in this group.

The following are the most common clinical types of traumatic psychosis and should be specified in the statistical record of the hospital:

(a) Traumatic delirium: This may take the form of an acute delirium (concussion delirium), or a more protracted delirium resembling the Korsakow mental complex.

(b) Traumatic constitution: Characterized by a gradual post-traumatic change in disposition with vasomotor instability, headaches, fatigability, irritability or explosive emo-

tional reactions; usually hyper-sensitiveness to alcohol, and in some cases development of paranoid, hysteroid, or epileptoid symptoms.

(c) Post-traumatic mental enfeeblement (dementia): Varying degrees of mental reduction with or without aphasic symptoms, epileptiform attacks or development of a cerebral arteriosclerosis.

2. **Senile Psychoses**

A well defined type of psychosis which as a rule develops gradually and is characterized by the following symptoms: Impairment of retention (forgetfulness) and general failure of memory more marked for recent experiences; defects in orientation and a general reduction of mental capacity; the attention, concentration and thinking processes are interfered with; there is self-centering of interests, often irritability and stubborn opposition; a tendency to reminiscences and fabrications. Accompanying this deterioration there may occur paranoid trends, depressions, confused states, etc. Certain clinical types should therefore be specified, but these often overlap:

(a) Simple deterioration: Retention and memory defects, reduction in intellectual capacity and narrowing of interests; usually also suspiciousness, irritability and restlessness, the latter particularly at night.

(b) Presbyophrenic type: Severe memory and retention defects with complete disorientation; but at the same time preservation of mental alertness and attentiveness with ability to grasp immediate impressions and conversation quite well. Forgetfulness leads to absurd contradictions and repetitions; suggestibility and free fabrication are prominent symptoms. (The general picture resembles the Korsakow mental complex.)

(c) Delirious and confused types: Often in the early stages of the psychosis and for a long period the picture is one of deep confusion or of a delirious condition.

(d) Depressed and agitated types: In addition to the underlying deterioration there may be a pronounced depression and persistent agitation.

(e) Paranoid types: Well marked delusional trends, chiefly persecutory or expansive ideas, often accompany the deterioration and in the early stages may make the diagnosis difficult if the defect symptoms are mild.

(f) Pre-senile types: The so-called "Alzheimer's disease." An early senile deterioration which usually leads rapidly to a deep dementia. Reported to occur as early as the fortieth year. Most cases show an irritable or anxious depressive mood with aphasic or apractic symptoms. There is apt to be general resistiveness and sometimes spasticity.

3. **Psychoses with Cerebral Arteriosclerosis**

The clinical symptoms, both mental and physical, are varied depending in the first place on the distribution and severity of the vascular cerebral disease and probably to some extent on the mental make-up of the person.

Cerebral physical symptoms, headaches, dizziness, fainting attacks, etc., are nearly always present, and usually signs of focal brain disease appear sooner or later (aphasia, paralysis, etc.).

The most important mental symptoms (particularly if the arteriosclerotic disease is diffuse) are impairment of mental tension, i. e., interference with the capacity to think quickly and accurately, to concentrate and to fix the attention; fatigability and lack of emotional control (alternate weeping and laughing), often a tendency to irritability is marked; the retention is impaired and with it there is more or less general defect of memory, especially in the advanced stages of the disease, or after some large destructive lesion occurs.

Pronounced psychotic symptoms may appear in the form of depression (often of the anxious type), suspicions or paranoid ideas, or episodes of marked confusion.

To be included in this group are the psychoses following cerebral softening or hemorrhage, if due to arterial disease. (Autopsies in state hospitals show that in arteriosclerotic cases softening is relatively much more frequent than hemorrhage.)

Differentiation from senile psychosis is sometimes difficult particularly if the arteriosclerotic disease manifests itself in the senile period. The two conditions may be associated; when this happens preference should be given in the statistical report to the arteriosclerotic disorder.

High blood pressure, although usually present, is not essential for the diagnosis of cerebral arteriosclerosis.

4. **General Paralysis**

The range of symptoms encountered in general paralysis is too great to be reviewed here in detail. As to mental symp-

toms, most stress should be laid on the early changes in disposition and character, judgment defects, difficulty about time relations and discrepancies in statements, forgetfulness and later on a diffuse memory impairment. Cases with marked grandiose trends are less likely to be overlooked than cases with depressions, paranoid ideas, alcoholic-like episodes, etc.

Mistakes of diagnosis are most apt to be made in those cases having in the early stages pronounced psychotic symptoms and relatively slight defect symptoms, or cases with few definite physical signs. Lumbar puncture should always be made if there is any doubt about the diagnosis. A Wassermann examination of the blood alone is not sufficient as this does not tell us whether or not the central nervous system is involved.

5. **Psychoses with Cerebral Syphilis**

Since general paralysis itself is now known to be a parenchymatous form of brain syphilis, the differentiation of the cerebral syphilis cases might on theoretical grounds be regarded as less important than formerly. Practically, however, the separation of the non-parenchymatous forms is very important because the symptoms, the course and therapeutic outlook in most of these cases are different from those of general paralysis.

According to the predominant pathological characteristics, three types of cerebral syphilis may be distinguished, viz.: (a) Meningitic, (b) Endarteritic, and (c) Gummatous. The lines of demarcation between these types are not, however, sharp ones. We practically always find in the endarteritic and gummatous types a certain amount of meningitis.

