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SOME POINTS IN THE DIAGNOSIS OF CERTAIN SIMULATED MENTAL AND NERVOUS DISEASES.*

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The symptoms exhibited by a shrewd malingerer or a clever hysterical patient may so closely simulate organic disease of the nervous system that the best diagnostician will at times hesitate in some cases before giving an opinion. In some instances persons suffering from actual disease of the nervous system may feign, for reasons best known to themselves, a different trouble, or the hysterical may simulate a certain organic nervous affection and at the same time be suffering from some other organic disease; and, on the other hand, we not infrequently find an array of so-called hysterical phenomena in patients who are afflicted with some serious organic brain lesions. The hysterical should not be confounded with the malingerer, but it is rarely we see a case of hysteria without some elements of malingering. The causes for the latter are different from those that result in hysteria.

* Read before the Colorado State Medical Society at its annual meeting.

Malingering.—In civil life the causes for malingering are found among the mercenary, who feign injury for the hope of gaining remuneration, from a corporation most commonly; among the criminal class, who hope to escape their deserved punishment; and among the tramp class, who are trying to "dead-beat" their way, in order to gain sustenance in hospitals, or to eke out a miserable existence by imposing upon the charitably inclined. Among the criminals and tramps epilepsy and insanity, according to the writer's experience, are the most common affections of the nervous system feigned; but among the mercenary feigners organic diseases of the spinal cord, and sometimes of the brain, are more or less imperfectly simulated.

The object of this paper is not to go into a lengthy discussion on the points in the differential diagnosis between real and feigned disease, but to call the attention of the members of the society to the subject of the paper in the hope of eliciting discussion and the narration of similar cases. I will illustrate the tramp, criminal, and mercenary malingerers by the following:

Tramp Class. Case I. *Feigned Epilepsy.*—A boy, eighteen years old, gave a history of convulsions dating over a period of three or four years. He professed to be a telegraph operator. He was found on the streets of Denver in a convulsion, and taken to a police station in an apparently unconscious condition. He was taken to the County Hospital the next day. He was having, on an average, two or three convulsions daily, but none of the attacks since his admission into the hospital had been witnessed by a physician. He was given large doses of sodium bromide, but his attacks continued and seemed to increase in frequency. This fact was reported to me and at once aroused my suspicion of their genuineness. On further inquiry, I found he did not bite his tongue, and that the attacks usually only occurred in the presence of certain persons whose sympathies he had enlisted in his favor. On getting a detailed history

from him of his attacks, I found his mental condition at the time of their occurrence and the seizures themselves did not correspond with the phenomena of epilepsy. I requested Dr. Baker, the resident physician, to have the nurses or attendants notify him of the attacks, and for him to study them. At my next visit the doctor reported that he had seen an attack in which the patient assumed grotesque positions, and that the eyes turned upward when he raised the lids to examine the pupils. I immediately had his bromide discontinued, and gave him, instead, large doses of milk of asafœtida by the mouth. He protested that he had no control over his seizures. Not long after this I witnessed one of his attacks. He frothed at the mouth, threw his limbs in every conceivable direction, and assumed an opisthotonic position. At this stage I made firm pressure over each supra-orbital nerve with the ball of each of my thumbs, and, as the pressure increased, it caused him so much pain that he struggled to free himself from my grasp, and caught hold of my hands and pulled them away from his face. On my again renewing the pressure, and this time with redoubled energy, he jumped up, and the spasm (?) was over. From this time he took the precaution to have no more convulsions when a physician was around. Only a few attacks occurred during the remaining weeks of his stay in the hospital, and these were always in the presence of persons whose sympathy he had enlisted in his favor. A few days after he was dismissed from the hospital he was again found by the police lying on the street in an apparently unconscious condition. He was returned to us for treatment. This time, from the first, he was treated as "a suspect," and denied many privileges of the hospital which the other patients enjoyed. No bromide was given him. He had a few attacks at chosen intervals, but these always occurred in the presence of certain persons, and away from the presence of the attending physician. After remaining at the hospital for a few days, he suddenly left to escape arrest for theft.

Case II.—An inmate of the hospital for one or two years, about forty years old, says that he has been subject to epileptic convulsions for three or four years, the attacks dating from the

time when his left knee, which is now ankylosed, first became affected. The patient is addicted to drunkenness, is disagreeable, quarrelsome, repulsive, and believed to be a masturbator. I first began to study his case in November, 1889. At that time he was taking large doses of potassium bromide, and was reported to be having one or two attacks during the day, and at times as many as three during the night. The night in November immediately preceding my seeing him he had had several seizures, and had kept the patients in his ward awake most of the time. Two or three persons had been engaged in holding him. I saw him about 4 P. M. He was then in an attack, and the nurse stated that he had had them almost continuously for hours. His face was flushed, and his movements were an admirable imitation of an epileptic attack. I had never suspected the genuineness of his malady, and now supposed he was in a condition of status epilepticus. On inquiry, however, I learned that he would sometimes throw himself from the bed in an attack and thrash himself around the room at a furious rate unless restrained. On raising the eyelids the eyes turned upward and the pupils reacted to light. The pulse was not much accelerated above the normal. I immediately made firm pressure over each supra-orbital nerve; the convulsive movements stopped, and the patient expressed his surprise by a silly laugh. He then admitted that he had been feigning "fits," but contended that he was subject to regular epileptic paroxysms. I had the bromide discontinued, and no convulsions occurred for several days. In a short time the nurse reported that he was again occasionally having a convulsion, but I did not have the good fortune to witness any more attacks, and Dr. Baker, the resident physician, said he had not seen any of them. He was urgent for medicine for his epilepsy. I ordered twenty grains of sodium chloride to be given him three times daily. As the medicine tasted salty, but different from his usual bromide mixture, he thought it was composed of potassium bromide and iodide, and again his paroxysms ceased, and have recurred only a comparatively few times since. At the present writing he has not had a convulsion for nearly ten weeks. I have a suspicion that this man may have true epilepsy, with a large element of

