INSANITY AND LAW
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A TREATISE ON FORENSIC PSYCHIATRY

BY

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PREFACE

As a natural outcome of his ideals, training and experience, the physician concerns himself primarily with the welfare of the individual. The law, on the other hand, is interested principally in the welfare of the social group. The former subordinates everything to the study and treatment of the man whose health is in question; the latter pays more attention to the effects of individual inadequacy on the community. Such divergence in point of view leads naturally to conflicting opinions, which will be most marked in relation to problems that concern mental health; for social existence depends on the control of the wants and desires of individuals by the operation of their minds. Yet there is no fundamental conflict between medicine and law. Difficulties disappear and cooperation becomes possible and imperative when each understands the other, for the views are really complementary. It is with the hope of contributing to this mutual understanding that this book has been written.

An excellent illustration of the feasibility of such cooperation is afforded in the adoption by society of measures for the control of infectious diseases; these are based on discoveries in medical science, in which the physician has assumed a social attitude without sacrificing his interest in the treatment of the individual. The problem here was comparatively simple and objective, the facts were clear and easily demonstrable. The facts of psychiatry are far more complex and less well established; also they enter more deeply into the foundations of social existence as they deal with human behavior. Much confusion has also been introduced by the lack of agreement, often more apparent than real, among
physicians themselves as to the nature and causes of mental disorders, and even as to the names to be used in describing them. Under these circumstances it is easy to understand why society has as yet appeared to pay little attention to the real advances that have been made in psychiatric science. Only when the physician can state his facts clearly and logically may he expect to receive the attention merited by the importance of his subject. It is essential also that he approach the question with a real appreciation of the social point of view and the foundations on which the law is built.

Society is awake to the fact that control of the rights and behavior of individuals in the interest of the group carries with it responsibilities that cannot be fulfilled by penalties inflicted after a wrong is done. Execution of the murderer does not help his victim; it is the duty of society to prevent the murder, and this means that the danger must be foreseen, a problem that often requires the aid of the psychiatrist.

Many physicians recoil from medicolegal work, repelled by the restrictions, regulations and red tape that surround legal procedure. But, cumbersome and senseless as these methods often seem to the uninformed, they are founded on the experience of ages and have been built up gradually to meet situations that the casual thinker could not anticipate. They cannot be waived without the certainty of injustice and the consequent undermining of the foundations on which society is built.

In this book the endeavor is made to state in simple language psychiatric facts that may be regarded as established, using a nomenclature that has been adopted as a standard by almost all the hospitals for mental diseases in this country. Unavoidable technical terms have been defined as concisely as seemed possible and these definitions have been collected in a glossary for ready reference in reading the text. The subdivision into reaction types and
diseases adopted, is intended partly to avoid duplication of description, but largely in the hope of rendering the wide variation in the clinical pictures presented by one disease more easily intelligible. Cross references have been given to the descriptions of the reaction types for convenience in reading the accounts of the different diseases.

In the section dealing with the legal aspects of mental disorder, an effort has been made to trace the origin and meaning of the various procedures and to illustrate the meaning by quotations of decisions by various courts. The references have been selected on the basis of practical experience in dealing with medicolegal problems. The aim throughout has been to outline the situation that now obtains both from the medical and the legal point of view, with the hope of bringing about a better understanding of the actual basis from which must start any practical effort to improve the relations between insanity and law. The requirements for this improvement are two-fold: the physician needs a better knowledge of legal practice and ideals, and the lawyer needs fuller information about mental diseases. If this book assists in supplying these needs, the authors will feel repaid for their efforts.

CHICAGO, ILLINOIS.
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INSANITY AND LAW

INTRODUCTION

In medicolegal work the relation which the physician bears to the patient is essentially different from that in the ordinary practice of his profession, even though in both the prime question is one of diagnosis. All legal problems concern, not only the welfare of the individual, but also his relations with the social group. Indeed, it is essential to realize that the prime interest of the law is in the community. Even when the point at issue is commitment to a hospital for treatment, the decision rests, not on the presence or absence of a particular disease, but on the question of the man’s ability to live in accordance with social conventions and regulations. A man is not deprived of liberty and sent to a hospital for mental diseases because he has general paralysis, but because this disease, by the damage it causes, renders him a menace to himself or others. Not a few persons die of general paralysis without commitment having been considered.

Laws relating to insanity have been framed for the dual purpose of protecting society and of safeguarding the rights of the afflicted individual. The rights of an individual include all of the inherent constitutional rights as to life, liberty and property of which he cannot be deprived without due process of law. All medicolegal problems are, therefore, essentially social, and extend beyond the immediate consideration of the patient to that of the community in which he lives. The principal factor in the maintenance of society is
the regulation of the behavior of individuals, which can only be effected through the operation of their minds. Disturbance of this regulation means social difficulty and it is only natural, when antisocial or unsocial behavior is observed, that there should often arise doubts as to the normal mentality of the offender. Because of the incapacity that results from mental disorder, there also frequently arise situations that require assessment of the amount of damage done to or caused by the person so afflicted.

In many instances there must also be considered the question of the degree of social responsibility the patient should assume. Strictly speaking, responsibility is determined judicially and not medically, but the physician cannot ignore this question, much as he would prefer to do so. He does not establish the standards by which responsibility is judged; these are usually set by legislative enactment and vary under different conditions and in different communities. But if he will perform his duty, the physician must study his patient in the light of the legal requirements, which presumably represent the opinions of the community.

There is often a fundamental difference between the scientific and therapeutic viewpoints on the one hand, and those that control in legal work on the other. Failure to appreciate this is responsible for much of the unfortunate divergence of medical opinion exhibited in expert testimony and the consequent, widespread derision to which medical experts are subjected. To the physician, insanity has a more or less constant significance, even though the definitions are not satisfactory or clear. To the lawyer, however, this is far from true. A man may be legally insane for one purpose and legally sane for another. For example, commitment to a hospital for insanity does not necessarily mean insanity when it comes to the question of making a will. So disconcerting is this variable use of the term that there
has been a very definite movement in psychiatric circles to eliminate the word insanity from medical nomenclature. Even if this effort were successful, which is extremely doubtful, it would but shift and not solve the problem, and it is probable that a substitute term would soon be used by laymen just as insanity is now.

Practically then, one may say that the physician is concerned with two problems in every medicolegal case. First, as to the facts by which he determines the quality of the patient's mental capacity, and second, as to the influence this capacity will have on the situation in question. In dealing with the former he will proceed just as in any other medical examination; in the latter he must take into account the legal aspects of the situation involved.

In reaching his conclusions, it is essential that the physician bear in mind that the opinions he expresses are to be used by laymen as an aid in reaching a judgment. He must therefore speak in terms that are intelligible to laymen. Technical terms are habitual to the specialist in any line of work and are necessary to save an endless waste of time. Unfortunately, even specialists do not always agree on the exact definition of such terms; many of them are quite local, sometimes even personal, in their significance. It is essential for the physician to be able to point out specific facts indicative of insanity that have been elicited during the examination of the person whose sanity is in question, or that are offered as hypotheses built up from evidence given in court. The technical diagnosis, which should always be made as precisely as possible to assist the physician in forming an opinion as to causes, duration, outcome and probable behavior, is of quite secondary importance to the court in reaching a decision and may often, with advantage, be omitted from the testimony unless it is specifically requested.
Popular concepts (including those of lawyers) of particular types of insanity are often far from the truth. This is an important fact in assisting the expert to detect malingering, but it is also a fact with which he must reckon in expressing his opinions if he is to do justice to himself and his patient, and really to assist the court.

Medically, we are well aware that it is impossible to draw a hard and sharp line between sanity and insanity. No entirely satisfactory definition has yet been achieved. Consequently, we are compelled to consider every case strictly on its own merits, a method of procedure that corresponds exactly with legal practice. Constitutionally, every man is sane until proved insane, though legally, it is occasionally true that, given a reasonable doubt, the burden of proof rests with the proponents of sanity. There is no sign or symptom that alone is absolutely indicative of insanity, and, contrary to much popular belief, insane people may behave in many respects like sane people. Indeed, it may be said that the behavior of insane people differs from that of the sane only in degree. In other words, insanity introduces nothing new, but merely exaggerates, modifies or distorts what was already present. The medicolegal expert will therefore be as meticulous in his examination of a person suspected of insanity as though the relations were those of physician and patient.

In addition to the changes in mind that constitute insanity, our subject also includes behavior that depends on the inherited make-up. This may be defective either in quantity or quality and must be studied in order to determine whether there has been subsequent alteration from disease (insanity).

The procedure that has been followed in this book is first to outline the various types of mental disorder and then to discuss the legal questions that may arise in connection with them. In outlining the forms of mental disorder we have adopted the plan of giving first a description of certain types
of reaction that may be encountered in many different diseases, in order to avoid duplication and with the hope of rendering the subject more clear. This is followed by a brief account of the principal types of mental disease. The legal aspects of the relations of insanity to the various phases of business and social life have been set forth by quoting and discussing the laws, methods of procedure and the important decisions of state and federal courts. Familiarity with these decisions will not only enable the physician better to advise patients and assist the courts, but will also give a better understanding of the reasons that underlie the various technicalities, many of which may seem otherwise so useless and objectionable.
PART I
MENTAL DISORDERS
I. TYPES OF REACTIONS

Differentiation between Structure and Function. One of the greatest stumbling blocks in the way of a clear grasp of the clinical pictures presented by mental diseases lies in the failure to differentiate between the consequences of structural damage to the brain on the one hand, and the kind of behavior of the individual on the other. Healthy people do not all behave in the same manner in identical circumstances. Given a situation that interferes with the acquisition of something strongly desired, one man will become angry and proceed forcibly to try to secure his own way; another will become depressed and retire from his fellows to brood over his disappointment; and a third feels wronged and will try to satisfy himself by ascribing his failure to the interference of others who are jealous of him. In each, the situation has evoked a certain type of reaction, the form of which could have been foreseen by anyone who knew, with sufficient exactitude, the habits of reaction peculiar to each man. These habits or tendencies to react in certain ways are what are spoken of as the personality.

In mental diseases, these tendencies to react in certain ways are still present and stand out in exaggerated form. They provide the groundwork for personal variations in the mental symptoms, which depend, not on the nature of the particular disease, but on the personality of the patient. The behavior of an insane man, like that of a sane man, is a reaction to some situation, and when accompanied by feeling is usually spoken of as a psychosis. Unfortunately, this term
has been used somewhat loosely and there is even a tendency to employ it as a substitute for the word insanity. This is undesirable as it has an important field of its own. Strictly it means a "state of mind," but it is quite generally accepted as indicating an abnormal state of mind. Anger might correctly be called a psychosis, but this term is commonly employed only when the anger is a symptom of disease and exceeds or is inappropriate to the conditions under which it is manifested.

But the reaction tendencies of a man—that is to say the manner in which he uses the tools with which he is equipped—are not the only factors that influence his behavior. This must also depend, in part, on the quantity and quality of the tools—the body organs as well as the brain and nervous system—with which he is endowed. A man who is blind or deaf, who has defective blood circulation from heart disease, who has poison in his system that interferes with the proper activity of brain and other nerve cells, or who, by reason of disease or injury, has lost part of his brain, must necessarily reveal the consequences of such deficiencies in the quality of his behavior. Yet, even then, he will still use the tools that remain capable of use in the various combinations that are peculiar to himself; his tendencies to certain kinds of reaction are still operative, though they are modified by the damage. The conduct of the person is therefore affected by both classes of factors; these may be distinguished as structural—the working tools—on the one hand, and functional—the manner in which the tools are used—on the other. Correspondingly, insanity may be due to structural disease or defect (also called organic), to functional disorder (the psychosis) or to a combination of the two.

As might be expected—though sharp distinctions cannot always be drawn—the manifestations of the two classes of disturbance are essentially dissimilar. Damage to structure
can only remove or exaggerate certain possibilities for action and does not change the tendencies to act in the manner peculiar to the man afflicted. In a psychiatric examination, attention should first be directed toward determining the presence or absence of structural defect. In other words, first determine the quantity and quality of the working tools. Without this information, it is impossible to judge the quality of use that is being made of them.

The study of mental diseases is also simplified by a realization that the symptoms due to structural damage do not depend greatly on the nature of the noxious agent, but rather on its location. The effects of destroying a particular part of the brain with a bullet will be exactly the same as those which would ensue if this same part were destroyed by a poison. The mode of onset and the course of the symptoms will, it is true, be different in the two cases, for the bullet acts instantaneously, the poison more gradually. Therefore, it is possible to outline in a general way the effects of diffuse structural damage to the brain in terms that will be applicable to all kinds of lesions, leaving for consideration under the names of the different diseases, the peculiarities that arise from the mode of development and special affinities for different parts of the brain by the different kinds of lesions.

Similarly, it is possible to outline certain of the more frequent types of psychoses. It is obvious from what has already been said that any one of these may occur in association with any kind of structural damage and may thus give rise to variations in the clinical picture that results from a structural disease. For example, a general paralytic person is suffering from a structural disease which progressively destroys his brain. Every case, therefore, presents evidence of this structural loss, the only variations in which are due to differences in the localization and severity of the damage. But the disease, general paralysis, occurs in all types of persons
and consequently the behavior may differ greatly in different cases. The majority show no psychosis, the structural damage symptoms appearing in pure form; one man reacts with happy excitement; another is severely depressed; a third develops a paranoid trend, and still a fourth shows schizophrenic features.

In describing the general pictures of organic disease, we shall deal first and most with the effects of diffuse brain damage, for these are the most frequent conditions in mental diseases. But it must be remembered that, in addition, there also occur localized lesions such as blood vessel thromboses, tumors, abscesses, bullet wounds, etc., which will cause symptoms limited more or less by the location of the damage. Many lesions that are primarily focal also cause diffuse damage secondarily, and some diseases that are essentially diffuse may do special damage in particular localities. Combinations between focal symptoms and those with which we are more particularly concerned, therefore, are not infrequent. The focal symptoms will be briefly considered following those due to diffuse damage. They are often of greatest importance in diagnosis, though they are not primarily psychic.
Change in nerve cell function may take place in either of two directions—increase or diminution of function. In its extreme degree the latter becomes complete suppression of function. Many lesions give rise to an initial increase, which is subsequently, if the damage is progressive, replaced by diminution. This is especially true of many poisons. There may, therefore, occur clinical symptom-complexes in which either the one or the other type of change predominate, and others in which the two exist simultaneously in different levels of the brain. In a general way it may be said that the phenomena of overaction are more frequent in damage due to poisons and are of more acute onset, shorter duration and less permanence than those due to other causes, though this is by no means universally true. These more acute forms will be considered first. The possibility and degree of recovery depend on the severity of damage. If this is so great as to lead to the death of nerve cells, loss of the corresponding function must necessarily be permanent. So long as a cell remains alive, recovery of function may occur, but there is no evidence that dead nerve cells are ever replaced in human beings.

Mild Confusional States (Symptomatic Depression). This type of disorder occurs especially in association with bodily diseases such as infections, and is of relatively slight importance medicolegally. There is always the possibility of suicide, and questions of the capacity to make contracts
and of extent of personal injury may arise. The picture is characterized by mental dulness and lack of ability to pay attention, with poor comprehension of the surroundings and a mood of depression with more or less apprehension. Misinterpretations of things and happenings are liable to occur and to be colored by the mood. At times, especially at night, the disorder may increase to a more definite delirium, with restlessness and defective sleep, which is interrupted by uneasy or terrifying dreams, as to the unreality of which the patient may not be clear on waking.

Delirium (Amentia of Some Authors). Though usually due to toxic conditions, delirium may arise in connection with grosser types of lesion such as trauma and the degenerative changes of old age, and also, at times, with severe emotional stress. Starvation, deprivation of water, severe hemorrhage and other exhausting conditions, which may be regarded as toxic, also may give rise to delirium.

The chief characteristics are clouding of consciousness with consequent disorientation, illusions and often hallucinations of illusory type. The mood is usually one of apprehensive depression and perplexity or confusion. The sense-falsifications and misinterpretations consequently are terrifying and depressive in content. Threats, torments, dangers, enemies, devils, etc., are perceived in the surroundings. Occasionally, most often in children, the mood on the contrary is happy and ecstatic, with corresponding alteration in the content of the illusions and hallucinations. The behavior of the patient is appropriate to the world as he perceives it and not to the surroundings as they actually are. He is restless, fretful, cries and screams, and tries to escape or to secure help. His efforts to avoid the dangers he perceives may become frantic and violent and he may suffer injury, harm others or even commit suicide in his efforts to get away.
The combination between the wealth of sense perceptions that result from over-excitatibility of the lower or perceptual paths with the diminution in ability to judge as the result of lowered excitability in the higher pathways, results in more or less complete inability to recognize where he is and the identity of those around him (disorientation). Insistent stimulation, such as loud speaking and repetition of questions, may result momentarily in clearness and perhaps correct, or partially correct, answers. Frequently, the misinterpretation of the situation in which he is takes the direction of confusing it with familiar surroundings, so that the shoemaker hammers at an imaginary last, the dressmaker goes through the movements of sewing and the stockbroker shouts his quotations (so-called occupation delirium).

With still more severe damage, the evidences of increased activity disappear and the perceptual paths become less instead of more easily stimulated, with the consequence of increasing stupor. When the patient cannot be roused to exhibit signs of consciousness by any stimulus, the state has become coma.

In the process of recovery, when the clouding has largely disappeared but the higher critical functions have not been fully restored, it sometimes happens that false explanations (delusions) will be evolved for the experiences through which the man has passed. He may attribute them to persecutions or interference by others, to mysterious influences or punishments for sins. Such paranoic states gradually pass away as the use of higher critical judgment becomes possible and the man realizes that his experiences were part of an illness; he is then said to have reached full insight into the nature of his trouble.

As might be expected, memories of events during the delirium leave little trace and there is always more or less complete amnesia, the degree of which depends on the degree
of clouding that was present. Such memories as are established, are usually vague and dream-like. It has already been suggested that nerve cells may die as the result of the injury by the poison; there will then remain more or less dementia. But the usual outcome, provided the patient does not die from the disease, is a practically complete mental recovery.

**Acute Hallucinosis.** This type of reaction is most frequent in connection with chronic intoxications, notably with alcohol. In it there is little or no clouding of consciousness and the picture is dominated by vivid hallucinations. To the patient these have the full value of ordinary sensations and he acts as if there were corresponding stimulations in the surroundings. The sense most commonly involved is that of hearing, but vision, skin sense, taste and smell may be affected. The mood is usually one of apprehension and depression with the consequence that the content of the hallucinations is threatening, defamatory and unpleasant. The man's behavior is appropriate to his sensory experiences and may include assaults on bystanders from whom the voices or other influences seem to come, efforts to escape and even suicide. A paranoic state, similar to that mentioned as occurring occasionally in delirium, is especially liable to develop in acute hallucinosis because the mind is clear and the man is able to think and reason.

This picture is often difficult to distinguish from dementia praecox of the paranoid type. Prolonged observation and careful study of the mode of onset may be necessary before reaching a decision. The principal points in the diagnosis are: the behavior is dominated by the hallucinations, to which the delusions are definitely secondary; the onset is acute and more or less clearly related to alcoholic excesses or other intoxications; abstinence from alcohol results in subsidence of the hallucinatory experience, though this may not
be obvious for days or weeks; and evidence of schizophrenic mechanisms is lacking. In this connection, however, it must be remembered that alcoholic excess by a man with dementia praecox may result in the development of an acute hallucinosis. Alcoholic insanities may be engrafted on other diseases also and render diagnosis difficult.

**Neurasthenic States (Postinfective Exhaustion; Toxic Exhaustion).** These conditions must be distinguished from the purely functional states that are also called neurasthenia.¹ The distinction depends on the presence of a definite toxic-infectious cause and evidence of real exhaustion. It is also true that, starting with an infection or a toxic disorder, the reaction may become a habit and be used as the means for escaping conditions that seem unbearable. The disorder is then no longer a true exhaustion but has become a psychoneurosis.

The characteristic features are those of "irritable weakness" and the great ease with which the evidences and feelings of fatigue are produced by slight exertion. Sensory and motor mechanisms are involved as well as the higher mental operations. The patient is fretful, irritable and complaining, cannot fix his attention for any length of time, and attempts to concentrate or to perform a task result rapidly in exhaustion. He sleeps badly, dreams much and unpleasantly, finds it difficult to think coherently or connectedly, and is easily stirred up to more or less violent explosions of anger or irritation. Light and noise bother him; he wants the shades drawn and cannot stand the ticking of the clock or the noise of the children playing. There are complaints of pains, aches and discomforts of all kinds; palpitation of the heart; indigestion, loss of appetite and gas in the intestines; etc.; all disorders in the realm of the vegetative nervous system.

¹See under psychoneuroses p. 191.
Physical examination reveals evidences in keeping with the symptoms enumerated. The heart beat is rapid and becomes markedly accelerated on slight exertion. Digestion is slow and incomplete, the juices secreted being relatively inefficient. Blood examination reveals a secondary type of anemia with, possibly, alterations in the absolute and relative white cell count. The reflexes are exaggerated, though not abnormal in type, and the fields of vision may show an helicoid form due to rapid exhaustion.

**Acquired Constitutional Deficiencies.** Particularly after severe traumatisms to the head, but also after chronic intoxications, changes may occur of slight degree and debilitating in character, in which no very obvious loss of memory or emotion is demonstrable. There is an alteration in the ability to withstand the stresses of life and it is for this reason that the condition is spoken of as constitutional. The chief features are loss of energy and efficiency with greater fatigability and lessened ease of recuperation from rest. Emotionally, the man is more irritable and unstable, his reactions being less effective. There is an increased susceptibility to the effects of poisons such as alcohol and the products of infection, delirium being more readily produced. Headaches, dizziness and rapid exhaustion are liable to occur on exertion. The condition may improve, but may be more permanent; not uncommonly there are temporary improvements and relapses. It has obvious resemblances, in certain respects, to the neurasthenic states already described and may be regarded as the more permanent result of the original damage.

**The Korssakow Symptom-Complex.** Described originally as the result of chronic alcoholic intoxication, in which it is usually combined with evidence of damage to the peripheral nervous system (multiple neuritis), the mental component of this syndrome may, nevertheless, develop in association with
other intoxications and also with more gross types of lesions such as trauma, senile degenerations, etc. The onset is usually subacute, with preliminary symptoms of delirium-like nature, but it may develop slowly and insidiously.

The most striking feature of the mental state is a peculiar loss of recent memories (especially retention) that seems out of all proportion to that of the more remote. Indeed, the latter may sometimes seem to be almost intact, though careful investigation will usually reveal evidence of loss. Sometimes there seems to be almost a sharp line of demarcation between good and bad memory, though this is not usually true. At the same time there is well preserved energy and activity, the vigor and degree of interest do not suffer to the same extent as the memories. In other words, the damage is preponderantly to the nervous tissues, and the other organs of the body are far less affected. Perception of the immediate surroundings is good and things in actual sight are correctly appreciated. Consequently the man may use objects correctly and present a surface appearance of approximately normal behavior provided the situation demands no recall of recent happenings. The moment an event is past or an object is removed from direct perception they are more or less completely forgotten. The gaps in the memory are characteristically replaced by older memories drawn, apparently in haphazard manner, from the more remote past. This process of confabulation gives a most extraordinary stamp to the picture. The patient tells of recent happenings and journeys which are obviously impossible and absurd, usually with calm assurance and entire lack of appreciation of the absurdity. The stories are forgotten as soon as related and an entirely different account of recent events may be given the next moment.

Judgment and orientation necessarily suffer severely, even though the patient may be able to give a fairly accurate
account of his early life and experiences. Every gradation between this state and more general dementia may be encountered. Marked improvement often occurs, but there is probably always some, and sometimes severe and permanent, dementia.

**Epileptiform Convulsions.** Convulsions may occur as the result of irritative brain damage of all kinds and may disappear with recovery from the injury. But, in addition, there also occur more permanent states of liability to convulsive seizures that are difficult, if not impossible, to distinguish from essential epilepsy. The acute and temporary fits and the more chronic epileptic state will be considered later.

**Dementia.** There is no universally accepted definition of this term. It is used so broadly by some as to become almost synonymous with insanity, an interpretation perhaps justifiable in view of the literal meaning of the word—loss of mind. But this use of the word is not customary and may lead to confusion. Far more commonly it is used with a narrower significance, and is so employed here, to indicate the permanent results of destructive lesions of the brain. Dementia resembles, in certain respects, feeblemindedness, but with the essential difference that, in the latter, the brain paths have never functioned, either because they were never developed or because they were destroyed by disease before they were fully developed. Dementia is the suppression of functions that had previously been performed. The behavior of the dement will always show methods of using the remnants of functioning brain tissue that required for their acquisition the presence of higher orders of brain associations than those which now exist. These could not have been established if these association paths had been absent from the start. Hence dementia does not imply simply a return to a more primitive state of brain function. If a
dement is compared with a feebleminded person (ament) of like degree of intellect, differences will be found which are due to the fact that the working tools of the former still preserve some greater capacity for effective use that had been established before the advent of the damage.

For convenience in description, a subdivision of dementia will here be made into defects of intelligence, emotion and will. In certain conditions one or other of these features may appear to suffer to a greater degree than the others. Yet the distinctions are artificial, especially as regards the will.

*Intellectual Defect.*—Functionally or psychologically, the intelligence may be regarded as the sum of available memories of past experience acquired by the individual. Anatomically, this depends on the integrity of the association paths of the brain. An idea, or memory, is the conscious state that exists when a previously used brain path is in action; destruction of the latter, therefore, implies absence of the former. In general it may be stated that the more recent memories are more easily destroyed than those that have been more frequently and variously used, for the reason that the latter have wider and better constructed nerve pathways. Furthermore, lesions that are abrupt and localized will necessarily result in instantaneous and more or less localized loss of memories, though here it must be insisted that memories are the activity of brain paths that connect widely separate parts of the brain and are, therefore, not exactly localized. In the following description, we shall deal with diffuse and progressive injury to the brain as a whole. Later, consideration will be given to the effects of damage to particular regions.

The ability to decide on a course of action in response to a given situation, depends on experience in meeting more or less similar situations in the past, together with the regis-
tration and possibility of recall of the memories of that experience. These memories include the consequences of reactions that have been made and possible modifications that may have been suggested in various ways. The selection of the response constitutes what is known as judgment and the statement just made is nothing more than an assertion that efficiency of judgment depends on experience. Damage to brain paths and loss of memories, therefore, means diminished efficiency of judgment, the degree being proportional to the extent of damage.

Bearing in mind that the earliest effects occur in the most recent and least well established memory or association paths, it follows that the first evidence of defective judgment will be observed in the highest and most critical activities, involving especially the so-called ethical standards. The man becomes less considerate of others, pays less attention to his social obligations and becomes more self-centered. The finer edge of his qualities as citizen of a community become dulled and he will do things which used to be "beneath him." Of course, the standard with which he is compared must be himself as he used to be, and not an hypothetical normal. As the destruction progresses, more fundamental memories become involved and his business judgment begins to suffer. Undertakings are entered into without consideration of all the factors necessary to avoid mistakes, which would previously have been taken into account. Little points are forgotten, engagements that may conflict are not recalled, and consequences, more or less obvious, are not foreseen.

Gradually there appear signs of failure to register events and happenings in the surroundings. Engagements are forgotten, duties neglected, contradictory orders issued, dates and hours mixed, and the man has become noticeably forgetful. As the dementia progresses, more and more essen-
tial and deep-rooted memories become unavailable. Mis-
takes are made in situations previously well known. There
is difficulty in finding the way in places relatively little known
and finally, in the home town or even the home. The man
becomes unable to establish memories of new acquaintances,
then forgets older ones and may finally fail to recognize his
wife and children. Similarly with the passage of time, the
conception of which depends largely on the recollection of
what has transpired. The days of the week or month become
hazy and memory may be lost for the month, year and even
the time of year.

As memories for recent events are lost, the mental activity
becomes limited to those of the past. Stories of earlier days
may be told several times in succession without appreciation
of the fact. In comparison with recent memories, the older
ones often present an appearance of surprising accuracy
which is usually not justified by closer analysis. Eventually,
with the loss of the earliest and best established memories,
the man approximates to a vegetative existence in which
thinking, or the use of memories, is entirely in abeyance.

Certain features of this process are emphasized and
described as special symptoms, which may be brought out by
appropriate tests, though they are capable of recognition by
sufficiently extended observation in the ordinary conditions
of life. These may be mentioned briefly under separate
headings:

Retentiveness (Retention): This refers to the ability to
retain new facts in memory. Auditory memory may be
tested by giving a series of digits, letters, names, addresses,
etc., which are again asked for after a certain period. The
ability to retain perceptions in other sense spheres may be
investigated by submitting: objects, colors, written sym-
bols to sight; geometric patterns traced on the skin, objects
to touch; odors or flavors to smell and taste. In addition,
the man may be asked to detail some event of the immediate past; to give: the articles of the last meal; his whereabouts on special days; etc.

Circumstantiality: The ability to give a concise and connected account of a sequence of events depends on the selection of the most important episodes in their proper order, a selection that is an exercise of judgment and thus of memories; the suppression of unimportant details; and a broad grasp of the problem as a whole. To the man who has a poor stock of memories on which to draw, every detail is of importance and the summing up of a situation in a few words expressing the salient features is impossible. His replies and statements are consequently detailed and tedious or circumstantial. In estimating the degree of this tendency the man must be compared with himself as he was; persons with poor opportunity for acquiring memories are often circumstantial. This feature is usually marked only in the slowly progressive dementias, notably in epilepsy and senile changes.

Perseveration: By this term is understood the tendency for a response or memory, once aroused, to be more easily excited for a time thereafter than any other. Thus a response, correct or not, having been given to one question, may be repeated in answer to another question on a different topic asked immediately afterwards. Only after a period of rest, or in response to some powerful stimulus, is there a chance of getting an appropriate reply. Perseveration may also be observed in acts other than those of speech.

Disorientation: This term designates a loss of the appreciation of the relations between self and objects, persons or places and their relations one with another in time and place. The occurrence of disorientation in dementia has already been sufficiently indicated.

Defect in Judgment: This has already been described in a general way. Here it seems well to point out that defect
in judgment and delusion are not the same. Delusion may even be a sign of good judgment, the conclusions reached being logical from the premises with which the person starts. He observes people looking at him, making remarks and threats and he concludes that they are jealous of him or desire to harm him. This may be not in accord with the facts, but is justified from the observations of the patient; his error lies in his perceptions and not in his judgment.

Special tests for judgment are sometimes used, all founded on placing the patient in some standard situation with the object of observing how he meets it. Most often this is done by question and answer and some of the tests of the Binet-Simon scale may be used for the purpose. But the reaction to life conditions is of far greater value if the facts can be learned.

Intimately related to this problem, obviously of the greatest importance medicolegally, is the question of the ability to comprehend situations. It often happens that a man can grasp and react appropriately to a simple situation, though he is unable to take into account several points at the same time. Thus, in making a will, he may be able to comprehend each individual item or clause taken one at a time, but unable to secure a grasp of the meaning and effects of the instrument as a whole.

Moral Deficiency: Morality involves instincts and emotions as well as intellect. Instincts are primitive tendencies to reaction, the mechanisms for which are present at birth either fully developed or prepared for development later. They are controlled and modified in accordance with social custom and regulation through the development of the memory mechanisms. When these last become more or less inoperative in dementia, there is a tendency for the man to revert to instinctive types of reaction, though this tendency may be modified by simultaneous diminution in
the intensity of the craving that underlies them. The dement often shows immoral behavior, immoral not only in comparison with his previous standards, but possibly also in comparison with those of the community in which he lives. Sex delinquencies, larceny and other offences may thus arise, which may bring the man into conflict with society but for which he cannot be held responsible, though he must be prevented from repeating them.

*Emotional Defect.*—The purpose of all nervous activity is reaction to the situations under which life must be maintained. Emotions are the consciousness of reactions of fundamental importance in this struggle. The more primitive types of emotional reaction are inherited associations of muscular and glandular cooperative action, activated through nerve centers that lie below the level of the cerebral hemispheres. The more highly selective types of emotional reaction are brought about through the control of these lower centers by the ideational paths in the cerebrum proper, the effects of damage to which we have already been considering from its intellectual aspects. But, even with regard to these higher feelings and sentiments, it is still correct to state that the degree of emotion is an index of the importance of the stimulus in the struggle for existence and self-expression. The importance, however, depends not so much on ancestral experience as on the experience of the individual himself as recorded in his memories. The more primitive reactions may be said to be connected with primitive desires or primary interests, to which we pay attention spontaneously and without individual education. The later evolved types are secondary or acquired interests and form the basis of secondary or sustained attention.

Emotion is not simply a state of mind, it is inevitably, perhaps even primarily, a state of the whole body. Being a reaction to situations of importance and one of the elements
of attention, emotion includes an automatic preparation of
the body to meet the situation vigorously. The vegetative
nervous system and the group of endocrine glands are inti-
mately concerned in it. It is extremely probable that
changes due to disease or injury of these structures, without
changes in the brain, may of themselves result in emotional
alterations.

Emotional dementia is evidenced by: lowering of moral
standards, already discussed; diminution in the energy or
"pep" with which the man goes about his work; lowering of
efficiency in prolonged and directed attention; diminution
in the breadth and selectivity of interests (indifference);
diminution in the effectiveness of emotional responses which
may be violent though short-lived and poorly selected; and
an increase in the ineffective types of reaction such as fretful-
ness and irritability. When dementia has progressed far in
loss of memories, the mood is usually one of negative content-
ment, negative in the sense that there is lack of appreciation
of difficulties and lessened interest in the events of the sur-
roundings. Such a condition is often called euphoria,
though by some psychiatrists this term is also used to describe
more positive states of a feeling of well-being. With deep
dementia and loss of vital energy, the interests become reduced
to reactions of the most primitive importance for the main-
tenance of life, ingestion of food and voidance of excreta.
These are no longer controlled and the man must be cared for
like a baby. Most of his time is spent in sleeping.

Volitional Defect.—It must be distinctly understood that
this subdivision is made for convenience only and does not
imply the existence of will as a separate entity. It has
already been pointed out that instincts and emotion are
tendencies to action which are subject to the control of indi-
vidual experience. Volition or will is the final stage of mental
activity in which translation into action occurs, the choice
being made by the play of instincts, emotion and memories. This assumes that there is a goal in view, something to be achieved that tends to the advantage of the individual in the maintenance of life and all that this implies in the way of social existence. Volition may therefore be considered under two aspects: intensity and quality.

Intensity means the urge to action, which is probably a function of the body as a whole rather than of the nervous system. Conditions that cause dementia may have more or less harmful action on all organs of the body. Diseases that are largely or entirely limited to the brain may change the intensity of will but little. This is probably an important factor in determining confabulation which is so striking a feature in the Korssakow mental picture. On the other hand, many diseases that cause progressive brain destruction at the same time affect other organs and may result in diminution of volition. The dementia is then accompanied by torpor and dulness and the man is content to sit or lie around inactive, often sleeping much of the time. Only the more powerful incentives lead to action and among these must be reckoned the appetites of hunger, thirst and sexual craving.

Of particular interest for our purpose is the increased suggestibility that is liable to result from diminished volition. Having no strong motives of his own to serve as guides and checks to action, outside influences are unduly effective and the man is liable to be led into acts which he has not the will to resist.

Defects in the quality of will mean practically defects in choice of reaction and have already been discussed in dealing with intellect and emotion. The relative inefficiency of reaction is also indicated in the results of lowering of intensity. In many instances, there is also an obvious deficiency, not only in the strictly volitional reactions, but also in those which express the emotions. Loss of facial expressions,
slouchiness in bearing and lack of vigor and tone in the voice belong in this category.

FOCAL BRAIN DAMAGE

Motor Symptoms. *Hemiplegia.*—This name is given to paralysis of voluntary movement of one side of the body, including the face, arm and leg. Movements that require the use of both sides of the body simultaneously, such as those of the eyes, forehead, tongue and respiration, are only slightly or not at all affected. The paralyzed limbs are stiff (spastic); the tendon jerks are usually exaggerated and there is often ankle and knee clonus; the abdominal skin reflexes are often diminished on the side of the paralysis and the plantar reflex is of the extensor (Babinski) type.

Hemiplegia is caused by damage to the pyramidal tract of nerve fibers, which starts from the central region (ascending frontal, precentral or prerolandic convolution) of the cortex of one hemisphere of the brain and then passes down through the internal capsule where it collects into a compact bundle. From there it passes through the brain stem, crosses over to the opposite side and its terminal fibers enter the spinal cord. It controls the voluntary movements of the face, arm and leg of the side opposite to that from which it starts. A left hemiplegia is caused by damage to the right, and a right hemiplegia by damage to the left pyramidal tract.

*Diplegia* (*Double Hemiplegia, Pseudobulbar Paralysis*).—This means paralysis of voluntary movement on both sides of the body, similar in character to a hemiplegia, though bilateral movements are here also affected. It is caused by damage to both pyramidal tracts, either from lesions in both hemispheres or from one lesion in the brain stem where the two tracts are close together. In the latter case, there is usually evidence also of damage to the nerve cells from which
start the nerves to the muscles of the eyes, jaws, face or tongue and which lie in the brain stem.

*Alternating and Crossed Hemiplegia.*—These names indicate paralysis of part of the body on one side and of the opposite side below; for instance, the right side of the face and the left arm and leg. Paralyses with this distribution arise from damage in the brain stem where the pyramidal fibers have only in part crossed over to the opposite side, or where the nuclei of the cranial nerves for one side and the pyramidal tract for the opposite side of the parts below are in close proximity.

*Paraplegia.*—This term is not usually applied to paralyses that result from injuries to the pyramidal tracts in the brain, but to lesions of both tracts in their continuation in the spinal cord. The paralysis therefore does not involve the face, but does affect both legs or both legs and both arms according to the level in the cord that is the seat of the damage.

*Monoplegia.*—Paralysis of voluntary movement confined almost completely to one limb or one side of the face, without marked change in the movements of the other segments of the body. Monoplegias are due to damage to the pyramidal tract in or near the cortex of the brain, above the level where the fibers have collected into a compact bundle, that is to say above the internal capsule. Strictly, a monoplegia is better considered as a partial hemiplegia as it is never entirely limited to the movements of the one segment of the body.

*Jacksonian or Focal Epilepsy.*—This refers to a type of convulsive seizure that begins in one segment of the body (side of face, arm or leg) and is not accompanied by loss of consciousness. The seizures are jerking or twitching (clonic) movements and may last from a few seconds to several minutes or longer. Sometimes the seizure spreads to other parts of the body than that in which it started; the spread
then follows the order in which the different segments are represented in the cortex of the brain. This order from above downward is leg, arm, face; a seizure starting in the leg will spread next to the arm on the same side before the face of the same side is affected. After involving the whole of one side, the seizure may spread to the opposite side of the body, and if it does, consciousness is lost. These fits are due to irritative damage in or near the motor area of the cortex from which the pyramidal tract starts. After the seizure, there is usually more or less paralysis of the part that was first involved in the fit; this paralysis is, as a rule, temporary and lasts from a few minutes to several days. Since the damage is near the pyramidal tract, there is great probability, if the damage is progressive, that sooner or later a permanent monoplegia or hemiplegia will develop. Jacksonian fits are characteristic of organic damage in this locality; they differ by their local origin and the absence of loss of consciousness, at least in the early stages, from the general fits of true epilepsy.

Rigidity and Spasm.—Rigidity or stiffness of the muscles has been referred to as occurring in hemiplegias (and also in monoplegias, diplegias and paraplegias) when the pyramidal tracts are damaged. It also occurs from damage to other tracts (extrapyramidal motor paths), characteristically in paralysis agitans (shaking palsy or Parkinson’s disease). Exactly similar conditions of general rigidity are also observed after attacks of epidemic encephalitis (so-called sleeping sickness) and other diseases that involve the midbrain. The stiffness is usually bilateral though it may sometimes be more or less limited to one side of the body. It resembles somewhat closely the rigidity observed in kata-tonia for which these states are sometimes mistaken. The face is stiff and mask-like and the expression of emotions becomes almost impossible. The arms and legs become stiff,
movements are slow and clumsy and finer movements, such as buttoning the clothes, may be very difficult. Walking is stiff and awkward and may be quite impossible. In extrapyramidal disease, there is no real paralysis although movements appear weak because of the stiffness. Often there is increase in the secretion of saliva which, when coupled with difficulty in swallowing on account of stiffness, may result in continuous drooling and thus give an appearance of utter idiocy. This appearance is not justified by the mental condition unless there is, in addition, involvement of higher centers. The rigidity is often combined with tremor and sometimes with myoclonic or choreiform movements.

_Tremor._—This term should be reserved for rhythmical movements, though it is sometimes used to designate irregular and jerky movements. The tremor may be fine or coarse in amplitude, and may be either rapid or slow. Fine tremors are seen in many brain diseases (senility, general paralysis, etc.); in states of general weakness; in chronic intoxications (alcohol, morphin, etc.); and occasionally in apparently healthy persons, sometimes running in families. The tremor may be observed in ordinary activity, be brought out only by requirements to hold the parts steady and is sometimes observed only when some purpose is in process of accomplishment (intention tremor). Tremor is most often observed in the hands, face and tongue, but may be widespread over the body.

_Athetosis._—This is a slow, peculiar, writhing movement, somewhat resembling the movements of the tentacles of an octopus. It may be unilateral or bilateral and is more common in children as a sequel to brain disease in childhood. It is therefore especially frequent in the feebleminded. Athetosis seems to be related to damage in the region of the lenticular nucleus which lies next to the internal capsule; it is therefore often combined with hemiplegia.
**Chorea.**—Choreic movements are rapid, irregular, constantly changing movements that are commonly spoken of as St. Vitus’ dance. They are usually bilateral, rarely unilateral and then often combined with athetosis and hemiplegia. Acute chorea (Sydenham’s chorea or St. Vitus’ dance) is due to an infection, possibly rheumatic, of the brain, and is almost limited to children and adolescents; severe cases are often accompanied by delirium (chorea insaniens). Chronic chorea (Huntington’s chorea) is a degenerative brain disease which is markedly hereditary and generally develops in middle life; it is usually accompanied by progressive dementia and sometimes by active psychoses, especially paranoic trends. Choreiform movements as well as athetoid and myoclonic movements are common as sequelae to epidemic encephalitis. They are sometimes simulated by hysteria. They arise in damage to the midbrain and may exist without mental alteration.

**Myoclonic Movements.**—These are quick, sudden contractions of muscles or groups of muscles, at irregular intervals. They may be mild or violent; in the latter case they may result in actually throwing the person down and thus may cause accidental injuries. They have been observed in epidemic encephalitis and other diseases of the midbrain; in combination with epilepsy (myoclonic epilepsy) and also without other obvious signs of disease (paramyoclonus multiplex). They are sometimes combined with choreiform movements and some examples have been described under the name of electric chorea.

**Motor Cranial Nerves.**—The cranial nerves have their origin in the brain stem and then pass out through various openings in the skull to reach the muscles they supply. They are mentioned only because they may be damaged by diseases or injuries of the brain, its membranes or the bones of the skull. Injury to these nerves causes either irritations
(spasms) or paralysis of the corresponding muscles. The paralysis is complete, that is to say it involves automatic and reflex activity as well as voluntary movement and thus differs from hemiplegia. The third nerves supply the muscles that move the eyeballs upward, downward and inward, the muscles that open the eyes and also the muscle that contracts the pupil. The fourth (pathetic) nerves supply the superior oblique muscles which rotate the eyeballs down and inward. The sixth (abducens) pair supplies the external rectus muscles that rotate the eyeballs outward. The fifth (trigeminal) nerves supply the muscles of mastication and the soft palate. The seventh (facial) pair innervates the muscles of facial expression—closing the eyelids, wrinkling the forehead, lip and nose movements. The ninth (glossopharyngeal) nerves supply the muscles of the pharynx and palate. The tenth (vagus) pair go to the laryngeal muscles (vocal cords) and also to the gullet or esophagus, heart and viscera. The eleventh (spinal accessory) nerves are really spinal and go to the sternomastoid and trapezius muscles. The twelfth (hypoglossal) nerves supply the muscles of the tongue. Damage to these nerves is in no sense mental, though it may be associated with damage to the brain that does cause mental change.

Sensory System. Vision.—The nerves of vision begin in the retina at the back of the eye where the actual nerve fibers can be seen with the ophthalmoscope, the only nerve in the body open to direct inspection. Passing backward into the skull through the optic foramen on each side, these nerves are known as the optic (second cranial) nerves. Soon after entering the skull the two nerves come close together on the under surface of the brain and a partial decussation takes place through what is known as the optic chiasm. This crossing over from one side to the other is in such form that fibers from the right half of both retinas
are collected together on the right side of the skull and those from the left halves on the left side. From this point backward, the nerve paths are known as the right and left optic tracts. The optic chiasm is just in front of the little cup (sella turcica) that houses the pituitary gland or hypophysis.

In consequence of the arrangement of the nerve fibers it follows that destruction of one retina or one optic nerve will cause blindness in the corresponding eye. Damage to the optic tracts or their continuation backward into the hinder part of the brain will not cause complete blindness in either eye, but blindness of the corresponding half of each eye (homonymous hemianopia or hemianopsia), though central vision which is represented in both tracts from both eyes, more or less completely escapes. Injury to the right tract causes blindness in the right half of each retina and in consequence the person cannot see things on his left side (left hemianopia). This is due to the fact that the lens of the eye, like that of a camera, reverses all images; objects on the left are seen with the right halves of the retinas. Because there is no loss of central vision, persons may have hemianopia without realizing it, especially if there is at the same time some mental dulness.

The optic tracts end in the upper part of the brain stem and optic thalamus and from there a fresh path starts, the optic radiation, which passes back to the hinder part of the occipital lobe on its middle aspect (cuneate lobule). The visual areas of the two sides lie immediately facing one another and are separated only by a fold of dura mater (falx cerebri) which separates the two hemispheres of the brain. In the cortex, the fibers of the optic radiation have spread out considerably; consequently, damage here, if small in extent, may cause loss of vision only in the upper or lower part of the half retinas. Such blindness is called quadrantic hemianopia and is almost characteristic of
damage to the occipital lobe in this region. If more extensive, the damage will cause a hemianopia.

There is another type of partial blindness, which results from damage to the optic chiasm, a not uncommon result of disease in the pituitary gland. Here the fibers destroyed will be those that are crossing over from the optic nerve of either side; the consequence is blindness of the inner (nasal) half of each retina. The person may be unaware of this defect unless he closes one eye, when he will be unable to see objects to the outer side of the open eye. With the right eye closed he could not see objects on his left and vice versa. This is called bitemporal or heteronymous hemianopia.

Disturbances of vision of these kinds are not in any sense mental, although the disease that causes the blindness may, of course, at the same time damage other parts of the brain and so give rise to mental symptoms.

Certain changes in the optic nerve, visible with the ophthalmoscope, are important concomitants of some brain diseases and are therefore worthy of mention. Optic neuritis and choked disk (papilledema), are frequent results of increase in the pressure within the skull, such as may arise from a tumor or from hydrocephalus, or of inflammation (meningitis). The nerve head swells and becomes dropsical, and sometimes there are hemorrhages among the fibers. If long-continued, the swelling leads to actual death of the nerve fibers and consequent blindness (secondary or post-neuritic atrophy). The optic nerve may also undergo degenerative changes (primary atrophy) in nerve syphilis (including locomotor ataxy and general paralysis); in poisoning by alcohol (particularly the methyl alcohol present in many forms of "moonshine"), lead, tobacco, etc., and in disseminate sclerosis and some other diseases of the nervous system. Those mentioned are the forms in which it is most likely to come into consideration in legal questions involving mental capacity.
Word-blindness and mind-blindness have more definite correlation with mental disturbances and will be considered in connection with language disorders and the so-called agnosias.

Hearing.—The organ of hearing (organ of Corti) is situated in the internal ear, inside the petrous part of the temporal bone at the base of the skull. The middle ear is another chamber in this same bone which contains a chain of small bones that transmit the vibrations of sound from the ear drum to the internal ear. The drum separates the middle ear from the external ear. The nerve of hearing (cochlear or eighth cranial nerve) starts from the organ of Corti and is intimately combined with another portion of the eighth nerve which comes from the so-called vestibule, which with the semicircular canals serves to give information as to the position of the head in space. The cochlear nerve enters the brain stem and finally reaches the cortex of the brain in the region of the hinder part of the first temporal convolution. The facts as to the course are not as well established as those of the visual path and little is known of deafness due to brain disease. Most examples of nerve deafness are due to damage to the nerve as it enters the brain stem or in the internal ear. It is liable to be damaged by skull fractures, tumors and inflammations of the membranes covering the brain (meningitis). Deafness is much more commonly the result of middle ear disease than of disease of the nerve.

Damage to the vestibular portion of the eighth nerves results in vomiting, dizziness, nystagmus (oscillation of the eyeballs) and incoordination of movements. These will be caused with deafness when the eighth nerve is injured between the internal ear and the brain stem.

Smell and Taste.—In man, these senses are not nearly so important as those already considered. They are occasionally damaged by focal lesions such as those with skull
fractures, but the cortical connections are not well known and will not here be discussed. The nerves that serve them are the olfactory (first cranial) and gustatory (chorda tympani) nerves respectively. The taste fibers follow a very devious course and reach the brain stem with the trigeminal (fifth) nerve after having first been mingled, inside the temporal bone, with the facial (seventh) nerve.

**Skin Sensibility.**—The only cranial nerve that has to do with skin sensibility is the sensory part of the trigeminal (fifth) nerve on each side; it supplies the skin of the top of the head, the face and the mucous lining of the mouth and nose. It may be damaged by skull fractures, tumors and inflammations at the base of the skull. From the rest of the body the sensory paths reach the brain by passing through the spinal cord.

The nerve paths for sensitiveness of the skin to touch, pain and variations in temperature, collect together to form a tract of fibers on each side corresponding to the pyramidal tracts for voluntary movement. Decussation takes place as with the motor path so that the sensory fibers from one side of the body reach the opposite brain hemisphere. The path is interrupted in the optic thalamus and then passes through the internal capsule behind the motor fibers and ends in the ascending parietal (post-central, post-rolandic) convolution just behind the motor area.

Damage to one sensory path in the brain results in hemianesthesia or loss of sensation on one side of the body. The loss is never complete except in hysteria; it is most marked at the ends of the arm and leg, forming a sort of glove and stocking; it is rarely definite on the trunk at all.

**Muscle Sense.**—This is not a sensation comparable to that of the special senses already considered, but is an awareness of the degree of contraction of the muscles and the position of the various joints. It thus serves to guide
movements in their proper gradation and sequence, and also to help in maintaining postures. The former is often spoken of as kinetic, the latter as static. The path for the kinetic sense goes to the cerebrum, and damage to it results in an inability to direct the activities of the muscles with consequent incoordination or ataxy. Most often this arises from damage to the sense path below the brain; occasionally it is due to brain lesions and may then be unilateral. This sense is also intimately concerned, in association with touch, in the recognition of the shape, size and nature of objects handled.

The muscle sense for position, static sensibility, goes to the brain proper (cerebrum) only indirectly, its first destination being the cerebellum. Here it comes into association with the path for vestibular sense, already mentioned, and with visual paths that help to direct movements by use of the eyes. Disturbance in this group of sensibilities results in staggering and the positive Romberg sign. The latter, however, is due to damage to this path in the spinal cord, before the junction with the visual paths; the test shows loss of ability to stand steadily with the eyes closed, though capable of doing so with them open, and means loss of the guiding sense from the muscles without loss of that from the eyes. Disease in the cerebellum, where these various senses for equilibrium come together, causes staggering even with eyes open and also the dizziness, vomiting, vertigo and nystagmus mentioned under disease of the vestibular (eighth) nerves.

Adiadochokinesis.—This term means a loss of the ability to pass rapidly from one movement to its opposite, such as from pronation to supination of the hand. This occurs as a symptom of cerebellar damage, or of the connections between the cerebellum and the spinal cord.

Disturbances in Language.—Language must be distinguished from the act of speaking or the mechanism of speech.
Speaking depends on setting in action the muscles of the lips, tongue and palate on the one hand, and of the larynx and chest on the other, in proper combinations and sequences. The lips, tongue and palate are responsible for the production of the consonantal parts of speech (articulation); the larynx and chest for the vowel sounds (phonation). Articulation is accomplished through the combined activities of the trigeminal (fifth), facial (seventh) and hypoglossal (twelfth) nerves of both sides. These may be damaged by diseases or injuries that involve the nerve trunks at the base of the brain (meningitis, tumors, skull fractures) or of the nuclei in the brain stem (bulbar paralysis, thrombosis). Phonation may be interfered with by damage to the vagus (tenth) nerves in similar manner. The nerve trunks may also be affected by injury or disease after they leave the skull, but as they are extracranial we need not here consider them. Disturbances in articulation are known as dysarthria (anarthria if completely lost) and of phonation as dysphonia (or aphonia). These may exist independently of one another and are not necessarily concerned with mental activity. They may occur separately or together as symptoms of hysteria.

But, in addition to these disturbances in the mechanism of speaking, there are also disturbances in the central nervous paths that are concerned with language proper and are spoken of as aphasia. Here we are dealing with the memories of written and spoken language which make up a large part of conscious thought and hence of mind. Two main subdivisions may be recognized for our purposes that are called sensory and motor aphasia respectively.

Sensory (Wernicke's) Aphasia.—This means a loss of the memories of the meaning of the sounds of spoken words (auditory aphasia) and of the meaning of written or printed symbols for words ( alexia or visual aphasia). A person with
sensory aphasia is able to hear and see words, but he is unable to recognize their significance. In this respect he resembles a person who hears or sees words in an unknown tongue. He can speak (articulate and phonate) but is unable to understand what he hears, even what he hears himself say. He is therefore liable to use wrong words without appreciating the fact. He may say common phrases that have been much used, but say them without consideration or knowledge of their meaning. Thus he may say yes or no indiscriminately, may utter an oath or an exclamation or repeat some meaningless string of words (paraphasia). In the slighter degrees, the memory loss is most marked for the names of things and for words that have the fewest associations in his experience. He may understand in his native tongue but not in a language acquired later. He may or may not be able to understand gestures and mimic play.

Such a person, obviously, is seriously handicapped in his ability to transact business as it is difficult for him to communicate with those around him. There is always some dementia associated with the loss and the degree must be estimated for the individual.

The lesions that cause such disturbances are usually situated in the left hemisphere in right-handed persons and in the right hemisphere in left-handed persons. The location is in the hinder part of the temporal or in the occipital lobe of the brain. In the former, auditory damage is marked, though word blindness is commonly also present; language is seriously interfered with and the incapacity is at its maximum. It is frequently, though not necessarily, accompanied by hemiplegia. When the lesion is in the occipital lobe, word blindness may be the more important element, and a concomitant hemianopia is frequent. Word blindness handicaps especially by the inability of the man to read what he is signing.
Motor (Broca's) Aphasia.—This is loss of the memories of the necessary combinations of movements that must be made in order to speak. It is commonly associated with loss of memories for the movements of writing (agraphia) and with more or less word blindness. In this condition, the person is still able to move his tongue, lips, palate and vocal cords (that is to say there is no dysarthria), but he cannot combine these movements into articulation. He can hear and understand what is said, but cannot utter words. He may or may not be able to express himself by signs and gestures. The lesion is usually situated in or beneath the hinder part of the frontal lobe (just in front of the motor area) on the left side in right-handed persons and on the right side in left-handed persons. When hemiplegia is present, as it most often is, it may be impossible to test for agraphia. The interference with mentality is not nearly so great as with sensory aphasia, for the person is able to understand what is said to him, but there is often some dementia and the degree must be determined by the facts.

Apraxia and Agnosia. Closely similar to the aphasias, but more general in character, are disturbances in the memories of the meaning of sense perceptions and of the movements necessary for the performance of purposeful acts. The inability to understand sensations in spite of the fact that they are experienced, is spoken of as agnosia from the Greek word meaning "I do not know." Different varieties are distinguished according to the particular sense involved.

Tactile Agnosia (Astereognosis).—This means the loss of the ability to recognize the shape, size and nature of objects by actively handling them, without use of the other senses. This may result from lesions in the upper part of the parietal lobe, without loss of the sense of touch. Of itself, it is not a serious mental handicap, but it is commonly associated with other symptoms that may be much more serious.
Visual Agnosia (Mind Blindness).—This means loss of the ability to recognize objects through the sense of sight without blindness. The lesion is usually situated in the occipital lobe. The condition is rare, but is a serious defect and prevents the transaction of ordinary business. Hearing is the most important sense for language purposes, but vision is more important for ordinary memories in the majority of persons.

Auditory Agnosia (Mind Deafness).—In this, there is loss of memories for the meaning of sounds without deafness. The ticking of a clock, the mewing of a cat, etc., are heard but not understood. The handicap here is also great. This defect arises from lesions in the hinder part of the temporal lobe.

Apraxia.—By this is meant the loss of the ability to perform purposeful acts in the absence of paralysis or incoordination. It resembles motor aphasia and the latter is often spoken of as a speech apraxia. The person knows what he wants to do and makes movements, but he does not combine them properly for the accomplishment of his purpose. Automatic and reflex activities are not lost. Thus the man can use his tongue automatically to lick crumbs from his lips, but he cannot put out his tongue on request or when he tries to do so voluntarily. He breathes naturally and blinks his eyes when they get dry, but he cannot draw a deep breath nor close his eyes when requested. The lesions responsible have been usually in the hinder part of the second frontal convolution on the left side in right-handed persons; other cases have occurred from damage to the big strand of nerve fibers (corpus callosum) that connects the two hemispheres of the brain together. In this last instance the apraxia will involve the left arm and leg (in right-handed persons) and not the bilateral movements.
2. Behavior Reactions or Psychoses

Manic-Depressive Psychoses

The mood, to a large extent, is the consciousness of the harmony or disharmony with which the body as a whole is working, both in its internal and external relations, and is largely dependent on the activities of the vegetative nervous system with which must be included the glands of internal secretion. Oscillations of mood from time to time are normal happenings; everyone has his "blue days" and days on which he feels unusually well for no obvious reason, as well as in response to appropriate cause. The manic-depressive psychoses are exaggerations of such oscillations, sometimes brought about by adequate causes in the surroundings though excessive in degree, and sometimes apparently arising without discoverable external cause.

A manic-depressive psychosis is essentially a frank expression of happiness or sadness; all thoughts, words and acts, including the movements of expression in the face and carriage of the body, are colored by the mood. All persons, however, do not express their feelings in the same way and instead of being frank, some may keep their feelings to themselves and thus more or less deceive those who observe them. Such persons, when they develop a psychosis, show the same lack of frankness in its expression and we shall have to consider them in future sections, the essence of the manic-depressive reaction being its frankness and intelligibility.

From what has been said of the relation of mood to the harmonious activity of the body organs, it is to be expected
that attacks of exaggerated affective oscillation are liable to occur in conjunction with brain and other diseases. Manic-depressive psychoses are observed under such conditions and, while they may render the recognition of the disease more difficult, yet they do not alter it as a disease and are nothing but the reaction of the patient to the situation, which includes the disease. In general paralysis, states of exaltation or depression are quite frequent, but the underlying disease is still evidenced by the progressive dementia. The co-existence of the dementia may modify the expressions of affect by rendering it more empty and less effective, but it is still an oscillation of mood.

The Personality. The type of personality that is liable to develop manic-depressive psychoses is the person who readily exhibits ups and downs in mood. Such oscillations are more marked than in the average individual and also more prolonged. They may be observed with all grades of intelligence from the superior intellect to the feebleminded levels. Frank expression of feelings is the primitive and natural mode of reaction, hence it is not surprising to find that psychoses in persons with lower grades of intelligence are most often of this type. The psychoses included under this heading may be divided into two classes according as the mood is one of exaltation (manic) or depression.

Manic States. The leading element is the exaltation of mood, all other features being frank expressions of this state. The feeling that exists, and is expressed in all the patient says and does, corresponds to an attitude toward the world of "being equal to" everything that may arise. The patient feels that nothing is beyond his ability and he is willing to tackle anything that comes along. The degree of exaltation varies from the mildest exaggeration of a normal sense of well-being to the wildest excitement and it is customary to speak of several different degrees of the reaction.
The mildest degree, often unrecognized as abnormal, is known as hypomania (*mania mitis* or *mania mitissima*). It is evidenced by an increased busy-ness and activity, with greater talkativeness and sensitiveness to sensory impressions. To the hypomanic person, everything looks brighter and more rosy, "the world is his oyster" and he cannot refrain from mixing into everything going on around him, whether it is any of his concern or not. Action promptly follows on perception, often with little or no consideration for consequences. He is witty and makes remarks or performs acts, the possibility of which might occur to anyone, but which would be instantly repressed because of the influence of breeding and consideration for others. Such persons comment on the appearance of others, tell risqué stories, make open or thinly veiled allusions to topics not usually discussed in public, give advice on how to do things, interfere officiously in the affairs of others and are consequently very liable to get into difficulties and quarrels. Increased sexual appetite may lead to embarrassing situations and possibly to venereal infections.

With all this hyperactivity there is a lessening in the sense of fatigue and the man is liable to boast of his energy, resourcefulness and ability to do and enjoy. Appetite for food is often increased and little judgment may be used in the selection of the materials. The ability to give prolonged attention to one topic is diminished and the grasp of situations is correspondingly more superficial. In consequence, memory may be hazy and incomplete. In appearance the man looks, for him, unusually bright and well; his eyes are clear, his carriage erect and dominating. The pulse is usually rapid though regular and of full volume. The reflexes may be increased; blood pressure is usually low.

More severe degrees of mania (mania excitement) show an exaggeration of the phenomena described. The hyper-
activity is more marked and the sensory distractibility is increased. As a consequence, the steadiness of application gives way to a constant change of interest; an act started is discontinued before it is completed, perhaps almost before it is begun. This fleeting duration to any train of thought or action is spoken of as “flight of ideas or of acts.” The stream of speech is broken up and more or less disconnected, attention being diverted from the main goal by sights or sounds in the surroundings. The sound of the words used by the patient himself will often distract his attention from their meaning and lead to a new train of thought or its expression in words which depends on similarities in sound with consequent puns, rhymes and common speech phrases in a constantly changing medley, in which the sensory nature of the distraction is more or less obvious. Similarly with the sequence of acts; they are constantly interrupted by something new, the kaleidoscopic changes being the result of sensory stimulations.

The interval between perception and act or speech is greatly lessened, no thought being given to the selection of the most appropriate reaction. The acts and speech have therefore the characteristics of primitive frankness and uncivilized directness; they are vigorous and may be violent. Restlessness is great and may spend itself in unbridled destruction of anything that comes in its way. Yet with all this, these patients are usually friendly and jolly, and remind one much of a state of happy intoxication. Sometimes, however, the mood contains more of the elements of irritability and anger. In such case, the patient may be extremely violent when some little thing thwarts his purpose, and since there is here an even greater absence of the sense of fatigue or exhaustion and at the same time a lack of consideration for consequences, it often happens that the man seems to have an almost superhuman strength.
Perception, as a rule, is clear and the patient understands his surroundings. But since his attention is so much distracted and flighty, it is obvious that he is very liable to make mistakes in interpreting the facts about him. This seems to occur more frequently as regards persons than objects; mistaking those around him for old friends and acquaintances is quite common. There is of course no real appreciation of the passage of time. Such disturbances in orientation may raise the suspicion that consciousness is clouded and it is not always easy to distinguish the more severe degrees of manic excitement from delirium.

In the most severe degrees (mania gravissima), distinction from delirium may be impossible. Here, disorientation is apparently complete and the mere fragments of words and phrases, incoherently mixed together, that result from the extreme flightiness and the apparently meaningless fragments of acts that seem reduced to mere muscular restlessness without purpose may make the picture indistinguishable from delirium. Indeed, in such cases it is entirely possible that there is a true delirium from the intoxication of exhaustion that rapidly ensues. Such states of maniacal frenzy may be accompanied by high fever and thus render the resemblance to an infective state very close.

The possibility of illusory interpretations has already been mentioned. Hallucinations are certainly rare and are never a prominent feature of the picture. Delusions of fleeting and changeable character sometimes occur and are usually expressions of the feeling of well-being. They include references to personal greatness, descent from nobility or royalty, wealth, wonderful business or social schemes and boasts of personal accomplishments. They are, however, fleeting and not leading in the sense that they bring appropriately planned activity, except in the mild grades. Sometimes the same thought or delusion crops up again and again,
even with the same details, over a period of many months, but this is true only in the milder degrees. When this does occur, there is an approximation to the psychosis that will be described as paranoid.

The physical condition varies with the degree of restless activity and distractibility. These features may be kept up day and night without interruption and then seriously interfere with eating, drinking and sleeping. The consequence is increasing exhaustion, which sometimes ends in death. Accidental injuries may occur and by becoming infected may add to the exhaustion.

**Depressed States.** There are two common varieties of depression of mood, both of which must be considered as coming under this head. The first may be characterized as a “sad” depression, the other as an anxious or “worried” depression. The former was originally described by Kraepelin, who first outlined the manic-depressive reactions, as pure depression; the anxious form was considered to be a mixture with certain features of manic excitement. The name used by older writers for states of depression was melancholia and the type of picture here characterized as sad was called *melancholia attonita*, the anxious form being designated *melancholia agitata*. The name melancholia, which comes down to us from the time of Hippocrates, is now reserved for a small group of cases, probably reactions to a definite disease process, which arise during the climacteric period of life. The reaction, however, belongs quite properly with the manic-depressive psychoses, even though it may be caused by a definite disease; it would then be entirely comparable to the anxious depressions that are often observed as psychotic reactions in such diseases as general paralysis.

**Sad Depression.**—In this state the mood is one of hopeless sadness, markedly opposite in many particulars to that of the manic states. The sufferer feels unequal to everything,
lacking in energy, and incapable of meeting any situation. Everything is a task and the smallest accomplishment means untold effort. Thoughts come slowly and speech, like action, is difficult, monosyllabic and scanty. The slowing and difficulty are usually spoken of as "retardation of thought and action." The thoughts that arise are all colored with sadness, hopelessness and personal inadequacy. Sometimes they are expressed in the form of more or less definite delusions indicative of self-depreciation and depression. The patient accuses himself of some sin, usually vague and indefinite, perhaps some youthful and trivial indiscretion is now recalled with renewed significance. There is no hope in the future, he can never get well and it is too late to think of repentance or reparation. Such ideas are expressed in fragmentary form as talking requires great effort. The voice is low, monotonous and sometimes almost inaudible. Movements of the body are slow, feeble, limited in degree and carried out with obvious effort. It may take fifteen minutes to raise the hand from the lap. Yet, from the response, it is obvious that the patient understands what is said to him and when he answers, shows that he comprehends the facts of his surroundings. Illusory interpretations are unusual and hallucinations rarely occur. Little attention is paid to the surroundings, and sensory stimulation causes appearances of discomfort and pain. Memories for the events are, therefore, liable to be incomplete, but, so far as they are registered, accurate.

In more severe degrees, the difficulty in thought and action results in more or less complete cessation of all voluntary activity, no response, except perhaps the faintest fragment of appropriate effort, all-important for diagnosis, being secured to any stimulus. Such a condition is known as stupor and it may be distinguishable only with prolonged observation from the stupor of severe intoxication or of katatonia.
The body is relaxed and there is an absence of anything approaching the waxy rigidity observed in the stupor of katatonic states. Passive movements may meet with resistance, but this has not the lead-pipe, unvarying character at all stages of the movement that is observed in *flexibilitas cerea*. When seated, there is an exaggerated attitude of dejection with drooping shoulders, hanging head and arms, drooping mouth, and dull listless eyes partly hidden behind closed lids. Tears are unusual. Appetite is deficient and feeding is often extremely difficult. In extreme cases, the bowels and bladder may be evacuated in the bed or clothing, but usually there are sufficient indications of distress to call the attention of a nurse to the needs. The pulse may be slow with high pressure, but is sometimes rapid and small. Tendon jerks are usually increased, but may be difficult to elicit. The extremities may be cold and bluish, but they do not have the blue moistness so common in dementia praecox. Though the patient is silent and motionless, sleep is often very slight.

**Worried Depression.**—This variety is more common and presents, instead of the sadness, an attitude of anxiety with more or less monotonous restlessness both in speech and act, that very materially alter the picture. The thoughts are more freely expressed, but are limited to a small circle of ideas that conform with the mood of worry and anxiety. The general appearance is that of restless tension with monotonous repetition of words and acts that express self-depreciation and suffering. The patient walks slowly up and down in an unvarying path, wringing his hands, moaning and tearing his hair. Such phrases as "Why ever did I do it?," "Oh! my God my God," "Won't you kill me please?," "Let me out so I may die," are repeated monotonously for hours and days in a loud wailing voice. When the patient is questioned, the repetitions may be interrupted
momentarily and further information may be gained which is to the effect that the patient has sinned against the Holy Ghost, is the cause of all the suffering in the world, is doomed to a horrible death from which nothing can save, his soul is lost and he is condemned to everlasting torment. Unexpected sounds are interpreted as the coming of the executioner, the laments and cries of some loved one in torment as a consequence of the patient's sins. To this may be added ideas of persecution by various groups or individuals, all justifiable because of personal sin, but none the less horrible. Feelings of being lost and of having nothing left to live for may result in so-called nihilistic ideas: the patient has lost everything; every one is dead but himself; the seeming world, correctly appreciated as to its effects, is unreal; the people are ghosts or visions. Not uncommonly, especially in the forms that appear during the climacterium, the body is felt to be altered and this may be expressed in delusional form by saying that parts of the body are missing, there is no stomach, no bowels, the feet are lead and the head is glass.

Such states of intense restless agitation may last for long periods, almost uninterruptedly even by sleep. Feeding and general care are difficult and the liability to the consequences of malnutrition is great. The dangers of suicide are unequaled in any other condition.

In milder degrees, many of which are cared for at home, the general trend of the symptoms is the same. The sense of unworthiness often leads to extremes of religious fervor, and the feeling of inadequacy results in worrying, fretfulness, hesitation and doubt, anticipations of approaching disaster and loss of property; portentous forebodings are read into simple mishances, and errors and fears of approaching insanity are based on the feelings of illness, forgetfulness and inability to work. Sleep is poor, some
degree of insomnia being almost invariable. Dreams of terrifying content interrupt the brief snatches of sleep that are secured. Appetite is poor and constipation very troublesome. Loss of weight is usually marked. The dangers of suicide are great even in the slighter grades, many such acts in later middle life, though often attributed to "nervous exhaustion," should be accredited to this condition.

SCHIZOPHRENIC (DEMENTIA PraecoX) PSYCHOSES

Definition.—It is still an open question whether dementia praecox is a disease of the brain causing a true dementia and comparable to general paralysis or to the effects of chronic alcoholic intoxication; or whether the whole clinical course, including the terminal stage of apparent dementia, is to be regarded as a mode of adjustment between the tendencies toward reactions of a certain kind and the facts to be adjusted to. This will be further discussed under the heading of dementia praecox. For the present we are concerned only with psychoses such as are observed, characteristically it is true, in dementia praecox, but also in association with other diseases. It is for this reason that the title schizophrenic has been used instead of dementia praecox. The former indicates a certain kind of mental reaction, the latter refers more specifically to a brain disease. It should be stated, however, that many psychiatrists use the words schizophrenia and dementia praecox as synonymous.

Schizophrenia, literally translated, means "splitting of the mind." It is not possible to look inside the mind, hence all conclusions concerning its operation are based on observation of what the person says and does, these being the resultants of his mental activity. In this category must be included the activities of the involuntary muscles and glands which cooperate in every activity of the body and play an especially prominent rôle in such as are accompanied by
emotion. When, therefore, one speaks of splitting of the mind (dissociation), this must be regarded as a descriptive term illustrative of what seems to happen in bringing about the outward behavior. The features in the behavior that have led to this concept are the apparent lack of harmony between the component parts of the reaction and between this as a whole and the situation that seemingly called it forth. The words uttered, for instance, do not correspond with the emotion expressed by the face and the attitude of the body; or the acts performed with arms and legs are out of keeping with the thoughts as expressed in words. The observer is thus struck by the incongruity between what is said or done and the actual situation under which these are performed.

There is something strange, inexplicable or odd, which seems to require further facts than those directly observable in order to be understood. In every-day life, it is not uncommon to observe a man do something that seems inappropriate to the circumstances and we wonder why. We usually satisfy ourselves by concluding he has some reason of his own, which, if it were known, would make the seemingly incongruous act intelligible. We observe him smile, fly into a rage or make some cryptic remark when there is apparently nothing to justify these reactions. Schizophrenic reactions are of exactly similar kind, with, in addition, the fact that the man himself is apparently unaware of the motive for the inappropriate features and is at a loss to explain them. It then appears as if the motivating force is in some way and for some reason kept out of conscious recognition and it is this which has led to the concept of "splitting." The impulse to action and the memories associated with it, while still active, yet operate independently of consciousness and are thus, as it were, "split off" from the conscious mind.
Probably one fundamental factor in bringing about an exaggeration of this tendency to repress and split off from consciousness certain instinctive desires and their expression, is a feebleness of the inherent energy of reaction with which the man is endowed. A social mode of existence inevitably means that the desires of the individual must be controlled and subordinated to the interest of the group. The man who lacks “pep” and forcefulness will necessarily find greater difficulty in holding his own in his contacts with others, and in asserting his rights to live and enjoy the gratification of his instinctive longings amid the restrictions of society. He learns only too well the lesson, quite commonly inculcated specifically, that desires should be not only controlled but even suppressed, an obvious impossibility. Being too timid to assert himself, he is liable to take to dreaming as a substitute for reality, and in order to simulate suppression, he may substitute symbols for the real desires and their more natural expression. The particular symbols are selected from chance experiences and accidental associations, which, therefore, more or less completely disguise the sense in which they are used. In this symbolism, he may succeed in deceiving not only his associates but also himself.

The Schizophrenic Personality. Such is the foundation of the schizophrenic personality, the manifest appearances of which may now be described before outlining the psychoses that are liable to develop on such a basis. The latter are exaggerations of the reactions that belong to this type of personality; they are exaggerated, either because the situations to be faced are such as to make big demands on the emotional life of the man or to accentuate his inadequacies, or else they represent affective oscillations similar to those of the manic-depressive psychoses. Schizophrenic persons are not exempt from such oscillations, but the outward expression of the mood, as of instinctive desires in general, is modified by
the tendencies to dreaming, repression and dissociation which belong to the personality. The clinical picture presented by such upsets in mood is consequently quite different from those of the manic-depressive person. The latter are characteristically frank and easily intelligible, while the schizophrenic reactions are odd and cryptic. The degree of oddity depends on the degree of schizophrenic tendency and every gradation is possible.