The acute meningitic form is the most frequent type of cerebral syphilis and gives little trouble in diagnosis; many of these cases do not reach state hospitals. In most cases after prodromal symptoms (headache, dizziness, etc.) there is a rapid development of physical signs, usually cranial nerve involvement, and a mental picture of dullness or confusion with few psychotic symptoms except those related to a delirious or organic reaction.

In the rarer chronic meningitic forms which are apt to occur a long time after the syphilitic infection, usually in the period in which we might expect general paralysis, the diagnostic difficulties may be considerable.

In the endarteritic forms the most characteristic symptoms are those resulting from focal vascular lesions.

In the gummatous forms the slowly developing focal and pressure symptoms are most significant.

In all forms of cerebral syphilis the psychotic manifestations are less prominent than in general paralysis and the personality is much better preserved as shown by the social reactions, ethical sense, judgment and general behavior. The grandiose ideas and absurd trends of the general paralytic are rarely encountered in these cases.

6. **Psychoses with Huntington's Chorea**

Mental symptoms are a constant accompaniment of this form of chorea and as a rule become more marked as the disease advances. Although the disease is regarded as being hereditary in nature, a diagnosis can be made on the clinical picture in the absence of a family history.

The chief mental symptoms are those of mental inertia and an emotional change, either apathy and silliness or a depressive irritable reaction with a tendency to passionate outbursts. As the disease progresses the memory is affected to some extent, but the patient's ability to recall past events is often found to be surprisingly well preserved when the disinclination to cooperate and give information can be overcome. Likewise the orientation is well retained even when the patient appears very apathetic and listless. Suspicions and paranoid ideas are prominent in some cases.

7. **Psychoses with Brain Tumor**

A large majority of brain tumor cases show definite mental symptoms. Most frequent are mental dullness, somnolence, hebetude, slowness in thinking, memory failure, irritability and depression, although a tendency to facetiousness is sometimes observed. Episodes of confusion with hallucinations are common; some cases express suspicions and paranoid ideas.

The diagnosis must rest in most cases on the neurological symptoms, and these will depend on the location, size and rate of growth of the tumor. Certain general physical symptoms due to an increased intra-cranial pressure are present in most cases, viz: headache, dizziness, vomiting, slowing of the pulse, choked disc and interlacing of the color fields.

8. **Psychoses with other Brain or Nervous Diseases**

This division provides a place for grouping a variety of less common mental disorders associated with organic disease of the nervous system and not included in the preceding larger groups. On the card the special type of brain or nervous diseases should be mentioned after the group name. The following are the conditions most frequently met with:

(a) Cerebral embolism (if an incident in cerebral arteriosclerosis it should be placed in group 3).

(b) Paralysis agitans.

(c) Meningitis, tubercular or other forms (to be specified).

(d) Multiple sclerosis.

(e) Tabes (paresis to be carefully excluded).

(f) Acute chorea (Sydenham's type). Hysterical chorea to be excluded.

(g) Other conditions (to be specified).

9. **Alcoholic Psychoses**

The diagnosis of alcoholic psychosis should be restricted to those mental disorders arising with few exceptions in connection with *chronic* drinking and presenting fairly well defined symptom-pictures. One must guard against making the alcoholic group too inclusive. Over-indulgence in alcohol is often found to be merely a symptom of another psychosis, or at any rate may be incidental to another psychosis, such as general paralysis, manic-depressive insanity, dementia praecox, epilepsy, etc. The cases to be regarded as alcoholic psychoses which do not result from chronic drinking are the episodic attacks in some psychopathic personalities, the dipsomanias (the true periodic drinkers) and pathological intoxication, any one of which may develop as the result of a single imbibition or a relatively short spree.

The following alcoholic reactions usually present symptoms distinctive enough to allow of clinical differentiation:

(a) Pathological intoxication: An unusual or abnormal immediate reaction to taking a large or small amount of alcohol. Essentially an acute mental disturbance of short duration characterized usually by an excitement or furor with confusion and hallucinations, followed by amnesia.

(b) Delirium tremens: An hallucinatory delirium with marked general tremor and toxic symptoms.

(c) Korsakow's psychosis: This occurs with or without polyneuritis. The delirious type is not readily differentiated in the early stages from severe delirium tremens but is more protracted. The non-delirious type presents a characteristic retention defect with disorientation, fabrication, suggestibility and tendency to misidentify persons. Hallucinations are infrequent after the acute phase.

(d) Acute hallucinosis: This is chiefly an auditory hallucinosis of rapid development with clearness of the sensorium, marked fears, and a more or less systematized persecutory trend.

(e) Chronic hallucinosis: This is an infrequent type which may be regarded as the persistence of the symptoms of the acute hallucinosis without change in the character of the symptoms except perhaps a gradual lessening of the emotional reaction accompanying the hallucinations.

(f) Acute paranoid type: Suspicions, misinterpretations, and persecutory ideas, often a jealous trend; hallucinations usually subordinate; clearing up on withdrawal of alcohol.

(g) Chronic paranoid type: Persistence of symptoms of the acute paranoid type with fixed delusions of persecution or jealousy usually not influenced by withdrawal of alcohol; difficult to differentiate from non-alcoholic paranoid states or dementia praecox.

