The Relation of Law and Medicine in Mental Diseases

(CONTINUED FROM NOVEMBER ISSUE)

Traumatic Neuroses

Following accidents—whether or not the patient is physically injured—there often develops a train of symptoms which have received the name of traumatic neurosis (variously called "traumatic hysteria", "traumatic neurasthenia", "shell-shock", during wartime). Primarily these patients are usually psychopathic or have an unstable nervous organization, and are very susceptible to "psychic" trauma, or slight physical trauma. In the majority of these cases there is an abnormal degree of suggestibility present. It will be assuming too much, however, to state that all the symptoms are caused by suggestion. It is equally wrong to claim that the symptoms develop because of expectancy of monetary compensation.

The onset of symptoms may be immediate or gradual. A case is recalled which demonstrates immediate onset. A man, aged about forty years, was loading merchandise in a box-car, carrying his load on his right shoulder and supported by his right hand and arm. It was necessary for him to avoid a rather large hole in the floor of the box-car as he carried his load from the loading platform to be stacked in the car. Many times he passed by this hole, knowing its presence. On one of his trips he stepped through the opening in the floor of the car with his right leg. The jar was sudden and his position cramped, so his entire leg went through the hole. The weight of his load was also on his right shoulder and arm. Immediately he became paralysed on the right side (hemiplegia). Careful examination did not reveal any organic changes, although every possible test was given. The patient was given an anesthetic (ether) and during the stage of excitement he waved both of his arms and legs about, which would not have been possible had there been a destructive lesion. The paralysis reappeared as soon as the anesthetic was withdrawn. A second attempt at anesthesia the following day was resisted and the patient jumped off the table, using his paralysed side to assist him. Again he relapsed—notwithstanding an explanation of the nature of his condition. Patient was recommended for compensation and later lost track of, although he was improving when last reported.
Such a case could well be diagnosed as hysterical paralysis (hemiplegia).

The traumatic neurasthenic cases are usually more gradual in their development, the principal symptoms being abnormal fatigability, inattention, loss of interest, poor concentration, depression, great irritability, poor, or even loss of emotional control (patient cries very easily). There are usually present insomnia, terrifying dreams, disturbances of digestion and of appetite, headache, vague pains, pains in back, vertigo; frequently a sensation of pressure in back of head and neck; irregular attacks of "palpitation of heart"; various peculiar sensations in the skin (sensations as of ants crawling, itching, etc.). Objective signs are difficult to find. There may be tremor of upper extremities, exaggeration of deep reflexes, and rapid pulse. Many of these cases occur in patients having an unbalance of the secretions of internal glands such as thyroid glands, adrenal glands, etc.

Physicians seeing many of these cases are often prone to become hardened and stamp all as hysterical and refuse to recommend for compensation. These patients are in need of treatment just as any other nervous cases would be, and they should receive treatment and not be turned loose with a small compensation in anticipation that the compensation will act as a therapeutic agent. In some cases it does, but one has only to look at the records of the various state compensation bureaus to realize the fallacy of this idea as applied to all. The case described below illustrates well the danger of being too positive regarding such cases.

It occasionally happens that persons suffering from grave organic nervous diseases bring suit against public service corporations for damages because of injuries supposed to have been received through carelessness of employees of such corporations. In reality such claims are not just, for it often happens that the accident or injury is the direct result of the patient's condition and not due to carelessness or negligence of employees of the corporations sued.

One of us was consulted by a woman, sent by her attorney, to determine her condition from a nervous standpoint. This woman claimed a sprained back and difficulty in walking as a result of a fall from a street-car. Examination revealed the fact that she was suffering from locomotor ataxia. In such cases it is common for the patients to misjudge distances and they may collapse suddenly, and it is not at all uncommon for them to attribute falls and
injuries to external conditions and overlook the actual cause—the
disease from which they suffer. Close questioning and investiga-
tion of facts in this case revealed circumstances which undoubtedly
placed the responsibility for the alleged injury upon the patient and
not upon the public service corporation. Instead of the disease
being the result of the accident, the accident was the result of the
disease. It just so happened that the collapse came when she was
boarding a car—a coincidence only. It is highly important to have
a neurological report on all such clients.

Cerebral Arteriosclerosis.

1. Brief Statement of Case

Your client consults you in regard to the will of decedent, her
father. The father was aged sixty-two at the time of his death.
He was married at the age of twenty-two, had three children—
two sons and one daughter. The wife died when he was thirty-
eight. He married again at the age of forty-one and had one
child (your client) by the second wife. Differences with the second
wife arose in later years. He brought an action against her for
divorce; the case was tried and submitted. On the night of the
submission the will was made, giving all the property, amounting to
$150,000, to the children of the first marriage and cutting off your
client.