From what has been said, it is clear that schizophrenic reaction tendencies are, at least in part, inherited and therefore liable to be manifested at an early age. But though the inherited make-up is of great importance, yet the character of the training received is far from negligible. Again, the environment in which the training is given, because of the possible variations in the demands that it makes on the child, is also important. The relative weights to be accorded to these different factors as determinants of the mode of reaction are difficult to estimate. The child of schizophrenic parents, in all probability, has not only inherited certain deficiencies in make-up, but has also received, by example if not by precept, training in adjustments of schizophrenic kind from association with his parents. It is also quite possible that disease and exhausting conditions of various kinds may cause diminution in the vital vigor or energy of a man originally well endowed and thus lead to acquired inefficiencies in reaction similar to those that are inherent. It is therefore obvious that wide variation in the age at which the characteristic features of schizophrenia become noticeable is possible. The earlier the habit of reacting in this way is developed, the more firmly does it become established and the more serious and difficult to remedy.

The intelligence of schizophrenic persons is usually good and is often above the average. Indeed, it seems probable that high grade intelligence is necessary for the development
of this mode of reaction. In certain respects, the reactions are exaggerations or caricatures of the modification of primitive instinctive adjustments that makes social existence possible and that is brought about by the evolution of symbolic thinking. Yet many authors admit the possibility of schizophrenia in persons who are intellectually defective and the title "Pfropfhebephrenie" has been coined in Germany to designate a combination between dementia praecox and feeblemindedness. The facts are usually far better explained by recognizing that there has been a failure to establish memories or associations (intellectual deficiency) as a result of the unusually early and extensive development of a tendency to autism which we shall discuss shortly. Typically, perception and the formation of memories with clear grasp and orientation are fully up to the average. The trouble lies not in the quality of the intellectual tools, but in the use that is made of them.

We have described the essence of the schizophrenic reaction as a bashful timidity associated with lack of energy. Consequently, the situations that will render it manifest are such as require self-assertion and active participation in the world of reality. So long as the individual can keep within himself and avoid the necessity for rubbing shoulders with his fellows, he may show but little evidence of difficulty. But it must be remembered that, even within himself, there are desires struggling for expression and gratification toward which he may be just as timid as he is toward other persons. Obviously, the period of life during which, as a rule, the demands for adjustment will be least is that of childhood. Then, responsibilities are few and instinctive desires are relatively simple and but little subject to social regulation. The sexual and parental instincts are as yet only foreshadowed and it is in this sphere especially that society places the greatest restrictions on individual behavior.
The schizophrenic child is quiet and retiring, prefers solitary games and amusements, and lacks the aggressive spontaneity and outspoken sensuality of the average child. He does not get into mischief and is often described as "unusually good," "never caused a moment's trouble," docile and easily amused. He may be fairly even tempered and yet subject to rather violent, and perhaps unexpected, outbursts of emotion on seemingly small occasion, usually short lived. He is affectionate though undemonstrative and displays his feelings little. He makes few friends and no confidants; in group games he is often on the outside looking in, rather than an active participant. This is not due, necessarily, to an ineptitude for athletic activities, he may even excel in them; but to the difficulty in getting outside himself.

In school he often does extremely well so far as scholastic acquisitions are concerned. He is liable to be absorbed in books and especially in topics that are philosophic and abstract rather than those that would bring him into dealing with the real and the concrete. Often the school successes give rise to hopes of a brilliant future, incapable of realization because of the impossibility of effectively meeting reality.

As the stronger passions and feelings develop, the difficulties in expressing them become proportionately greater and there is an increasing tendency for the youth to shut himself up within himself (autism) and to dream rather than to react openly. The process of repression and substitution results in the appearance of mannerisms and oddities in behavior, often with increased bashfulness and awkward clumsiness, when the schizophrenic is obliged to mix with others or when his desires and feelings are touched on. The interests displayed continue to be abstract and there is a tendency to turn to artistic pursuits, music, poetry, painting, etc., in which real life is translated into symbols and thus
the necessity for actual contacts is avoided. Many schizophrenic persons have considerable talent in some form of artistic expression, but this is not liable to lead to great accomplishment because of the autism. Similarly, religion and various cults and fads offer opportunities for symbolic expression without the need for social intercourse and may be eagerly grasped.

Oftentimes, these persons develop wonderful dreams of the futures for which they are destined, but these remain as veritable “castles in Spain,” unpractical and without the application that would be necessary to bring them to fruition. The dreams and plans are vague and indefinite, though possibly highly colored, and little consideration is given to the practical facts of the situation. The mood is often exalted, but instead of leading to increased activity and sensual interest, it takes the form rather of an ecstatic dreaming. On the other hand, the mood may be of depressive color and is then evidenced by fretful worrying, with irritability, and is ineffective in producing any change in the situation. Sometimes it is rather a moody brooding, with occasional outbursts of violence.

It would be a mistake to assume that every person with a schizophrenic trend is going to develop a psychosis or become insane. Very many never do so at all, possibly because the complexes that are split off do not involve a very large part of the man’s personality, or because the conditions under which he has to live do not make demands that he cannot meet sufficiently well to “get by.” One of the subgroups of dementia praecox comprises such individuals under the name of dementia simplex. They do not often come under the observation of the psychiatrist and have but little importance for the medical jurist. It is readily intelligible, however, that the outbreak of a psychosis is especially liable to occur when special demands in the way of responsibility and direct
contact with the real world are made. One such period is that of leaving school and emancipation from home control; another is concerned with the problems of puberty, marriage and the establishment of a home. These are frequently found as precipitating factors in the psychoses that arise on the basis of the schizophrenic personality. But the outbreak may appear with any special demand, such, for instance, as that which came with induction into the military service during the war. Necessarily, the liabilities to a breakdown diminish with advancing years for the reason that susceptible individuals have been steadily eliminated by the varying stresses that have had to be faced. With the appearance of the degenerative diseases of later life, fresh cases of this type are liable to appear, the disease causing possibly a decrease in the factor of energy which leads to an increasing resort to schizophrenic reactions in persons in whom this tendency was formerly slight.

The Psychoses. The schizophrenic psychoses are exaggerations of the features that have just been outlined, but need description for the reason that many additions appear which, at first glance, may seem to be entirely new. It would take us entirely too far afield to explain many of these in detail and we shall, therefore, content ourselves in the main with formal descriptions. We would again emphasize the fact that we are not here describing dementia praecox, but only a reaction type. There will, therefore, be no subdivision into the types of that disease. It will, however, be necessary to speak of the deterioration, so-called, that seems to be the logical outcome of the psychosis.

First, it should be said that the intellectual mechanism remains undamaged, though this is not always easy of demonstration because the patient is more or less inaccessible to study and examination. The difficulty is increased by the fact that absorption in the dream world, which we
found characteristic of the schizophrenic personality, is here exaggerated to such a degree that the real world may be entirely ignored and the man may fail to use his powers of perception and grasp. In consequence, he establishes only scanty and haphazard memories of what transpires around him and may thus seem to have lost his memory.

Under the conditions of stress, whatever their nature, that lead to the psychosis, there is a demand for the expression of feelings and instinctive cravings exactly similar to those of persons of a more frank and open personality. Frank expression being contrary to the habits of reaction, there results an increase of mental splitting and symbolization. The man experiences longings and feelings, the real meaning of which is repugnant and they are therefore refused recognition. Yet they occur, and some explanation for these feelings must be sought. Often at first this takes the form of a belief in something vaguely wrong with him and, in consequence, there arises a state of hypochondriac depression with evidences of perplexity and irritability. The tendencies toward action appropriate to the real desires arise, but are, like the feelings, refused recognition and thus seem odd to the man himself.

Feelings of Influence and Hallucinations.—Out of this perplexing state of wish and counterwish, technically spoken of as ambivalency and ambitendency, many odd appearances may arise. The thoughts and feelings that come in spite of himself are regarded by the sufferer as unwelcome intruders, not his own, but introduced from without. He concludes that he is being influenced by others who can in some way control his mind and acts, and perhaps also read his thoughts. The strange, unwelcome thoughts are known as autochthonous ideas and the acts that the man performs, apparently against his will, as pseudospontaneous acts. From this starting point, the patient begins to watch per-
sons around for evidence of interference and is liable to refer to himself (ideas of reference) any little gestures or chance remarks in his surroundings which could, by any stretch of imagination, be interpreted as comments on himself. From this, it is but a small step to the development of hallucinations. The strange thoughts become so vivid that they are heard as voices and the expectation of comments from bystanders becomes an actual hearing of them, though as a fact they have not been uttered. The content of the hallucinations is usually unpleasant: Comments, invectives, sneers and suggestions referring more or less openly to the repressed desires, or perhaps expressed only in the form of symbols that the man has adopted in his own mind for dealing with the complexes that have been dissociated.

In addition to the hallucinations of hearing, others connected with sensations from the body organs are also frequent. His stomach or intestines are being manipulated and ill treated, his sexual organs mutilated, etc. Hallucinations of other senses may also occur, but are somewhat less frequent. The voices, which are by far the most frequent form of hallucination, are rarely lacking altogether, and may be referred to as coming from particular persons in the surroundings; more commonly they are said to come from some distance away, in the room above, outside the house, or even from within the patient's own body. While they seem to be spoken of as real perceptions, there are evidences that the man does not confuse them with real voices. He knows at once what is meant when he is asked about the "voices" and often characterizes them in ways that render it clear he can distinguish between the real and the false. Yet he may speak and act as if he believes they are perceptible to others and are actual facts of experience.
Delusions and Acts.—The hallucinations and feelings of influence often lead to false explanations (delusions) of being under "the evil eye," hypnotized, worked on by extraordinary machines and supernatural powers. The choice, as explanations, of such mysterious influences is a further indication that the patient recognizes that the hallucinations are outside ordinary experience and hence need an extraordinary explanation. Another indication of the same kind is the fact that the reactions made to them are often entirely inadequate and ineffective. The man may complain bitterly when questioned, but if left to himself, he usually does nothing more than brood and worry, and he makes no coherent effort to discover the cause nor prevent their recurrence. This does not mean that he will not at times make abortive, usually short lived, and sometimes violent and explosive efforts to reply to them. He may go to the police and ask for protection, or he may make a desperate assault on some one in his surroundings, perhaps commit murder or other serious damage, but he does not follow a coordinated plan. The manner in which such assaults are carried out is such as to stamp them at once as pathologic. The outbreak is sudden, unexpected, unplanned (though he may provide himself with weapons), and apparently without motive; a truly impulsive and unconsidered act. The man's attitude toward the deed after its accomplishment is devoid of remorse. It is almost as though he fails to accept authorship, he is not a free agent, and he apparently often experiences considerable relief after the act is performed. Yet he may retain full memory for the whole event. Sometimes, however, there is some clouding of consciousness with the extreme excitement, and the memories then will be proportionately vague and incomplete.

Autism.—In the description given thus far, considerable stress has been laid on the indications that the man himself
seems to realize that the feelings and hallucinations are really part of himself and are distinct from the ordinary happenings of the world outside. They are, indeed, expressions of the split off complexes, split off because of their insistent demands for recognition and of the inability of the patient to face them. Because they refer to powerful instinctive cravings, they are inherently interesting, more so than the ordinary events transpiring in the world around. Hence they occupy much of the man's time and he may justly be described as living in a world that lies within himself and having no contacts with his surroundings. It is this self absorption that is referred to as autism and the thoughts and symbols used in the process are alluded to as autistic. There are further consequences that follow from such absorption.

Conduct.—Having but little interest in the things of the outside world, the man will do little or no work, but will sit or walk around idly, perhaps fitfully starting this or that, dreaming and fussing about his thoughts and feelings; he pays no attention to relatives or friends and may seem to have lost all affection for them; he becomes careless of personal appearance and cleanliness and may show oddities in dress and manner that have reference to the autistic world and are hence unintelligible to the onlooker; his speech and acts become disconnected and scattered owing to the fact that they are guided from within and not by the things in the actual world. Questions may or may not be attended to and the answers given, even if partly responsive, show carelessness and sudden inexplicable twists and turns, odd phrases, new words and words used with unusual meanings, which may seem utterly senseless because they refer to the autistic and not to the real world. These peculiarities may be so marked as to constitute a meaningless jargon (verbigeration). The stream of words and acts differs
markedly from that of the manic individual; in that form of reaction the disturbance is more or less obviously due to distraction by things happening in the world around in which the manic is only too much interested. In schizophrenic persons, on the other hand, there is less interest in the sense stimulations of the real world and absorption in a dream world that is out of the reach of the observer.

The oddities and mannerisms of speech and act suggest a hidden meaning, utterly inexplicable by anything that is actually happening. Dysharmony between words, acts and expressions of feeling is often striking and can be explained only on the basis of dissociated complexes. The odd reactions are symbols used to express the repressed desires and wishes, which the patient cannot even think of consciously, still less express frankly. Their use is a source of satisfaction since they gratify, in symbolic manner as in a dream, the reprehensible longings which the man is not forceful enough to satisfy in a more natural manner.

_Automatism._—Reference was also made to ambivalency and ambitendency or the existence of contradictory wishes and tendencies to action respectively at one and the same time. These, in reality, are only exaggerations of perfectly normal occurrences, necessary to permit the selection of the best reaction in a given situation. Conscious selection of reaction means a choice between the various possibilities of response of which we are aware from experience. "To be or not to be," to act or not to act, to do this or the opposite, are important elements in this selection. The decision requires force and vigor, especially if the problem is one of serious importance and therefore endowed with strong feelings. In schizophrenic persons, the doubts and hesitations as to what to do or think may often fail of solution and the perplexity will then be expressed in the behavior. It is quite common to find that the "voices" make suggestions
of quite contrary character: "do this" as well as "don't do this" and the conflict as to whether to comply or not may be kept up indefinitely, with the consequence that nothing is accomplished. Often it happens that the suggestions to act, coming from some person or situation in the surroundings, or even arising within the man himself, result in the performance of the opposite. When asked to put out his tongue, the lips are tightly compressed, etc. Such opposite responses are spoken of as negativistic, and negativism in some form or other is an extremely common manifestation. On the other hand, it may happen that a suggestion is complied with at once, without time for consideration at all. A sudden movement in front of the patient, the sudden raising of the voice, the asking of a question, may be reacted to simply by mimicry. This tendency to a machine-like compliance with suggestions is spoken of as automatism; negativism is an entirely similar phenomenon for it means only the carrying out of the opposite of the suggestion, which always arises in consciousness as one possibility when action is proposed. Both negativism and automatism are evidences of absorption in an autistic world with consequent lack of sufficient interest or energy to select a response to the real world.

Stereotypy.—The various oddities and peculiarities in speech and act, the ideas of reference, hallucinations, delusions, mannerisms, etc. are liable to continue in relatively unchanging form because they are related to a more or less constant and unchanging complex of ideas and feelings. They therefore contrast markedly with disturbances in behavior that depend on the relatively inconstant and shifting conditions in the world outside the patient. Being a source of gratification and compensation for failures in the world of reality, they are also liable to frequent repetition. Beginning as responses to the stimulation of instinctive desire and, at
first, more or less plastic and elaborate, they tend later to become habits and then to be continued even after the original stimulations have subsided. When this occurs, they are said to have become stereotyped or fixed; stereotypy is a striking characteristic of this type of reaction. Like other habits continued for long periods of time, they tend to become shortened and abbreviated to such an extent that they may be eventually unrecognizable as expressions of any intelligible action.

Deterioration.—It may be said then, that there is a distinct tendency in the schizophrenic psychoses for certain symptoms to become habitual or stereotyped. This means that the autistic attitude, with all its secondary consequences of distorted and abbreviated forms, becomes a settled habit of life. There is more or less complete withdrawal from the world and more or less entire indifference to things and persons; the only outward expressions are reduced to a heterogeneous collection of scattered fragments of hallucinations, delusions, and stereotyped oddities of speech, act and attitude which present to the onlooker an appearance of utter dementia. If, however, responsive answers in word or act can be obtained, it will be found that there is no true dementia. The man still recognizes and understands those things to which he attends and memory is intact in so far as it is established. The deficiency of interest in the happenings of the world must result in vagueness and scattering of memories, scattered because of the lack of the guiding influence of interest that would select the important and discard the unessential. This state is commonly spoken of as affective deterioration and sometimes as dementia. The latter term is not appropriate if the definition adopted here is accepted. The deficiencies in memory and judgment are not due to loss of brain substance, but to lack of interest; there is no loss of working tools but only deficiency in their use.
This termination in deterioration, though very frequent, is not invariable. With the subsidence of the emotional conflict that precipitated the psychosis, either by the subsidence of the instinctive desire or by a change in the demands for adjustment made by the circumstances, there may follow a corresponding diminution in the attractions of the autistic world; if the schizophrenic reactions have not become too habitual and stereotyped, there may be a return to the previous interests in the real world. This is especially liable to happen if the precipitating cause was an unusual and limited demand, limited in the sense that the associations with the inner life of the patient were not too broad. The broader the associations and the more simple the difficulty which constituted the exciting factor for the psychosis, the greater the liability to perpetuation of the autistic habits. This means that a greater number of situations and a larger proportion of the instinctive cravings are too difficult for this man to meet and he will find few or no circumstances under which he will not take refuge in a dream world.

PARANOID PSYCHOSES

The title "paranoia," literally meaning distortion of mind or crankiness, has been used since the time of Hippocrates to designate a group of mental disorders that are characterized particularly by the development of false judgments (delusions), which are reasoned out calmly and logically. For this reason it was long taught that they were essentially disorders of intelligence rather than of behavior. This view is no longer accepted; it is now recognized that the mainspring of the reaction lies in the affects. It must be understood that we are here considering, not a disease, but a mode of reaction and the title employed is therefore not paranoia, but an adjective derived from that word. Some confusion has arisen from the use of different adjectival forms; the
strict form would be paranoic and this is reserved by some for its literal meaning of "pertaining to paranoia." The termination "oid," on the other hand, contains the meaning "like" and the word paranoid should, therefore, be interpreted as "like paranoia" and not as necessarily "of paranoia." But since there is still no real knowledge of the essential nature of a disease paranoia, these fine distinctions have little weight and many authors use the two adjectives synonymously.

The Paranoid Personality. It is necessary to distinguish between the paranoid personality or temperament and the psychoses that arise on this foundation. The paranoid temperament is of frequent occurrence and the vast majority of such persons do not develop a psychosis of sufficient intensity to prevent continuation of social relationships nor to interfere with social responsibility. Indeed, so closely do they conform to traits observable in the average individual that their recognition as abnormal may be difficult.

The essence of the paranoid personality is an exaggerated appreciation of self. Everything that happens is considered in relation to the effects it has on the self, and there is a corresponding diminution in the sentiments of altruism and gregariousness. The vigor or energy of reaction is great, but there may be variations in this respect which will have a marked influence on the outward behavior of the individual. When the forcefulness is less, there is an approximation to the schizophrenic reaction type with its scattering, dreaming and inefficiency. But, even then, the "egocentric" character of the reactions is obvious (paranoid dementia praecox).

The social existence that has been adopted by man results, as pointed out in the last section, in the necessity for controlling and limiting the desires and instinctive impulses of the individual. To the paranoid person with his concen-
trated self-interest, such restriction and regulations necessarily bring many difficulties and conflicts, often with failure to find self-gratification. He is unable to obtain satisfaction through the substitute channels of altruistic interests, as does the better balanced man, because in him these instincts are less well developed. His failures are painful to the heightened appreciation of self, and he seeks to assuage this by placing the blame on society. Experiencing longings that are prevented from satisfaction by social convention, he cannot admit that he is inferior in his ability to control them and he endeavors to establish his superiority by exaggerated efforts to correct similar cravings in others. Being so important to himself, he transfers this sense of his importance to others and hence comes to the conclusion that people watch him and comment on his doings.

Assuming, then, the typical state of well developed energy of reaction, the paranoid personality may be described more concretely as follows: The man is a dominant, aggressive person, anxious to be in the forefront and careless of the feelings and interests of others. He takes life seriously, works hard and with purpose, is always sure of himself, is satisfied with his own views and constantly endeavors to impose them on others. He is quick to take affront, yet seldom fights openly, and continually seeks for hidden motives and meanings behind the words and acts of others that do not tend to his own advantage or accord with his own views. Naturally, he is not popular and he does not make friends though he may have many acquaintances. His mood is one of self-satisfied superiority, often combined with irritability which vents itself in words rather than deeds, but may lead to contentious litigation. He prides himself on his intelligence and control of emotions, and, as a matter of fact, reasons logically and connectedly; but his premises are liable to be vitiated by personal interpretations and slight
distortions that contribute to his amour propre and may be so subtle as to be difficult of refutation. The intellectual endowment is usually good and may be superior, but there does not seem the same necessity for contrasting low-grade intelligence with a paranoid trend that seemed indicated with the schizophrenic reaction. Necessarily, however, the lower the intelligence level, the less logical and well worked out will be the judgments that are reached.

The mental attitude is often strongly reflected in the bodily attitude and bearing. This has the features of erectness, vitality and assurance in action that give an appearance of arrogance and domination.

From these characteristics, it is easy to understand a not uncommon further development in which the man adopts some cause. Many cranks, reformers and apostles of so-called human welfare schemes, are built in this mold. One group is that of the so-called litigants, who devote themselves to righting all sorts of wrongs, real and imaginary, through the courts. Sometimes the subject of litigation concerns questions of individual privilege and right, at others it is more general and of the nature of reform. Every court has had examples of such causes. Many times there is justice in the claims and the claimant or disputant will win his case. This serves to spur him to further efforts and to add to his pride of self. Should he fail, he is liable to use propaganda in his endeavor to prove himself right and the court wrong. Unquestionably, should the cause be meritorious, such persons may sometimes do valuable civic service, for they possess restless energy and secure real pleasure from their efforts. But the great danger is that the spirit of intolerance, which is inherent in such efforts of persons of this type, may lead to extravagances of assertion and vindictiveness, and thus do injury rather than good. There is an inherent dishonesty in the efforts, which depends on the selfish
interests of the personality and causes exaggeration of everything favorable to the cause and the suppression of all that opposes it. The logic is one-sided and bigoted, biased by the interests of the proponent.

Publicity and advertisement are eagerly sought and nothing serves so well to maintain the crank or reformer as opposition that can be interpreted as evidence of martyrdom and lack of understanding. The worst fate such a person can meet is that of being ignored. He does not realize the essential selfishness of his activities, and claims instead a lofty altruism and interest in abstract justice. So thoroughly may he thus deceive himself, and so deeply may the gratification of self be bound up in the desire for dominance, that the man will submit to privations and suffering. But the real fact of self-interest becomes apparent from a study of the life history; there is evident lack of love for others and appreciation of their feelings, and at the same time the indications of arrogance and intolerance are unmistakable.

The Psychoses.—The psychoses that develop on such a basis are again only exaggerations of these trends and are brought about by situations of restraint and denial of satisfaction that are too great to be faced. Ideas of reference play a prominent rôle. The increased feelings of interference with securing personal satisfaction lead to close observation of the sayings and doings of others, with the object of detecting plots and schemes that are responsible for his own failures. Gradually he manages to collect together evidence that convinces him that such plots actually do exist, and from then there is a steady accumulation of facts of actual observation, each slight in itself, often so much so as to appear altogether unworthy of consideration to the unprejudiced observer, from which the whole scheme is pieced together and the authorship established. With this material at hand, the memory is combed for further evidence that points in
the same direction (retrospective falsification of memory). These memories are more or less true to facts, but are so divorced from context and twisted as to details that they appear more or less plausible grounds for the present beliefs.

So logically and systematically with regard to detail is the system of "delusion of persecution" worked out that it may be only with the greatest difficulty that the validity of the assertions can be disproved. Usually, however, the premises on which the whole contention is based are so trivial, circumstantial and often improbable, that the delusional nature of the beliefs is obvious.

Throughout this process, which takes long for its evolution, the man remains active, energetic and tensely interested in the world as it relates to himself. His reactions to the situations he unearths are vigorous and appropriate, usually, at least at first, within the bounds of law. Prolific writing and speaking, denunciations and threats, frequently lawsuits and appeals to the police constitute the earlier modes of meeting the "persecution." Failing to secure redress in these ways, he may, under conditions of increased emotional stress, take the law into his own hands. This may result in acts of violence, either against property as a means of coercion and reprisal, or against the persons of his persecutors. The striking feature of these acts is that they are logical; if one granted the premises from which he reasons, one would admit that the man's reactions were appropriate to the circumstances, though too violent.

As a necessary corollary to the belief in systematic persecution developed in this way, there follows a further development. Persecution must mean jealousy or fear on the part of the persecutors; and it is logical then to conclude that there must be something about the persecuted that is desired or feared by those who oppose him. The same logical investigation of past and present happenings that
resulted in the belief in persecution leads gradually to the discovery of possible explanations for it; in this manner there may arise convictions of personal greatness, noble descent, divine prerogative, wealth of which he is deprived, etc.; these constitute the "delusions of grandeur" that mark the further development of the picture. Observations of fact, their distortion to suit the purpose and falsifications of memory play the same part in the evolution of the ideas of greatness that they did in that of the belief in persecution.

Throughout, the intelligence remains intact; perception is clear and there is no disorientation in the narrower sense of this term. Memory is good in spite of the falsifications in meaning and context that have been mentioned. The man remains in contact with reality, active, alert and interested and there is no tendency to deterioration or dementia. Hallucinations are unusual, though they may occur during periods of marked excitement.

The tendency to adopt a cause and thus to develop false conclusions with activities appropriate to these conclusions has led to a concept of an insanity limited to some one topic or complex of ideas; and, formerly, much stress was laid on the possibility of a "partial insanity" or "monomania." To-day all alienists are in accord in negating such a possibility. Even though the excitements and incorrect conclusions seem to center around some one subject, the reasoning and judgments on topics apparently unrelated to this complex being seemingly correct or "normal," yet such isolation of a group of ideas is psychologically inconceivable. All activities are so intimately interrelated, often by associations that result from purely personal and individual experience, that it is impossible to conceive a disconnection between any sets of ideas. The mind is not a thing, divisible into separate compartments or units. It functions as a whole, even though some sets of ideas are more active at one moment
than are others. Such a conception of partial insanity is much like that of the isolation of a country under present conditions of human life. There are so many points of contact that practically anything that happens in one hemisphere of the world is of importance in the other.

The paranoid personality is not inherently incompatible with either of the others that have been considered and it is not surprising to find combinations between these various types of reactions in almost endless variety. Affective oscillations occur in paranoid persons and the picture then presented will be colored by the persecutory, egotistic trends and ideas of reference peculiar to these persons. Such association is far more commonly with exalted moods, which have obviously a closer correlation with ideas of self-appreciation than have those of depressive color.

Associations between the paranoid make-up and the weakness of the schizophrenic attitude have already been mentioned. The resulting clinical pictures are greatly modified by the autistic trends which diminish the logic and systematization of the delusion formation, and introduce features of hallucinatory experience, oddity and symbolism. Such combinations are quite frequent and there is an almost endless number of subdivisions into types that have been called paraphrenia and paranoid dementia praecox. Indeed, many persons refuse to recognize the existence of a true paranoia and prefer to include all examples of the personality type described in this section under the heading of schizophrenia.
II. THE CLASSIFICATION OF THE INSANITIES

It is not our purpose to write a textbook of psychiatry and we shall endeavor as far as possible to restrict the descriptions of the different forms of mental disease to the practical needs of our subject. The alienist, in the application of his studies to legal questions, is not strictly concerned, as a rule, with diagnosis of types. It must be insisted, however, that the methods of investigation on which the conclusions as to sanity or insanity are based, should be of the same kind as in examinations made for the purpose of treatment. The physician, so far as possible, should endeavor to make a diagnosis, even though he may refrain from stating this opinion when testifying. Only by such detailed study can he reach conclusions that will be of value in estimating the prognosis, the degree of damage, the amount of compensation, etc. Frequently, also, he will be called on to name the mental disease and to justify his opinion by detailing the facts that indicate and differentiate this conclusion.

Unfortunately, there are many systems of classification in use, most of them possessing certain advantages of their own. But the practical consequence is that the layman, who has no knowledge of the good reasons that exist for variations in the methods of classification, is misled into thinking that two alienists are not in accord, even when there is only a divergence in nomenclature. Within the past few years, an earnest effort has been made to minimize this difficulty by establishing a compromise system with more or less arbitrary definitions. This effort, which was undertaken by a committee of the American Psychiatric Association, has resulted in the adoption by practically all state hospitals for mental
diseases of the classification that we propose to use. It is admittedly imperfect in many particulars and is subject to revision at five year intervals.

It is difficult to compare one system of classification with another for the reason that the criteria used in making the divisions are often entirely dissimilar and there is, in consequence, much overlapping between the different groups. In so far as possible, we shall indicate titles used in other nomenclatures; but it must be understood that the extra names are often not true synonyms. The subdivisions of certain groups are also frequently somewhat artificial, with the consequence that there may be considerable difference of opinion as to the definition. This is especially striking in the subdivisions of the dementia praecox group as will be seen from statistics of different hospitals. These considerations must be borne carefully in mind by the medical witness in order to avoid in so far as possible the confusion and apparent contradictions that may diminish the effectiveness of the medical expert as an aid to the courts.

In the last revision of the scheme of classification, few changes were made. One of the most striking was the elimination of the word insanity. This resulted largely from the fact that the scheme was designed primarily for the use of hospitals for mental diseases and to facilitate the collection of uniform and comparable statistics. Not a few patients are committed to such hospitals who are really in need of segregation, but who are not insane in the strict meaning of the term. Statistics containing the group "not insane" are very liable to misinterpretation, even though the fact is correctly stated from a medical point of view. The term psychosis has been introduced in order to eliminate that of insanity, though the two are not synonymous. In the discussions of various forms of mental disorder, it will become clear that a man may have a constitutional defect, such as
feeblemindedness, which, though not an insanity, requires removal from society as a measure for protecting him and others from the consequences of his acts. He may, at times, become insane, that is to say there is a change in his manner of reacting which is due to intercurrent disease. The mental reaction is then spoken of as a psychosis and the case is classified with the particular form of disease that produces the psychosis. Should there be no psychosis, the case is classified simply as mental deficiency without psychosis.

Without changing the names adopted in the scheme of the American Psychiatric Association, we have grouped some of the special varieties into broader categories in which they naturally belong and from which they were sorted out for special statistical purposes. In the following outline we have placed beside each group the statistics of frequency that were collected by the National Committee for Mental Hygiene and tabulated by Pollock and Furbush. These figures were derived from 21,742 first admissions to seventy-two state hospitals during the year 1920. From them should be deducted 435 psychoneuroses and 730 other cases without psychosis. This leaves a total of 20,577 patients with psychoses. The numbers placed in front of each type correspond with those in the original classification.

1 Pollock, H. M. and Furbush, Edith M., Comparative Statistics of State Hospitals for Mental Diseases, National Committee for Mental Hygiene, New York, 1922.
**SCHEME OF CLASSIFICATION**

<table>
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<tr>
<th>No. of Cases</th>
<th>Percentage</th>
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**I. Psychoses with structural damage to the brain:**

1. Traumatic ........................................ 48 0.23
2. Senile ........................................... 2,550 12.39
3. Arteriosclerosis ................................ 1,350 6.56
4. General paralysis ................................ 2,219 10.77
5. Cerebral syphilis ................................ 235 1.14
6. (7) and (8) Other brain and nervous diseases .... 209 1.02
7. (14) Involutional melancholia ..................... 683 3.29 35.43

**II. Psychoses with toxi-infectious conditions:**

9. Alcoholism ........................................ 476 2.39
10. Drugs and other exogenous poisons ............... 103 0.50
11. Pellagra ........................................... 741 3.60 6.41

**III. Psychoses without discovered damage to the brain:**

15. Dementia praecox ................................ 5,676 27.50
16. Paranoia and paranoid conditions ............... 594 2.89
17. Epileptic reactions ................................ 560 2.71 49.41

**IV. Psychoses with constitutional deficiencies:**

19. Psychopathic personalities ..................... 492 2.39
20. Mental deficiency ................................ 680 3.30 5.69

**V. Admissions without psychosis:**

18. Psychoneuroses .................................. 435
19. Without psychosis ................................ 730

**VI. Unclassified cases:**

595 2.89 2.89

**Total** ............................................. 20,577 99.83
III. FORMS OF INSANITY

1. Psychoses with Structural Damage to the Brain

Psychoses with head injuries (traumatic insanity)

Natural Protective Mechanisms. Head injuries are a fertile source of medicolegal controversy and there has been much discussion of the results they may cause. The brain is well protected from damage by being entirely surrounded with fluid, the so-called cerebrospinal fluid, and enclosure within a relatively unyielding box, the bony skull. The skull has only few openings or deficiencies and these, for the most part, are closed with the stout membrane, the dura mater, that lines the inner surface of the bony skull. The only large opening is through the foramen magnum which communicates with the cavity in the bones of the spinal column. Through this opening the brain is continuous with the spinal marrow. But even this cavity, the spinal canal, is lined with a dura mater that is continuous with that which lines the skull. The pressure within the skull is maintained at an almost constant level by means of mechanisms for absorption and production of fluid. Large variations in the contents of the craniospinal cavities can be accommodated in this way provided they do not occur too rapidly.

Concussion and Commotion. One result of the fluid support of the brain is that the effects of blows on the head are diffused in all directions and are thus minimal at any one point of the brain structures. Further, head injuries of sufficient severity to cause brain damage must affect

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the whole brain, except in the case of punctured wounds such as those caused by bullets. Clinical experience supports this a priori reasoning and establishes that all severe injuries that do not puncture the skull and yet damage the brain are accompanied by evidence of general damage in the form of loss of consciousness.

Many of the injuries that cause such concussion effects are also liable to cause fracture of the skull; but it is unquestionably true that fracture does not necessarily occur even when the brain is severely injured. In the majority of instances the state of concussion is due to general commotion of the brain as a whole and there is no local destruction of brain tissue. The immediate effect of the commotion is loss of consciousness, which may last from a few seconds to several minutes or longer. On coming to himself, the man may be dazed for a while and may experience more or less severe headache, perhaps with vomiting. Another striking effect is loss of memory for the injury. Such a loss of memory involving a certain period is known technically as amnesia. The period of the amnesia in cases of head injury includes not only the actual moment of the injury, but also a variable time preceding it (retrograde amnesia). This may be an important fact in determining that the injury caused sufficient concussion to produce unconsciousness. Frequently, in addition to this retrograde amnesia, there is also a failure to establish memories for the events that transpire after consciousness has apparently been recovered (anterograde amnesia). When questioned some time after an injury of this kind, there will then be a gap in the memory involving the actual injury, and the events that immediately preceded it and for a variable time after it. A man who has fallen in alighting from a street car, for instance, will not only fail to remember the fall, but will also be unable to recall that he was about to get off at the time
when he fell and may not remember even that he was on a car at all; also, even though he appeared to recover consciousness and talked within a few minutes after the fall, he may have no recollection later for anything that happened for some hours or days afterward. In estimating the degree of loss of memory it is important to consider the question whether the account given by the man is not the result of what he has been told by others, or of his reasoning as to what would be the logical sequence of events, which has led him to fill in the gap from imagination.

In addition to commotion, there may be actual damage to the brain substance and consequent evidence of loss of function, sometimes coupled with signs of irritation. The damage may be done by small or large hemorrhages, or there may be actual lacerations of the brain tissue; these are most often associated with fractures of the skull. It is also possible, though not proved, that areas of softening may develop as the result of the commotion similar to those that have been produced experimentally in animals in the spinal cord. But, in any event, there must always be evidence of severe commotion before such later degenerations can be alleged: more or less prolonged loss of consciousness, vomiting, convulsions, and perhaps symptoms of local character such as the loss of certain senses or of the control of movements. In the absence of severe initial symptoms it is rarely justifiable to make a diagnosis of injury to the brain substance from trauma to the head.

Reactions to Injury. Judged by the proportion of cases admitted to state hospitals for mental diseases, traumatic insanity is one of the rarest forms of mental alienation. In over 20,000 first admissions to seventy-two hospitals in the year 1920, only 0.23 per cent. were attributed to this cause. It is, however, extremely probable that many with the lesser effects do not need commitment and these figures mean
nothing more than that head injury rarely causes com-
mittable insanity.

The chief characteristics of traumatic lesions, as of other
kinds of structural damage, to brain tissue, are those which
belong to the destruction of brain pathways. Such damage
may be temporary, that is to say the nerve cells are not
injured to such a degree that they actually die, and after a
variable time, which depends on the nature and degree of
damage, recovery occurs. The clinical pictures that result
are those of delirium, more or less prolonged states of con-
fusion, and the more protracted types of the Korssakow
character. The first two may result in complete recovery;
the last often leaves some permanent damage, though the
improvement may be very marked. The permanent damage
results in what has been described already as dementia.¹
This is usually not severe and falls into the category
described under the title of constitutional defect. The
dementia is particularly liable to be of more or less focal
character and to be associated with evidences of injury to
lower brain levels, including those of sensation and control
of movements: hemiplegia, hemianesthesia, aphasia, apraxia,
hemianopia, etc. The exact form will depend on the
particular location of the injury to the brain.

Relation to Epilepsy. Special mention should be made of
the occurrence of epileptic manifestations. When the
damage is in the neighborhood of the motor areas of the
brain, there may be localized or Jacksonian fits. These are
usually good evidence that local damage has been done. On
the other hand there may occur seizures quite indistinguish-
able from those commonly called genuine epilepsy. In
estimating the relation that these bear to the trauma, the
greatest care must be exercised, and attention must be paid to
the earlier history of the patient and to the severity of the

¹ See p. 18.
trauma. There are few persons who do not, at some time, suffer from head injuries of greater or less severity; yet epilepsy is relatively infrequent. There is also a natural tendency on the part of relatives of epileptic persons to find some excuse for the condition that does not blame the family strain. Fits, at first Jacksonian in type, may later assume a more generalized character, and when a history of such early features is established, there is a far greater possibility, though not a certainty, that the primary cause was local. It is true that most genuine epilepsies begin in early life and that onset in middle life or later always arouses a suspicion of the existence of some structural lesion. It is also true that the history of fits in early life is not always easy to elicit, even in the absence of a motive for concealing the facts. Epileptiform seizures occur in many different diseases, both toxic and more grossly structural. These must be excluded before the conclusion can be reached that the cause was trauma.

It should also be pointed out that the trauma may be caused by an epileptic seizure; this sequence, indeed, is probably far more frequent than the reverse relation.

The relation of trauma to other forms of mental disease will be discussed under the heading of each disease. Here, however, it will not be amiss to mention some of the more frequent types in which such relationship has been alleged, though, in all probability, none has been altogether exempt from such allegation. The most frequent has been with general paralysis; others are: manic-depressive insanity, dementia praecox, brain tumor, arteriosclerosis and senile dementia.

SENILE PSYCHOSES

Relation to Age. By senile insanity is meant the decay of mental functions that results from old age; it shades off imperceptibly into the ordinary dotage, of which it is only an exaggeration. In most of the older text books no
distinction was made from the dementia that may result from arteriosclerosis. But the two disorders are pathologically distinct, though they may be, and often are, associated together in the same person. When this is true, it is the present practice to group the case with the arteriosclerotic diseases.

No exact age can be set at which a man can be said to have become senile. Tissues appear to have a certain span of life which varies according to the initial vigor with which they start and the stresses and strains to which they have been subjected during life. It is entirely probable, too, that there is a variation in the vitality of different tissues and that in some persons the nerve tissue, for example, may have a less span than others. When all are more or less equally endowed, the decay will progress in all parts of the body at once. But it is possible for the nervous system to reach the limit of endurance before other systems and then there will be a disproportionate decay in that system. One man may be old at 60, while another is young at 90. While, therefore, it is permissible to say that this decay belongs to old age, the limits within which it may appear are rather wide and the manifestations will differ according as the senility involves the whole body or only special parts.

**Dementia.** Typically, senile insanity comes on insidiously and progresses slowly but steadily. The nerve cells die gradually and temporary excitement and stimulation may sometimes produce evidences of activities that had seemed to be almost entirely in abeyance. The fundamental symptom is dementia, as in all other forms of destructive lesions. The features that stand out are the loss of the most recent memories with a consequent bringing into relief of those that are more ancient. The happenings of the moment are soon forgotten and from this arises the tendency to tell

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1 See p. 20.
the same story over and over which is so frequently observed in old men. There are usually evidences also of progressive loss of energy so that the man becomes more dull and sleepy and less active. Often this drowsiness is more marked in the day than at night when there may be even restlessness. The general feebleness and dementia tend to increase slowly until finally the man has to be cared for much like a child.

When the decay in the brain tissues exceeds that of other systems, there may be retention of bodily vigor with consequent variation in the clinical picture. This condition is often spoken of as presbyophrenia, which resembles in many particulars the reaction described as the Korssakow type\(^1\) of dementia. The gaps in the memory for the immediate past are filled in with memories drawn from times more remote (confabulation) with the consequence that the statements seem utterly incomprehensible.

**Deliria.** With lessening in vitality of the body tissues, there may ensue low-grade infections and intoxications, especially in connection with the kidneys, bladder and the prostate gland, which are liable to cause states of delirium. Such states may be the principal evidence of a pneumonia which is a very common cause of death in old people.

**Medicolegal Relations.** The mental defect is, obviously, a serious handicap to the transaction of business. No rules, however, can be laid down as to the degree of capacity that remains; this must in each case be decided by a study of the facts as to the amount of memory possessed. Careful attention must be paid to the ability to grasp broad problems. Even though a number of items may be comprehended and correctly dealt with separately, it does not follow that the meaning of them taken together can be grasped. Things that are habitual and have been carried out often may continue to be performed with apparent correctness, even when

\(^1\) Page 18.
there is no real ability to modify the decisions and make adjustments in accordance with variations from routine.

PRESENILE PSYCHOSES

The classification in use makes no separate provision for a rather heterogeneous group of cases that appear to arise in more advanced years, which are for that reason included here. But there is good reason for considering them definite diseases, predisposed to, perhaps, by the lessened vitality of advancing years. In addition to the late appearance of various diseases and psychoses such as general paralysis, arteriosclerosis and manic-depressive insanity, which occur occasionally, there are forms of insanity that seem to belong peculiarly to the later periods of life, early for true senility but beyond the climacterium. Many will include here the cases of involutional melancholia though they appear at an earlier age; in the classification used here, these are given a separate position.

The pathology of these presenile conditions is still very obscure, only one variety, known as Alzheimer’s disease, having characteristic anatomic changes. All tend to pass into dementia after a more or less stormy course, and the dementia is out of proportion to the loss of vitality in other tissues. The onset is usually rather acute, with delirium or severe depression and agitation. The depression is colored especially with beliefs that everything is lost, the poor-house is the only refuge, the body is changed (nihilistic and somatic delusions). Paranoid features may appear and the patient may believe he is being persecuted, robbed or abused in various ways. This leads to worry and agitation with efforts to escape and perhaps to retaliate. Wills may be changed and gross injustice done to members of the family. Suicidal attempts are always possible.
One interesting group includes cases with katatonic symptoms (Spätkatatonie) which are sometimes placed in the group of dementia praecox. The Alzheimer's disease is very acute in its onset and development, and the psychosis is one of intense anxious agitation which leads rapidly to dementia. Accompanying the mental symptoms there are evidences of focal damage such as aphasia, apraxia, hemiplegia, etc. The duration is about two years, death usually supervening from pneumonia or a septic infection.

The whole group of senile and presenile conditions as here outlined make up about 14 per cent. of first admissions to state hospitals, and of these approximately two-thirds are senile as opposed to presenile insanities.

**ARTERIOSCLEROTIC PSYCHOSES**

**Nature of the Disease.** The changes in the brain in arteriosclerosis are due to disease of the blood-vessels and not to primary brain disease. But the brain tissue depends for its nourishment and supply of oxygen on the materials carried by the blood. Arteriosclerosis is a degenerative disease and is therefore most common in the later periods of life, and it is not surprising that it should long have been included with the senile changes. The causes of arteriosclerosis are probably manifold and sometimes obscure; it depends in great measure on the strains to which the heart and blood-vessels have been submitted; but there is also much individual variation, the liability to this condition being often noticeably familial. It is often closely related to chronic degeneration of the kidneys (chronic Bright's disease) and to similar changes in the heart. Among the causes may be mentioned: Chronic intoxications such as syphilis, tuberculosis, septic infections of long duration, chronic alcoholism, lead poisoning, etc.; prolonged mental worry and emotional stress which
put a large strain on the heart and vascular system; repeated attacks of manic-depressive insanity.

The symptoms vary according to the distribution of the disease in the vessels. This may be widespread and involve the smaller arteries generally. On the other hand, it may be especially marked in larger arteries, perhaps in certain particular vessels. As a result of the thickening, hardening and tortuosity of the arteries, the brain tissue supplied by them receives insufficient nourishment and the waste products that arise from activity of the cells are not so well disposed of. The amount of nourishment may be sufficient for ordinary demands, but insufficient for unusual stress.

In consequence, the symptoms may come and go and are liable to show marked variations from time to time. Undernutrition usually results in hyperexcitability at first. If the deprivation becomes greater there will be a change to diminished excitability and if this be continued, it will lead ultimately to death of the cells.

**The Small Vessel Type.** In the small vessel type of the disease, the symptoms are often slight for a long time, except under stress. Then there develop irritability, restlessness, insomnia and a great tendency to attacks of delirium. These states are especially marked at night, apparently because then the vitality of tissues is at its lowest ebb. It is common to find that arteriosclerotics seem almost well during the day, but are very troubled at night; they usually sleep only in short snatches and wake very early in the mornings. In the state of hyperexcitability, little things are no longer passed over with equanimity, but may result in violent explosions of anger. Headache and dizziness are very frequent and there may be evidence of kidney trouble, especially the need to urinate several times during the night.

With increasing damage there ensues evidence of destruction of brain cells in the form of loss of memory,
especially for recent happenings. The onset of this demen-
tia is often more or less sudden and abrupt and it may then
improve again for a time. These abrupt changes are due to
small hemorrhages or blood clottings that shut off an artery
completely and result in death of the part of the brain they
should supply. As these changes progress, there is a
progressive dementia closely similar to that of general
paralysis and this picture has for that reason been spoken
of as "pseudoparesis."

The Large Vessel Type. In the large vessel type, the
chief characteristics are the abrupt changes that come from
occlusion or rupture of a diseased artery. Both of these are
liable to occur, the former from clotting of the blood owing to
disease of the membrane that lines the artery and normally
prevents clotting, the latter from bursting of the wall which,
though thickened, has lost its elasticity and stretches and
becomes weaker than normal. These accidents result in
what are commonly known as "strokes." The character
and extent of the damage that follows depend entirely on the
position and size of the artery affected. Any of the focal
symptoms that have been outlined may occur. More or less
dementia is also liable to appear and to come suddenly; it
may improve as tissues which were damaged only, and were
not destroyed, regain their function; or the condition may
remain stationary until another stroke supervenes. If the
vessel was very large, death may ensue within a short time
after the stroke.

It is also possible to have a combination between the large
and small vessel types of the disease and there will then be
manifestations belonging to both forms.

Mental Capacity. The mental capacity in a given case
must be estimated from a study of the facts as to memory
and orientation, for the condition is so variable that no
general rules can be laid down. It may be said that aphasia,
especially of the sensory type, agnosia and apraxia always entail serious interference with mental capacity. As in other forms of dementia, it is important to remember that a person may be able to grasp separate items more or less well, and yet be unable to obtain a broad grasp of several items at one and the same time. He may also be able to carry out habitual activities with little apparent defect, and yet be unable to modify them to meet variations from routine.

**Psychoses.** In addition to the dementia, which is fundamental and essential, there may also occur other types of mental reaction, or psychoses of various kinds, which will materially modify the picture for longer or shorter times. States of delirium and confusion are quite frequent, and it is common to find marked suspiciousness, doubts and hesitation, with querulousness and irritability which may readily increase to more definite paranoid conditions, and states of agitated, anxious depression. Manic excitement, and even katatonic psychoses, may also be observed.

**Comments.** The arteriosclerotic disorders make up about 5 per cent. of first admissions to state hospitals; probably one half of these have had a definite and obvious stroke, some of them more than one. The bodily symptoms are usually marked, apart from the evidences of a stroke. The heart is enlarged and often irregular, with accentuation of the second aortic sound; blood pressure is usually high, though this is by no means necessarily true. The urine often shows signs of chronic nephritis, though these may be absent. When large arteries are involved, it may be possible to feel them in the limbs and, especially when lime salts are deposited in the artery walls—as is common in advanced degrees—it may be possible to secure photographs of them with roentgen rays. In the back of the eye, arteries can be viewed directly with the ophthalmoscope, and the thickening and tortuous course
can here be observed directly. It must be understood, however, that arteriosclerosis may be much more marked in—perhaps even limited to—the bloodvessels of the brain than in those elsewhere in the body, so that the absence of palpable and visible changes is not proof of the absence of cerebral arteriosclerosis. Severe hardening of the larger cerebral arteries may also exist for years without causing serious mental loss.

**GENERAL PARALYSIS OF THE INSANE (PARESIS)**

Other names for this disease are: paresis, progressive paralysis, softening of the brain, dementia paralytica, parenchymatous syphilis of the brain, chronic progressive meningencephalitis, etc.

**Relation to Syphilis.** The one essential cause is syphilis. It is not, however, a necessary outcome of infection with syphilis, even when untreated, and there are probably other factors in its causation, as yet unknown. Figures as to the frequency with which this disease develops in persons infected with syphilis are not satisfactory. Probably the best are those of Pilcz who reported that of 5,000 German soldiers known to have had primary syphilis during the years 1881 to 1890, about 5 per cent. have since developed general paralysis. The disease appears late in the course of the infection, the average duration between primary sore and the onset of the brain disease being about ten to fifteen years. It occasionally appears within two or three years and may be delayed as long as twenty or twenty-five years. It may also develop as the result of congenital infection and then usually appears about the age of 10 or 12. This last type is known as juvenile general paralysis and is somewhat rare. Onset after the age of 20 may be considered practically to rule out an inherited or congenital syphilis.
The assertion that general paralysis is always due to syphilis is now quite generally accepted, though it was long contested. With modern methods for detecting infection with syphilis, positive results are obtained in practically 100 per cent. of general paralytics, and the germs can be found in from 50 to 70 per cent. of the brains. Indeed, there is today a strong tendency to deny a diagnosis of general paralysis in the absence of positive findings with laboratory tests that have been properly performed and repeated. When reliance had to be placed on the history of infection, many cases were found in which, quite honestly, the patient denied infection. It is indeed rather striking that general paralysis seems to occur more frequently in individuals in whom the primary and secondary manifestations were mild or unnoticed.

With regard to other factors, there are some who believe that the syphilis germ (*Spirochaeta pallida*) that causes the late nervous diseases, tabes (locomotor ataxy) and general paralysis, is a special variety of the organism. Others maintain that the question of whether a man will develop general paralysis after being infected with syphilis depends on something in his make-up. Certain it is that in some races in which syphilis is extremely frequent, general paralysis is rare. This is partly true of the negro, but more so in some eastern races. Women are less prone to develop this disease than men, the proportion of those infected being about 1:3. There seems also to be some relation between the liability to general paralysis and brain work, the disease being more common in brainworkers than handworkers. Krafft-Ebing even said that the principal causes of general paralysis are "syphilization and civilization." Heredity seems to play little or no part; it almost seems as if degenerative inheritance brings a less liability to this disease. Among the individual factors, it is probable that abuse of alcohol facilitates the
occurrence of general paralysis in the presence of a syphilitic infection.

**Relation to Trauma.** One factor that it is important to discuss here is that of trauma. First, it may be said that trauma alone cannot produce the disease. But the question whether trauma does not sometimes precipitate the onset of symptoms, or aggravate the disease when present, is not so easily answered categorically. It may be said, however, that the burden of proof unquestionably rests with the claimant. It is probable that general paralysis much more frequently causes head injuries than the reverse. Seizures of syncopal or epileptic type are often among the earliest symptoms and may cause falls and accidental injuries. Usually the degree of injury alleged as the cause of the symptoms, is so trivial that it has caused no immediate signs of traumatism, and may not have interfered with work. The excellent protection afforded to the brain by the skull and its contained water cushion should again be emphasized and we would once more insist on the necessity for the trauma to cause unconsciousness before credence can be given to brain injury as the result of head trauma. It is extremely common to find that the earliest symptoms of mental disturbance in general paralysis, the slight forgetfulness and lowering of business efficiency and ethical standards, are overlooked or attributed to overwork or some passing indisposition. Careful inquiry will usually elicit the fact that the disease began some time before the trauma alleged as the exciting factor; such inquiries must be carefully pushed. A trauma may well draw attention to the man’s state and thus apparently bring realization that there is something wrong.

Clinical experience with developed general paralysis does not tend to bear out the suggestion that traumatism will hasten or materially modify the course of the disease. Natur-
ally, this does not mean to imply that the general paralytic is not susceptible to the usual consequences of a trauma. In fact he is liable to show more effects than a healthy person; his tissues bruise more easily and his bones are more fragile, sometimes extremely so, than those in health.

To sum up the situation as regards trauma, it seems possible to say definitely that trauma does not cause general paralysis and that the influence of traumatism in precipitating or hastening the disease in a syphilitic person is practically negligible. A syphilitic is liable to suffer the same consequences as a non-syphilitic from head injury, but more liable to suffer broken bones and tissue damage than a healthy man.

Mental Symptoms. The disease consists essentially in a progressive destruction of the brain tissues and, consequently, the fundamental mental symptoms are those of progressive dementia. This has already been described under the organic brain reactions\(^1\) and the reader is referred to that section. But the dementia is often obscured by the occurrence of behavior reactions or psychoses which may render the investigation and detection of the loss of memories difficult, but it is always present. The onset is usually very insidious and the early features are often overlooked. The first recognition of serious trouble may come only with the outbreak of an acute psychosis and it may then seem as if the disease has begun acutely.

The early manifestations are often of neurasthenic type (see under psychoneuroses\(^2\)); the man becomes irritable and tires easily; he complains of vague sensations of illness and discomfort and cannot concentrate his attention on his work. Often he is thought to be suffering from a nervous breakdown or to have overworked. This stage may last several months

\(^1\) Page 20. \(^2\) Page 191.
or a year before the increasing dementia or the onset of a psychosis become noticeable.

Types. The development of psychotic reactions has led to the subdivision of general paralysis into a number of types, but it must be realized that these are only variations in reaction and are not different diseases. Through them all runs the essential and progressive dementia. Among the more common types may be mentioned: (1) Simple dementing type. In this, the most frequent form, there is little or no acute psychosis and the patient presents only a progressive dementia. (2) Exalted type. Here there is a reaction of manic kind, which constitutes the most classical form of the usual descriptions. The happy exaltation results in over-activity and exaggeration, which may lead to undertaking ill-chosen business deals, extravagance and sexual excess. The lack of judgment peculiar to the exaltation is exaggerated and emphasized by the simultaneous judgment defect of the dementia, with the consequence that the activities are often extremely absurd and obviously abnormal. The manic or hypomanic condition may last for long periods and only gradually subside when the dementia outweighs the tendency to activity. (3) Agitated type. In this reaction the psychosis corresponds to the anxious depression of the manic-depressive insanities. Here again, the dementia more or less rapidly renders the complaints and anxiety empty and inefficient. There is the same danger of suicide that exists in the manic-depressive depressions. (4) Paranoid, and (5) Katatonic types are less frequent forms in which the dementia is colored by psychoses of forms corresponding to the titles.

In addition to these psychoses, mention should also be made of the possibility of the development of more temporary attacks of the nature of delirium and sometimes of Korssakow-like upsets. These are probably dependent on the occurrence of intoxications from the growth of the syphilitic
germs or from disease of other organs. These reaction types and the psychoses have already been described and therefore need not detain us here.

**Bodily (Somatic) Symptoms.** The brain destruction is not limited to one region of the brain, though it is usually much more marked in some parts than others and the frontal lobes tend to suffer severely. If the various special centers happen to be affected by the syphilitic disease, there will occur symptoms of focal kind. In addition, the disease is not limited to the brain; late syphilitic disease of the blood-vessels, heart and kidneys are quite liable to occur simultaneously and there will then be symptoms dependent on these lesions.

Evidences of focal damage are: seizures of epileptiform, syncopal, hemiplegic, aphasic, apraxic, etc., nature. These are often temporary, though they may result in more or less sudden death. They are temporary because they are due to a more or less temporary damage, intoxication or a local dropsy. They may, however, leave permanent effects, such as hemiplegia or aphasia. Acute meningeal inflammations (pachymeningitis interna hemorrhagica) may cause acute and rapidly fatal complications.

The physical signs that are commonly stressed, though not all of them are constant, are: Argyll Robertson pupils; tremor of tongue and face, especially in talking; dysarthria with specially marked tendency to reduplicate syllables or words and to leave out others; tremor of hands and tremulousness of writing, with the same tendencies to omissions and reduplications noted for speaking; exaggeration of tendon jerks, with sometimes clonus and extensor type of plantar reflexes (Babinski sign). As the disease progresses, there is an increasing tremulousness and loss of power which result finally in more or less complete immobility and a vegetative kind of existence, in which everything has to be done for the patient as if he were a baby.
The signs just given belong to the anatomical type that is spoken of as cerebral and is by far the more frequent. Occasionally there is a combination with syphilis of the spinal cord or locomotor ataxy (tabes dorsalis). The Argyll Robertson pupil is then more constant, the pupils are often pin-point in size, palsies of the eye muscles cause squints and drooping of the eyelids, the tendon jerks are lost or diminished and there may be blindness from atrophy of the optic nerve. Such cases are usually much slower in their development and course, and are spoken of as the spinal type or "tabo-paresis." It is really a combination of the two diseases, tabes and general paralysis.

The laboratory tests most used are: the Wassermann test, which is usually positive in the blood and constantly positive in the spinal fluid; the spinal fluid is under increased pressure, contains an increased number of cells (normally there are less than five cells in each cubic millimeter) up to several hundred in each cubic millimeter, mainly of lymphocytic type; albumin and globulin are increased in the spinal fluid (Nonne-Apelt, Pandy, Noguchi and other tests) and the colloidal gold (Lange), mastic and benzoin precipitation tests are positive; sugar is usually diminished.

It would lead too far to attempt to outline the symptoms that may arise from damage to other organs, but mention should be made of the increased fragility of the bones and the readiness with which the tissues often bruise. Slight injuries may be sufficient to cause fracture of bones and extensive hemorrhages, and may erroneously give rise to the belief that a patient has been very roughly handled. Spontaneous hemorrhages may sometimes occur and cause bruises. In advanced stages death may result from inhaling food particles into the lungs or from the lodging of larger fragments in the larynx. The greatest care is necessary in feeding such patients. Bedsores are also very liable to
develop and may lead to death from blood poisoning. In the later stages there is loss of control over the bladder and bowels, and inflammations may develop in the former and spread to the kidneys.

**Course and Outcome.** The disease is characteristically progressive and usually ends fatally in about two to two and a half years. It is sometimes more rapid and may run its course in a few months, but it may also last several years. Cases are on record of a duration of twenty years, but are quite exceptional. The possibility of sudden death at any stage from seizures or intercurrent affections must always be borne in mind.

In a considerable proportion of cases the course is not steady and there may be remissions in which the patient seems to become almost well for a time that varies between a few weeks and several months or possibly years. Such remissions are probably more numerous under modern treatment and give hope that perhaps cure may be possible, though as yet this is not established. It is, therefore, at present correct to consider the outcome as inevitably fatal. In some cases a series of remissions may occur.

**CEREBRAL SYPHILIS AND OTHER FORMS OF BRAIN AND NERVOUS DISEASE**

The insanities that arise as the result of brain disease of necessity present evidences of organic or structural kind, that is to say delirium and the various grades of dementia that have been described under reaction types. The mode of development and the severity vary with the nature of the disease process and its extent, but the actual symptoms depend on the location of the damage and the effects, whether irritative or destructive, they produce on the nerve tissue. In addition, there may, as in general paralysis and arteriosclerosis, be psychoses or behavior reactions that depend a
great deal on the personality of the patient. The clinical picture may thus be colored by manic-depressive, dementia praecox or paranoid features, and psychoneurotic traits are very liable to appear. The essential points for diagnosis, however, are the discovery of the dementia or the focal loss of memories which always indicate destructive damage. We shall therefore give no detailed description of these various diseases. Some account of cerebral syphilis and its relation to general paralysis, however, seems advisable.

In cerebral syphilis, the germ of syphilis (*Spirochaeta pallida*) is growing in the bloodvessels or connective tissues and damages the nerve cells indirectly by: circulation of the poisons produced in the growth of the germs through the blood and fluids that bathe the nerve cells; swelling of the lining of the arteries with consequent diminution of the blood supply; clotting of the blood in the arteries or rupture of the vessel; pressure from the growth of a syphilitic tumor (gumma); development of meningitis. In general paralysis the germ has penetrated beyond the bloodvessels into the immediate neighborhood of the nerve cells. The bloodvessel and connective tissue disease occurs, as a rule, much earlier in the course of the syphilitic infection than does general paralysis, usually in the second or third year after the initial sore. Some syphilitic nervous affections, due in the main to circulation of the poisons in the blood, may appear even earlier during the secondary stage.

One practical difference between general paralysis and cerebral syphilis, as here defined, concerns the effects of treatment. The latter can often be cured, provided brain tissue has not been actually destroyed. Cerebral syphilis, as distinct from general paralysis, is the cause of approximately 1 per cent. of first admissions to the state hospitals. The reactions are those of delirium and dementia with focal symptoms dependent on local damage. Being often blood
vessel disease, it is intelligible that such cases closely resemble the effects of arteriosclerosis, though they usually occur in younger persons. There may even arise a picture that closely resembles general paralysis, often spoken of as "syphilitic pseudoparesis," comparable to that met with in arteriosclerosis.

The medicolegal problems concerned are exactly similar to those of general paralysis and arteriosclerosis; the mental capacity and responsibility must be determined from the facts as to the degree of dementia and other damage in each individual case.

Among other diseases that may be accompanied by dementia should be mentioned: Huntington’s chorea, brain tumors and abscesses, disseminated or multiple sclerosis, epidemic (lethargic) and other forms of encephalitis, etc.

Epidemic encephalitis (sleeping sickness) has been so prevalent in the past few years and gives rise to such severe sequelae that a brief description of the mental symptoms seems desirable. They have been studied in detail by many observers. During the acute attack, delirium, confusional states and Korssakow complexes are frequent, but are not in any way characteristic. Later, there is great liability to the development of a paralysis agitans syndrome with generalized rigidity of the muscles including those of the face and an appearance of utter stupidity that is often enhanced by drooling of saliva. Movements are slow, stiff and awkward, and such cases have not infrequently been mistaken for katatonia. Patient study, however, usually reveals no evidence of autism or schizophrenia, and there is little loss of

memory. Even apart from these states of rigidity, emotional disturbances, explosive tears or laughter, outbursts of excitement and irritability, and psychopathic traits of behavior may develop and may lead to the need for institutional care.

**INVOLUTIONAL MELANCHOLIA**

Under the title of involutional melancholia is placed a small group of cases that are not well differentiated from the presenile dementias on the one hand, and the manic-depressive psychoses on the other. The principal features are those of an anxious, agitated depression, arising about or soon after the climacterium—about the ages of 45 to 55 in women and 50 to 60 in men. The anxious depression does not differ essentially from that described under manic-depressive insanity, though there is a greater tendency to the development of beliefs concerning changes in the patient’s own body—organs or limbs are missing or changed—which probably depend on the changes that are actually taking place in the body with involution.

The disease is generally prolonged, its duration being a matter of several years, and there is, in addition, more or less dementia. This dementia involves especially the emotional side of mental life, the intelligence or memories often escaping more or less completely. In this respect, the disease corresponds to the presenile dementias, with which it would be probably better grouped.

The principal medicolegal interest, apart from the need of commitment and guardianship, is the great danger of suicide. This may be attempted with the utmost persistence and sometimes with careful planning, at times with the most horrible means. In addition to suicide, the patient may murder children or spouse under the belief that, by so doing, he is removing them from harm and suffering in this hopeless, horrible world. The ability to transact ordinary business or
make a will is obviously lacking if the condition is at all severe. Yet there are probably many persons with milder degrees of this disease who stay at home without the friends realizing the fact of insanity and the serious dangers it entails. Many suicides attributed to neurasthenia or nervous breakdown in late middle life, really belong in this category.
2. Psychoses with Toxi-Infectious Conditions

ALCOHOLISM

Under the general heading of alcohol may be included the various alcoholic beverages, which often contain other poisons in addition to alcohol, as it will serve no useful purpose to attempt finer discrimination. Alcohol is popularly deemed one of the most important of the many causes of insanity; but the general trend of modern psychiatric opinion is to the effect that, in most instances, the tendency to excessive indulgence is a symptom rather than a cause of mental disorder. This applies particularly to prolonged chronic drinking and there is much evidence to show that only persons with poorly constructed nervous systems are liable to become drunkards. The well balanced man may, as the result of circumstances, drink to excess and become intoxicated, but, except under unusual conditions, is not likely to succumb to the chronic abuse of liquor. It is for this reason that alcoholism is often found to run in families, the inheritance being an unstable construction rather than simply a tendency to drinking. The stresses and strains of modern civilization have a greater effect on the poorly constituted individuals and thus bring about a tendency to seek relief in drugs. While, therefore, alcohol does give rise to psychoses and gives certain special characters to mental disorders, it must be realized that behind the alcoholic indulgence there is usually a primary defect of some kind.

Alcohol is a general poison with a special affinity for the nervous system, but there are marked differences in the susceptibility to its effects in different persons. Indeed, two or three generations ago, it used to be customary to
gage a man's virility by the amount of liquor he could imbibe before becoming intoxicated. Some persons are so constructed that very small amounts will produce severe toxic effects and such susceptibility may be acquired as well as be inherited. Such an acquired susceptibility is not uncommonly observed after head injuries or severe illnesses such as a prolonged attack of typhoid fever. This susceptibility is often evidenced also by ready intoxication with other poisons such, for instance, as those of the infectious fevers, delirium being caused by even a slight rise in temperature. When it is inherent, there are often other tares of poor nervous inheritance such as epilepsy and psychopathic traits.

**Acute Intoxication.** The immediate effects of acute alcoholic intoxication are progressive loss of mentality, comparable to a rapidly increasing dementia, in which the highest levels suffer first, perhaps combined with a more or less temporary stage of increased function. As a result of the loss of the higher controlling mechanisms, there occurs a lowering in ethical and moral standards with diminished sense of responsibility and mental tension in relation to the duties owed to self and society. It is this relief of tension with the consequent feeling of relative ease and comfort that is usually sought by the drinker. At the same time there is often an actual stimulation and excitement with greater ease of reaction to stimulation and the man becomes more active and talkative, laughs, and expresses thoughts and feelings that would ordinarily be kept in check by the control of higher associations. In such a state the man may often do and say things that not only are foreign to him when in full possession of his faculties, but also may bring him into conflict with social rules and laws. For such acts, however, in the eyes of the law he is deemed responsible for the reason that his loss of control is the result of his own act. In some instances it
may be necessary to take into account the question of susceptibility as an extenuation of this responsibility, though such occasions are rare.

As intoxication progresses, there is loss of control of lower levels of mentality, combined with damage to the nerve paths that control the movements, and eventually complete loss of consciousness and a state of coma. If the dose has been sufficiently great, death may ensue from the paralysis of the centers that control breathing and heart action. Quite commonly there is more or less extensive loss of memory (amnesia) for the events that transpired during the major part of the period of intoxication, the earlier phases being recalled perhaps dimly or vaguely.

Pathologic Intoxication. At this point reference should be made to the condition known as pathologic intoxication, by which is meant a grossly exaggerated effect of small doses, such as occurs only in persons who are definitely psychopathic, particularly the epileptic. In this state there is, perhaps after a single glass of beer, a violent and unmotivated emotional outburst with clouding of consciousness and often sense-falsifications in which the man may commit the most senseless and brutal acts, including murder and suicide, with every evidence of wild excitement. The onset is usually sudden, the duration brief and the attack is followed by sleep with complete amnesia for the whole episode. Such attacks are rare and were included by earlier writers among the forms of *mania transitoria* or more specifically *mania a potu*.

Chronic Alcoholism. Most chronic drinkers are liable to temporary disturbance in mood—irritability and anger, sexual excitement, depression, anxiety and apprehension. These vary in severity and duration and may be of sufficient intensity to lead to serious trouble.

Associated with chronic alcoholism there is a marked tendency to mental deterioration in the nature of a slow
dementia. The man becomes less reliable and efficient, though he rather characteristically shows a striking abruptness and briskness of movement, which may be somewhat deceptive. His standards of morality become lowered and he ceases to realize that he is slipping, often indeed, showing a striking levity and cheerfulness; yet when taxed with his failures, he often admits them with tearful promises of reform. He neglects his duties, becomes careless in dress and appearance, shows less consideration for his family and will practice all kinds of subterfuge to secure the means with which to gratify his appetite for drink. With those over whom he has authority he is often brutal and domineering, blames them for the fact that the home and children are not well cared for, pities himself and tries to shift the responsibility for the situation to others or to the unavoidable consequences of circumstances. There is often increased sexual appetite coupled with actual and relative impotence.

**Delirium Tremens.** On the basis of this chronic deterioration there may develop various acute psychoses and other more chronic types of insanity. The most acute form is that known as delirium tremens. The occasion for its development may be a period of unusually excessive drinking, an enforced abstinence or some shock, a bodily injury or an infection such as pneumonia. Delirium tremens bears close resemblance to other types of toxic delirium but has features that more or less distinguish it. There is marked clouding of consciousness with vivid hallucinosis, particularly of the visual sense, with consequent seeing of snakes, animals and other terrifying forms. Apprehension is marked and may lead to the most violent reactions in efforts to escape, perhaps culminating in suicide. Occupational delirium is also common. The onset is usually acute, sometimes almost sudden, and the termination may be almost as abrupt after a prolonged and profound sleep.
The duration is usually about a week or ten days, but sometimes is more prolonged and the delirium may pass over into a Korssakow psychosis. Bodily symptoms are also marked, tremor being the most characteristic and the reason for the name. The tremor involves the hands, face and sometimes the whole body. The reflexes are usually increased and the pupil reactions may be sluggish; the pulse is rapid and there is often fever; albuminuria is common and sugar may be found in the urine. Mild, abortive attacks that belong in this category are often observed, the principal features being apprehension, insomnia and bad dreams.

**Acute Alcoholic Hallucinosis.** Another acute mental disturbance is acute hallucinosis. In this, there is no clouding of consciousness and the man remains approximately oriented as to his surroundings. But he experiences a wealth of hallucinations, especially auditory but also involving other senses, which are so persistent that they occupy all his attention. The voices are generally threatening and insulting, and are reacted to in an entirely appropriate manner. The man answers them back, threatens to get even and may take violent measures in his efforts to deal with them. The fear of injury, which the voices threaten, may lead also to efforts to escape and even to suicide. During the acute phase of the disorder, no explanation may be offered for the occurrence of the voices, but, as the hallucinations subside and leave time for thought, a more or less well formed system of delusion may be developed to explain the persecution experienced. This paranoic state may persist for some time and may become chronic (chronic hallucinatory paranoia). The duration of the acute hallucinatory period is, as a rule, not more than a few weeks, though here again there may be a transition to a chronic hallucinosis resembling dementia praecox or to a Korssakow psychosis.
The Korssakow Psychosis. The Korssakow psychosis has already been described under the mental reactions. The onset is usually acute with more or less hallucinosis and apprehension, perhaps definitely delirious in type. Sometimes the disease begins more insidiously and without an acute stage. The mental picture is commonly associated with evidences of poisoning of the lowest levels of the nervous system in the form of a multiple peripheral neuritis. This may be slight and evidenced by little more than loss of tendon reflexes, but is sometimes so severe as to cause complete paralysis of the limbs, with severe pains and tenderness.

Acute Paranoid Psychoses. The possibility of the development of systematized delusions in the later stages of the acute hallucinosis reaction has already been mentioned. Sometimes such an acute paranoid state develops without a preceding acute hallucinosis. Hallucinations occur but are not so marked, and there is correspondingly greater systematization of the experiences. The man is irritable, and suspicious; his delusions are of persecution and are especially liable to include beliefs that the spouse is unfaithful. The reactions are appropriate to what the man believes and may include murder. There is no clouding of consciousness and the acts may be planned and carried out with a shrewdness that renders such persons extremely dangerous. When acute in onset, these psychoses often subside with abstinence from alcohol, but they may pass over into a more chronic mental disorder with dementia.

Chronic Paranoid Psychoses. Of the more chronic forms of mental derangement, the most important is a chronic paranoid state, which is often the sequel of an acute psychosis. It may, however, be insidious and gradual in development. The delusions are founded largely on sense-falsifications and are commonly ideas of persecution and jealousy, as in the acute form. But here the disease may continue for years
and seems to be little influenced by abstinence. This fact has led to the conclusion that it is not strictly the result of alcoholism, but is a form of dementia praecox, the alcoholic excess being a symptom, though it perhaps colors the picture by causing hallucinosis. With it there is commonly a progressive dementia (sometimes called alcoholic pseudoparesis) which may be alcoholic, but, on the other hand, may be part of the dementia praecox disease. From a medicolegal point of view, the distinction is not important as, in either case, the fact of mental disease is sufficient to remove responsibility. Judgment is so modified by the delusions that the man cannot be considered to have sufficient intelligence of the real facts. The acts may include murder, and such persons are obviously not fit to be at large, in spite of the fact that they may seem to reason logically and to see things as they really are.

**Bodily Symptoms.** Little has thus far been said of the bodily symptoms that often accompany chronic alcoholism. Alcohol is a general poison and gives rise to stomach catarrh and chronic inflammations in the liver (cirrhosis) which result in indigestion, vomiting and lack of appetite, especially for breakfast. It is also probable that alcohol plays a part in causing arteriosclerosis and degenerative changes in the heart and kidneys. There is no doubt that alcohol may cause epileptic seizures which may occur in conjunction with the various types of psychoses described, but also without them. In many instances there is a definite relation between the fits and the ingestion of alcohol; they may disappear with abstinence and return again on resumption of the habit. It is quite possible that alcoholism may assist in determining the development of general paralysis in persons infected with syphilis.