(h) Alcoholic deterioration: A slowly developing moral, volitional and emotional change in the chronic drinker; apparently relatively few cases are committed as the mental symptoms are not usually looked upon as sufficient to justify the diagnosis of a definite psychosis. The chief symptoms are ill humor and irascibility or a jovial, careless, facetious mood; abusiveness to family, unreliability and tendency to prevarication; in some cases definite suspicions and jealousy; there is a general lessening of efficiency and capacity for physical and mental work; memory not seriously impaired. To be excluded are residual defects due to Korsakow's psychosis, or mental reduction due to arteriosclerosis or to traumatic lesions.

(i) Other types to be specified.

10. Psychoses Due to Drugs and other Exogenous Toxins

The clinical pictures produced by drugs and other exogenous poisons are principally deliria or states of confusion;

although sometimes hallucinatory and paranoid reactions are met with. Certain poisons and gases apparently produce special symptoms, e. g., cocaine, lead, illuminating gas, etc. Grouped according to the toxic etiological factors the following are to be differentiated:

(a) Opium (and derivatives), cocaine, bromides, chloral, etc., alone or combined (to be specified)

(b) Metals, as arsenic, lead, etc. (to be specified)

(c) Gases (to be specified)

(d) Other exogenous toxins (to be specified)

11. **Psychoses with Pellagra**

The relation which various mental disturbances bear to the disease pellagra is not yet settled. Cases of pellagra occurring during the course of a well established mental disease such as dementia praecox, manic-depressive insanity, senile dementia, etc., should not be included in this group. The mental disturbances which are apparently most intimately connected with pellagra are certain delirious or confused states (toxic-organic-like reactions) arising during the course of a severe pellagra. These are the cases which for the present should be placed in the group of psychoses with pellagra.

12. **Psychoses with other Somatic Diseases**

Under this heading are brought together those mental disorders which appear to depend directly upon some physical disturbance or somatic disease not already provided for in the foregoing groups.

In the types designated below under (a) to (e) inclusive, we have essentially deliria or states of confusion arising during the course of an infectious disease or in association with a condition of exhaustion or a toxaemia. The mental disturbance is apparently the result of interference with brain nutrition or the unfavorable action of certain deleterious substances, poisons or toxins, on the central nervous system. The clinical pictures met with are extremely varied. The delirium may be marked by severe motor excitement and incoherence of utterance, or by multiform hallucinations with deep confusion or a dazed, bewildered condition; epileptiform attacks, catatonic-like symptoms, stupor, etc. may occur. In classifying these psychoses a difficult problem arises in many cases if attempts are made to distinguish between infection and ex-

haustion as etiological factors. For statistical reports the following differentiations should be made:

Under (a) "Delirium with infectious diseases" place the *initial deliria* which develop during the prodromal or incubation period or before the febrile stage as in some cases of typhoid, small-pox, malaria, etc.; the *febrile deliria* which seem to bear a definite relation to the rise in temperature; the *post-febrile deliria* of the period of defervescence including the so-called "collapse delirium."

Under (b) "Post-infectious psychoses" are to be grouped deliria, the mild forms of mental confusion, or the depressive, irritable, suspicious reactions which occur during the period of convalescence from infectious diseases. Physical asthenia and prostration are undoubtedly important factors in these conditions and differentiation from "exhaustion deliria" must depend chiefly on the history and obvious close relationship to the preceding infectious disease. (Some cases which fail to recover show a peculiar mental enfeeblement.) In this group should be classed the "cerebropathica psychica toxaemica" or the non-alcoholic polyneuritic psychoses following an infectious disease as typhoid, influenza, septicaemia, etc.

Under (c) "Exhaustion deliria" are to be classed psychoses in which physical exhaustion, not associated with or the result of an infectious disease, is the chief precipitating cause of the mental disorder, e. g., hemorrhage, severe physical over-exertion, deprivation of food, prolonged insomnia, debility from wasting disease, etc.

Of the psychoses which occur with diseases of the ductless glands, the best known are the thyroigenous mental disorders. Disturbance of the pituitary or of the thymus function is often associated with mental symptoms.

According to the etiology and symptoms the following types should therefore be specified under "Psychoses with Other Somatic Diseases:"

(a) Delirium with infectious disease (specify)
(b) Post-infectious psychosis (specify)
(c) Exhaustion delirium
(d) Delirium of unknown origin
(e) Cardio-renal disease
(f) Diseases of the ductless glands (specify)
(g) Other diseases or conditions (to be specified)

13. **Manic-Depressive Psychoses**

This group comprises the essentially benign affective psychoses, mental disorders which fundamentally are marked by emotional oscillations and a tendency to recurrence. Various psychotic trends, delusions, illusions and hallucinations, clouded states, stupor, etc. may be added. To be distinguished are:

The *manic* reaction with its feeling of well-being (or irascibility), flight of ideas and over-activity.

The *depressive* reaction with its feeling of mental and physical insufficiency, a despondent, sad or hopeless mood and in severe depressions, retardation and inhibition; in some cases the mood is one of uneasiness and anxiety, accompanied by restlessness.

The *mixed* reaction, a combination of manic and depressive symptoms.

The *stupor* reaction with its marked reduction in activity, depression, ideas of death, and often dream-like hallucinations; sometimes mutism, drooling and muscular symptoms suggestive of the catatonic manifestations of dementia praecox, from which, however, these manic-depressive stupors are to be differentiated.

An attack is called *circular* when, as is often the case, one phase is followed immediately by another phase, e. g., a manic reaction passes over into a depressive reaction or vice versa.