2. Legal Facts

In favor of the will there is the estrangement from the mother
of contestent. Decedent was a lawyer in active practice, engaged
in trying cases up to the time of his death. He carried on at the
same time important work for the government. Legal testamentary
capacity exists under the following conditions: "If he is able to
understand and carry in mind the nature and situation of his
property and his relations to his relatives and those around him,
with clear remembrance as to those in whom, and those things in
which, he has been mostly interested, capable of understanding the
act he is doing, and the relation in which he stands to the objects
of his bounty, free from any delusion, the effect of disease, which
might lead him to dispose of his property otherwise than he would
if he knew and understood what he was doing, he has the capacity
to make a will."36

There is not even a suggestion that the decedent did not know

36 In re Ross (1916) 173 Cal. 178, 159 Pac. 603; Estate of Dole (1905)
147 Cal. 188, 81 Pac. 534; Estate of Motz (1902) 136 Cal. 558, 69 Pac. 294;
based on Whitney v. Twombly (1883) 136 Mass. 143.
3. Medical and Psychiatric Facts

This being a testamentary case, the examination of the person whose sanity is in question is not possible. Fortunately in this case there was an autopsy. The autopsy showed cause of death in an aneurism of the heart with a general condition of arteriosclerosis (hardening of the arteries), and especially a cerebral (brain) arteriosclerosis, together with resulting hemorrhages and lesions. Further investigation showed that four years before his death decedent had an apoplectic attack. He was very sensitive about it, and left the hospital in a week, but was confined to his home and partially paralyzed for over a month, his physical and mental condition being seriously impaired thereafter. There is nothing special to note in the family history.

**BEFORE APOLECTIC ATTACK**

**Health History**

- Apparently normal, vigorous, fond of walking.
- Nothing abnormal especially noticeable; seemed to have control over his emotions.

**Personality**

- Lawyer, active in the profession and trial of cases; interested in politics; government official; public speaker.

**Work**

- Easily fatigued; unable to work at night; obliged often to quit work early in the day. Unable to speak in public as he became too excited; voice thick; memory poor. Forgetful of appointments and of money. Disliked trying cases in court, realizing that he became personal and angry with the opposing counsel.

**AFTER APOLECTIC ATTACK**

- Could not walk with vigor and strength. Easily fatigued. Fell down frequently. Painting spells. Insomnia at night. Fell asleep in the day in public places and at meals. Speech thick. Talked to himself. Eyelid drooped. Eye puffed, Jaw sagged. Limbs dragged. Emaciated. Walked with effort. Suffered most severely from trouble with heart, kidneys, and from acute indigestion, partially paralyzed in one arm, continually massaging same. Intense pain in the head, described as if a band were cutting into it. Massaged his head continually.

- Weak, irritable, despondent, violent and enraged at trifles, silent, no control over emotions; crying at the least occurrence, preoccupied, dreaming, careless of personal appearance, untidy.
Disappointment with the children of the first marriage, long continued and often expressed. Educated one son for a lawyer and disappointed because he adopted a menial employment and was a general failure. Other son refused to become educated, and it was necessary for decedent to find him job after job. The third child was disliked by decedent on account of refusing a position obtained for her by decedent and on account of an alleged spiteful attitude. To the daughter of the second marriage his attitude was one of unusual affection. Walked to school with her and in the park on Saturdays and Sundays. She visited him almost daily at the office; he took her and her friends to theatres and dances, sending flowers and candy, always referred to her in terms of endearment with a peculiar cadence in his voice; expressed himself as worshiping the ground she walked on. Generous, and often referred to the fact that he never broke a promise to her.

With this combination of progressive physical and mental disorder there came the excitement of the divorce trial, during which decedent suffered severely, at times being unable to go on. At the conclusion of the trial he was very sick, and vomited, shaking and trembling that entire evening. In that condition he made a will on a yellow sheet of paper; although a lawyer, he appointed no executor. He was obliged to ask for the postponement of the trial of another case in which he was interested, and a few days later dropped dead from the causes above described.