**Comments.** When there is a definite insanity, even as the result of chronic alcoholism, the problem of responsi-
bility is different from that of acute intoxication, and the man is usually deemed irresponsible. Alcoholic intoxication brought about by a mental disease, such as manic-depressive insanity, is also grounds for diminution of responsibility for the reason that the disease removed the ability to choose in the matter of drinking. Chronic alcoholism may also be grounds for the appointment of a conservator and, in some states, for commitment to an institution for inebriates.

The toxicity of alcoholic beverages obtainable since the passage of the Volstead law, has brought with it certain modifications in the effects produced. Many of these drinks contain most virulent poisons and acute delirious episodes of the severest kind may develop even after a small amount and in persons who are not chronic drinkers. It has also seemed true that multiple neuritis and psychoses of the Korssakow type may develop acutely after the ingestion of small quantities of liquor. Certain constituents of "moonshine" whisky also have special toxic effects on the nerves of the eye and cause rapidly progressive blindness.

**DRUGS AND OTHER EXOGENOUS POISONS**

The principal poisons to be considered here are opium and its derivatives, and cocaine. Not uncommonly their use is combined with indulgence in alcohol which may serve to complicate the effects of these drugs alone. As with alcohol, it is possible to distinguish between transient effects of acute intoxication and the more permanent effects of chronic addiction. It is also extremely probable that, in most cases, drug addiction is a symptom of a psychopathic state, though it produces symptoms and effects of its own as is the case with alcoholism.

**Acute Morphinism.** The general effects are those of all toxic agents that damage brain tissue and are expressed out-
wardly in the form of delirious and demential features; yet there are some characteristics that are more or less peculiar to morphine and cocaine. In persons not accustomed to opium (one of the principal toxic principles of which is morphine) and its derivatives (morphine, heroin, codeine), these substances cause a brief period of stimulation with lowering of mental inhibitions, which may be compared to the effects of alcohol. This, however, soon gives place to sedative effects and sleep or coma may result. The stimulating effects are more prolonged in habitues and the final stage of general loss of brain function may not appear, unless the dose has been unusually large.

**Chronic Addiction.** The opium habit also results in permanent change in character which is of the nature of dementia. It involves especially the higher mental functions and causes lowering of ethical standards, lessening of mental vigor and lability of emotional reaction. The man becomes unreliable, untruthful, selfish and inefficient; temporarily, after a dose, there is stimulation and increased function, perhaps even hilarity and pressure of activity. The general mood, however, is one of depression, often with episodes of anxiety and apprehension which increase as the time since the last dose increases. Periods of delirious clouding of consciousness with hallucinations and severe apprehension somewhat resembling delirium tremens may also occur. More chronic paranoid states are also frequent; the man becomes suspicious, blames others for his failures and inefficiency with finally systematized delusional explanations for his feelings.

**Withdrawal Symptoms.** Sudden abstinence in a chronic opium addict always causes severe symptoms; this may be an important indication of the fact that addiction had preceded. When such withdrawal symptoms do not occur, it is good evidence that the habit had not been carried very far. The symptoms include severe restlessness and insomnia
with marked tremors that often involve the whole body. The mental state is one of anxious depression, frequently combined with clouding of consciousness and horrible sense-falsifications. This is accompanied by general exhaustion and sometimes extreme collapse; the heart dilates and becomes feeble and rapid, appetite is practically absent and there may be both vomiting and diarrhea. When the amount of opium consumed has been large, sudden withdrawal may result in death.

**Prognosis.** Prolonged supervision is essential to break the habit, even after recovery from the immediate effects of withdrawal. The occurrence of the least strain or feeling of undue responsibility is sufficient to rearouse the craving even months later. Recovery is usually incomplete in the sense that the man does not get back the condition of mental vigor and capacity he possessed before the development of the habit. There is some degree of permanent dementia, proportional to the degree and duration of the period of intoxication.

**Cocainism.** The effects of cocainism are somewhat similar, though the deterioration is, if anything, more rapid and more severe. The stage of stimulation after a dose is more marked and there is often a decided hyperactivity, with elation and great restlessness. The periods of delirium are frequently characterized by the occurrence of hallucinations of vision, particularly of minute objects (micropsia), animals, etc. Disturbances in skin sensation are also common, a feeling of ants crawling under the skin, itching, etc. The deterioration is similar to that of opium and here also there may occur states of paranoid type, quite like those of alcoholism.

**Comments.** Medicolegally, drug habitues are liable to come into conflict with the law in efforts to secure the drugs as well as from violations of the antinarcotic law. Thefts,
assaults and even murder may occur in this manner. Neglect of family, dissipation of property and general unreliability may necessitate the appointment of a guardian or even commitment. Various crimes, including assaults, murder, suicide and disturbance of the peace, may be committed in the states of delirium.

Of less importance, but still occasional causes for mental upsets that may lead to medico-legal difficulties, are other drugs such as cannabis indica (hashish), chloral, veronal, bromides, cantharides, etc., all of which may cause delirious states. Among the industrial poisons that may lead to mental derangement, special mention should be made of lead, mercury and arsenic. These will not be dealt with in greater detail as they lead to medico-legal difficulties only because of the questions of care and possibly compensation.

The contractual capacity, ability to transact business or make a will, must often be seriously impaired by drug addiction. The deterioration and the tendency to sacrifice anything to secure supplies of the drug must seriously interfere with judgment and the ability to avoid undue influence or decide questions of vital importance. Paranoiac states, with suspicions of jealousy and persecution may easily lead to gross injustice and misinterpretation of motives.

**PSYCHOSES WITH SOMATIC DISEASES (INFECTIVE-EXHAUSTIVE PSYCHOSES)**

Here are placed the mental disturbances that arise as the result of diseases of the body such as typhoid fever and other infections, heart disease, diabetes, exophthalmic goiter, etc. The mental reactions are chiefly of the nature of delirium or the Korssakow psychosis. The presence of bodily disease, as a rule, makes the recognition comparatively simple and the incapacity for business, the dangers belonging to
delirium (particularly suicide), and the need for protection are usually obvious. They need not therefore detain us. It must be remembered, further, that such diseases may serve as the precipitating cause for the outbreak of mental diseases such as manic-depressive insanity and dementia praecox.
3. Psychoses without Discovered Damage to the Brain

MANIC-DEPRESSIVE INSANITY

Definition. Under this heading is included a group of psychoses, the essential characteristics of which are unduly prolonged and intense oscillations of mood, which are not explained by the circumstances under which they arise. In describing the types of behavior reaction, the essential features of the pictures have already been outlined\(^1\) and there is no need to detail them again. The special group of manic-depressive insanity is made up of cases presenting these psychoses without discoverable cause of an organic nature and they are, therefore, diagnosed by exclusion. The situation is much the same as obtains in epilepsy which is a symptom of many different diseases, but also occurs without disease that can be recognized by methods now available.

The combination of the two terms, manic and depressive, in one word in the title must not be misunderstood. It does not imply that both manic and depressive features are present in the same patient, though they may be at different times. Both states are essentially affective disturbances, one in the direction of exaltation, the other in that of depression; the title implies nothing more than exaggerated affect reactions. Included under this head are a large proportion of types of insanity that were classed earlier as mania, melancholia and circular insanity. As now defined, however, the disorders grouped here are essentially benign in character, by which it is meant that they do not lead to dementia or deterioration. Hence, some cases included in the older groups of mania and melancholia are now classed elsewhere.

\(^1\) Page 44.
One feature that has played a part in determining the collection together of manic and depressive states under one head is the very marked tendency they show to recur, sometimes many times during the course of the individual's life. The recurrent attacks are not always of the same type as that which occurred first. One man may have none but manic attacks, another may have only attacks of depressive type and a third may have attacks sometimes of one and sometimes of the other kind. It is this last type of course that has led to the use of such descriptive terms as circular, alternating, etc., insanity.

In addition to the periodic or alternating occurrence of manic excitement and depression, Kraepelin, the author of the group name here used, also alleges that the two states may be combined together in the same person at the same time. For such combinations he has introduced the title "mixed states." While not accepting this conception of their interpretation, there can be no hesitation in recognizing the occurrence of clinical pictures such as he describes under this term, and since it is generally adopted we shall continue to employ it.

Etiology. It has already been pointed out that the mood may be regarded as the conscious representation of the harmony or disharmony with which the body is working, both in its internal and external relations, and that this is largely dependent on the activities of the so-called vegetative nervous system, in which must be included the ductless glands. It, therefore, seems permissible to hypothecate some disorder in this system as the basis for the upset which is expressed in these psychoses that develop without obvious brain disease. It is certainly true that disease and other upsets in body organs are often accompanied by feelings of depression, and oscillations of mood are especially frequent, for instance, in connection with disease of the thyroid gland. It seems
justifiable then to state that two groups of factors enter into the production of manic-depressive insanity: the make-up (constitution) of the individual, and disturbing elements inside his body (disease) or affecting circumstances in the world around. Both probably play a part in every case, the constitution representing the predisposing cause or soil, and the disturbing factor the exciting cause or seed. The greater the predisposition or the more fertile the soil, the less severe need the exciting cause be to furnish a virile growth and vice versa. The man possessing a constitution particularly prone to affective oscillations may exhibit severe psychoses under conditions which seem entirely free from obvious exciting cause, while the better balanced man will do so only under severe stress such, for instance, as an attack of typhoid fever or the conditions of war. Both factors must be considered in attempting to grade the weight to be assigned to either. The history of the man’s life and the manner in which he has reacted in the past is the only guide to an estimate of the constitutional endowment. These questions also are of fundamental importance in endeavoring to determine the liability to future attacks in any particular case.

Under another heading we shall consider two other groups of psychotic reactions which represent peculiarities in reaction under stress. It should be realized that all persons are subject to oscillations of mood, even those with dementia praecox and paranoid peculiarities, and it is therefore not surprising that some essentially affective oscillations are colored by the manner of reacting described under those titles. When the special dementia praecox or paranoid peculiarities are dominant, it is customary to group the resulting psychosis under the name of the appropriate disease. But when they are only slight, the prominent feature being a frank exaggeration of mood, they are more usually classed with the manic-depressive psychoses, and it is these admix-
tures of personal ways of expressing feeling that give rise to the so-called mixed types and atypical forms. Practically, every gradation between the various pictures of manic-depressive mood disturbance and the clear examples of dementia praecox and paranoid reaction may be encountered, and there is very liable to be some difference of opinion as to the particular category into which any given case will be placed by different alienists.

It is customary to subdivide the manic-depressive reactions into: (1) manic states; (2) depressed states; (3) mixed and atypical forms. The first two have already been described\(^1\) under the head of psychoses and we have here only to mention some of the features of medicolegal importance. A brief account will then be given of the third subgroup.

**Manic States.** The principal questions here concern the care of the patient and his affairs. Occasionally the excitement, especially in the milder forms, will result in sexual and alcoholic excesses that may lead to legal difficulties, chiefly in the form of breach of the peace, though, if drunk, more serious offenses may be committed. The recognition of these milder degrees is by no means easy as the man is active, alert, and thinks and reasons more or less clearly; indeed, he is often good company, witty and talkative, and it may be said that some men do their most brilliant, though not their most steady, work when in such a state. The disorder lies in the loss of control and the inability to consider before acting. The deficiency is in the ability to choose and control the actions rather than in the ability to think. To detect the fact of a change, it is essential to compare the man with what he was before and not with some hypothetical standard. It is also unfortunately true that in the mild state of elation a man may do incalculable damage to his business and reputation by his extravagance in thought and act. In the more

\(^1\) Page 44.
severe degrees there is usually little difficulty for anyone to recognize the fact of insanity; the behavior approximates more to the usual popular conception of insanity than any other.

Depressed States. The most important element here is the danger of suicide, which may be attempted in the most gruesome manner and may be accompanied by the murder of those near and dear. The milder degrees are again the more dangerous, as the fact of insanity is not appreciated, the person being regarded as nervous or overworked.

Mixed and Atypical Forms. In describing the manic and depressive psychoses, brief mention was made of the occurrence of angry mania and a more lengthy description was given of agitated depression. Originally these were included with the mixed states. In addition, there are others of somewhat frequent occurrence. First may be mentioned what is called by Kraepelin "manic stupor." In this state there is an exaltation of mood, but instead of the typical restless activity of frank exaltation, the man retires into himself to dream ecstatically. He takes less interest, instead of more, in the sensory stimulations of the world around him and may become entirely mute and motionless, lying for hours in bed with the covers drawn over his face as if trying to shut himself up to enjoy his fancies. Such expressions as can be obtained contain allusions to pleasant fancies and often refer to marriage or sexual gratifications. Now and again there may be suggestions of sensory distractibility in the form or rhymes, references to objects in the surroundings, etc., but they are not followed up by corresponding activities of any duration. Definite katabonic features (see under dementia praecox) such as waxy rigidity, negativism and stereotyped movements are not uncommon. Under these circumstances it is not surprising that physicians often differ in opinion as to the particular
group of mental diseases into which the case fits. It is also of interest to note that such types are less benign in their outcome than the more frank manic reactions, many of them tending to result in more or less deterioration, perhaps only after several attacks with apparent recoveries in the intervals.

Another type is that of the paranoid variety, in which belief in persecution continues to recur in the course of a manic excitement. These delusions may sometimes be marked and fairly well systematized, the persecution being explained on the basis of jealousy because of special gifts, powers, prerogatives or properties that the patient believes belong to him. As a rule the degree of exaltation is not great; the patient may therefore react appropriately to what he believes and thus be a menace to those he thinks are acting against him. The steadiness with which he will endeavor to carry out his reactions depends largely on the degree of distractibility present. There is here then an affective oscillation, an exaltation, in a person of paranoid make-up and again the classification may be difficult. Many of these psychoses are prolonged, some lasting for many years and, though the manic excitement may subside, the paranoid attitude with its delusional system may persist. In other cases complete recovery occurs, though such a man is always liable to react in a paranoid way when difficulties arise.

The types mentioned here do not by any means exhaust the possible variations nor even the forms that are described, but they do cover those that are most frequent and important for our present purpose.

Comments. The manic-depressive psychoses without discoverable disease constitute about 16 per cent. of first admissions to the state hospitals and are at the same time the most favorable form of insanity, since the tendency is for all to recover. This hopeful outlook is somewhat diminished by the fact that a considerable proportion have further
attacks. It is in this form, perhaps, that there is the greatest justification for speaking of lucid intervals, but this term is more generally used to designate shorter intervals in which the symptoms subside only to recur. In the manic-depressive attacks it is usually spoken of as recovery, and this is just as correct as to speak of recovery between attacks of a disease such as tonsillitis. One attack may possibly predispose to another at a later date, but there is a true recovery between. Allusion was made to the fact that the more severe attacks, especially of the manic form, approximate the popular conception of insanity. Yet we feel justified in saying that it is not possible for anyone to simulate these attacks. Nearly, if not quite, always there will be additions which do not fit into the picture; certain elements are overdone and the strain that is required to maintain the constant activity or the continuous depression is impossible under skilled observation for any length of time.

DEMENTIA PRAECOX

Definition. Under the title dementia praecox have been collected a number of superficially different clinical pictures which were formerly described by many different names. Probably the closest approximation to a similar group was that of "adolescent insanity" though this was much smaller. Many of the cases grouped here were formerly called mania, melancholia, masturbational insanity, puerperal insanity, paranoia, etc. Indeed, many psychiatrists still regard dementia praecox as a convenient basket into which to place all sorts of odds and ends that do not conveniently fit somewhere else. But it may be said that the cases grouped here have in common the development of a schizophrenic psychosis, the features of which have already been described.¹ This is characterized outwardly by evidences of loss of interest in

¹ Page 53.
the objects and happenings of the world, and an inward absorption that was described under the name of autism. Since schizophrenic reactions occur in association with well defined brain diseases, it must be insisted that in dementia praecox there is no evidence of the structural damage characteristic of those diseases, and the diagnosis must, in part, be made by exclusion.

Many psychiatrists see in dementia praecox nothing more than the logical development of the schizophrenic personality. The majority, however, while they recognize the influence of personality in determining the type of psychosis and its manifestations, yet believe that dementia praecox is a definite disease and not simply a mode of reacting to difficulties. The disease process may act in some way to diminish the fundamental energy of reaction with which the individual was endowed, feebleness of which has already been stressed as an important element in the causation of the schizophrenic mode of reacting, and thus lay the foundation for the outbreak of the psychosis. There is no widespread agreement as to the nature of the disease nor as to its seat. Many changes in the body structure have been described, but none of them can be said to be either constantly present nor peculiar to dementia praecox. The abnormality most often suggested is that there is an intoxication of some kind, but this is as yet purely hypothetical. Here, however, we need not concern ourselves with this controversial question as we are more interested in the recognition and consequences of the disease.

The name dementia praecox is an old one, having been employed by Morel as long ago as 1860. But the modern concept of the term is comparatively recent and was formulated by Kraepelin. In the eighth edition of his text book (1913), he gives the following definition: "a series of clinical pictures which have in common a peculiar disorganization of
the inward coherence of the psychic personality which damages most the affective life and the will.\footnote{\"setzt sich aus einer Reihe von Zustandsbildern zusammen, deren gemeinsames Kennzeichen eine eigenartige Zerstörung des inneren Zusammenhanges der psychischen Persönlichkeit mit vorwiegender Schädigung des Ge- mütsslebens und des Willens bildet.\"}

The evidences of this disorganization are the odd, unexpected and incongruous acts and expressions of feeling which were outlined under the schizophrenic psychoses.

Because of the great variations in the outward manifestations, which are due to variations in the personality and the conditions that have to be met, it is customary to subdivide the clinical pictures into types. Subdivision can be carried to any desired limits and it must be realized that there is no sharp line between them. Before discussing these types, certain general features may be described. In addition to the schizophrenic features with the associated loss of interest in the external world, there are certain bodily symptoms which may be found in all forms, though they are by no means constant. Not only may they be very marked in some patients and absent in others, but they may vary in the same patient at different times. Their presence or absence, therefore, is in no sense conclusive for the purpose of diagnosis, which must rest on the mental manifestations and the exclusion of evidence of other, better differentiated disease processes.

**Bodily or Somatic Symptoms.** Complaints of pain or pressure in the head, vague discomforts and even pains in various parts of the body are quite frequent and often lead to a diagnosis of neurasthenia. They should always lead to an especially careful search for evidence of bodily disease before the conclusion is reached that they are mental in origin. Sensitiveness to painful stimulation is often diminished and, in stuporous states, may even appear to be absent (analgesia). Respiratory tracings and galvanometric studies will still, however, demonstrate that pain is perceived. Sleep is more
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or less disturbed and insomnia is common even when the patient lies motionless.

Among the more objective manifestations, the pupils are often variable in size from time to time, usually dilated, sometimes unequal and oval instead of round. The light reflex may be sluggish and the accommodation reflex difficult or impossible to elicit owing to lack of cooperation by the patient. An Argyll Robertson type of reflex does not occur in the absence of complicating disease. The psychic or pain reflex of the pupil, in which the pupil should dilate under emotional or painful stimulation, is rather frequently impossible to elicit.

The tendon jerks are usually more or less increased, though they may be normal and even diminished; in rare cases ankle and knee clonus may be obtained. The skin reflexes are usually diminished, but show the same variability as the tendon jerks. The plantar reflexes, when present, are always of flexor type, but they are not always obtainable.

The muscles may show stiffness and slowness in action and there may be marked diminution in the sense of fatigue, so that postures requiring steady muscular contraction, such as holding the arms outstretched, may be maintained for a long period, many times that possible for the normal person. This is often spoken of as catalepsy. Tremors of the fingers and about the face, and spasmodic twitchings or contractions of various muscle groups which result in grimacing, oscillations of the eyeballs, sucking and lip-smacking movements, etc., are somewhat frequent. Prolonged contraction of the muscles about the mouth, which results in the formation of a kind of snout, is rather common and is, because of the appearance that results, spoken of as "snout spasm" (Schnautkrampf).

Vasomotor and secretory disturbances are also common. Cyanosis of hands and feet, a peculiar sensitiveness of the skin
to stroking which causes vivid white wheals with a red margin that may last for hours (dermographia), disturbances in the sweat and sebaceous glands of the skin giving rise to moist clammy hands and acneiform eruptions and profuse dandruff in the scalp, excessive secretion of saliva and variations in the size of the thyroid gland belong in this category. The blood pressure is usually low and may show marked variations from time to time.

Appetite is often capricious, sometimes diminished and at others excessive; constipation is frequent. The body weight may show the most marked oscillations between extreme emaciation and gross obesity. The menses are often irregular and may be absent for months, especially in the more acute upsets. The blood may show alterations in the proportions, and even the absolute numbers, of the leukocytes, with a marked tendency to an increase in mononuclear and eosinophil cells. Metabolic disturbances are frequent in the acute stages, all of them indicative of a deficiency in oxidation.

An important symptom that is not infrequent in the earliest stages of the disease is the occurrence of seizures. These may be in the nature of fainting (syncopal), hysterical or, occasionally, definitely epileptoid attacks. Hemiplegic attacks have been described which are transient and leave no permanent paralysis. Often there is only one such seizure, but sometimes there are several.

**Clinical Types.** The most usual subdivision is into four types: (1) simple dementia; (2) hebephrenic; (3) katatonic; and (4) paranoid types. Kraepelin now makes many further subdivisions and has separated off a special group which he places outside dementia praecox and calls paraphrenia. These last cases are more commonly included with the paranoid variety. It is not necessary again to describe the schizophrenic features which are common to all forms and we shall
only indicate the chief points of distinction between the different types.

Simple Dementia (Dementia Simplex).—This is, in all probability, the most frequent variety, though no statistics are available for the reason that such cases rarely come under the observation of the psychiatrist. Essentially, the condition is what has been described as the schizophrenic personality without the development of a psychosis. The lad of promise fails to make good when he leaves school and enters the world of affairs. He seems to lose interest and to lack initiative, so that he is liable to settle down in a station of life which carries few responsibilities and requires little more than automatic routine. Usually there is no realization that there is anything wrong mentally and the youth is regarded as lazy or a failure.

Hebephrenic Type.—Literally the word hebephrenia means "with adolescent mind" and the principal characteristics are those of the bashful awkwardness, self-consciousness and gaucherie that belong normally to that period of life. The development of the psychosis is usually insidious, but may be stormy and even abrupt. It begins nearly always during the adolescent period, rarely after the age of 25. There is little that needs to be added to the description already given of the schizophrenic psychosis, which is here presented in practically pure form. Remissions and exacerbations in the severity of the psychosis are common and there may be short or long episodes of acute excitement or depression and more or less prolonged periods of stupor. This last state differs from that of the katatonic type in the scanty evidence of disturbance of muscle tone, but every gradation may be found and there may be times when it is not possible to decide between hebephrenia and katatonia. Some authors even refuse to make the distinction, but speak of a hebephrenic-katatonic type.
Katatonic Type.—The mental features are essentially those of the schizophrenic psychosis and the chief distinguishing points are the alterations in muscle tone which give the name to the type. There are, however, some schizophrenic features that tend to be especially well marked in this form. The disease usually appears in manifest form during adolescence, but may develop later in life. Indeed, much has been written of katatonia appearing in the sixth decade, but, in all probability, the reaction is brought about by some other disease such, for example, as the presenile degenerations.

The onset may be insidious, but is usually rather more acute than the hebephrenic type; it may be abrupt and develop to severe degree in the course of a few hours. Even then, however, there have usually been mild evidences of something wrong for some time which can be elicited by careful inquiry into the previous history. Sometimes the early signs are of hysterical or other psychoneurotic kind, or there may have been episodes suggestive of a manic-depressive oscillation. Even more interesting for our purpose are the not unusual cases in which the earliest signs have been strongly suggestive of the characteristics of a psychopathic personality, with perversities and antisocial behavior which may bring the man into conflict with society. But in all these types, careful study will reveal autistic types of reaction that render the appearances suspicious. Yet it must be admitted that errors in diagnosis at such times are quite possible (Urstein).

The classical description of katatonia, which dates from 1860, divides the clinical course into three stages before the final deterioration is reached. Practically, this distinction into stages is not always obvious and many variations are possible. The prodromal stage is one of worry and perplexity, with feelings of influence and hypochondria similar to those described under the schizophrenic psychosis. The duration of this stage is very variable from a few days or
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weeks to several months or even longer. It may subside without further progress for a time and then reappear.

The next stage is one of excitement, often with acute onset, which may reach the most extreme degree. In this excitement, the chief points of distinction from that of the manic form of manic-depressive insanity, lie in the tendency to repetition of words, acts and movements of expression without reference to the happenings in the environment. The determining causes here are the internal dissociations, which are relatively unchanging and constant as compared with the stimuli that come from the shifting conditions of the outside world. It is the latter that control the stream of thoughts and activities in manic-depressive excitement. The catatonic restlessness tends to be confined to a small space and the acts and words to be repeated monotonously (stereotypy and verbigeration), often in exactly the same form for long periods. In them can be observed the oddity, incongruity and inexplicability that stamp them as schizophrenic. Sudden and violently impulsive acts, homicidal, suicidal or blindly destructive, may develop without obvious cause. Often they can be traced by context as reactions to schizophrenic hallucinations, and the expressions of mood in the face and body attitude may seem quite inappropriate to the reaction. The moment after an act of this kind has been performed, the patient may become relatively calm and return to a monotonous repetition of act and speech. In the more extreme degrees of excitement, the picture may become one of muttering delirium. Except in these severe forms, memory is good if the patient can be induced to talk. Though he remembers what he has done, he shows no real interest in it and often seems to regard it as something entirely outside himself.

After the excitement there may again be a period of remission with later recurrence. The duration is very vari-
able and this stage may be lacking. The next stage of stupor often comes on rapidly, sometimes within a few hours and the change from wild excitement to stupor may be startling.

In the stupor there is more or less complete cessation of most activities, but without loss of consciousness. This can be discovered from the reactions to stimulations which still occur. It is in this state of stupor that the extraordinary disturbances in muscle tone become so prominent. They consist of a rigidity which renders passive movements stiff, much as if one were attempting to bend a piece of lead pipe or wax (waxy flexibility or flexibilitas cerea). The resistance to the movement is not voluntary and remains practically constant throughout the whole movement, not increasing nor diminishing as the bend becomes greater. If the movement is interrupted suddenly, there is no spring back such as would be inevitable if the resistance were voluntary. It must not be forgotten, however, that active resistance may be encountered in addition to that of the waxy rigidity. Something similar pictures may be observed in certain organic diseases of the nervous system in the region of the midbrain, especially in epidemic (lethargic) encephalitis. In these diseases, however, the katatonic mental symptoms are lacking.

In addition to the rigidity of the skeletal muscles, there are suggestions that the involuntary muscles suffer in similar manner. Sluggishness of pupils with irregular contractions, sluggishness of stomach and intestinal movements, rapid heart beat with low blood pressure, vasomotor disturbances with blueness of hands and mottling of the skin, may all be regarded in this light. Disturbances in secretory glands are also often marked: increased salivary secretion which may drool from the mouth, clammy sweating hands and feet, oily scalp and severe acne and much dandruff.

There is also a marked tendency to the development of automatisms. By this it is meant that the motor mechan-
isms seem to go off automatically and without choice or selection by the patient. The suggestion of a movement is sufficient to set it in action, or sometimes to cause the opposite movement to that suggested (negativism). Among the automatisms, special mention should be made of the so-called catalepsy in which any posture suggested is maintained for long periods, apparently regardless of fatigue. Sometimes the performance of an act or the uttering of words in the presence of the patient will immediately be copied or echoed by him. These are spoken of as echopraxia and echolalia, respectively. Often the only response that can be obtained to a question is the repetition of some words or phrase of the question. The tone of the questioner's voice may be copied as well as the words. When negativism is present, the patient performs a movement opposite to that suggested. If asked to put out his tongue, the jaws clench and the mouth is puckered up; if asked to sit down he stretches himself up stiffly and resists any effort to place him in a chair. Even his own impulses to action may be converted into the opposite. Thus he may refuse food even though hungry and willing to be fed. Combinations between negativism and automatic compliance with suggestions are very frequent and serve to render the picture still more strange and conflicting.

Throughout this period it is often difficult to obtain responsive answers to questions. Sometimes the answers are directly related to the question but are careless and may be extremely silly. If a date is asked for, some date may be mentioned but one that may have no relation to the question; occasionally correct responses are obtained as it were by accident and the next moment the same question will draw an absurd response. A patient may say that he has five noses, fifteen sisters, that January 1 is Christmas day, this country is Germany, etc. The sense of the question has been
grasped to the extent of arousing the correct kind of answer but without the attention necessary to select the proper reply. To describe this type of careless response, the Germans use the term “vorbeireden” which has no exact equivalent in English but means talking “beside the mark.” The symptom resembles superficially the so-called Ganser syndrome commonly encountered in certain hysterical states, which has been described as characteristic of certain “prison” psychoses. This subject and its differentiation from vorbeireden is discussed under hysteria.\(^1\)

After a variable duration, there is usually a more or less gradual return to increasing activity and interest in the world which may continue to practically complete recovery. Usually, however, it does not proceed to that point, though much seems to depend on treatment and the depth and extent of the tendency to dissociation. When recovery does not occur, there remains a final stage of deterioration which closely resembles that after hebephrenic attacks. Indeed, it may be impossible to distinguish in the end state the type of disorder that existed during the acute phase; this is one element in determining the grouping of these various types together under one disease name.

In the katatonic variety, the end-stage tends to present well marked evidence of motor upset in the form of stiff, clumsy movements, with many stereotypies and odd mannerisms. A certain degree of more or less automatic activity is usually possible which can be directed by training into more or less useful channels. But the patient remains indifferent to his surroundings, chary of words, inaccessible to conversation and shows little evidence of emotion. Even at this period there may be sudden impulsive acts, quite unexpected and without apparent cause. Assaults on others and sudden suicidal attempts may be observed in these states.

\(^1\) Page 187.
These late manifestations, however, do not particularly concern us here as they are practically limited to hospitals for the insane and rarely come under medicolegal consideration except in such matters as the establishment of guardianship and commitment.

Paranoid Type.—The features that distinguish this type are due to the addition to the schizophrenic characteristics of elements that belong to the paranoid personality. Every gradation between what is described as pure paranoia and pure schizophrenia may be encountered. The former is characterized by the aggressive, self-centered ideas of reference, with consequent delusions of persecution and later of grandeur, which are well systematized and logical. The schizophrenic mechanism necessarily interferes with the logic and system and results in vagueness and scattering of the delusions and the addition of symbolic oddities, mannerisms and hallucinations. Furthermore, the autistic tendencies prevent any very energetic pursuit of a means of fighting the persecution and sooner or later lead to loss of outward interest and emotional deterioration. Such an outcome is foreign to the conception of true paranoia and has hence been emphasized as a means for distinguishing between it and the paranoid type of dementia praecox.

In the absence of knowledge of the nature of the disease processes involved, it is only natural that there will be many differences of opinion, and some psychiatrists group together all paranoid developments (except those that occur in association with some clear-cut and definite disease) under the head of dementia praecox and refuse to recognize paranoia as an entity. The view that we have adopted here is that the schizophrenic and paranoid personalities are different modes of reaction that are not fundamentally antagonistic and hence may be combined in one individual. At one end of the scale might be placed hebephrenia as a practically
pure expression of the schizophrenic mechanism; at the other end the cases described as paranoia. Between lie all the manifold combinations that are variously known as paranoid dementia praecox and paraphrenia.

The paranoid psychoses of dementia praecox tend to develop somewhat later in life than do these of more purely schizophrenic kind. This is intelligible when consideration is given to the greater energy and aggressiveness of the paranoid personality which permits effective adjustment to the lesser difficulties of life, even if the adjustments are not entirely satisfactory. The onset is gradual and insidious and usually occurs between the ages of 20 and 30. The paranoid trend tends to render these persons dangerous to the community in which they live. They may commit acts of violence in retaliation for the persecution to which they believe themselves subject. Homicidal attacks and destruction of property may be carefully planned before execution or may bear the stamp of impulse; suicide may also occur under similar conditions. The greatest care is therefore necessary in deciding whether such persons should be allowed any degree of liberty of action. The more marked the schizophrenic inadequacy, the less the danger, although, as has already been indicated, sudden impulsive acts may occur even then, especially in states of excitement.

The degree and date of onset of the final deterioration is very variable and, as already indicated, is dependent on the degree of autism. When it does develop, the delusions and hallucinations become more empty and scattered, often quite fragmentary and lacking in evidence of real interest on the part of the patient. In this final state, it may be quite impossible to distinguish between paranoid and other types of dementia praecox.

**Frequency.** There is considerable variation in the statistics of different hospitals as to the frequency of dementia
praecoxx which is largely a matter of differences in exact definition. The following facts may be quoted from the figures collected by the National Committee for Mental Hygiene and studied by Pollock and Furbush. Of 21,742 first admissions to seventy-two state hospitals in 1920, dementia praecox accounted for more than any other disease and constituted 27 per cent. of the total. In this report there is no subdivision into the different types. In another study,\(^1\) Pollock reported that, of 12,188 cases of dementia praecox, the proportion of the types were:

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>5,627</td>
<td>46.17</td>
</tr>
<tr>
<td>Katatonic</td>
<td>1,584</td>
<td>12.99</td>
</tr>
<tr>
<td>Hebephrenic</td>
<td>3,957</td>
<td>32.47</td>
</tr>
<tr>
<td>Simple dementia*</td>
<td>1,020</td>
<td>8.37</td>
</tr>
</tbody>
</table>

These figures were collected from a number of hospitals and it is interesting to compare the proportions for different groups of hospitals:

<table>
<thead>
<tr>
<th></th>
<th>New York</th>
<th>Massachusetts</th>
<th>Other hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Per cent.</td>
<td>Number</td>
</tr>
<tr>
<td>Simple*</td>
<td>625</td>
<td>10.19</td>
<td>165</td>
</tr>
<tr>
<td>Hebephrenic</td>
<td>1,463</td>
<td>23.84</td>
<td>828</td>
</tr>
<tr>
<td>Katatonic</td>
<td>468</td>
<td>7.63</td>
<td>678</td>
</tr>
<tr>
<td>Paranoid</td>
<td>3,579</td>
<td>58.34</td>
<td>1,248</td>
</tr>
</tbody>
</table>

\(^*\) These figures represent only admissions to state hospitals and therefore contain only the very small number of cases of simple dementia that need commitment. They do not represent the proportions as they might occur in the community.

**PARANOIA AND PARANOIC STATES**

The essential features of the type of insanity included under the name of paranoia have already been outlined under

\(^1\)Quoted with minor changes, from "Mental Disease a Public Health Problem" by James V. May, Boston, Richard G. Badger, 1922, page 457.
the head of paranoid psychoses. They will, therefore, not here be repeated. The onset is slow and insidious and it is often extremely difficult to say when the disorder started, a difficulty which is increased by the falsifications of memory that play such a large part in the logic on which the delusions are built. The age is usually between 20 and 30 when something is noticed to be wrong, but it may be several years before it is realized that the man is mentally unbalanced. The disorder is more common in men than women and we may summarize the evolution by stating that the first stage is one of ideas of reference, next comes a stage of ideas of persecution which gradually merges into the final development of delusions of grandeur. The disease is typically progressive and recoveries are extremely rare. Occasionally there is subsidence of the thoughts of persecution, without, however, correction of them. Typically there is no emotional deterioration or loss of interest, but there is every gradation between this pure form and paranoid dementia praecox.

Under the title of paranoid states are included a group in which there is a more acute development of persecutory delusions with good logic and systematization, which in a cross section at any moment is indistinguishable from paranoia. The difference lies in the more rapid onset and in the fact that the disorder tends to subside after a variable time. Such temporary pictures have already been mentioned as occurring during recovery from toxi-infectious states of delirium and also in connection with acute alcoholic psychoses and other intoxications. Such states should be classified with the appropriate disease condition. In addition, there sometimes develop similar episodes without any discoverable preceding disease condition, and which, therefore, seem to be personal reactions, perhaps similar in their causation to a manic-depressive psychosis.
The medicolegal problems that are liable to arise are numerous and depend on the fact that the paranoid person reacts in accordance with his beliefs. Though the delusions sometimes seem to be concerned with some one topic (monomania), the whole mentality is involved and the man cannot be held responsible for his acts. The logical reasoning may render the proof of delusion difficult, though sooner or later the conclusions become so manifestly improbable and perhaps impossible that their falsity is readily recognized. In the earlier stages, however, it may be very difficult to convince a court or jury that the beliefs are not simply personal views, a little odd perhaps, but permissible. Unfortunately failure to recognize the fact of alienation may result in serious delinquencies and even crimes. It is therefore essential to investigate in the most painstaking manner the premises on which the reasoning rests and to emphasize the triviality and, if possible, the incongruity of the facts that are alleged as evidence on which to build up the conclusions.

The group of paranoia is not large and its size will vary with the views of the psychiatrist as to the relations with dementia praecox. In the statistics cited, a little less than 3 per cent. of first admissions to state hospitals were included in this category.

PSYCHOSES WITH EPILEPSY

Varieties. Epilepsy is a symptom of many diseases and not itself a disease. Yet there are many cases in which no disease has been detected and in which the epileptic seizure is therefore the principal manifestation. This group, in consequence, is often spoken of as “essential” or “idiopathic” epilepsy; when the term epilepsy is used alone, it is this group that is usually implied. Epileptiform seizures occurring with a definite disease (symptomatic epilepsy) are considered as symptoms of that disease and the case is classified under its name. The diagnosis of essential
epilepsy must be made by exclusion as it has no positive distinguishing marks of its own. We are here concerned mainly with essential epilepsy, but it will not be amiss to mention some of the disease conditions in which epileptic seizures may occur in order to indicate their extreme diversity.

For convenience they may be grouped under six headings: (1) Brain diseases—trauma, general paralysis, cerebral syphilis, arteriosclerosis and its sequelae, tumors, abscesses, hydrocephalus, infantile cerebral palsies, encephalitis, etc.; (2) mental diseases—dementia praecox; (3) intoxications—alcohol, arsenic, lead, etc.; (4) metabolic diseases—uremia, eclampsia of pregnancy, etc.; (5) endocrine gland disorders—pituitary disease, Addison's disease, etc.; (6) reflex irritations—dental caries, phimosis, etc. The convulsions that occur under these various conditions may be quite indistinguishable from those of essential epilepsy. Focal or Jacksonian epilepsy has already been described and its significance noted. In addition, there are convulsions of hysterical nature which, when characteristic, are quite distinctive and will be considered under hysteria. It is quite possible for both hysterical and epileptic seizures to occur in the same individual, when differentiation may be proportionately difficult. Indeed, the term hystero-epilepsy is sometimes used to denote the combination of the two disorders, or cases in which the diagnosis is not clear.

The Convulsion. The characteristic feature of epilepsy is the seizure, fit or convulsion, without which the diagnosis cannot be established, though there are certain mental characteristics that may lead to suspicion. It is, therefore, necessary briefly to describe the fit. These are usually divided into two types known respectively as major (grand mal) and minor (petit mal). The latter may be considered an abbreviated or abortive form of the former, the fit ending before some of its most striking features have appeared.
Many persons have both types of fit; others have only major or only minor seizures.

The fit may be divided into stages, though these run insensibly into one another: (1) The warning or aura (sensation). This is often absent and may occur in some attacks and be absent from others in the same person. When it does occur, the aura is usually constant for the individual. It is usually quite momentary and consists of some sensation: flashes of light, a veil over the eyes, buzzing or ringing in the ears, odors, tastes, skin sensations and sensations of more or less indescribable character in various parts of the body. Less frequently the aura is motor in character: difficulty in speaking, sudden impulsive movements such as running forward (procursive epilepsy) or backward (retropulsive epilepsy), or some spasmodic movement. Psychic auras may also occur: feelings of fear or anguish, of being dazed or lost, etc. The aura must be distinguished from the more prolonged warnings such as headache, dulness, irritability, emotionalism, etc., that may be noticeable for hours or days before the onset of an attack. These are sometimes alluded to as prodromes. (2) Loss of consciousness: This is the most characteristic and constant feature of the fit and appears with absolute suddenness; it usually lasts throughout, and often for some time after, the convulsion. (3) Tonic spasm: The muscles of the body become rigid and may, by forcing the air out of the chest, cause an inarticulate cry which is long drawn out and is almost characteristic. At this time the patient falls, wherever he may happen to be, and may bite his tongue as the result of the spasm in the jaw and tongue muscles. (4) Clonic spasm: In this stage there occur jerking contractions and relaxations of the muscles of the face, arms, legs and trunk, in which the tongue may be chewed and the body injured by striking against objects. Evacuation of the bowels and bladder are frequent. After reaching a varying
degree of severity, the jerkings gradually diminish in force and extent and finally cease. (5) Coma: With the cessation of the clonic jerking, the patient becomes limp and exhausted, and remains unconscious for a variable period.

The color of the face varies in the different stages; at the onset it is usually pale, becomes red in the tonic stage and deeply blue or cyanotic in the clonic stage; it then resumes a normal color in the final stage. The total duration of a complete convulsion to the end of stage (4) varies from one half to about two minutes. The final coma may be quite brief or may continue for an hour or more. Sometimes another fit succeeds before consciousness has been regained and when this repetition continues the patient is said to be in status epilepticus in which the danger to life from exhaustion is great. Such a "status" may last for several days. Recovery of consciousness after a fit is usually gradual and the patient may appear dazed and stupid for some hours; often he complains of severe headache and he may, after recovering consciousness, go into a deep sleep that lasts for several hours.

In the minor attacks, the seizure ceases at stage (2) and there is no convulsion. The loss of consciousness may be extremely brief—so short that, as a rule, the patient does not even fall. Such attacks frequently pass altogether unnoticed. There is merely a momentary cessation of what the man was doing—he may drop things he happens to have in his hand—and then he continues as if nothing had happened. An attentive observer would note that the patient became pale, gazed in front of him in a dazed manner, perhaps made some peculiar movement—turned his head and eyes stiffly, made chewing movements, etc. In these attacks, also, it may happen that urine is voided and this is probably the explanation of some cases of diurnal or nocturnal enuresis in children and adults.
After the seizures, both major and minor, the patient remembers nothing (amnesia) of what has transpired, except the aura if such occurred. This is to be expected when it is realized that he was unconscious. Unless there is headache, soreness of muscles or some injury in the fit, he may be quite unaware that a fit has occurred. The possibilities of injury are due to the helpless fall, suffocation from burying the face in a pillow when the fit occurs in bed, striking against objects and biting the tongue.

Scars are often relied on as evidence of injury in previous seizures, but it is important to realize that bites of the tongue may leave no trace even when they have occurred many times. Not more than one-fourth of epileptics show scars on the tongue. While, therefore, a positive scar is often valuable evidence, the absence of scars is no proof that the tongue has not previously been bitten.

Seizures may occur at all hours of the day or night and with variable frequency. Some persons have all fits during the night and the fact of epilepsy may thus remain unknown for many years. Fits may occur at intervals of weeks or months, or may be repeated many times every day.

In addition to the typical fits outlined, there are certain psychic upsets—sometimes spoken of as epileptic equivalents—that are of great importance medicolegally. There is still some doubt whether these are really equivalents, that is to say take the place of a fit, or whether they do not rather follow a fit. They are more frequent in association with minor than with major fits and it is therefore quite possible that a preceding minor fit passed unnoticed. When they follow a fit, they are spoken of as post-epileptic states. We shall disregard this point and describe them together.

Epileptic Equivalents and Post-epileptic States. States of Automatism.—Following a fit, especially a minor fit, the patient may seem to have more or less recovered conscious-
ness and may enter on some activity in an automatic manner, avoiding obstacles and handling objects as if aware of what he is doing. Yet he may be actually unconscious and when he "comes to himself" know nothing of what he has done. Not uncommonly, these activities take the form of undressing or adjusting the clothing. It was suggested by Gowers that such acts might be considered appropriate to the feeling of illness that was the last conscious experience. Undressing may be carried out in public with evident disregard for the situation, and naturally may bring serious social difficulties.

Sometimes the automatic acts are those habitual to the man in his ordinary avocation. Thus a truck driver may continue to drive his truck through the streets, usually without accident, but certainly not without great danger to himself and others. After a period of a few minutes or half an hour, the man comes to himself, entirely at a loss to explain how he reached the spot where he finds himself. A newsboy, in hospital for study, was observed to have a minor fit without cry or fall, and then to pick up a newspaper from the bed, carefully fold it and walk off down the ward with the paper under his arm as if peddling, but without saying a word. He threaded his way between a number of people without running into anyone, reached and opened the door and then came to himself, entirely unconscious of what he had done or how he got to the door.

Another man, as the result of such a seizure, was arrested for theft. He was a bank clerk who was not known to be suffering from epilepsy. Some negotiable securities disappeared and were later found locked in a drawer belonging to the patient. He denied knowledge of how they had come there; as he had a good reputation it was suspected there might be something wrong and he was sent by the court to a hospital for study. There he was seen to have a number of
minor attacks that could readily have escaped notice. The probable explanation was that, in an automatic state, he had picked up the papers and put them away. Such acts are not at all uncommon in these states and are carried out without knowledge of the meaning of the act and without recollection of the fact afterward. Many acts of petty thievery and pilfering may be performed in this way.

Cases have been recorded in which much more complex acts have been performed in automatic states. It is asserted that men have wandered from home and traveled long distances, even by steamer, have undertaken business and led a more or less natural life for months. The epileptic nature of such episodes must be regarded with the gravest doubts; it is far more probable that they belong in the category of hysterical automatism. Epileptic automatisms rarely last more than a few minutes and we question whether they ever last more than an hour. They may be followed by prolonged sleep or headache.

*Emotional Outbreaks.*—Outbreaks of severe emotion occur episodically in many epileptics, sometimes definitely as post-epileptic phenomena, sometimes apparently independent of fits and perhaps replacing them. In these states there is a sudden—apparently unmotivated—outburst of emotion, often of great violence and short duration, in which the patient may react with blind fury, striking and smashing anyone or anything that gets in his way. These are the attacks of so-called epileptic furor, sometimes listed with *mania transitoria* by older writers. The most brutal and ferocious attacks with murder, sexual assaults, and acts of vandalism, sabotage, arson, etc., may be committed. Fortunately, such seizures are rare even in a community composed entirely of epileptics, but it should be realized that a man who has had one such attack is quite liable to have others. As it is impossible to foretell the time of their recurrence, any
epileptic who has experienced one such attack must be considered permanently unfit for a social existence.

In making a diagnosis of epileptic furor, the points to be stressed are: a definite history of epileptic seizures; abrupt onset; lack of plan and usually lack of motive, though the latter may sometimes appear to be present when the victim happens to be someone against whom the epileptic had a grudge; absolute lack of consideration for self or consequences and complete amnesia afterward. In this last point, which may of course be simulated, it is important that the subsequent acts are in accord with a real absence of memory; there is no effort to avoid or escape the consequences and the man goes about his business as if nothing had happened. Frequently there is a prolonged sleep and severe headache immediately after the attack.

In addition to these severe episodes, there also occur other forms of emotional disturbance such as despair, anxiety and apprehension, which may lead to appropriate reaction in the form of suicide or running away. Occasionally there are outbursts of hilarity with excessive drinking, sexual irregularities and disturbances of the peace.

Some attacks are more prolonged and merit special mention. Among them are episodes of delirium-like character, often spoken of by the German name "Dämmerzustände" or twilight states. In them there is marked clouding of consciousness or dazedness, often accompanied by vivid hallucinations of dream-like nature, usually of unpleasant or terrifying content. These states may last for days and perhaps months and, unless the fact of epilepsy is known, are usually thought to be of toxi-infectious nature.

Some examples of dipsomania are also thought to be epileptic. At varying intervals, a man becomes moody and depressed, often with blinding headache and craving for alcohol. He may resist for a time, but one drink is followed
by a prolonged spree in which all self-control and resistance are lost and the drinking becomes a reckless debauch which is continued until complete intoxication ends in a drunken coma. Between these attacks, for months or even years, the man may not desire or touch liquor at all. Whether these episodes are truly epileptic is not clear; they certainly occur without other evidence of epilepsy. Most epileptics are very susceptible to the effects of alcohol and, in extreme cases, a single glass of beer results in a state of pathologic intoxication; it may also precipitate an epileptic furor. The relation of alcohol to epileptic seizures has been considered also in the chapter on alcoholism.

**The Permanent Mental State.** The epileptic is typically dull and immature, markedly egotistical, irritable, obstinate and unreliable, with a low grade of intelligence. But there are many exceptions to this characterization, some—Julius Caesar, Napoleon—possibly historical. One of the striking observations among enlisted men in the army during the recent war was the discovery of many unsuspected cases of epilepsy, some in men who had made good and perhaps had been promoted. Occasionally one meets lawyers, doctors and more or less successful business men who are afflicted in this way without having aroused suspicion, their fits occurring always at night. On the other hand, epilepsy, probably most often symptomatic rather than essential, is especially common in the feebleminded.

Emotional instability, with especial tendency toward irritability and violent reaction on slight cause, is extremely common and renders the epileptics, as a class, very difficult to live with. The irritability is sometimes definitely episodic, with or without the concomitance of seizures. The breadth of grasp of facts and situations is usually limited, and there is a tendency to the adoption of dogmatic and more or less parrot-like codes and rules of conduct. Conclusions and
judgments are justified by quotations from or references to mother or the Bible. The epileptic is usually self-satisfied and sanguine as to the outcome of his affliction, but yet absorbed in it and able to talk of little else. He is frequently much more contented and agreeable in the company of other epileptics than with normal persons.

The mental characteristics of the epileptic are difficult, if not impossible, to separate from the dementia that intensifies the features described and becomes slowly but progressively more marked in about three-fourths of the cases. As a rule, there is some proportion between the degree of dementia and the severity, and to a less extent the frequency, of the fits. Yet severe dementia may be observed in patients who have only occasional fits, especially if severe, and may be very slight in others who have numerous seizures. The mental loss is very gradual and extends over many years, but is otherwise similar in its general characteristics to that which results from diffuse organic brain disease. There is a lowering of ethical and moral standards, perhaps never very high if the epilepsy developed, as it usually does, in early life, with contraction of the circle of interest and of the store of memories or ideas. In consequence, there is a marked tendency to circumstantiality and monotonous recurrence of the same small group of thoughts and activities, which center especially around the self. In some instances, it seems probable that the drugs commonly administered in the effort to control the fits do more damage to the mentality than the fits themselves; but, even apart from the use of nerve sedatives, progressive dementia is almost the rule.

Bodily Symptoms. There are no constant and characteristic bodily signs except the seizures. Yet certain features may sometimes, in conjunction with the behavior characteristics, suggest the possibility of epilepsy. The pupils of the eyes are often wide, contract promptly when light is thrown in,
but the initial contraction is followed by oscillating dilata-
tions and contractions (hippus-like) before finally coming to
rest. When the eyeballs are rotated strongly to one or other
side, a few oscillations (nystagmoid jerkings) may often be
observed. Special stress has also been laid by Scripture on
the peculiarly monotonous quality of the voice, which is
common in advanced cases. The tendon and skin reflexes
are approximately normal (they may be sluggish or brisk)
and there is no paralysis or incoordination, though the move-
ments are often distinctly clumsy and awkward. Distur-
bances in skin sensitiveness, especially to painful stimulation,
have been described as appearing before a fit, and also as
being constant, but they are certainly often absent and not
characteristic.

The more general bodily functions show no constant
changes. The complexion is often muddy, the skin oily and
the hair coarse and abundant. Digestion may be easily
upset and appetite is often excessive. Sometimes before or
after a fit there is an insatiable craving for food (bulimia) and
there may be a similar heightening of sexual appetite. Con-
stipation is common.

Causation. There is no need here to discuss in detail the
question of the causes of essential epilepsy, concerning which
there is no very definite knowledge. Yet certain points may
be raised from a medicolegal point of view which should be
given brief consideration. One of these is that of heredity,
undoubtedly an important factor. It is difficult to decide,
however, what should be regarded as poor heredity. Epi-
lepsy in the parents is said by various investigators to exist
in from 6 to 20 per cent., the lower figure being probably more
nearly correct. Epilepsy in the family, other than in parents,
is more frequent and is said to be present in from 15 to 25 per
cent. Gowers, from the study of a large material, concluded
that in at least 50 per cent. of the cases there is either
epilepsy or insanity in the family. If other traits of so-called neuropathic taint (hysteria, migraine, alcoholism and various degenerative nervous diseases) are included, an even larger proportion of bad inheritance will be found.

Toxic conditions in otherwise healthy parents may damage the germ cells, with the consequence that epilepsy may develop in the offspring. This has been alleged especially for alcohol. But in weighing this evidence it is important to take into consideration the fact that chronic alcoholism is almost always a symptom of nervous instability and that this inferiority in construction may be more effective in damaging the offspring than alcohol. The facts are more clear with regard to some other poisons such as those due to syphilitic infection. Epilepsy and other forms of nervous degeneracy may be found in children born to parents after infection with syphilis, while those born before may be entirely healthy. Sometimes this means that the offspring is also infected with the germs of syphilis and then the disease will more probably be symptomatic of syphilitic brain damage and not essential. But epilepsy may appear without other evidence of congenital syphilis and thus seem to be the result of toxic damage to the germ cells of the parent. While it may appear that we are here making a somewhat definite distinction between essential and symptomatic epilepsy, there is probably no real justification for such an attitude; future investigation may reveal a disease process underlying the epileptic symptom even in what is now called essential epilepsy.

**Medicolegal Relations.** The liability to personal injury and the dangers of delinquent and criminal kinds of behavior have been sufficiently stressed. It should be pointed out that questions of guardianship, commitment, contract capacity and liability for torts may also arise. Here, as in other dementing diseases, these questions must be answered
for the individual case by a study of the actual facts. They cannot be stated in general terms. It does, however, seem permissible to assert that the establishment of a diagnosis of epilepsy places the burden of proof of responsibility for criminal acts on the prosecution. When such questions arise, it is also obvious that the irresponsibility, once admitted, is an abiding condition which must be met by adequate steps to prevent repetition of the abnormal behavior and its consequences.

The handicap from which the epileptic suffers is severe. Not only is he liable to injury from falling, but this fact alone renders it difficult for him to secure employment because of the liabilities that the employers must assume. The fits are always disturbing to the environment and often cause much alarm to those who observe them, though they are rarely fatal except as the result of accident or exhaustion in status epilepticus. The possibility of steady attendance at work is diminished in proportion to the frequency of the fits or other seizures. Furthermore, the personal characteristics—the irritability, obstinacy and egocentricity—render those who suffer in this way objectionable and unpleasant associates. The epileptic is therefore strikingly extrasocial and unfortunate. Nevertheless, it is also true that some epileptics do succeed more or less well in self-support and industrial, especially agricultural, activity.
4. **Psychoses with Constitutional Deficiencies**

**Psychopathic Personality (Constitutional Psychopathic Inferiority)**

**Definition.** Nowhere in the field of mental disorders is there so much confusion, both as to nomenclature and interpretation, as in that which here, in conformity with the classification of the American Psychiatric Association, we are designating as psychopathic personality. There is also none of such great importance in its bearings on crime and delinquency, and their treatment. While the title of this chapter deals strictly with the psychoses that arise on the basis of psychopathic personality, it is more convenient to consider at the same time the psychopathic state itself.

For long these disorders were grouped with the insanities and even today we find them designated by such terms as "moral insanity" and "impulsive insanity." It is now, however, generally recognized that they are essentially reaction tendencies of personalities, inherent in the individual, and are not diseases. In other words they are forms of deficiency which have closer relations with feeblemindedness than with insanity. Indeed the title moral insanity has often been replaced by that of "moral imbecility" a term that is also objectionable; moral is open to misconstruction and imbecility has a definite connotation as a certain degree of intellectual deficiency. Mairet and Euzière use the title "moral deficiency" and insist that this disorder "is a malformation, whereas insanity is a disease." They\(^1\) also point out that intellectual maldevelopment and moral}

\(^1\) Mairet, A., and Euzière, J.; Les invalides moraux, Montpellier, 1910.
deficiency are frequently, but not necessarily, associated together.

The personality defect is a defect in behavior and thus intimately concerned with the problem of free will. Being behavior it is the use that is made of tools, in themselves more or less well developed (intelligence), and is far less objective than a deficiency in the tools themselves (intellectual defect or feeblemindedness). Socially, personality defect is for the same reason of far greater importance than intellectual defect. This is well exemplified by studies of the intelligence levels of convicts, who are found to differ little in this respect from members of the average community. But the proportion of psychopathic personalities is very high, insanity being almost negligible. Indeed, it may be said that the great majority of "bad men," "born criminals" and "recidivists" belong in the category here under consideration. It may also be pointed out that the use of such descriptive terms of itself implies recognition of differences from ordinary people, though it does not justify the assumption of insanity. It does, however, raise a question that needs most serious consideration—the responsibility of such persons for crime and delinquency.

Relation to Responsibility. The law at present provides no alternative between complete responsibility and entire irresponsibility; the only choice in the way of treatment lies between the penitentiary and the hospital for the insane. Yet the persons here under consideration belong in neither the one nor the other. The protection of society is of vastly greater moment than the welfare of any one individual, even though he be defective and unfortunate. Hence the decisions reached in court under existing circumstances are in reality compromises, and are often very unsatisfactory. In the hospital such persons give rise to incessant trouble, and detract greatly from the possibilities for the care and
treatment of the insane for whom these institutions are established. So great is this disturbance that hospital officials often take advantage of the fact that there is no true insanity (or psychosis) and discharge the patient or fail to prevent his escape. In a penal institution these personalities are not understood and, as they very readily become insubordinate, disorder is inevitable and leads to the adoption of repressive measures which are liable to enhance rather than diminish the difficulties. The so-called indeterminate sentence, as at present administered, means that sooner or later the psychopath will be released to prey on society once more. This has done much to bring unjust criticism on parole and probation laws and to influence popular and legal opinion against what are often alluded to as the sentimental whims of psychiatrists.

It should be emphasized that the detection of the true character of such an offender with certainty is not by any means a simple task. There is nothing in the crimes or delinquencies, nor even in the motives that lead to them, that is characteristic. Exactly similar types of misconduct may result from dementing disease which removes the machinery through which the selection of correct behavior is made. They may also result from faulty training and associations in persons quite capable of social behavior if properly educated. The diagnosis must be made from a study of the entire life history, and the observation, often prolonged, of the manner of reacting to varying situations. No known tests will of certainty reveal the facts.

Unfortunately, the present system of legal procedure minimizes the possibility of making such investigations and, unquestionably, many convictions are returned and punishments awarded which can be justified only on the grounds of expediency. We propose to discuss these problems in a later chapter and shall here rest content with the assertion, that
not only would the ends of justice be better served, but, of even greater importance, society would receive better protection if due consideration were given to the real facts and needs.

**Classification.** Here we are concerned with the task of describing and specifically characterizing the features that constitute the psychopathic personality. For this purpose some classification seems necessary, for the varieties are almost as numerous as the number of cases. No classification can be said to have been very widely adopted. Sollier,\(^1\) in 1891, in a monograph on feeblemindedness, clearly outlined the essential differences between intellectual deficiency, which he called “idiocy,” and behavior disturbance, which he described as “imbecility.” He pointed out that the former included individuals who are extrasocial by reason of the infirmity, but are educable to a level that depends on the degree of defect. The imbecile of Sollier, on the other hand, is actively antisocial and, from a behavioristic point of view, uneducable. Sollier, however, studied defectives in an institution for the feebleminded and consequently dealt only with persons with more or less severe degrees of intelligence defect.

Mairet and Euzière, working with cases in which the predominant defect was in behavior, subdivided their material into four groups: (1) moral atrophy; (2) moral perversion; (3) moral inversion; and (4) moral instability. More recently Adler\(^2\) has proposed a title for this group from which the ambiguous term “moral” is omitted—egocentric personality—which includes the second and third groups of the French authors. From a behavioristic point of view, of

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\(^1\) Sollier, Paul: Psychologie de l’idiot et de l’imbécile, Paris, 1891; Ed. 2, 1901.

Adler divides mental disorders into three groups: inadequate personality, egocentric personality, and emotionally unstable personality. The first includes feeblemindedness, the second many of the forms that we are here designating psychopathic and the third will include also some forms of insanity.

Kraepelin\(^1\) who has done much to delimit fundamental grounds for the classification of the insanities, divides psychopathic personalities into seven groups: (1) the emotionally unstable (Erregbaren); (2) the inadequate (Haltlosen); (3) the impulsive (Triebmenschen); (4) the perverted (Verschrobenen); (5) the pathologic liars and swindlers (Lügner und Schwindler); (6) the antisocial (Gesellschaftsfeinden); (7) the quarrelsome personalities (Streitsüchtigen). The similarity of the first two with those of Adler is obvious. The remaining five are terms descriptive of certain characteristics in the behavior and do not indicate fundamental differences in the personality.

In the present state of knowledge concerning this type of disorder, distinctions which aim at too great exactitude are liable to increase rather than to eliminate confusion. We, therefore, propose to adopt a simple classification in accord with that of Adler and shall discuss two types, the emotionally unstable and the egocentric, leaving the inadequate group for consideration under the heading of mental deficiency. In addition, there is a special group of perversions that seems to need separate consideration.

The Emotionally Unstable Personality. As the title suggests, the principal element here is a lack of control over emotional reaction. When occasion arises, the man does not simply become angry or sad, but passes into a state of rage or despair in which he may say or do things that will hurt himself or others. He is largely the sport of circumstances

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\(^1\) Kraepelin, Emil: Psychiatrie, Leipzig; Barth, Ed. 8, Vol. IV, 1915.
and gets into difficulties because of the violence of his reactions. His intelligence is usually average or better. Kraepelin states that women are more commonly affected than men and that more than 50 per cent. do well at school, less than 25 per cent. do poorly. The usual mood, when not disturbed by outbreaks of emotional violence, is one of doubting, hesitating depression; occasionally it is more exalted and the outbreaks then are more liable to be of the type of anger and excitement with tendencies to sexual irregularities and excesses. Addiction to alcohol or drugs, as a means of escaping from the moodiness, is common and these people are often particularly susceptible to their effect and become readily intoxicated.

The types of delinquency to be anticipated are those in accord with violence of reaction, suicidal attempts being perhaps the most frequent; but disturbances of the peace and homicidal attacks may also occur. The offenses are typically not planned and are carried out with evidence of passion. The fact that the cause was trivial would lead to suspicion that there was something pathologic in the reaction and that the past history should be carefully weighed. Under present conditions, it is impossible to consider such persons irresponsible, but presentation of the facts will materially assist the court in passing sentence. Obviously such people cannot be permitted to return untrammeled to social life and the greatest care must be exercised in granting paroles, as the outbreaks come in explosive fashion and cannot be foreseen except in a general way. Fortunately, with increasing age there is a tendency toward improvement, dependent, in all probability, on the lessening of the instinctive desires that are responsible for the outbreaks.

The Egocentric Personality. In the selection of this title, Adler has emphasized an outstanding and apparently fundamental feature that is present in all persons of this
kind. Naturally, it is but an exaggeration of features that are present in normal persons, the presence being doubtless of value in social adjustment. The name means a centering of the interest on self-gratification; everything that happens or is done is considered only in regard to the effects it will have on the self; little or no consideration is shown for the feelings and rights of others. In other words there is a lack of the gregarious sentiment and the instinct of the herd, which in normal persons modify and control the self-seeking instincts.

Most authors lay stress on the features of antisocial behavior and ineducability. These, however, striking as they are, are the outcome of the egocentricity and cannot be considered prime factors. They may be more or less marked. The individual may, in some cases, be deterred from antisocial behavior because he is afraid of the consequences and in this sense he is educable. But the lesson is usually learned only in words and is often forgotten again in the appeal of something strongly desired. It will be noted that, in some respects, there is a strong bond of resemblance between these persons and the paranoid personality. Indeed, for a time Adler classified these cases as paranoid, not from any belief that they were insane, but because this feature of egocentricity was so well marked. They differ from insanity by reason of the fact that the trouble is inherent and not progressive. It does not lead to systematic delusion and falsification of memory such as we found characteristic of the paranoid developments. There is also a striking absence of a steady guiding purpose or interest, the presence of which in the paranoid individual is pronounced and is responsible for the progressive evolution and systematization. The term paranoid has therefore been eliminated from use in these cases; it not only leads to confusion in regard to mechanisms, but also to misapprehension as to the relations with insanity.
Individuals of this type are often endowed with a facility for learning in a parrot-like way, which enables them to acquire their lessons easily and to do well scholastically in school; many are capable of passing through college. But the quality of the learning is poor and there is no really broad grasp of the relation of the material learned to the situations in life. Such men can often quote from books and persons correctly and may express in words the highest ideals which are, for them, mere platitudes and copy-book maxims.

The principal interest and aim in life is the gratification of personal desires; happiness, as opposed to pleasure, is not even thought of by these people. They are uninterested in the feelings or welfare of others and may take delight in witnessing the sufferings of people and animals. They are alert and active, usually talkative, pleasant mannered so long as things go to suit them and like to be thought much of; they are boastful and talk glibly of past accomplishments and future plans, embellishing the accounts with imaginary happenings and stories that are forgotten again as soon as uttered, so that not infrequently they get into difficulties through contradictions. These they will smooth over, often with considerable ingenuity and if necessary with fresh lies. Their bearing is strongly influenced by the company in which they find themselves and they will endeavor to outdo their companions whether in soft-spoken refinement or in gross obscenity.

Combined with the ability to live in the moment and to disregard all considerations of the past or the future so long as they secure present gratification, they usually have a more or less pleasing appearance. They are generally tall and slender with well shaped hands and feet and are well dressed, though usually in extreme fashion. They are often pleasant companions for a short time and have many acquaintances
though few friends. Their attractiveness may result in the most astounding successes in victimizing others by confidence games and tricks. In state hospitals they easily attract the good will of visitors, and even of nurses and attendants, and secure privileges which are promptly violated as soon as some opportunity for pleasure offers. Running through the whole life history are instances of trusts and their violation.

At school, they are the terror of teachers, constantly in the center of mischief, which is not always harmless, and shrewd and unscrupulous enough to shift the blame to others or to secure immunity by more or less well colored confessions. Their work is erratic, sometimes brilliant, sometimes grossly faulty owing to the fact that there is no real secondary interest or capacity for applied attention. Often they will "play hookey" and may cover up absences by fictitious or forged excuses; they may thus succeed in deceiving parents and teachers for long periods. When attempts are made to control them they readily become insubordinate and may react with gross violence and abuse, which they justify by exaggerated tales of the punishments and restrictions that have been inflicted on them.

On leaving school they show anew their instability; they do not apply themselves, are tardy and lazy, grumble and complain of long hours, exacting duties and insufficient compensation. Consequently, they change positions frequently and usually have plausible excuses to offer in explanation. Pleasure and excitement are eagerly sought and gambling, dancing and "the bright lights" generally, have an irresistible appeal. Often they show considerable skill in activities which call for dexterity, such as billiards, sleight of hand, dancing, etc. From these they may succeed in earning more money than by steady work. From them to more questionable methods of cheating, forgery and swindling
of all kinds is an easy step. From a physical standpoint they are usually cowards, though when brought to bay they may fight with frenzy. But fighting in cold blood is not within their capacity, in spite of boasting; they readily take to the use of a gun and are then extremely dangerous, cunning, shrewd and utterly devoid of consideration for others.

As will be gathered from this brief survey of the high lights of the picture, there is an essential lack of the ability to profit by experience or to make use of the information on consequences and ideals that they can often glibly recite. Their interests are intensely sensual and higher sentiments are lacking. It is for this reason that so much stress has been laid on ineducability—using this term in the broadest sense and not merely in regard to acquiring information—and antisociality.

Variations in the picture may be brought about by exaggeration of some features and subordination of others. The mood may be more irritable with consequent greater quarrelsomeness; the imaginative boasting and talkativeness may result in lying for the sake of lying; the search for pleasure and excitement may be so pronounced as to make the acts seem almost impulsive; and there may be additions of oddities and symbol-like substitutions that remind one of schizophrenia. These variations will result in the development of types that correspond with the groups described by Kraepelin, groups that are very real in actual clinical experience.

Occasionally there is a tendency to the abuse of alcohol, though this is not frequent and such persons may be total abstainers. They are usually very susceptible to its effects and readily become intoxicated. Sometimes there is observed a more or less periodic craving for alcohol resulting in a dipsomania. Drug addiction is considerably more frequent and, when adopted, leads rapidly to deterioration. The condition is more common in men than women, and in the
former is rarely accompanied by gross sexual excesses, though they are far from being continent. There seems to be a lack of this urge in concentrated and natural form and masturbation is probably more frequent than heterosexual intercourse. Women more commonly give way to sexual excesses, probably because it is an easy way of securing the means for excitement and a life of pleasure. Women of this type also are more prone to drug habituation than are the men.

It has already been insisted that the condition of psychopathic personality is not an insanity; but it should be pointed out that in it there is greater liability to the development of psychoses than in better balanced individuals. Such psychoses are sometimes grouped under a special heading of prison psychoses (Haftpsychosen). But there is as little justification for such a special group as there was for that of "war psychoses" to designate psychoses that developed during the war. They are, it is true, more common in prison for the reason that psychopathic persons tend to gravitate into prison; but they also occur in civil life. It is probably also true that the conditions of prison life may be important factors in their development.

Psychoses. From what has been said of the psychopathic personality, it is not surprising that there is a marked tendency for the psychoses that arise on this basis to have a distinctly paranoid coloring, and this may be observed in all forms of psychosis. Most of them are of acute onset and short duration, usually in direct association with problems of discipline and disappointment, though sometimes there is no discoverable cause for the outbreak other than deprivation of liberty and pleasure. The psychoses include: (1) delirium-like states with clouding of consciousness and vivid hallucinations, closely resembling the twilight states described under epilepsy; (2) outbreaks of violent excitement with
furious attacks on fellow prisoners and guards; (3) the Ganser syndrome, which is essentially hysterical and is described under the psychoneuroses. This appears to be essentially an effort at self-deception as to the horrors of the situation; the prospects are so dark that they must be unreal and the whole world is changed.

In addition to these short-lived attacks, there is also the possibility of the development of any of the forms of insanity that have already been described, especially the paranoid type of dementia praecox. The possibility of malingering must also be kept in mind; in our experience it has been more common than a definite insanity, particularly during a trial, but also inside the penitentiary. The motive for the deception in the former case is obvious; in the latter it is usually to secure some change from the monotonous routine of prison life. Frequently these prisoners have made themselves such a nuisance and have caused such repeated disorder in the prison that the authorities are only too glad to accept the excuse of insanity to get rid of the patient. This serves to emphasize the need for special provisions for their care, provisions that must take cognizance of the problems to be met and the dangers that ensue from escape or release.

**MORBID IMPULSES**

Under this heading may be included a small group of morbid states that are characterized particularly by an irresistible impulse to perform some antisocial act. The impulse tends to recur periodically, usually in the same form for the same individual. These conditions are little understood and generally receive scant consideration in textbooks on psychiatry. In many respects they resemble the hysterical and psychopathic personalities, though they also present differences. Probably the best known examples
are those classed as pyromania (impulsive incendiarism) and kleptomania (impulsive stealing). They are sufficiently rare to be justly considered psychiatric curiosities, though their striking results often make them into causes célébres. When offered as a defense for crime, the allegation of a morbid and irresistible impulse must always be regarded with suspicion and release from responsibility on such grounds under present circumstances, when no provision for proper segregation is made, can rarely be justified.

In addition to pyromania and kleptomania, there may be mentioned impulsive anonymous letter writing, senseless spending, impulsive poisoning and possibly some cases of dipsomania. In all, the impulse to perform the act seems to give the person no rest until it is carried out. While the tendency is for these impulses to recur many times and for the act to be repeated in the same form, it must not be assumed that the mere repetition of a crime implies the existence of such a morbid impulse. The essential characteristic is the absence of adequate motive. The perpetrator gains nothing financially or otherwise and satisfies no grudge; the sole reason for the act seems to be that its performance brings satisfaction and relief of tension. The deed is usually carried out without any elaborate plan to escape detection, though there may be evidence of shrewdness. The plans are made at the moment and success in avoiding discovery depends far more on the straightforward openness with which the act is perpetrated, the absence of obvious motive to connect the offender with the crime and the subsequent attitude that he adopts, than it does on careful planning.

While there can be no question that, in a formal and parrot-like way, these offenders know the difference between right and wrong as regards the particular offense, yet they experience no remorse or regret; on the contrary, they seem to
experience a genuine feeling of relief and comfort which persists until the impulse again arises. When caught, usually redhanded, they may at first deny guilt in a sullen manner, but as a rule there is little difficulty in getting them to admit the facts. The only explanation offered, as a rule, is that they felt they had to do it. There is no clouding of consciousness and all details are remembered fully. The crime is recognized by the culprit as his own act and there is no suggestion that it was the result of outside influence. This failure to plan a defense or excuse is quite striking and fits in well with the fact that most of these people are of low grade intelligence. This intellectual deficiency, however, is not as a rule of a degree that would place the offender in the feebleminded level, though it may be noted that such impulses, particularly pyromania, are occasionally observed in committable feebleminded persons.

The great majority of such offenders are women, many of them quite young. In other respects their mode of life may appear to be conventional; friends and relatives are often dumbfounded when they learn the facts. Yet it will always be found that, though criminal activities were not suspected, there has been something more or less peculiar in the behavior; this has often led to serious difficulties in the home. The background is the personality of the offender, which resembles closely that of hysteria. The culprit is intensely self-centered and has marked lability of affect; tantrums, fainting spells, or hysterical convulsions are very common, and on arrest it is not rare to observe the development of a Ganser syndrome. The family history usually contains evidences of neuropathic degeneracy: constitutional types of psychoneuroses, epilepsy, feeblemindedness and possibly frank insanity.

The impulsive outbreaks often seem to have a definite relation to change in or activity of the reproductive organs—
puberty, menstruation, pregnancy and the climacteric. It is possible that many of them are perversions of sexual excitement. Medico-legally, these views must be regarded as speculative and of little significance, though it is a fact of some importance that the impulses tend to fade out with advancing years.