Cases formerly classed as allied to manic-depressive should be placed here rather than in the undiagnosed group.

In the statistical reports the following should be specified:

(a) Manic attack
(b) Depressive attack
(c) Stuporous attack
(d) Mixed attack
(e) Circular attack

14. **Involution Melancholia**

These depressions are probably related to the manic-depressive group; nevertheless the symptoms and the course of the involution cases are sufficiently characteristic to justify us in keeping them apart as special forms of emotional reaction.

To be included here are the slowly developing depressions of *middle life and later years* which come on with worry, insomnia, uneasiness, anxiety and agitation, showing usually the unreality and sensory complex, but little or no evidence

of any difficulty in thinking. The tendency is for the course to be a prolonged one. Arteriosclerotic depressions should be excluded.

When agitated depressions of the involution period are clearly superimposed on a manic-depressive foundation with previous attacks (depression or excitement) they should for statistical purposes be classed in the manic-depressive group.

15. **Dementia Praecox**

This group cannot be satisfactorily defined at the present time as there are still too many points at issue as to what constitute the essential clinical features of dementia praecox. A large majority of the cases which should go into this group may, however, be recognized without special difficulty, although there is an important smaller group of doubtful, atypical allied or transitional cases which from the standpoint of symptoms or prognosis occupy an uncertain clinical position.

Cases formerly classed as allied to dementia praecox should be placed here rather than in the undiagnosed group. The term "schizophrenia" is now used by many writers instead of dementia praecox.

The following mentioned features are sufficiently well established to be considered most characteristic of the dementia praecox type of reaction:

A seclusive type of personality or one showing other evidences of abnormality in the development of the instincts and feelings.

Appearance of defects of interest and discrepancies between thought on the one hand and the behavior-emotional reactions on the other.

A gradual blunting of the emotions, indifference or silliness with serious defects of judgment and often hypochondriacal complaints, suspicions or ideas of reference.

Development of peculiar trends, often fantastic ideas, with odd, impulsive or negativistic conduct not accounted for by any acute emotional disturbance or impairment of the sensorium.

Appearance of autistic thinking and dream-like ideas, peculiar feelings of being forced, of interference with the mind, of physical or mystical influences, but with retention of clearness in other fields (orientation, memory, etc.).

According to the prominence of certain symptoms in indi-

vidual cases the following four clinical forms of dementia praecox may be specified, but it should be borne in mind that these are only relative distinctions and that transitions from one clinical form to another are common:

(a) Paranoid type: Cases characterized by a prominence of delusions, particularly ideas of persecution or grandeur, often connectedly elaborated, and hallucinations in various fields.

(b) Catatonic type: Cases in which there is a prominence of negativistic reactions or various peculiarities of conduct with phases of stupor or excitment, the latter characterized by impulsive, queer or stereotyped behavior and usually hallucinations.

(c) Hebephrenic type: Cases showing prominently a tendency to silliness, smiling, laughter, grimacing, mannerisms in speech and action, and numerous peculiar ideas usually absurd, grotesque and changeable in form.

(d) Simple type: Cases characterized by defects of interest, gradual development of an apathetic state, often with peculiar behavior, but without expression of delusions or hallucinations.

16. **Paranoia or Paranoic Conditions**

From this group should be excluded the deteriorating paranoic states and paranoic states symptomatic of other mental disorders or of some damaging factor such as alcohol, organic brain disease, etc.

The group comprises cases which show clinically fixed suspicions, persecutory delusions, dominant ideas or grandiose trends logically elaborated and with due regard for reality after once a false interpretation or premise has been accepted. Further characteristics are formally correct conduct, adequate emotional reactions, clearness and coherence of the train of thought.

17. **Epileptic Psychoses**

In addition to the epileptic deterioration, transitory psychoses may occur which are usually characterized by a clouded mental state followed by an amnesia for external occurrences during the attack. (The hallucinatory and dream-like experiences of the patient during the attack may be vividly recalled.) Various automatic and secondary states of consciousness may occur.

According to the most prominent clinical features the epileptic mental disorders should therefore be specified as follows:

(a) Deterioration: A gradual development of mental dullness, slowness of association and thinking, impairment of memory, irritability or apathy.

(b) Clouded states: Usually in the form of dazed reactions with deep confusion, bewilderment and anxiety or excitements with hallucinations, fears and violent outbreaks; instead of fear there may be ecstatic moods with religious exaltation.

(c) Other conditions (to be specified).

18. **Psychoneuroses and Neuroses**

The psychoneurosis group includes those disorders in which mental forces or ideas of which the subject is either aware (conscious) or unaware (unconscious) bring about various mental and physical symptoms; in other words these disorders are essentially psychogenic in nature.

The term neurosis is now generally used synonymously with psychoneurosis, although it has been applied to certain disorders in which, while the symptoms are both mental and physical, the primary cause is thought to be essentially physical. In most instances, however, both psychogenic and physical causes are operative and we can assign only a relative weight to the one or the other.

The following types are sufficiently well defined clinically to be specified:

(a) Hysterical type: Episodic mental attacks in the form of delirium, stupor or dream states during which repressed wishes, mental conflicts or emotional experiences detached from ordinary consciousness break through and temporarily dominate the mind. The attack is followed by partial or complete amnesia. Various physical disturbances (sensory and motor) occur in hysteria, and these represent a conversion of the affect of the repressed disturbing complexes into bodily symptoms or, according to another formulation, there is a dissociation of consciousness relating to some physical function.