4. Diagnosis

The diagnosis shows from a medical point of view a perfect case of cerebral arteriosclerosis. The legal problem presented by the foregoing facts is by no means easy of solution. In a criminal case, as has been already pointed out, the remedy is simple. Whether sane or insane, the defendant has demonstrated by his act that he is a custodial case. Where there is doubt as to his sanity an institution for the criminal insane is the proper place of confinement. In a will contest, however, the problem cannot be solved so easily—the will is valid or invalid. It is true that if invalid the property goes according to a prior valid will, if
there is one, or if not, then in accordance with the intestate laws of the state—and the state makes a pretty good will for a man. Indeed, on the continent, the power of a decedent to cut off his children is considerably curtailed. On the other hand, it is a serious thing to break a will and the courts are inclined to scrutinize closely the verdicts of juries. Non-suits are freely granted against contestants and the verdicts of juries in favor of contestants set aside. There must be substantial evidence of insanity before the case can be left to the jury. Accordingly we frequently find statements to the effect that "the evidence falls far short of showing that the testamentary act was affected in the slightest degree by any or all of these abnormalities." It is thus easy to find cases to the effect that old age does not deprive one of testamentary capacity, nor arteriosclerosis, nor epilepsy, and so on, with each form of physical or mental ailment.

Even in California the power to dispose of the community property was formerly curtailed: O. K. McMurray, Liberty of Testation and Some Modern Limitations Thereon, 14 Illinois Law Review, 96.

Note L. R. A. 1915A 443, commenting on Estate of MacCrellish (1914) 167 Cal. 711, 141 Pac. 257. In Estate of Chevalier (1911) 159 Cal. 161, 113 Pac. 130; Estate of Purcell (1912) 164 Cal. 300, 128 Pac. 932; Estate of Kendrick (1900) 130 Cal. 360, 62 Pac. 605 and Estate of Dole, supra, n. 1, either a non-suit was granted or the verdict of the jury in favor of the contestants set aside. In the Estate of Kendrick one judge dissented from the order denying a rehearing. On the other hand, in the Estate of Martin (1915) 170 Cal. 657, 151 Pac. 138, the court found that there was evidence to sustain a verdict either way, and the contestant was also sustained in Estate of Wasserman (1915) 170 Cal. 101, 148 Pac. 931 and Estate of Jones (1913) 166 Cal. 108, 135 Pac. 268; while in In re Ross, supra, n. 1, a non-suit was held to be erroneously granted. In the Estate of Scott (1900) 128 Cal. 58, 60 Pac. 527, the verdict upheld the will, and this was sustained on appeal. The testatrix there tried the interesting experiment of having an examination of herself made by alienists to determine whether she made a will. The Estate of Scott was followed in Estate of Allen (1918) 177 Cal. 668, 171 Pac. 686, where in a concurring opinion Mr. Justice Wilbur comments as follows: "With reference to what is said concerning an insane delusion I concur because of the fact that the question as to what constitutes an insane delusion has heretofore been treated by this court as a question of law, and the court has defined, as a matter of law, what constitutes an insane delusion. In this, I think, the court has been in error. An insane delusion is one that is the product of a disordered mind produced because of the disorder. In other words, it is a symptom of a condition of mental disease. The question of whether or not a person is suffering from mental disease is a question of fact to be determined in the light of increasing medical knowledge. To say that a person is not suffering from an insane delusion because his conduct in reference thereto does not measure up to a legal standard is, in my opinion, as fallacious as it would be to say that, as a matter of law, a man does not have syphilis if he does not have the symptoms which were recognized as indicia of the disease before the discovery of the Wasserman test, which, modern research has disclosed, practically demonstrates the existence or nonexistence of syphilis."

Sooner or later this view is certain to prevail. While an examination of the foregoing cases shows that the courts rightly require substantial evidence of mental disease, and proof that the mental disease caused the execution of the will, it is also evident that the court is guided by certain
This can be conceded, but it does not solve the problem. A normal man can make a will; the raving maniac or the idiot cannot. How far must the deviation from the normal progress in order to deprive a person of testamentary capacity? It must be substantial and the will must be the product of the mental alienation. Two considerations of importance should be noted: (1) Does the will express a material deviation from the normal attitude of the testator? Not that testators must act like normal men, but it is a factor of considerable significance when the testator exhibits as a result of mental disease a change in personality manifested by a complete reversal of his attitude toward the people around him. (2) Is there a correlation of symptoms physical and mental that taken together manifest an advanced stage of the disease? These two considerations taken together assist in arriving at a solution, although after all the limits of variation in judgment are great. In the principal case the picture accords closely with the clinical symptoms of cerebral arteriosclerosis:

"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."