From a practical standpoint, the chief feature to be grasped is that punishment seems to be entirely without effect; in spite of knowledge, even from personal experience, of the consequences that follow detection, the impulses seem to be irresistible. Even in prison, incendiarism and theft may be indulged in when occasion offers. The principal problem, therefore, is to place such persons under conditions in which opportunities for carrying out the impulse are lacking. The state hospital is not suitable for the reason that the disorder is not an insanity and these hospitals are planned to deal with a different kind of behavior.

**SEXUAL PERVERSIONS**

Anomalies of the sexual instincts and desires occasionally give rise to medico-legal problems, the principal feature of which is the question of responsibility. In considering this question, it must be realized that anomalies in this sphere may arise on the basis of insanity or feeblemindedness, may be due to inherent defects in the makeup of an otherwise normal appearing person, and may sometimes be the direct outcome of the conditions under which he is living. The decision as to responsibility will obviously depend, not on the fact of the existence of the anomaly, but on the results of the whole examination and history. It is therefore unnecessary to describe in detail the various forms of disturbance. It is usually accepted that there are considerable variations in the intensity of sexual desire in different persons. The factor of greatest importance, however, is not intensity but
the degree of control over the appetites. Such control is the outcome of mental activity and, therefore, it is to be expected that all conditions of mental defect that are not associated with diminution of desire will be liable to lead to unsocial sexual behavior. Such behavior is in fact common among the feebleminded and those who are suffering from dementia. The methods by which gratification is sought under these circumstances are not, however, real perversions, though they may be more or less brutal and lacking in modesty and shame. Masturbation, prostitution, unbridled solicitation, assaults on children, bigamy and rape are well known, not only in the mentally defective but also in senile and arteriosclerotic dementia and in other destructive brain diseases. Self control may also be removed in other forms of mental disorder such as the states of manic excitement, alcoholic intoxication, etc., with similar consequences.

Onanism, or masturbation, is not to be regarded as a perversion, but rather as evidence of poor self control and may readily become a habit. It is so common among young people about the time of puberty as to be almost universal, though the practice is soon abandoned with more mature development. It used to be taught that masturbation is an important cause of adolescent insanity. This view is now practically abandoned; onanism is regarded as evidence of insufficient self-control and, therefore, a common symptom rather than a cause of insanity and other forms of mental inadequacy.

By perversion it is implied that the satisfaction of sexual desire is fully secured only in a manner that seems unnatural, though perversions are often exaggerations only of elements that enter into natural heterosexual intercourse. We are not here concerned with the biologic or psychologic explanations of the manner in which such perversions arise. In some instances they seem to be the outcome of chance experi-
ences in early life; in others they seem to be inherent in the makeup of the individual. The true pervert usually finds no pleasure in normal sexual relations and may even be entirely impotent under such conditions. Some of them, however, lead a dual life; they may marry and raise a family while seeking perverted satisfaction elsewhere.

Among the common forms described the following may be mentioned:

**Exhibitionism.** Gratification is here sought by more or less frank exposure of the genitals to members of the opposite sex. Often this tendency seems to be episodic and impulsive, and in this respect comparable to some of the acts described in the last section. Exhibitionists are almost always men, usually possessed of average or even superior intelligence. As a special variety may be mentioned the persons who find pleasure in telling doubtful stories and using words with double meaning before members of the opposite sex, which is often spoken of as psychic exhibitionism. Others will write scurrilous letters which they may or may not mail anonymously to unknown persons of the opposite sex.

**Fetichism.** By this is understood the gratification of sexual appetite by handling or fondling articles of clothing, parts of the body, or special belongings of members of the opposite sex. The articles employed for the purpose are extremely varied and may be more or less obviously related to the generative functions. Many cases of hair-clipping and the fortunately rare jack-the-ripper murders belong in this category. The fetich worship may or may not be accompanied by onanism.

**Sadism and Masochism.** In the former, sexual gratification is secured or enhanced by torturing or ill-treating the sexual partner. In the latter the pervert, on the contrary, desires to be beaten or ill-treated. The measures adopted may be merely indicated by more or less harmless maneuvers,
but occasionally the sadist will actually commit murder. These two features are sometimes combined in the same individual.

**Homosexuality.** In this condition there is a morbid desire for relations with members of the same sex in either the active or the passive rôle. Perversions of this type may be observed in persons of either sex and the morbid nature of the desires is usually obvious; they rarely lead to medicolegal complications. It must also be realized that homosexual practices may result from absence of opportunity for heterosexual relations as in prison or on long voyages.

**Other Forms.** A group of perversions that are often the result of circumstances and opportunities, though they may also be due to inherent defect, are the conditions of sodomy, pederasty, bestiality, necrophilia.

**Comments.** When the perversions appear to be inherent to the makeup of the individual, there will rarely be lacking other evidences of psychopathy in the life history of the individual and of neuropathic degeneracy in the ancestry. True perverts are usually at least of average intelligence and are sometimes brilliant. They tend, however, to be unstable, superficial, unsteady in application and to be attracted especially by activities that are emotional and sensual. Some have high artistic talents, such as music, writing, painting or acting. They perceive acutely, even if superficially, and are able to portray faithfully what they perceive; often there is no deep appreciation of the meaning of what is portrayed, the interest being purely sensual. Drug and alcoholic addiction are quite frequent among perverts; possibly a larger proportion tend to suffer from episodic oscillations of mood, usually depressions, than is the case with more average persons.

Sufficient stress has already been laid on the need for the careful study of persons accused of such practices to
determine whether there is not some underlying mental defect or insanity. When such is not present, the problem resolves itself practically into the question of protecting society from the consequences of the anomalous behavior. Under present conditions, this would seem to be best secured by holding the pervert responsible, even though the prospects of securing a cure by punishment are nil. That perverts know their acts are wrong and subject to penalty there can be no question; the only possible difference of opinion is in the question whether they are able to control their conduct in accordance with that knowledge.

MENTAL DEFICIENCY (FEEBLEMINDEDNESS)

Definition. By mental deficiency is meant failure in the development of mental capacity; it is, therefore, a condition that appears before development has been completed and in this lies one chief distinction from insanity. Brain development is not completed until several years after birth; it is hardly capable of functioning at the time of birth. Hence, mental deficiency may be the result of a primary defect in the cells of which the brain is constructed—defects that are handed down from the parents—or from damage by disease or injury to the growing tissues at any time before full development. This means that the state of mental deficiency is present at birth or appears during the earlier years of life and is permanent.

At first glance it might seem that the effects should be much the same as those that result from destruction of brain tissue after full development, which we have already described as dementia. But the destruction of cells that have reached full growth and have functioned will always leave traces of the fact that methods of reaction of higher type had been in operation; these will be evident in the activity of the parts that have not been destroyed by the condition that
causes the dementia. It is common in this country to speak of mental deficiency as amentia\(^1\) (absence of mind) to distinguish it from dementia (loss of mind). Yet it must be realized that the distinction is not absolute for the reason that if the damage occurs after some development has taken place, there will be a combination of dementia, or loss of what had developed, with the amentia from prevention of the growth of what has not yet developed. A pure amentia can only result when the damage is so early that brain function has not appeared at all. For practical purposes, however, the definition of mental deficiency or feeblemindedness includes all intellectual defects present at birth or appearing within the first two or three years of life (according to some before puberty).

**Intelligence Tests.** Modern psychiatry has adopted certain standards of measurement for designating the degree of mental deficiency, the significance of which must be clearly grasped if serious misunderstandings are to be avoided. A priori, it might be expected that when arrest of development occurs at a certain stage, the mentality of the person would more or less closely correspond with that of an immature person of the age at which the arrest occurred. But this is not correct for many reasons. The conditions that cause the arrest in development of the brain are not operative in a uniform manner; they involve some parts of the brain to a greater degree than others. What actually happens, therefore, is an irregular development which cannot correspond with any normal stage in evolution. Instincts and desires, such as those of sex, that do not depend, except for their control, on the functioning of the brain appear with maturity of the body even in feebleminded persons. These introduce motives and tendencies to action that belong to the adult and

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\(^1\) Some authors, especially in continental Europe, use the term amentia more in the sense of delirium.
not to the child. It is, therefore, entirely improper to com-
pare the defective mind of an adult whose body has developed
to more or less maturity with that of a normal child who as yet
lacks these incentives to action. Furthermore, a develop-
ing brain presents always evidences of the fact of growth;
there is a plasticity which is absent from the brain whose
growth has been arrested. It is, therefore, unfortunate that
the units of measurement adopted have been expressed as
years.

The manner in which this has come about is as follows:
All children do not develop with the same rapidity nor to the
same degree of perfection. In studying the development of
normal children, psychologists devised tests which, by appli-
cation to large numbers of children, have gradually been
sorted out and standardized so that a certain set of tests will
be correctly answered by the average child of a given age.
Younger children will fail while older ones can do more
difficult tests. This applies, of course, to the average of a
large number of children and not to any particular child.
The level is not absolute and there are many individual
variations. But, since the tests do correspond with an aver-
age development at a certain age, these tests have come
to be known by the year of age with which they correspond; a
particular child examined with a certain set of tests is said to
have the mental age of the highest test year that he can pass.
If the tests have been successfully graded and appropriately
prepared, about 75 per cent. of children will have a mental
age that agrees with their actual or chronologic age. Of the
remaining 25 per cent., some will grade above and the others
below this average. For comparing one child with another,
these tests serve as a sort of yard stick or measuring rod that
enables one to express in concrete form the relative develop-
ment with regard to the particular functions that are inves-
tigated by the tests used. In practice the tests most
commonly used in this country are those of the Binet-Simon series as modified by Terman of Stanford University, commonly spoken of as the Stanford-Binet tests. They work very satisfactorily with children of school age.

Since the establishment of standards for normal school children, these same tests have been applied to the measurement of intelligence in defective children and also in adults. But it must be distinctly understood that such tests measure only certain particular features and are not in any sense a measure of the capacity of the individual to adjust himself to conditions of life. When it is stated, for example, that the mental age is 10 years, it means only that, with the tests used, the man has succeeded in passing satisfactorily tests that are passed by the average child of 10; it does not mean that he has the mind of a child of 10. There are many other factors that enter into the question of mind and influence accomplishment with the tests, especially with adults, which must materially modify the significance that is to be attached to them. Intelligence, often assumed to be the chief feature measured by the tests, is highly important for successful adaptation to the conditions of life; but the kind of use that is made of the intelligence is of at least equal importance, and this depends on such factors as energy, interest, instincts and training.

A less ambiguous method of speaking of the results of such tests is by stating the intelligence quotient. This is the ratio between the mental and the chronologic age and is secured by dividing the former by the latter and usually multiplying by 100. Thus an average child of 10 would have a mental age of 10 and the intelligence quotient would be $\frac{10}{10} \times 100$ or 100. If the child, however, had a mental age of 8, the quotient would be $\frac{8}{10} \times 100$ or 80. In dealing with adults, it is obvious that the chronologic age cannot be used for this purpose and since it is asserted that, on the average, performance with the tests reaches its maximum at
about the age of 16, it is customary to use 16 (some testers use 15 or 14) as the divisor in obtaining the intelligence quotient of adults. Thus a man of 30 who scores a mental age of 10 would have an intelligence quotient of $\frac{10}{16} \times 100$ or 62.5.

**Objections to the Tests.** Many objections have been raised to the method which are not really valid, though at first glance they may appear so. All children do not have the same opportunities to acquire knowledge that is asked for in the tests. But the tests have been applied to so many thousands of children that unquestionably there have been included all kinds and degrees of opportunity. Such tests as failed to give fairly uniform results have been gradually eliminated and the process of standardization is still going on. Obviously, it is important that the tests be given in exactly the same manner in every case; even slight variations in the method of application or in the grading that is applied to the results will seriously modify the conclusions. But, if applied in standard manner, there are many tests that give strikingly constant and comparable results. The objections to the use of the tests with adults are more valid, as the standardization is not so good. Gradually these difficulties are being overcome and many laboratories are working on methods and tests which will eventually result in securing standards that are applicable with the same degree of accuracy and the same limitations as with children. For the present, however, it seems permissible to use with adults the standards for children, provided one takes into account the strict limitations of their meaning.

**Causes.** It has already been suggested that mental deficiency may come about as the result of defect in the germ cells from which the individual grows (inherited), or from damage received during the process of development (acquired). Medically, these factors are of great importance for treatment
and prevention. But medicolegally, the kind of disease or defect is comparatively unimportant; the principal question is the degree of damage and the consequences that ensue as regards the behavior and responsibility of the person so affected. We shall therefore not concern ourselves with special diseases and types, though we must recognize that the state of health of the parents at the time of conception, and during pregnancy and lactation, are important factors as causes of mental defect in the offspring. Certain types of deficiency also are directly transmitted from parent to child, these being particularly those types that are not associated with obvious disease. They are malformations rather than deformations and are liable to affect all the offspring. Acquired disease may, however, result in mental defect in one child and have no influence on the development of others in the same family. In considering such questions in a medicolegal case, it is not sufficient to show that parents or relatives are feebleminded or defective. The facts must be established for the person in question; heredity only offers an explanation for the fact and does not establish it.

Damage due to trauma at the time of, or soon after, birth is often alleged as a cause for mental deficiency. The situation is identical with that discussed in regard to the traumatic origin of insanity. Careful attention must be paid to the history of the child before the injury, and also to the evidences of brain damage at the time of the injury.

Classification. It is customary to divide the degrees of mental defect into four classes, which have become more precise since the adoption of intelligence tests as a means of definition. These classes are: (1) Idiots, with intelligence quotients between 0 and 25 (mental ages below 2); (2) imbeciles, with intelligence quotients between 25 and 50 (mental
ages between 2 and 7); (3) morons\(^1\) with intelligence quotients between 50 and 75 (mental ages between 7 and 12); (4) backward persons, with intelligence quotients between 75 and 90.

The term feebleminded is generally used in this country to designate mental deficiency of the grades (1) to (3) inclusive. In England, and by some authors here, it is used more specifically to apply to the higher grades here designated as morons. In this country, therefore, feebleminded usually indicates mental deficiency of such degree as to render commitment to a special institution permissible.

In order to indicate the limitations that must be placed on the mental ages obtained by special tests with adults, it should be stated that the average mental age of men drafted for the army was about 12. This indicates clearly that the tests are not average for the adults of the community, for it gives an intelligence quotient of 81.25 instead of the theoretical 100. It shows also that a mental age of 12 does not mean the possession of the mind of a child of 12. There is also ample evidence to show that many persons with a mental age as low as 10 may be quite capable of successful self support provided the demands made on them are not too great and they have qualities that insure the efficient use of the intelligence they do possess.

**Responsibility.** When we turn to the question of the responsibilities and capabilities of the mentally deficient, it is obvious that we cannot be guided by mental age or intelligence quotient alone, even though we recognize that these

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\(^1\) The term moron means "a foolish one." It has no justifiable connection with sexual crimes, a connotation which has unfortunately become popularized as a result of its application in this sense by newspaper reporters and others. Sexual perverts may sometimes be morons in the strict sense, but as a rule they are not; many indeed have a high intelligence quotient. The moron, on the other hand, is often a very useful member of society, even though not capable of highly intellectual vocations. It has even been asserted that the work of the world is done by morons.
facts, if properly secured, have considerable weight. That a man with low grade intelligence cannot be expected to react to and comprehend the nature and meaning of his acts in the same degree as one with higher capacity is evident, and brings with it the further consideration that his incapacity is permanent. It follows that, since society cannot establish varying standards of responsibility in accordance with varying degrees of intelligence, the community must, for its own protection, deprive those incapable of full responsibility of freedom of action, either by guardianship or segregation.

The lower grades of mental deficiency, including the idiot and the imbecile, are so incapable of self-support and independence of action that the question of responsibility will rarely arise. Such persons are truly extrasocial and would speedily succumb if some protection were not provided. Under the most favorable circumstances, high grade imbeciles can perform certain routine, manual tasks and may thus be useful; in institutions they do much of the work that requires little thinking. The liability to delinquencies is very small and it may almost be said that such tendencies do not appear much below the mental age of 9. With mental defect of the lower grades, there is generally combined some degree of bodily defect and the probability of procreation is small. Most cases in these grades are the result of disease rather than malformations in the sense in which this term was used before.

But as the scale of mental development is ascended, there begin to appear problems of increasing complexity. Many such persons are well formed in body and reach full maturity as regards the possibilities for reproduction; often they are very fertile. But the lack of judgment results in many difficulties. They easily acquire habits, as do even the lower animals, and these may be good or bad according to the nature of the environment and training. They are not cap-
able of appreciating the handicaps from which they suffer and are often strikingly self-satisfied and easily pleased. Unscrupulous persons readily take advantage of these traits and flatter them and lead them into violations of social rules; many become prostitutes, spreaders of venereal disease, and the tools of criminals and fakers. They also make convenient scapegoats on which to fasten blame so that the real leaders, possessing greater shrewdness, may escape.

Such persons cannot be accorded a full measure of responsibility for their acts, but the physician must be prepared to substantiate his diagnosis with something more than intelligence tests and family history. This means a careful investigation of the life history and the manner of reacting to situations manifested during his progress through the world. If this is not available, as sometimes happens, the task is more difficult, especially in face of popular indignation over some atrocious crime. Reliance must then be placed on observation of the manner in which the suspect meets the daily situations under which he is placed at the time and others devised for the specific purpose of seeing what he will do. It must also be realized that relief from responsibility by such demonstration should not mean freedom to go out and commit the same offense; it should mean permanent segregation as the condition is a defect and is as permanent as an amputated limb.

Sometimes, mental deficiency is combined with tendencies to reactions that belong to the type we have described as psychopathic personality. Such cases, necessarily, are far more dangerous and difficult to control. They are often spoken of as defective delinquents and need provisions for their segregation separate from the simple mental defectives. But these two conditions are not at all the same any more than dementia and a psychosis are identical.
**Psychoses.** Psychoses may develop in mental defectives, usually of the nature of emotional upsets and delirious episodes. Defective mentality does not lend itself to the development of dementia praecox reactions, which seem to require a fairly high degree of social appreciation. Epilepsy and various paralyses and deformities are common. Mental defectives are also liable to develop psychoneuroses, particularly of the hysterical and anxiety types. They have inherent handicaps that render the struggle for existence difficult even when conditions are favorable and thus the occasions for psychoneurotic reactions are quite liable to appear.

In estimating the degree of deficiency, the possibility of extreme inequality in the distribution of the defect must be borne in mind. This possibility is emphasized by the occasional occurrence of the so-called “idiots savants” who may possess astonishing ability for retaining facts in memory and even performing calculations, without, however, the capacity to grasp and understand quite simple reasoning and judgments. Of somewhat similar kind is the ability to learn in parrot-like fashion platitudes and rules of conduct and to reproduce them on request without understanding what they mean. This may lead, at times, to an erroneous conception of the lack of intelligence that, as a fact, exists.

**THE PSYCHONEUROSES**

**Definition and Relation to Insanity.** The psychoneuroses are mental disorders that present problems in some respects similar to those of the insanities, from which, however, they are separate and distinct. Yet the line of demarcation is not easily drawn and it is difficult to express precisely the features that distinguish them. Some psychiatrists, indeed, seem almost to consider that a psychoneurosis may be only a milder degree of the same kind of disturbance as and may pass
over into insanity. This depends on the fact that psychoneurotic symptoms are often observed in the earlier stages of the development of an insanity. But even then, evidences of the insanity can usually be discovered if they are carefully sought and correctly interpreted. In other words, it seems probable that there are inherent differences between the two types of disorder. The principal mental feature of this difference resides in the patient's attitude toward the real facts of the world. In insanity there is always some loss of orientation to reality, some evidence that the person has actual falsifications of the facts in his thoughts or feelings, which are dependent on changes in himself; they are not merely faulty reactions to facts that have been correctly grasped.

The psychoneurotic, on the other hand, sees the facts as they are, but adopts a faulty way of meeting them. Because of this, he often gives the observer an impression of wilful misrepresentation or intentional disability; it frequently appears as if he could do better if he would; there is no real falsification in orientation. Indeed, the distinction from malingering is often by no means easy. In the main, no attempt was made to differentiate between malingering and psychoneurosis in the army during the war. The crux of the distinction is the question of awareness of the meaning of his behavior by the patient himself. Malingering would mean that the man knows what he is doing and why. The psychoneurotic is generally supposed to adopt his reaction without such awareness. Yet there are some points that make this difficult to appreciate. In speaking of hysterical symptoms, Hughlings Jackson maintained that they were always such as could be produced voluntarily. The definition of hysteria by Babinski characterizes hysterical symptoms as produced by suggestion and cured by persuasion. The striking and instantaneous results that may be
obtained by suggestive treatment certainly seem to point in this direction. The differentiation from malingering will be discussed further in the chapter on the latter condition.

While it is permissible to say that insanity is a definite change in the person, a disease of some kind, it seems to be true that at least some forms of psychoneuroses may develop in any person. In spite of the careful process of eliminating the weakly and unfit that took place in the army between enlistment and reaching the front, large numbers of men in the highly selected group that reached the actual fighting line broke down under the strain, not with a disease, but with a psychoneurosis. While, therefore, it is necessary to realize that some persons adopt such ways of meeting difficulties more readily than others, yet most persons may do so, provided only the strain be sufficiently great.

In this last statement, there is an indication of the most commonly accepted view of the nature and meaning of a psychoneurosis. It is a way of reacting to a difficult situation. Difficulty in this connection means strong feeling, especially the feelings concerned with the fundamental instincts of self and race preservation, the most important of which is fear. This concept has been well expressed in the statement that a psychoneurosis is an attempt (whether consciously or not may be questioned) to get out of an intolerable situation. It means that the person, more or less clearly, refuses to face the facts and takes refuge in a subterfuge of some kind that either ignores the truth or removes him from participating in the situation. This is not a question of falsification of reality, but an effort to ignore or evade it.

While this seems to be the underlying mechanism in all forms of psychoneuroses, there are many varieties of subterfuge that may be adopted, and this permits classification into different types. There are also differences that seem to have a definite relation to the personality make-up.
It would take altogether too long to attempt a detailed explanation of the various manifestations and we shall content ourselves with formal mention of the characteristics of the different types in brief outline with sufficient detail for medicolegal purposes.

One field of forensic work into which the psychoneuroses enter largely is that of personal injury, and it is often a matter of considerable difficulty to determine the degree and to forecast the duration of the incapacity and its relation to an injury. It is necessary to insist that the only method of reaching a decision is detailed study of the individual case and the establishment of a diagnosis by exactly the same methods as would be employed for purposes of treatment. In general, it may be said that hysteria and psychasthenia are largely personality defects and are not caused by injuries. Yet the outbreak of symptoms may be precipitated by injury, especially if accompanied by emotional stress. The symptoms of hysteria are easily removable and always serve a purpose— they cannot be regarded as grounds for heavy compensation. Psychasthenic symptoms are usually chronic and are rarely related to a specific injury. But the situation is different in neurasthenia and will be discussed after describing the symptoms.

For practical purposes the psychoneuroses may be grouped into three types: (1) hysteria; (2) psychasthenia; and (3) neurasthenia.

**HYSTERIA**

The Hysterical Personality. The hysterical mode of reaction arises in persons with more or less well marked constitutional deficiency. The more marked the defect, the earlier and more readily will symptoms occur; in other words, the less severe need be the difficulties that must be faced in order to bring about the hysterical symptoms. When the constitutional defect is marked, the ordinary simple difficulties
of every-day life may be sufficient to precipitate them. As a corollary, heredity of neuropathic kind plays an important part in the genesis of the disorder. Since the difficulties of adjustment are enormously enhanced by the advent of puberty and emancipation from parental control, it is readily intelligible that hysteria is liable to occur about this period of life. It should be understood that the term deficiency used here, does not mean intellectual defect or feeblemindedness. Hysterical persons may have good intelligence, though they may also be definitely low grade in this respect.

The features that especially characterize the hysterical personality are: self love, lability of affect and suggestibility. Self love is indicated by the desire to be always in the forefront and to dominate every situation. The hysterical person wants to be in the center of the stage; he is not happy unless he is receiving homage and attention from his entourage. To secure this he may adopt various devices, usually without consideration of the possible consequences of more remote kind (evidence of judgment defect); extremes of dress, striking colors or contrasts, risqué behavior, tantrums, scenes, sickness and even self-mutilation.

By lability of affect is meant an easy transition from one mood to another, each tending to be extreme in degree; the hysterical flies into a tantrum on the slightest cause and may suddenly, when this secures, or fails to secure, the desired results, or something more attractive offers, become joyous, smiling or pleading. Such transitions are in keeping with the desire for homage and attention, and it is usual to find that the hysterical member of a family is allowed his own way in order to avoid scenes and explosions. Naturally such submission tends still further to increase the allure of reactions of this kind.

Suggestibility is the tendency to subordinate personal judgment to the influence of the surroundings, regardless of
the real value of the influence. In accepting suggestions, the principal factor is that what is suggested appeals to the desires or feelings of the recipient at the moment. Dominated by self love, the hysterict is ready to seize anything that ministers to that love, whether it serves to avoid something painful or to enhance the attention and interest of others in himself. In either case the suggestion is accepted only so long as it serves its purpose and, since it has not been subjected to criticism and is therefore not a personal judgment, it will be discarded as soon as it ceases to serve the purpose or becomes for any reason unpleasant.

The active symptoms of hysteria are all of this nature. They are reactions which have been suggested by some more or less chance experience and which serve one of the purposes mentioned. For the same reason, the symptoms are easily removed by other suggestions that offer greater momentary advantages, or by measures that render them ineffective or positively unpleasant. Removal of symptoms, however, does not cure the underlying defect. The more or less accidental nature of the suggestions necessarily implies almost infinite variety in the symptoms and we shall give but a sketchy outline of them.

Hysterical Symptoms. First it may be said that the symptoms are most often of bodily character—some more or less obvious manifestation that simulates the effects of structural disease—though certain types that appear to be more definitely psychic will need special consideration. Secondly, one of the most striking and diagnostic features is the lack of concern displayed by the patient for the symptoms themselves. He seems to ignore or accept them with equanimity, almost as if he fully realized that they are not real disease. This is true even when the symptoms entail considerable discomfort or even pain, and is entirely in keeping with the conception that they have been adopted, whether consciously
or not, as a means to an end; they help in some way and are therefore friends rather than enemies. Thirdly, the development of the symptoms is more or less obviously contemporaneous with, and the result of, some emotional upset. They may be grouped under three heads: sensory, motor and psychic.

*Sensory Symptoms.*—These are rarely, if ever, entirely lacking in a developed hysterical attack and for that reason are often spoken of as stigmata. For the most part they consist of loss of sensitiveness (anesthesia) and are symbolic of the desire to ignore or forget which is so characteristic of the hysteric. The anesthesia may involve any of the senses; it may be partial or complete and the distribution is variable. In its manifestations there are often striking inconsistencies and it is common to observe incidental activities that necessitate the use of the sense that is apparently lost. The blind hysteric may seem to go out of his way to run into objects and will avoid obstacles that threaten danger. A woman with apparently complete loss of the sense of touch in the fingers knitted easily without unusual use of her eyes. Loss of skin sensibility is often limited to one side of the body and ends abruptly at the midline of the body; this is unknown in organic disease. Also the loss of sensation is usually more complete than is common in brain diseases. Often it is possible to trick the patient into reactions that prove sense perception is actually present. Thus the request, with eyes closed, to say, “yes” when touched and “no” when not touched will often elicit the latter response to touches on the anesthetic area. Such errors are liable to be corrected as soon as the patient grasps the significance and absurdity of the replies. Loss of pain sensibility is sometimes so complete that the patient can be used for a veritable pincushion without eliciting objections, though special investigation of the pupils, pulse and respiration may indicate that perception of pain

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really occurs, though this may not be discernible with rough examination. It is probable that the anesthesias are often unwittingly suggested by the medical examination and they can certainly be provoked by intentional suggestion.

In addition to loss of sensation, there may also be increased or disturbed sensibility (hyperesthesia and paresthesia) of various senses. Pressure over certain areas (so-called hysterogenic zones), below the breasts, in the groins and elsewhere, may precipitate hysterical seizures or convulsions. Complaints of unpleasant odors or tastes, disturbances in vision, ringing or noises in the ears, dizziness and even pain sometimes occur. Even when such complaints are made, there is usually a striking absence of evidence of real concern; on the contrary, they often appear to be appreciated and almost enjoyed.

Motor Symptoms.—These are manifold and may roughly simulate most of the consequences of organic nervous diseases, though here again one meets glaring inconsistencies that usually render detection easy. Paralyses, spasms, tremors, chorea-like and athetoid movements, and convulsions may all occur and the distribution and combinations are extremely variable. Hemiplegias, paraplegias, monoplegias, generalized rigidity, spasm in small or large groups of muscles, may all be observed. The muscles that are not subject to voluntary control, such as the pupils, the heart and the intestinal muscles, are usually not involved; incontinence of the bowels or bladder is very rare. Very exceptionally, pupillary and cardiac changes have been recorded; they always arouse suspicion that something more than hysteria is present, though it must not be forgotten that some normal persons can voluntarily dilate their pupils and modify the action of their hearts.

The inconsistencies in the paralyses are well illustrated by such observations as: a patient with complete limp and
flail-like paralysis of the right arm and leg when lying down was nevertheless able to walk with a crutch; in walking she held the paralyzed leg drawn up sufficiently for the toes to clear the floor and used the crutch under the paralyzed right arm. Often when a person with hysterical paralysis is urged to bend a joint, careful observation will reveal a contraction in the muscles that oppose the bending, though these same muscles are paralyzed for efforts to straighten the joint. The tendon jerks are generally not altered though they may be brisk and occasionally a spurious clonus can be obtained at the ankle. The skin reflexes, as a rule, are not altered and there is never an extensor (Babinski) type of plantar reflex. But it is common to find the pharyngeal and corneal reflexes diminished or even absent.

The convulsions of hysteria differ in many particulars from those of epilepsy, the chief points being: no real loss of consciousness; absence of tongue biting or injury in falling; a large degree of dramatic effect and irregularity in sequence; duration often prolonged; cry, if present, usually articulate; almost invariable absence of incontinence of urine and feces.

*Psychic Symptoms.*—Under this head may be grouped a number of manifestations that seem to approximate more to the type of symptoms observed in insanity; the differentiation may not always be simple. Yet we feel justified in asserting that there is no condition for which the term hysterical insanity is warranted. Hysterical symptoms may be observed in insanity, just as they may in organic nervous diseases (disseminated sclerosis, locomotor ataxy, etc.), but this does not make the insanity or the nervous disease hysteria. The mechanism of the hysterical symptoms remains the same, and in spite of appearances there is no real disorientation. Some of these conditions are of special medicolegal importance and we shall confine our remarks to them.
Delirium: In states of severe emotion there may occur apparent clouding of consciousness with seeming hallucinations that result in a picture strongly resembling the deliria of toxi-infectious nature. There may even be a slight rise in body temperature. Possibly these are true intoxications arising from the chemical changes that accompany emotion. More commonly the state is not a true delirium, but an ecstatic dreaming, usually of short duration and capable of abrupt termination by circumstances that render its continuation unpleasant.

Fugues or Ambulatory Automatism: Under this title are included the somewhat rare, but dramatic, episodes in which a man leaves home suddenly without warning and disappears. After a period varying from a few hours to months or even years, he comes to himself more or less abruptly with complete loss of memory (amnesia) for what has happened during his absence. In the "absence" he may appear dazed or confused and do nothing but wander aimlessly. On the other hand, he may lead an apparently normal life—adopt a new name, earn his living, travel and mix with people, without arousing a suspicion that anything is wrong. He may be quite different in his habits, usually in the direction of being less conventional and less moral; he may drink to excess, gamble and commit other delinquencies.

In every instance, when the facts can be elicited, it will be found that the fugue (running away) is a means for escaping some intolerable situation—monotony, responsibility, danger, conventionality, etc. Such episodes are relatively frequent among men in the army, especially during war, and many a man has been executed for desertion under such circumstances.

1 These states are sometimes alluded to popularly as "aphasia," with which, however, they have nothing to do. This term is probably used in place of "amnesia" which is partly correct.
Closely resembling the fugues are the so-called dual personalities of which Dr. Jekyll and Mr. Hyde is an excellent though highly dramatized example. The memories are not really lost but are ignored; the man can usually be led to recall them by proper persuasion and suggestion, especially under hypnosis.

States of Stupor: Closely allied to the last group are the not rare examples of going to sleep in order to escape unpleasant situations instead of running away. Such periods of apparent sleep may last for weeks. The patient may show no evidence of perceiving pinpricks or other painful stimuli. Practically always, it can be learned that he gets up surreptitiously to seek food and attend to the calls of nature, though he may succeed in deceiving friends and unobservant physicians into believing that these functions are not performed at all, perhaps for weeks. Such conditions were not rare in the trenches during the war, and it is related that three men who had been apparently unconscious for several hours, suddenly recovered and ran away when shells began falling around the ambulance in which they were being transported to hospital. Such attacks may not only serve to escape unpleasant situations, but also to attract attention and notoriety or to pay off scores.

The Ganser Syndrome: This extraordinary group of symptoms derives its name from that of the physician who described it. It has been designated as an especially characteristic example of the so-called "prison psychoses." It is probably more common under the conditions that obtain in prison, especially during trial, but it also occurs in civil life and in the army. It may pass over into a state of stupor such as that just described. Finding the conditions under which he is placed utterly horrible and unbearable, the man adopts an attitude in which he distorts and denies the everyday facts of the world, as if trying to assert that the whole
thing is unreal. He appears indifferent and careless, and his answers to questions are obviously and palpably absurd. Usually they are responsive in the sense that they relate to the subject of the question asked and thus indicate that it has been more or less grasped. He may say that there are fifteen days in the week, a horse has six legs, the place in which he is confined (the jail) is a hotel and the town is named with that of some other place.

The appearance presented resembles closely that described in dementia praecox as vorbeireden. The differentiation depends on the recognition of other signs of dementia praecox and the observation that the answers in vorbeireden are essentially careless and indifferent. In the Ganser syndrome, attempts are usually made to carry out logically and more or less to justify the absurd answers; the man is painting a picture and is guided by a purpose which is that of falsifying the facts, he is not simply careless. Like other examples of "prison psychoses," the Ganser syndrome is a reaction to the momentary situation and is not a true disorientation; it is usually possible to find evidences of real grasp of facts and of inconsistencies in attitude.

Pseudocyesis, Vomiting and Self-Mutilation: The tendency to make believe or pretend and even to deceive himself (possibly successfully, at least for a time) may lead the hysteric to stage various dramas that are often wish fulfills. Among them may be mentioned the simulation of pregnancy (cyesis) which may be carried out with all details up to and including a spurious labor. Connected with this, and also without it, vomiting with or without relation to meals is not uncommon. Sometimes this is an expression of disgust with the situation or merely designed to create sympathy. Closely related are the examples of self-mutilation in which wounds, accidentally acquired or intentionally produced, are kept open with pins, caustics, etc., so cunningly that
detection may be difficult. The possibility of this origin for inexplicable sores and wounds must be kept in mind, especially in girls of hysterical personality.

PSYCHASTHENIA

**Personality.** Psychasthenia, like hysteria, is fundamentally constitutional, but comes less frequently into medico-legal consideration. The type of personality is characterized especially by doubt and indecision. There is a large element of self-deprecation and the predominant moods are worry and anxiety. Such persons dislike change, which means making new adjustments, and they readily adopt routine habits that are meticulously followed. They are diffident with others and hesitate to express themselves openly and frankly. They prefer symbols to reality and many of the symptoms are symbolic expressions of desires that cannot be frankly avowed. Yet when pushed into action they may be harsh and severe, especially with those who are more or less dependent on them.

**Symptoms.** Unlike hysteria, the symptoms of psychasthenia are extremely unpleasant to the patient and are the cause of much complaint and distress; but they are maintained because they, symbolically, gratify some desire that is considered reprehensible and improper. In many respects they are exaggerations of social restrictions or tabus, and this suggests that the psychasthenic is of comparatively high grade intelligence, a suggestion that is borne out by actual studies. He lacks particularly in energy and self-assertion and thus resembles more closely the schizophrenic personality; indeed, the distinction is by no means always easy. But the psychasthenic realizes the absurdity of his worries and fears, and retains orientation to reality. He does not give himself up to an autistic gratification, but
worries and blames himself for his symbolic pleasures much as if he realized their real significance.

Because of the weakness and lack of energy, psychasthenia leads but rarely to legal consideration and then chiefly to questions as to sanity and need of guardianship. Occasionally this state may be alleged to be the result of an injury, but the history, if it can be secured, will show that the trend of doubt has always been present to a greater or less degree, though it may be intensified by the shock of an accident, or the accident may offer an acceptable excuse for giving way to his doubts and fears.

Briefly stated, the symptoms are almost entirely mental and of the nature of obsessions or ruminations. These may take the form of continually recurring thoughts, abhorrent and unpleasant to the patient: thoughts of self-depreciation, bodily defects, mental defects, crimes, sacrilege—which, seem unescapable. Or they may be terrible fears (phobias), spontaneous or arising only under certain conditions: closed spaces, open spaces, high places, crowds, solitude, lightning, street cars, and sometimes more general: personal uncleanliness, disease, dirt, blushing, growing fat. These fears may dominate the life and activities to such an extent that the patient is unable to earn a living. A third type of obsession involves tendencies to perform certain acts and may at times seem to involve serious danger; these acts the patient feels he is compelled to perform against his will and inclinations. The impulses may be harmless and absurd: step on every crack in the pavement, do everything over so many times or in certain ways; but they may also concern the commission of a crime: murder, theft, suicide. But though the man may make a pretense at carrying out these more serious acts, he never does, except occasionally by accident. Janet records the case of a wealthy man who experienced the impulse to steal the table silver when he
went out to dinner; he therefore always took a valet with
him whose duty it was to restore the articles his master had
put in his pocket. If this man went out alone, he never
put things in his pockets though the impulse to do so was
present. Such impulses therefore differ essentially from the
acts of the so-called kleptomaniac.

Psychasthenia thus presents many features that strongly
resemble symptoms observed in insanity and sometimes the
thoughts that obsess the patient may seem to be like hallu-
cinations. Yet the element of disorientation is lacking; the
patient realizes that his obsessions are subjective and are not
real, and they do not develop into insanity. This does not
mean that psychasthenic symptoms may not be observed in
the insanities (dementia praecox, general paralysis, etc.), but
there will always be evidences of the psychosis if they are
carefully sought and correctly interpreted. The incapacity
produced by psychasthenia may be so extreme that public
care becomes necessary and, for this reason, not a few such
cases go voluntarily or are committed to hospitals for the care
of the insane. They find there an absence of responsibility
and a systematic routine which are often a relief and may,
at times, be the best solution of the problem. Such patients
must, however, be regarded as responsible and their judg-
ment is essentially sound.

NEURASTHENIA

Definition. Under this title are included a large group of
cases, often strikingly dissimilar in outward appearance,
that may develop in various ways. First, it seems essential
to make a distinction between true exhaustion and a psy-
choneurosis. This is not always easy as the mechanisms
involved are, in certain respects, similar. In using the
phrase exhaustion it is intended to imply that there is an
actual using up of the materials that serve as a source of energy. This may come about as the result of an infectious disease, loss of blood, starvation and intoxications of various kinds. It may also result from intense emotion, especially if prolonged, from protracted worry, and from overwork. This last factor always implies situations involving strong feeling. Such actual exhaustion, however, is distinctly temporary and will disappear with removal of the cause and the provision of adequate rest and food. Many cases of this kind occurred, as might be expected, during the recent war as the result of the excitement, hardships and lack of food and sleep. They were frequently grouped for purposes of classification with the psychoneuroses, but a very large proportion recovered in a few days with rest and food.

The state of exhaustion may serve as a starting point for a psychoneurosis, the feelings of fatigue and disability being continued as a means of escaping return to the conditions of conflict and responsibility that led to the breakdown. In spite of rest and opportunity for recuperation, the symptoms do not disappear. There is no doubt that persons of poor constitution break down in this way more easily than others who are more robust, so that it is to be expected that inheritance will play some part in the etiology. Yet it seems probable that every one has a breaking point and will succumb if only the strain be sufficiently great.

The essential feature of the neurasthenic psychoneurosis is that it is a way out of difficulties and is not founded on the presence of a definite disease. The principal factor in its causation is emotional stress, which is only another way of saying that the man finds himself in difficulties. These may be conditions that another man finds relatively simple—the responsibilities of his position, the struggle for subsistence, unhappiness in the home, failure to achieve some hoped for success, worries over erring children, etc.


**Relation to Injury.** Often, and this is especially true in connection with medicolegal work, the onset seems to be related to a sudden shock or severe emotional stress of temporary character—the occurrence of an accident with or without actual injury. Even then, careful study will usually reveal that there has been either: (a) Some prolonged stress or worry that has been hitherto more or less successfully concealed and refused recognition. The shock of the sudden happening then offers itself as a justifiable and permissible excuse for giving way and thus escaping the chronic difficulty which the man is not willing to acknowledge even to himself. (b) More or less genuine apprehension for the future. Frequently without conscious intent, the doctor, lawyer, relatives and friends, by their attitude and advice engender a fear of permanent disability and the need for adequate compensation in the form of damages. (c) The care, attention and solicitation to which the injured person is subjected may fill an unsatisfied longing for greater consideration that has long been present, but not acknowledged.

In making these comments on the relation of the neurasthenia to personal injuries, there is no intention to deny causal relations. The injury or shock precipitated, if it was not the only cause of, the actual breakdown. This, however, emphasizes the importance of a speedy adjudication of the extent of damage and a settlement of the claims for compensation. The longer the doubts and worries are continued, the longer will the provocative conditions operate and the more habitual will become the psychoneurosis. A settlement made at once in a spirit of helpfulness and appreciation of the facts will do more than anything to restore the courage and normal attitude of self dependence that are so essential to recovery.

**Symptoms.** The symptoms of neurasthenia are extremely varied, the particular form being dependent largely on
accidental associations. These include trivial defects and anomalies that the patient may happen to possess and which serve as a convenient peg on which to hang the feelings of distress and discomfort; fears (sometimes resembling the phobias of psychasthenia) and apprehensions that have been acquired at various times and in diverse ways; chance injuries, more or less trivial, received at the time of the shock or accident; the observation of symptoms in others under more or less similar circumstances. It becomes, therefore, almost impossible to describe them in detail sufficient to cover any particular case; but certain general characteristics may be noted. They are manifestations of fatigability and irritable weakness, and in large measure they represent, in exaggerated form, the bodily manifestations of emotion, especially of the anxious and apprehensive types. The symptoms are mainly subjective and the complaints are out of all proportion to those due to real bodily disease. They are also the center of the patient's thoughts, acts and conversation.

Any system of the body may be incriminated in the symptoms. Mentally there are: feelings of exhaustion, lack of energy and interest, inability to concentrate or to think consecutively; every act requires an effort that seems almost insurmountable. In consequence there may be extreme irritability, fretfulness and outbursts of tantrums which leave the patient utterly exhausted. The attitude is one of worry and apprehension; fears of going insane or of imminent death are very frequent; there is almost invariably serious difficulty in sleeping and such sleep as is secured is fitful and often interrupted by unpleasant dreams. Various sensations are experienced in different parts of the body: pressure in the head, pains, palpitation of the heart, a sense of suffocation, indigestion and gas in the stomach and bowels, irritability of the bladder, and sexual impotence and irregularity. These symptoms may be combined or may fluctuate with one
another from day to day. But through them all there runs the feeling of fatigue and exhaustion, and the anxiety.

Yet, physical examination reveals no evidence of actual disease. The reflexes are usually brisk and often accompanied with unpleasant sensations, but are not otherwise abnormal. Power in muscular action is capricious and readily exhausted after a few efforts. The special sense organs are hypersensitive, strong light is unbearable and sounds are intensely annoying. The ability to see, as in reading, becomes rapidly exhausted and may result in a characteristic (helicoid) disturbance in the fields of vision. All these are quite obviously subjective and there are few really objective signs. The heart action in most cases shows marked increase in rate with slight exertion, the pulse increasing by twenty or thirty beats in the minute on rising from a sitting to a standing posture. The pupils are often unduly wide, but the reflex reactions are normal. These manifestations are similar to those that occur in strong emotion and are also observed in disease of the thyroid gland. There may be an excessive secretion of urine with increase of indican and the blood count may show an actual anemia. Not rarely, persons who are especially susceptible to this type of breakdown are found to have some structural anomalies such as floating tenth ribs, acute subcostal angle, deflections of the nasal septum, flat feet and particularly malposition of the uterus, undue mobility of the abdominal viscera (visceroposis), with movable kidney, sagging of the liver, etc., which may of themselves produce symptoms. These, however, are not due to the neurasthenia, but are only evidences of poor construction.

Outcome. The outcome of neurasthenia depends very much on the question of the constitutional vigor or deficiency in nervous construction. The slighter the cause under which the breakdown occurs, the less chance for permanent
improvement. As a matter of fact this is only another way of saying that the patient cannot be made over anew into a better constructed man. The outlook also depends on the duration of the disorder when efficient treatment is instituted; for invalidism can readily become a habit, and habits of long duration are proportionately difficult to break. This serves to emphasize the recommendation already made that damage suits should be settled promptly and at the earliest possible moment.

The liability for the conversion of the psychoneurosis into an insanity is practically nil. Neurasthenic reactions are quite frequent in the early stages of general paralysis, dementia praecox, arteriosclerosis and other diseases, but evidences of the presence of these diseases should be discoverable even early. Very occasionally, under prolonged emotional stress such as is liable to cause neurasthenic symptoms, there may occur temporary states of delirium-like nature comparable to the twilight states (Dämmerzustände) of epilepsy, in which the patient may commit acts of violence for which he has but an unclear recollection or complete amnesia afterward. These, in reality, are emotional upsets in a state of actual exhaustion rather than neurasthenic.

The neurasthenic patient is clear mentally, and, in spite of his complaints to the contrary, has no loss of memories that would interfere with his judgment. He is swayed by his feelings more than he would be in health, but he is responsible for his acts, the only exception being in the condition of twilight state mentioned in the last paragraph. As a matter of expediency, he sometimes goes, voluntarily or by commitment, to a hospital for the insane, but he is not insane and should not stay there. He may prefer to do so rather than face the responsibilities under which he broke down, but as a rule he is anxious to get home.
The subjective nature of the symptoms and the absence of objective manifestations must often arouse suspicion that the disorder is voluntarily assumed and the differentiation from malingering when a motive exists, such as a suit for damages, may not be simple. In neurasthenia the suffering and discomforts are genuine and will therefore be consistent. Prolonged observation may be necessary to demonstrate the consistency or the reverse. The malingering undertakes a difficult task; first, in the lack of knowledge of what should be the symptoms and second, in the constant watch and guard he must maintain to avoid giving himself away.
IV. SIMULATION OR MALINGERING

Definition. Malingering means the simulation of symptoms of illness or injury with the intent to deceive. In practice, its recognition is by no means always simple. Two elements are concerned: (1) the assumption of the symptoms, and (2) the intent to deceive. It may be comparatively easy to determine that there is no serious lesion to account for the symptoms, though this is not always true, especially if the symptoms simulated are purely subjective such as pains, fatigue, depression or anxiety. The second element, however, is more difficult to establish and the difficulties become manifest at once from a study of the conditions described under the title of psychoneuroses. These were characterized as subterfuges adopted in the effort to escape from an intolerable situation. In them there is no disease nor injury, or if present, it is altogether too trivial and insufficient to account for the complaints. It is generally accepted that the psychoneurotic person is not aware of the subterfuge, or in other words that he deceives not only or chiefly those around him, but also deceives himself. He finds himself at an impasse and to avoid it he becomes ill, using as the foundation for the self-deception the feelings that belong to the worry or anxiety aroused by the difficulty he wishes to avoid; or possibly some minor injury, ailment or deformity he may have experienced or discovered. Undoubtedly he actually experiences the pains and discomforts of which he complains. The malingerer, on the other hand, does not really suffer; his effort is to deceive others and not himself.

In the ordinary practice of medicine, questions of simulation rarely arise, for the reason that motives are lacking.
In medicolegal work, however, the situation is very different. Strong motives often exist such as the desire to extort damages or to escape responsibility for a crime. The possibility of malingering must therefore always be kept in mind; it represents one of the major questions for differential diagnosis. This may tax the skill of the examiner to the utmost, especially under the conditions that obtain in jail where expert observation is always difficult and often impossible. The possibility of shamming insanity is a common thought among criminals, not only during trial but also when in prison after conviction, which is fostered by well meaning sentimentalists and the statements of some physicians. It is often suggested, whether intentionally or not, by lawyers and relatives as well as by other inmates of the jail.

The recognition of malingering depends on a careful analysis of the results of observation and study, with the object of establishing the consistencies or inconsistencies of the various symptoms with one another, the mode of onset, the course and the duration in relation to the stage that has apparently been reached. No hard and fast lines can be laid down which will be universally applicable, each case must be judged on its merits. It is also necessary to bear in mind that, in the eyes of the law, a man is sane until the reverse is proved. It is not uncommon to hear it said that the fact of malingering implies some mental disorder. If this were true, it would be difficult to find any normal people, for there are few who do not adopt subterfuges at some time or another.

Since simulation is not a disease, it cannot be said that there are any characteristic symptoms. The most practical way to deal with the problem, therefore, seems to be to consider the points that may be of assistance in distinguishing from each of the major types of reaction. It may be pointed out in general that, though insanity is evidenced chiefly by subjec-
tive signs, that is to say by signs that are within the individual's control, the simulation of insanity requires a knowledge of the various types of insanity and also a capacity for self control that is possessed by very few. The effort must be continued day and night under all conditions. Unexpected and unforeseen circumstances must continually arise that will distract the attention from the purpose of deception, and will betray to the attentive observer the fact that the complaints are not genuine. Few laymen, and indeed few physicians, possess sufficient knowledge of the symptoms of insanity to know how to act in accordance with any particular form of insanity. Even if a man does possess this information, it would be necessary for him to think before responding to any situation and the facts of lack of spontaneity and the need for a choice of response will almost certainly give rise to incongruities which cannot fail to excite suspicion if the observer is on the watch for them.

Relation to Psychoneuroses. Before taking up the different forms of insanity, it seems wise to consider the differentiation from the psychoneuroses, the difficulties of which have already been mentioned. It is important to point out again that a psychoneurosis is not insanity and the reader is referred to the discussion of that point in the chapter on psychoneuroses. The psychoneurosis and simulation are both reactions adopted with the object of gaining something. In the former it may be described, perhaps, as negative gain in the sense that difficulties and responsibilities are avoided. In the latter the gain is more positive whether this be in the form of damages or escape from the consequences of committing a crime. Unfortunately for any effort to make a real distinction on these grounds, it often happens that both negative and positive gains operate simultaneously. The man who has long worried over the possible failure of his business and has longed for some
acceptable excuse for giving up the struggle may suffer a more or less trivial injury. This may afford not only the desired excuse but also the possibility of compensation which will help to avoid future worries. The man who is indicted for murder may not only malinger in order to escape the consequences, but may also endeavor to deceive himself in order to escape from thinking of the horrible situation in which he finds himself. This is well shown in the so-called prison psychoses with the Ganser syndrome.

The distinction that has been made between the suffering of the psychoneurotic and its absence in the malingerer cannot be observed directly. The fact, however, seems to be established by information that can be secured after recovery. The psychoneurotic prefers his suffering to facing the problems from which he is fleeing, but his pains and discomforts are usually more intense than those of a man afflicted with a real disease. The malingerer, on the other hand, merely puts up with inconveniences and will often laugh afterward at the difficulties in diagnosis to which he gave occasion. One man who had cleverly and consistently feigned insanity until the last avenue of appeal from a conviction for murder had been exhausted, remarked “Well! I nearly put it over, didn’t I, Doc?”

Since the psychoneurotic, whether consciously or not, is in reality feigning or exaggerating in order to secure an advantage, it may well be questioned whether there is any essential need to distinguish between malingering and the psychoneurosis. This question, indeed, is very similar to that which will be discussed in a later chapter on responsibility for crime. Is the deception “wilful” or intentional? This means does the man deceive himself as well as others? Assume that he does and that it can be said he is not aware of his deception, should he then be allowed to accomplish his purpose and mulct some one who has injured him or be relieved of his
responsibility? In the army during the war many such problems arose. Practically all were listed as psychoneuroses and the diagnosis of malingering was rarely made, chiefly because it made no practical difference. The physician who treated the man undoubtedly made allowances for the attitude of his patient, and the therapeutic measures adopted varied between making the complaint extremely unpleasant and a sympathetic explanation and encouragement. These differences, in ultimate analysis, depended on the physician's recognition of the degree of awareness of the fact of deception shown by the patient.

Medicolegally, the situation is much the same. In whatever light one regards the matter, there can be no doubt about the fact that the psychoneurotic and the malingeringer are both trying to gain something and it makes little difference from the standpoint of society or the defendant in a damage suit whether the deception is practiced consciously or unconsciously. The most that can be claimed is that the psychoneurotic, in so far as his suffering is the direct outcome of an injury for which some one else is responsible, should be recompensed. This, however, should not include any possibility that permanent injury has occurred. Such a conclusion is not only unfair, but is also very poor treatment for the psychoneurosis. The malingeringer, of course, is entitled to nothing. When the psychoneurosis is the reaction to the situation brought about by the man's own acts, as when it arises during the trial for a crime, it should of course receive no weight. The Ganser syndrome is practically a fear reaction, fear of the consequences of his behavior, and it is difficult to see why these consequences should be withheld because the man is afraid of them.

**Relation to Insanity.** It cannot be said that there is any one type of insanity that is particularly liable to simulation. The efforts of the malingeringer are usually directed toward
presenting an appearance which corresponds with the particular conception of insanity that he has acquired. Most often this is vague and indefinite. The insane person is commonly supposed to appear foolish, ill dressed and unkempt, vacant and indifferent to his surroundings, and to have a poor memory with absurd hallucinations and false beliefs. These manifestations are not conceived as having any consistent underlying attitude of mind and they therefore fail to present a coherent picture. Some elements may appear to suggest one type of insanity, others to be more consistent with another. Therefore, in considering the different types it is possible only to stress points that may be found of value when the preponderance of evidence seems to point in one direction rather than another.

The psychoses associated with organic lesions are also accompanied by objective signs that will be absent in simulation. A complete examination is therefore important. A brief consideration of the mental symptoms may, however, be useful.

Distinction from Delirium.—In delirium the behavior of the patient is consistent with the clouding of consciousness and sense-falsifications which constitute the main elements. The errors in orientation are consistent and the man is not completely clear on some things and completely clouded on others. His attitude toward the illusions and hallucinations he is experiencing is appropriate; he tries to escape from terrifying situations and does not just talk about lions or tigers in his surroundings with perhaps at the same time beautiful flowers on the wall. He is consistently terrified and reacts as if the objects of which he speaks are actually present. He is capable of being roused by strong stimulation to a temporary appreciation of the facts unless the clouding is extreme. Food and sleep are interfered with and there will be signs of exhaustion and intoxication.
Distinction from Intoxication.—The intoxications due to poisons taken into the body, such as alcohol and morphine, cause acute psychoses which rapidly subside as the poison is withheld. Withdrawal symptoms in morphine and cocaine poisoning are always present if the indulgence has been of such degree as to cause a psychosis, except in cases of intoxication by single doses. As in the other deliria, the hallucinosis of these intoxications is reacted to appropriately as if the things seen or heard were actually present.

Distinction from Dementia.—Dementia of organic origin is always accompanied by some sign of bodily change, the nature of which depends on the particular disease that causes the dementia. The loss of memory in dementia is selective in the sense that it involves first and most those memories that have been most recently acquired and least used. But it is not selective in the sense that the loss involves especially those memories whose retention would be detrimental to the patient in the cause at issue. It is very common to find that the simulator retains well the memories that will help, but conveniently forgets those things that would hurt him. Under the present system of partisan examinations by physicians for the opposing sides, it is often noticeable that memory is much better for questions asked by physicians called in by the simulator than for those asked by experts for the opposite side. Similarly with regard to the attitude of the man on the witness stand; he does far better with the direct than with the cross examination when it is a question of remembering. In the everyday events of life in the jail, it will often be found that the man who is simulating loss of memory fails to forget the little things such as his score with the man who sells candies and cigarettes, the way to the barber shop or bath room, the days when visitors come, the names of jailors and fellow prisoners, etc., and yet cannot recall these things when questioned by the
physician. Chance or inadvertent remarks often reveal the fact that he does know the day of the week and the approximate date when he cannot recall them in direct answers to questions. Such observations are incompatible with a real loss of memory and illustrate what is meant by the inconsistencies of the simulated symptoms.

In the psychoses without organic disease, though the condition is more completely subjective, simulation presents perhaps greater difficulties if it is to be consistent.

**Distinction from Depressive Psychoses.**—Depression of pathologic degree is rarely simulated. It might be thought to be one of the most easy to assume, but the maintenance of an attitude of real depression night and day is extremely difficult. It implies a continuous disregard for happenings and conditions in the world and a corresponding absorption in the depressive thoughts within. This extends to neglect of food and drink, true insomnia and disregard of the calls of nature, which would rapidly lead to evidences of exhaustion. Interest in the visits of friends is more or less in abeyance and all movements are more or less difficult. The content of the thoughts is in keeping with the attitude of depression, hopeless, self-depreciative, and sad. They contain nothing that does not correspond with this attitude; and delusions that may be expressed convey the same type of thought. Yet characteristically, such answers as are obtained to questions are correct and there is no real disorientation for time, place or persons. The simulator is almost certain to make some mistake or slip during the everyday events of life in jail that will be inconsistent with this bearing. Attempts at suicide are sometimes made by simulators to bolster up the deception. As a rule they are clumsy and quite obviously planned for the effect they produce on others.

**Distinction from Manic Psychoses.**—The happy excitments are also quite difficult to maintain. The fatigue
caused by the continual activity and talkativeness will rapidly lead to exhaustion and sleep, instead of to increased restlessness as in true manic excitement. A flight of ideas and activity can hardly be forced; it is characterized especially by its appearance of spontaneity and enjoyment. As in the depressions the content of the thoughts is in keeping with the mood and such delusions as may be expressed are fleeting but consonant with a feeling of happiness and wellbeing. Hallucinations are quite exceptional. The memory and orientation are proportional to the degree of attention that the patient pays to his surroundings.

**Distinction from Dementia Praecox.**—Schizophrenic, or dementia praecox, attitudes are more often suggested than any other, chiefly by the appearance of indifference and silly behavior which are more easily assumed than some more positive mood. The differentiation, too, may be more difficult because oddity and incongruity are some of the most striking features of schizophrenic behavior. Yet the oddity and inappropriateness follow a definite plan, the essential element being the autism described under the schizophrenic psychoses. While it is true that dementia praecox sometimes has an acute or subacute onset, it far more frequently comes on gradually, and a considerable time is necessary for the development of the degree of indifference that is generally shown by the simulator. When the onset is more acute, there are usually definite signs in the attitude of the body, as described under the head of cataleptic or catatonic phenomena.

The simulated loss of interest nearly always shows certain inconsistencies. The nature of the answers to questions bearing on the difficulties in which the man is will usually reveal the fact of very decided interest as opposed to a carelessness from real loss of interest. This point was discussed in describing the differences between “vorbeireiten” and the
Ganser syndrome. In the latter, which often accompanies simulation, the answers are carried out to more or less logical conclusions which stamp them at once as evidence of interest rather than carelessness. The appearance of loss of interest, in simulation, is the outcome of thought, study and interest, and hence lacks spontaneity and the appearance of genuineness.

The reactions of the schizophrenic person are conditioned by a more or less constant autistic world of thoughts and motives which lead to definite types of complaint. These consist of the feeling of loss of individuality and control by outside agencies which is expressed in the delusions and hallucinations as well as in the acts of the patient. They thus have a very definite relation to the behavior, and the picture, in spite of its incongruities, is consistent.

*Distinction from Paranoid Psychoses.*—Paranoid trends are characterized by slow evolution and logical reasoning with appropriate reactions to the beliefs that are developed. There is no loss of memory, though facts may be slightly falsified to fit the views the man holds. Everything has been thought out and there is a logical explanation for any objections that can be raised. A true paranoia can hardly be simulated for it takes years to develop and the conduct during that time will inevitably show that the man has been reacting to false beliefs with regard to the attitude of others toward him. Paranoid dementia praecox does lead eventually to deterioration of interest but this stage is reached only after long progress. In the earlier stages there are also evidences of the autism that was alluded to before.
PART II

LEGAL ASPECTS
I. THE LEGAL DEFINITION OF INSANITY

Historical. The great difficulty of defining and delimiting insanity is evidenced in the recorded judicial decisions as well as in the phrasing of the statutes of various states and countries. Lord Blackburn, an eminent legal authority of England, in the course of testimony before a Committee of the House of Commons some thirty years ago stated, "I have read every definition (of insanity) which I could meet with and never was satisfied with one of them, and I have endeavoured in vain to make one satisfactory to myself. I verily believe it is not in human power to do it." And yet a survey of decisions in the various jurisdictions during the last twenty-five years establishes that insanity is now clearly defined by the courts. In fact, the legal definition is more satisfactory and comprehensive for its purpose than is the average medical definition.

In law, the word "insane" has been variously defined as meaning: unsound in mind, memory or intellect; mad; deranged in mind; distracted (probate court decisions), and lunacy is held to be a more or less prolonged condition in which the mind is directed by the will but is wholly or partly misguided or ill governed. The oldest definition given is: "Lunatick is a technical word, coined in more ignorant times, as imagining these persons were affected by the moon, but discovered by philosophy and ingenious men, that it is entirely owing to a defect of the organs of the body." As a matter of historical interest it may be noted that the term "lunatic" appears in the statutes for the first time in

2 Nicewander v. Nicewander, 151 Ill., 156;
Hawe v. State, 11 Neb., 537.
the reign of Henry VIII (33 Hen. 8, C. 20) and there definitely
denotes persons who have become insane since birth.

**Terminology.** It is now held that "insane" may imply
any and every degree of unsoundness of mind. The terms
"lunatic," "insane," "of unsound mind" and "non compos-
mentis" are generic terms that are now regarded as convert-
able and co-inclusive, and comprising all the specific forms of
mental disease recognized by medical authorities. This
makes it permissible for us to use them as interchangeable
terms.

Mere weakness of mind, or mental debility, does not con-
stitute insanity for legal purposes. Soundness of mind
depends on the general power or habit of mind and not on
particular actions. Eccentricity is not insanity, no matter
how great it may be. A belief in spiritualism does not, in
and of itself, afford a test of insanity, or testamentary capa-
city, unless such a belief amounts to a monomania in which
case it will be treated as such. Belief in witchcraft is not
an insane delusion in law, neither is mere passion insanity
for legal purposes. Cases of irresistible impulse are to be
carefully distinguished from instances in which persons in
possession of their reasoning faculties are impelled by passion.
Likewise "emotional insanity," sometimes used as synony-
mous with "impulsive insanity," is more properly applied to
the state of mind of one who, while in possession of his
ordinary faculties and unaffected by mental disease, gives
way to passion, such as anger. This is not insanity at all
from the legal standpoint, which requires the existence of
some mental disease.

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1 Seitzinger v. M. W. of A., 204 Ill., 58.
2 Emerick v. Emerick, 83 Iowa, 411.
3 Foster v. Means, 17 S. C. Eq., 569.
4 Owen v. Crumbaugh, 228 Ill., 380.
5 Connor v. Stanley, 72 Calif., 556.
6 Addington v. Wilson, 5 Ind., 137.
In the earlier history of law, a person who was born deaf and dumb was considered to be an idiot, but this doctrine no longer prevails although some decisions intimate that a person born deaf, dumb and blind is to be considered in law as incapable of understanding, on the theory that it is impossible for him to receive ideas.¹

**Distinction from Mental Deficiency.** As a rule we find, in law as in medicine, that insanity does not include idiocy. "An idiot, or natural fool is one that hath no understanding from his nativity; and therefore is by law presumed never likely to attain any."² An idiot is a natural fool; a fool from birth; a human being in form, but destitute of reason and of the ordinary intellectual power of man. An idiot is "a person who has been defective as to intellectual powers from the instant of his birth, or at least before the mind has received the impression of any idea."³ "An idiot is known by his perpetual infirmity of nature; a nativitate, for he never has any sense or understanding."⁴ A man is not an idiot if he has any glimmering of reason, so that he can tell his parents, his age or like common matters. A man may be of imbecile mind and yet not be an idiot.⁵

Idiocy is a total want of reasoning powers, arising from organic defect and existing from the time of birth, while imbecility is applied to the condition of a person destitute of strength either of body or mind, weak, feeble, impotent, decrepit.⁶

Imbecility is that feebleness of mind which, without entirely depriving the person of the use of his reason, leaves

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¹ Brown v. Brown, 3 Conn. 299.
² I. Blackstone Comm., 302, 303.
³ People v. Crosswell, 13 Mich., 435.
⁵ Clark v. Robinson, 88 Ill., 498; Somers v. Pumphrey, 24 Ind., 231.
⁶ Campbell v. Campbell, 130 Ill., 466.
him the faculty of conceiving the most common ideas, which relate almost always to physical needs and habits. This legal distinction between idiocy and imbecility is quite in accord with the modern medical differentiation into:

1. **Idiocy**—This is a congenital defect or a defect that has intervened so early in life that there has been no mental development. An idiot cannot preserve himself from the risks of physical danger that are ordinarily presented to a growing active child, he cannot earn his own living or look out for the commonest physical needs and is unable to adapt himself to the simplest environment.

2. **Imbecility**—This is a condition (arrested development) in which the mental defect is of such degree that the person so afflicted cannot earn his own living. An imbecile, however, may do work of a simple nature under supervision, but he is not capable of any form of occupation that gives his labor a real market value so that he could secure employment at such remuneration as to enable him to support himself. He can fit himself only into the most simple environment of the home or a school colony especially adapted for such as he. A dull or weakminded adult can manage to earn his living while an imbecile cannot do so.

3. **Moronism**—It may be added that the term moron (a foolish one) is applied to the highest grade of feebleminded individuals. Morons are mentally deficient adults who, by the standard intelligence tests in common use, secure a grade that is obtained by the average child between the ages of 7 and 12 years.

The Mental Deficiency Act of Great Britain, enacted in 1913, classifies mental defectives into four main groups for purposes of public administration:

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1. Idiots: that is to say, persons so deeply defective in mind from birth or from an early age as to be unable to guard themselves against common physical dangers.

2. Imbeciles: that is to say, persons in whose case there exists from birth or from an early age mental defectiveness not amounting to idiocy, yet so pronounced that they are incapable of managing themselves or their affairs.

3. Feebleminded persons: that is to say, persons in whose case there exists from birth or from an early age mental defectiveness not amounting to imbecility, yet so pronounced that they require care, supervision or control for their own protection.

4. Moral imbeciles: that is to say, persons who from an early age display some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no deterrent effect.

While some states, for example Colorado and New Hampshire, by statutory enactment define “insane person” to include idiots, the tendency in all the states, in revising their laws, is to exclude idiots from the application of the statutes relating to insanity. This is explicitly done in the Illinois statutes under which “no person idiot from birth or whose mental development was arrested by disease or physical injury occurring prior to the age of puberty, and no person who is afflicted with simple epilepsy is regarded as insane, unless the manifestations of abnormal excitability, violence or homicidal or suicidal impulses are such as to render his confinement in a hospital or asylum for the insane a proper precaution.” Practically the same statement occurs in the Kansas statutes.

Forms or Phases of Insanity. Before completing the discussion of the legal definition of insanity, attention must be called to certain specific utterances of the courts as to particular phases or forms of insane behavior.
Partial Insanity.—One of the most striking terms employed in various legal decisions is that of "partial insanity." To the medical man the use of the term partial insanity is as ridiculous as to say a patient has a "touch of pneumonia" or a "touch of typhoid fever," and to the psychiatrist, recognizing as he does that mental disease in some degree extends throughout the warp and woof of the entire mental fabric, it is as much an error to describe a given case as one of partial insanity as it would be to diagnose a case as partial pregnancy.

This situation is better understood when one considers the judicial deliverances in which the term is employed. In one group of court decisions, the term partial insanity is applied to cases in which the mind, as a whole, is clouded or weakened, but not entirely incapable of remembering, reasoning and judging. 1 In another and larger group of cases partial insanity refers to monomania in which a person is regarded as insane on one particular subject, but apparently sane on all other matters.

A man may be "mad on all subjects," and then, although he may have glimmerings of reason, he is not a responsible agent. This is general insanity. 2 Partial insanity is the derangement of one or more faculties of mind which prevents full freedom of action. 3 It does not mean some intermediate stage in the development of mental derangement, but disturbance at some particular point which does not involve the mind at any other point. A mind thus affected is said to be under the influence of a delusion. 4 Partial insanity is confined to a particular subject, the man being sane on every other 5 and

1 State v. Jones, 50 N. H., 369.
5 Com. v. Wireback, supra.
the mere existence of a delusion not connected with the act done will not excuse an unlawful act committed by one partially insane.\textsuperscript{1}

The modern tendency to transmute the term partial insanity into monomania and that in turn into paranoia is well illustrated in the decision by Mr. Justice Farmer of the Illinois Supreme Court in the \textit{Lowhone} case, to-wit:

"It is evident from the proof that plaintiff in error was not generally or entirely sane. Whatever insanity he exhibited was of the partial order formerly called monomania, now denominated paranoia, which is defined to be progressive insanity.

"It has three recognized stages. The first stage is one of mild depression or hypochondria. The second is the persecutory stage, when the afflicted individual becomes possessed of the belief or delusion that he has enemies who are conspiring to injure him and deprive him of his rights and privileges, and these delusions sometimes drive him to appeal for help to government or judicial authorities and sometimes to himself wreak vengeance on one or more of his supposed enemies. In the second stage of the disease the individual occasionally has lapses of self-control, but for a greater portion of the time may be capable of restraining his inclinations to violence and destruction. The disease is regarded by the medical profession as incurable. One so afflicted may, if cared for, live to an advanced age. On other subjects than the delusions of the afflicted individual he may appear entirely normal and sane, and by his acts and conversation show a proper recognition of his relations with and duties toward his fellow man. The acts and conversations of plaintiff in error testified to by a large number of witnesses from October, 1918, up to the time of the homicide are characteristic of a typical case of paranoia in the second or persecutory stage.

"A paranoiac is, according to the medical authorities, capable of distinguishing generally between right and wrong and know and appreciate the effect and consequences of his acts, but there are times when, affected by his delusions, he either is incapable of distinguishing right from wrong or is incapable of controlling and restraining the impulse to do a criminal act." \textsuperscript{2}

\textsuperscript{1} State v. Spencer, 21 N. J. L., 196.

\textsuperscript{2} People v. Lowhone, 292 Ill., 45.
Delusions.—From the first, the law has taken cognizance of the significance of delusions in determining insanity, and defines delusion as a belief that something exists which does not exist, and which no rational person, in the absence of evidence, would believe to exist.¹ Again, a delusion is a false belief for which there is no reasonable foundation, and which would be incredible, under the given circumstances, to the same person if of sound mind and concerning which the mind of the person is not open to permanent correction through reasoning or argument.² Further, insane delusions are of two kinds: belief in things impossible; and belief in things possible, but so improbable under surrounding circumstances that no man of sound mind would give them credit.³ Generally the delusion centers around the person himself and his relations to the outside world and his fellow men. Thus it comes to involve his rights,⁴ the wrong done him by others, his sufferings because of the intrusion by others into his circle of activity or sphere of rights, and the persecution he experiences from the conduct of others because he asserts his rights. His delusion may be that he possesses great mental capacity or physical prowess, or that he is prince, potentate or king and should therefore receive homage from his fellows. The term paranoia is applied to monomania or to delusional insanity that has been systematized.⁵

The law naturally recognizes a distinction between an insane delusion and prejudice, though prejudice may result from a delusion. Thus a person may have a delusion that some member of his family is persecuting him or is in league with his persecutors and thus may have a prejudice against one who is a natural object of his bounty in the making of

² Kimberly's Appeal, 68 Conn., 428.
³ Medill v. Snyder, 61 Kansas, 15.
⁴ People v. Lowhine, 292 Ill., 45.
⁵ Jackson v. Jackson, 37 Hun (N. Y.), 306.
his will. Such a prejudice may be so unreasonable that the judge or jury is fully warranted in ascribing the prejudice to an insane delusion.¹ But, in and of themselves, neither eccentricity nor prejudice, nor both together, can be regarded as an insane delusion. Belief as to marital infidelity, or the illegitimacy or misconduct of children may be based on delusion and has been the occasion of many legal disputations as to the validity of wills. No opinion on questions of mere speculative belief, such as religious belief, can be said to constitute insanity. Insane delusion does not relate to mere sentiment or theories, or abstract questions in law, politics or religion. All these are the subject of opinions and, however absurd, are not insane delusions.² No belief, however preposterous, can be refuted only by advancing some other belief which itself cannot be based on positive knowledge.³

Hallucinations and Illusions.—Hallucinations have been defined as a morbid error in one or more of the senses; a perception of something that does not exist objectively and hence can make no impression on the organs of sense. Hallucinations are illustrated by the voices heard by the alcoholic paranoic or the visions of the faces of persons, long since dead, seen by the senile dement. In an hallucination the perception arises not from a stimulus or impulse from without but from a disorder within—somewhere in the perceptive apparatus itself. It may be due to a toxemia, to some organic derangement, or to a functional disorder. Hallucinations refer to false perceptions of objects that do not exist, while delusions refer to false ideas and beliefs.⁴

² Guiteau’s Case, 10 Fed. 161.
³ Bonard’s Will, 16 Abb. Pr. N. S., 128; Chafin Will Case, 32 Wis., 557.
⁴ 37 L. R. A., 283, Note.
An illusion is a false interpretation of an actual sensory stimulus, as when an object, for example a pencil, makes an impression on the retina, but the brain and mind behind the retina interpret the object to be something other than a pencil, such for instance as a snake. This may be due either to a functional disorder or to a structural derangement somewhere in the perceiving apparatus.

*Moral Insanity, Mania and Alcoholism.*—The term "moral insanity" has been variously used in legal phraseology to denote mental disease that destroys the ability to distinguish between right and wrong as to a particular act of conduct, or to denote a mere perversion of the moral sense. In some jurisdictions it is used synonymously with "irresistible impulse." The term "moral mania" is occasionally employed in legal statements and is then practically equivalent to "moral insanity." Homicidal mania is a morbid propensity to kill other human beings; kleptomania is a morbid desire to steal (without discretion as to the value of the objects stolen), and pyromania is a morbid passion for the burning of buildings. Ambulatory automatism and somnambulism have been successfully advanced in the defense of criminal cases, especially when related to epilepsy in the defendant, the capacity for intent being then supposedly absent.