(b) Psychasthenic type: This includes the compulsive and obsessional neuroses of some writers. The main

clinical characteristics are phobias, obsessions, morbid doubts and impulsions, feelings of insufficiency, nervous tension and anxiety. Episodes of marked depression and agitation may occur. There is no disturbance of consciousness or amnesia as in hysteria.

(c) Neurasthenic type: This should designate the fatigue neuroses in which physical as well as mental causes evidently figure; characterized essentially by mental and motor fatigability and irritability; also various hyperaesthesias and paraesthesias; hypochondriasis and varying degrees of depression.

(d) Anxiety neuroses: A clinical type in which morbid anxiety or fear is the most prominent feature. A general nervous irritability (or excitability) is regularly associated with the anxious expectation or dread; in addition there are numerous physical symptoms which may be regarded as the bodily accompaniments of fear, particularly cardiac and vasomotor disturbances: the heart's action is increased, often there is irregularity and palpitation; there may be sweating, nausea, vomiting, diarrhea, suffocative feelings, dizziness, trembling, shaking, difficulty in locomotion, etc. Fluctuations occur in the intensity of the symptoms, the acute exacerbations constituting the "anxiety attack."

19. **Psychoses with Constitutional Psychopathic Inferiority**

Under the designation of constitutional psychopathic inferiority is brought together a large group of pathological personalities whose abnormality of make-up is expressed mainly in the character and intensity of their emotional and volitional reactions. Individuals with an intellectual defect (feeblemindedness) are not to be included in this group.

Several of the preceding groups, in fact all of the so-called constitutional psychoses, manic-depressive, dementia praecox, paranoia, psychoneuroses, etc., may be considered as arising on a basis of psychopathic inferiority because the previous mental make-up in these conditions shows more or less clearly abnormalities in the emotional and volitional spheres. These reactions are apparently related to special forms of psychopathic make-up now fairly well differentiated, and the associated psychoses also have their own distinctive features.

There remain, however, various other less well differentiated types of psychopathic personalities, and in these the

psychotic reactions (psychoses) also differ from those already specified in the preceding groups.

It is these less well differentiated types of emotional and volitional deviation which are to be designated, at least for statistical purposes, as constitutional psychopathic inferiority. The type of behavior disorder, the social reactions, the trends of interests, etc., which the psychopathic inferior may show give special features to many cases, e. g., criminal traits, moral deficiency, tramp life, sexual perversions and various temperamental peculiarities.

The pronounced mental disturbances or psychoses which develop in psychopathic inferiors and bring about their commitment are varied in their clinical form and are usually of an episodic character. Most frequent are attacks of irritability, excitement, depression, paranoid episodes, transient confused states, etc. True prison psychoses belong in this group.

In accordance with the standpoint developed above, a psychopathic inferior with a manic-depressive attack should be classed in the manic-depressive group, and likewise a psychopathic inferior with a schizophrenic psychosis should go in the dementia praecox group.

Psychopathic inferiors without an episodic mental attack or any psychotic symptoms should be placed in the *not insane* group under the appropriate sub-heading.

20. **Psychoses with Mental Deficiency**

This group includes the psychoses with various types of intellectual deficiency or feeblemindedness. The degree of mental deficiency should be determined by the history and the use of standard psychometric tests. The intellectual level may be denoted in the statistics by specifying moron, imbecile, idiot.

Acute, usually transient psychoses of various forms occur in mentally deficient persons and commitment to a hospital for the insane may be necessary. The most common mental disturbances are episodes of excitement or irritability, depressions, paranoid trends, hallucinatory attacks, etc.

Mentally deficient persons may suffer from manic-depressive attacks or from dementia praecox. When this occurs the diagnostic grouping should be manic-depressive or dementia praecox as the case may be.

Mental deficiency cases without psychotic disturbances should go into the group of *not insane* under the appropriate sub-heading.

21. **Undiagnosed Psychoses**

In this group should be placed the cases in which a satisfactory diagnosis cannot be made and the psychosis must therefore be regarded as an unclassified one. The difficulty may be due to lack of information or inaccessibility of the patient; or the clinical picture may be obscure, the etiology unknown, or the symptoms unusual. Cases placed in this group during the year should be again reviewed before the annual diagnostic tables are completed.

Cases of the type formerly placed in one of the allied groups should not be put in the undiagnosed group except for some special reason. Most of the cases hitherto called allied should be placed in the main group to which they seem most closely related.

22. **Not Insane**

This group should receive the occasional case which after investigation and observation gives no evidence of having had a psychosis. The only difficulty likely to be encountered in the statistical reports will arise in the grouping of patients who have recovered from a psychosis prior to admission. In such cases, if the history, the commitment papers or the patient's retrospective account shows that a psychosis actually existed immediately before admission, that is, at the time of commitment, then the case should be considered as having suffered from a mental disorder, and classification under the appropriate heading should be made.