What makes judgment more than usually difficult in these cases of cerebral arteriosclerosis is that in this disease we have the suspicious and paranoid ideas, but the personality remains. "In arteriosclerotic dementia the patient has better insight into his condition. The delusions are more closely related to his practical considerations. An irascible, changeable, spiteful individual is likely to make any kind of a will, depending upon the way he happens to feel at the time he makes it. Such a will will be upheld, although the testator is undoubtedly suffering from some pronounced abnormality. When, however, the mental disease results in a change of personality, so that the will indicates a complete reversal of the testator's lifelong attitude toward his family, then it is fairly safe to say that the will is the result of a mental disease. Correspondence with the person's normal acts and conduct is commented on in L. R. A. 1915A 463. A persistent aversion to wife and children and long residence with other relatives was held sufficient to sustain a will in favor of the relatives, although the jury had found for the contesting children. Estate of Riordan (1910) 13 Cal. App. 313, 109 Pac. 629.

\[39\] Statistical Manual for the Use of Institutions for the Insane, p. 16.
previous life, to the vocation and social position of the patient. They are less unnatural, 'the nucleus of the personality' has been retained."

As so many cases are lost by the failure to present the combination of facts necessary to establish the existence of the disease, i.e., physical, mental, life and family history, it may be well to emphasize the opportunity which the law gives for presenting these facts in court. In the first place, much of the theory can be presented, if desired, in the examination of the jurors. The proper atmosphere can be there created. Then in the opening statement the theory may be stated clearly, the nature of the mental disease and the evidence by which it is proposed to establish it. Then come the witnesses, each testifying as to facts—family history, physical condition, appearance, conduct, etc. Then comes the question to the expert. Properly constructed, in a case where it is justified, the hypothetical question should begin with the statement: "Assume the following facts." It should not thereafter be weakened by a repetition of the idea that the facts are assumed. The question should contain a narrative in simple language of the actual facts to which the various witnesses have testified. These facts, organized logically and marshalled dramatically, should show irresistibly a complete picture of the advanced stage of the mental disease it is desirable to present. To this question the expert replies and gives the reasons showing the significance of the facts as justifying the medical point of view.

For some of the trouble experts get into on the stand they are themselves to blame. Often so-called experts think they can testify without any special preparation on the particular case from their general fund of information. They become angry if their opinion is questioned. Then the lawyer often fails to protect his expert; opposing counsel on cross-examination asks a trick question or a misleading one, gets the laugh on the expert and refuses to permit an explanation. A lawyer well prepared on the medical side can on the redirect examination ask the proper questions that will expose the unfairness of the cross-examination and enable the witness to place the truth before the jury. As in the above case, the cross-examiner will take one piece of evidence at a time: "You say the decedent complained of the amount of the bills each month? Is that a sign he was crazy?", and with a wink and side remark to the jury, "This fellow will have us all crazy." He will go on with the questions: "Is a man unable to make a will

40 White, Outlines of Psychiatry, p. 208.
because he suffers from headaches?”, etc., etc. Perhaps the most effective answer to all this is to take advantage of the opportunity on redirect examination to complete the picture by showing how the various facts in evidence, no one conclusive in itself, but accumulated and combined, present an unmistakable case of mental alienation.\[41\]

\[41\] Declarations of present pain and suffering are received as an exception to the hearsay rule. It is true they might be simulated. Nevertheless, as it is the only evidence available, as a rule the courts receive it. The intimation in Green v. Pacific Lumber Co. (1900) 130 Cal. 435, 62 Pac. 747, that the declarations should be involuntary is not law in California. "His declarations are taken, because although they may be feigned, still it is the best we can do. Whether feigned or not must be left to the jury." Lauge v. Schoettler (1896) 115 Cal. 388, 47 Pac. 139. People v. Bray (1919) 29 Cal. App. Dec. 428, 183 Pac. 712, contains the fullest statement of the doctrine at the present time in California. Declarations of past pain or suffering are not received. Such declarations, however, come in when made to a physician to enable him to prescribe for his patient. This is not by way of exception to the hearsay rule, but simply as a part of the ground for the expert's opinion. Some courts, however, refuse to allow the physician to base his opinion on anything told to him by the patient when he is not the attending physician called to prescribe for, and actually treating the patient. In other words, where the expert is consulted for the purpose of giving testimony in the case, his opinion must be based on what he discovers for himself (objective symptoms), but not on what the patient tells him (subjective symptoms). This doctrine is well-established in Illinois: Greinke v. Chicago City Ry. Co. (1908) 234 Ill. 594, 85 N. E. 327; Casey v. Chicago City Ry. Co. (1908) 237 Ill. 140, 86 N. E. 606, 608; Fuhry v. Chicago City Ry. Co. (1909) 239 Ill. 548, 88 N. E. 221, 222; Shearer v. Aurora, Elgin & Chicago R. Co. (1916) 200 Ill. App. 225, 226.