Delirium tremens, in many jurisdictions, is held to be a form of insanity as distinguished from drunkenness which, in the language of the statutes, is no excuse for crime. Mere sexual perversion, high temper and immoral tendencies alone do not constitute insanity. Neither depravity of character

1 Boswell v. State, 63 Ala., 307.
2 Andersen v. State, 43 Conn., 514.
3 Lewis v. Lewis, 44 Minn., 124.
4 Evers v. State, 31 Tex. Crim., 318;
  Fitzpatrick v. People, 98 Ill., 269;
  Dunn v. People, 109 Ill., 635.
5 Schick v. Stuhr, 120 Iowa, 396.
and abandoned habits,¹ nor the commission of an unnatural and atrocious crime² are, in themselves, necessarily evidence of insanity.

**Definition of Insanity.** From the foregoing we are entitled to construct this somewhat general legal definition. *An insane person or lunatic (not being an idiot or imbecile) is one in whom there exists, due to disease, a more or less prolonged deviation from his normal method of behavior and who is therefore incapable of managing his own affairs or transacting ordinary business, who is dangerous to himself, to others, or to property, or who interferes with the peace of society.*

It is quite apparent that there are essential differences between the legal and medical conceptions of insanity and that the differences relate to content or substance. "The failure to keep this difference in mind," according to Bouvier, "has been a fruitful source of confusion in trials involving the question of mental capacity for crime or contract and has tended to render valueless and often absurd the testimony of witnesses called as experts. Many testify without any conception of the real nature of the insanity which alone could have relation to the case at bar." The medical expert, in any specific case on trial, must always bear in mind the old dictum of Dr. Ray that insanity in the law covers nothing more than the relation of the person to the particular act which is the subject of the judicial inquiry.³ The medico-legal problem in each instance is a special problem peculiar to the case at bar and this problem always resolves itself into the question whether there was mental capacity and moral freedom to do or abstain from doing a particular act.

¹ People v. Spencer, 264 Ill., 124.
² Hill v. Hill, 27 N. J. Eq., 214; 
   In re Guiteau, 10 Fed., 161.
II. THE DETERMINATION OF INSANITY

Historical. At an early period in England the custody and control of the person and property of lunatics or idiots was vested in the king. From this was derived the authority to initiate an inquiry as to soundness of mind in a given case. This authority was delegated by the king to the lord chancellor as representative of the crown by means of an official document that bore the king's signature and was sealed with the king's privy seal. On this account this legal instrument was called the "sign manual" from the crown.¹

After this special jurisdiction had been conferred and a person had been adjudged insane or lunatic, legal provisions had to arise for the care and custody of the person so adjudged as well as for the guardianship of his property. In the United States, the care and custody of persons of unsound mind and the possession and control of their property were deemed to be vested in the people. This is but a natural reaction of the democracy of the congregate American mind following the Revolutionary War, and caused a modification of the old English custom by which the person and property of the insane belonged to the king as a part of the royal prerogative.

After the special jurisdiction conferred by the "sign manual" had been exercised in any particular case by adjudging an individual to be a lunatic and by appointing a committee or guardian of his person and property, a further jurisdiction then arose in the court of chancery to supervise and control the official conduct of the committee.

¹ Dodge v. Cole, 97 Ill., 338.
or guardian. The power of the committee to deal with the estate was at common law very limited.

In some states (as Maryland) the court of chancery did not at first possess any greater or larger powers with respect to lunatics and their estates than the English chancery was clothed with when the colonies separated from the mother country.\(^1\) The rights or powers in England, to the extent that they existed in the king, did not exist in the courts of chancery and therefore under this situation it was deemed necessary in some states to enact statutes giving this power to courts of chancery. The courts of other states overlooked the point and took jurisdiction as by inheritance.

It is the rule in this country that an inquisition into the mental condition of one alleged to be insane is an essential procedure before the state can assume control over his person or property. When insanity has been judicially determined, the entire legal status of the individual involved changes. He becomes a ward of the court and his civil rights are suspended both as to person and property. The whole world is bound by the inquisition as long as the judgment obtains.\(^2\)

**Legal Procedure.** In this country the various states have enacted statutes prescribing the definite method of procedure to be followed in determining whether a person is insane, and in each state the statute must be strictly followed. In reviewing the laws of various states one is struck with the lack of uniformity. On no other subject have the laws enacted by the different states been so divergent and conflicting. In many states the legal steps prescribed by statute are humane and considerate, while, in others, the person who is mentally afflicted is regarded in much the same manner as a criminal. This is reflected in the phraseology of the

\(^1\) Hamilton v. Traber, 78 Md., 26.

\(^2\) Id.;
statutes by such expressions as "the accused," "charged with insanity," "trial by jury" and the like. Detention in jail, which is authorized by law in some states pending legal inquiry and commitment to a state hospital, does not detract from the suggestion of criminality, and certainly gives added stigma. In some instances the very methods of procedure in inquiry as to sanity prescribed by statute serve to increase the difficulties of later hospital care and cure in that the modus operandi incident to inquiry and commitment may intensify delusions or make certain morbid ideas more tenacious.

The Petition.—As a general rule, the law as to the institution of proceedings in a case of alleged insanity, is set in motion by a petition sworn to and filed as information by some one who assumes to act in the matter. While in most cases the petitioner who thus initiates the proceedings is a member of the family\(^1\) of the alleged lunatic, it frequently occurs that he may be merely a friend or even an entire stranger\(^2\) such as a law officer of the state, especially in certain cases of emergency. The cumbersome method of commitment prescribed by the statute in Florida provides that the petition must be signed and sworn to by not less than five reputable citizens, not more than one of whom may be a relative of the person whose sanity is to be the subject of inquiry. In this affidavit they state that they believe the person to be insane and ask that a legal examination be made. This petition is then filed before a county judge or circuit judge having jurisdiction.

What the courts are mainly concerned with is not who institutes the proceedings, but whether it is for the best interest of the individual alleged to be insane and of the community in which he resides. When, however, an inquest touching the insanity of a person is once begun, the interest

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\(^1\) Insane Hospital v. Belgrade, 35 Me., 497.

\(^2\) Jessup v. Jessup, 7 Ind. App., 573.
of the petitioner is held subordinate to the interest of the people and that of the respondent, and no petitioner, whoever he may be, can dismiss the inquiry unless the court consents.\textsuperscript{1}

Notice.—Under the early English practice, notice of the commission in lunacy was not given as a matter of right to the party alleged to be insane, he having the right to traverse the allegations of the petition; but, since 1853, an alleged lunatic is entitled to notice of proceedings as a matter of right.\textsuperscript{2} In the United States it is held that “So important a proceeding as that of declaring a person a lunatic, and taking charge of his person and property should not be consummated without personal notice.” Great weight of authority supports this view.\textsuperscript{3}

In some states, for example in Georgia, it is required that a notice be served on the alleged lunatic’s relatives or friends, but notice given to the husband or wife of the party or to one or more relatives does not do away with the necessity of notice to the party himself.\textsuperscript{4} Even if the court is satisfied that the respondent cannot be produced without jeopardy to his health, notice to the alleged lunatic is still necessary in order to give the court jurisdiction. Notice to the alleged lunatic is specifically set forth as a jurisdictional requisite in most states. While it has been held that notice cannot be waived, want of notice is generally deemed cured if the party appears and contests the proceedings. In most states, the statutes provide that the notice must set forth the time and place of hearing and must be served a certain number of days prior to the holding of the inquisition, and when this is the case the

\textsuperscript{1} State v. Guinotte, 257 Mo., 1.
\textsuperscript{2} 22 Cyc., 1124.
\textsuperscript{3} McGee v. Hayes, 127 Calif., 336;
   In re Blewitt, 131 N. Y., 541;
   Eddy v. People, 15 Ill., 386;
\textsuperscript{4} Jessup v. Jessup, 7 Ind. App., 573.
statutory provisions must be strictly complied with to make the proceedings legal.

*Presence of Respondent.*—Not only must the person alleged to be insane have proper and ample notice, but he must be produced before the court or commission conducting the inquiry as to his mental condition, unless sufficient reasons are set forth for dispensing with his personal presence. If necessary, attendance of the respondent may be compelled by a warrant issued to the sheriff or other authorized court officer. In emergency cases, the police power of the state may intervene and place the alleged lunatic in custody until lunacy proceedings can be initiated and the inquiry concluded. Thus in Illinois, for example, the statute provides that no person not legally adjudged to be insane may, by reason of his insanity or supposed insanity, be restrained of his liberty, except that the temporary detention of an alleged lunatic is permitted for a reasonable time, not to exceed ten days, pending a judicial inquiry as to his mental condition. A commission to hold inquiry as to alleged insanity of a non-resident cannot be executed outside the state.

*Legal Steps.*—The statutes in the various states are so different in their provisions that it is impossible in the scope of this chapter to give in detail the distinct steps in legal procedure. Often, the hearing must be before a jury as in Georgia, Kentucky and Wyoming. In other states the hearing is before a commission of two physicians either sitting with the judge of the court possessing jurisdiction or reporting their findings to said court (New York). In Maryland, the decision as to whether a person should be committed to a hospital for the insane rests solely on the certificates of two physicians without other formalities. As a

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2 Chavannes v. Priestley, 80 Iowa, 316.
safeguard, the Maryland law provides that the patient or a relative may sue out a writ of habeas corpus to determine whether the person is legally detained as insane. In Illinois the inquisition as to lunacy may be either by jury or by a commission of two licensed physicians. In all cases of inquiry by jury in Illinois, the jury must consist of six persons, one of whom at least must be a qualified physician. If a commission is appointed, it must consist of two qualified physicians in active practice, who are residents of the county and of known competency and integrity. They are required to make a personal examination of the patient and to file with the clerk of the county court a sworn report of the results of their inquiries together with their conclusions or "verdict." The commissioners have power to administer oaths and to take sworn testimony. The court may set aside the verdict of the jury or commission and order another inquest.

In Illinois the lunacy hearing may be in open court, in chambers, at the home of the respondent or in a hospital where he may be a patient. The selection of the place of hearing is discretionary with the court. Likewise, the judge may require all persons other than the patient, his friends, attorneys and officers of the court to withdraw during the inquiry—certainly a humane provision in some cases.

Delaware admits to the state hospital for the insane on the certificate of two physicians and also on court commitment. If the latter procedure is employed, it is not necessary to have the physicians' certificates.

In England the statute expressly provides that the alleged insane person may demand trial by jury. This situation obtains in many states in this country. In other states in which the statute does not specifically so provide it has been held that one alleged to be a lunatic or insane has the right to trial of the issue by jury.¹ Some decisions hold, on the

¹ De Hart v. Condit, 51 N. J. Eq., 611.
other hand, that the inquiry not being a criminal action at law the constitutional guarantee of trial by jury does not apply, and that a lunacy hearing is not a trial by jury either civil or criminal but is merely an inquiry conducted fundamentally for the benefit of the respondent.

Summary.—The legal procedure in the determination of insanity, as outlined in the statutes of the various states, embraces, in general, the following steps:

1. Filing of a sworn petition alleging insanity. This may be done by a relative, a friend or any citizen, depending on the laws of the particular state in which proceedings are initiated. It must be done in that particular court on which the statutes of the state confer jurisdiction; e.g., county court (Illinois), superior court (California), probate court (Indiana) supreme court (New York), district court (Louisiana), town officers (Maine), or board of commissioners (Nebraska).

2. A physician's certificate setting forth the results of an examination made within certain time limits prior to the hearing.

3. Legal notice to the alleged insane person. What constitutes a legal notice to the respondent in such an inquiry is defined by the laws of the several states. In some states, notice to near relatives and others is also required by statute.

4. Hearing of evidence as to the alleged insanity of the respondent, at which hearing he, the person alleged to be insane, must be present unless the judge presiding at the hearing holds, with the statute of that particular state, that the health of the respondent would be jeopardized by his presence at the inquiry.

5. The hearing may be before a jury (of six, twelve or twenty-three fellow citizens) or before a commission (usually of physicians, two in number).

6. A verdict or return must be brought in by the jury or commission. Such verdict or return must be worded in
the language of the statute conferring the jurisdiction. It is essential that the verdict shall define, substantially in accordance with the statutory definition, the disability with which the person involved is found to be affected.\textsuperscript{1} In some states the verdict or return must state of what the lunatic's estate consists.

The verdict may be set aside by the court and a new hearing may be ordered. In some states, on the granting of a new trial, the inquisition may be changed from a hearing before a commission to a hearing before a jury.

7. Judgment on the verdict—by which the person found insane is committed to the care and custody of an institution (usually a state or county hospital for the insane, though in some states the commitment may be to a private sanitarium). In some states, he may be committed to the care and custody of an individual.

8. Transportation of the insane person to the institution to which he has been committed by the court. Funds for such transportation as well as the cost of maintenance of the patient at the institution are provided for by the laws of the several states.

Not all of the above steps are explicitly set forth in the statutes of each state, but they may be said to constitute the elements of procedure in cases \textit{de lunatico inquirendo}.

When the judgment that ensues from the inquisition of sanity is formally entered, the status of the person involved in the inquiry is fixed, and until it is voided or revoked it is deemed conclusive to all the world; being a proceeding \textit{in rem} it is one to which no one can be said to be a stranger. An inquisition finding a person insane at the time of the verdict affords no evidence "that he was insane at any previous time;" \textsuperscript{2} "it raises no presumption of insanity at a prior date."

\textsuperscript{1} In \textit{re} Clark, 175 N. Y., 139.
\textsuperscript{2} Southern Tier Masonic Relief Assn. \textit{v.} Laudenbach, 5 N. Y. Supp., 901.
\textsuperscript{3} Lilly \textit{v.} Waggoner, 27 Ill., 395.
As to insanity after the time of the finding or verdict it must be held that an adjudication of insanity substitutes for the general presumption of sanity, a presumption of insanity, and the party's civil acts are therefore invalid prima facie;¹ they cannot be ratified by his guardian or by himself on later restoration to reason.² However, in a will contest based on such person's mental capacity, an adjudication of insanity is only prima facie evidence of his sanity or insanity at the time when the adjudication was made.³

A finding in lunacy proceedings in a sister state or a foreign country is entitled to the same faith and credit as it receives in the jurisdiction wherein it was found.⁴ When a commission in de lunatico proceedings was held in New York, it was held that the decree could not be attacked on the ground that the patient was then a resident of Virginia.⁵ When a person who has been judged incompetent has recovered, relief may be obtained only by application to the court which exercised original jurisdiction.⁶

**Voluntary Admission to State Insane Hospital.** Twenty-two states now provide for the admission, as patients for care and treatment in state hospitals for the insane, of persons who apply voluntarily. The conditions under which voluntary patients are received are almost as various as the laws for legal commitment already noted. In some states the person voluntarily making application to become a patient

¹ Blandy v. Blandy, 20 D. C. App. Cas., 535;  
Lilly v. Waggoner, 27 Ill., 395;  
² Fitzhugh v. Wilcox, 12 Barb. (N. Y.), 235 (on ratification by guardian); and Musselman v. Cravens, 47 Ind., 1 (on ratification by party on restoration to reason).  
³ Holliday v. Shepherd, 269 Ill., 429;  
In re Weedman's Est., 254 Ill., 504.  
⁵ Id.  
⁶ Id.
in a hospital for the insane need receive only the approval of the judge of the county court where he resides. In other states he must pay for his care, while the laws of still other states require formal certification by physicians. The statutes of most states provide that voluntary patients must be released within a limited number of days (in some states three, others five, and others ten days) after they serve written notice on the medical superintendent of the hospital. Pennsylvania's statutory provision as to voluntary admission, while none too good, is one of the best and reads:

"Persons who are threatened with mental disorders and voluntarily place themselves in institutions for the insane may be received for the period of one month or less by an agreement, which must specify the time and be signed by them at the time of their admission. At the end of one month they may renew the agreement, but no agreement is valid unless signed in the presence of some adult person attending as the friend of the applicant and by the medical attendant."

While, theoretically, voluntary admission is an important step in advance, as a practical procedure it does not work well, except in comparatively few instances. The majority of such applicants are drug or liquor addicts. They present themselves to the institution in good faith. The care and treatment naturally involve deprivation and withdrawal of the drug or alcohol, and in many cases physical restraint is required. The patient's rebellion at such restrictive measures may soon develop into active violence. Though in no condition to judge as to what is best for him, he may serve written notice on the hospital authorities requesting release. After three, five or more days (according to statutory requirements) have elapsed, the patient must be released unless the law further provides, as in West Virginia—"if he is in fit condition." Some hospital superintendents in such cases safeguard themselves against later prosecution for forcible detention or false imprisonment by causing a petition for an
insanity inquisition to be filed, thus initiating the procedure provided by law in that particular state. Such proceedings can be completed, including the finding and verdict, before the time limit of three, five or more days' notice accorded to the voluntary patient has expired, and the voluntary patient may thus become a legally committed patient without having left the hospital.

Much more satisfactory than the voluntary admission feature is the provision for temporary care and observation in a special psychopathic hospital or the psychopathic department of a general hospital. This is of especial value in cases of acute psychosis or temporary mental disturbance which may be cured by a short hospital residence, when the patient may be discharged able to resume his work without the stigma of legal adjudication of insanity having been placed against him. Even if a cure has not been wrought, the sojourn has afforded opportunity for a complete diagnosis in a well staffed hospital with good laboratory equipment. The facilities for temporary care and observation such as obtain at the Boston Psychopathic Hospital and the Psychopathic Department of the Bellevue (New York) and Cook County (Chicago) Hospitals have yielded satisfactory results in a large number of cases. It would seem that certain cases of acute toxic insanity, many of which are capable of recovery within a comparatively short period of time, should be provided for in some such humane manner, thus sparing the individual who is the victim of such temporary insanity, the odium that attaches to legal proceedings for commitment as insane.

Patients in Private Institutions. Insane patients are frequently placed in private hospitals and sanitariums without any form of legal procedure to serve as warrant for such detention. The embarrassing complications that may arise from such a situation could have been provided against had
a formal inquisition as to sanity been held and a finding or verdict returned with the provision that the patient be placed in the care and custody of some individual—a friend or relative. This individual would then be legally empowered to place the patient in a private sanitarium or hospital for the insane for care and treatment which would also involve his legal detention at such institution.

**Parole of Patients.** A parole system is in operation in thirty-nine states. The patient in a state hospital for the insane whose condition has improved or become more stable is permitted to go to his home, or to the home of some responsible person, on probation. The length of the parole period is usually provided by statute and varies from thirty days to six months in the different states; in a few states the parole period is one year, while in three states no time limit is fixed. In states where the parole system is well organized, paroled patients really become out-patients of the hospital; they are supervised during the sojourn at home by competent social workers connected with the hospital, and may also be required to report to the hospital in person at stated intervals for re-examination. Some state hospitals provide for such examinations at designated times and places in the cities or more congested centers of population, easier of access to the majority of paroled patients than is the institution itself on account of geographical situation. The larger number of state hospitals for the insane are in the country while the greater number of patients are from the cities. As an economic measure it is found of advantage for the hospital to send a member of its medical staff at stated periods to the designated centers to conduct examination of patients under parole. Furthermore, away from hospital atmosphere and environment, the medical examiner will often secure better and more exact understanding of the condition of the paroled patient.
If the patient on parole exhibits improvement and stability, more or less commensurate with the social and economic requirements of the immediate community in which he lives and moves, he may be legally discharged from the institution at the expiration of his parole period, or the parole may be extended for another definite period. If he has shown himself as yet unfit to live and work outside he may be returned to the institution. A parole can be revoked at any time.

The authority to parole patients is usually vested in the medical superintendent of a state hospital, though in some instances this power inheres in the state board of control or the trustees of the hospital.

In some states no provision is made for the examination and supervision of patients on parole and they may be automatically discharged at the expiration of the parole period without any knowledge on the part of the institution as to the patient's actual condition or fitness.

**Discharge of Patients.** As already indicated, the parole of a patient from a hospital for the insane may be regarded as a sort of probationary discharge. If during his parole period the patient shows continued improvement and manifests an ability to adjust himself so as to be able to live and work outside, he may be legally discharged from the institution. During parole the original order of commitment remains in force and is effective until the patient is officially discharged by the authorities of the hospital.

The authority to discharge patients is usually vested solely in the superintendent. In some states, the law directs that such discharge be made by the hospital board of trustees on recommendation of the superintendent. In still other states, the power to discharge a patient from a hospital for the insane is vested in a state board of control. In a minority of states it is required that the patient be examined by the physicians
of the hospital in staff session and the result of such examination determines the patient's eligibility for discharge. The patient may be discharged (a) as recovered; (b) as improved; (c) as stationary, and (d), by expiration of parole. Once discharged the patient cannot be readmitted, after a specified lapse of time, except by a legal process similar to the original commitment. Indigent patients, on discharge, are provided with money, suitable clothing and transportation as provided in the laws of the several states. The statutes also require that the court originally making the commitment to the hospital shall be notified by the hospital authorities of a patient's discharge.

The power of the hospital authorities to discharge patients does not extend to insane criminals who are held on a mittimus or order of a criminal court.

A patient in a hospital for the insane has the right, at any time, under the law, to have his sanity determined by habeas corpus proceedings.¹ This is not an infrequent method of securing the discharge of a patient.

¹ See p. 357.
III. GUARDIANSHIP

Historical. The right to appoint a guardian, committee or conservator for an insane person inheres in the sovereignty of the state. The procedure to be followed in such appointment is statutory. The criterion for such appointment is the degree of mental unsoundness of the person concerned, i.e., whether the unsoundness of mind exists in such degree that the person is incapable of conducting the ordinary affairs of life, so that to leave his property in his possession and control would render him liable to become the victim of his own folly or of the fraud of others.

As a matter of history, long before there was any mention made of the restraint or isolation of the insane for their care or custody, provisions were made for guarding those thus afflicted by relatives in their homes.

The Roman law was the first to safeguard those of unsound mind by the appointment of a "curatelle." At first this provision was made for the purpose of preventing improvidence and profligacy, and referred primarily to the reckless spending of a patrimony. Such a spendthrift was placed on the same level as a minor child. This decree of interdiction operated to make the spendthrift incompetent to execute a will. Likewise, transactions carried on in a state of insanity, when the insanity became generally known, were without validity or effect. If the insanity was prolonged, a guardian was appointed to act in the stead of the insane person. Thus the establishment of a "curatelle" led to the appointment of a guardian (curator) for the insane in much the same manner as in the case of the profligate who was inclined to dissipate his patrimony.
Out of this old Roman custom developed the civil and criminal statutes of Germany. These laws assume that there is diminished power of choice and lessened responsibility in those who are feebleminded, habitually alcoholic, or spendthrifts. Persons in any one of these groups, regardless of age, are placed under guardianship and considered as children under the law. Gradations in punishment are also established according to the mental maturity of the person under guardianship. The old English law did not go so far. According to it, there are no degrees of responsibility. A person is sane and entirely responsible or he is insane and wholly irresponsible. There is, therefore, much justification in the contention that the German law is more in harmony with modern psychiatry than is the old English law.

**Meaning.** Laws of guardianship are really the formal expression of the attitude of the state toward the mentally afflicted. The amount of restriction and protection afforded by guardianship, as well as the extent of the custodial care ordered by the court having jurisdiction, is determined according to the degree of the mental affliction. Thus, for the squanderer or spendthrift, as well as the habitual alcoholic, the interdiction of guardianship would only operate as to custody of the property, while in the case of the feebleminded or insane it would affect both the property and person.

The jurisdiction of the proper court to appoint a guardian is not limited to cases of insanity, lunacy or idiocy, strictly so called, but extends to every case of mental unsoundness which has reached such a degree as to render the subject incapable of conducting the ordinary affairs of life, and has left him in condition to become the victim of his own folly or the fraud of others; but such a degree of mental unsoundness should be clearly made to appear.\(^1\) It is

\(^1\) McCammon v. Cunningham, 108 Ind., 545.
error to charge that to render one a fit subject for guardianship his mind must be so impaired that he has no more intelligence than an idiot.¹ A guardian may be appointed for any one who, through drunkenness or other cause, has become incapable of managing his affairs.²

The operation of the principle of guardianship as to criminal responsibility and torts will be discussed later in this section.

**Grounds for Appointment of a Guardian.** In most jurisdictions it is usual to appoint the same person as guardian of both the person and the estate of the lunatic, yet this is not always done. When an insane person possessed of property is committed to a state hospital for the insane, the verdict at the close of the procedure usually contains a clause stating, in addition to the finding of insanity, that “we the jury (or commission) further find that the aforesaid insane person is possessed of property to the approximate amount of ——dollars and we recommend that a conservator be appointed.” The appointment of a guardian or conservator in most states automatically follows the finding of insanity. Also, in most jurisdictions there can be no appointment of a guardian or conservator unless the mental unsoundness be first adjudicated.³ A guardian may be appointed on legal proof of an inquisition as to lunacy in another state.⁴

In some states, as Ohio, the probate court has power to appoint guardians for deaf and dumb persons of full age whom they find incapable of managing their affairs, without subjecting the question of incompetency to a jury of any kind.⁵

¹ Jackson v. Jackson, 37 Hun (N. Y.), 306.
² Reeves case, 6 Wash., 271.
⁴ In re Holcomb, 111 Iowa, 525.
⁵ Shroyer v. Richmond, 16 Ohio St., 455
The fact that, owing to sexual perversion and mental temperament, a man 75 years old is liable to develop a disposition to squander his property, though his previous business career has been marked by ordinary thrift and prudence, will not warrant the appointment of a guardian; the policy of prevention is subordinate to the right of every man not to be restrained of his liberty until circumstances actually arise necessitating its curtailment. Nor will the fact that he may at any time, owing to his high temper and immoral tendencies, commit wrongs rendering his estate liable in damages warrant an appointment under the statute; if he is mentally responsible, a guardianship will not protect his estate, while, if he is not, in no event can he be charged in damages for malicious injuries.\(^1\)

A peculiar situation arises in the cases of convicts who become insane while in prison and are transferred to a state hospital for the insane. The law holds that for such a person, sane when convicted of crime, transferred to an insane hospital on the certificate of the prison physician setting forth the insanity, there can be no appointment of a guardian without formal legal procedure to determine the convict's incompetency.\(^2\)

In Louisiana, a curator or guardian can be appointed only on a recommendation from a family meeting, which meeting must be composed of at least five relatives, or, in default of relatives, friends of him in whose interests they are called to deliberate. The code, specifying this method of procedure (Rev. Civ. Code La. 1892), also provides that women are not eligible as members of a family meeting called for the purpose of recommending a curator for an interdict. When the curator of an interdict has been removed, the judge must

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\(^1\) Schick v. Stuhr, 120 Iowa, 396.

convoke a family meeting to recommend a fit person for appointment as permanent curator to replace the removed curator.¹

**Selection of a Guardian.** The appointment of a stranger as guardian without the request of the relatives of the ward is unauthorized.² In some states the appointment of a relative is practically mandatory. In Georgia, where the contest arose for the guardianship of an idiot who was a colored man, one applicant was a white person, and the other an only sister and next of kin of the idiot. Proof showed that both were unobjectionable. The state Supreme Court held that the next of kin by blood, if otherwise unobjectionable, shall be preferred.³ In case the insane person is a wife, there is no rule of law which prefers the husband as such guardian, if he is not a fit person to discharge such duties as guardian.⁴ It is, however, a presumption of law that lunatics will be treated with more affection by near kin than by strangers; consanguinity is considered a recommendation in choosing a guardian and strong ground must be shown before it will be disregarded. When a married woman becomes insane and stands in need of a guardian, and the husband is otherwise a suitable person for that trust, he should be preferred to a third person.⁵ In the appointment of a guardian of a lunatic it has come to be regarded by the courts that there is no rule of preference of relatives over strangers, or the reverse, but the court is to do whatever is best for the lunatic.⁶

One for whom, as an incompetent person, a guardian is sought is entitled to legal notice, and the appointment of

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¹ State v. King, 113 La., 905.
² Hayden v. Smith, 49 Conn., 83.
³ Johnson v. Kelly, 44 Ga., 485.
⁴ In re Fegan, 45 Calif., 176.
⁵ In re Drew, 57 N. H., 181.
⁶ In re Page, 56 How. Prac. (N. Y.), 100.
a guardian without notice to the alleged insane person is invalid.¹

A decree appointing a guardian for the estate of an alleged incompetent person is a determination of his incompetency and is conclusive as to his insanity² both at the time of the decree and subsequent thereto.³ The disability of incompetency begins only on the actual qualifying of the guardian⁴ as to bonds and similar details.

Powers of a Guardian. The powers of the guardian, as may be gathered, fall into two categories. The first group relates to the guardian’s rights and powers with reference to the person and property of his ward. The second group includes his obligations to the court that appointed him as well as obligations to the ward himself. The rights and powers of the guardian of an insane person, may be best considered under subheads:

Custody and Control of Person.—Unless the ward by order of court, has been committed to an asylum, sanitarium or hospital for the insane for care and custody, the guardian of such ward is entitled to his custody and may care for him and control him in any reasonable manner. He can change the domicile of the ward and determine the locality that best lends itself to his care, and can also elect the treatment, medical and other, that the ward shall receive. This right, however, does not bestow power on the guardian actually to confine his ward without a specific order of court.⁵

If anyone should remove the ward from the domicile where the guardian, in the exercise of his rights, has placed him for

² Pavey v. Wintrode, 87 Ind., 381.
³ Messenger v. Bliss, 35 Ohio, 587.
⁴ Baker v. Potter, 51 Conn., 78.
⁵ State v. Lawrence, 86 Minn., 310; Com. v. Kirkbride, 3 Brewst. (Pa.), 393.
care and custody, then the guardian may maintain action for false imprisonment against the one who has thus unlawfully removed him.\footnote{Barker v. Washburn, 200 N. Y., 280.} A guardian has the right to remove his ward to another state, but such change must always be in good faith and it is usual for the guardian first to secure express permission by application to the court that appointed him. This right of change of residence or removal by the guardian is always subject to the power of the court of chancery to restrain an improper removal, and such a removal must always be made with a view to the benefit of the ward.\footnote{State v. Lawrence, 86 Minn., 310.}

The wife rather than the father is considered the natural guardian of her insane husband of full age and without a legal guardian and she may enter the domicile of the father of an insane person where both the husband and wife had resided temporarily in an exclusive apartment, and remove her husband in spite of the father's opposition.\footnote{Robinson v. Frost, 54 Vt., 105.}

In transporting a lunatic from place to place, it is the duty of the guardian to select the cheapest mode consistent with the comfort and safety of the lunatic. If the public conveyance is suitable and cheaper than a private one, it is the guardian's duty to take it.\footnote{Alexander v. Alexander, 8 Ala., 796.} This application of the law would operate against the somewhat growing tendency for a guardian to take an extensive motor trip at the expense of his ward's estate.

The care of the lunatic involves the expenditure of money out of the lunatic's estate and the paramount rule in all courts is that the lunatic's health and comfort must first be provided for without regard to the interests of the next of kin.\footnote{In re Colah, 3 Daly (N. Y.), 529.} This is so even if it may involve the expenditure of the
principal of the ward’s estate or the conversion of his real estate into personal or his personal into real estate. As a general rule, the guardian is authorized to expend a sufficient amount to maintain the ward and his home and to support him in the manner to which he has been accustomed if consistent with his best interests, or to permit him to travel under proper superintendence, to reside abroad or to be conveyed to his home in a foreign land.

The guardian has the custody of the children of his ward and may direct their education when no other guardian is appointed to function in this capacity, unless the court orders otherwise "but the mother of the children shall not be deprived of their custody and education without her consent if she be a fit person to have such custody and education."

Management and Control of Property.—The legal guardian occupies, generally speaking, the same position as did the insane person prior to his guardianship in relation to his property. He has control and possession, and in all ordinary matters of business has the right to deal therewith. In the investment of the funds of an insane person by the guardian, supervision by the court is generally exercised. This leads the guardian to make investments in established securities such as government bonds. If the guardian invests in securities of a private concern without sanction of the court, the guardian personally must bear the loss caused by insolvency if it occurs. However, the guardian of a lunatic will not be deprived of his right to compensation merely because he made some mistakes in the management of the estate, provided he has not been guilty of serious misconduct, negligence or lack of good faith with reference to his ward’s affairs. While the guardian will be allowed

2 Commonwealth v. McConnell, 226 Pa. St., 244.
reasonable compensation for fees paid to counsel employed to collect and preserve the property of a lunatic, he has no right to use the funds of the lunatic's estate to pay counsel for the purpose of procuring his own retention in the office of guardian.¹

The guardian, in the eyes of the law, is merely the servant or "bailiff" of the court and, as such, is subject to the court's direction, approval or disapproval in all matters that pertain to the management of the lunatic's estate and the maintenance of him and his family.² The guardian may maintain ejectment proceedings against a stranger to secure the possession of the ward's real estate but not against the wife for the purpose of ejecting her and his children from the home he provided for them before he became a ward.³ A guardian may be allowed, in a proper case, to invest personal property of the lunatic in the improvement of unproductive real estate by the erection of buildings thereon,⁴ and he may be authorized by the court to invest all of the property of his ward in the purchase of an annuity on his life.⁵ He may, under the authority of the court, continue the business of his ward,⁶ but without such authority he has no power to engage in business for the lunatic or to bind his estate by contracts relating to such business.⁷ He cannot, by any promise which he may make, render his ward liable to an action as on his own contract.⁸ The guardian of an insane person must keep his ward's money and property separate from his own, keep account thereof and make investments,

³ Id.
⁴ In the Matter of Livingston, 9 Paige Ch. (N. Y.), 440.
⁵ In re Hooper, 120 Mass., 102.
⁶ State v. Jones, 89 Mo. 470.
⁷ Kent v. West, 53 N. Y. Supp., 244.
⁸ Thacher v. Dinsmore, 5 Mass., 299.
not in his own name, but as guardian, and keep those investments separate from his own.\(^1\)

**Lease or Mortgage.**—Formerly the guardian’s functions as to the real estate of his ward were really those of a conservator. His actions and dealings in relation thereto chiefly concerned the preservation of the estate, the collection of its income and the application of this income to the support and maintenance of his ward as well as the wife and children of his ward if there were such. This was under the provisions of the old common law.

Statutory enactment has conferred larger powers on guardians in most states. They may have power to lease from year to year, or to lease for a term of years, but in some states the lease does not bind the ward after his restoration to sanity. Practically all states confer on the guardian the power to mortgage real estate of his ward when the income is not sufficient to provide for proper medical treatment and the comfortable and suitable maintenance of his ward and his family.\(^2\) Such mortgage is a valid mortgage only when authorized by order of the court. Before executing the mortgage the guardian must enter into an agreement therefor, which agreement sets forth the terms of the proposed mortgage and this agreement must be submitted to the court. If the mortgage is made without entering into an agreement approved by the court, it is invalid.\(^3\) It is also held that a mortgage can only be made for maintenance and support and not for the debts of the ward. A guardian has no authority to make a mortgage for the purpose of paying the debts of his ward, and the guardian who so acts binds himself and not his ward.\(^4\)

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1 McIntire v. Bailey, 133 Iowa, 418.
3 Corbin v. Dwyer, 63 N. Y. S., 822.
Accounting and Settlement.—The authority and rights of a guardian are associated with certain correlative duties and obligations, chief of which is that of accounting for his stewardship. The liability of guardians, conservators, or curators appointed for insane, incompetent, spendthrift or distracted persons in the matter of their accounts is similar to that of guardians of minor children. On assuming guardianship, he must first make an inventory of his ward's property and submit such inventory to the court. A guardian has the right to enter the dwelling of his ward without his permission and against his will for the purpose of taking an inventory of the property of his ward, or attending to any other duties of his office that require such entry. The guardian is not allowed to make any profits, as such, out of his trust. He will receive as compensation only such fees as are authorized by statute and allowed by the court that appointed him. He will not be held responsible for losses that do not arise out of negligence, maladministration or fraud.

Termination of guardianship may occur by removal for neglect of duty, improper conduct, or failure to render an accounting within the statutory time limit. The guardian cannot resign his office. The court usually displaces a guardian if he removes to another state. The death of the ward abrogates the relationship and the guardian remains merely as custodian of the estate until properly discharged by the court. The same applies when the ward ceases to be incompetent.

Restoration to Rights of Sanity. The method of restoration to the status of legal sanity is usually expressly provided by statute. The general rule is that one who has been declared a lunatic, and for whom a conservator has been appointed, may make application to the same court where the

1 State v. Hyde, 29 Conn., 564.
former proceeding took place, for the discharge of the conservator and the restoration of the property in his hands. As an instance of such statutory provision we quote the portion of the revised laws of Illinois relating thereto:

"When any person for whom a conservator has been or may be appointed under the provisions of this act shall be restored to his reason, or in case such drunkard or spendthrift shall become so reformed as to be a proper and safe person to have the care and management of his estate, such person may apply to the county court of the county in which said conservator was appointed, to have said conservator removed, and the care and management of his property or so much thereof as shall remain, restored to him.

"Notice of such intended application shall be given to the conservator ten days before the commencement of the term of court to which application shall be made.

"A jury is to be summoned to try the question whether the applicant is a fit person . . . then the court shall enter an order fully restoring such person to all the rights and privileges enjoyed before the conservator was appointed . . .". A reasonable time must be allowed for the conservator to effect the settlement.

"No application for the removal of a conservator shall be entertained by the court within less than one year, unless for neglect of duty or mismanagement."  

The discharge of a person from an insane asylum by the physician in charge, though the certificate does not state that such person is restored to reason, is held by the California courts to be prima facie evidence that such person is so restored, or was improperly committed to the asylum. The Kansas Supreme Court held that when a woman was discharged from an asylum as improved (not as recovered), but thereafter recovered her reason, a contract subsequently made by her, seven years after the adjudication of insanity, was valid, without an adjudication of restoration to reason.

1 Ill. Revised Statutes, Cahill, 1921, Chap. 86, Secs. 38, 39.
2 Clements v. McGinn, 33 Pac., 920.
The New York courts hold differently: "In case any lunatic against whom an inquisition has been found shall be restored to his right mind and becomes capable of conducting his affairs has no effect on the status of the lunatic until the insanity inquisition and guardianship are superseded by court decree." 1 As a matter of legal practice it is almost unanimously held in all jurisdictions that a court order of restoration is necessary to prevent entailment of property and other rights of citizenship.

When a person who had been adjudged insane is later restored to a status of sanity by order of court, he may elect either to ratify or revoke actions of a contractual nature that occurred before such restoration. Thus, in Arkansas, a passenger injured on a railroad train, who is insane when he executes a release to the company, may ratify it on becoming sane. 2 In Indiana the contract of a person who has been judicially pronounced to be of unsound mind is void, but if he has not been so adjudged by a court such contract is only voidable, and is capable of ratification or annulment when reason has been restored. 3

1 Carter v. Beckwith, 128 N. Y., 312.  
3 Musselman v. Cravens, 47 Ind., 1.
IV. INSANITY AND CONTRACTS

Theory. In considering the effect of insanity on the power to enter into contracts, one must first recall the general theory of the law of contract. It is a fundamental principle of the English law of contract that there must be free and full consent of all parties in interest in order that any contract be binding. The law insists on free and full consent, and the courts, in construing the law, imply that "consent is an act of due deliberation," the mind "weighing the pros and cons" in a given case so as to determine the advantages or disadvantages of the pending agreement—the real merits of the proposed contract—and also to consider the ability of the parties to carry out the terms involved in the contract. Consent being the essence of a contract, it follows of necessity that one must be capable of giving his consent, and this implies the use of reason as well as the free use of one's powers to carry out the contractual terms.

A contract is therefore the expression of the will of the persons involved, as well as a conclusion reached through the function of the reasoning powers of the parties. No agreement becomes a contract unless its effect is to bind the parties by a promise or set of promises to perform certain acts in a prescribed manner to the attainment of a certain result, usually within a definite time. No valid agreement is possible unless there be full and free consent of all of the parties. Consent cannot exist when either party is without intelligent mind; therefore, in the strict sense, an insane person cannot give consent, for in the theory of the law he lacks one or both of the essential elements of consent, to wit: it must be free and it must be intelligent.
Parsons, in his authoritative work on contracts, clearly states the situation thus—"They who have no mind cannot agree in mind with another; and, as this is the essence of a contract, they cannot enter into a contract. Mere mental weakness or inferiority of intellect will not incapacitate a person from making a valid contract. There must be such a condition of idiocy or insanity as disables him from understanding the nature and effects of his acts and therefore disqualifies him from transacting business and managing his property." A practical application of this principle is set forth in a decree in which the court held that "it is not material that in taking the deed the grantee acted in good faith and without knowledge of the grantor's insanity, because he who deals with the insane, as with an infant, does so at his peril."

The first entering wedge toward modification of the wholesale principle that a lunatic could not enter into a contract was driven early in the last century when the courts began to hold that a person could not, after he had recovered his reason, void a contract by pleading his own insanity at the time the contract was made. A little later, some courts went so far as to hold that when, in an action on contract, the defense is set up that the defendant was insane when the contract was made, it is necessary to show that at the time of the contract such insanity was known to the plaintiff.

The unfairness of this latter position becomes evident when one compares it with the application of the common law to infants. The legal infant (a person under 21 years of age), whose intelligence at most is only limited, is treated much more considerately than the lunatic who, under the law, has no intelligence whatever. If a merchant enters into a contract with a youth, aged 20, who appears to be over 21, the former will have to bear the loss resulting from his mistake unless the goods supplied were necessaries. This legal infant
may have intentionally deceived the tradesman, but the fact does not give the contract validity. The merchant acts at his peril. The English law that protects the infant on the theory that his reasoning is immature should equally protect the lunatic who, under the law, has no reasoning at all.

The old doctrine of the English law that a person could not stultify himself by pleading his own insanity in order to avoid a contract he had made has been uniformly rejected in the courts of the United States. Some decrees show a tendency to go to the other extreme in holding that all contracts entered into by the insane are absolutely void. But according to the greater weight of authority the situation is: when a contract of an insane person is made prior to an adjudication of his insanity and the appointment of a guardian, the contract is voidable only and not void;¹ but when the contract is made by an insane person after he has been legally adjudged insane it is held to be absolutely void on the theory that the adjudication is a notice to all the world of the fact of the insanity of the person involved.

The trend of the courts is best evidenced by specific instances. Thus, in Connecticut in 1808, it was held by the Supreme Court that a person may prove, in avoidance of his contract that he was non compositus when he entered into it.² In Louisiana, in 1818, the State Court held that, to annul a contract, it must be shown that one party’s insanity could not possibly have been unknown to the other party.³

The Supreme Court of Maryland declared, in 1859, that lunatics and persons non compositus are not bound by their contracts even though no fraud or imposition has been practiced on them.⁴ In New Hampshire, in 1863, it was held

¹ McClain v. Davis, 77 Ind., 419;
McCormick v. Littler, 85 Ill., 62.
² Webster v. Woodford, 3 Day (Conn.), 90.
³ Louisiana Bank v. Dubreuil, 5 Mart (O. S.), 416.
⁴ Chew v. Bank of Baltimore, 14 Md., 299.
that mere mental weakness will not incapacitate a party from contracting. There must be such a state of insanity as actually to disqualify him from transacting his business and managing his property. He must, it seems, be incapable of understanding the act he performs.¹ Likewise in New Jersey, in 1872, it was decreed that when a contract is impeachable purely on the ground of alleged mental incapacity of the party to make it, unconnected with any charge that he was defrauded into making it, the true test is whether he had the ability to comprehend in a reasonable manner the value of the particular transactions. Proof of delusions on independent subjects is not enough.² Deeds and contracts of a person of unsound mind, who has not been judicially declared incompetent, are voidable and not absolutely void (1908).³ A still wider variation from the old English Law is set forth in a Texas case (1914), to wit: "The deed of an insane person is not void but only voidable since it may have been executed during a lucid interval, or ratified on the incompetent's regaining his sanity."⁴ And the deed of a lunatic is binding on him, if not disaffirmed, when his disability is removed.⁵

Degree of Mental Capacity Necessary. The attitude of the courts at the present time, with reference to the test of mental capacity to make a contract, may be said to be that weakness of mind is not of itself an objection to the validity of a contract, if there remains a capacity to see the things involved in the contract in their true significance and to form correct deductions relative thereto, and that one can make a contract who has the ability to understand the nature of the act in which he is engaged—its scope or effect or its nature and

¹ Dennett v. Dennett, 44 N. H., 531.
³ Smith v. Ryan, 191 N. Y., 452.
⁴ Porter v. Brooks, 159 S. W., 192.
consequences. To put it in another way in the language of a recent decision—"Mere mental weakness on the part of a contracting party does not justify a court of equity to set aside an executed contract unless the weakness amounts to inability to comprehend the contract."¹ The language of an Iowa Supreme Court decision is of the same portent: "To avoid a contract free from fraud or undue influence, on the ground of the insanity of a party thereto, it must appear that, by reason of his insanity, he had no reasonable understanding of the nature and terms of the contract."² Partial insanity, (monomania or paranoia) will not make a given contract voidable unless the delusions are related directly to the subject of the contract.

The modern construction of the law of contract is capable of extensive application and possesses far-reaching significance. For instance, a man may have a life insurance policy carrying certain options to be exercised at term, e.g., twenty years. If the insured has been adjudged insane after the issuance of the policy but before the expiration of the term at which option may be exercised, and he has been prevailed on to exercise a certain option provided for in his policy, said exercise of option is invalid though it grows out of the original contract made while he was yet sane and before his mental condition had been in question. The surrender of the policy under the terms of the option is held to be a new contract and as such invalid.³

Contracts for Necessaries. The law, as now interpreted, universally makes an exception to the general rules on matters of contract discussed above when it comes to necessaries supplied an insane person or his family. A contract for necessaries furnished an insane person stands on the

¹ Saffer v. Mast, 223 Ill., 108.
² Swartwood v. Chance, 131 Iowa, 714.
same footing as a similar contract with an infant or persons under 21 years of age. The courts, in practically all jurisdictions, hold that an insane person is liable for necessaries supplied to him in good faith and under circumstances that justified their being furnished. While the contract as to necessaries may in and of itself be void or voidable, the insane person is liable for necessaries furnished. Thus—"While under the statute all express contracts by the insane are prohibited, their estate may be held liable when the law implies one for services and necessaries rendered and furnished in good faith, and under circumstances justifying them."¹

From almost the beginning, the courts in this country have held that the contracts of persons non compotes mentis are, if not wholly void, at all events voidable, except when they relate to necessaries suited to their station in life (1847).²

And likewise as to the immediate family: "A husband is liable for necessaries furnished to his wife, although he is, at the time of such supply, a person non compos mentis and residing separately from her in an institution" (1834).³ "Necessaries" include not only articles of first necessity such as fuel, groceries, clothing, etc., but everything proper for the insane person's condition. Medical services rendered the insane person as well as the services of a nurse and other services that make for the insane person's health and comfort all come within the term "necessaries" as interpreted by the courts. The rule of the courts is explicit in this regard.⁴

A physician who renders necessary medical services to a lunatic or his family may recover a reasonable amount therefor. The decisions are not so clear with reference to legal services. Some decrees affirm such services to be necessaries while others deny it.

¹ Reando v. Misplay, 90 Mo., 251.
² Fitzgerald v. Reed, 17 Miss., 94.
³ Shaw v. Thompson, 33 Mass., 198.
⁴ Waldron v. Davis, 70 N. J. L., 788.
Loans, Sureties and Promissory Notes. With reference to loans and cash advances to an insane person, made in good faith, the law is also explicit as interpreted by the courts. Thus it is held that the insanity of a borrower, unknown to the lender, who acted fairly and in good faith, is not a defense to a suit to foreclose a mortgage. "Where A in good faith and without information to put him on inquiry as to the insanity of B, has lent B money, A may recover the same of B, although B has afterwards, upon inquisition taken, been declared to be insane."\(^1\)

The same liberality of interpretation does not occur in cases of suretyship. Both state courts and federal courts are in full agreement as to this. "An insane person is not bound by his contract of suretyship, even though the creditor accepted him as surety without knowledge of his incapacity."\(^2\)

As to promissory notes given by insane persons, the general rule is that a promissory note given by a person non compos mentis has no legal validity, although its consideration was necessaries furnished,\(^3\) yet, though the note is void, the price of such necessaries is a legal demand against the estate. But this rule has been expressly modified in certain specific cases and it has been held that it is error to enjoin a judgment on a note given by a lunatic for necessaries when there is nothing about his appearance or in the management of his business to indicate his incapacity to contract, though he may have been adjudged insane.\(^4\) This ruling in the *McCormick v. Littler* case not only makes provision for the doctrine of contract as to necessaries supplied to an insane person, but involves also the principle of notice, as well as that of "lucid interval." The doctrine in this decision has

\(^{1}\) *Mutual Life Ins. Co. v. Hunt*, 79 N. Y., 541.


\(^{3}\) *Davis v. Tarver*, 65 Ala., 98.

prevailed in so many jurisdictions that it is worth presenting in detail. The facts are these:

“On July 1, 1869, the agent of a well-known reaping and mowing machine manufacturing company, sold one of its machines to Laban Littler, a farmer of Champaign County, Illinois, taking two notes therefor, one of which had been paid. Suit was brought on the other note before a justice of the peace, and judgment rendered for the amount and interest. An execution being sued out, Mary Littler, the wife of Laban Littler and his next friend, applied for and obtained an injunction to stay proceedings on the writ, on the allegation that at the time of the purchase and the giving of the note Laban Littler was an insane person, having been so adjudged by the county court in March, 1868, which disability was removed by an order of the same court in 1872, three years after the purchase of the farm implement in question.

“The answer alleges that the defendants, when the sale was made, did not know of the disability of the purchaser, but deny he was a lunatic or insane, or unable to contract at the time of the sale; that he was at the time of the purchase, sane and rational, and knew the nature of the contract he was making; that he had need for the machine, and it was of great value to him and his family in carrying on his farm; alleges that Mary Littler, the wife, knew of the purchase of the machine at the time it was purchased, and made no objection thereto; that Laban Littler paid part of the purchase money before the commencement of the suit, with the knowledge of his wife, who made no objection, and that she repeatedly expressed herself as well pleased with the machine, and promised the note should be paid.

“The proof tends to show that Laban Littler was a man of feeble intellect. Some witnesses say he was crazy; some, insane; some, simple and foolish, and incapable of doing business; but he had acquired a handsome property, and a good farm, and traded with his neighbors. At the time of the purchase of the machine there was nothing in his conduct or appearance to excite suspicion. He came to the agent to buy the machine in company with his son, a lad about fourteen years of age, and seemed fully to understand what he wanted, and what he was doing. The agent went to the farm and set up the machine and started it in the grain, it working all right. He took dinner there on that day and saw Littler’s wife and children. They all knew that he had bought the machine and that the agent was there to set it up, and
no one raised any objection, or told him Littler was insane. No one of the family ever complained of the machine, and they have used it now about four years—in fact, ever since its purchase—in harvesting their crops of hay and grain.

"The question before the court is, whether, under such circumstances, the payment of the note can and ought to be enforced. The note was given in July 1869, the judgment was rendered on it October 1873. The statutes render all contracts with idiots, lunatics, insane or distracted persons, after the finding of a jury that such person is unfit to manage or control his property, either by note, bill, bond or otherwise, void as against such person. The statutes also provide for the appointment of a conservator when the jury shall find the facts. In this case, it has not been shown that a conservator had been appointed. How is it to be known a person is a lunatic and incapable of transacting business, when there are no outward manifestations of such a condition, and the records do not show his estate and affairs are in the hands of a conservator? He, in the view of the public, is in the exclusive possession of property, in this instance a farm, and a good one—apparently the master and manager of it.

"The machine was necessary and useful to the purchaser, and, like infants, he ought to be charged on the contract for its purchase. The statutes, we do not think were designed to annul contracts made for necessaries, if made in good faith, and under circumstances which justify the contract. The party purchasing had a large farm which he and his family cultivated, on which were growing grass and grain ready for the harvest. This machine was used in the harvest and in every succeeding harvest for four years thereafter. It was an article indispensable to him, suited to his condition, and he is liable to pay the price he agreed to pay, and that is proved to be the usual market price for such an article.

"But, notwithstanding the statute, a contract made with a lunatic in a lucid interval has been held, by this and other courts, binding. True, the purchaser presented no indications of insanity or lunacy at the time of purchase; his wife and family knew all about the purchase and not one of them suggested an inability to make a contract, and nothing was apparent, at the time, of any disability, and no witness swears he was in that condition at that time. It would be unjust and iniquitous, under the circumstances disclosed in this record, to hold this contract void.
"The decree making this injunction perpetual is reversed, and the cause is remanded, with directions to the circuit court to dismiss the original bill and give full effect to the execution."

We might also add that the injunction should have been denied for the further reason that the machine was a family necessity and that value was delivered and the judgment just.

**Lucid Intervals.** As early as 1603, the English courts made place in their decisions for the doctrine of lucid interval, the first enunciation of this simple principle occurring in the Beverley case decided that year. It was later held in the Selby case\(^1\) that the acts during a lucid interval are valid even though the actor may be confined and under restraint in an insane asylum; and in a later case\(^2\) the English court held that a contract entered into by a lunatic during a lucid interval is as binding as if made by a person of perfectly sound mind. The courts of this country are equally explicit. An insane person may have lucid intervals, and his contracts then made are valid and binding. Even one who is affected by a progressive disease, such as softening of the brain,\(^3\) may have periods of complete comprehension and understanding of transactions, especially when such transactions are not of a complicated character.\(^4\) A person may be insane and have been in an asylum, and yet his acts done in a lucid interval are valid.\(^5\) It is not, therefore, to be stated as an unqualified maxim of law that "once insane, presumed to be always insane." "In the case at bar," declares one court, "it is no more a presumption of law that a person rendered unconscious and incapable of

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\(^1\) Selby v. Jackson, 6 Beav., 192.
\(^2\) Hall v. Warren, 9 Ves., 605.
\(^3\) A popular name for general paralysis.
\(^4\) Critchfield v. Easterday, 26 App. D. C., 89.
\(^5\) Lilly v. Waggoner, 27 Ill., 395.
mental action by a stroke of paralysis will continue so for four months thereafter, than that he would so continue when the same effect were produced by a wound on the head. Such a result might follow in either case, but the law does not presume that it would in either. If the insanity is recurrent or temporary, the presumption arising from the finding of a person insane does not prevail."

In practice, when a person who had entered into a contract was subsequently discovered to have been a lunatic from a date prior to the contract, it is competent for the other party to sue for specific performance. This brings before the court three distinct phases of the question to be decided: (1) Was the defendant a lunatic at the time of making the contract? (2) If so, did he have lucid intervals? (3) Was the contract in question executed during such a lucid interval?

**Deeds and Conveyances.** Deeds and conveyances, being among the simplest forms of contract and those easiest of comprehension, are more liberally construed, as a rule, by the courts than are contracts involving ordinary business dealings. The courts tend to hold that it takes less mind to convey land than it does to transact ordinary business. This phase of the situation will be discussed more specifically with the making of wills under the heading "Testamentary Capacity."

The statutes declare the contracts of an idiot void, if made after the finding of a jury, but only voidable if made before the finding. Deeds and conveyances are contracts and the authorities are overwhelming that a deed executed by a person of unsound mind, if made before an inquisition, is not void but only voidable. The burden of proof is

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1 Trish v. Newell, 62 Ill., 201.
on the person claiming that the deed is invalid.\(^1\) Neither the grantor, nor his guardian or conservator, can disaffirm the contract of deed in any court, without first refunding the purchase money and expenditure for taxes. Naturally he cannot retain the money and recover the land.\(^2\) A party cannot affirm a contract in part, and rescind as to the residue. If he rescinds he must do so \textit{in toto} and he must put the opposite party in as good condition as he was before the sale was made. \textit{He who seeks equity must do equity.}\(^3\) An insane person may either ratify or disaffirm an act, contract or deed, made when he was insane, after he becomes sane.\(^4\) But this ratification of a deed after restoration to sanity must be the intelligent act of the grantor, who, with full knowledge of the conveyance, clearly evinces an intention to abide and be bound by it,\(^5\) and when he has received the purchase money on his restoration to sanity such a ratification is deemed to have taken place.\(^6\)

It is well settled that a court of equity has the power to cancel a deed procured from any person of weak understanding if it is made to appear that he was unable to guard himself against imposition or to resist importunity.\(^7\)

While an insane person, by reason of his insanity, may be relieved of the terms of any contract, the same relief is not


\(^2\) Tisdale \textit{v. Buckmore}, 33 Me., 461;
Jennings \textit{v. Gage}, 13 Ill., 611;

\(^3\) Smith \textit{v. Brittenham}, 98 Ill., 188;
Fay \textit{v. Burditt}, 81 Ind., 433;
Young \textit{v. Stevens}, 48 N. H., 133;


\(^6\) Blinn \textit{v. Schwarz}, 177 N. Y., 252;
Searle \textit{v. Galbraith}, 73 Ill., 269.

\(^7\) Sprinkle \textit{v. Wellborn}, 140 N. C., 163;
afforded to the other party to the contract, deed, mortgage or conveyance. The statutes in most of the states expressly provide:

"Every bill, note, bond or other contract by any idiot, lunatic, distracted person or spendthrift, made after the finding by jury or commission shall be void as against the idiot, lunatic, distracted person or spendthrift and his estate. Every contract made with an idiot or lunatic before such finding may be avoided except in the favor of the person fraudulently making the same. The person making any contract with such idiot, lunatic, distracted person or spendthrift shall be bound thereby."1

While it is the law that to entitle one to rescind an executed contract, made while he was insane, with another having no notice of his insanity, he must return whatever consideration he has received,2 this rule does not apply when the contract was fraudulent, i.e., when advantage was taken of the insane person's condition. For instance when a plaintiff, an incompetent and a spendthrift, being unable to get a loan on a farm in which he had an equity of $12,500, was induced to convey the farm to the defendant in consideration of a house and lot valued at $3,000 and mortgaged to the defendant's brother-in-law; this mortgage the incompetent assumed, and also received certain worthless mining stock and a check for $1,250, which he immediately cashed and wasted; and since any reasonable person conversing with the incompetent would have discovered his incapacity, he was not required to return the proceeds of the check as a condition of the setting aside of the conveyance.3 The entire doctrine as to deeds and conveyances, and their ratification or avoidance, is well set forth in one decision

1 Cahill, Revised Statutes of Ill., 1921, Chap. 86, Secs. 14 and 15.
2 Morris v. Gt. Northern Ry. Co., 67 Minn., 74;
Merry v. Bergfeld, 264 Ill., 84.
3 Fecht v. Freeman, 251 Ill., 84;
Hardy v. Dyas, 203 Ill., 211.
which holds that a conveyance by a lunatic made in ignorance of his insanity, and without advantage, and in good faith, will not, be set aside if the parties cannot be restored to their original situation. Only in cases of fraud should the deed of an insane person be set aside without a return of the consideration, but in cases in which it was made in good faith the grantee should be reimbursed.¹

Certain contracts made by a person while sane may be enforced, although the party making the contract has since become insane. In case of mortgages, the subsequent insanity of the mortgagor does not suspend the power of sale under the mortgage or render such a sale void.² Insanity cannot be regarded as an excuse for the failure to perform an obligation such that the rights of the insane person will remain the same as if he had performed the agreement. An excellent illustration of this principle is found in the case of one failing to pay the premium of an insurance policy because of insanity. The courts hold that failure to make payment of premiums is not excused by reason of insanity nor does insanity serve to prevent the policy from being forfeited by reason of such non-payment of the insurance premiums as designated in the policy.³

A subscription does not constitute a binding contract. Dr. Beach signed his name in subscribing $2,000.00 toward the building of a church at Fairbury, Illinois, the amount to be paid in three instalments at times designated. He paid the first two instalments. Before the last instalment of $666.66 was due he became insane, was so adjudged in the county court of Livingston County and a conservator was appointed. The church brought suit for the payment of the final instalment, claiming that certain expenditures had been made on

¹ Walton v. Malcolm, 264 Ill., 389.
² Lundberg v. Davidson, 72 Minn., 49.
the basis of the subscription, including the balance due and unpaid. The Supreme Court held that the subscription was not a binding contract; that the payment of the last installment, for which suit was brought after the insanity of the subscriber, is revoked by his insanity.¹

Is an insurance contract vitiated by the suicide of the insured, on the ground that the suicide demonstrates the insanity of the policy holder?

The legal presumption of insanity does not arise from an act of suicide. Neither an act of suicide, nor an attempt or threat to commit suicide, would of itself justify a jury in finding a person insane (1879).² When suicide is offered as evidence of insanity, the presumption of sanity is not overthrown by the fact that the deceased committed suicide (1895).³ The law draws no inference as to insanity from the suicidal act⁴ *per se* in view of the fact that there is a difference of medical opinion as to whether suicide is necessarily an indication of insanity, it being maintained by some that sane persons take their own lives. It is generally held, however, that the fact of suicide may be considered, in connection with other evidence, in the effort to establish insanity.⁵

¹ Beach v. First M. E. Church, 96 Ill., 177.
⁴ Wilkinson v. Service, 249 Ill., 146.
⁵ Grand Lodge, I. O. M. A. v. Wieting, 168 Ill., 408.
V. INSANITY AND MARRIAGE

Historical. The term "marriage" in law is usually employed to designate two things that are in their nature widely different, to wit:

1. A contract, meaning the act, or series of acts, or the ceremony by which a man and a woman stipulate to live together as husband and wife.

2. A status, that is the relationship toward each other and toward the community which arises out of the contract.

The marriage status differs from a contract in that when once created it cannot be abrogated or dissolved by the act of the parties, and ends only with death or dissolution by legal process. As defined by English law, marriage is essentially "the voluntary union for life of one man and one woman to the exclusion of all others."¹

Historically, the evolution of the marriage contract is an interesting development. The earliest custom of primitive peoples seems to be that of wife capture from a hostile tribe. Wife capture becoming more and more difficult it gave way to wife purchase. To such a transaction some form of celebration or ceremonial was easily attached. This ceremonial readily yielded to the tribal religious influences. A religious marriage soon supplanted the sale, and later was substituted for the sale marriage; thus the wife's position steadily improved, for, when it became a religious relation, the wife was protected in her rights by the priests. Thus, the sale became fictitious, and, in lieu of purchase money, so many cattle or sheep or goats, a ring or a coin was tendered as

a symbol of such purchase. This symbolic sale was in essence a contract—at first a contract between the man and the woman's father or guardian, "who giveth her to be married to this man," the woman's consent not being essential. When the woman's consent began to be considered necessary, marriage, as a contract, attained its modern character and aspect.

**Degree of Mental Capacity Necessary.** Marriage, in so far as its validity is concerned, is treated as a civil contract; but, aside from the essential element of consent of the parties thereto, is very unlike any other contract. It cannot be revoked at will\(^1\) and the rights, privileges and duties arising from the contract cannot be transferred or assigned.\(^2\) As a contract, it may be entered into by persons not capable of participating in other forms of legal contract; inasmuch as the contract to marriage is extremely simple, it does not require a high degree of intelligence to comprehend it.\(^3\) On the other hand, in some countries marriage is more than a civil contract because of the religious element added thereto—an element due to the close relationship between church and state. Thus in English Law it is still in a measure regarded as more than an ordinary civil contract; this arises from the custom that, prior to 1858, matrimonial cases were heard in the Ecclesiastical Courts where rules of civil and canon law both applied.

In the United States, however, marriage has always been considered, by the law, as a civil union depending on contract, which involves the exercise of reason; and a person of unsound mind cannot enter into a valid contract of marriage,\(^4\)

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1 Green *v.* State, 58 Ala., 190; Hulett *v.* Carey, 66 Minn., 327.
2 Hayden *v.* Vreeland, 37 N. J. L., 372.
3 Turner *v.* Meyers, 1 Hagg Cons., 414 (England); Green *v.* State, *supra*.
except during a lucid interval, since he cannot consent to any contract. The validity of a marriage is determined by the mental capacity of the party at the time of the marriage and not by the condition of his mind before or after the marriage. The evidence of mental incapacity must be clear to have sufficient weight. "A marriage is not to be declared void because of the mental incapacity of one of the parties, except on the clearest and most definite evidence; and but little weight should be given to the opinion of a physician who did not, at the time of the marriage, see or know the mental condition of the party claimed to be insane."

Special insane tendencies are not sufficient to procure annulment of the marriage contract. Thus, nullity of a marriage cannot be decreed because the wife, otherwise sane and able to understand the nature and obligations of the contract, was at the time a kleptomaniac. Mere mental weakness of a party will not invalidate a marriage unless it produces such derangement as to do away with the power of consent. Mental weakness or even unsoundness not amounting to inability to contract in ordinary affairs will not alone avoid a marriage.

The degree of unsoundness is a determining factor in the court's consideration of marriage annulment on account of mental defect. It is really immaterial whether the mental incapacity and the consequent want of consent arises from idiocy or lunacy or the two combined. The test is the capacity of the party in question to understand the nature

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1 Rawdon v. Rawdon, 28 Ala., 565;
2 Inhab. of Unity v. Inhab. of Belgrade, 76 Me., 419.
3 Hancock v. Peaty, L. R. 1. P & D., 335;
4 Cole v. Cole, 37 Tenn., 57;
7 Lewis v. Lewis, 44 Minn., 124.
8 Adams v. Scott, 93 Neb., 537.
and obligations assumed by the marriage. A decree of
nullity can be granted only if the court is satisfied that, at the
time of marriage, the party whose insanity is in question was
incapable of understanding the nature of the marriage con-
tract and the duties, obligations and responsibilities such a con-
tract entails, and, however abnormal and insane the conduct
of the party may be soon after marriage, the court will not
annul the marriage unless the actual insanity existed at the
time of marriage. A person, to possess mental capacity to
enter into a marriage contract, must be capable of entering
understandingly into the relation. "A mere marriage
ceremony does not make a man and woman husband and wife.
Capacity and consent are absolutely essential, but celebration
only contingently so."

If, however, fraud or concealment has been employed,
then a less degree of mental incapacity may be required to
invalidate the marriage and procure the annulment. Thus
marriage was annulled when one of the parties was insane at
the time the marriage took place and the insanity was
unknown to the other, having been concealed by the fraud-
ulent practices of the friends of the insane party with whom she
resided, and who knew the fact of the insanity.

A marriage that has been voided on account of the lunacy
of a party cannot be cured by cohabitation after restoration.
And in one case in which a woman was at no time in her life
possessed of sufficient mental capacity to make any contract
whatever, her husband procured the annulment of the
marriage, notwithstanding the fact that he had lived with her
for nineteen years after the marriage. However, a marriage

1 Dunphy v. Dunphy, 161 Calif., 380;
Adams v. Scott, 93 Neb., 537.
2 Hagenson v. Hagenson, 258 Ill. 197.
4 Keyes v. Keyes, 22 N. H., 553.
5 Sims v. Sims, 121 N. C., 297.
6 Chapline v. Stone, 77 Mo. App., 523.
with a lunatic is not void if no legal proceedings are taken, and on his death the wife becomes entitled to the rights of a widow.¹

Mental incapacity can arise from any cause, so that with reference to drunkenness at the time of marriage, the courts hold that, if the intoxication be of such degree that the party in question is, for the time being, deprived of his reason and does not know what he is doing, the marriage is invalid but is not voidable if the intoxication is of a less degree.² The insanity of delirium tremens voids a marriage contract.³

From this discussion it will readily appear that the law, in regard to the mental capacity of the parties to a marriage to enter into such a contract, applies the general rule governing all contracts—namely, that the parties must be capable of understanding the nature and consequences of the contract entered into. What constitutes such mental capacity is decided by considering the simple nature of the marriage contract and its immediate and more direct consequences, (obligations, rights and duties) rather than those more remote and secondary (property rights).

As a group, the cases of early senile and arteriosclerotic dementia supply, in proportion to their number, the most deviations from the straight moral path (such as offenses against decency) arising from perverted excitement and incitement of the sexual sense which may attend involution. Naturally, therefore, this same group (those in the early stages of senile dementia) constitute proportionately the greater number of the mentally unsound who endeavor to enter into the marriage relation. Their promises to marry, as well as the marriages themselves, are but the result of a peculiarly perverted urge—a behavior reaction belonging to their peculiar type of mental disease.

¹ Wiser v. Lockwood’s Est., 42 Vt., 720.
² Prine v. Prine, 36 Fla., 676.
³ Clement v. Mattison, 37 S. C. L., 93.
Breach of Promise. Since a contract of marriage, like other contracts, is of no validity if either of the parties is of unsound mind,\(^1\) imbecile\(^2\) or insane,\(^3\) unless the contract be made in a lucid interval,\(^4\) it can readily be seen why a lunatic should not be held responsible for damage because of his failure to carry out a contract of marriage as pledged on betrothal. If the insanity existed at the time of the betrothal, there could be no possibility of the consent essential and integral to all contracts. If the insanity is subsequent to the betrothal he cannot be sued because there is no possibility of performance since his mental incapacity will not permit him to complete the marriage contract though sacredly pledged and solemnly trothed while sane.

Divorce. Postnuptial insanity is not a ground for divorce except in a few jurisdictions; as a rule, when a marriage has been validly contracted, such contract endures notwithstanding the subsequent insanity of either party. The power of the legislature to enact laws empowering the court to grant divorces on account of postnuptial insanity has been upheld.\(^5\)

In none of the dominions of the British Empire, save New Zealand and Western Australia, is insanity a ground for divorce. In New Zealand, since 1908, a divorce may be obtained on the ground that the respondent is a lunatic or insane person who has been confined in an asylum for the insane for at least ten years of the twelve immediately prior to the suit, and is unlikely to recover. The provision in Western Australia is practically the same except that the

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3. Turner v. Meyers, 1 Hagg Cons., 414 (England); Wightman v. Wightman, 4 Johns Ch. (N. Y.), 343.
period of confinement of the respondent in an institution for the insane is five out of the six years immediately prior to the filing of the suit. The German civil code of 1900 provided that insanity of three years duration after marriage was absolute ground for divorce throughout the then German Empire. The same law obtains in Norway, Sweden and Portugal, if it be shown that the insanity is, in all probability, incurable. Switzerland made a similar provision in its code in 1907. In no other European country or state is insanity a ground for divorce, save in Denmark where limited divorce may be secured. Neither Japan nor China, nor any African or South American country provides for divorce on the grounds of insanity supervening after marriage.

At the present time only four of the states in the Union provide for divorce on the grounds of insanity supervening after marriage: Pennsylvania, Idaho, Utah and Washington. Arkansas formerly had a statute of this nature but it was repealed in 1895. A similar statute that was enacted in Florida in 1901, was repealed in 1905. North Dakota, in a law that became effective in 1899, made incurable insanity of two years duration a ground for divorce. At the next session of the legislature in 1901, in response to popular protest, this statute was promptly repealed. The state law of Washington provides that "In case of incurable, chronic mania or dementia of either spouse having existed for five years or more while under confinement by order of a court of record, the court may, in its discretion, grant a divorce."

The Idaho statute is a little more explicit:

"Providing, that no divorce shall be granted on the ground of insanity unless such insane person shall have been duly and regularly confined in an insane asylum of this state, or of a sister state, for at least six years next preceding the commencement of the action for divorce, nor unless it shall appear to the court that such insanity is permanent and incurable. . . . The plaintiff in such a suit for
divorce shall be a resident of the state and shall have resided therein for one year next preceding the commencement of the action for divorce."

Pennsylvania has an old statute, enacted in 1843, which provides that the husband may obtain an absolute divorce when the wife is a lunatic or insane and the petition is brought by a relative or next friend of the wife.

This old statute of Pennsylvania was so amended in 1905 as to apply to both husband and wife and so modified that the affidavit can be made by the petitioner and service can be had on the committee or guardian of the lunatic. This amendment further provides that, on hearing, the lunacy shall be fully established by expert testimony and any other circumstance of value in reaching a conclusion as to the alleged lunacy. This law as amended specifically states that "no divorce shall be granted unless proven beyond a reasonable doubt that the husband or wife of the petitioner is hopelessly insane; provided, that if the husband or wife has been ten or more years an inmate of an asylum for the insane it shall be conclusive proof of hopeless insanity." This was reaffirmed by the legislature in 1909.1

Thus, only a small minority of states include insanity as a ground for divorce. The greater number of states in listing the grounds for divorce do not include insanity. A large group of states absolutely prohibit suits for divorce on any grounds provided by statute if the respondent is insane at the time the suit for divorce is filed or at the time of the commission of acts that would otherwise afford ample grounds for divorce. Thus it is held in most jurisdictions that culpable actions which ordinarily would be sufficient of themselves as basis for divorce, are nullified completely when the offender is insane. In other words, insanity becomes a complete defense to a suit for divorce on any ground.

1 Penn. Revised Statutes, Section 9,150.
As far back as 1811 it was held that adultery committed by the wife while insane is no ground for divorce on the application of the husband. Likewise, in 1882, though a statute makes failure to provide support a ground for divorce, the wife is not entitled to a divorce on that ground when the failure is caused by the husband’s insanity. Furthermore, cruel and inhuman treatment caused by the insanity of the party guilty thereof is not ground for divorce.

As a corollary to this line of ruling, it is held in most jurisdictions that an insane person cannot bring suit for divorce even by his guardian, no matter how glaring the offense. The right to bring such suit is held to be purely personal and under the volition and control of the person injured by the infidelity or inhuman treatment of the other. A wife being insane, cannot give consent to the proceedings had in the divorce case, and hence everything that was done in her name was invalid. Since a petition for divorce must be verified by the oath of the plaintiff, and there being no provision for substituted verification, a guardian of an insane person cannot maintain an action in her behalf for divorce.

In the small minority of the states in which chronic postnuptial insanity is a ground for divorce, provision is made by statute for the appointment of a guardian ad litem. This does not violate the general rule that incapacity to be sued, on account of insanity, also carried with it as a corollary an incapacity to sue. Neither does it militate against the practice in the case of suit for annulment on

2 Wertz v. Wertz, 43 Iowa, 534; Tiffany v. Tiffany, 84 Iowa, 122.
3 Worthy v. Worthy, 36 Ga., 45.
4 Bradford v. Abend, 80 Ill., 78.
5 Mohler v. Shank’s Estate, 93 Iowa, 273.
account of insanity before marriage when the proceedings may be brought in the name of the lunatic by his guardian, or by the guardian himself. 1

In England the following recommendation has been made by the Royal Commission on Divorce and Matrimonial Causes with reference to insanity as a ground for divorce: 2

"That insanity should be introduced as a ground for divorce subject to the following limitations and conditions:

(1) The insanity which should form a ground for divorce should be certified as incurable, and

(2) The insane spouse should have been continuously confined, under the provisions of the Lunacy Acts for the time being in force, for not less than five years.