If it is determined that no psychosis existed, then the condition which led to admission should be specified. The following come most frequently into consideration:

(a) Epilepsy without psychosis
(b) Alcoholism without psychosis
(c) Drug addiction without psychosis
(d) Constitutional psychopathic inferiority without psychosis
(e) Mental deficiency without psychosis
(f) Other conditions (to be specified)

STATISTICAL TABLES RECOMMENDED

A series of eighteen statistical tables is recommended for the use of all institutions for the insane. These provide for the systematic presentation of the data that should be annually compiled by every such institution and that should be available for use by everyone interested in psychiatry or the treatment of mental diseases. These tables are:

Table 1. General information.
Table 2. Financial statement.
Table 3. Movement of patients.
Table 4. Nativity and parentage of first admissions.
Table 5. Citizenship of first admissions.
Table 6. Psychoses of first admissions, types as well as principal psychoses to be designated.
Table 7. Race of first admissions classified with reference to principal psychoses.
Table 8. Age of first admissions classified with reference to principal psychoses.
Table 9. Degree of education of first admissions classified with reference to principal psychoses.
Table 10. Environment of first admissions classified with reference to principal psychoses.
Table 11. Economic condition of first admissions classified with reference to principal psychoses.
Table 12. Use of alcohol by first admissions classified with reference to principal psychoses.
Table 13. Marital condition of first admissions classified with reference to principal psychoses.
Table 14. Psychoses of readmissions, types as well as principal psychoses to be designated.
Table 15. Discharges of patients classified with reference to principal psychoses and condition on discharge.
Table 16. Causes of death of patients classified with reference to principal psychoses.
Table 17. Age of patients at time of death classified with reference to principal psychoses.
Table 18. Duration of hospital life of patients dying in hospital, classified with reference to principal psychoses.

The National Committee for Mental Hygiene has printed a series of forms to be used in preparing the foregoing tables and will furnish them free to every institution requesting them or that signifies its willingness to cooperate in the general movement for uniform statistics. The forms are numbered to correspond with the tables. In order to secure uniformity in filling out the blanks the following explanations and definitions are submitted:

DIRECTIONS FOR THE PREPARATION OF STATISTICAL TABLES

TABLE 1. GENERAL INFORMATION

The data relative to hospital plant, medical service, employees and patients, called for in this table, should be given as of the last day of the fiscal year of the institution.

Hospital plant: The value of the hospital property should be estimated at cost unless its original value has been diminished by depreciation. In case a considerable amount of depreciation has occurred, a reasonable allowance therefor should be made. As the estimates of the value of hospital property in different institutions will be subject to comparison, the appraisal in each case should be made with care and should represent as nearly as possible the true value of the property.

Medical service: The term "assistant physicians," as used in the table, includes all physicians regularly employed in the hospital in a grade below that of superintendent and above that of medical interne. The term "clinical assistants" includes physicians and medical students who are employed temporarily or permanently in hospital work below the grade of medical interne.

Consulting physicians, eye and ear specialists, dentists, and pharmacists, are not to be included in the report of the medical service.

Employees: The term "graduate nurses" includes only those nurses who have graduated from a school of nursing maintained by a general hospital or a hospital for the insane giving a course covering at least two years.

The term "social workers" refers to persons regularly employed by the hospital to look after the interests of parole and other out-patients. Voluntary workers in this field are not to be included in the table.

Table 2. Financial Statement

The data should be given in accordance with the headings provided in the table so far as possible. If it is impossible to supply the data pertaining to any of the items the total receipts and disbursements should be given and explanations concerning their classification may be submitted in detail on a separate sheet. The various terms in the table are used in the ordinary sense and are self-explanatory.

Table 3. Movement of Insane Patient Population

This table calls for a report of movement of *insane* patients apart from other patients, who may be cared for in the same institution. As rates of admission, discharge and death will be computed from the data submitted from this table, it is important that the directions included therein, be very carefully followed. For convenience of reference, the principal terms used in this table are herein defined. These terms have the same significance wherever used in the tables described in this manual.

"First admissions" includes all insane patients admitted for the first time to any institution for the insane, public or private, wherever situated, in or outside of state, excepting institutions for temporary care only.

"Readmissions" includes all insane patients admitted who have been previously under treatment in an institution for the insane, excepting transfers and patients who have received treatment only in institutions for temporary care.

"Recovered" indicates the condition of patients who have regained their normal mental health so that they may be considered as having practically the same mental status as they had previous to the onset of the psychosis.

"Improved" denotes any degree of mental gain less than recovery.

A "voluntary patient" is one who is received in an institution upon his own application and without commitment.

Table 4. Nativity of First Admissions and of Parents of First Admissions

Care should be taken to ascertain the country of birth of every first admission. Changes in national boundaries made by the present war should not be recognized until its close and until the new boundary lines, if any, are definitely fixed.

The following is the list of countries to be used in reporting nativity:

Modified Form of United States Census Classification of Nativity

Africa	France	Porto Rico
Asia†	Germany	Portugal
Australia	Greece	Roumania
Austria	Hawaii	Russia
Belgium	Holland	Scotland
Bohemia	Hungary	South America
Canada‡	India	Spain
Central America	Ireland	Sweden
China	Italy	Switzerland
Cuba	Japan	Turkey in Asia
Denmark	Mexico	Turkey in Europe
England	Norway	Wales
Europe†	Philippine Islands	West Indies*
Finland	Poland	Other countries

† Not otherwise specified.
‡ Includes Newfoundland.
* Except Cuba and Porto Rico.

Table 5. Citizenship of First Admissions

Accurate data concerning the citizenship of first admissions in the several states is highly important as the matter has a direct bearing on the policy of the United States relative to immigration.

The following notes pertaining to citizenship may be found helpful:

Foreign-born persons (with few exceptions) are aliens unless naturalized and should be so reported if evidence of their naturalization can not be produced.