The questions are discussed at some length in Wigmore on Evidence, §§ 698, 1719; Chamberlayne, Modern Law of Evidence §§ 2635, 1911A; Jones, Blue Book on Evidence, § 349 a, 39 L. R. A. 305, note. In many cases the difficulty is practically removed by having the patient testify to all his symptoms, and then include them in the hypothetical question to the expert. Where this is not done we have conflicting lines of authority: (1) apparently no opinion allowed based on what the party has said to the physician for the purpose of obtaining his testimony on trial: Smith v. St. L. & S. F. R. Co. (1915) 95 Kan. 451, 148 Pac. 759. (2) The opinion may be given, but not the statement on which it is based, unless the opposing party wishes it on cross-examination: Stearns Coal & Lumber Co. v. Williams (1917) 177 Ky. 698, 198 S. W. 54. This qualifies Chicago, R. I. & N. O. R. Co. et al. v. Rowell (1912) 151 Ky. 313, 151 S. W. 950, 954; Chesapeake & O. Ry. Co. v. Wiley (1909) 134 Ky. 461, 121 S. W. 402, 409; State v. Alexander (1920) 103 S. E. 383 (N. C.), qualifying the earlier North Carolina case of Cooper et al v. Seaboard Air Line R. Co. (1913) 163 N. C. 150, 79 S. E. 418; Flessher v. Carstens Packing Co. (1916) 93 Wash. 48, 160 Pac. 14. (3) The opinion may be given and the entire statement for what it is worth, not as proof that the patient actually suffered as described, but simply as part of the grounds for the expert's opinion. The fullest statement of this view is to be found in Chicago, R. I. & P. Ry. Co. v. Jackson (1917) 162 Pac. 823 (Okla.). See also St. Louis & S. F. R. Co. v. McFall (1917) 163 Pac. 268, 271 (Okla.); Ft. Smith & W. Ry. Co. v. Hutchinson (1918) 175 Pac. 922 (Okla.); Cronin v. Fitchburg Ry. (1902) 181 Mass. 200, 63 N. E. 335. The courts adopting this view would exclude, and rightly, all statements concerning the cause of the injury, the narrative of the events not necessary to understand the nature of the disease and the injury. For example, the physician would be allowed to state that the patient told him he was thrown off a car and struck on his head. The details of the altercation with the conductor, and
The expert always has the advantage of the lawyer, for the
lawyer must examine the expert on the expert's specialty. He
must play the other man's game. The expert has nothing to fear
if he will keep his head and observe a few simples rules: (1)
prepare thoroughly both the general theory and the facts of the
particular case; (2) tell the exact truth and refrain from attempting
the placing of the responsibility would be irrelevant for the purposes of
treatment.

In the case of insanity as a defense in criminal cases, however, all the
facts of family history, health history, life and work are important. The
modern physician for diagnosis finds it necessary to probe into the entire
life of the patient. Psychoanalysis, which will be discussed briefly in a
later article, has made us realize more than ever the importance of things
perhaps forgotten by the patient. Every expert, therefore, in his diagnosis
for mental disease relies in part on the statement of the patient, not
merely as to his physical and mental symptoms, but as to his family and
life history. It would be impossible for him to eliminate the patient's
statement as a factor in the diagnosis. It must not be supposed that a
competent expert accepts the patient's statement at its face value. If he
knows his business, he will do a little cross-examining on his own account
to assist in getting the truth, and will verify the statements where verifica-
tion is possible. All this is necessary in order to determine with what kind
of a patient he is dealing—a paranoiac, a pathological liar, a victim of
hysteria, etc., etc. In other words, the expert's testimony comes with the
weight of his experience. No one is better able to sift the statements
of a person. It must not be overlooked that an admittedly insane person
may nevertheless give an accurate and trustworthy account of past events.
Chamberlayne's Best on Evidence, p. 132.

The exclusionary rule seems to rest on the theory that the patient and
the expert have entered into a conspiracy to present false testimony, or at
least to win the sympathy of the jury by presenting a harrowing life
history of the patient not subject to cross-examination, and which could
not otherwise be admitted. This is of course possible, but the exclusionary
rule overlooks the safeguards which the law provides: (1) the fact that the
expert is an expert in diagnosis and in appraising the value of the state-
ments of the patient; (2) the discretion of the trial court in excluding
statements not necessary for diagnosis, and thus preventing an abuse of
the general rule which permits the expert to give the grounds of his
opinion; (3) the opportunity of contradicting by cross-examination and by
other witnesses, thus demolishing the opinion of the expert. As has been
said, it is easy to lie, but not easy to lie circumstantially, and the fuller
the statement the greater the opportunity the other side has to discredit it,
and the expert who bases his opinion thereon.