(3) The insanity should be found to be incurable to the satisfaction of the court.

(4) This ground should operate only when the age of the insane person is, if a woman, not over fifty years, and if a man, not over sixty years."

**Marriage and Epilepsy.** It should also be noted that certain states prohibit the marriage of epileptics. From the context of such statutes it is plain that this prohibition arises from the consideration of eugenics rather than the mental incapacity of the afflicted party. Thus, in the state of Washington, such marriage is prohibited unless the woman be over 45 years of age, and the infraction of this law is punishable by a fine of not more than one thousand dollars or by imprisonment in the penitentiary for not more than three years or by both. The Michigan statute is even more sweeping:

"No person who has been confined in any public institution as an epileptic, feeble minded, imbecile or insane patient shall be capable of

1 Crump v. Morgan, 38 N. C., 91.
2 Cook—"Insanity and Mental Deficiency in Relation to Legal Responsibility"—E. P. Dutton & Co., New York, 1921, pp. 121 and 122.
contracting marriage without, before the issuance by the county clerk of the license to marry, filing in the office of the said county clerk a verified certificate from two regularly licensed physicians of this state that such person has been completely cured of such insanity, epilepsy, imbecility or feeble mindedness and that there is no probability that such person will transmit any such defects or disability to the issue of such marriage."

This statute provides further that any person who intermarries with such an individual, or any person who aids or abets such a marriage without such a prescribed certificate shall be deemed guilty of a felony punishable by a fine of not more than one thousand dollars or by imprisonment in the state penitentiary at Jackson for from one to five years or by both.
VI. INSANITY IN RELATION TO TORT

Principles. It is the well settled rule in this country that an insane person or his estate is civilly liable in damages to one injured by reason of a tort committed by him, except perhaps when malice, therefore intention, is an essential element in the plaintiff's recovery, as in a case of libel, slander or malicious prosecution. And it has been held that this liability is not affected by the fact that the plaintiff knew the mental condition of the defendant and might have prevented the act\(^1\) or that the defendant was under guardianship at the time.\(^2\)

This rule is based on the principle that, when a loss must be borne by one of two innocent persons, it shall be borne by him who caused it. Furthermore, it is held that public policy requires the enforcement of the liability of an insane person or his estate for his torts in order that those connected with him, as friends or relatives, be interested in restraining him for the good of society as well as himself, and also to prevent tortfeasors from simulating or pretending insanity as a defense for wrongful acts that result in damage to others.

The attitude of the courts toward the torts of insane persons is well illustrated in the case of McIntyre v. Sholty.\(^3\) Hannah Sholty was the wife of Levi Sholty, a farmer living in McLean County, Illinois. About February 17, 1886,

\(^1\) Morse v. Crawford, 17 Vt., 499.
\(^3\) McIntyre v. Sholty, 121 Ill., 660.
David Sholty, an insane brother, was discovered hiding in the granary at one end of the large barn on the premises of Levi Sholty. He shot twice with a pistol at the two observers who were trying to prevent his escape and capture him. Presently there was a cry of fire and flames were seen to be breaking out at the eastern end of the barn, being the end nearest to the house. At that time Mrs. Hannah Sholty, plaintiff’s intestate, went from the home toward the barn and covered about half of the distance, when David Sholty, appeared at the door at that end of the barn with a shotgun. He was plainly visible in the light made by the fire that had broken out. He called upon Hannah Sholty and her daughter, Mary, who was with her, to stop. They stopped, turned and had proceeded a few feet on their way back to the house, when David Sholty fired at them with the gun in his hand. The daughter was wounded and the mother, Hannah Sholty, was killed. Her husband, Levi Sholty, as administrator of her estate, sued to recover damages for her death from the estate of David Sholty who is said to have perished in the flames of the burning barn. The defense sought to show that David Sholty was insane at the time Hannah Sholty was killed, thus raising the issue as to the liability of an insane person for injuries committed by him.

The court in deciding this case declared it is well settled that, though a lunatic is not punishable criminally, he is liable in civil action for any tort he may commit. However justly this doctrine may have been subject to criticism originally, on the grounds of reason and principle, it is now too firmly supported by the weight of authority to be disturbed. There certainly can be nothing wrong or unjust in a verdict which merely gives compensation for the actual loss resulting from injury inflicted by a lunatic. He has, properly speaking, no will. He lacks the element of intent.
Hence it would seem that the only proper measure of damages in an action against him for a wrong is the mere compensation for damages to the party injured. Punishment is not the object of the law when persons of unsound mind are the wrongdoers.

There is, to be sure, an appearance of hardship in compelling one to respond for that which he is unable to avoid for want of control of the reason. But the question of liability in these cases is one of public policy. If an insane person is not held liable for his torts, those interested in his estate, as relatives or otherwise, might not have a sufficient motive so to care for him as to deprive him of opportunities for inflicting injuries on others. There is more injustice in denying the injured party the right of recovery of damages for the wrong suffered than there is in calling on the friends or relatives of the lunatic to pay the expenses of his confinement or to draw on his estate if he has an estate ample for that purpose. The liability of lunatics for their torts tends to procure more efficient custody and guardianship of their persons.

Again, if parties can escape the consequences of their injurious acts on the plea of lunacy, there will be strong temptation to simulate insanity with a view of masking the malice and revenge of an evil heart.

In light of the principles thus announced, the judgment of the circuit court in assessing damages to the amount of $2,500 against the estate of David Sholty was affirmed.

A Federal Circuit Court of the United States makes a narrower application of the same principle that an insane person is liable in a civil action for his torts in a case\(^1\) that came before this high judicial body on appeal from the United States District Court of the Western District of North Carolina.

\(^1\)Avery v. Wilson, 20 Fed., 856.
The plaintiffs in this case were owners of patent rights. The defendant admitted infringement, but insisted that he was a lunatic, or insane, at the time and had been so found and declared by inquisition of a jury. Later, on recovery of his sanity, another jury found he had become sane and capable of attending to business. In this case the court held to the general rule that a person non compos mentis is not responsible for crime. A lunatic is, however, often civilly liable for his torts, as he is not exempt from the general doctrine of the law that whenever one receives an injury directly from the voluntary act of another, that is a trespass, although there was no design to injure.

Torts against Property. Injuries to property, corporeal and incorporeal, include another class of torts in which it is generally conceded that lunatics are responsible for compensatory damages to the extent of the actual injury sustained. A lunatic can only be liable for compensatory damages. In these cases the law does not so much regard the intent of the wrongdoer as the loss and damage of the person injured.

In the case of Avery v. Wilson (supra) the defendant infringed on the corporeal right conferred by law on the plaintiffs. A patent right is an exclusive liberty conferred—it is the personal right of the inventor or his assigns. If it be infringed, he has remedy at law by action for trespass in the case for damages and a remedy in equity, by injunction, to prevent the continuance of the wrong. "Therefore in this case the plaintiffs have right to perpetual injunction and to an accounting to ascertain the profits derived by the defendant from his infringement, though such infringement took place while the defendant was insane. And the plaintiffs are entitled," says the court, "to recovery of such amounts of money, when determined by said accounting, and the costs of the suit are assessed against the defendant."
Likewise, if a lunatic sets fire to the insured property of another, the insurer having paid the loss may recover the amount thereof from the lunatic.\(^1\) Insane persons have been held liable in damages for assault and battery;\(^2\) for damages in causing the death of another by an act that would have been felonious except for the insanity;\(^3\) for compensation to a guardian for damages done to the guardian's property by the insane tort of his ward;\(^4\) for injury caused by the defective condition of land under control of his guardian, and not in exclusive occupancy and control of a tenant.\(^5\) One so weak intellectually that he is incapable of managing his estate, and who on that account is under a guardian, may still be capable of perpetrating a fraud for which he will be held responsible.\(^6\) He may also perpetrate a nuisance, that is, do a wrong to a man by unlawfully disturbing him in the enjoyment of his property or in the exercise of a common right.

**Libel and Slander.** With reference to libel and slander and the civil liability of an insane person in damages therefor, the authorities are somewhat in conflict. It is generally held that in such cases the same rules that preclude criminal responsibility are applicable, since certain essential elements as intent, malice and the like are necessary ingredients of such responsibility. It has been held, however, that the insane person is liable for actual damages done by his slanders and libels just as for other torts,\(^7\) but, being incapable of malice, smart-money damages cannot be given against him. If greater than mere compensatory damages are sought,

\(^2\) Moore v. Horne, 153 N. C., 413.
\(^3\) Jewell v. Colby, 66 N. H., 399.
\(^4\) Brown v. Howe, 75 Mass., 84.
\(^6\) Spaulding v. Harvey, 129 Ind., 106.
insanity is a good defense thereto. In action for slander, insanity is a good plea in defense as an excuse for mitigation of the damages. In an action for conspiracy, the unsoundness of mind of one conspirator at the time of the trial is no defense for him or for the other conspirators sued.

**English Law.** American law and English law are at variance in the matter of torts. The common law of England regards a lunatic generally as incapable of committing a tort unless it be shown that the particular nature of his insanity did not prevent him from understanding the nature and consequences of the particular act in question. In the latter case, if it can be shown, he will be liable for his torts just as any other person is liable on the ground that he intended the natural consequences of his act.

Sir Fredrick Pollock goes so far as to state that the liability of an insane person for his torts is based on the theory that inevitable accident is no excuse, that this theory is now obsolete, and that its abandonment is now recognized by the common law of England. Likewise, Sir John Salmond, K. C., says that there is no adequate authority in English law, as it now stands, for holding lunatics liable for their torts. On the other hand, as seen from cases cited above, the American authorities are agreed that, while insane persons are not liable for their torts when intention or malice is an essential ingredient of liability, they are liable in other torts on the broad principle that when one of two innocent persons must bear a loss, he must bear it whose act caused it. As thus construed by two such eminent legal authorities, the attitude of the common law of England in comparison with

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1 Jewell v. Colby, 66 N. H., 399.
2 Yeates v. Reed, 4 Blackf. (Ind.), 403.
3 Tucker v. Hyatt, 151 Ind., 332.
4 Law of Tort, p. 56.
5 Id., p. 61.
American decisions is all the more surprising, especially when one recalls that the English legal practice tends to hold the alleged culprit to stricter accountability for his acts than is the case in this country.
VII. INSANITY AND CRIMINAL RESPONSIBILITY

Historical. It requires but the most cursory survey of the history of criminal jurisprudence to reveal glaring defects in the earlier administration of law as applied to criminal responsibility. These defects were chiefly due to the crude and crass notions of insanity that then obtained. At a period when meager and erroneous notions prevailed as to the nature and causes of insanity, the legal authorities, of necessity, were crude in their consideration of criminal responsibility. It has always been a well settled principle that a person cannot be legally punished for the consequences of an act committed while he is insane, which same act would be punishable if done by a sane person. No one can commit a crime unless he has sufficient capacity, mentally and otherwise, to commit it. The difficulties that arose from time to time, and the notable defects in legal administration as voiced by the courts, were plainly due to insufficient knowledge of what constitutes insanity.

One of the earliest legal tests used to determine the degree of mental unsoundness that would exempt a person from punishment was what was known as the "wild-beast" test. It was first voiced in 1723, in the trial of Arnold for shooting at Lord Onslow. Mr. Justice Tracy then said, "It is not every kind of frantic humor, or something unaccountable in a man's actions, that points him out to be such a madman as is exempted from punishment; it must be a man that is totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, than a brute or wild beast; such a one is never the object of punish-
This is but a judicial pronouncement of the principle previously laid down by Lord Hale.

Even at that early date a distinction was maintained between civil and criminal acts. The courts would not exempt a person from criminal responsibility unless his reason was entirely gone; but for a less degree of insanity these same courts would deprive a person of the care of his own personal affairs and the management of his property. A man might not possess mental capacity sufficient to sign a deed, execute a will, or conduct his business affairs and yet be held responsible for a criminal act. A man could be legally hanged for murder and yet be regarded, by the same court, as unfit to take care of himself or his property. Something of the same distinction between civil and criminal cases obtains in the courts even at the present time. "While a slight departure from a well balanced mind may be pronounced insanity in medical science, yet such a rule cannot be recognized in the administration of law when the person is on trial for the commission of a high crime. The just and necessary protection of society requires the recognition of a rule which demands a greater degree of insanity to exempt from punishment."  

Criminal Intent. From time immemorial the real question has always been whether the person accused of crime was capable of criminal intent. The aim of the law has always been to exempt from punishment as criminals those who, from the state of knowledge then existing, were incapable of criminal intent. Criminal intent is an essential element of crime. If a person is mentally unable to form such intent he cannot be regarded as guilty under the law.

   U. S. v. Lancaster, 26 Fed. Cas. No. 15,555;
   Marler v. State, 67 Ala., 55;
Since a crime includes both the act and the intent, and an unsound mind cannot form criminal intent, insanity is a complete answer to a criminal charge.\(^1\) A lunatic cannot be guilty of crime as he is not a free agent and is therefore incapable of guilty intent.\(^2\) Insanity will not constitute a proper ground of defense to a criminal accusation, unless it is shown to exist to such an extent as to blind its subject to the consequences of his acts, and to deprive him of all freedom of agency.\(^3\) Want of capacity is a complete defense and not merely a mitigating circumstance.\(^4\) Therefore there is no insanity that will acquit of murder and permit the afflicted defendant to stand convicted of manslaughter.\(^5\)

*Criminal Intent Defined.*—What is criminal intent? The short definitions given in the law dictionaries are usually unsatisfactory. Thus a standard work\(^6\) defines criminal intent as “the intent to commit a crime; malice, as evidenced by a criminal act.” There is no satisfactory short definition which would fit all cases. Some statutes attempt to define a crime as a joint operation of criminal act and intention, but this is obviously defective, for persons can be guilty of crime without committing any act in cases wherein the law imposes upon them the duty of action. There are also cases in which the law punishes as criminals those who perform certain acts regardless of their intention *e.g.* violation of the law prohibiting the changing of automobile license numbers, the adulteration of food, and the sale of cigarettes to minors.

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1 Braswell *v.* State, 1 Ky. Law Rep., 285 (1880).
2 Krom *v.* Schoonmaker, 3 Barb. (N. Y.), 647 (1848).
3 Com. *v.* Mosier, 4 Pa., 264.
5 U. S. *v.* Lee, 15 D. C., 489.
Intent or intention means a purpose, design, resolve or determination of the mind. With this in mind the following points should be noted:

1. To render an act criminal a wrongful intention must exist.

2. In considering whether an act is done with criminal intent the prior and accompanying acts are all to be considered.

3. Courts and juries must judge the intent a man has in the doing of an act by the means he employs and the things to be accomplished.

4. As a general rule when any wrongful act is committed the law infers that it was intentionally committed e.g. the intent to take life may be inferred from the character of the assault and the attendant circumstances. In other words, the law recognizes a general maxim to the effect that one intends the natural consequences of his acts so that if one hits another on the head with an iron bar he cannot maintain that he intended no injury. But the use of an iron bar as a deadly weapon does not always imply the existence of criminal intent for a weapon can be lawfully used in necessary self defense.

5. Generally speaking, ignorance of the law is no defense.

6. The proof of intent may be the external and visible acts and conduct from which the court and jury may infer the intent; or the proof of the acts committed may prove the intent; thus proof of a burglary and stealing from the domicile burglarized conclusively proves the intent to commit burglary.

7. The law supplies the element of the intent when a person is engaged in the commission of a felony and punishes for unintended results. Thus, when a man intending to commit one wrong (as a burglary, hold-up, or robbery with a gun) fails but accidentally commits another (homicide), he will be held to have intended the act he did commit.
From the above considerations it will be seen that criminal intent has a wide scope and it is equally clear that a particular state of mind is not always required. The best short definition we can frame is: Criminal intent is a knowing disregard of criminal law (bearing in mind that ignorance of a law is no defense as knowledge of the law itself is presumed). Any person manifesting this disregard is an outlaw, that is to say he is a criminal in the eyes of the law.

Intent is often wrongly confused with motive; motive is merely that which impels, and as far as the criminal law is concerned there is no necessity of its proof, although the presence or absence of motive may be shown in establishing the facts in the trial of any given case.

**Tests of Responsibility.** The old test of Lord Hale, "the test of a child of fourteen years" and the "wild-beast" test as invoked in 1723 received the first severe setback, in 1800, at the trial of Hadfield for shooting at the king in Drury Lane Theatre, and a distinct step in advance was made. The Attorney General as prosecutor made appeal to the old doctrine of total deprivation of memory and understanding as the only ground of exemption from punishment on the plea of insanity. Counsel for the defense, Mr. Erskine, maintained that the fixed insane delusions of the defendant were the direct cause of the attempted homicide and but for these delusions the alleged crime would not have been committed. By means of his persuasive eloquence and the appeal to common sense rather than prevailing legal dogma he won a verdict of acquittal. From this time on, somewhat insidiously, the knowledge test crept in and supplemented the wild-beast test. Thus the law changed considerably without formal acknowledgment of its change. The knowledge test, that is the power of distinguishing right from wrong, was, however, not in relation to the particular act in question, but was general and applied to right from wrong in the abstract.
This was specifically set forth by Chief Justice Mansfield, in 1812, in the Bellingham case when he stated that "if such a person were capable in other respects of distinguishing right from wrong, there was no excuse for any act of atrocity which he might commit as the result of a delusion."

Thus the Hadfield case, with acquittal on the grounds of particular delusions, and the Bellingham case with conviction and execution on the basis of knowing right from wrong generally without reference to the particular act in question, gave rise to two distinct lines of procedure in criminal trials when insanity was invoked as a defense. These two theories of criminal responsibility were inconsistent and gave rise to endless confusion. There was no settled principle and no uniformity in English practice and this uncertainty obtained until the sensational revolution in 1843, occasioned by the McNaughton case. McNaughton shot Drummond to death, mistaking him for Sir Robert Peel and under the influence of a delusion that Sir Robert Peel was one of many persons who, so he believed, followed him everywhere, blasted his reputation and otherwise made his existence a torment. McNaughton had exhibited no obvious signs of insanity in his ordinary conduct and had capably transacted business before the homicide. He was acquitted.

The acquittal of McNaughton caused such a popular furore and clamor that the House of Lords propounded a set of questions to the Trial Judges. These questions, which need not be given in detail, referred to the law as applied to insanity as a defense in criminal cases. The answers of the trial judges were exhaustive and became organized into law as a guide for the courts of England and have been applied since that time to the defense of insanity in criminal prosecutions. The gist of that symposium may be stated thus: To establish a defense on the ground of insanity, it must be clearly proved that at the time of committing the act the accused was
laboring under such a defect of reason from disease of the mind as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong.¹

The question of abstract right and wrong was hereby laid aside, and the test was specifically applied to the particular act that made the accused a prisoner at bar; it was also limited to the time at which the act was committed. The decision also enunciated the principle that every man is presumed to be sane and to possess a sufficient degree of reason to be responsible for his crime until the contrary is proved to the satisfaction of the jury.

The rule thus proclaimed has been the unquestioned law of England and, generally speaking, the accepted principle of the courts of the United States. For the courts of the United States, having inherited the common law of England, naturally followed the English decisions. But some jurisdictions of the United States soon began to take advanced ground. Under the English decisions the defense of irresistible impulse to do what is known to be morally wrong and what is legally a crime cannot be set up and it is held that "if the accused was conscious that the act was one which he ought not do, and if the act was at the same time contrary to the law of the land, he is punishable." This tenet was held to be erroneous in some early cases in this country.² The early decisions in the United States manifested an effort to get away from the older and somewhat defective views of insanity and evidenced a desire to bring the law more into agreement with the results of medical observation. The endeavor of the courts was evidently to have juries determine

¹ Maudsley, H.: Responsibility in Mental Disease, D. Appleton & Co., New York, 1876, p. 95.
whether a given criminal act was the offspring or product of mental disease. In the Hopps case it is stated:

"We have come to the conclusion that a safe and reasonable test, in all such cases, would be, that whenever it should appear from the evidence, that at the time of doing the act charged, the prisoner was not of sound mind, but affected with insanity, and such affection was the efficient cause of the act, and that he would not have done the act but for that affection, he ought to be acquitted. But this unsoundness of mind, or affection of insanity must be of such a degree as to create an uncontrollable impulse to do the act charged, by overriding the reason and judgment, and obliterating the sense of right and wrong as to the particular act done, and depriving the accused of the power of choosing between them." 

The fundamental legal principle, according to this view, must be that a product of mental disease cannot become a contract, a deed, a will or a crime. But, as Judge Doe well holds, 2 "it is often difficult to determine whether an individual has a mental disease; but these difficulties arise from the nature of the facts to be investigated, and not from the law; they are practical difficulties to be solved by the jury and not legal difficulties for the court." In other words, as Chief Justice Perley states in the same decision, "certain tests of mental disease are laid down by the court as a matter of law but the application of any and all such tests is purely a matter of fact for the jury."

It is certainly a hopeful sign that legal opinions are seeking and receiving more light from medical science instead of holding to certain cast iron tests as immutable principles of law. As a result, the courts in this country no longer construe the law as referring to the power to distinguish and choose between right and wrong conduct in general, 3 but

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1 Hopps v. People, 31 Ill., 385 (1863).
2 State v. Pike, 49 N. H., 399.
3 Com. v. Wireback, 190 Pa. St., 138;
Stevens v. State, 31 Ind., 485.
limit the application of the right and wrong test to the specific act charged as a crime at the time of its commission. This, and not the capacity of the accused to distinguish right from wrong in the abstract,\(^1\) is made the test of criminal responsibility. Therefore, according to this view, a person may be sane on every subject except one; yet if that particular one is causally related to the act with which he is charged as crime, and in reference to which he cannot distinguish or choose as to right and wrong, his defense is complete.\(^2\) The capacity to distinguish between right and wrong need not be general, but must relate to the particular act in question at bar.\(^3\)

The accused need not know that the act he committed, and for which he is placed on trial, was *legally* wrong. It is the capacity to determine the *moral quality* of the act that determines responsibility.

**Irresistible Impulse.** The doctrine of irresistible impulse has little standing in our courts at the present time.\(^4\) As a rule, the uncontrollable nature of the impulse depends on the statement of the criminal on trial, and is thus a self-serving declaration. The means employed, the thing accomplished, the prior, the accompanying and the subsequent acts, as set forth in the facts testified to in a given case, usually offset any possible claim of irresistible impulse. An irresistible or uncontrollable impulse, to be of avail, must be such as results from mental disease and not from natural passion. Passion or frenzy produced by anger or jealousy

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\(^1\) Thomas *v.* Com., 245 S. W. (Ky.), 164 (1923);
Hawe *v.* State, 11 Neb., 537;
Boswell *v.* State, 63 Ala., 307;
Flanagan *v.* People, 52 N. Y., 467.

\(^2\) State *v.* Shippey, 10 Minn., 223;
Flanagan *v.* People, *supra*.

\(^3\) People *v.* Lowhone, 292 Ill., 32;

\(^4\) People *v.* Morisawa, 180 Calif., 148.
will not excuse a person from criminal responsibility for his acts.¹

**Drunkenness and Criminal Responsibility.** All authorities are agreed that voluntary drunkenness, or a temporary insanity produced by voluntary drunkenness, is not an excuse for crime, nor, under our system, a mitigation of it; for otherwise it would be within the power of every criminal to make himself immune from punishment by becoming drunk when he intends to commit a crime. An irresistible appetite for liquor is no excuse for crime, though it may override the will and reason.

**Partial Insanity and Criminal Responsibility.** Partial insanity (monomania or paranoid trend) is no excuse for crime unless it deprives the accused of the power to distinguish right from wrong and to choose between them in relation to the specific act charged.² If he can so distinguish and so choose in regard to the act in question at bar, he is criminally responsible though he be insane on other subjects at the time.³ If a person has an insane delusion on a particular subject only, and commits a crime not connected with that particular delusion, his delusion is no defense.⁴ Neither eccentricities of conduct, oddities of dress and demeanor, hypochondria nor loss of memory constitute an excuse for criminal acts.⁵

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¹ Guetig v. State, 66 Ind., 94; State v. Lauth, 46 Ore., 342.
² Freeman v. People, 4 Denio (N. Y.), 9; People v. Lowhone, 292 Ill., 32.
³ Com. v. Rogers, 48 Mass., 500; People v. Lowhone, *supra*.
⁵ Hawe v. State, 11 Neb., 537; State v. Clark, 34 Wash., 485.
Somnambulism as a Defense. Somnambulism and ambulatory automatism have been employed successfully as a complete defense in homicide cases to our personal knowledge, when the facts clearly showed that they negatived the possibility of criminal intent, but the courts do not concede that one can be compelled to do a criminal act by hypnotic influence and thus evade responsibility. Legally, somnambulism and ambulatory automatism are included under insanity, and if the person is incapable because of being so far unconscious that he does not comprehend the character of the act he performed, or, if comprehending, he cannot choose, or is under an insane delusion from which his acts proceed, then he, while in that state, cannot be held criminally responsible for the act.¹

Proper Use of Insanity as a Defense. The real question in a trial in which the defense is insanity is not whether the mind is unsound, but whether it is unsound to the extent of being unable to determine right from wrong, or whether, if able so to do, the accused was unable to resist the impulse to commit the act as charged in the indictment. If such was not the test, with the many opinions which may be indulged with regard to the soundness or unsoundness of mind, the punishment of criminals would be rendered almost an impossibility. Usually in a case in which there is no other chance of escape from the enormity of a crime, insanity is put forward as a forlorn hope, and many persons indulge the conclusion that, because a crime is committed from a motive which they may regard as insufficient to justify such an action, the action of the party arises from mental disease. Insanity is not, however, proved by evidence that the slayer entertained no known ill will, or by the enormity of the crime, or by the barbarous manner in which it was committed, or by the fact that there was no apparent provocation.²

¹ Fain v. Com., 78 Ky., 183.
² Thomas v. Com., 245 S. W. (Ky.), 164 (1923).
Growth of the Legal Conception of Insanity. A short review of the codes of the various civilized countries readily reveals to the student that the progress of medical science—especially psychiatry—has greatly modified the almost fetichistic worship of the legal criteria of criminal responsibility. The tests of insanity in our courts are becoming less and less mere legal formulas. Rather, the tendency is more and more to consider the mental condition of the accused in each particular case. Formerly the law charged that the defendant was sane or insane according to the presence or absence of a particular symptom, e.g. the knowledge of right and wrong in general. As a result of this modern development the tests of insanity are becoming more clearly matters of fact rather than matters of law. By this we mean that in each criminal case the behavior reactions of the defendant at bar must afford the basis for determining responsibility.

The "mind-of-an-infant" test and the "wild-beast" test have been relegated to the realm of human mistakes. Likewise, the knowledge of right and wrong in the abstract has been repudiated. Psychiatry and psychology have forced the administrators of law to become administrators of justice by compelling the courts to recognize the difference between him who will not and him who cannot fulfil the claims of the law. "That cannot be a fact in law which is not a fact in science; that cannot be health in law which is a real disease in fact."\(^{1}\)

In England, opinions as to criminal responsibility have been gradually undergoing changes ever since the legal rules were promulgated as a result of the acquittal of McNaughton. Difficulties constantly arose in the administration of law in criminal cases, when insanity was an issue, and caused an unsatisfactory situation. Because of this condition, the British Medico-Psychological Association, in

\(^{1}\) Boardman v. Woodman, 47 N. H., 150.
January 1923, appointed a committee consisting of leading psychiatrists and penologists to investigate the question of criminal responsibility. Three months after their appointment, the committee issued an important report and forwarded the same to a committee of judges, appointed by the Lord Chancellor, to consider whether any change should be made in the law relating to criminal trials when the plea of insanity is raised as a defense. Some of the recommendations of the committee are practical and quite easy of adoption in legal procedure. As reported, the unanimous conclusions of this committee are:

"(1) The criteria of responsibility expressed in the rules in the McNaughton case should be abrogated, and the responsibility should be left as a question of fact to be determined by the jury. (2) In every trial in which the prisoner's mental condition is at issue, the judge should direct the jury to answer the questions (a) Did the prisoner commit the act alleged? (b) If he did, was he at the time insane? (c) If he was insane, has it been proved that his crime was unrelated to his mental disorder? (3) When a prisoner is found unfit to plead, the trial, on the facts, should be allowed to proceed. (4) The verdict "guilty but insane" should rank as a conviction for purposes of appeal. (5) A panel of experts should be appointed, any of whom can be called to give evidence when insanity is raised as a defense."

The appointment of such a committee, the studied character of their deliberations as evidenced by their conclusions, and the serious regard given these conclusions by the highest legal authorities in England bespeak an early modification of the McNaughton rules that have occasioned irritating difficulties in the administration of criminal law for eighty years. It should be recalled that judges and physicians necessarily have different points of view. The law has regard for the good of society, irrespective of the individual; medicine always considers the welfare of the

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1 London letter of regular correspondent to Journal of American Medical Association, April 2, 1923.
individual. This accounts for the fact that, while the legal doctrines of criminal responsibility as related to insanity as promulgated by the judges in the McNaughton case have been unanimously condemned by all physicians who have practical knowledge of the insane, judges engaged in the administration of criminal law have quite generally approved of these self-same rules.

**Time at Which the Insanity Exists.** The law does not recognize that the insanity exists for any definite period of time before or after the commission of the offense. It is only necessary that it existed at the time of the commission of the particular act for which the accused is arraigned at bar.⁠¹ Likewise, if the defendant was sane at the time the act was committed, it is immaterial whether he was insane at some other time either before or after the offense. When a person becomes insane after the commission of a crime he cannot be tried while in that condition,² but such insanity does not exempt him from responsibility and prosecution if he afterward becomes sane.³ Prior insanity of the defendant does not excuse his crime if it appear he had recovered from this insanity before the commission of the crime; but in the absence of such proof the insanity will be presumed to continue to and including the time of the crime.⁴ The law does not recognize that the insanity has existed for any definite length of time, but only that it existed at the precise period when the alleged criminal act occurred.⁵ The law presumes that a crime committed by a person who has lucid intervals

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¹ Freeman v. People, 4 Denio (N. Y.), 9 (1847).
² State v. Spencer, 21 N. J. L., 196;
   Com. v. Winnemore, 1 Brewst. (Pa.), 356;
³ Jones v. State, 13 Ala., 153.
⁴ In re Buchanan, 129 Calif., 330;
   State v. Spencer, *supra*.
⁵ U. S. v. Sickles, *supra*.
was committed by him during a lucid interval.\textsuperscript{1} Insanity arising after the commission of an offense has no bearing on the question of guilt or innocence of the defendant, but affects only the legal procedure to be followed as a result of such contingency. The rule at common law is that no person while insane can be tried, sentenced or executed for the offense charged. The test of insanity, when it is set up to prevent a trial on the issues, is whether the accused is mentally capable of making a rational defense, and not whether he is able to distinguish between right and wrong and choose between them.\textsuperscript{2} One capable of rightly comprehending his own condition in reference to the proceeding against him, and of conducting his defense in a rational manner is not insane within the meaning of the rule, although on some other subjects his mind may be deranged.

\textit{Insanity at Time of Arraignment.}—In general, where the common law prevails, and in some jurisdictions by express provision of the statutes, it is held that if a person becomes insane after the commission of a crime and is insane when arraigned before the court, he cannot be required to plead guilty or not guilty, and he cannot be tried for the offense while insane, whether he was insane when he committed the act or not.\textsuperscript{3}

The court should then legally determine by statutory procedure whether he is insane, and if he is found insane should remand him to jail or commit him to a hospital for the insane

\textsuperscript{1} Ford v. State, 71 Ala., 385 (1882).
\textsuperscript{2} Freeman v. People, 4 Denio (N. Y.), 9; In re Buchanan, 129 Calif., 330; Guagando v. State, 41 Tex., 626; U. S. v. Lancaster, 26 Fed. Cas. No. 15,555.
\textsuperscript{3} State v. Arnold, 12 Iowa, 479; Com. v. Hathaway, 13 Mass., 299; State v. Peacock, 50 N. J. L., 34; State v. Roselot, 69 Ohio St., 91; State v. Kelley, 74 Vt., 278.
until his recovery; then he will be tried for the offense as charged in the indictment. We recall from personal experience a case in which a homicide was committed; and while confined in jail awaiting trial, the accused became insane. A jury found that he had become insane after the commission of the act and was insane at the time this jury was impaneled, and he was committed to a state hospital for insane criminals. In nineteen months he recovered his sanity and was returned to the county having original jurisdiction, and in due time he was placed on trial for murder, was found guilty, and the death penalty was fixed by the jury. A new trial was granted and he was again convicted. Another new trial was granted and some months later, nearly four years after the homicide, he was found not guilty.

Insanity at Time of Trial.—If a defendant becomes insane during the trial the proceeding must stop.¹

No formal plea of insanity or petition is required if the insanity suddenly becomes apparent at the time of the trial; the issue may be raised orally by the attorneys or by the trial judge on his own observation.

Insanity after Conviction.—If the defendant becomes insane after conviction, judgment cannot be rendered or sentence pronounced so long as he is in such condition;² nor can he be executed if he becomes insane after judgment and sentence. Upon restoration to sanity, one who became insane after the commission of the act may be punished as if he had always been sane.

Perhaps the most thorough-going decision bearing on the insanity of a defendant after conviction and entering of

¹ State v. Reed, 41 La. Ann., 581;
State v. Roselot, 69 Ohio St., 97;
Gruber v. State, 3 W. Va., 699;
² State v. Helm, 69 Ark., 167;
People v. Farrell, 31 Calif., 576.
judgment is that of the Illinois Supreme Court in the Geary case.\(^1\) The defendant, Eugene Geary, had been tried on an indictment in September, 1920, charging him with the murder of one Harry Reckas. At this trial, insanity was interposed as a defense and the jury found the defendant not insane at the time of the commission of the homicide or at the time of the trial, but found him guilty and fixed his punishment at death. Judgment was entered on the verdict November 10, 1920, and the date of execution was set for December 17, 1920, in accordance with the provision of the statute. A writ of error was prayed, which was made a supersedeas and all further proceedings on the judgment were stayed until further orders of the Illinois Supreme Court. At its April term this court affirmed the judgment of the criminal court and entered an order for the execution of the defendant on June 17, 1921.\(^2\) Defendant's petition for a rehearing was denied at the June term.

On May 19, 1921, his attorneys filed in the criminal court a petition supported by affidavits representing, in substance, that since the said judgment and sentence and while confined in the Cook County Jail the defendant had become insane and incapable of realizing or comprehending that he was under the sentence of death. The petitioners prayed that a jury be impaneled to try the question as to the defendant's sanity at the time this jury was impaneled and that a date be set for hearing.

Upon the filing of that petition with accompanying affidavits, three alienists were appointed by the court, by agreement of counsel, who were to, and did, examine the defendant for the purpose of determining if he were sane or insane and to testify to their findings; the hearing was set for May 31, 1921. At this hearing, the court refused to

\(^1\) People v. Geary, 298 Ill., 236.

\(^2\) People v. Geary, 297 Ill., 608.
grant the request of defendant's counsel for a jury trial, nor would the court enter an order to postpone the execution of the death sentence; two questions were propounded by the court to the alienists in addition to preliminary questions as to their qualifications and competency as specialists in mental diseases. Those two questions were propounded to each of the three alienists, and are in their order as follows:

"Question 1. In your opinion, Doctor, did Eugene Geary at the time of your examination of him have sufficient intelligence to understand that he had been indicted, charged with the murder of Harry Reckas, that he was tried in the criminal court of this county on such charges, that he was convicted and sentenced to be hanged therefor, and that said sentence of death is about to be carried into execution?

"Question 2. In your opinion, Doctor, did Eugene Geary at the time of your examination of him have sufficient understanding to know any facts that might exist which, if known, would exonerate him or mitigate his punishment, and the intelligence requisite to convey such information, if any, to his attorneys or to the court?"

The answer to each of those questions was the same by each of the alienists, to wit, "He did." Counsel for the defendant objected to the questions, both as to form and substance, and for the further reason that they did not embody the correct legal test of insanity and were constructed on lines too narrow for this inquiry, and also upon the further ground that the inquiry or trial was before the court and not by a jury, as provided by the statute. The court in each instance overruled the objections. At the conclusion of the examination counsel for defendant again moved the court that a jury be impaneled for the purpose of determining the sanity or insanity of the defendant, but the motion was denied, and the court also denied the defendant's counsel the right to cross examine the witnesses, the court stating that the examination was one conducted by the court; that the investigation had been made and that it
satisfied the court that the petition should be denied; and the court entered judgment dismissing the petition and striking the affidavit filed in support thereof from the record, to which action of the court exceptions were taken and were preserved by the bill of exceptions.

On June 7, 1921, counsel for defendant filed in the Illinois Supreme Court the record of said final order and judgment in this cause refusing to prolong the time of the execution of the original judgment and sentence and to impanel a jury to try the question whether or not the accused has become insane or lunatic since the judgment. A writ of error was granted, and the same was made a supersedeas by the Illinois Supreme Court.

The Illinois Statutes provide as follows:

“A person that becomes lunatic or insane after the commission of a crime or misdemeanor shall not be tried for the offense during the continuance of the lunacy or insanity. If, after the verdict of guilty, and before judgment pronounced, such person become lunatic or insane, then no judgment shall be given while such lunacy or insanity shall continue. And if, after judgment and before execution of the sentence, such person becomes lunatic or insane, then in case the punishment be capital, the execution thereof shall be stayed until the recovery of said person from the insanity or lunacy. In all of these cases, it shall be the duty of the court to impanel a jury to try the question whether the accused be, at the time of impaneling, insane or lunatic.”

In rendering its opinion the Supreme Court said in substance:

“The contention of defendant’s counsel that he was entitled to a trial by a jury is clearly right. The statute is plain and mandatory. The question of such insanity was raised, and the court treated the question as properly raised before him, and having done so could only try it legally in the manner provided by statute. In the absence of a statute requiring a jury trial it has been the practice of a number of
courts in this country to try the question with or without a jury, but under our statute a jury trial in such cases therein mentioned is imperative, and such question, when, so raised, cannot be legally tried otherwise. Other courts have made similar holdings on statutes providing for jury trials in such cases.¹

¹Our own statute contemplates that both the defendant and the State shall be permitted to introduce all competent and legitimate evidence that they may have bearing upon the single and only question to be tried in the case, and that the verdict of the jury shall be based only upon the facts that are properly provable in the case. Each side is entitled to the right of cross examination, and is also entitled to the same number of peremptory challenges in selecting the jury as in civil cases. In this case the only questions for trial are: Has the defendant become lunatic or insane since the entry of the original judgment and sentence in the criminal court? And was he lunatic or insane at the time of the impaneling of the jury, within the meaning of said section of the statute? There can arise on the trial no question as to the sanity or insanity of the defendant at the time he committed the crime for which he stands convicted, neither can there be any question raised as to his guilt or innocence of the crime charged in the indictment. Those questions were all settled upon the former trial and cannot again arise, and ought not to be referred to in the trial of the questions now sought to be tried. The question of the insanity of the defendant at the time he committed the crime has been settled by the verdict of the jury, and the presumption now is that he is sane. The burden of proof upon the question now sought to be tried is upon him, and he is required, under the law, to establish his insanity by the preponderance of the evidence. We think this ought to be so because of the fact that the question of his sanity at the time of his crime and of his guilt has been conclusively settled by the jury in the trial of the issues in the criminal case. This presumption is a continuing one, and the question now to be tried is collateral to the main issue with reference to his sanity and his guilt, which have been settled heretofore against him. The question to be tried before the court and jury in this case is not the question whether the defendant is sane, or insane, in the

¹State v. Roselot, 69 Ohio St., 91;
Sears v. State, 112 Ga., 382;
State v. Helm, 69 Ark., 167;
Holland v. State, 52 Tex. Crim., 160;
Ex parte Maas, 10 Okla., 302.
sense of being responsible for crime, but the questions, as already indicated, are, is he or was he insane or lunatic at the time of the impaneling of the jury, and has such lunacy or insanity originated since November 10, 1920, the date on which his original judgment of conviction was entered?

"We think it is clear that within the meaning of our statute the defendant is to be regarded as sane, and not insane or lunatic, when he has sufficient intelligence to understand the nature of the proceedings against him, what he was tried for originally, the purpose of his punishment, the impending fate which awaits him, and a sufficient mind to know any facts which might exist which would make his punishment unjust or unlawful, and sufficient of intelligence to convey such information to his attorney or the court. When he has not such intelligence and mental ability he is to be regarded as insane or lunatic by the verdict of the jury, if so found, and his execution stayed or prolonged.\(^1\)

"The statute only provides for one trial to determine such insanity or lunacy of the defendant, and no review can be had either by appeal or writ of error from the final order and judgment of the court.\(^2\)

"The order and judgment of the criminal court of Cook County are reversed and the cause remanded, with directions to that court to impanel a jury and try the question of insanity or lunacy of the defendant in accordance with the opinion of this court."

In accordance with this mandate of the Illinois Supreme Court a jury was impaneled and trial held in the criminal court of Cook County, in October, 1921, and the verdict of the jury was that the defendant had become insane after Nov. 10, 1920, the date on which the original judgment was entered. In accordance with this verdict, from which there could be no appeal, the defendant was committed to the Chester State Hospital, an institution for insane criminals.

**Insanity a Question of Fact for the Jury.** From the preceding it will be readily gathered that insanity as a defense in criminal prosecutions is a question of fact for the jury to

\(^1\) Freeman v. People, 4 Denio (N. Y.), 9.

\(^2\) People v. Bechtel, 297 Ill., 312.
determine\textsuperscript{1} under proper instructions of the court, just as other facts are to be determined by the jury.\textsuperscript{2} The character of an insane delusion, for example, is a matter of fact and it has been held improper for the court to instruct that a certain belief, if existing in the defendant’s mind, was as a matter of law an insane delusion, this being a matter of fact for the jury alone to decide. The existence, character and extent of the insanity in question in any criminal case lies wholly within the province of the jury.\textsuperscript{3} It is not error for the court to instruct the jury to examine the evidence of insanity with care, lest a counterfeit of mental disease be made to furnish immunity from guilt.\textsuperscript{4} While in certain jurisdictions it has been held proper for the court to thus caution the jury concerning the insanity defense, this must be done without attempting to cast discredit or suspicion on this defense in the particular case on trial.\textsuperscript{5}

\textbf{Legal Presumption of Sanity.} In criminal cases the presumption of law is that all persons are sane, and, therefore, when the criminal or his counsel admits the actual commission of the act but claims he was irresponsible therefor by reason of insanity, the entire burden of proof is upon the defense.\textsuperscript{6} The degree of proof required varies in the different jurisdictions. In some, the insanity must be proved

\textsuperscript{1}State v. Geier, 111 Iowa, 706; People v. Hubert, 119 Calif., 216; State v. Jones, 50 N. H., 369.
\textsuperscript{2}Stevens v. State, 31 Ind., 485.
\textsuperscript{3}Plake v. State, 121 Ind., 433.
\textsuperscript{4}People v. Allender, 117 Calif., 81.
\textsuperscript{5}State v. Crowe, 39 Mont., 174; Aszman v. State, 123 Ind., 347.
\textsuperscript{6}Montag v. People, 141 Ill., 75; People v. Finley, 38 Mich., 482; O'Connell v. People, 87 N. Y., 377; Davis v. United States, 160 U. S., 469; U. S. v. Ridgeway, 31 Fed., 144.
beyond a reasonable doubt,¹ in others, by a fair preponderance of the evidence;² and, in still others, to the satisfaction of the jury.

In some jurisdictions it is held that if on all the evidence the jury has a reasonable doubt as to the insanity of the defendant they must acquit him.³ In law, the atrocity or barbarity of the crime does not alone justify the jury in finding that the defendant was insane at the time of the commission of the crime.⁴ When the insanity is of a chronic or progressive type and has a permanent or continuing character, as distinguished from an acute or temporary mania, it is presumed to have continued until sufficient evidence to rebut this presumption is introduced.⁵ This rule, however, does not apply to insanity other than that of a nature liable to be permanent;⁶ and, as already stated, when it is shown that the defendant has had lucid intervals, it will be presumed that the offense was committed during a lucid interval.⁷ The order of a commission in lunacy committing the accused to an insane asylum, while relevant, is neither conclusive⁸ nor, ordinarily, even prima facie evidence that the accused was

² State v. Robbins, 109 Iowa, 650; Kelch v. State, 55 Ohio St., 146.
⁵ Langdon v. People, 133 Ill., 382; State v. Spencer, 21 N. J. L., 196; State v. Johnson, 40 Conn., 136.
insane at the time of the commission of the crime; for the presumption arising from the commitment to an asylum for the insane may be rebutted by evidence of subsequent sanity; likewise, the discharge from an asylum is not conclusive of restoration to sanity.

**Admissibility of Evidence as to Insanity.** As to the admissibility of evidence in reference to the insanity of the defendant, it is regarded as proper to allow considerable latitude in the testimony taken to prove insanity. The evidence is not strictly confined to the mental condition of the accused at the instant of the act, although all the facts in evidence must tend to show his mental condition at that time. The prior insanity of the accused and his prior mental condition not too remote in point of time, are always relevant. The appearance and conduct of the accused while testifying, the fact that the defendant has been subject to epileptic fits or to insomnia or nervousness, his mental condition subsequent to the crime, his coolness and unconcern after its commission, his efforts to escape, his conversations, exclamations and declarations, letters and other writings by him, within a reasonable period of the crime, and generally

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1 Wheeler v. State, 34 Ohio St., 394; Guiteau's Case, 10 Fed., 161.
2 State v. Wright, 112 Iowa, 436; State v. Duestrow, 137 Mo., 44.
4 Com. v. Winnemore, r Brewst. (Pa.), 356.
5 Boswell v. State, 63 Ala., 307.
6 Moore v. Com., 92 Ky., 630.
7 Hopps v. People, 31 Ill., 385; Green v. State, 64 Ark., 523.
10 Blume v. State, 154 Ind., 343.
his previous acts\textsuperscript{1} are relevant to prove his mental condition or insanity. But evidence that the defendant, or a member of his family, was generally reputed prior to the crime to be of unsound mind is inadmissible because it is hearsay.\textsuperscript{2} The theory on which all kind of evidence is admissible is that it purports to show the condition of mind of the accused, and not to establish the truth of any of his statements.\textsuperscript{3}

Insanity in the family of the accused is relevant if not of too remote a degree of relationship, provided there is independent evidence to show that he is insane,\textsuperscript{4} but not otherwise.\textsuperscript{5} It is always relevant to show that the cause of the defendant's alleged insanity was not hereditary.\textsuperscript{6}

A conviction establishes the defendant's sanity when it was directly in issue,\textsuperscript{7} and a subsequent refusal to inquire into his sanity is proper in the absence of some definite evidence that he has since become insane.

**Forms of Verdict.** The form of verdict returned by the jury, when insanity is properly introduced in evidence to negative the criminal responsibility of the accused on trial, must be in accordance with facts shown as to when the alleged insanity intervened with reference to the time at which the


\textsuperscript{3} Wilkinson v. Service, 249 Ill., 146; Robinson v. Adams, 62 Me., 369.

\textsuperscript{4} State v. Windsor, 5 Del., 512.

\textsuperscript{5} Walsh v. People, 88 N. Y., 458; Guiteau's Case, 10 Fed., 161; Reg. v. Tucket, 1 Cox (England) C. C., 103.

\textsuperscript{6} State v. Hoyt, supra.

\textsuperscript{7} Stover v. Com., 92 Va., 780; French v. State, 93 Wis., 325.
criminal act was committed. Was he insane at the time of the commission of the act and is he still insane? Was he insane at the time of the commission of the act and has he now permanently and entirely recovered his sanity? Was he sane at the time of the commission of the acts charged in the indictment and has he become insane since the acts charged were committed and is he still insane? Specific forms of verdict are prescribed by the statutes in many states to meet each of these conditions, all of which are submitted to the jury for consideration. From among these forms the verdict deemed proper for the particular case at bar is selected and signed by the jury and formally returned to the court, in the usual manner, as their verdict. For example, if the jury find the defendant committed the acts charged in the indictment, but was insane at the time and has since permanently and entirely recovered the jury will render the verdict:

"We, the jury, find the defendant, John Blank, committed the acts charged in the indictment, but at the time of the commission of said acts he was a lunatic or insane person, and that since the commission of said acts he has permanently and entirely recovered from such lunacy or insanity."

If the jury find the defendant committed the acts charged in the indictment, but was insane at the time and has not yet recovered, the verdict will be:

"We, the jury, find the defendant, John Blank, committed the acts charged in the indictment, but at the time of the commission of said acts he was a lunatic or insane person, and that he has not permanently recovered from such lunacy or insanity. And we further find from the evidence that the said defendant, John Blank, is now about the age of ______ years."

If the jury find the defendant committed the acts charged in the indictment while sane, but since has become and still is insane, the verdict will read:
"We, the jury, find the defendant, John Blank, committed the acts charged in the indictment, and we further find that at the time of the commission of said acts he was of sound mind, but since the commission of said acts he has become and now is a lunatic or insane person. And we further find from the evidence that the said defendant, John Blank, is now about the age of ______ years."

If the jury find that the accused committed the act while sane and is still sane, no mention of sanity or insanity is made in the verdict. The situation is the same as if self-defense or an alibi had been offered but not believed by the jury. The verdict would therefore read:

"We, the jury, find the defendant, John Blank, guilty of (murder, assault to kill, rape or whatever the crime may be) in manner and form as charged in the indictment and we fix his punishment at (death, life imprisonment, or a term of years)."

If the jury find that the accused did not commit the act they bring in a verdict:

"We, the jury, find the defendant, John Blank, not guilty."

without any mention of the insanity defense raised in the trial of the issue.

**PRISON PSYCHOSES**

At times, apparently, too much significance has been given to the so-called prison psychoses. Each case of prison psychosis is a reaction to the situation in which the prisoner finds himself. The type of reaction is distinct in each case. It is a mistake to regard these prison psychoses as constituting a definite group or class of mental diseases. The essential characteristics of these reactions are discussed elsewhere in this volume (p. 187). That the courts have come to regard these manifestations of prisoners in their proper significance
rather than as true insanity is evidenced in the attitude maintained in the Gonzales case.\(^1\)

The opinion was expressed by the medical expert that the petitioner (Gonzales) was suffering from prison psychosis—a newly discovered type or phase of insanity which is described as “essentially a reaction to the situation in which he finds himself, from its realization.” The diagnosis, it was admitted, “is not inconsistent with definite efforts at malingering with which those who have previously examined him were impressed.” In the second and more elaborate comment on the case, it was said that the “whole reaction is an extremely shallow one—that Gonzales’ knowledge of the crime of which he was convicted and his realization of the situation in which he is, lies only a little bit beneath the surface, and at times it forces itself upon his attention in spite of his defensive efforts, and so we see in some of the later notes of his case his plots to escape, and expressions which show a very complete realization of the trouble he is in. This merely means that his defenses are weak and that from time to time they break down.” And the medical expert added that “in all probability this present disturbance would all disappear very rapidly if the causes for its existence were removed.” The foundation for the theory was that the “pathological reaction” would not be expected in anyone but a “more or less distinctly abnormal individual,” and that petitioner was an abnormal individual, else he would not have committed the homicide, because the abnormal character makes the criminal. It is a frequently expressed opinion that all crime is insanity; nevertheless such general insanity does not exempt one from the consequences of the criminal act. The practical test of the law is whether, notwithstanding his abnormal character, he was capable of distinguishing between right and wrong—of realizing

\(^1\) Gonzales v. U. S., 40 App. D. C., 450.
what is right and what is wrong, and doing the one and refraining from doing the other.

We agree thoroughly with the learned trial judge, who said, in denying the petition: "What would be the result in any case, almost, where a man has committed a murder and is sentenced to be hanged, and knows that if he appears sufficiently terrified and peculiar, and shows sufficient signs of being crazy because he is going to be hanged, that he will not be hanged? How many cases would there be where they would not have prison psychosis? Petition denied.'"

SIMULATION OF INSANITY

The tendency to simulate or malinger is most frequently met with in criminal cases. True, we have clear cases of malingering in personal injury suits for damages, but the number of these is small when compared with the number who seek an escape from the expiation of their crime by shamming insanity after every other recourse has failed. The courts have come to recognize these attempts at malingering, and in the Schneider1 case made extensive analysis of the entire situation by scrutinizing every phase manifested and reported by the medical experts on both sides.

The Schneider case decision is on insanity after the sentence of death and arose from a petition for an order postponing execution of a criminal alleged to be insane.

On the part of the United States it is contended Schneider never was and is not now insane; that his alleged illusions and mental peculiarities have no existence in fact, but are merely feigned to enable him to escape punishment, and that he is only malingering.

Although this term is comparatively modern, the practice it describes is neither new nor unusual. It is mentioned in the earliest history, sacred and profane. When David fled from the wrath of Saul, he took

1 Ex parte Schneider, 21 D. C., 433.
refuge with Achish, the King of Gath; but fearing the King had not forgotten the death of his champion, Goliath, he sought to excite his pity by assuming to be insane.

In the classics we are told that Ulysses sought to escape service at the siege of Troy by feigning madness; and that the herald Palamedes found him plowing the seashore with a bull and a horse yoked together and sowing the furrows with salt. Palamedes detected the trick by placing the infant Telemachus before the plow, and taxed Ulysses with the deceit when he observed he carefully turned the furrows to save the child.

Junius Brutus and Rienzi, each assumed the character of half-witted to save their lives and at the same time to study the designs of the tyrants they had resolved to overthrow; and this was continued by each without discovery or suspicion for years.

A considerable part of the testimony was addressed to the mental condition of the prisoner’s father and to the behavior in early youth of the son; but these statements are comparatively unimportant in view of the great mass of testimony bearing upon the real point of the inquiry—the mental condition of the prisoner at this time, commencing with the day of the sentence.

The testimony of the witnesses for the prisoner was designed to show that about the time of the sentence various alterations in the personal appearance and mental condition of Schneider developed themselves. The first relied on was the change in his personal appearance. During the trial he had been a neat and rather dressy person; but, from the time of the sentence, he began to present a slovenly look; his handsome clothes were laid aside; he appeared at the time of the sentence without a white shirt or collar, in old, ill fitting clothes, the same he wore when before the court here; with a shabby overcoat pinned around his neck, and with hair and beard untrimmed and uncombed.

Indifference to neatness is not an uncommon accompaniment of real madness; but its studied assumption is the almost unvarying device of the malingerer. Shakespeare gives to Hamlet, and to Edgar in King Lear these readily assumed pretensions to insanity. Hamlet appears:

"With his doublet all unbraced; no hat upon
his head, his stockings foul’d,
Ungarter’d and down-gyved to his ankle;
Pale as his shirt . . .
His bedded hair, like life in excrements,
Starts up and stands on end."
Edgar, when determining to assume the part of an insane outcast, to save his life, says:

"My face I'll grime with filth,
Blanket my loins, elf all my hair in knots,
And with presented nakedness outface
The winds."

So simple a device, in itself, can have but little probative force. But the proof here shows that Schneider himself suggested to his mother the removal of his good clothing and that the old butternut pantaloons and other shabby garments he has been wearing constantly since the sentence, were not his own old clothes, formerly worn by him, but were specially obtained for him; that his outward appearance of squalor did not prevent him from changing his underclothing at proper intervals, and that these were found clean, instead of befouled, as is the custom with the insane who fall back to the helplessness of infants in this respect; and further that as his beard and hair had already attained a long growth on the day of the sentence, he must have determined upon this carelessness long before that day arrived; and that he in fact appeared in all this disorder of dress and person before the sentence had been actually pronounced, and therefore before the alleged shock could have been fully realized. The explanation that the old clothes were furnished him to lounge in while in his cell does not explain why he should have persisted in wearing them at this hearing, where he was not lounging on his bed, but was all the time seated quietly in his chair.

The alleged delusion that his food was or would be poisoned in the jail, and his refusal on this account to eat, is the subject of much of the testimony. One physician testifies that a real refusal to eat was evinced from his first admission to the jail, on the night of the murder. When the doctor's attention was called to it, he endeavored to induce Schneider to take food; but he refused, declaring he would never eat again; but he gradually rallied and his appetite returned. Surely it was not unnatural that one guilty of such a murder should not, when first imprisoned, be able to enjoy his meals as if he were at liberty and innocent. From this time until the sentence, there is no defined proof of any failure on his part to take the jail food. After the sentence on the 9th of May, at which time this and all the other delusions, according to the weight of the testimony, developed themselves, the evidence shows that although he refused to take his meals in the day time, as the
other prisoners did, he yet ate that same food in his cell every night for at least a month, undeterred by fear of poison and that he ate it is clearly shown by his physical condition.

The witnesses for the prisoner dwell especially upon Schneider's reiterated assertion that he could not sleep at all; and this assumed fact is much relied upon as evidence of insanity. Could it be possible that a man in his situation, having even the remnant of a conscience, could expect to sleep tranquilly all night without its goadings reminding him of the cause of his imprisonment? He would not have been the first homicide to exclaim—

"Methought I heard a voice cry 'Sleep no more.'"

Persons in ordinary health frequently exaggerate their own wakefulness, apparently to excite sympathy or to give themselves a temporary consequence; and Schneider may have mistaken a troubled sleep for wakefulness; even if the entire idea be not unfounded.

The foregoing are all the alleged physical delusions or symptoms complained of by Schneider that may be considered external, and which are therefore capable of actual verification or contradiction by witnesses. The other—such as the whisperings; the voices; the fear of poisoning; the faces on the wall; the throwing of acids in the cell; the refusal to have his hair trimmed from apprehension of personal injury; the alleged belief that his brothers and his mother had turned against him; the pretended electrical inventions; his belief that he owned swift horses and had money in bank—must be taken as actual beliefs and delusions solely upon Schneider's assertion, or not at all. It makes no difference that a score of persons may say he asserted them to be true, there is but one witness to the truthfulness of either of them after all, and that is Schneider himself. Of course, if he did not believe all or either of them, the entire story must be discarded as a cheat. Was there anything in the account given of his previous moral characteristics by his own witnesses, to justify us in believing him in this instance? With one accord all these witnesses agree that from his earliest youth, preeminent over all his other vices, was his addiction to falsehood; that his whole talk was a gasconade of impossible exploits and ridiculous lies.

Schneider's testimony before the jury was a coherent defense of himself, from his standpoint, but it was contradicted at every point by disinterested witnesses, who were not on trial for murder and struggling for their lives; and the jury refused to believe him. Why
should we believe the present story simply because it comes from him? "What will not a man give in exchange for his life?" In the light of his character, as shown by the testimony of his own witnesses, can any man of sense doubt that if the prisoner really believed he would be allowed to walk unmolested from this court-house if he should now charge the murder of his wife upon his counsel or any other person present, he would hesitate to make the charge?

There are forms of simulation not difficult to detect. Such are the noisy imitations of maniacs which ignorant people who have made no careful observation of insanity suppose to be a constant type of mental alienation. Nature itself aids in the detection of this clumsy form of malingering, for no human frame, not belonging to a madman indeed, can continue such devices indefinitely; and the trickster, if steadily watched, will sooner or later be found remitting his violence when he believes himself unobserved. The more difficult form that seems sometimes to defy detection, is the dull, moody, morose manner—the appearance of imbecility, of inaction rather than action. This is precisely the form Schneider has adopted.

We have before us the proof that few persons were more competent to imitate this special form of mental aberration than Schneider; for from his birth he has had before him his father, whose manner, as described by his poor wife and sister, is almost precisely like that now assumed by the prisoner.

Another class of testimony detailed Schneider's evil deeds during his youth and before this crime was committed. It is enough to say that admitting the truth of any one of the iniquities described by these witnesses, or admitting them all together, there is no court in Christendom that would not have told the jury that either or all combined would not be proof of such mental alienation as would justify a verdict of acquittal of crime under the defense of insanity. Wickedness is not insanity. No matter how vile a man may be, he is not to be exculpated and freed from punishment, simply because he is shown to be enormously bad.

In arriving at our conclusions we think we have given just weight to the opinions of the three experts who testified on behalf of the prisoner. They all admit the case presented here is exceptional—that symptoms are not present that would usually be found in either of the recognized types or forms of insanity, while there are present other symptoms that do not accord with any other type; that the prevailing symptoms are such as would not be expected to develop suddenly, but would
present an onset in a primary or incipient form, followed by an acute form, and then by a terminal stage; that this case is either in the chronic or the terminal form, but that there is no proof of the evolution from the primary stage. If insanity came at all to Schneider it must be admitted the proof shows it came just after the sentence, in a fulminate form, and fully equipped with all the delusions at once. We have, therefore, the final or the chronic stage established by the proof, and no precursor is shown to have ever existed. We do not feel justified in assuming the present case to be so entirely exceptional, as we are convinced that the alleged delusions are all feigned for a purpose.

MENTAL DEFICIENCY

Feeblemindedness, or mental deficiency, assumes the same rôle as insanity as a legal defense. When feeblemindedness is introduced in evidence the same legal test is applied as is applied to the insanity defense. Was the accused capable of forming criminal intent? Was he able to distinguish right from wrong in reference to the particular act in question, and if able so to distinguish could he resist the impulse to commit the act? The courts put the defense of feeblemindedness upon the same basis as the defense of insanity.

Tests of Mental Age. Numerous sporadic attempts have been made to excuse from responsibility those charged with crime who show some phase of mental deficiency. Occasionally we meet with the bizarre claim that a defendant in some particular criminal trial, though an adult in actual years, has the mind of a child of ten, eleven, or twelve years as the case may be. This bald statement does not really mean what it purports.

Modern psychiatry has adopted certain standards of measurement of intelligence for designating degrees of mental deficiency. These standards are discussed elsewhere in this volume. It is unfortunate that the units of measurement in
the Binet-Simon and other scales are expressed in years. While these standards work comparatively well with children of school age, they measure only certain particular features of the intelligence in adults and are in no sense a measure of the capacity of the adult individual to adjust himself to conditions of life. When it is stated, for example, that the mental age of a defendant is ten years it means only that, with the tests used, the man has succeeded in passing certain intelligence tests that are passed by the child of ten years; it does not mean that he has the mind of a child of ten.

That the courts refuse to be stampeded and misled by these mental age tests in case of adult defendants is evidenced by recent clear cut decisions. In the Schilling case this issue is clearly met as follows:

In the present case the defendant is twenty-eight years of age, and there was some proof that he was deficient in mentality and that his reasoning powers were not beyond that of a normal child of eleven years of age, but there was also contradictory proof given by eminent and reliable physicians that the defendant was normal in mentality, fully aware of the quality and nature of his act, and that he knew whether his act was right or wrong. It appears that this man, twenty-eight years of age, seeks to escape punishment for his crime upon the ground that his mentality is, to a certain extent, deficient, and that, according to the testimony of some of the experts, it did not exceed that of a normal person of eleven years, and it is urged that there is a presumption that he would be incapable of committing a crime to the same extent as if of the age of eleven years. But that is not the precise question presented, which, after all, is whether at the age of twenty-eight he had sufficient mentality to distinguish between right and wrong, for at that age he would be presumed to be capable of committing the crime unless he was able to overcome that presumption by proof of a mental condition rendering him incapable of committing the crime, and whether he did so was a jury question, and they by their verdict have found that he had sufficient mentality to determine that it was wrong to kill this officer. We think that when a person twenty-eight years of age kills an officer to escape from arrest and sets up as a

1 State v. Schilling, 95 N. J. L., 145.
defense that he had not sufficient mentality to form in his mind an intent to take life, or to deliberate and determine to execute that intent by a premeditated act, the burden is on him to show his lack of sufficient mental power to conceive and execute the crime. There is a vast difference between a child at the age of eleven years and that of a man of twenty-eight, and while perhaps there is a presumption that an infant of tender years is incapable of committing a crime, that presumption does not extend to one of advanced years, requiring the state to rebut it. When a man reaches manhood the presumption is that he possesses the ordinary mental capacity normally pertaining to his age, and it is for him to overcome that presumption, and whether he has done so is for the jury to determine. The presumption of the lack of power of thought and capacity in favor of a child is due more to the number of years he has lived than to the character of the development of his mind, and it is a merciful rule established by the courts due to his tender years, but that reason does not apply when he comes to manhood. Deficiency of intellect is a species of insanity, and when that is set up as a defense for crime the burden is on the accused to prove it, the presumption being that he is sane.

The responsibility of an adult charged with commission of a crime is not to be measured by a comparison of his mental ability with that of an infant of twelve years, or in any other way. The true test is, does he appreciate the nature and quality of his act and that it is wrong, and if he does he is responsible to the law without regard to his other mental deficiencies.

Also, in the Ehlers\footnote{State v. Ehlers, 119 Atl. (N. J.), 15.} case the court states that expert testimony that an adult defendant in a trial for murder is of the mental age of twelve years, coupled with the further testimony of the same expert that twelve years was the average mental age of our American soldiers in the World War, the court views as tending to demonstrate, as the expert frankly admitted, what has been the observation of practically all our judges, that the so-called mental age theory of the experts, at least as applied to adults, is based on so arbitrary and unnatural a scale of ages as to be utterly misleading to a layman and practically useless, if not actually harmful, in the administration of justice by trial by jury.
VIII. INSANITY AND TESTAMENTARY CAPACITY

Historical. The right to dispose of property by will is not inherent in the recognition of property rights in general. In the history of society there were long periods of time in which the right of disposing of property by will was regarded as incompatible with the right of property. In a modified form the right of testation existed in Egypt as early as 1500 B.C.; but it did not appear in Greece until the time of Solon, and its first recognition in Rome came with the Twelve Tables. To the Romans belongs the credit of inventing the will which, as Sir Henry Maine\(^1\) has pointed out, next to contract, has exercised the greatest influence in transforming society. The last will and testament was not originally a mode of distributing a dead man's goods, but was one way of transferring the representation of the household to a new chief. Contrary to popular belief, the law has never allowed free and unlimited choice to testators in disposing of property by will. Considerations of public policy and the rights of family have always operated more or less against the free and unfettered distribution of property according to the fancy of the owner. As in life a married man cannot dispose of real estate without the joint action of his wife, so in death her dower interest is preserved. The laws on inheritance taxes are also an expression of the same policy of conservation. Furthermore, a man may do many things while living which the law will not do for him after he is dead. The power of disposing by will is by no means as unlimited as the power of alienating property by a living person. The courts take the view that the right to make a

\(^{1}\) Ancient Law.
will, instead of being an inherent\(^1\) natural right, is created by statute,\(^2\) and is therefore within legislative control. The statutes prescribe the exact conditions under which a will is admitted to probate and no court has the power to dispense with any of these prescribed conditions and to substitute something different on the basis of inherent, natural constitutional or other property rights.\(^3\) Instead of calling the privilege of distributing property by will a sacred or inherent right it is more correct to say that by the grace of the law a man may, through a last will and testament, project his individual desires and wishes beyond the grave and thus be allowed to control property after death and do many other things.

Whether a document is a will or not depends on the intent of the maker. In the absence of testamentary intent there can be no will. On the other hand a will cannot be established by merely proving an intent to make one. The first and foremost rule in regard to a will is to ascertain the intent of the testator and give it effect.\(^4\) If, however, the testator attempts to effect through his last will and testament what the law forbids, or to make a disposition contrary to public policy,\(^5\) no matter how clear his intent, his will must yield to the rules of law that will not permit his intent to be accomplished.\(^6\)

A common restriction against unlimited power of testation is some form of a law of perpetuities found on the statute books of most states. In whatever form it exists, this law of perpetuities of necessity conflicts with untrammeled disposal

\(^1\) Lane v. Walker, 110 Calif., 387; In re White, 208 N. Y., 64.
\(^3\) Hill v. Kehr, 228 Ill., 204.
\(^4\) Travers v. Reinhardt, 205 U. S., 423.
\(^6\) Dennis v. Holsapple, 148 Ind., 297.
of property by will. A common form of this law is that which prescribes the management of an estate by will for a period longer than twenty-one years after the life of the grantor. The purpose of such a law is to prevent large estates left in trust from becoming too formidable by continuous accretions of earnings without a possibility of disintegration. A large productive estate left in trust grows by compound interest so to speak, and if permitted to do so indefinitely might become a great obstacle to the economic life and growth of the community. The statutes on perpetuities specifically limit the period into which a man can by will project his desires and wishes as to the care and management of his property after his death.

**Testamentary Power and Testamentary Capacity.** Such statutory limitations as these clearly illustrate the distinction between testamentary power and testamentary capacity. This distinction is fundamental. One may have the capacity to make a will but the power to thus dispose of his property may not be bestowed on him by statute. For example, persons under certain ages (varying in different states and countries) are denied testamentary power. By the old common law a married woman had no power to make a will devising her real estate even with her husband’s express consent. Such a will was absolutely void. The question of testamentary capacity did not enter, but testamentary power was denied. The removal of the disabilities of married women as to testamentary power was accomplished by degrees, so that now the statutes almost universally confer upon her the same testamentary power as that possessed by her husband or by an unmarried woman of legal age.

The age limitations below which testamentary power is denied, vary in different states and the rule is quite different in the case of real estate from that which obtains with reference to personal property. It has been quite generally held in both
England and this country, in the absence of specific statutes to the contrary, that a male infant over fourteen years of age and a female infant over twelve years have power to dispose of personal property by will. If in the same will an individual over fourteen years of age made a properly attested will disposing of both real estate and personal property it has been held valid as to personal property. In many states, because of specific legislation, a legal infant cannot make a valid will under any circumstances. In some jurisdictions women at eighteen are allowed to make wills while that power is not conferred upon men until they are twenty-one.

Testamentary Capacity. Various attempts, by the text writers and in court decrees, have been made to establish arbitrary standards of testamentary capacity, but in the nature of things these attempts have not been successful, for new combinations of facts and circumstances arise in each new will case in which the sanity of the testator is involved. We have already stated that, in legal procedures, the sanity or insanity of the person involved is a question of fact. This is particularly true in contested will cases. The question of testamentary capacity or incapacity becomes a question of fact regardless of the legal tests applied.

It may be said in a general way that there are four elements necessary to constitute mental capacity on the part of a person making a will:

1. A knowledge or understanding of the nature of the business in which he is engaged at the time of making the will.

1 Deane v. Littlefield (1822), 18 Mass., 239;
   Holzman v. Wager, 114 Md., 322;
   Davis v. Baugh, 33 Tenn., 477.

2 Deane v. Littlefield, supra.

3 Goodell v. Pike, 40 Vt., 319;
   Moore v. Moore, 23 Tex., 637.

4 In re Tuller, 79 Ill., 99.
2. A mind and memory sufficient to recollect the property he possesses and which he is about to bequeath, that is, the testator must have sufficient understanding to know the nature and extent of his estate.

3. A remembrance of the persons who, by ties of blood and affection, are the natural objects of his bounty.

4. Ability to keep these (nature and extent of his property and the persons who would naturally be supposed to be objects of his bounty) long enough in mind to form a rational judgment in relation to them.

Mental capacity to make a last will and testament, according to our courts, has thus become a question of degree. The multiplicity of legal decisions on testamentary capacity, and the seeming inconsistency of some of these decisions are due to the different conceptions held by the courts as to the extent to which each of the above four elements must be present in order that the testator may be legally regarded as possessing a disposing mind and memory.

Comparison with Ability to Transact Business.—It is no longer held that the capacity to transact ordinary business is a proper test of mental capacity to make a will. The real test is whether at the time of making his will the testator had sufficient mind and memory to understand the business in which he was then engaged, namely, the making of his will. The transaction of ordinary business is a higher test of mental capacity than the law deems sufficient to show ability to make a will. The law requires a less degree of capacity to make a will than is necessary to make contracts and transact ordinary business which involve a contest of reason, judgment and experience and the exercise of mental powers not at all necessary to the testamentary disposition of property.¹

This theory is based on the fact that, at various times in their lives, all persons have given consideration to the

¹ Rowcliffe v. Belson, 261 Ill., 566.
question of the disposition of their property by will, and consequently when they seek to put their intentions in writing they have less difficulty in stating these intentions than they would have in undertaking to transact business that is in some measure new and in which they come in competition with other minds holding other views on the business matters under consideration.

It is not necessary that a testator should actually recollect all of his property, the objects of his bounty and similar matters. It is sufficient that he was mentally capable of so doing.\(^1\) Thus the description of the home farm as the north one-half instead of the south one-half of a certain section of land does not tend to show that the testator did not know his property.\(^2\) Persons of large means and various holdings rarely know precisely what property they own or even the nature and present condition of each parcel of property.\(^3\) The law does not require the testator to possess a mind to know the exact extent and value of his property, the number and names of those who are the natural objects of his bounty, their respective deserts and necessities and that he shall have sufficient memory to retain all these facts in mind long enough to have his will prepared and executed.\(^4\) The law does not require that the testator's mind exist in an unimpaired state; it is sufficient if his mind and memory were sound to such a degree as to enable him to know and understand the business in which he was engaged at the time he executed his will. Even an actual mistake by a testator as to the extent of his property does not show that he was lacking in testamentary capacity; nor does the fact that he was misinformed as to how many of his nephews, nieces or similar relatives are alive when he makes his will exhibit want of

\(^1\) Holmes v. Campbell College, 87 Kan., 597.
\(^2\) Rowcliffe v. Belson, 261 Ill., 566.
\(^3\) Havens v. Mason, 78 Conn., 410.
\(^4\) Bundy v. McKnight, 48 Ind., 502.
testamentary capacity. It is not even necessary that a testator name all his children in his will or that he bestow on each of them a portion of his estate. The fact that one grandchild out of a total of twenty-five was not mentioned in the will does not in any way tend to show that the testator did not know the natural objects of his bounty.

Relation of Testamentary Capacity to Insanity. It is difficult to adopt an absolute or fixed rule as to what will constitute insanity in all cases bearing on testamentary capacity. Temperament, nervous organization and physical strength differ in infinite degree and these all have direct or remote influence on the intellect. The derangement, to incapacitate a person from making a valid will, must be of that character which renders him incapable of understanding the effects and consequences of his act. The ability of a testator to comprehend the effects and consequences of his will does not mean he must know the legal effect or construction to be given his will. It only means he must know how the will disposes of his property. The testator need not comprehend the provisions of his will in legal form or understand the language in which the will is expressed.