Aliens may be naturalized in several ways, as follows:

1. By making required declarations and receiving final naturalization papers from a court of competent jurisdiction.
2. A woman, by the naturalization of her husband or by marriage to a citizen.
3. Minors, by the naturalization of their parents.

All persons (with few exceptions) born in the United States are citizens regardless of parentage.

A woman loses her citizenship by marriage to an alien.

A declaration of intention does not confer rights of citizenship; a foreigner is an alien until naturalized. An alien, to be eligible for citizenship, must have resided in the United States continuously for five years.

Table 6. Psychoses of First Admissions

In diagnosing the mental diseases of patients, the instructions given in this manual (pages 14-29) should be carefully studied and followed so far as possible. In making out the table, give the total for each numbered group and so far as may be determined the number in each subdivision thereof.

Table 7. Race of First Admissions Classified with Reference to Principal Psychoses

The *race* of patients admitted should be designated by the terms given in the following list:

Condensed Form of List of Races Adopted by the United States Immigration Service

African (black)	Greek	Scotch
American Indian	Hebrew	Slavonic*
Armenian	Irish	Spanish
Bulgarian	Italian†	Spanish-American
Chinese	Japanese	Syrian
Cuban	Lithuanian	Turkish
Dutch and Flemish	Magyar	Welsh
East Indian	Mexican	West Indian (except Cuban)
English	Pacific Islander	
Finnish	Portuguese	Other specific races
French	Roumanian	Mixed
German	Scandinavian‡	Race unascertained

† Includes "north" and "south."

‡ Norwegians, Danes and Swedes.

* Includes Bohemian, Bosnian, Croatian, Delmatian, Herzegovinian, Montenegrin, Moravian, Polish, Russian, Ruthenian, Servian, Slovak, Slovenian.

The "Dictionary of Races" prepared by the Immigration Commission should be used as a guide for the determination of race. A pamphlet copy of this excellent manual may be obtained from the Superintendent of Documents, Washington, D. C., for twenty cents.

The following suggestions relative to race classification should be carefully noted:

African. This term should be applied to all negroes of *pure* or *mixed blood*, whether coming from Africa, Cuba or other West Indian Islands, Europe or North or South America.

Armenian. Care should be taken not to confuse Armenians with Syrians.

Bulgarian. The Bulgarians who come to the United States are all from Bulgaria but, with the readjustment of boundary lines which may follow the present war, it is likely that in the future it will not always be possible to distinguish Bulgarians by their starting place in Europe. The language should identify them in all cases.

Cuban. Care must be taken not to include negroes and Spanish-Americans among "Cubans."

Dutch and Flemish. Nearly all the Dutch who come to the United States come from Holland. They call themselves "Hollanders." The Flemish come principally from Belgium.

East Indian. This term refers to the natives of the East Indies, including Hindus, and is a very loose term, ethnologically. This is a matter of small importance, however, as very few immigrants come to the United States from the East Indies.

English. Care must be taken to exclude Hebrews who are born in England, also English-speaking people of other races.

Finnish. All natives of Finland are not Finns; many of them are Swedes. Of the Finns living in Europe, more than 1,000,000 live outside of Finland.

German. Care must be taken to classify Germans from Russia as Germans.

Hebrew. No difficulty will be experienced in identifying Hebrews and they should be so classified without regard to the country from which they come.

Italian. Very few Italians come to the United States from any country except Italy, although some come from Brazil and the Argentine Republic. Care must be taken not to confuse these with Spanish-Americans.

Lithuanian. Lithuanians in the United States are quite likely to be confused with Poles or Slovaks. They are quite distinct from the "Slavonic" people and should be enumerated separately.

Magyar. Magyars are often called "Hungarians," "Huns" or "Hunyaks" in popular language in this country.

Roumanian. In reporting patients born in Roumania, the only chance for error is the failure to exclude Hebrews and Gypsies. There are about half as many Roumanians in Hungary as there are in Roumania and so it is necessary to consider them in reporting the race of natives of Hungary.

Slavonic. This is a very important racial division as a very large number of Slavonic immigrants have come to the United States in recent years. It is believed that the use of this term will solve a great many difficulties as it makes it unnecessary to distinguish between Poles, Slovaks, etc. The only danger to guard against is that of including Lithuanians, Finns, Magyars or Roumanians.

Spanish. Care should be taken not to apply this term to Spanish-Americans.

Spanish-Americans. This term refers only to "the people of Central and South America of Spanish descent."

Turkish. Armenians and Syrians should not be included under this designation.

West Indian. Care should be taken to exclude negroes, Cubans and Spanish-Americans. Only a very small number of West Indians not negroes, are admitted to the United States.

Mixed. This term should be used to designate the race of a patient whose ancestors were of two or more races.

The terms "American," "Swiss," and "Austrian," should not be used to designate race (see discussion of these terms in the "Dictionary of Races:" American, p. 102; Swiss, p. 138; Austrian, p. 20).

TABLE 8. AGE OF FIRST ADMISSIONS CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES

In filling out this table and the other tables in which the principal psychoses are correlated with other items, care should be taken to give the same totals for each group in every table.

Age groups as designated in the headings are inclusive, e. g., 15-19 years includes the years 15, 16, 17, 18 and 19.

TABLE 9. DEGREE OF EDUCATION OF FIRST ADMISSIONS CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES

"Illiterate" denotes persons who cannot read and write.