The New York courts, while adopting the rule excluding statements
of past events when made for the purpose of testifying in cases where
insanity is in issue, admit an exception where insanity is claimed at the
time the physician made the examination. People v. Nino (1896) 159 N. Y.
317, 53 N. E. 856. On the theory of the other New York cases, present
insanity can be simulated as well as past. People v. Hill (1909) 195 N. Y.
16, 87 N. E. 813, rejecting the statement of the defendant, and by way of
dictum even the opinion based on such statement. Yet the expert in New
York need not give the grounds of his opinion. People v. Faber (1910)
199 N. Y. 256, 92 N. E. 674, 20 Ann. Cas. 879. In California the court has
apparently taken the position that statements made to the expert for the
purpose of testimony are not excluded, and has held definitely that state-
ments of past pain and suffering come in, not as an exception to the hearsay
rule, but as part of the expert's testimony. The case apparently did not
involve family and life history, but the same reasons for admission would
apply when insanity is in issue. People v. Shattuck (1895) 109 Cal. 673,
42 Pac. 315.
to stretch the evidence in favor of the side calling the witness; (3) speak clearly and definitely, keep to the subject, and resist the temptation of being led away into a contest of repartee with the opposing counsel; (4) use simple words—where necessary for accuracy to employ technical terms, explain them in language understandable to the layman; (5) prepare counsel thoroughly on the medical theory.

**Senile Dementia.**

1. **Statement of Case**
   
   Defendant, a gardener, stole a garden hose and concealed it.

2. **Legal Facts**
   
   Had stolen a garden hose about a year before and served a term for it—in fact, had been out of prison only a few days when arrested for the present offense.

3. **Medical and Psychiatrical Facts.**
   
   Age, about 65. Organic changes in brain and spinal cord. Injury eighteen years before may have contributed to preparing the soil for the destructive processes.\(^{42}\) The defendant was acquitted.

   A case of senile dementia may usually be distinguished from cerebral arteriosclerosis, as it comes on later in life as a rule, and medical examination often discloses differentiation in the blood-vessels, there being sometimes no hardening of the arteries. In the extreme condition of senility with almost total impairment there is no question of the condition, but it is often unrecognized in the earlier stage, as its development is gradual. A perfectly normal person around seventy begins to be irritable, restless, confused, makes accusations against members of his family, often absurd fabrications, shows extreme jealousy. A good client, he surprises his lawyer by unreasonableness in the attempted settlement of disputes; shocks the family by being arrested for theft, indecent exposure, assaults upon children, arson, etc. Many of the cases of larceny by elderly women are senile, as it is one of the manifestations of the disease to pilfer and hide things. In the case of the gardener, however, the theft seems rather the result of a confused state of mind, in which he was carrying on his usual occupation. There is a tendency to drunkenness and a susceptibility to alcohol. There is often aphasia (inability to express thought in words) and amnesia. There is, of course, no

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\(^{42}\) The possible effects of such injury have been previously noted. 9 California Law Review 25.
cure, but the condition may be ameliorated and life made tolerable to the patient and those about him by proper medical treatment. An early recognition of such cases will save much trouble to the public and to all concerned later on. There is perhaps nothing more cruel and distressing than the usual court procedure in such cases.

Epilepsy.

1. Brief Statement of Case

Decedent had wronged the sixteen-year-old daughter of defendant. Defendant bought a pistol, sought out decedent, went with him to his office in a building and there shot and killed him.

2. Legal Facts

In addition it is merely important to point out that the defendant shot the decedent several times in a savage manner. He had known of the act of the decedent for a week, so that ample cooling time had elapsed. It was therefore a case of murder, not manslaughter.

3. Medical and Psychiatrical Facts

An examination of the defendant reveals epilepsy and other physical and mental disease. We have here no abrupt change in personality, but rather a continuous and logical development from the defendant's early physical and mental condition.

Family History:

Father was alcoholic, died of alcoholism and rheumatism. Two other members of the father's family were epileptic. One brother of defendant died of epilepsy. The family was well-to-do and defendant's mother was prominent socially, paying little attention to the family, so that from the age of nine to thirteen defendant was for the most part in a boarding-school.

Health History:

Gonorrhea and syphilis at 13. Suffered from effects of latter disease most of his life. Severe headaches. Epileptic attacks beginning when 31 and continuing with considerable severity to time of trial. As a result of illness unable to work for months at a time.