As already stated, the ability to transact ordinary business is regarded as too high a test of the mental capacity required to make a valid will. Hence, generally speaking, a person capable of transacting ordinary business possesses testamentary capacity. But there are cases in which one may have

1 Havens v. Mason, 78 Conn., 410.
3 Rowcliffe v. Belson, 267 Ill., 566.
4 Meeker v. Meeker, 75 Ill., 260.
5 Dowdey v. Palmer, 287 Ill., 42.
7 Walter's Will, 64 Wis., 487.
8 Campbell v. Campbell, 130 Ill., 466; Rowcliffe v. Belson, supra; Carnahan v. Hamilton, 265 Ill., 508; Wright v. Upson, 303 Ill., 120 (April, 1922).
the mental capacity to attend to ordinary business affairs and yet be devoid of capacity to make a will because of the existence of insane delusions that bear directly on the disposition of property by will, or are directed specifically toward one or more of the natural objects of his bounty.

**Insane Delusions.**—The existence of insane delusions is recognized by all courts. These may be of such form, character and tenacity as to invalidate any will made by the person subject to the delusions. The courts hold, however, that the existence of delusions on a given subject may not be incompatible with sanity on other subjects. An insane delusion which will render the sufferer incapable of making a will has been difficult for the courts to define. A delusion is said to be a belief in a state or condition of things, the existence of which no rational person would believe. It has also been defined as a spontaneous conception and acceptance as a fact of that which has no existence except in imagination, and persistent adherence to it against all evidence. A person who believes supposed facts which have no existence except in his perverted imagination and which are against all evidence and probability, and who conducts himself, however logically, on the assumption of their existence is, in so far as they are concerned, under an insane delusion. Whatever form of words is chosen to express the legal conception of an insane delusion, it is clear, under all the authorities, that it must be such an aberration as indicates an unsound and deranged condition of the mental faculties as distinguished from a mere belief in the existence or non-existence of certain supposed facts or phenomena based on some sort of evidence.

1 In re Forman, 54 Barb. (N. Y.), 274.
2 Smith v. Smith, 48 N. J. Eq., 566;
   Rush v. Megee, 36 Ind., 69;
   Potter v. Jones, 20 Ore., 239.
3 In re Shaw, 2 Redf. (N. Y.), 107;
   In re White, 121 N. Y., 406.
4 Owen v. Crumbaugh, 228 Ill., 380.
Thus when the testator has actual grounds for suspecting the existence of something in which he believes, though in fact not well founded and disbelieved by others, the misapprehension of the fact is not a matter of delusion which will invalidate his will.¹

An Indiana case² is quite instructive on this doctrine of insane delusions. The testator believed that he could locate hidden treasure by means of a small metallic ball suspended from a thread. He spent a great deal of time in going over the fields trying to locate the hidden metallic treasure, and holes were dug in so many places that they became a nuisance and he had to be stopped. It was shown that a silver dollar hidden under a carpet in a room could be located by the peculiar vibrations of the metallic ball when suspended over the silver dollar, and this circumstance afforded some basis for the testator's belief that he could locate money buried in the ground by the same means. The fact that there was this basis for the testator's belief, however mistaken or erroneous the conclusion drawn therefrom, distinguished the belief from an insane delusion. The belief was not the spontaneous creation of a diseased mind. "The fact is notorious that there are many intelligent and conservative persons," says Mr. Justice Hadley in the opinion in this case, "who claim the power of locating water in the earth by means of a forked stick, and thousands of wells located by them have been dug and are still being dug. Many scholars and successful business men sincerely believe in spiritualism, and in being able through naturally qualified mediums to converse with and be advised by the spirits of departed friends, and believe they recognize the voices and handwriting of the

¹ Stackhouse v. Horton, 15 N. J. Eq., 202;
Martin v. Thayer, 37 W. Va., 38;
Mullins v. Cottrell, 41 Miss., 291.
² Wait v. Westfall, 161 Ind., 648.
dead. Mental phenomena are as various as the hues of the autumnal forest."

In a Wisconsin case it is stated that business men have searched for minerals under the direction of clairvoyants; others believe in Christian science; others in witchcraft; others in the transmigration of souls. "To affirm or deny the truth of these things establishes nothing and demonstrates the believer to be neither a sage nor a fool. If we affirm that witches do not ride broomsticks and practice their evil arts upon us, and there are no witches, then we have Blackstone, the father of our common law, Chief Justice Matthew Hale, Coke; Sir Francis Bacon, Richard Baxter, John Wesley, Martin Luther, Cotton Mather, and a host of other savants and eminent jurists against us."

In disposing of an appeal in a contested will case it is stated: "The great majority of civilized human beings believe in the existence of a life beyond the grave. Based upon that belief, many religious creeds, differing widely, have been established. The fact that a person holds any particular belief in regard to a future existence cannot, of itself, be evidence of insane delusion or monomania." No creed or religious belief, so far as it pertains to life after death, can be regarded as a delusion, because there is no test by which it can be tried and its truth or falsity demonstrated. The owner of an estate may devise it to aid the Methodist, Baptist, Catholic, Universalist, Swedenborgian or any other religious organization he may choose; or he may, like Stephen Girard, give his property to a non-sectarian school and provide that no ecclesiastic or minister of any sect whatever shall hold or exercise any station or duty therein, nor be allowed, even as a

1 Chafin's Will, 32 Wis., 564.
2 Id.
3 Scott v. Scott, 212 Ill., 603.
visitor, to enter the school or to go upon its premises, and such will is valid and will be upheld.\textsuperscript{1}

The fact that a person believed in witchcraft, clairvoyance, spiritual influence, presentiments of the occurrence of future events, dreams, mind reading, and the like does not affect the validity of his will. A man’s belief cannot be made the test of his sanity. When we leave the domain of experience and enter on the field of belief the range is limitless, extending from the highest degrees of rationality to the wildest dreams of superstition. What to one man may be reasonable belief is to another wholly unreasonable.\textsuperscript{2}

In this connection the observation should be made that the courts in both this country and England were at one time disposed to hold that any mind possessed of an eccentricity, aberration or erratic trend, such as amounted to an insane delusion, was not a sound mind within the meaning of the statute, and hence was incapable. This doctrine has since been repudiated for the most part by the courts in both countries.

There is now an apparent tendency to go to the other extreme as if a mind laboring under an insane delusion were in all other respects sanely operating. To one familiar with the insane it is always evident that a mind possessed of a fixed delusion is otherwise impaired and weakened, though the delusion is the most striking feature. There are either self-centered ideas related to the delusion that give birth to some ruling passion or selfish desire, or the person afflicted with the delusion is abstracted or absent-minded and inattentive. In this condition his interests and affections become submerged or distorted so that he is rendered incapable of applying himself to the business in hand, such as the simplest occupations, social converse, reading with

\textsuperscript{1} Vidal v. Girard’s Exrs., 43 U. S., 127.
\textsuperscript{2} Whipple v. Eddy, 161 Ill., 114.
attentation or making a will. The person with an insane delusion (monomania, paranoid trend) soon forgets the persons who were objects of his strongest attachment, and if he thinks of them at all it is only to accuse them of injustice or disloyalty on the flimsiest pretexts and suspicions. "The very fact that an insane delusion does persist in the mind is proof enough that the man cannot reason soundly; he will reason insanely, feel insanely, and sooner or later act insanely. Its foundations are not laid in reason, but in disease; and it holds its ground in the mind just as a cancer or other morbid growth holds its ground in the body—by drawing to its own use and converting to its own nature the nutriment which should support healthy activity, and so render its existence impossible." ¹

But taking the law as we find it the courts now hesitate to void a will because the testator had a delusion or set of delusions unless it is clear that the delusion is an insane delusion and the will, under judicial scrutiny, is the product of that delusion. It would seem that a delusion sufficient to invalidate a will must be one whose influence controls the mind of the testator and destroys his freedom of action. ² No matter how sound the mind of the testator may have been in other respects, if his disposition of his property was affected by an insane delusion his will is invalid. When a will is shown to be the result of an insane delusion it must be set aside. ³ The court cannot say as a matter of law that a person is insane because he holds a belief that he can communicate with spirits and can be and is advised by them in his business transactions, ⁴ but if the testator was laboring

¹ Maudsley, Henry: Responsibility in Mental Disease.
² Johnson v. Johnson, 105 Md., 8x;
   Owen v. Crumbaugh, 228 Ill., 380.
⁴ Brown v. Ward, 53 Md., 376;
   In re Keeler's Will, 3 N. Y. Supp. 629.
under the delusion that spirits of the dead were directing him in all his business and in making the will in fact as he did make it, this would be undue influence as universally defined.\(^1\) Persons contesting the validity of a will on the ground that the testator at the time of its execution was suffering from an insane delusion have the burden of showing, not only that the delusion existed, but that such delusion affected the testator in the very act of making the will.

**Prejudice.**—Prejudice of the testator against a relative is not ground for setting aside a will unless the prejudice can be explained on no other basis than on that of an insane delusion. A person may be prejudiced against some of his children or other persons who are natural objects of his bounty; he may make unfair remarks about them without having a proper foundation for his conduct, but it does not necessarily follow that he is without testamentary capacity. Unreasonable prejudice against relatives is not ordinarily ground for invalidating a will. That can only be done when the testator’s aversion is shown to be the result of an insane delusion, his conduct not admitting of explanation on any other ground.\(^2\) Thus a testator’s antipathy toward a near relative may be so baseless as to amount to an insane delusion.\(^3\) In an action by a daughter to set aside her mother’s will, evidence that the mother, when dying, refused to see the daughter without apparent reason, is admissible as tending to show mental disorder.\(^4\)

A “monomaniacal delusion” entertained by a testator against one who would otherwise have been a natural object

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\(^1\) Middleditch v. Williams, 45 N. J. Eq., 726; Robinson v. Adams, 62 Me., 369.

\(^2\) Nicewander v. Nicewander, 151 Ill., 156; Schmidt v. Schmidt, 201 Ill., 191; Snell v. Weldon, 243 Ill., 496.

\(^3\) Thomas v. Carter, 170 Pa. St., 272; McDonald v. McDonald, 120 Ky., 211.

\(^4\) Ballantine v. Proudfoot, 62 Wis., 216.
of his bounty, and this being shown to be the reason that has excluded him from the benefactions of the will and to have no existence except in the disordered imagination of the testator, invalidates a will.\(^1\) On the same ground, the Wisconsin Supreme Court set aside a will as invalid in a case in which it was apparent that the testatrix labored under the insane delusion that her only daughter and her daughter’s family had ill-treated her and attempted to poison her, and in which, in all probability, this delusion influenced the disposition of her property; the court held that it did not matter that such disposition accorded with the intentions of the testatrix as previously expressed to various persons.\(^2\) Any will that is shown to be the direct offspring of partial insanity or monomania should be declared invalid, even though the testator’s general capacity be unimpeached.\(^3\)

In determining the capacity of a testator, it is held that the question to be determined by the jury is not the soundness of the views entertained by him, but whether they so impressed his mind as to control his judgment in the disposition of his property, and thereby to prevent him from appreciating the duty he owed to his family.\(^4\)

If an insane delusion relates to the property of the testator he is incapable of making a will.\(^5\) Such a person cannot make a valid will, even though his memory is not impaired and he has ability to reason.\(^6\) Testimony that property devised by

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1. Leech v. Leech, 5 Pa. Law J., 86;
   Merrill v. Rolston, 5 Redf. Surr. (N. Y.), 220.
   In re Black's Est., Myr. Prob. (Calif.), 24;
5. Stanton v. Wetherwax, 16 Barb. (N. Y.), 259;
a testatrix did not belong to her is relevant to the issue of testamentary capacity.¹

**Prior Insanity.**—If prior to making his will the testator had once been insane and, while thus insane, formed a prejudice against one of the natural objects of his bounty, if this prejudice continues after his recovery from insanity such prejudice may be regarded as an insane delusion and thus invalidate the will.² A person who in lunacy proceedings has been adjudged insane and against whom the judgment of the insanity court is still in force is not necessarily incapable of making a will. Such a person may still possess testamentary capacity.³

**Lucid Interval.**—A will made in a lucid interval by one who both before and afterward stood adjudged as insane is valid.⁴ But in such a case the burden of proof is upon the proponents rather than the contestants of the will. Those who seek to maintain the will must establish that it was made during a lucid interval.⁵

It has even been held that the deliberation and thought necessarily employed in the execution of a will, may establish a complete, though temporary, intermission of the insanity of one afflicted with a chronic form of insanity;⁶ even though in one case it was shown that both before and after the execution of a will the testator was insane, the jury found that the will was executed during a lucid interval.⁷ If it is sought to be established that a will was made during a lucid interval it must also be shown that at the time of its execution the testator was laboring under no

¹In re Buckman's Will, 64 Vt., 313.
²Lucas v. Parsons, 24 Ga., 640.
³Harrison v. Bishop, 131 Ind., 161.
⁵Elkinton v. Brick, 44 N. J. Eq., 154;
   Jackson v. Van Dusen, 5 Johns. (N. Y.), 144.
⁷Wright v. Lewis, 39 S. C. L., 212.
delusions with reference to those who had claims on his bounty.\textsuperscript{1} The fact that the testator made his will on the day after he had been seized with an epileptic fit, and that within a few minutes after making the will he was seized with another fit, and died a day or two subsequently, does not show want of testamentary capacity, when it appears he was in possession of his faculties at the time he executed the will.\textsuperscript{2}

\textit{Lucid Interval as Defined in Law.}—A lucid interval is not necessarily a complete restoration to the mental health previously enjoyed. It means that the patient has had a remission of sufficient degree to be in such a mental state that he is temporarily capable of transacting the business in hand, such as making a will. Lucid interval for the question at issue does not mean the suppression or cessation of the symptoms of the mental disease from which the man is suffering; it means only the recovery of testamentary capacity.

The contestants of a will must show the mental incapacity of the testator before the proponents can be called upon to show that the will was made during a lucid interval.\textsuperscript{3}

\textit{Senility and Physical Infirmity.}—To sustain an allegation of want of testamentary capacity something more must be shown than mere physical disease and old age.\textsuperscript{4} Testamentary capacity is not destroyed by the simple failure of memory incident to old age.\textsuperscript{5}

\textsuperscript{1} In re White, 121 N. Y., 406.
\textsuperscript{2} In re Lewis' Will, 51 Wis., 101.
\textsuperscript{3} Murphree v. Senn, 107 Ala., 424.
\textsuperscript{4} Woodman v. Ill. Trust & Savings Bank, 211 Ill., 578.
\textsuperscript{5} Whitenack v. Stryker, 2 N. J. Eq., 8; Carnahan v. Hamilton, 265 Ill., 508; Speer v. Speer, 146 Iowa, 6; Higgins v. Carlton, 28 Md., 115.
or infirmity,\textsuperscript{1} or disease\textsuperscript{2} are not of themselves inconsistent with testamentary capacity, but such facts are admissible in evidence for the purpose of aiding the jury in determining the presence or absence of testamentary capacity at the time of executing the will. The circumstance that a person is on his deathbed or in extremis does not deprive him of testamentary capacity. It has been held proper to instruct the jury that a testator, when in a dying condition, has sufficient mental capacity if, when his attention is aroused, his mind acts clearly in respect to the act to be done.\textsuperscript{3}

Deafness, difficulty in articulation, slowness in learning, mere weakness of intellect, and eccentricities or peculiarities springing from such weakness do not incapacitate a person from making a will unless there is inability to understand the nature of the act of testamentary disposal of property.\textsuperscript{4}

The same tests for estimating testamentary capacity are applied to an aged person as to one in the prime of life, namely: has he sufficient mind to know the nature and extent of his property, the natural objects of his bounty, and to understand the business of making a will in which act he is then engaged? In deciding on the capacity of a testator to make his will the soundness of his mind and not the condition of his bodily health is to be considered.\textsuperscript{5} The capacity to make a valid will cannot be denied to an old person with merely a \textit{physiologically} enfeebled mentality; but when such enfeeblement has reached an extreme degree and has become \textit{pathologic} it is necessary to determine how much mental capacity still exists.

\textsuperscript{1} Richmond's Appeal, 59 Conn., 226; Dillman \textit{v.} McDaniel, 222 Ill., 276; Schmidt \textit{v.} Schmidt, 201 Ill., 191.
\textsuperscript{2} Richmond's Appeal, \textit{supra}.
\textsuperscript{3} Bevelot \textit{v.} Lestrade, 153 Ill., 625.
\textsuperscript{4} Wood \textit{v.} Wood, 4 Brewst. (Pa.), 75.
\textsuperscript{5} Chrisman \textit{v.} Chrisman, 16 Ore., 127.
In the absence of any allegation of fraud or mental unsoundness, the fact that another person did the writing because the testatrix was physically too weak to do it raises no presumption against the validity of the will. Great intellectual and physical weakness, accompanied by only partial failure of mind and memory caused by paralysis are not in themselves ground for setting aside a will. But, on the other hand, evidence that a will was executed by one whose mind was impaired by old age and by apoplectic attacks followed by partial paralysis so that she was unable to understand to a reasonable degree the effect of the will on her property and those entitled to receive it, led to the sustaining of a finding of incapacity. Whether arteriosclerosis, or hardening of the arteries, has affected the mind is not a question of what the tendency of the disease is, but the proof must be as to the effect in the particular case at bar.

Drunkenness, Morals, Etc.—As to the testamentary capacity of habitual drunkards, the same rules apply. The courts hold that it cannot be maintained as a rule of law that because a man is a drunkard he is of unsound mind. And the intoxication of the testator at the time of making the will does not of itself void the will, if it does not prevent him from knowing what he is about. To void a will because of the testator’s intoxication it must clearly appear that the testator was so much under the influence of liquor at the time of making the will as not to comprehend his act.

1 In re Guilfoyle, 96 Calif., 598.
2 Hall v. Dougherty, 10 Del., 435.
3 Hudson v. Hughan, 56 Kan., 152.
4 Brainard v. Brainard, 250 Ill., 613.
5 Whitenack v. Stryker, 2 N. J. Eq., 8; In re Lang’s Est., 65 Calif., 19.
7 In re Howard’s Will, 9 N. J. Law J., 144; In re Tracy, 11 N. Y. St. Rep., 103.
As to the moral character of the person making the will, the courts hold that evidence on this phase of a testator’s behavior is inadmissible for any purpose. In one case the specific rule laid down by the supreme court was that “evidence tending to blacken the reputation of the testatrix for honesty and fair dealing and thereby prejudice the jury against her is not admissible on the issue of mental capacity in a will contest, and such evidence cannot be made the basis of hypothetical questions put to expert witnesses.¹

Content of the Will. Because of the fact that the intent of the maker of a will is the basic consideration, the courts, in considering a will in issue at bar, give more heed to the will itself than to the statements or other evidence concerning the mental condition of the person making the will. If the last will and testament before the court clearly represents the desires expressed by the maker during his sane life, it would in all probability be upheld according to prevailing rules as announced in court decisions, though evidence be submitted that he showed distinct symptoms of insanity.

There is thus a basis for the conclusion than an insane person may make a sane will. This does not apply only to those cases in which persons adjudged to be insane have a lucid interval at the time the will is executed. The courts have specifically decreed that “unsoundness of mind arising from disease is not necessarily destructive of the testator’s capacity to dispose of his property. He may have been of unsound mind, and yet of sound disposing mind. An instruction which directs the jury that if they believe that at the time of the execution of the will the testator was so diseased mentally as not to be of sound mind they must find for the contestant is inaccurate and, in a case where the evidence is conflicting, ground for reversal.”²

¹ Wright v. Upson, 303 Ill., 120.
² Freeman v. Easly, 117 Ill., 317.
One of the writers has personal knowledge of an instance that illustrates the possibility of error arising from this line of reasoning. A business woman possessed of considerable property became ill. The attending physician pronounced her illness serious and her physical condition grave; a lawyer was called for the purpose of assisting the patient in executing her last will and testament. He observed that the patient was physically very weak, but that she answered responsively all of his questions as to the nature and extent of her property, the disposition of the same and the natural objects of her bounty. He reduced the will to writing and it was legally executed. About three months later, during convalescence, the woman stated she had a faint recollection of signing some document while she was ill and made inquiry as to what it was. She was informed that she had signed a will disposing of her property. She was startled at this information and on recovery visited the lawyer's office, asked for and received the will she had executed. On reading it she declared that she had no intention of disposing of her property in the manner and to the persons set out in the document, and that the person named as executor in the will was one toward whom she had had a distinct aversion for many years and in whom she had no confidence whatever. The will itself was a logical document and on its face was in every respect a sane will. But it did not express the intent of the maker, a fact that would not have been disclosed had not the patient recovered from her serious illness. The document proved to be but the emanation of a mind made unsound by severe and protracted physical illness and was revoked on the patient's recovery. This is an illustration of the occasional instance when the context of the will itself is not the best evidence of the testator's sanity.

The accepted view of the courts is that the unnaturalness of a will does not raise a presumption of incapacity.1 The

unreasonableness of a will is not of itself intrinsic proof of the want of a disposing mind.\(^1\) If the provisions of a will are just and reasonable under all the circumstances, this should be taken as corroborative evidence of the capacity of the testator.\(^2\) When a will is just and equitable, and displays memory, reason and benevolence, and the same was made without advice or dictation, it is conclusive evidence of the sanity of the testator.\(^3\) On the other hand, an unjust will is not per se an irrational act,\(^4\) for a testator possessed of mental capacity may make an unreasonable and unjust will\(^5\) and may even disinherit his children.\(^6\) A jury has no right to reject a will because they think its provisions are unjust.\(^7\) Nevertheless the unnaturalness and unjust character of a will may be taken in connection with other facts as evidence tending to shed light on the testator's mental capacity.\(^8\) The dispositions in a will may appear so injudicious and unreasonable that they can only be explained as emanating from a disordered mind. In such a case the unnaturalness of a will is a circumstance which the jury may consider with other facts in passing on the soundness of mind of the testator.\(^9\) The unnatural exclusion by the testator of his only daughter, with whom he had had no difficulty, to whom he had never given more than a pittance, and who was in need of aid from him,

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\(^3\) In re McDaniel's Will, 25 Ky., 331.  
\(^4\) In re Finn's Estate, 22 N. Y. Supp., 1066.  
\(^6\) Addington v. Wilson, 5 Ind., 137; Kitchell v. Beach, 35 N. J. Eq., 446; Snow v. Benton, 28 Ill., 306.  
\(^7\) Higgins v. Carlton, 28 Md., 115.  
\(^8\) Crandall's Appeal, 63 Conn., 365; Dillman v. McDaniel, 222 Ill., 276.  
is a strong circumstance to show mental incapacity. In another case it was held that the fact that a testator affected with delusions with reference to his relatives gave them but $11,000, and the residue, about $300,000, to his executors in trust for charitable purposes with an express provision dis-inheriting his relatives, was evidence of testamentary incapacity. The courts recognize the tendency of the jury in a contested will case to overthrow an unjust will when there are no other facts supporting the contention of mental incapacity and seek to prevent this by express rulings. "While the law is that the testator may make such disposition of his property as he sees fit and may bestow his bounty where he wishes, the common mind is disinclined to recognize it, and jurors will too frequently seize upon any pretext for finding a verdict in accordance with what they regard as natural justice." The jury has nothing to do with the equity or inequity of the will.

**Date of Incapacity.** The mental capacity of the testator that must be determined in a will contest is his mental capacity at the time he executed the will. This is quite analogous to the procedure in criminal cases in which the criminal responsibility of the accused is determined with reference to the time of the commission of the act charged in the indictment. Evidence as to the testator’s mental condition the day following may be of no value in determining his condition the preceding day when he made the will. When there is no evidence that prior to the execution of a will the testator was insane, the court will not hold that he lacked testamentary capacity. When a testator was

1 Reynolds v. Root, 62 Barb. (N. Y.), 250.
3 Nieman v. Schnitker, 181 Ill., 400.
4 Rutherford v. Morris, 77 Ill., 397.
5 Speer v. Speer, 146 Iowa, 6;
6 In re Lewis' Will, 51 Wis., 101.
addicted to intoxication, but not thereby habitually incompetent to transact business, the party impeaching the will, on the ground of his incapacity from intoxication, must show its existence at the time of the execution of the will. When a testator was delirious within four hours before the execution of the will, but the attesting witnesses, without contradiction, testified that at the time he executed the will he was perfectly conscious, the burden was held to rest on the contestents to prove their allegation that an unnatural condition of mind existed in the testator at the time. When it appears that the testator was afflicted with senile dementia, it is incumbent on proponents to show that at the time the will was made the testator was of sound mind.

Evidence as to the testator's habits, business ability, conduct, and mental condition at times other than on the day he executed his will is competent and material evidence if it tends to shed light on his testamentary capacity at the time the will was made. While there is no arbitrary limit, the general rule is that this evidence should not be too remote in point of time, but that the facts detailed as evidence should have occurred within a reasonable time prior or subsequent to the day of making the will. In 1841, the courts of New York and Connecticut declared a man insane, and in 1845 he died insane. It was held that this did not establish incompetency to make a will in April, 1843, but that the question of testamentary capacity was still open to inquiry.

**Summary.** By way of recapitulation, it may be said that there are three well-marked stages in the history of the

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4. In re Winch, 84 Neb., 251;
   *Irish v. Smith, 8 Serg. and R. (Pa.), 573;
law of testamentary capacity as related to insanity, both in this country and in England. The first period is that from the earliest court decisions on record down to 1848, during which period each contested will case, involving the mental capacity of the testator, was determined on its own merits. The second period is from 1848 to 1870—the period inaugurated by the famous decree of Lord Brougham. During this period of more than twenty years, in harmony with this decision, it was held in the English courts that the least degree of insanity would invalidate a will made under its influence. The dictum of Lord Brougham was to the effect that mental disease was so subtle and intangible that no legal tribunal could with any safety undertake to define its degrees, and the only wise course was to hold any degree of insanity fatal to civil capacity.

On the other hand, the courts of this country, for the most part, followed a trend directly opposite to that guiding the English courts during this period, though based on the same postulate. American law, during this period, inclined to the view that the mere possession of understanding was enough to create testamentary capacity. The law as thus applied took a low standard of capacity in determining legal competency. Thus, in one case during this period, it was held that "weak minds differ from strong ones only in degree; unless they betray a total loss of understanding, or idiocy, or delusion, they cannot properly be considered unsound." This doctrine could not long obtain and was distinctly repudiated in the Parish Will Case (1862).

The third period dates from 1870, when the epoch-making decision of Lord Chief Justice Cockburn was promulgated. Since this decree, the courts have reverted to the

1 Waring v. Waring, 6 Moore P. C. (England), 341.
2 Stewart v. Lispenard, 26 Wendell (N. Y.), 255.
4 Banks v. Goodfellow, L. R., 5 Q. B., 548 (England).
earlier and sounder criterion of deciding each controverted will case on its own merits. Was the mental capacity of the testator adequate to the act? By this move the courts advanced from the proposition—Was the testator sane or insane?—to the proposition—"Was the testator sane or insane for the purpose of making a will at the time the will was executed?" This decree of the chief justice, Lord Cockburn, sets forth in clear language the measure of mental capacity that should be insisted upon:

"It is essential to the exercise of such a power that a testator should understand the nature of the act and its effects; shall understand the extent of the property of which he is disposing; shall be able to comprehend and appreciate the claims to which he sought to give effect; and, with a view to the latter object, that no disorder of the mind should poison his affections, pervert his sense of right, or prevent the exercise of the natural faculties; that no insane delusion shall influence his will in disposing of his property, and bring about a disposal of it which, if the mind had been sound, would not have been made. Here then we have the measure of the degrees of mental power which should be insisted upon. If the human instincts and affections, or the moral sense, become perverted by mental disease; if insane suspicion or aversion take the place of natural affection; if reason and judgment are lost, and the mind becomes a prey to insane delusions calculated to interfere with and disturb its functions, and to lead to a testamentary disposition due only to their baneful influence, in such a case it is obvious that the condition of the testamentary power fails, and that a will made under such circumstances ought not to stand. . . . No doubt when the fact that the testator had been subject to any insane delusion is established, a will should be regarded with great distrust, and every presumption should in the first instance be made against it. When an insane delusion has once been shown to have existed it may be difficult to say whether the mental disorder may not possibly have extended beyond the particular form or instance in which it has manifested itself. It may be equally difficult to say how far the delusion may not have influenced the testator in the particular disposal of his property; and the presumption against a will made under such circumstances becomes additionally strong where the will is, to use the terms of the civilians, an inofficious one, that is to say, one in which natural
affection and the claims of near relationship have been disregarded. But when the jury are satisfied that the delusion has not affected the general faculties of the mind, and can have had no effect upon the will, we see no sufficient reason why the testator should be held to have lost his right to make a will, or why a will made under such circumstances should not be upheld. Such an inquiry may involve, it is true, considerable difficulty, and require much nicety of discrimination, but we see no reason to think that it is beyond the power of judicial investigation and decision, or may not be disposed of by a jury directed or guided by a judge.¹

**Medical Examination.** It sometimes occurs, when large property holdings are to be disposed of by will, that the legal advisor about to draw the will calls in one or more psychiatrists to make an examination as to the mental capacity of the testator to execute such an instrument on the day of the examination. This very act on the part of the lawyer may often be said to invite suspicion, but under some circumstances it seems to be necessary, especially when expectant beneficiaries are divided into antagonistic groups, insuring a later contest at law as to the mental capacity of the testator no matter what is stated in the will.

Every medical man with experience understands the importance of taking comprehensive notes at the time of making an examination of the mental condition of a person about to execute a will. Nothing should be trusted to the examiner’s memory, as months or years may intervene between the examination and the chancery hearing. In addition to the usual routine examination it is well to ascertain if the testator has ever made a previous will, in what respects it differed from the proposed will, and the cause of any marked changes as to beneficiaries. It is also well to ascertain the length of time the testator has thought of disposing of his property in the manner he now proposes. Obviously it is best for the medical man to see the testator alone for at least

¹Banks v. Goodfellow, L. R., 5 Q. B., 548 (England).
a part of the examination to exclude the possibility of influence by other persons. Likewise it is well to determine whether he is under the influence of any drug. The medical examiner should constantly bear in mind that the question of testamentary capacity is chiefly a question of facts, and the more facts he collects and notes at the time of his examination the more weight will his evidence have before a jury when he expresses his opinion of the mental capacity of the testator to make a will and adduces the facts on which he bases his opinion.

Conclusions. In conclusion, it may be well to repeat that an analysis of the whole law on the subject resolves itself into this: Each will case must be decided on its own merits with the fullest possible knowledge of all the facts and circumstances attendant upon the execution of the document in controversy. Testamentary capacity is a question of fact rather than a question of law. The duty of the judge presiding at the trial ends with his instructions as to the rules of the law involved in the case at bar and his rulings as to the character of the facts admissible as evidence for the jury's consideration. The jury must then decide, not whether the testator was sane or insane, but whether he was mentally competent to make the will in question at the time he did make it. The province of the jury is as difficult as it is important.
IX. MISCELLANEOUS LEGAL ASPECTS OF INSANITY

Up to this point we have sought to present only the more important relations that exist between law and insanity. There are, however, numerous other legal aspects of insanity to which allusion should be made. Compared with the subjects already discussed, these are of minor significance because of the infrequency with which they arise. They are of necessity miscellaneous in character and reference to them will be brief.

Rape. An attempt or assault with intent to have sexual intercourse with a woman who is insane is an assault with attempt to rape. If a woman is too imbecile to resist any attempt to have carnal knowledge of her it is an assault with attempt to commit rape.\(^1\) In the eyes of the law such a woman is incapable of giving consent and, as in the case of a woman under the age of consent, one who attempts to have intercourse with her is guilty of attempt at rape notwithstanding her actual consent. It is no defense that the accused did not know that the woman was incapable of giving consent.\(^2\) The fact that a woman is incapable of giving legal consent by reason of unsoundness of mind does not preclude her from testifying against the accused. She may be mentally unsound to such degree as to be incapable of giving legal consent and yet possess sufficient understanding to know the nature of an oath and its obligations, and have sufficient capacity to give a correct account of what occurred

\(^1\) State v. Austin, 109 Iowa, 118.
\(^2\) People v. Griffin, 117 Calif., 583.
between her and the accused with reference to matters at issue.¹

**Lunatics as Witnesses.** It was held at common law and in earlier American cases that every insane person was incompetent to testify. But with the progress of science the courts have come to have a better understanding of the nature of insanity and its various forms or phases, and to some extent have relaxed the old rule; they agree that an insane person may testify² provided he knows the obligation an oath involves and can give a correct account of what he has observed in reference to matters at issue in the case on trial. The judge decides on the competency of the witness from his appearance, conduct and speech, the examination of witnesses acquainted with him and any information available.³ The examination by the court of a person offered as a witness for the purpose of ascertaining his competency should be made with special reference to the subject matter concerning which the witness is to testify.⁴ A person may have many delusions and yet be capable of narrating facts truly; but if he is afflicted with insane delusions concerning matters involved in the case on trial he is an incompetent witness and obviously should not be permitted to testify. The court passes on the competency of the witness; the jury passes on the weight of his testimony. Any objection to the competency of a witness on account of his mental condition must be made at the time he is sworn,⁵ and not

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² Tucker v. Shaw, 158 Ill., 326; People v. Enright, 256 Ill., 221.
⁵ People v. Enright, *supra*. 
later, unless his mental condition was unknown beforehand and was only disclosed in the course of giving his testimony. Objections must be made as soon as the mental incompetency of the witness becomes apparent. When no objection has been made as to the witness' competency and a motion to exclude his testimony on the ground that he is insane has not been made, it is not error for the court to refuse to permit proof that the witness is of unsound mind after he has testified.\(^1\)

**Depositions of Witness Who Has Become Insane.** It has been held that when a witness has been sworn and has testified or his deposition has been taken on a former trial between the same parties and on the same issues, and that since the former trial the witness has become insane, his testimony or deposition as previously given is in evidence.\(^2\) This view is founded on necessity arising from the exigency, there being no actual difference between death of the mind of the witness through insanity and death of the body through accident or disease.

**Drug Addiction and Mental Capacity.** The law recognizes that a change in a person's character results from the habitual use of narcotic drugs, such as opium (and its derivatives—morphine, heroin, etc.) and cocaine. The destruction of brain integrity by the use of such drugs tends to dement the addict by blunting his intellect, lowering his moral standards and increasing his emotional instability. Hence, in some courts, the broad view prevails that the habitual use by a witness of a drug, or narcotic, which tends to impair the mind, destroy the memory and lower the character may be shown for the purpose of affecting the credibility of the witness or the weight of his testimony.\(^3\)

\(^1\) People v. Enright, 256 Ill., 221.
Also evidence of the fact that an interpreter, employed in taking a dying declaration, was addicted to the use of opium and other drugs is competent for the purpose of showing the mental balance of such interpreter and his capacity to remember the questions that were propounded and the answers thereto. The court in handing down its decision in a case in point declares: "We believe it will be admitted that habitual users of opium, or other like narcotics, become notorious liars. The habit of lying comes doubtless from the fact that the users of those narcotics pass the greater part of their lives in an unreal world, and thus become unable to distinguish between images and facts, between illusions and reality. Accordingly evidence of the morphine habit, so far as it may have had such effect, should be received." And another court has held: "The testimony of an opium consumer, while unreliable, is competent, but juries should be cautioned as to the credence to be given it."

Other courts hold that it is not enough to show merely the habit of using narcotic drugs, but the proof must go further and show that either the mind of the witness is impaired generally by its use, or that he was under the influence of the drug at the time of testifying, or at the time of the occurrence concerning which he testified. This position is consistent with the view taken by the courts generally in reference to acute and chronic alcoholism in similar situations. The United States Supreme Court makes the same application in one of its decisions. In the course of a trial for violation of the Mann Act, the defendant was put on the stand and asked if she was addicted to the use of morphine; she admitted this and, also, that she had last used it before

1 State v. Fong Loon, 29 Idaho, 248.
2 State v. White, 10 Wash., 611.
3 State v. Gleim, 17 Mont., 17;
Eldridge v. State, 27 Fla., 162;
coming into the court room that morning. She was then asked how often she used it and if she had the "implements" with her with which to "take the dose," to which she replied in the affirmative. Exception was taken by the attorney for the defendant and final appeal carried to the United States Supreme Court, which "over rules on the ground that from the evidence it was not offered for its bearing on her character so much as to show that she was so addicted to the use of the drug that the question, whether at the moment of testifying she was under its influence, had a material bearing on her reliability as a witness. In this aspect the evidence was admissible."¹

Insanity of a Juror. The insanity of a juror is not ground for a new trial if such insanity was known to the accused or his counsel at the trial and he was not challenged.²

Bail Exonerated by Insanity. Insanity, like other sickness or bodily injury, of such degree as to prevent the principal from meeting the terms of a bond by appearing in court at the time specified is a good defense to an action brought against the sureties for recovery of the amount of said bail bond.³ Such visitation of insanity is considered in law as an act of God rendering the performance of the requirements of the bond impossible. It is held, therefore, that sureties are not liable for the appearance of the principal if the failure to appear was due to some fact, condition or circumstance beyond the control of the principal. But it has been held that it is no defense in a suit for the forfeiture of a bail bond for the sureties to show that at the time specified for the principal to appear in court, he was insane and had been taken out of the state and confined in an insane asylum in another state

² Mackin v. People, 115 Ill., 312; Douthitt v. State, 144 Ind., 397.
to be treated for his insanity—on the ground that the sureties had no right to permit him to be sent or taken out of the state.  

**Rights of the Holder of a Note of an Insane Person.** If the maker of a note is insane to the degree of not possessing capacity to contract, the holder of the note cannot enforce its terms. The absence of contractual capacity, whether the maker be an infant, imbecile or insane, nullifies the attempted transaction at the outset. However innocent or ignorant the holder of the note may be, his equity is deemed inferior to that of the maker of the note when the latter does not possess the legal capacity to contract. A lack of actual knowledge of the maker's mental condition when the holder received the note and when it was signed makes no difference in this respect.  

Insanity of the signer, whether he is the maker or indorser of the note is a defense even as against a bona fide holder.  

This is not the case if the mental condition is but the temporary incapacity resulting from intoxication, since drunkenness is a temporary disability voluntarily produced as distinguished from insanity or feeblemindedness. "The person who through his voluntary actions deprives himself of reasoning power and thereby exposes himself to imposition and fraud does not receive the same considerate protection of the law as is extended to the unfortunate insane and imbecile."  

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1 Adler v. State, 35 Ark., 517.  
2 Walker v. Winn, 142 Ala., 560; Hosier v. Beard, 54 Ohio St., 398.  
Effect of the Insanity of the Drawer of a Check. When the statute declares that insane persons shall be deemed to have no capacity to contract, a bank will not be protected in paying the check of a person who was lawfully adjudged insane when the check was drawn though the insanity was unknown to the bank at the time. This is true though the adjudication of insanity took place in another state.¹

Insanity Terminating Employment. It is a general proposition and rule of law that a contract for personal service or labor, be it skilled or unskilled, is terminated by the insanity of either the employer or the employee. But it has been held that the employer’s insanity does not prevent recovery of wages or other emoluments for services rendered on the terms of the contract if the guardian of the insane employer has recognized said contract as continuing.²

Public Office Vacated by Insanity of Incumbent. As a rule, provisions in the constitutions of the various states or in statutory enactments include insanity of the incumbent as one of the causes through which a public office becomes vacant. Sureties of a public officer, such as sheriff, auditor or treasurer, have no more right to operate the office or exercise its duties than they would have in case of said public officer’s death. The right of such an officer, as a sheriff, to exercise his duties ceases immediately when he becomes insane and the agency of his deputies is terminated.³

Insanity of Voter. It has been held by the common political law of both England and the United States that idiots and lunatics are excluded from exercising the right of suffrage and in the constitutions of many states it is expressly provided that no person under guardianship, non compos mentis or insane, shall be qualified to vote at any election. Nevertheless, the vote of a man otherwise qualified, who is

² Sands v. Potter, 165 Ill., 397.
³ Somers v. Burke County, 123 N. C., 582.
neither a lunatic nor an idiot, but whose mental faculties are merely greatly enfeebled by age, ought not to be rejected.\(^1\) It has also been held that it is competent for the purpose of rejecting a vote to show that a person is non compos mentis and this without any finding in lunacy.\(^2\)

"A person who has been laboring under some kind of illusion or hallucination, but not so as to incapacitate him from the general management of business, which illusion or hallucination is not shown to extend to, or deal directly with, political matters, cannot be denied the privilege of the elective franchise on the ground of want of mental capacity."\(^3\)

**Broker’s Authority Terminated by Insanity.** The death or insanity of either the broker or the one who employed him to consummate a pending or future transaction terminates the relationship of employment, regardless of the fact that the parties may have contracted to the contrary.\(^4\)

**Eminent Domain as Affected by Insanity.** As in the case of minors, land owned by insane persons may be taken by eminent domain for public use. If the land of such person is taken over his objection and he makes claim for damages the court may take action to protect his rights.\(^5\)

**Carriers—Care of Insane Passengers.** When railroads, street car companies or other common carriers transport passengers whom they know to be of unsound mind, they are required to exercise a higher degree of care toward them than they would exercise toward persons in full possession of their faculties. One of the chief reasons for this rule is that such passengers are not capable of assuming or appreciating risk. When carriers have accepted persons

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\(^1\) Sinks v. Reese, 19 Ohio St., 306.
\(^2\) Thompson v. Ewing, 1 Brewst. (Pa.), 67.
\(^3\) Clark v. Robinson, 88 Ill., 498.
\(^5\) Hutchinson v. McLaughlin, 15 Colo., 492.
incapacitated on account of physical or mental infirmities from caring for themselves, it is deemed that they owe to such passengers the degree of care adequate to their condition.¹

When a passenger is insane, although the insanity arises during the course of his transportation, and by reason of that condition injury to his fellow passengers is threatened, it is the duty of the railroad employees to refuse to carry him further than is necessary to place him in the care and custody of an officer and to use all reasonable care to prevent injury to the other passengers in the meantime. Thus a railroad company was held liable in damages when a passenger was killed by a man insane from drink who imagined he was going to be beaten and robbed and who had been removed from a sleeping car to a smoking car of the same train by the conductor and brakeman.² In another case, in which suit was brought for the death of a passenger at the hands of an insane fellow passenger, the United States court, in its opinion handed down by Mr. Justice Shiras, held that "the insanity of the assaulting passenger was such that the defendant railroad company could not help but have knowledge thereof and therefore the company was charged with the duty of doing whatever a high degree of care would demand for the protection of the other passengers on the train."³ If the safety and reasonable comfort of the other passengers will not be imperiled thereby, the company may carry the insane passenger to the end of his journey, or he may be removed at the first station where he may be properly cared for; but whether he be carried on the train for a longer or shorter distance, the company is bound so long as he is on the train to do whatever, in the way of restraint or isola-

² King v. Ohio, etc., 22 Fed., 413.
tion, is reasonably demanded for the comfort and safety of the other passengers.¹

While a carrier may not absolutely refuse to transport insane persons, it may be required that said insane persons be restrained or attended and the railroad company is not bound to carry insane persons in the same cars in which other passengers are being conveyed and the carrier may be entitled to reasonable notice in order that proper equipment may be provided and suitable arrangements made for the transportation of such insane persons.²

**Employer Liable for Mental Incompetency of Employees.**

The law presumes a certain degree of circumspection on the part of the employer in the selection of his employees. This presumption has given rise to the modern custom of requiring applicants for employment to submit to medical examination. Such examination usually includes some form of test by means of which the mental caliber of the applicant is at least roughly invoiced. If the employer does not exercise reasonable diligence and circumspection in ascertaining the competency of an employee he will be held liable for injuries done another.

Says one court,³

"In a sense workmen are appliances. If a master knowingly employs servants who are incompetent he is liable for injury to a fellow employee or to others caused by their incompetency just as he would be liable for injury caused by a defective machine."

While it will be presumed that competency of an employee continues,⁴ and the employer is warranted in assuming that a competent employee will continue competent⁵ yet he is

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⁵ Blake v. Maine Central Ry., 70 Me., 60.
bound to keep himself informed as to the continued fitness of those already in his employ so far as this can be accomplished by proper supervision and superintendence.¹

**Wrongful Certification of Insanity.** A civil action for damages against a physician for certifying to a person’s insanity cannot be based on the insufficiency of the methods which he employed in reaching his conclusion. In an action against a physician for falsely certifying, through malice or negligence, to the insanity of the plaintiff, the falsehood and not the insufficiency of the certificate is the ground of action against the defendant physician.² A physician who signs a certificate of insanity which is false without making due inquiry into the question of the person’s sanity, and without exercising ordinary care and prudence in making the examination is liable to an action for damages.³ But the physician is not liable for signing such certificate after making an examination if it can be shown that his mistake was due merely to an error of judgment and not due to negligence.⁴ In an action against a physician for wrongfully issuing a certificate of insanity the burden is on the plaintiff to show negligence and the burden is also on the plaintiff to show that, at the time the certificate was issued, he was then sane.⁵

**Privileged Communications between Physician and Patient.** When a person is examined for sanity on behalf of the state, the relation is not one of physician and patient and the physician is not held to so high a degree of care as he would owe to a patient.⁶ When, however, a physician, sent by the prosecutor or court, in addition to the examination as to the

² Pennell v. Cummings, 75 Me., 163.
³ Ayers v. Russell, 50 Hun (N. Y.), 282.
⁴ Williams v. LeBar, 141 Pa. St., 149.
⁵ Pennell v. Cummings, *supra*.
⁶ Niven v. Boland, 177 Mass., 11; People v. Austin, 199 N. Y., 446.
sanity of the prisoner, does treat him or prescribe for him the relation of physician and patient is thereby created and any disclosures made to the physician by the defendant are privileged in those jurisdictions where the statutes provide for the privileged character of communications between physician and patient during the course of professional attendance.\(^1\) In many jurisdictions the prohibition placed by the statute on the medical witness revealing privileged communications is relaxed in criminal cases. Thus,

"In the Courts of the District of Columbia no physician or surgeon shall be permitted, without the consent of the person afflicted, or of his legal representatives, to disclose any information, confidential in its nature, which he shall have acquired in attending a patient in a professional capacity and which was necessary to enable him to act in that capacity: Provided, that this section shall not apply to evidence in criminal cases where the accused is charged with causing the death of or inflicting injuries upon a human being, and the disclosure shall be required in the interests of public justice."\(^2\)

Communications between a patient and his physician were not privileged at common law, and in those states operating under common law, unless statutes provide to the contrary, a physician when called on to testify as a witness has no right to refuse to disclose any information that has been acquired from the patient in the course of his professional attendance.\(^3\)

**Records of Hospitals and Asylums Privileged.** When provisions obtain as to privileged communications between physician and patient, the records of a hospital or insane asylum are inadmissible as evidence, since the introduction of such records would be an evasion of the statutes by seeking

\(^1\) People v. Sliney, 137 N. Y., 570; Freel v. Market St. City Ry. Co., 97 Calif., 40; People v. Murphy, 101 N. Y., 126.
\(^2\) Section 1073, Code of District of Columbia.
to place in evidence matter recorded in the course of treatment and sought to be excluded by preventing the testimony of the physician participating in the treatment.¹

A statement made by one physician to another whom he has called into consultation, made in the presence of the patient, is a privileged communication² and likewise the privilege extends to information acquired by a partner of a physician from communications in his presence.³

**Habeas Corpus.** It is the rule that the writ of habeas corpus may be issued to determine the legality of the confinement of a person in a state asylum for the insane.⁴ When one in the care and custody of a hospital by reason of insanity is detained after he becomes sane such detention is illegal and may be ended by habeas corpus. Though the confinement has been illegally brought about, or there has been some defect in the process of commitment, yet, if the freedom of the insane patient in going at large may be fraught with danger to himself or to others, he will not be set at liberty by a writ of habeas corpus but be detained until proper steps can be taken for his legal commitment.

A commitment to an institution for the insane can last only so long as the patient is insane, and he has the right at any time, under the law, to have his sanity determined on habeas corpus proceedings.⁵ The court to which the writ was made returnable has the right to examine the question of sanity and the patient is not entitled, as a matter of right, to the trial of this question by a jury.⁶

³ 16 L. R. A. (N. S.), 888, note.
⁵ People ex rel Peabody v. Chanler, supra.
⁶ Id.
The right of the writ of habeas corpus is insured by the constitution of the United States and by several state constitutions. As applied to the insane, the theory under which the writ of habeas corpus lies is that either the patient has been sent to a hospital for the insane without due process of law or that he has recovered, or is not insane, therefore confinement is illegal.

The statutes of the several states outline the procedure to be followed in securing a writ of habeas corpus. In seeking release from an institution through such a writ it is necessary to examine the constitution and laws of the state wherein the application for the writ is to be made and it is also necessary to consult the laws of that particular state concerning insane persons, as certain steps are usually provided to entitle a patient to discharge upon his recovery. When the law provides that a superintendent or some board in control of a hospital for the insane should certify to the patient's recovery it is a complete defense to any writ if it can be set up that no request has been made for such certification. If, however, the request has been made and the superintendent or board fails or refuses to act, then the matter of discharge might be brought before a court in habeas corpus proceedings.\(^1\)

The procedure in Illinois, for example, would be as follows:

The first step in suing out a writ of habeas corpus is the preparation of the writ (forms of which are provided in the various form books and supplied by the law stationers) which sets up that a certain person or persons named and referred to as relators, are unlawfully detained and restrained of liberty, the details being made to fit the particular case. The writ states that the detention is not one of those mentioned in the statute for which a writ will not lie.

\(^1\) Swager v. Gillham, 278 Ill., 295.
It is necessary that this petition be sworn to, and it may be brought by a relative or anybody. The case is brought in the name of the People of the State, *ex rel* the name of whoever signs the petition, and runs against whomever it is claimed is detaining the person; if a police officer or a police department, the writ is made against the chief of police. Of course it might run against a private person or those in control of any institution.

It is necessary to secure an order of court or some judge before the writ is issued. This order is generally attached to the foot of the petition and the judge is asked to sign the same, to the effect that the writ should issue and be made returnable at whatever time the judge fixes. If the judge signs this order, the petition and order are taken to the clerk of the court in which the judge sits and he issues the writ; that is, he fills out forms which are turned over to the sheriff; in effect, this commands the sheriff to summon the persons complained of, with the order that they produce the relator in court, the time and place being specified, so that the question of his detention may be inquired into. This writ is served by the sheriff in the manner usually followed in the service of processes. The cause is docketed and is called as a case.

In matters involving the application of criminal law, the state's attorney appears for whomever might be named as respondent, and under the law a written return is required setting up the reason for the detention, together with a copy of the mittimus or other papers under which the authorities claim the person has been confined. But in actual practice this return is often made orally. The matter is heard and the court has the power to continue the hearing and admit the respondent to bail pending such continuance. Or he may dispose of the writ by dismissing the same or remanding respondent to the custody of the person having him, or he may
change the custody, or he may discharge the respondent, in accordance with his finding.

The writ is an original proceeding and may be brought in the superior or circuit court, or in any court of like jurisdiction, or it may be directly applied for in the supreme court. When federal questions are involved, it may be sued in the federal court. If the finding be against the state or prosecuting authorities or the superintendent of a hospital for the insane, they have no right of review, except there is a method of trying out the legal question by mandamus. But if the decision be against the person who claims to be unlawfully restrained he is given the right to carry the proceedings to a higher court. The rules of procedure at the hearing are somewhat similar to other trials, but the parties involved are not entitled to a jury trial. This is often spoken of as one of our extraordinary remedies. It is not a criminal case, and, strictly speaking, it is not civil, but it has been held to be civil in its nature.
X. THE PHYSICIAN IN COURT

Frequency of Medical Testimony. Practically every medical man is destined to appear in court, if not as a medical expert then as a witness to fact. This is because so many cases that come to trial are dependent for proper adjudication, at least in part, on the physician's observations. The family physician is frequently the person best qualified to recount the history of the accused and to state the extent of the havoc wrought by prior illnesses. The plaintiff's attending physician is almost indispensable in a personal injury suit. No one has better opportunity for becoming familiar with the mental condition of a person who is executing a will than the testator's physician. This is also usually true when such questions as commitment, guardianship, restoration, capacity to contract and criminal responsibility arise. The law as applied to insanity touches medical science at so many points that the physician must needs be available to give the court the benefit of the knowledge he has gained with especial reference to the case at bar.

History. In the early history of our courts testimony was confined to the statements of fact witnesses. The members of a jury were selected with reference to their special fitness to consider the facts involved in a given case. If the case concerned the cost or value and workmanship of a saddle, the jury was composed of saddlers; if housebuilding was involved in the case at issue, the jury was made up of carpenters, stonemasons or others actively employed in the building trades. As society became more complex and the cases in court more numerous and more varied, it
became impracticable to select "specialists" as a jury to pass on the claims and counter claims in each issue. Questions began to arise in cases on trial concerning which the average man on a jury knew little. The courts found it necessary in some cases to call in some one specially skilled with reference to the facts at issue to aid the court and jury in correctly interpreting the facts. Thus it was that the expert was developed out of the very needs of the courts for such knowledge as he possesses, whether it be of chemistry, engineering, real estate values or medicine. While medical experts were called as early as 1550, the giving of expert medical opinions in court did not become established until the eighteenth century.

**Necessity of Medical Expert Testimony.** An expert witness may be defined, in a general way, as one who is asked to enlighten the court and jury on matters beyond the range of ordinary observation and knowledge in some particular province of art or science. In England, as early as 1553, Justice Saunders stated: "If matters arise in our law which concern other sciences, we commonly apply for the aid of that science which is concerned therein, which is an honorable and commendable thing in our law, for thereby it appears that we do not despise all other sciences but our own, but we approve of them and encourage them as things worthy of commendation." In no class of cases is the use of expert testimony so general and so necessary as in that in which the issue is sanity or insanity. Unless the person whose mental condition is to be determined is a raving maniac or a complete dement the average jury is not competent to reach a decision. The mental condition of the person whose case is on trial may require explanation by an expert in psychiatry concerning manifestations of disease and the significance of symptoms already in evidence before the court and jury.
"The opinions of medical experts and experts with relation to mental disease, are admissible in evidence generally on an issue as to sanity or insanity and they may be based on the symptoms and circumstances which come within their own observation, or testified to by others, or some hypothetical question or statement assuming their existence. The opinions of an expert are received because the facts are of such character that they cannot be weighed or understood by the jury, the expert giving his opinion as to what they do or do not indicate."

When the physician is called as a witness to fact he states what he has learned or experienced through his own senses; his own powers of observation are the measure of truth in reference to the subject matter of his testimony. When he is called as an expert or an opinion witness, after qualifying as such, the physician is requested to assume a group of facts as true—facts that have been gathered from the evidence that has already been legally admitted by the court. Assuming these facts to be true he is asked if he has an opinion or judgment based on all or any part of the facts, provided, in the opinion of the court a sufficient number of facts are stated in the assumption to furnish the witness a proper basis for an intelligent opinion. If he has such an opinion he is requested to express it before the court and jury and thus becomes an opinion or expert witness.

Differences between Expert and Non-expert Witnesses.
A non-expert witness will not be permitted to express a general opinion as to sanity, nor can he give an opinion that is not based on facts that have come within his own knowledge; but he is allowed to detail from the witness chair facts that he has himself observed, which to him show the mental condition of the person on trial, and to express an opinion as to the sanity of such person based solely on the facts he has detailed. The non-expert witness is first asked, as a foundation for his testimony, to state the length of time

1 Boardman v. Woodman, 47 N. H., 120.
he has known the person whose sanity is in question, the opportunities he has had for observation, and what dealings, business or social, they have had with each other; he is then requested to detail such transactions to the court and jury and recount any observations he may have made as to behavior, mannerisms or appearances of such person. After relating all these facts the non-expert witness may be then asked: "Have you an opinion, based on the facts you have detailed here, as to the sanity or insanity of the individual in question?" If he has such an opinion he may then proceed to state it.

"The opinion of a witness not an expert is competent as to the sanity of another when the opinion is formed from facts within the personal knowledge of the witness, and deposed to by him before the jury, that it may know what weight to attach to the opinion."1

The purpose of the non-expert witness first stating the facts on which his opinion as to sanity is based is decisively to limit non-expert opinion and prevent an opinion being based on hearsay; for the opinion must not be even partly based on hearsay, such as the observations of others. If a witness were permitted to base an opinion on facts without disclosing them he would be considering facts he alone knows, and the jury would not know what weight to give to the opinion of the witness. Usually the jury judges from the facts rather than the opinion based on them.

It is well settled that it is proper to admit in evidence the observations and opinions of lay witnesses as well as medical witnesses regarding the mental status of a plaintiff in a personal injury suit before the injury and continuously from and after the injury, and it has been held that "any witness that had any knowledge upon the subject covering any part of the time to which the inquiry was open was com-

1 Thomas v. Com., 245 S. W. (Ky.), 164 (1923).
petent and such evidence material." It is also held that non-expert witnesses who have known the plaintiff both before and after the injury, and who have observed his actions, not with a view to testifying, but as they have met him from time to time, socially or in a business way, at his home or on the street, may testify to the manifestations of his nervous and mental condition at such times.

The range of the medical expert is immeasurably wider. It is now a well settled rule that the opinion of the medical expert in reference to disease of the mind, founded on facts detailed by other witnesses or gained from personal observations of the person alleged to be insane, is admissible evidence.

Qualification of an Expert Witness. That the witness possesses the requisite qualifications must appear in evidence before he can properly be permitted to give expert testimony. The competency of the witness is determined by the court, and for this purpose a preliminary examination is made in which the witness states his studies, preparation, experience and opportunities as related to the subject matter under inquiry. In other words, he must reveal to the court what he has done to qualify himself as an expert in the particular field under consideration. The preliminary inquiry as to the competency of the witness to testify as an expert may be greatly shortened. The extent to which qualifications of an expert witness are gone into is discretionary with the court. Opposing counsel on cross examination have opportunity to impeach the skill and test the competency of the witness. It is not easy for an incompetent person to maintain himself in the character of an expert witness. If he has not made the subject on which he gives his opinion a matter of particular

1 Union Traction Co. v. Lawrence, 211 Ill., 373.
2 Lauth v. Chicago Union Traction Co., 244 Ill., 244.
3 Boardman v. Woodman, 47 N. H., 120.
study, observation and experience so as to possess special knowledge on the subject, such deficiency is liable to be disclosed quickly in the course of his testimony, regardless of what questions as to qualifications were asked and answered at the outset.

Other witnesses may be called to enlighten the court as to the qualifications of the expert witness about to testify, but the expert cannot give his own opinion as to his own qualifications. He cannot be asked, for example, whether he is an expert. Nor is the evidence of other witnesses admissible as to such qualifications after the testimony has been given.

Whether a witness is or is not expert in any particular science or art must be determined before he is permitted to testify either before a grand jury or in the trial of a case.¹

**How Qualifications Are Determined.** Such a witness may be qualified (a) by professional, scientific or technical training or (b) by practical experience in some field of human activity which confers on him an especial knowledge not shared by men in general.² Superior qualification is attained when the two are united in the same person. The man of scientific or professional attainments is a more valuable witness if he has extensively practiced his calling. "In order that a person should be eminent in a learned profession, it is necessary that he should combine a knowledge of its principles with that judgment, tact, dexterity and promptitude of applying them to actual cases which are derived from habits of practical experience."³

The ultimate judges of the qualifications of an expert are the jury. The court's *voir dire* has been preliminary and furnishes only a quasi endorsement of credibility. But, once the court has admitted the expert's testimony, it is

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² Siebert v. People, 143 Ill., 571.
for the jury to decide whether any, and if any what, weight is to be given to the testimony.\(^1\) The judgment of an expert is valuable precisely in accordance with what is back of it.\(^2\)

More recently the courts have taken the position that special knowledge of psychiatry and experience in the treatment of insane persons is a requisite qualification for an expert witness on insanity. Formerly, in the majority of the states any physician could appear as an opinion witness, regardless of experience or special study. Thus, when the mental derangement is of a common type, the American courts as a rule have shown an inclination to accept a practicing physician in good standing as competent to testify as an expert,\(^3\) even when he is not a specialist on the subject, although special training may add weight to his judgment.\(^4\) In some jurisdictions greater care and scrutiny have been exercised as to the qualifications essential to expert knowledge of insanity, and more recently the tendency in all courts is to restrict expert testimony on mental conditions to those who have made special study and have had extensive opportunities in that line of medical research.\(^5\) One court in its decree sums up the situation in these words:

"Expert testimony in insanity cases has, in general, proved so unsatisfactory that only those who are expert in mental diseases or psychological studies are regarded as authority, for it is a knowledge rarely attained and involves much study, observation and experience.\(^6\)"

\(^1\) Spring Co. v. Edgar, 99 U. S., 645; Page v. Parker, 40 N. H., 47.
\(^2\) Guetig v. State, 66 Ind., 94.
\(^3\) Davis v. State, 35 Ind., 496.
Such a statement exhibits some recognition of the fact that graduation in medicine does not imply training in psychiatry and a cognizance of the truth that some medical schools do not require any study of psychiatry as a pre-requisite to graduation. Courts are therefore warranted in holding that a witness appearing as an insanity expert must be shown to have capability, knowledge and experience commensurate with the nature of the subject matter sought to be presented for his opinion. The higher the standard set for medical experts, the better will the status of the expert become and the more remote will be the likelihood of a pseudo-expert being thrust on the courts. The law recognizes no particular school of medical practitioners as being best qualified. The only criterion is seasoned knowledge gained by painstaking study and extensive experience. Such knowledge possessed by the medical witness on insanity enables him to "speak as one having authority"—makes him an expert.

Again the courts are more and more inclined to apply the ancient homely precept that "the shoemaker should stick to his last." While it used to be held that a physician may be examined as to injury done to the eyes of a person by external violence although he was neither a surgeon nor an oculist,¹ and might testify as to the effect of a certain drug on the uterus although he had no personal knowledge of the effect of the drug,² such anomalies are no longer countenanced.

Hypothetical Questions. In the majority of cases in which medical experts are examined their testimony is based largely on hypothetical questions. A hypothetical question propounded to the witness is one in which a group of facts is assumed and detailed by counsel for the purpose of securing from the expert witness an opinion as to the bearing of such facts on the behavior of such a person as the one on

¹ Castner v. Sliker, 33 N. J. L., 95.
² State v. Wood, 53 N. H., 484.
The hypothetical question must be based on the facts in evidence, and must not give a false coloring to them. The more closely the facts assumed in the hypothetical question correspond to the facts as they appear to the jury from the evidence, the greater the weight that will be attached to the opinion which the expert witness delivers in his answer. While a hypothetical question must be based on facts that are in evidence, they "may be addressed to any reasonable theory that might be taken of them." ¹

What facts the hypothetical question must cover is determined by the judge. Facts that have too remote a bearing or no bearing may be excluded. The court may also properly require that sufficient facts be included in the question propounded to the witness to enable him to give an opinion of some value to the jury, and may reject any item obviously misleading because of ambiguity or conjecture or because too involved or complicated. It is not necessary that the facts assumed be stated in the exact language of the witnesses who testified to them. A hypothetical question to an expert witness is not improper simply because it includes only a part of the facts in evidence,² provided the testimony tends to establish such facts as are embodied in the question;³ counsel may assume any state of facts which there is evidence to establish and may ask the opinion of the expert on the facts so assumed.⁴ If a hypothetical question does not embrace all the facts in evidence the opposing counsel can on cross examination ascertain from the witness whether such omitted facts would in any way change or modify the

¹ People v. Durrant, 116 Calif., 216.
² Stearns v. Field, 90 N. Y., 640.
³ Parrish v. State 139 Ala., 16;
⁴ Cole v. Fall Brook Co., 159 N. Y., 68.
opinion he expressed in his answer to the hypothetical question on direct examination.\(^1\)

In considering a hypothetical question for the purpose of answering the same, the witness must confine himself strictly to the statements included in the hypothesis and must consider no other facts or circumstances than those stated. If on cross examination it appears that the witness did take into consideration some fact in addition to those assumed in the question, then his answer to the hypothetical question may be stricken from the record, and his expert opinion be disregarded.\(^2\)

**Expert Opinion Based on Personal Knowledge.** It has become sufficiently established that in asking a question of an expert witness for the purpose of securing his opinion, it is necessary to base such question on a series of facts assumed to be true. This statement of facts or hypothetical question is founded on evidence already before the jury and must be expressed in clear language, free from conjecture and ambiguity. It is also well established that an expert cannot be called on to express an opinion that is based on facts concealed in his own mind, which have not been disclosed to court and jury. All the facts must be stated hypothetically in the question, and the opinion expressed must be based thereon.

When, however, a medical expert has himself examined the person whose sanity is in question and testifies to his conclusions that result from such examination, the procedure is different. This opinion is based not on an assumed state of facts but on the personal knowledge of the psychiatrist, and the questions put to him are not hypothetical in form. But when the opinion is founded on personal knowledge of facts gained from observation of the alleged insane person

\(^1\) Stearns v. Field, 90 N. Y., 640.

\(^2\) Turnbull v. Richardson, 69 Mich., 400.
in or out of court or elicited by examination of such alleged insane person, these facts must first be stated by the expert so that the court and jury may determine whether his conclusions are justified. The method of procedure then resembles that employed in the case of a non-expert witness who must first detail the facts; he may then express his opinion based on the facts as detailed to the court and jury. Questions calling for the opinion of an expert without his having first detailed the facts on which such opinion is based have been held improper in a decree by the United States Supreme Court because no foundation had thus been laid.\(^1\) Chief Justice Fuller said: “Clearly the opinion of a witness from facts he did not disclose was inadmissible. If from his investigations he knew anything about the mental condition of the deceased other than what he had stated, and which aided him in arriving at a conclusion, that knowledge should have been developed in the course of his examination as a witness. It is a situation of assumption of facts for which there is no evidentiary foundation and basing an opinion thereon.” When the witness states a conclusion based on facts which he alone knows, and does not disclose them in his testimony there is an assumption of the existence of facts for which there is no foundation or evidence and such a position is untenable.

Furthermore, the jury must be placed in a position to judge the facts on which opinions as to sanity are based. Obviously this cannot be done if the psychiatrist testifying as an expert withholds any part of the facts on which his opinion is based. The jury may find that the facts stated by the expert witness were true, but that the expert’s reasoning was false, or that while the facts may justify his inference they are equally consistent with another conclusion.

\(^1\) Raub v. Carpenter, 187 U. S., 159.
"The relevancy of the facts must be determined by the court, their truth by the jury.""1

After he has testified to the facts elicited in his examination and observation, and has expressed his opinion as to the sanity of the person examined, the medical expert properly may be asked to assume all these facts he has detailed as applied to some hypothetical person. This enables counsel to put to the expert witness a hypothetical question that assumes part or all of the facts in evidence from other witnesses, together with the facts the expert has himself set forth in his testimony, and thus to secure an opinion as to the sanity of the subject of this hypothetical question. This procedure enables the medical expert to express an opinion based on the fullest possible information without invading the province of the jury.

In some jurisdictions it is now held that the medical expert, having been present throughout the trial and having thus heard all the testimony, may be asked to assume all the facts in evidence, excluding all opinions expressed by witnesses, and to express an opinion as to sanity based on such assumption.2 In asking hypothetical questions it is not proper to embrace the opinion of other witnesses. The expert’s opinion must rest on fact and cannot be based on other opinions. As expressed in one decision: "While an expert may give his opinion upon facts assumed to have been established, it would be against every rule and principle of evidence to allow him to state his opinion upon the conclusions and inferences of other witnesses."3 In another case it was held:

"It is not proper in asking hypothetical questions to incorporate in them the opinions of other witnesses. An opinion of an expert witness cannot be based upon opinions expressed by other experts. Facts,

1 Burns v. Barenfield, 84 Ind., 43.
2 People v. Lowhone, 296 Ill., 403.
3 Williams v. State, 64 Md. 384.
not opinions, must be assumed in the questions. If it were otherwise, opinions might be built upon opinions of experts and the substantial facts driven out of the case. An opinion cannot rest, in whole or in part, upon other opinions but must rest upon fact. 1

An Expert May Give Reasons for His Opinion. After his opinion, the expert may state the reasons and grounds for such opinion. If this is not permitted, it has been held to be reversible error. 2 In a Massachusetts case, the depositions of medical experts as to a person’s sanity were rejected because the experts did not state the reasons for their opinion. 3 Neither the court nor the jury can decide what credence to give a mere opinion, unless the reasons on which it is based are set forth. The weight and value of the testimony of expert witnesses largely depend on the foundation of fact and of reason on which their opinions stand.

It is held improper to so formulate a question to an expert as to call for an opinion as to the law in the case on trial. For example, in a contested will case, it is not proper to ask a medical expert whether a person had sufficient mental capacity to make a will. 4 That is the question the jury has been called to answer. The question that may be asked is whether the testator’s mind and memory were sufficiently sound to enable him to know and understand the business in which he was engaged at the time he executed the will. 5

Cross Examination of Medical Experts. In cross examination of the expert witness wide latitude is allowed. His

5 McClintock v. Curd, 32 Mo., 411.
qualifications may be subjected to searching inquiry. Having
placed himself in the position of one especially qualified
in and possessing superior knowledge of the subject matter
under inquiry, the expert must give the jury the benefit of
any information as to the nature of his special qualifications
and the source of his knowledge, so that they may know what
weight to attach to the opinions he has expressed.
Queries as to any matter collateral to the subject under
inquiry may be asked. Hypothetical questions may be pro-
pounded assuming a different state of facts from those in the
question he has answered in giving his opinion on direct
examination. Any counter hypothesis may be presented if
it can be shown that it is for the purpose of testing the knowl-
edge of the witness as an expert in his special field.\(^1\)
On this
theory almost any question may be asked of an expert witness.
The extent to which such an examination may go in respect
to matters collateral to the subject involved in the case on
trial rests on the discretion of the court, and such discretion
will not be reviewed on appeal unless palpably abused;
consequently, on the cross examination of a witness testifying
as an expert, counsel may be permitted, for the purpose of
testing the skill and accuracy of the witness, to ask him hypo-
thesitical questions pertinent to the inquiry whether the facts
assumed in such questions have been testified to by witnesses
or not.\(^2\)
To test the knowledge and competency of the wit-
ness, counsel may ask purely imaginary or abstract ques-
tions, asuming facts and theories having no foundation in
evidence.\(^3\)
Not only is wide latitude given opposing counsel in testing
the competency of an expert, but the same liberty exists as to

\(^1\) Davis v. State, 35 Ind., 496;
People v. Augsberry, 97 N. Y., 501.
attacks on his credibility. Expert witnesses, like other witnesses, are subject on cross examination to such tests as are necessary to reveal whether they are accurate, impartial and credible. They may be asked if they have not previously testified in other cases when they expressed a different opinion from the one now stated,¹ they may also be asked what compensation they have received, or expect to receive, for their attendance in court. The expert witness may be compelled to answer any questions put to him on cross examination that tend to test his accuracy, knowledge or credibility, unless he desires to weaken his standing by taking refuge on the ground of constitutional rights that such answer would tend to incriminate himself.²

**Catch Questions.** Pitfalls are often laid for the medical expert by the opposing counsel to make the witness appear ridiculous or at least to discount the force of his direct testimony. Some of these legal traps have become threadbare from frequent use. The old artifice in which counsel in cross examination, on the theory of testing the knowledge of the witness, asks a medical expert if he has read certain books, for example, "Smith on Epilepsy and Crime" or "Jones on Moral Mania," books that are wholly fictitious both as to title and authorship, is an illustration of such time-worn stratagem. To the alert medical witness who is well informed in his special subject, who keeps his poise and has gained a reasonable knowledge of the facts of the case from the trend of the direct examination and from the facts related in the hypothetical questions already put to him, and who, therefore, has in mind the general purpose of the investigation, such cross examination does not involve the slightest danger of embarrassment.

¹ Sanderson v. Nashua, 44 N. H., 492.
² Storm v. United States, 94 U. S., 76.
The medical expert must be always on his guard to detect inconsistencies in the counter hypothetical questions propounded on cross examination. The separate facts of the question may be assumed to have been proved and therefore taken as evidence by the witness. But these facts can be grouped so craftily that any answer to a question that includes them could be made to appear ridiculous. When asked a hypothetical question the expert witness is required to assume certain facts as true; but he cannot be compelled to assume facts as true that do violence to reason. A simple illustration of such an hypothesis would be to assume that $2 + 3 = 6$. The medical expert can assume readily as a fact, stated in one hypothesis, that prior to a certain date the hypothetical person was in good health. He can assume also as a fact, stated in another hypothetical question, that the person described in this question had a congenital and continuing disease; but he cannot assume both these hypotheses as applying to the same person. The inconsistencies in the counter hypothesis of opposing counsel are as a rule not so obvious and glaring as those suggested in these examples; they may be far more ingenious and subtle, and the medical witness must be always alert to detect them.

Each side to a controversy has a theory of its own with regard to the interpretation of the facts in the case at bar, otherwise there would be no suit; the hypothetical question asked on cross examination, therefore, may include a set of facts entirely different from those contained in the question put to the witness on direct examination. In answering the hypothetical question of the cross examiner the witness does not necessarily contradict himself if he gives an opinion different from that he expressed on direct examination; for the second opinion is based on a different array of facts and the expert witness is not permitted to act as arbiter to decide which of the assumed facts in the case are to be accepted and
which rejected. His answer can only be: “On such an assumed state of facts my opinion is thus and so” regardless of what opinion he may have expressed with reference to a different state of facts. If he does otherwise, the witness is at once a partisan and defeats the very purpose for which, as an expert, he was called into the case. The reason for the summoning of the expert has been well expressed by one authority as “to furnish instruction from a source wherein we may justly expect is combined high ability and sterling integrity, which, while it cannot in any event impede the solution of the truth, visibly tends to promote it.”

As a safeguard, when a counter hypothesis including a state of facts different from those in the question presented on direct examination is put to him on cross examination, he may inquire, before answering the question, whether he is to leave out of consideration all previous assumptions and regard the question now put as distinct and without connection with or relation to the facts assumed in the former hypothetical question. If he is told by counsel to regard it as a new and separate question, thereby assuming a new hypothetical person, he can readily answer it. If, however, he is requested to “add it to the question previously propounded and answered on direct examination,” he may refuse on the grounds that there are inconsistencies between the facts contained in the two questions, and, if permitted, he may point out the inconsistencies that prevent him from making the assumption required.