Under "reads and writes" should be included those who have attended a common school but who have not completed the work of the fourth grade. Common school, high school, and college should be interpreted as meaning graduation from such institutions respectively or completion of at least half of the prescribed course. Two years of a course taken in a professional school, such as medicine, dentistry and pharmacy, should be considered as college education. Business schools are principally of common school grade although a few are of high school or college grade.

TABLE 10. ENVIRONMENT OF FIRST ADMISSIONS CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES

"Urban" and "rural" are used in this table as in the United States census classification. Places having a population of 2,500 or more are considered as "urban." All other places are considered as "rural."

TABLE 11. ECONOMIC CONDITION OF FIRST ADMISSIONS CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES

The term "economic condition" refers to the patients' circumstances before the onset of the psychosis. The terms used in classifying "economic condition" are defined as follows:

Dependent: Lacking in necessities of life or receiving aid from public funds or persons outside the immediate family.

Marginal: Living on daily earnings but accumulating little or nothing; being on the margin between self-support and dependency.

Comfortable: Having accumulated resources sufficient to maintain self and family for at least four months.

Patients should not be classed as "dependent" because they are not able to reimburse the hospital for their maintenance provided they were previously able to maintain themselves. Minors and aged people cared for by their families

should not be classed as "dependent." Their economic condition should be considered as that of their family.

A pensioner who has no accumulated resources should be classed as "marginal."

TABLE 12. USE OF ALCOHOL BY FIRST ADMISSIONS CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES

The term "use of alcohol" refers to the alcoholic habits of the patient previous to the onset of the psychosis.

The term "abstinent" should be applied to persons who use no alcoholic liquor whatever. "Temperate" denotes persons who use some liquor but not in sufficient quantities to be classed as intemperate. Intemperate use of liquor should be inferred from (1) repeated intoxication, (2) physical, mental or moral deterioration or any disease due to alcohol, (3) unsocial acts due to alcohol.

TABLE 13. MARITAL CONDITION OF FIRST ADMISSIONS CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES

The terms denoting "marital condition" used in the headings are to be applied in accordance with the ordinary usage of the words. "Separated" means living apart through estrangement, whether legal or not, but not divorced.

TABLE 14. PSYCHOSES OF READMISSIONS

The term "readmission," as previously stated, includes all insane patients admitted who have been previously under treatment in an institution for the insane, excepting transfers and patients who have received treatment only in institutions for temporary care.

TABLE 15. DISCHARGES OF PATIENTS CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES AND CONDITION ON DISCHARGE

The terms "recovered," "improved," "unimproved," and "not insane," are to be used as in Table 3, and the totals under the respective headings should equal those given in section 3 of that table.

TABLE 16. CAUSES OF DEATH OF PATIENTS CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES

Each institution should procure from the Superintendent of Documents, Washington, D. C., a copy of the "Manual of the International List of Causes of Death" and report the deaths of patients in accordance with the directions contained therein. If this manual is carefully used the death tables from the several institutions will be made comparable.

The following quotations from this Manual will be found helpful:

"1. Select the primary cause, that is, the real or underlying *cause of death.* That is usually

(a) The cause first in order.

(b) The cause of longer duration. If the physician writes the cause of shorter duration first, inquiry may be made whether it is not a mere symptom, complication, or terminal condition.

(c) The cause of which the contributory (secondary) cause is a frequent complication.

(d) The physician may indicate the relation of the causes by words, although this is a departure from the way in which the blank was intended to be filled out. For example, 'Bronchopneumonia *following* measles' (primary cause last) or Measles *followed* by Bronchopneumonia (primary cause first).

2. If the relation of primary and secondary is not clear, prefer general diseases, and especially dangerous infective or epidemic diseases, to local diseases.

3. Prefer severe or usually fatal diseases to mild diseases.

4. Disregard ill defined causes, and also indefinite and ill defined terms (e. g., 'debility,' 'atrophy'). Neglect mere modes of death (failure of heart or respiration) and terminal symptoms or conditions (e. g., hypostatic congestion of lungs).

5. Select homicide and suicide in preference to any consequences, and severe accidental injuries, sufficient in themselves to cause death, to all ordinary consequences. Tetanus is preferred to any accidental injury, and erysipelas, septicaemia, pyaemia, peritonitis, etc., are preferred to less serious

accidental injuries. Prefer definite means of accidental injury (e. g., railway accident, explosion in coal mine, etc.) to vague statements or statement of the nature of the injury only (e. g., accident, fracture of skull).

6. Physical disease (e. g., tuberculosis of lungs, diabetes) are preferred to mental diseases as causes of death (e. g., manic-depressive psychosis), but *general paralysis of the insane is a preferred term.*

7. Prefer puerperal causes except when a serious disease (e. g., cancer, chronic Bright's disease) was the independent cause.

8. Disregard indefinite terms and titles generally in favor of definite terms and titles."

TABLE 17. AGE OF PATIENTS AT TIME OF DEATH CLASSIFIED WITH REFERENCE TO PRINCIPAL PSYCHOSES

The remark made with reference to age groups in connection with Table 8 applies to this table and to Table 18.

TABLE 18. TOTAL DURATION OF HOSPITAL LIFE OF PATIENTS DYING IN HOSPITAL CLASSIFIED ACCORDING TO PRINCIPAL PSYCHOSES

The term " total duration of hospital life " means the total time spent by the patients in hospitals for the insane whereever located.

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