Personality:

Moody, irritable, sullen; contemplated suicide; influence of wife helped him to control himself.

Work and Delinquency History:

Stole from family in early years, reform school, held up people,
burned buildings; craved excitement; hobo; homosexual tendencies; pathological lying (lying without any apparent motive). Early delinquencies perhaps exaggerated. Inherited some money, lost it right away in oil business; saloon business for a short time. Married at about 20 and thereafter worked hard except as health prevented, and no delinquencies.

Attitude Toward Family:

Family consisted of wife and four children. Kind and apparently a sincere effort to control his disposition and temperament.

Referring to the classification, we have here a constitutional psychopathic inferior with epilepsy. The constitutional psychopathic inferior will be discussed later. Epilepsy is the more significant disease in the present case. The epileptic condition is common to many diseases, so that psychiatrists speak of the epilepsies, reserving the term epilepsy for those cases where the form is not apparently a symptom of some other condition. The convulsions that are properly associated with epilepsy are common to other diseases and may be artificially produced. In the convolution or just before or just after, the patient is liable to do anything. The most savage, brutal crimes, crimes resembling the Murders in the Rue Morgue, are committed by epileptics, often in an epileptic delirium succeeding or replacing a convulsive attack, which latter may be slight and thus overlooked. When exaggerated the delirium is known as epileptic furor. Furthermore, and this is most important, the disturbance may not take the form of a convolution, but there may be an attack of mental disturbance, an epileptic equivalent. These attacks of psychic epilepsy are called epileptic automata (absence) or epileptic dream states. In some cases, this condition may exist for days. The patient retains not the slightest recollection of what he has done. In this it is like other cases of amnesia.43

Lawyers and the public protest against evidence of amnesia being allowed in a criminal case. It is a curious attitude. The law

43 Amnesia is a disorder of memory. There are three phases of memory—the fixation of a representation, its conservation, and its revival or reappearance in the field of consciousness. The inability to fix representations is known as anterograde amnesia. All conditions where preceptions are vague or uncertain are accompanied by more or less marked amnesia of fixation. This is often the condition in an epileptic delirium. The amnesias of conservation and reproduction are called retrograde. Amnesia of reproduction is loss of memory for certain things or for events extending over a very definite space of time. It usually has a definite beginning and a fairly definite ending. The onset may be sudden or gradual. See White, Outlines of Psychiatry, 7th ed., p. 78; de Fursac and Rosanoff, Manual of Psychiatry, 4th ed., p. 51.
could hardly take the position of suppressing the truth. The truth is that the condition does exist. In epilepsy and several other diseases, acts are done of which no consciousness is retained, or there is a dissociation of consciousness in which there is no recollection of what was done in the previous state. This happens with patients every day and no comment is made. Let one of the patients in that condition kill somebody and we are told no such condition can exist. Such an attitude is childish. We must recognize the existence of these conditions. What effect the law should give is another question. It may be perfectly logical and proper to say that persons afflicted with epilepsy who have committed a crime while in that stage should be imprisoned in a hospital for criminal insane. They are usually very dangerous. It is worth while emphasizing this matter because there is so much popular prejudice and ignorance on the subject. Epilepsy, for example, may or may not be accompanied by noticeable mental deterioration, so that between seizures, convulsive or otherwise, the defendant may appear to the jury a perfectly normal and intelligent man. How prevent the abuse of such a dangerous defense? Again we say, if the law made the choice one between the state prison and an institution for the criminal insane, instead of between imprisonment and freedom, there would not be so much difficulty. Under the law as it now stands, unfortunately, the jury should acquit in such cases. The danger of a fraudulent defense can be to a certain extent guarded against by requiring strict proof. There should be independent evidence of epileptic seizures, as there was in the case under consideration. Again the automatic acts are usually in accordance with the life of the patient. This was noted in the first case considered, of a dream state resulting from injury, where the defendant in killing the decedent went through his habitual hunting movements.

To return to the principal case, what conclusion should be drawn? We have an undoubted epilept. But was epilepsy the

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44 The automatic acts occurring in epileptic dream states are more simple than in dream states resulting from alcohol and hysteria. The latter may last for days and may not be automatic. "It would be in perfect harmony with the observations that have been made to find an epileptic butcher having assaulted another individual with a knife, nor would it be strange to find a soldier in a post-epileptic state shooting an individual.