Again, as a rule, few questions put to a medical expert can be answered categorically, and though “yes” and “no” answers are frequently demanded by the counsel, the witness has the right under the law to explain or qualify his answers; he is not bound to confine himself to categorical replies unless the question is such that simple “yes” or “no” fully and completely answers it. The decisions of the courts give the
expert witness the right to give reasons for the opinion he expresses and cases that have been appealed to higher courts, not infrequently, have been reversed and remanded when this right has been denied.

Another situation that sometimes confronts the medical expert witness arises from the fact that in answering a hypothetical question he must, in giving his opinion, confine himself strictly and entirely to the facts assumed in such question. This sometimes gives cross examining counsel the opportunity to include an insufficient number of facts, or facts of such minor importance to the main issue that an expert opinion cannot be formed. To illustrate:

Doctor, assume a man, 42 years of age, employed as a structural steel worker for the past ten years, who has been married for five years though no children have resulted from such marriage. Assume further, doctor, that this man who is the subject of this hypothetical question has never been ill and it is stated that he has never had any venereal infection and has never indulged in alcoholic drinks as a beverage. Assume that on August 1, 1923, he was struck a glancing blow on the head by a large chain, weighing about 200 pounds, which was attached to the traveling crane used in hoisting steel beams and girders; that he was knocked down and, though not unconscious, he was somewhat dazed and was assisted to an automobile and removed to his home, where he remained in bed for five days, and for a few days longer was confined to his home but not kept in bed. Assume further that on August 25, or a little more than three weeks after the accident in which he was struck on the head, he resumed his employment and worked steadily up to and including November 3, 1923. On the evening of November 3, 1923, he was observed to be exceedingly restless, at times becoming almost maniacal, but for the most part gave himself over to the utterance of extravagant statements as to his wealth, his physical strength, and proceeded to order a dozen automobiles to be utilized in furthering a new business in which he claimed he was about to engage. Assume, further, that he had no financial resources sufficient for the purchase of one automobile. Also, assume, that on the next day he had a slight convulsion, epileptiform in character, after which time he could not speak distinctly, apprehend facts
clearly or comprehend questions or answer them responsively, and
that he was unable to orient himself as to time or place. Add to these
assumptions, the further one that the pupils of his eyes are unequal
and do not react to light but do react in accommodation as already
testified to here.

Now, doctor, from the facts assumed in this hypothetical question
have you an opinion, based upon a reasonable degree of certainty as
to the medical or surgical connection of the accident I have described
with the conditions that have developed since November 3, 1923?

To this question the medical expert can readily answer that
he has an opinion and his opinion is that the accident was
not a sufficient or competent cause for the mental symptoms
described.

But in some jurisdictions the question would terminate
thus: Doctor, what, in your opinion, is the cause of the mental
condition of the hypothetical person just described? To
such a question the medical expert would be compelled to
answer, if he exercises due care, "I do not know. Since I
must limit myself to the facts stated in the hypothetical
question, I can only state that your question does not include
a cause sufficient and competent to produce the effect you
have described as existing since November 3, 1923. The only
cause provided for in your question is trauma, and trauma
could not cause such conditions as your question sets forth."
If further pressed for an answer by the insistence of counsel,
the expert may well say "Your question does not include
any cause competent or sufficient to produce the results you
have described. Further investigation must be made and
more facts elicited. For instance, there should be made a
Wassermann test of the blood and spinal fluid, a test of the
pressure of the spinal fluid, a count of the cells per cubic
millimeter of the spinal fluid and a Lange's colloidal gold test
or similar test. If these tests are made and you assume the
results as facts with reference to your hypothetical man then
I may be able to give you the cause of the symptoms you have described."

This is a much better course for the expert to pursue than to do as an inexperienced witness might feel obliged to do under the restrictions imposed, namely, limit himself exclusively to the statements in the hypothetical question and reply that trauma must be the cause since it is the only cause provided in the question. Such testimony could be readily overthrown in rebuttal by a great preponderance of evidence. It is far better to state that one does not know from the question what the cause is, that the question does not include facts sufficient to reveal the cause of the condition claimed and that one knows as a specialist in nervous and mental diseases that trauma cannot cause the conditions described as existing since November 3, 1923.

**Exclusion of Medical Books as Testimony.** Medical books are excluded as testimony. This is no new doctrine. As early as 1843, in a Massachusetts case,¹ this rule was promulgated by Chief Justice Shaw, in which, with reference to the exclusion of books, it was said:

"Where books are thus offered they are in effect used as evidence, and the substantial objection is that they are statements wanting the sanction of an oath, and the statement is made by one not present and not liable to cross examination. If the author of the book were cross examined as to the statements in the book and called to state the grounds of his opinion, he might himself alter or modify it, and it would be tested by comparison with the opinion of others. But as the whole range of medical literature is not open to persons of common experience, a passage may be found in one book favorable to a particular opinion, when perhaps the same opinion may have been vigorously contested, and perhaps triumphantly overthrown, by other medical authors, but authors whose words would not be likely to be known to counsel or client or court or jury. . . . Furthermore, a medical witness would not only give the fact of his opinion and the grounds on

which it is formed, with the sanction of his oath, but would state and explain it, in language intelligible to men of common experience."

And in another decision it is stated:

"Facts or opinions on the subject of insanity as on any other subject, cannot be laid before a jury except by the testimony under oath of persons skilled in such matters."

And the fact that the book was written by the witness himself makes no difference as to its admissibility, according to the ruling in a New York case.2

The reasons for excluding books are therefore fourfold:

1. Experiment and discovery are so constantly changing theories on scientific subjects that the books of last year may contain something that is now rejected.

2. The book may be merely the compilation of a compilation and is then hearsay evidence of the most extreme character.

3. Authors do not write their books under oath.

4. They cannot be cross examined as to the grounds for their opinions.3

It has become a settled rule that medical treatises may not in any way be used to contradict an expert when such expert does not assume to base his opinion on the work of any particular writer. If, however, the witness states that his opinion is based wholly or in part on a particular book, then he can be cross examined on that book to test his recollection and credibility; but if he gives no particular treatise as a basis for his opinion and states that his opinion is based on his experience, including the practice of his specialty, the care and treatment of patients, and general reading of various

1 Com. v. Wilson, 67 Mass., 337.
2 Mix v. Staples, 17 N. Y. S., 775.
3 Ware v. Ware, 8 Me., 42; Davis v. State, 38 Md., 15.
authors dealing with the subjects within his specialty, then no particular book can be brought into the case for any purpose in cross examination.

But when the witness has referred to a particular book as an authority for an opinion, the book is admissible to test his knowledge or contradict him. In a Michigan case the Supreme Court commented thus:

He (the expert witness) borrowed credit for the accuracy of his statement in referring his learning to the books before mentioned, and by implying that he echoed standard authorities like Dodd. Under the circumstances it was not improper to resort to the book, not to prove the facts it contained, but to disprove the statements of the witness. . . . The final purpose was to disparage the opinion of the witness and hinder the jury from being imposed upon by a false light."

Thus it is seen that when certain books are listed or named by an expert witness as the source of his professional knowledge, these selfsame books can be resorted to by counsel on cross examination for the purpose of showing that witness was mistaken in giving such books as his authority. The books cannot be used to contradict the expert generally, but merely to show that he has misquoted or mistakenly cited certain books as the sources of his opinion.2

In an Illinois case3 one of the authors of this book appearing on behalf of the defendant testified that the plaintiff could not have suffered epilepsy as the result of the accident in question saying that "fright does not cause epilepsy though it may in some cases of established epilepsy apparently evoke an epileptic manifestation or fit." He also stated that he based his opinion on his experience with over two thousand cases of

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2 City of Ripon v. Bittel, 30 Wis., 614;
   Gallagher v. Street Ry., 67 Calif., 13;
   City of Bloomington v. Schrock, 110 Ill., 219.
epilepsy. The attorney for the plaintiff in the course of his cross examination, after having identified through the witness a certain book on nervous diseases written by a Professor Starr asked whether Professor Starr did not say in his book that "about one-half of the cases of epilepsy is caused by fright." Questions to the same import were repeated and so framed as to appear to be statements of what was contained in Starr's book. Objections were made and overruled and exceptions taken. At the conclusion of the taking of testimony, plaintiff's attorney exhibited the book to the court and jury and stated in effect, that he proposed to show by this book that it was therein stated that epilepsy may be caused by fright. On appeal to the higher court the presiding judge in passing on the case stated:

"In Ullrich v. Chicago City Railway Company (265 Ill. 338), just such questions by the plaintiff's attorney were held to be grounds for reversal. In that case, as here, the medical witness based his opinion on his own personal observations and not on what was said by writers of text books. The court in its opinion said:

'The law is well settled in this State that scientific books may not be admitted in evidence before a jury, and that such books cannot be read from to contradict an expert witness except where such expert assumes to base his opinion upon the work of a particular author, in which case that work may be read in evidence to contradict him.'

"In City of Bloomington v. Shrock (110 Ill. 219), this question was involved and the authorities reviewed at length, and it was there so held, the court saying:

'Since the books are not admissible as original evidence in such cases, it must follow that they are not admissible on cross-examination, where their introduction is not for the direct contradiction of something asserted by the witness, but simply to prove a contrary theory.'

"And in the Ullrich case (supra) the language used is especially applicable to the circumstances of the present case:

'In the case at bar counsel did not offer any of the medical works which he pretended to have before him and which he used in the cross-examination of these witnesses, but he cannot be permitted to do indirectly that which he is not allowed to do directly. He succeeded in
conveying the impression to the jury that these two witnesses were testifying against recognized authority on the subject of hysteria, and that is the only purpose which we can perceive counsel could have had in the use he was making of these various medical books. The cross-examination of these witnesses was improper and constitutes reversible error."

"The cross-examination in the case before us and the conduct of plaintiff's attorney and his statement before the jury constitute reversible error. The judgment is reversed and the cause remanded."

It sometimes occurs that expert testimony in a given case is set out at length in official reports such as the published decisions of a court. These opinions in the original case were testified to by the expert under oath. Counsel has no right, however, to make use of them in another case, for such procedure affords no opportunity for cross examination. In a murder trial in Illinois, a states attorney read to the jury the testimony of a professor of chemistry as officially reported in another case in another state concerning the symptoms of arsenical poisoning. The supreme court of Illinois pronounced this to be flagrant injustice and judgment was reversed.¹

**Books of Exact Science Are Admissible.** As distinguished from the inductive sciences such as medicine, books on exact science may be admissible as evidence. Among such books are the established tables as to life expectancy or the probable duration of life as recognized by insurance actuaries as well as the courts, chief of which are the "Carlisle Tables of Mortality" "Northampton Tables," "Wigglesworth Tables" and "American Experience Tables." In England, and in some jurisdictions in the United States, the almanac has been admitted as evidence to show the time the sun or moon rises and sets, or the time of the tides. The same rule of admissibility applies to tables of logarithms, annuity tables, interest

¹ Yoc v. People, 49 Ill., 410.
tables, tables of weights and measures, and astronomical calculations.

Use of Notes for Refreshing Memory. As previously stated, the physician will understand the importance of taking full notes at the time of making an examination for the purpose of determining a person's mental condition. It may be many months, sometimes years, before the examiner's evidence is required, as in cases in which the person examined was about to make a will.

Before taking the witness stand, the physician should prepare himself by carefully reading his notes, thereby reviving his memory of the details of the examination. If a physician has interviewed or examined a person, such as a defendant or a testator, as to his mental condition at the time involved in the case at bar, he may relate on the witness stand what he remembers of the examination. After he has exhausted his recollection, he may refresh it by reference to the notes he made at the time of his examination. While, ordinarily, an admission that his memory has failed has a tendency to weaken the testimony of such a witness, when a memorandum is made contemporaneously with an examination or observation and when the memory is thereby refreshed by reference to such memorandum the witness' testimony may have enhanced value.1

When the witness refers to his notes, one of two courses may ensue:

1. If the memoranda refresh his recollection, he may then testify from memory as to what took place at the examination; that is, as to the facts themselves as distinct from the notes. His statement of the facts so recollected is admissible in evidence.2

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1 Corpus Juris, Vol. 23, Sec. 1769 (Subject "Evidence"), and citations in note 33.
2 Starkie on Evidence, 10 Amer. Ed., 1876, p. 177.
2. If the notes do not refresh his recollection, but he testifies that he made them at the time of the examination, and made them accurately, then such notes are admissible as evidence. With regard to occasions when a report or memorandum may be received in evidence\(^1\) the following should be noted:

"Where a witness testifies that he made a written report or memorandum of the occurrence at or near the time of its happening, but that upon examination of it he has no present recollection of the matters therein stated except that he knows that it is correct, then such report or memorandum is admissible in evidence."\(^2\)

**Subjective and Objective Symptoms.** An objective symptom is one that the examining physician ascertains regardless of what the patient may say or do. It is not under the control of the patient. A subjective symptom is one whose existence depends on the veracity of the patient. A broken leg is an objective symptom. The physician determines its existence by means of certain physical signs such as crepitus, deformity or roentgen-ray pictures, irrespective of what the patient may or may not say or do. It is elicited in spite of the patient and is not under his control. On the other hand, headache is a subjective symptom. The examining physician must take the patient's word for it. The claim by a patient that he cannot move his arm, that it is paralyzed, is a subjective symptom. If the neurologist

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\(^1\) Koch v. Pearson, 219 Ill. App., 468.

tests the muscles and nerves of the arm with electric currents and elicits a reaction of degeneration, the paralysis becomes an objective symptom, for the reaction can be elicited whether the patient wills it or not, and regardless of whether he is asleep or awake. It is not within the patient's control.

This distinction becomes important when one considers the admissibility of evidence as to the medical findings in a given case. The general rule is that a physician who has examined a patient for the purpose of treatment and has treated him professionally, the examination having been made before suit was started, is permitted to testify as to subjective symptoms as well as to objective symptoms disclosed by such examination. They are admissible in evidence on the theory that when the patient is examined for treatment only, and not for litigation purposes, he will not simulate. Experts who have not had the patient under treatment, but have examined him solely for the purpose of giving testimony as opinion witnesses, cannot testify to statements or manifestations of the patient that are subjective; nor can they base an opinion on such subjective symptoms. An expert witness called under such circumstances must base his opinion on objective and not on subjective conditions. Subjective symptoms may be self serving declarations and, therefore, are not admissible as evidence.\(^1\) This settled rule limiting medical expert testimony to objective symptoms is clearly expressed in the following decision of the Illinois Supreme Court:

"A physician, when called as a witness, who has not treated the injured party but has examined him solely as a basis upon which to give an opinion in a trial to recover damages for the injury, cannot

testify to statements made by the injured party to him or in his presence during such an examination or base an opinion upon the statements of the injured party. The law admits in evidence the declarations of the injured party as to the physical condition given to a physician during treatment because it is presumed that the injured person will not falsify in his statements made to the physician when he expects and hopes to receive medical aid, but no such presumption arises when he is examined by an expert for the purpose of giving evidence in a case about to be tried.\(^1\)

But this rule as to testimony in personal injury suits and law cases generally does not apply when the medical expert has made an examination as to sanity for the purpose of testifying in a criminal case. An examination of a defendant as to sanity must of necessity include observation of his conduct. The statements of the defendant and the manner of making them are part of his conduct. If a physician visits a person, and from actual examination or observation becomes acquainted with his mental condition, he may give an opinion respecting such mental condition—that is, he may, under such circumstances, state to the jury his opinion as to the sanity or insanity of the person at the time when he observed or examined him. It is also proper to question him as to the person's state of mind both before and after the time when the offense under investigation was committed.

\(\text{"Upon the question of sanity at the time of committing the offense, the acts, conduct and habits of the prisoner at a subsequent time, may be competent as evidence in his favor. But they are not admissible as of course. When admissible at all, it is upon the ground, either that they are so connected with, or correspond to evidence of disordered or weakened mental condition preceding the time of the offense, as to strengthen the inference of continuance, and carry it by the time to which the inquiry relates, and thus establish its existence at that time; or else that they are of such a character as of themselves to indicate unsoundness to such a degree, or of so permanent a nature, and to}\)

\(^1\) Shaughnessy \textit{v. Holt}, 236 Ill., 485.
have required a longer period than the interval for its production or development."

The difficulty that the courts experience in distinguishing between statements that are self serving declarations and statements that indicate the mental condition is well illustrated in a North Carolina case in which it was held, in a murder trial defended on the ground of insanity, that although a physician testifying for the accused could relate declarations or statements of the accused made in his presence, as a basis for the physician’s opinion as to the mental condition of the accused, self serving declarations by the accused as to past events or as to previous statements of the accused were not admissible. The court, in the course of the opinion, stated as follows:

"Exceptions 6 and 7. The expert had been testifying at great length for the defense when the following occurred:

'Defendant proposes to show by the witness that in an examination of Edgar Alexander, the defendant, relative to his history and of the crime he is charged with, and the answers that he made to such questions to the expert under the examination, formed the basis of his conclusion of the mental condition of the defendant. The state only objects to so much of the examination as brings out the declarations of Edgar Alexander and the conversation with him. No objection to the conclusions he reaches.

'The jury is sent out while the court examines the witness. After the jury came in the court told the jury as follows: 'The witness is permitted to state to the jury any act that was performed by the defendant in his presence, or any declaration or statement made by the defendant in his presence upon which he based his opinion as to his mental condition. But the witness is not permitted to state any declarations which may have been made to him by the defendant as to events that had happened in his past life, or his statement of any declarations that he may have made in his past life for the purpose of basing his opinion as to the mental condition of the defendant.'

"Again, the court restated his ruling as follows:

2 State v. Alexander, 103 S. E. (N. C.), 386.
'The ruling is that you are not permitted to state what the witness told you about his past life, and not to consider what he told you about his past life; but if there is anything in the manner in which he told you things that made you form your opinion, then that would be competent. In other words, if he said anything at the time that indicated to your mind that he was a man of unsound mind, the manner in which he did it would be competent, and you may narrate it; but if your opinion is based upon what he told you about the past transaction it would not be competent.'"

The court in these somewhat muddled rulings was attempting to make a distinction between facts drawn out in the physician's conversation with the defendant that tended to show the state of the defendant's mind and those which did not. Conversation is, of course, one of the best tests of the state of a man's mind. If, however, there are incorporated in the conversation self serving declarations which in themselves throw no light on the present condition or the past condition of the man's mind, then these declarations are not admissible. But it should be observed in this connection that conversation which does not express one's mental condition, either past or present, is practically inconceivable. The effort of the North Carolina court apparently verges on the ridiculous. It fails to steer the legal ship through the fog, but keeps it floundering without reaching its destination.

The later opinion in a New York case is much more intelligible and states the situation clearly and decisively.

"All that this defendant said and did during these several examinations by the experts was competent, as bearing upon his mental condition at the time he was examined. . . . This is not the case of a man claimed to be insane at the time of the homicide, and admitted to have been sane ever since. This is a case where it was asserted that the defendant had been continuously insane from a period of four months before the killing up to the time of trial. The examination of the experts was directed to his mental condition at the time they saw him; and from the conclusion they then reached and the medical
and other facts proved, they would be competent to give, on the trial, an opinion as to his sanity or insanity at the time of the homicide. The jury are entitled to the facts on which an insanity expert bases his opinion, and when those facts are the result of his own interviews with the defendant, it is not only competent, but necessary, that they should be laid before the jury.”

Confusion has arisen in some cases in which the trial court permitted the experts for the prosecution to state what was said in the conversations and describe the manner of the accused during the course of jail examinations, but denied the experts for the defense the same privilege. Evidently the theory of the trial judge was that what was observed by and testified to by experts for the defense might well be self serving manifestations of the defendant. This situation arose in a murder trial in Illinois, in which the authors of this book both were expert witnesses; and the decision of the trial judge was promptly overruled by the supreme court:

“The court should not permit the people to introduce a certain class of testimony denied to the accused. If the court refused to allow witnesses for the defendant who saw him while in jail to testify as to what they noticed about his eyes or as to his conversation it should also refuse to allow other witnesses who were called by the people to answer the same character of questions. A consistent rule would require all this testimony to be received or all rejected, as well that offered by the people as that offered by the defendant.”

Admissibility of Roentgenograms as Evidence. The rules as to admissibility of roentgen-ray films as evidence are becoming more strict. The failure of the physician taking the picture to lay the proper foundation often precludes the introduction in court of what might be most valuable evidence. In a recent decision (1923), a case was reversed and

1 People v. Nino, 149 N. Y., 326.
2 People v. Penman, 271 Ill., 82.
3 Stevens v. Ill. Central Ry., 306 Ill., 370.
remanded by the Illinois Supreme Court because of the admission of incompetent evidence in the form of a roentgenogram which purported to show the condition of the plaintiff's skull. In the course of the trial in the lower court a doctor identified a film produced in court as one prepared by him and testified that it was a roentgen-ray picture of the plaintiff's skull. Said the court of review:

"Although a skiagraph produced by X-rays cannot be verified as a true representation of the subject in the same way as a picture made by a camera, the rule in regard to the use of ordinary photographs on the trial of a cause applies to skiagrams of the internal structure and condition of the human body taken by the aid of X-rays, and such a skiagram, when verified by proof that it is a true representation, is admissible in evidence. Like other photographs, they cannot be received as evidence until proper proof of their correctness and accuracy is produced.\(^1\) It must be established by competent evidence that the picture correctly portrays the condition it purports to represent before it has any place in the case. Some witness must be able to testify that the picture offered in evidence shows accurately what the witness saw when he looked into the body with the fluoroscope, or he must be able to say that he is skilled in the use of the X-ray machine and in taking and developing X-ray pictures, and that he took the picture offered in evidence with the body in a certain position (describing it) with a machine which he knew to be in good working condition and accurate, and that from his experience he was able to say that the picture produced by the machine was an accurate picture of the internal condition of the body. These methods of establishing the accuracy of the picture are not exclusive, but whatever method is used, its accuracy must be established before it is admitted.\(^2\) Applying these well established rules to the facts in this case, it is apparent that plaintiff failed to establish the preliminary requirements necessary to make the X-ray film admissible. The doctor did not state that he saw the condition of plaintiff's skull nor that the film correctly represented this condition. Nor did he state how the film was taken,

\(^1\)Chicago City Railway Co. v. Smith, 226 Ill., 178; Chicago and Joliet Electric Railway Co. v. Spence, 213 Ill., 220.

nor that he had ever had any previous experience whatever with an X-ray machine, nor that he had ever made an X-ray photograph, nor that he knew anything about how they ought to be made, nor that the X-ray machine used by him was accurate, nor that it was in working condition at the time the exposure was made, nor whether he had ever checked a picture made by his machine with a condition seen by his eye with the use of the fluoroscope, to determine whether the machine accurately portrayed the internal condition of the part of the body under investigation."

**Speculations of Expert Witness as to Probabilities.** In the decision in the case just cited, the supreme court also found that the error admitting the film and the photograph produced therefrom was compounded and aggravated by permitting two physicians to examine the film and the photograph and then say what diseases and disabilities might, in their opinion, possibly result to the plaintiff from the injury to his skull which the roentgenogram purported to show. They testified that he might possibly have an abscess of the brain, that there might be an adhesion of the brain to the dura and a consequent lessening of the caliber of the skull, and that epilepsy might result. They were permitted to say further that these things might result in his death.

"It has been repeatedly held by this court that a mere possibility that future pain or suffering may be caused by an injury or that some disability may result therefrom is not sufficient to warrant an assessment of damages. Mere surmise or conjecture cannot be regarded as proof of an existing fact or of a future condition that will result. Expert witnesses can only testify or give their opinion as to future consequences that are shown to be reasonably certain to follow."\(^1\)

The opinion of a medical witness on matters of mere speculation is inadmissible. While a physician may testify as to the present condition of bodily injuries or mental or

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physical health or as to their permanence, and as to their cause, he cannot testify as to the possible outbreak of some new disease or suffering (nervousness, epilepsy, etc.) having its cause in the original injury or condition. This would be speculation. Neither can the physician say that a given condition "sometimes" or "nine times out of ten" has specified results. He can only testify as to what is, what he has found and not as to what might be.  

Alleged Bias of Medical Experts. One hears much criticism of what is alleged to be the bias of medical experts when serving as witnesses. Statements of this character are sometimes made seriously by responsible persons; but more often they emanate seriously by responsible persons; but more often they emanate from the garrulous gossip of court "fans" and loungers. In some instances it must be admitted that such criticism is not entirely without foundation. In the majority of cases, however, it is without basis. The appearance of bias is in most instances due fundamentally to the nature and function of expert testimony.

As already stated at the beginning of this chapter, expert witnesses are opinion witnesses as distinguished from fact witnesses. Opinion may be defined as a deduction or conclusion concerning a matter about which two persons can, without absurdity, think differently. Considering expert witnesses other than medical, it is generally conceded that there may be honest differences of opinion. Real estate experts are frequently called by the two sides in a controversy to testify as to the probable benefit of certain public improvements to adjacent property and as to the amount of the special assessment that should be spread against such property. On the same statement of facts as to the nature and character of the improvement, two real estate specialists of vast experience may differ widely as to the increment of

1 Atkins v. Railroad Co., 10 N. Y. S., 432; 
value that will accrue to abutting property because of the improvement, and though they differ perhaps by thousands of dollars in their conclusions, little or nothing is heard as to bias on the part of such experts. Railroad employees operating trains are permitted by the courts to testify as experts in regard to the distance a certain train, consisting of an engine and a certain number of cars of specified weight and going at a definite speed, would go after brakes were applied in a specified manner before it could be brought to a stop. Even with definite physical facts of weight, speed and momentum to reason from, one may hear as many different opinions as there are expert witnesses on the stand, and yet there is no thought of criticism or comment that bias or the payment of a fee has influenced the conclusions drawn. The same applies to handwriting experts in forgery cases, banker experts in fiscal cases, and mechanical experts in cases in which there is litigation as to basic ideas in patents. Any or all of these experts may differ from each other more widely than do the medical experts in an insanity case, in spite of the fact that the data serving as the basis for the opinion are far more tangible.

The situation of the medical expert is, as a rule, more difficult than that of other opinion witnesses. He is consulted by an attorney in a given case and certain facts are set before him as capable of proof in an ensuing trial. At the trial these facts are established in evidence, are embodied in a hypothetical question and the opinion of the expert as to the sanity of the hypothetical person is called for. In answer, the medical expert expresses an opinion, which must be based on the facts assumed, and gives reasons for such opinion. An attorney for the other side in the case collects a different set of facts that are consistent with his theory of the cause at issue and establishes them as evidence. He also confers with an expert and secures an opinion based on the facts he has
collected. The opinions of the medical experts differ chiefly because they are based on different facts, or on facts presented in a different setting, with stress placed in accord with the theory of the opposing counsel. The question may well be asked: Why criticize two medical experts for being of opposite opinions in a trial in which insanity is an issue and make no comment as to the integrity of the two lawyers who are on opposite sides in the same case? Clearly two medical experts of known integrity, with profound learning in psychiatry and wide experience with insane persons, can, without absurdity or falsehood, think differently as to the insanity of a person on trial. The hypothetical questions put to the experts by opposing counsel assume certain facts to be established and the jury then decides which set of facts is true, and which expert opinion, with the reasons given therefore, is most in accord with the facts it accepts.

Weight of Expert Opinion in the Estimation of the Courts. The attitude toward medical experts discussed above is somewhat variously reflected in court decisions. All of the courts hold that the mere fact that an expert requires and receives pay for time spent in court and in conferences with lawyers does not discredit him. "Men who have informed themselves by long and patient study, experience and observation in any particular specialty cannot be compelled to come into court and give their opinion as experts for the ordinary witness fee. They have the same right to charge for their advice and opinions as other professional men." 1

As an example of the changing attitude toward medical expert testimony, attention may be directed to two decisions of one state supreme court—these two decisions having been delivered at times separated by a number of years. In

1 Harvey v. Evansville Packet Co., 11 Fed. Cas., No. 6,179.
1876, the Illinois Supreme Court embodied in one of its decisions the following statement:

"Physicians may be regarded experts as to the condition of the body and as to what diseases tend to impair the mind, but it does not follow from the mere fact that they are physicians that they are any better judges of the degree of mental capacity than other men of good common sense."¹

In 1923, in reversing a judgment confirming an award of the industrial commission which granted an injured employee of a coal company compensation for total permanent disability, and, in addition, a pension for life, the Illinois Supreme Court stated that:

"The plaintiff testified that he was struck a glancing blow in the back by an elevator chain weighing about 1,000 pounds. The finding that he was wholly incapable of performing any work rested entirely on his unsupported testimony, while there was the testimony of several physicians that tended to show that he was not wholly and permanently incapable of work. Expert evidence is legal and competent evidence and is to be received, treated and weighed precisely as other evidence by triers of fact in this character of cases. The weight of such testimony must be determined by the character, capacity, skill, opportunities for observation and apparent state of mind of the experts themselves as seen and heard, and estimated by the triers of fact and by the nature of the case and its developed facts."²

Some physicians when testifying as experts in mental diseases lose sight of the fact that there is a difference between insanity from the legal point of view as it affects a man's responsibility and the medical conception of mental abnormality. In a criminal case, for example, it is sought to determine whether the individual on trial knew the nature

¹ Carpenter v. Calvert, 83 Ill., 63.
² Madison County Mining Co. v. Industrial Commission et al., 138 N. E. (Ill.), 212.
and quality of the act with which he is charged at the time when the act was committed; and, further, whether he had the power of will to choose to do the right and refrain from doing the wrong in reference to this particular act at the time it was committed. Did there exist in the person at bar at the time the act was committed, a more or less prolonged deviation, due to disease, from his usual method of behavior, and because of this was he dangerous to himself or others and did he on this account interfere with the peace of society? In other words, was he legally insane? The question for medical experts to determine is not whether the defendant in question has some sort of "mental twist," a peculiarity or abnormality of mind that makes him different from the average man or from a hypothetical norm. Neither are they to determine that the defendant was under the influence of liquor at the time the crime was committed, since drunkenness is no excuse for crime under the law. The failure to grasp this distinction is the cause for many of the aspersions cast on medical testimony as to insanity; in a recent case it certainly was the cause for the disregard by the jury of the medical testimony and the strictures put on such testimony by the upper court in reviewing this case on appeal.¹

In affirming a judgment of conviction of murder, in the case just cited, the Court of Appeals of Kentucky says that three expert witnesses testified that, from an examination made by them some days after the homicide and at the time of the trial, the defendant was in their opinion of unsound mind at the time of the killing and at the time of the trial. As no expert testimony was introduced by the prosecution to rebut this testimony, it was argued on appeal that the jurors, in returning a verdict to the effect that the defendant was of sound mind at the time of the shooting and at the time of the verdict, disregarded the preponderance of the evidence on

¹ White v. Com., 245 S. W. (Ky.), 893.
this subject and were therefore moved by passion and prejudice in reaching their verdict and a new trial was prayed.

"But it has been said by this court and many other courts that expert testimony is regarded in law as the weakest kind of testimony, because it is not only a species of hearsay, but is, from necessity, based on, in a large measure, the statements of others with reference not only to the symptoms that may have appeared in the person under investigation, but is further based on the statement of facts from others which are said to have occurred in the past, and from the very necessities of the case the opinion of the expert is often based on things said to have happened in the past, which, in fact, may never have happened.

"In this case, the experts, in giving their opinion as to the sanity of the defendant, must have based it on information they got from him and his family or friends with reference to his family relations and his family history, all or part of which may have been wholly inaccurate. When this court, therefore, considers the weakness of this class of testimony and considers, on the other side, the fact that the defendant appeared before the jury and testified at great length about a great many details and circumstances covering a long period of time, and admitted on the stand that he knew exactly what he was doing all the morning of the homicide, and knew perfectly what his actions were up until he pulled his pistol and fired the first shot, the court is not willing to say that the verdict of the jury in the light of these things was palpably or flagrantly against the weight of the evidence on this issue.

"Nor is this court willing to say that the trial judge abused his discretion in not stopping the trial and impaneling a jury to inquire into the insanity of the defendant. The three expert witnesses did not testify until after the defendant himself had testified. At the time they testified, the court already knew from the demeanor of the defendant on the stand, and from his going into the minutiae of many occurrences covering a period of several months, whether he had the appearance of a man of unsound mind. The court knew that he had admitted that he knew exactly what he was doing all of that morning, and that he could and did account for every act of his during that day and for a long period of time prior thereto, and that he had admitted he had full possession of his faculties, and knew exactly what he was doing until after he had fired the first shot. Under these circumstances, it was not unreasonable or unfair to the defendant for the court to be of opinion that he was in fact then a man of sound mind, notwithstanding the introduction of the expert testimony."
Such testimony, due to the failure of the physicians in this case to comprehend the meaning of insanity from the legal point of view, that is, the responsibility of the defendant to society for his acts, was rightly characterized by the court as the "weakest kind of testimony."

"There is a distinction, however, between insanity as the term is understood in medical science and insanity as the term is understood in legal science, so as to relieve from criminal responsibility. A person may be insane, as that term is ordinarily understood, and still be responsible for the commission of crime."¹ "Anything short of a normal and healthy mind free from any defective coordination arising from disease or decay, in a medical sense, may constitute insanity or unsoundness of mind, but the law does not demand such perfection to give capacity to manage one's affairs and make valid dispositions of property."²

The Supreme Court of Ohio in one of its decrees thus expresses its position:

"Medical testimony is of too much importance to be disregarded. When delivered with caution and without bias in favor of either party or in aid of some favorite theory, it becomes a salutary means of preventing even the more intelligent juries from following a popular clamor or prejudice, and deciding the case on inconsistent and unsound principles. But it should be given with great care and received with great caution, and like the opinions of neighbors and acquaintances, should be regarded as of little weight if not well sustained by reason and facts that admit of no misconstructions, and supported by authority of recognized credit."³

The Supreme Court of Texas gives this estimate:

"The opinions of medical men are received with great respect and consideration, and properly so."⁴

¹ People v. Nyhan, 171 N. Y. S., 466.
² In re Guilbert's Est., 188 Pac. (Calif.), 807.
³ Clark v. State, 12 Ohio 483.
⁴ Thomas v. State 40 Tex. 65.
And the Georgia Supreme Court similarly expresses itself:

"It (medical expert testimony) is competent testimony; and where the experience, honesty and impartiality of the witness are undeniable, as in this case, the testimony is entitled to great weight and consideration."\(^1\)

The Pennsylvania Supreme Court, in passing on the comments of the judge in the trial court which depreciated medical expert testimony held that these remarks of the trial judge constituted error and stated:

"It is well settled that the knowledge and experience of medical experts is of great value in questions of insanity. They are like those of experts in all other branches of science and art. Evidence has been given of the observation, experience and skill of these medical experts, sufficient to enable them to form intelligent opinions, and they had testified to those opinions. We cannot understand on what principle the learned judge said to the jury that in this case he questioned whether they would realize much, if any, valuable aid from this testimony. . . . We see no especial circumstances in this case to justify taking from the evidence of these medical witnesses that consideration to which the testimony of experts is generally entitled."\(^2\)

That the opinion of the expert is of value and weight in accordance with the experience and knowledge back of it is well set forth by the Supreme Court of Delaware:

"The opinions of witnesses, who have long been conversant with insanity in various forms, and who have had the care and superintendence of insane persons, are received as competent evidence, even though they have not had opportunity to examine the particular patient and observe the symptoms and indications of mental disease at the time of its supposed existence. . . . Such opinions, when they come from persons of great experience, and in whose correctness and sobriety of judgment just confidence can be had, are of great weight and deserve the respectful consideration of a jury. But the opinion of

\(^1\) Choice v. State, 31 Ga., 424. 
a medical man of small experience, or of one who has crude and visionary notions, or who has some favorite theory to support, is entitled to very little consideration. The value of such testimony will depend mainly upon the experience, fidelity and impartiality of the witness who gives it."

And, in conclusion, the Circuit Court of the United States, in its instructions to a jury, put the following appraisement on medical expert testimony:

"The value, however, of the opinion of experts differs largely in degree in different cases. It is of first importance that the facts upon which they are founded be satisfactorily established. In the present case it does not occur to us that there was any dispute as to the facts in relation to which the expert spoke. It is next of importance that the integrity and skill of the witness be known. I may add here, that no question is made of the competency of the witness who has testified here or of the confidence due to his integrity. But this is not all. Where the expert states precise facts in science, as ascertained and settled, or states the necessary and invariable conclusion which results from the facts stated, his opinion is entitled to great weight. Where he gives only the probable inference from the facts stated, his opinion is of less importance, because it states only a probability. When the opinion is speculative, theoretical, and states only the belief of the witness, while yet some other opinion is consistent with the facts stated, it is entitled to but little weight in the minds of the jury.

"Testimony of experts of this latter description, and especially where the speculative and theoretical character of the testimony is illustrated by opinions of experts on both sides of the question, is justly the subject of remark, and has often been condemned by judges as of slight value. Like observations apply in a greater or lesser degree to the opinions of witnesses who are employed for a purpose, and paid for their services, who are brought to testify as witnesses for their employers. This last observation has no pertinency to the present case, and is only made for the purpose of explaining the reason why testimony of this sort has been the subject sometimes of such comments as have been made in your hearing. This condemnation is not always applicable. Often it would be unjust. Where an expert of integrity and skill states conclusions which are the necessary or even the usual results of the

1 State v. Windsor, 5 Del., 541.
facts upon which his opinion is based, the evidence should not be lightly esteemed or hastily discredited. But, after all, the question of fact in issue is not for the expert to decide. The question of fact in this case is neither for the expert nor for the court. It is for you to decide, upon your sound judgment, under the oaths which you have taken, to render a verdict according to the whole of the evidence submitted to you for consideration."

This basis of estimating the value of medical expert testimony seems to be the proper one.

Much of the variance in the testimony of medical experts in a given case is due to the difficulty encountered in securing enough facts to afford a basis for an opinion. If provision were made for prolonged observation and complete examination of the defendant in a criminal case in which the issue is insanity, there would be more likelihood of agreement in the opinion of the medical experts called as witnesses at the time. The usual method is to limit the medical expert to such facts as accord with a given theory selected by either the attorney for the defense or prosecution, or the medical witness is restricted to observations made at arms length at court or in the jail cell or corridor. Even taking all of the facts in evidence produced by both sides, facts that have been elicited by a lawyer rather than a specialist in mental diseases, the information thus presented may be either too meager or too confusing to afford a basis for an unqualified medical opinion as to sanity.

"Raving mania or utter imbecility, violent and incoherent jargon, make up the vulgar conception of insanity, and hence almost every case of feigned madness takes one or the other of these forms. The insanity that cannot be seen at a glance is rarely assumed. If the disease is not patent on the surface, the simulator avoids it as unsuited to his purpose. If it be latent, difficult of detection requiring, like any other secret inflammation, skill and knowledge and patient examination to find it out—if especially it be that type that most resembles crime, the

1 Gay v. Union Mutual Life Insurance Co., 9 Blatch. (Conn.), 142.
criminal is sure never to feign it. . . . The science dealing with insanity is emphatically a science of observation and no past age has furnished the proper facility for such observation of criminals reputed to be insane. . . . The worst of all madness is 'that which wears a reasoning show' and it is at the same time the most difficult of detection."¹

Some states have wisely provided measures eliminating this difficulty. For example, Vermont has the following statute:

"When a person is indicted or informed against for a criminal offense, or is committed to jail on a criminal charge by a justice's, municipal or city court, the presiding judge of the county court before whom said person is to be tried, may, in term time or vacation, if a plea of insanity is made in court or if he is satisfied that a plea of insanity will be made, order said person into the care of the Superintendent of the Vermont state hospital for the insane, to be detained and observed by said superintendent until the further order of said judge, or of such county court, that the truth or falsity of such plea be ascertained."²

A few other states make similar provisions and the state of New York has given impetus to the movement enhancing the function and value of medical expert testimony by its enactment of laws containing, among other features, provisions for the appointment, by the judge in whose court the mental condition of a defendant is an issue, of a commission composed of three disinterested competent physicians to examine the accused as to his sanity. The commission must summarily proceed to make their examination, first taking the oath prescribed in the civil code to be taken by referees. The session, or sessions, of the commission must be attended by the district attorney of the county. The counsel for the defendant may take part in the proceedings. When the commissioners have concluded their examination, they must forthwith report the facts to the court with their

¹ State v. Worrell, Am. State Trials, Vol. X.
² Laws of Vermont (1917), Chap. 124, Sec. 2, 602.
opinion thereon. Any such examining physician may be sworn as a witness at the instance of either the prosecution or the defense. The provisions are similar whether the examination of the defendant occurs before or during trial or after conviction. The costs of any such commission of lunacy shall be a charge upon the county in which the commission shall have been executed. The commissioners are entitled to such compensation for their services as the court may direct.

At the meeting of the American Institute of Criminal Law and Criminology in 1914, a model bill for the regulation of medical expert testimony was unanimously approved, its main provisions being as follows:

1. Summoning of medical expert witnesses by the court.
2. Opportunity for examination of the accused by psychiatrists on behalf of the prosecution.
3. Temporary commitment of the accused to a state hospital for the insane for the purpose of observation by the expert witnesses summoned in the case.
4. Written reports by each of the psychiatrists who made the examination.
5. Consultation by the various experts with each other, and, if agreement be reached, the preparation of a joint report as to the mental condition of the accused.

While, in its entirety, this model bill in the form recommended has not been enacted as yet by any state legislature, some one or more of its provisions are already incorporated in the statutes of a few of the states. This is a good omen and discloses some degree of appreciation of the need for reform in court procedure as applied to medical expert testimony.
XI. SUGGESTIONS FOR REFORMS IN PROCEDURE

In preceding chapters we have dealt with the facts of medicolegal practice as it is today, this being the practical situation that must be met. Much has been written by psychiatrists and lawyers in condemnation and criticism of this state of affairs with which we are heartily in accord. Yet we feel that appreciation of the shortcomings and inadequacies of the system is not a justification for refusal to serve in the capacity of a medicolegal expert, as some have advocated. Such refusal is a failure in the duty owed to society. The constitution and the law represent the views and wishes of the majority, to which all must conform whether they approve or not so long as they continue to live in this country. To abstain from service might possibly bring forcibly home the need for reform, but is most liable to result in making matters worse by compelling the courts to rely solely on their own judgment or on the advice of physicians who are not qualified to assist. Furthermore, refusal to comply with established law, even on the ground of "conscientious objection" to the law, is an effort to establish minority rule which is objectionable even when the minority is in the right. This does not prevent constitutional efforts to change the law, which are indeed the duty of every citizen.

In this chapter we propose to discuss briefly the conflicts that apparently exist between medical opinion and legal method, especially as they relate to criminal procedures, and to suggest certain modifications of present practice that would in our opinion conduce to better results.
It is true that the medical expert does not carry the weight with the courts that he should and, indeed, is often ridiculed by lawyers and laymen. Many factors undoubtedly enter into this situation and the faults are not all on one side. The expert is only too often chosen, not because he is particularly qualified by training and experience to advise the court on the matter at issue, but because he is willing to say the things the lawyer wants said. Naturally, a physician who is not trained in psychiatry is liable to make many inaccurate and misleading statements. It is difficult to convince many laymen that graduation in medicine does not imply such training, though as a fact many colleges do not even require instruction in psychiatry preliminary to graduation. The inaccuracies of a witness may or may not be exposed on cross examination. In the former case the discredit reflects unjustly on alienists as a group. In the latter, the testimony will have equal weight with that of the competent expert.

Again, it is popularly believed that the layman is as competent to decide whether a man is insane or not as a physician trained for the purpose. In criminal procedures the decision as to sanity is a matter for the jury. The expert is not allowed even to express an opinion on this point; he is limited to hypotheses and assumptions selected for him by the counsel, selections made with the object of securing an opinion favorable to the side of the case which the lawyer represents. On this basis the alienist is expected to explain what constitutes insanity, apparently on the assumption that, in answer to questions submitted by a partisan layman, he can impart to a jury, consisting of men who have had no preliminary training, the knowledge that he has spent years in acquiring. This is no more anomalous that it would be to submit to a similar jury, under similar circumstances, the question whether a man has appendicitis before deciding if an operation should be performed.
It is popularly believed that there are certain special tests and signs that can be applied to determine whether a person is insane. It is not realized that insanity is behavior, that is to say a process and not a thing. The detection of insanity means the study of the man in action, what he does and says under various conditions. Consequently it is necessary to know something of the conditions under which he acts, the motives that set him into action. Furthermore, since insanity is a change in the manner of thinking, feeling and acting brought about by disease, it is also necessary to know something of the kind of behavior he showed before the onset of the disease. As has already been pointed out, insanity is not itself a disease but is the alteration in behavior that arises as the result of disease. It is not sufficient to establish the presence of disease, it must also be shown that this has resulted in a change in the manner of thinking, feeling and acting. In other words, the psychiatrist must study the life history of the man suspected of insanity. This is equally true in medicine generally, but is even more important for the proper investigation of mental disorders than it is for that of bodily disease. There are no specific tests for, nor absolute signs of, insanity, and the conclusion of insanity can only be reached by a detailed analysis of many facts, each one of which, taken alone, may be capable of a different interpretation. The restrictions of the law as to admissibility of evidence are founded on experience in the effort to insure justice and cannot be lightly set aside because they interfere with special questions and render the determination of insanity difficult and uncertain.

The conditions under which a man charged with crime must be examined by a physician are generally entirely inadequate. As a rule it is not possible to secure a history of the man's life or even, at times, of the grounds on which the insanity is alleged. If called by the defense, the physician
will perhaps get a history in which every possible element tending to prove the solution desired is put forward and all else is suppressed. If employed by the prosecution, he may get no history at all except such as is obtained from the suspect himself, who is alleged to be insane and unreliable. Often the alienist learns the facts, in so far as the rules of evidence allow them to be presented in court, only during the trial, and they are submitted to him in the light most favorable to the side for which he appears. The examination of the criminal is often hampered by the surroundings; the jail may have no conveniences of any kind; and sometimes even, conversations must be carried on through the bars of a cell. The guards in a jail as a rule are quite incapable of giving an account of the behavior of the man while under observation.

The question of insanity is treated as of exactly similar nature to that of guilt. In spite of the fact that the law clearly recognizes insanity as the outcome of disease and, under other circumstances, often requires that the matter be submitted to physicians for adjudication, when the disease results in the performance of an act that contravenes the law the diagnosis must be made by laymen.

It is alleged that the attitude of physicians toward the causes of crime and the mental condition of criminals differs fundamentally from that of laymen. The psychiatrist analyses behavior in terms of a deterministic psychology and has little regard for such abstract, though popular conceptions, as free will and absolute right or wrong. Unusual conduct implies unusual conditions, either in the situation reacted to or in the mentality of the man who reacts. As a matter of fact, in this respect the psychiatrist does not differ widely from the layman, though he expresses his views in different words. The layman describes the habitual offender as a "bad man," "crook," "criminal" or other such term,
all of which contain the concept that criminality is something which the man has chosen wilfully; but it should also be noted that they express equally the idea that there is something different about this man that distinguishes him from others. If one eliminates the hypothetical element of wilfulness, and adheres to observable facts, there is nothing left but the difference from his fellows. The psychiatrist says the same thing when he asserts that the man is abnormal mentally. The difference is in the definition of terms, the essence of which lies in the abstract conception known as responsibility. This conception is obviously and fundamentally legal and is intimately concerned with the existence of laws and the purposes that lie behind them.

Laws are necessary because men live in social groups and not as individuals. To render the continued existence of social groups possible, it is essential that such personal desires as lead to conflict between individuals be regulated by convention; otherwise disruption of society is inevitable. Throughout the evolution of society runs a history of continual conflict between individual desire and social regulation. The subordination of the individual has of necessity increased progressively with the growing complexity of social relationships. The development of machinery and the ability to direct natural forces have resulted in progressive equalization of individual capacity, which depended at first largely on personal might. With modern weapons and machines the physically weak are more nearly the equals of the strong. Yet among the weak must be included the mentally deficient, whether this be a deficiency in intelligence or in the control of innate desires.

The laws of society express more or less clearly the will of the majority at the time. They are continually being modified as they are found to foster or to interfere with the welfare of the majority. Their prime purpose is the mainte-
SUGGESTIONS FOR NEEDED REFORMS

nance of the common weal by insisting on behavior that will not infringe on the rights of others. Their enforcement has been attempted by providing penalties for infringement. Society assumes that every citizen knows the law and is capable of abiding by it. This is what is meant by responsibility. Failure in observance is assumed to be wilful, to be the result of a "wicked and malignant heart." While it is generally recognized that people differ in intelligence or the ability to grasp and understand the problems of social existence, it is not so well realized that, apart from wisdom, there are variations in qualities that permit development of control over desires. The legal definition of insanity takes both these factors into account, for in most states it recognizes that responsibility may be removed by disease that causes either insufficient intelligence to know the difference between right and wrong, or inability to direct the behavior in accordance with that knowledge. Insanity, however, is specifically a change in the man from what he was.

The law also recognizes, though not so clearly, the fact that a man may be inherently deficient in intelligence or feebleminded, and responsibility is removed if this defect is of such degree as to prevent knowledge of right and wrong as they relate to the particular act in question. But the man who is capable of knowing this difference may still be defective in his ability to control his behavior in accordance with that knowledge. Such persons are the true criminals for whom the penalties of the law are provided. Society, or the majority, demands that they be held responsible. The alienist has no right to try and evade this view, though it is his duty to endeavor to establish the need for its modification by education. The attempt to get round the difficulty by asserting that these offenders are insane only clouds the issue, and brings contempt on the witness and the profession. That this view of the situation is correct is established by a
review of the rulings of supreme courts, both state and federal, already given.

The only observable fact in such situations is that the man has not learned how to behave socially—the why is a conclusion. It may be that: (1) he has not been trained to control his desires; (2) he has been trained to give way to them; (3) he is defective in qualities necessary to permit control of his desires; or (4) as the law and public opinion assumes, he will not control them. Only in the last case is the responsibility his. In the other three the responsibility rests with society which has failed to give the man an opportunity to get the right kind of training or else to recognize the fact of deficiency in time to prevent the criminal act. Society, that is to say the majority of the organized group of individuals that imposes its will on all citizens, by prescribing rules of conduct assumes the responsibility of protecting its members from the consequences of infractions of its laws. Theoretically, members of society who suffer from the act of a lawbreaker should be recompensed by society. The resentment that is aroused by crime should be directed against society rather than against the criminal.

In the fourth possibility mentioned, that the crime is wilful, there is assumed the extremely vague hypothesis of free will, the definition and justification of which has taxed the ingenuity of the greatest philosophers of the ages without success. There is, however, hardly an occasion on which some crime is committed when the average member of society does not feel a sense of wonder as to how the offender could do such a thing, either because of its atrocity, its daring or its folly. Does not this imply that the man who committed the crime is different? Strictly, all that has happened is that the man desired something so strongly that the inhibitions of society have not been sufficient to keep the desires in check. Most often the man knows that he is contraven-
ing law and shows more or less ingenuity in evading the consequences. But the chief fact is that he has not learned how to control his desires.

It is often urged that to remove the concept of personal responsibility and of penalty for offenses against the law is to undermine the social structure. This would be true if taken literally. But the whole question turns on the definition that is given to these terms. The test of responsibility should be the ability to live in accordance with social law and it should not be clouded by discussion of the problem of will. Regarded in this light, the problem becomes objective and impersonal. Violation of law becomes evidence of unfitness for a social existence regardless of the reason for the violation. It matters not whether this be insanity, feeblemindedness or a "wicked and malignant heart." These become matters for consideration only in regard to the treatment that is to be applied. Sentimental considerations, which include the feelings of sympathy for the persons injured by the crime, abstract objections to the punishment provided in the law, and passionate sentiments of all kinds, should not enter into the problem. More injustice is caused by such subjective considerations than by anything else, and every advantage is taken of them by counsel to influence juries. In many instances the testimony of physicians is based on similar considerations, their feelings are allowed to run away with their real appreciation of the law.

Possibly the biggest stumbling block in the way of eliminating these objections lies in the question of capital punishment, which is now, in times of peace, reserved for the crime of murder. There are many who are opposed to it, though it still is the will of the majority in most states. Disregarding the theoretical considerations of its advisability, we may point out that murder would become rare if adequate steps were taken to treat the criminal rather than the crime.
Most murders are committed by persons who have already, often repeatedly, proved themselves incapable of social behavior. When the sentence is adjusted in accordance with the enormity of the crime, the man is often released after a term of years in prison whether he is really fit to return to society or not. Even the indeterminate sentence, which has been advocated to meet this situation, is rendered inoperative by reason of the fact that the decision to release or parole is usually founded on the judgment of a body of men who know little of behavior in a scientific manner and are often guided by set rules, which depend on the nature of the offense for which the man was convicted rather than on his ability to avoid such temptations in the future. Impassioned appeals and sentimental reasons, also, are often introduced to modify their judgment and are successful because this judgment is not founded on observed facts in the individual case, but rather on statistics for groups.

The logical solution of this state of affairs is fairly obvious and will probably some day be adopted. Briefly stated, it consists in eliminating from the trial all question of punishment. The jury should determine only whether the accused committed the offense charged. If he did commit the offense the convict should be submitted to a real study, unbiased by partisan influence or impassioned rhetoric, to determine the reason why he did so. A diagnosis having been made in this way, there will automatically follow a decision, not on a particular form of punishment, but on the treatment that is most likely to remedy the defect found. Treatment would be continued until the man is fit to live in the social world. This would be given in a penal institution, so-called, in a hospital for mental diseases or under properly supervised parole as may be deemed appropriate after expert study.
This plan is not new. It is already in force in connection with the juvenile courts, except for the important modification that jurisdiction ceases when the boy comes of age; then, regardless of his capabilities, he is assumed to have reached years of discretion and to be fully responsible, unless he has been deemed insane or feebleminded. The plan has the great advantage that it eliminates from the trial all questions of the mental condition of the accused and deals only with facts; the work of the expert does not begin until it is known that the man did commit the offense. Every necessary safeguard can be placed on the expert decisions by submitting them when it seems wise to the court. Far from rendering the treatment of criminals more lenient or more subject to sentimentalism, it would render it more effective by making it objective and impersonal. The determination of the existence of mental disease and deficiency would be far more accurately carried out and the prime purpose would be to reform rather than to punish. This does not interfere with the possibility of making restitution in so far as that is possible.

Adequately to carry out this proposal, there will be need for better segregation and classification of convicts than is generally available now. The various subdivisions must be planned in accordance with the problems to be met and the treatment to be given, instead of merely as a safe place to lock up bad men.

Even apart from the plan as here advocated, there are many improvements that can be introduced in connection with the present system of procedure. Among them it seems especially important to select the medical expert in a non-partisan manner and to see that he is qualified to express an opinion on the matter at issue. Certain standards of experience can be set and those qualified and willing to serve may well be listed with the court. The experts should be selected
by the court with the cooperation of both sides, and be given opportunity to study the suspect and to secure the story in the same manner that all other medical work is done. The conclusion reached from this study and the reasons therefor should be expressed directly instead of in answer to questions, preferably in writing; the expert could then be subject to cross examination by both sides.

The evidence given by the expert strictly has no concern with the question of guilt or innocence of the accused and could, therefore, well be excluded from consideration in determining this question. This would obviate the difficulties of using facts not in evidence. The opinion is of value only in deciding the treatment, or as it is more commonly called "the sentence," to be imposed. If preferred, it could be heard only by the court that passes sentence and need not be presented to the jury. This, however, would necessitate a change in the law in states in which the jury is required to fix the penalty, a requirement that undoubtedly often leads to disagreement and mistrial. Lawyers who regard it as their duty to free their clients regardless of the facts will probably object to the plan, for it removes one of the pleas under which it is possible to inject a doubt and thus to bring about a mistrial, which is often as effective as an acquittal.

The appointment of a commission to investigate the mental condition prior to sentence would not interfere with the right of either party to employ his own experts if he wishes, though there is little doubt that a non-partisan commission appointed by the court would carry far greater weight with the judge and the jury.
APPENDIX

SUGGESTED FORMS FOR INCORPORATION IN STATE COMMITMENT LAWS

The following suggestions are quoted by permission from a report dated January 27, 1919, of a Committee on Legislation of the National Committee for Mental Hygiene appointed at the request of the Surgeon General of the United States Army in 1918. The members of the committee were: Dr. George M. Kline, Commissioner of Mental Diseases for Massachusetts, Chairman, Dr. Charles W. Pilgrim, State Hospital Commission of New York, Dr. Owen Copp, Department for Mental and Nervous Diseases of the Pennsylvania Hospital, Philadelphia, Dr. Frank P. Norbury, Alienist to the Board of Administration of Illinois and Acting Medical Director of the National Committee for Mental Hygiene, and Maj. Frankwood E. Williams, M. C., U. S. A., Office of the Surgeon General, Washington, D. C.

In offering these suggestions, the Committee advised that before any of the forms are introduced as bills, they should be carefully examined by an attorney in the state concerned in order that such changes may be made therein as will bring them into harmony with the constitutional provisions of the state.

Observation and Care. If a person is found by two physicians qualified as examiners in insanity to be in such mental condition that his commitment to an institution for the insane is necessary for his proper care or observation, he may be committed by a judge or other officer authorized to commit insane persons to any state, private or incor-
porated institution for the insane under such limitations as the judge may direct, pending the determination of his insanity.

Emergency Commitment. The superintendent or physician in charge of any institution public, private or incorporated, to which an insane person may be committed, may, without an order of a judge (here insert the proper title of officers authorized to commit insane persons), receive into his custody and detain in such institution for not more than ten days, any person whose case is certified to be one of violent and dangerous insanity or of other emergency by two physicians, duly qualified as examiners in insanity, by a certificate conforming in all respects to the provision of law required in a medical certificate of insanity, and said certificate may, if the commitment of such person as insane shall be duly completed, be used as the certificate of insanity required by law. The officers required by the laws of commitment of the insane, or any member of the state or district police shall, upon the request of the applicant or of one of the said physicians, cause the delivery of such alleged insane person to such superintendent or physician. The person applying for such an admission shall within ten days cause the alleged insane person to be duly committed as insane or removed from the institution and, failing thereof, be liable to the institution for the expense incurred and to a penalty of fifty dollars which may be recovered by the institution by an action of contract.

Temporary Care. The superintendent or physician in charge of any institution, public, private or incorporated, to which an insane person may be legally committed, may when requested by a physician, by a member of a Board of Health or by a health officer, by an authorized agent of the State Board of Insanity, by a police officer of a city or town or by a member of the state or district police, receive and
care for as a patient in such institution for a period not exceeding ten days (or fifteen days), any person who needs care and treatment because of his mental condition.

Such request for admission of a patient shall be in writing and filed at the institution at the time of the reception of the patient, or within twenty-four hours thereafter, together with a statement in a form prescribed or approved by the State Board of Insanity (or insert the proper title of the State Supervising Board) together with a statement giving such information as said Board may deem appropriate.

Such patient who is deemed by the superintendent or physician not suitable for such care shall, upon the request of the superintendent or physician, be removed forthwith from the institution by the person requesting his reception and, if he is not so removed, such person shall be liable for all reasonable expenses incurred under the provisions of this act on account of the patient, which may be recovered by the institution in an action of contract.

Said superintendent or physician shall cause every patient to be duly committed according to law, provided he shall not sign a request to remain as a voluntary patient, or to be removed therefrom before the expiration of said period of ten days.

All reasonable expenses incurred for the examination of the patient, for his transportation to the institution and for his support therein, shall be allowed, certified and paid according to the laws providing for similar expenses in the commitment and support of the insane.

Voluntary Admission. The superintendent or physician in charge of any institution, public, private or incorporated, to which an insane person may be committed, may receive and detain therein as a boarder and patient any person who is desirous of submitting himself to treatment, and who makes written application therefor, and whose mental condition
in the opinion of the superintendent or physician in charge is such as to render him competent to make the application. Such superintendent or physician shall give immediate notice of the reception of such voluntary patient to the State Board of Insanity (or insert the proper title of the State Supervising Board). Such patient shall not be detained for more than ten days after having given notice in writing of his intention or desire to leave the institution.

The charges for support of such voluntary patient shall be governed by the laws or rules applicable to the support of an insane person in such institution.

Community Service. Section 1.—Every state institution, to which an insane, feebleminded, or epileptic person may be committed, shall appoint a physician experienced in the care and treatment of such persons, also the necessary assistants to such physician, and shall organize and administer under his direction a department for community service in the district served by the institution. The duties of said department shall be:

1. The supervision and assistance of patients who have left the institution with a view to their safe care at home, suitable employment and self support under good working and living conditions, and prevention of their relapse and return to public dependency.

2. Provision for informing and advising any indigent person, his relatives or friends and the representatives of any charitable agency, as to the mental condition of any indigent person, as to the prevention and treatment of such condition, as to the available institutions or other means of caring for the person so afflicted, and as to any other matter relating to the welfare of such person.

3. Whenever it is deemed advisable the superintendent of the institution may cooperate with other State Departments such as Health, Education, Charities, Penal, Proba-
tion, etc., to examine upon request and recommend suitable treatment and supervision for: (a) persons thought to be afflicted with mental or nervous disorder; (b) school children who are nervous, psychopathic, retarded, defective or incorrigible; (c) children referred to the Department of Juvenile Courts.

4. The acquisition and dissemination of knowledge of mental disease, feeblemindedness, epilepsy and allied conditions, with a view to promoting a better understanding and the most enlightened public sentiment and policy in such matters. In this work the department may cooperate with local authorities, schools and social agencies.

Section 2.—The necessary expenses of said department shall be paid from a special appropriation for this purpose not exceeding . . . dollars, subject to the approval of the Supervising State Board or Boards.

Conveying Patients to the Hospital. The judge or magistrate of the court may appoint a proper person to convey the patient to the hospital. If a woman is committed to an institution under the supervision of the State Board or Commission, the committing judge or magistrate must, unless she is accompanied by her father, husband, brother or son, designate a woman of reputable character and mature age to accompany her thereto.

Parole and Discharge of Patients. The superintendent of a state hospital may grant a parole to a patient under regulations prescribed by the State Board (or other supervising authority) for a period not exceeding one year, and may receive said patient again when returned by the proper authorities, relatives or friends, or upon personal application of the patient within this period without a new commitment.
GLOSSARY OF TERMS

Affect.—The state of feeling that is aroused by situations or by stimulations of the bodily organs.

Ageusia.—Loss of the sense of taste.

Agnosia.—Loss of ability to understand the meaning of sensations without anesthesia. Tactile agnosia (astereognosis), visual agnosia (mind-blindness), auditory agnosia (mind-deafness) are applied respectively to inability to recognize sensations in the fields of touch, vision and hearing.

Agraphia.—Loss of ability to write words (language) without paralysis of the muscles used in writing.

Alexia.—Loss of ability to understand written language without blindness.

Amentia.—Literally, absence of mind. In this country usually applied to mental deficiency or feeblemindedness as opposed to dementia or loss of mind. In continental Europe sometimes applied to delirious states.

Amnesia.—Loss of memory; usually applied only to loss of memories for the experiences of a more or less limited period of time.

Analgesia.—Loss of sensitiveness to painful stimulation.

Anesthesia.—Loss of sensitiveness to stimulation of sense organs.

Anosmia.—Loss of the sense of smell.

Aphasia.—Loss of ability to use language without paralysis of the muscles used in speaking or anesthesia of the senses of hearing or vision. Motor aphasia (Broca) is loss of ability to express thoughts in words. Sensory aphasia (Wernicke) is loss of ability to understand spoken (auditory aphasia) or written (visual aphasia) language.

Aphonia.—Loss of ability to utter sounds.

Apraxia.—Loss of ability to make the necessary combinations of movements for purposeful acts, without paralysis of the parts involved in the act and without incoordination. The ability to perform acts is known as eupraxia.

Argyll Robertson Pupil.—A pupil that does not contract on sudden increase of illumination but does contract when the eyes are focussed on a near object.

Attention.—The process of consciousness whereby thoughts or perceptions are brought from the margin to the center of consciousness.

Automatism.—The machine-like performance of acts.

Babinski Sign.—On stroking the skin of the sole of the foot the big toe turns upward, (i.e. extends); normally the big toe turns down (flexes).
Character.—The reaction tendencies of an individual to situations of conventional kind; it is therefore included in personality.

Consciousness.—The subjective awareness of the relation of self to everything that is not self, including sensations, thoughts, feelings and will. The mind now.

Constitution.—The bodily make-up; the bodily reaction tendencies to disease, food, noxious agents of all kinds, etc.

Delirium.—A state of mind characterized by uncleanness or clouding of consciousness with sense-falsifications of illusory type. Most often due to an intoxication.

Delusion.—A false conclusion or belief. An insane delusion is a false belief that is out of harmony with the beliefs commonly accepted by persons of similar training and experience and which cannot be corrected by reasoning.

Dementia.—Loss of mind, usually applied to the loss that results from organic (structural) disease.

Deterioration.—Loss of efficiency. Often used almost as if synonymous with dementia.

Diplegia.—Paralysis or weakness of both sides of the body.

Disposing Mind and Memory.—A sound mind, in the legal sense, capable of making a will; capable of understanding the nature of the business of making a will; remembering the property to be disposed of and the persons who are the natural objects of bounty, and comprehending the manner in which the property is to be distributed.

Dysarthria.—Disorder in articulation or speaking.

Emotion.—A state of feeling that is active and interrupts the general tenor of comfort or discomfort known as the mood.

Equity.—Natural right and justice independent of expressed or positive law. "Equity is the correction of that wherein the law by reason of its universality is deficient."

Fixed Delusion.—A false belief that persists without change.

Habit.—A reaction that has been acquired by personal experience; the tendency to repeat what was done on a previous occasion with less and less conscious consideration, ultimately without consciousness or automatically.

Hallucination.—A false perception of things or happenings without foundation in actual fact. Typically, the insane hallucination is accepted as a fact of experience and is not corrected by the use of other senses. Hallucinations may occur in any of the different forms of sense.

Hearsay.—Evidence based on the statements of others and not on the witness' own observation; hence, evidence that depends on the veracity and competency of some person other than the witness.

Hebephrenia.—Literally youthful minded; a form of insanity that is apparently a pure expression of schizophrenia and is one form of dementia praecox. Characterized by oddities and gaucheries in behavior similar to those observed in adolescents, though in exaggerated degree.
Hemianesthesia.—Loss of sensation on one side of the body.

Hemianopia or Hemianopsia.—Loss of one-half of the field of vision. If there is loss of the corresponding halves of both eyes (e.g. the right half of both eyes) it is spoken of as homonymous; if the loss is of the right side with the right eye and of the left side with the left eye it is called heteronymous hemianopia.

Hemiplegia.—Paralysis or weakness of one side of the body.

Hypnotism.—The name applied to certain peculiar states of consciousness which are characterized by increased suggestibility and concentrated attention. The slighter degrees are often spoken of as hypnoidal, in which the man remains aware of what is transpiring around him and has no loss of memory. In the deeper stages he shows catalepsy and somnambulism, and presents the appearance of one talking or walking in his sleep. On awaking there is usually no recollection of what transpired during the “sleep.”

Illusion.—A false interpretation of an actual sense perception in any sense sphere; an insane illusion is one from which the person cannot be reasoned and which he does not correct by the use of other senses.

Imagination.—A form of thinking in which memories are rearranged in new associations and sequences.

Impulse.—A tendency to perform some act that is not based on deliberation. An irresistible impulse would imply a tendency of such strength that the performance of the act cannot be inhibited by the doer of it.

Inquisition.—The legal proceedings and findings of a jury of inquiry.

Insanity.—A disorder of the mind due to disease, characterized by more or less prolonged departure from the individual’s usual method of thinking, feeling or acting.

Instinct.—An inherent or inherited mode of reaction to a situation; more complex and prolonged than a reflex; often difficult to distinguish from a habit.

Judgment.—The conclusion or belief that is reached as the result of the process of thought and reasoning.

Katatonia.—A disturbance in muscle tone, most commonly observed in schizophrenia, but also in some organic nervous diseases. It is applied specifically to a form of dementia praecox in which such changes in tonus are especially marked.

Lucid Interval.—Periods of such freedom from insanity that the ordinary legal consequences of insanity do not apply. “A lucid interval is not a perfect restoration to reason, but a restoration so far as to be able, beyond doubt, to comprehend and do the act with such perception, memory and judgment as to make it a legal act.” (Frazer v. Frazer, 2 Del. Ch., 263.)

Mania.—Sometimes applied to the exalted form of manic-depressive insanity. It is also used to indicate an unreasoned and exaggerated desire or impulse. Popularly has much the same meaning as obsession.
Manic-depressive Insanity.—A form of insanity characterized by exaggerations of mood, either exaltation or depression.

Mannerisms.—Oddities or peculiarities that do not belong to the purpose of the act with which they are associated.

Memory.—The property of mind whereby conscious experiences are retained and recalled (or recognized) through the association of ideas.

Mind.—The subjective state that is indicated by the word “I;” it includes all conscious processes of thinking, feeling and acting that have been experienced, retained, and are subject to recall for use in determining present reactions. As used legally mind means “the ability to will, to direct, to permit, or to assent.” (McDermott v. Journal Association, 43 N. J. L., 492.)

Mind-blindness and Mind-deafness.—See agnosia.

Monoplegia.—Paralysis or weakness, of central origin, of one limb or of one side of the face.

Mood.—The conscious feeling of the state of the body; it is comparatively prolonged and stable and thus contrasts with emotion. The general feeling of well or ill being, comfort or discomfort.

Negativism.—The automatic performance of the opposite of an act suggested by a stimulus.

Nihilistic Delusion.—A false belief in the nonexistence of friends and property, and of the unreality of the facts of the surroundings.

Nystagmus.—Rhythmical oscillation of the eyes from side to side (lateral), up and down (vertical), or in a circular movement (rotary).

Obsession.—A thought, feeling or tendency to action that dominates consciousness and interferes with attention to other things.

Orientation.—The appreciation of the relations in time or space between different items or happenings.

Pallesthesia.—Sensitiveness to vibrations, as of a tuning fork.

Paranoia.—Distortion of the mind. Used to designate a form of insanity characterized by progressive evolution of systematized delusions.

Paranoic.—Of or pertaining to paranoia.

Paranoid.—Like paranoia, but differing in certain respects as in the paranoid form of dementia praecox in which the evolution is more rapid and there are added features of schizophrenic type and a tendency to deterioration.

Paraplegia.—Paralysis or weakness of part or all of both sides of the body below the neck.

Paresis.—Weakness; a partial paralysis. Often used to indicate the disease general paralysis of the insane.

Parole.—Literally, “word;” an agreement under which a person may be released from custody; a promise to abide by certain conditions.

Partial Insanity.—A legal conception of a state in which insane delusions are restricted to a particular subject or group of subjects leaving other subjects uninfluenced; monomania or paranoia.
Personality.—The sum of the reaction tendencies of an individual, both inherited and acquired, to situations of all kinds. It is broader than and includes character.

Prejudice.—An unreasoning judgment; a conviction reached without due examination of facts and reasons that are essential to a just determination; a decision based on grounds other than reason or justice.

Preponderance of Evidence.—The greater weight (not necessarily the greater volume) of evidence; evidence that has superior credibility.

Presumption.—A deduction which the law expressly directs to be made from particular facts. A rule of law that a particular inference must be drawn unless and until disproved; e.g. "presumption of innocence," "presumption of sanity."

Psychic.—Mental; using the mechanisms of consciousness.

Reasonable Doubt.—A substantial lack of satisfaction in the correctness of a conclusion. Proof beyond all reasonable doubt is not proof beyond possible or imaginable doubt, but such proof as precludes every reasonable hypothesis except that which it supports. It is proof "to a moral certainty" as distinguished from an absolute certainty.

Reasoning.—The process of recalling associated ideas and judgments leading to the formation of new judgments and decisions for action.

Reflex.—An unchosen response to a stimulus. These reactions are inherited and very primitive; they may be modified by nervous diseases and by general disturbances in nutrition, by intoxications, etc. Modifications are not evidence of, though they may accompany, mental disease. Reflexes are commonly divided into: superficial (including responses to stimulations of the skin and mucous membranes: corneal, pupillary, pharyngeal, epigastric, abdominal, cremasteric, and plantar); deep (including the tendon jerks: jaw, wrist, biceps of arm, triceps, knee or patellar, and ankle or achilles, and periosteal: supraorbital and scapulohumeral), and organic (bladder or vesical and rectal sphincters, sexual, vomiting, sneezing, oculocardiac, etc.).

Responsibility.—Legal (or social) accountability for acts or omissions.

Romberg Sign.—The comparison between the amount of swaying of the body while standing that occurs when the eyes are closed and that when the eyes are open, the feet being placed close together. The sign is said to be positive when the person sways more under the former conditions.

Schizophrenia.—Splitting of the mind.

Sensation.—The state of consciousness aroused by the stimulation of a sense organ.

Somatic.—Appertaining to the soma or body; in distinction from mental or psychic.

Stereognosis.—The recognition of form or shape through the sense of active touching.
Stereotypy.—A reaction that has become so habitual as to recur always in the same form.

Systematized Delusion.—Delusions that are logically linked together so as to be mutually supporting. They are not fixed but are continually being modified to include the facts of new experience. Often accompanied by retrospective falsification of memory.

Temperament.—The sum of the affective tendencies of an individual; often used much as the word personality.

Testamentary Capacity.—A degree of mind and memory sufficient for making a valid will.

Thermesthesia.—The sensitiveness of the skin or mucous membranes to variations in temperature (local).

Thinking.—A process of consciousness that involves the successive revival of connected memories of past experience.

Tort.—An act or omission in violation of another's right, not arising out of contract, and for which the injured party may maintain an action at law for damages, such as trespass, accidental injury or libel. "A private or civil wrong or injury. A wrong independent of contract." (I. Hill: Torts 1.)

Tortfeasor.—One who commits a tort.

Undue Influence.—The use of reposed confidence or authority unfairly to the injury of the person who is swayed by it, or of those whom if left to himself he would have benefitted; or an unfair advantage taken of another by reason of his weakness of mind, necessity or distress.

Verbigeration.—The stereotyped repetition of words, phrases or fragments of words or phrases, without relation to the momentary situation and without obvious meaning.

Verdict.—The decision of a trial jury on an issue of fact submitted to them in a court action.

Will.—The tendencies to action or inaction that arise from the activities of consciousness including the play of instincts and feelings.
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