The handling of a gun or knife are habitual acts of the soldier and butcher respectively; but should a butcher kill an individual by administration of poison, we should be exceedingly slow to regard such a crime as an expression of epilepsy, since the handling of drugs is a foreign procedure to the act of cutting meat." Paul E. Bowen, Clinical Studies in the Relationship of Insanity to Crime, p. 25.
cause? It does not seem to have been a dream state, for the
defendant retained consciousness and retained a clear and accurate
recollection of the whole affair. In the spontaneous and appar-
etently uncontrollable manner of killing, in the feeling of clearness
and relief when the act was done, the effect of the epilepsy is
apparent. Was it really uncontrollable as it would certainly be in
a typical case of epileptic convolution or dream state? It can hardly
be claimed that it was. What we have is a man with bad heredity,
bad youthful environment, a constitutional psychopathic inferior,
weakened by syphilis and epilepsy. Under a normal environment,
with the influence of wife and family, he restrained his suicidal
impulses and with considerable effort "got by" in society and with
his family. Then came the sudden revelation of his daughter's
disgrace, the impulse to save her reputation struggling with the
impulse to avenge, a week of nervous agitation—"Nobody knows
what I suffered for three days before that."

The belief that the decedent was evading him, the accidental
meeting, recrimination and insult, a pyramiding of emotions, and
the already weakened nervous organization gave way with a rush
like a river breaking a dam.

Natural as the act of the defendant seems, under the law of
California one would almost certainly have to pronounce him
responsible. The jury, however, disagreed, induced probably less
by expert testimony as to insanity than by a sympathy with the
defendant and an application of the unwritten law in his favor.

GENERAL PARALYSIS
(Paretic dementia, paresis.)

Statement of Case.
Defendant attacked his aged mother; she fled to the police
station; he followed her. A policeman tried to disarm him; he
shot the policeman three times, killing him.

From a legal point of view there is nothing to add.

Medical and Psychiatric Facts
Defendant about forty-four years of age, did fairly well at
school; not a great success in later life; worked at odd jobs;
would leave his family for years at a time and never communicate
with them; a "shut-in personality". For the last couple of years,
the family realized he had become insane but did not know how
dangerous he was. He did no work, destroyed several sets of
books, pictures and furniture in the house; was in trouble over
chopping down a telephone pole and later a sidewalk tree. The
examination revealed many physical symptoms, including restlessness, pupillary disturbances, aphasia, changes in reflexes and disorders of sensation. The mental symptoms were equally pronounced, including intellectual enfeeblement, boastfulness, euphoria (giving rise to illusions of great increase in physical and intellectual power) and a host of delusions of persecution, not systematized.

General paralysis may imitate and manifest the symptoms of all known forms of mental disease. The Wasserman test in this case for blood, and an examination of the spinal fluid showed conclusively syphilis. Every case of paresis means syphilis in the brain. It may not attack the brain for years after the original infection. There may be some remission, but death is almost certain to result within five years, usually less. The defendant in the principal case was obviously insane and was sent at once to a state hospital. It cannot, of course, be concluded that paresis is necessarily the cause of the crime. In one case a man with a rather bad heredity (mother insane, one sister epileptic) got along all right until about twenty-eight years of age. He was well educated, speaking and writing French and German. At about twenty-eight he contracted syphilis and began a criminal career, about a dozen burglaries being charged up to him in one of the bay cities. He also served a term in a penitentiary of another state. When about thirty-eight he was arrested for a burglary, sent to a state hospital and diagnosed as a paretic in the early stages. His crimes, however, began shortly after the original infection. Soon after he escaped and being arrested for burglary in another state was committed to the penitentiary. The weakness of our penal system is here strikingly revealed. Why should he have been allowed to commit in all probability hundreds of burglaries? Why when committed to an insane asylum was he not kept there? A number escape every year from the California state hospitals. It is probable that many of those so escaping belong to the criminal class. Certainly we need a special institution for the criminal insane, like Matteawan in New York.

It will be noted in the cases commented on under this heading that the defendants were of a weak nervous organization originally, and therefore susceptible to an attack of paresis. This view, however, is not subscribed to by all neurologists. "But here we have a disease, afflicting one when at the very zenith of his physical and mental powers, insidious in its onset, yet capable of so changing the character in a few weeks that the previously honest, upright,
moral, truth-loving, sober citizen becomes the votary of every form of vice, sinks to the depths of drunkenness and debauchery, and may even stain his hands in blood." Many lawyers will recall clients who suddenly become imbued with grandiose ideas of great wealth and embarked on some wild speculative scheme. Many a paretic has lost all his money before his disease was recognized. An interesting legal question might be raised as to the liability of such persons on their contracts.  

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(To be Continued)

45 White, Outlines of Psychiatry, 7th ed., p. 133.  
46 Southard and Solomon, Neurosyphilis, Case 84, p. 295.