"pure cussedness." On one occasion, Dr. Baker informed me, he acted strangely in a dazed kind of manner, and afterward seemed to have no recollection of what he had done during this time.

Criminal Class. CASE I.—In the spring of last year a man by the name of T., whose paramour, with whom he had lived for ten years, claiming her as his wife, left him and became intimate with a man by the name of K. T. threatened to kill K. and the so-called Mrs. T., and purchased ten grains of strychnine at a drug-store in the name of K. T. soon left Denver and went to Omaha. A few weeks later T. arrived in Denver about four o'clock, P. M., and secreted himself until dark, when he went to the rear of the house in which K. and Mrs. T. were staying. He there met K. and fatally shot him. He remained in the city twenty-four hours and escaped to Kansas City. He was arrested and brought back to Denver. At the trial, at which he was convicted of murder in the first degree and sentenced to be hanged, he gave me the details of the killing, the causes that led to it, and many of the particulars quite connectedly. He is a man below the average intelligence, but cunning, and shows an infatuation for his unworthy paramour. There certainly was no evidence of insanity, and I so testified. A short time after T. was removed to the State Penitentiary at Cañon City he was alleged to be insane. He was brought to Denver early in the fall of 1889—this time in order to have the question of his insanity tested. He then professed to have forgotten almost everything; he had never heard of a man by the name of K.; never heard of a place called Denver; never knew that he had been tried for killing any one; did not know where he had been staying. He gave expressions to delusions of depression and expansion at one and the same time. He at times very feebly and imperfectly imitated the paretic dement, but usually best played the rôle of a dement. This was done so poorly as to expose the deception to any one at all conversant with mental diseases. He feigned to have forgotten everything connected with the past—especially everything connected with his crime, things that stamp themselves almost indelibly upon a mind capable of remembering anything. But, at the same time, he could relate

what was given him to eat, how he was treated, and little occurrences in prison life. This man is still in the State Penitentiary, and is alleged by some to be insane.

The diagnostic points in this case are: First, the character of the delusions. No one, sane or insane, can be depressed and animated at one and the same time. An insane person can not have delusions of expansion (mania) and depression (melancholia) at one and the same time. Such delusions may alternate, but there is always a change in the person's actions while possessed of an expansive or depressed delusion.

Second, as regards memory: In dementia, memory of past events is always retained after memory of recent events have faded away.

Case II.—A male criminal, about thirty years old, was confined in the Arapahoe County jail, accused of obtaining money under false pretenses. He had been incarcerated for several months, and seemed to be in fair health. About four weeks before the time set for his trial he began to have convulsive paroxysms. These continued for three weeks, although he was taking large doses of potassium bromide. The attendants at the jail were up with him night and day, two or three being required, they thought, to prevent his injuring himself against the iron bars, as he threw himself about at a violent rate. Dr. McLauthlin, the county physician, had seen him a number of times and pronounced the attacks hysterical or feigned. He requested me to see him. I visited him early one morning, found him strapped down and three attendants by him. They stated that he had been having convulsions every few minutes all night, and that it was with great difficulty that they could prevent him from injuring himself. His pulse was 110; breathing rapid; temperature normal. His face was pale and haggard. While I was talking with him he said: "Now it is coming again," and began to roll his eyes upward. His face was twisted from side to side, not spasmodically jerked by individual muscles. Soon his arms and legs were involved and he assumed an

opisthotonic position. I spoke to him; he neither answered nor gave the least sign of hearing. I opened the eyes and found the pupils reacted to light. Without further examination I placed the balls of my thumbs over the supra-orbital nerves at the point of their emergence from their foramina, and pressed with considerable force. The result was marked and almost instantaneous. He at once endeavored to turn his head from me, but, failing in this, he clinched my hands with both of his and pulled, and at the same time freed his head from my grasp by a voluntary rotation of his head. I requested the attendants to leave the cell. I then told the prisoner that I had caught him feigning, and that if he had another such spell while he was in jail I would go into Court, if called upon to testify in his case, and swear that he was feigning, which would prejudice the jury's mind against him. He promised to desist from another attempt. I had him unstrapped and dismissed his attendants, assuring them that he had no further need of their services. His epilepsy was cured. His object in feigning epilepsy was to be transferred to the County Hospital for treatment, from which he knew he could effect his escape.

Mercenary Class. Case I.—Miss O. fell, in stepping from the car of the Denver Tramway Company in January, 1889, striking the back of her head against the ground. She seemed to be dazed or semi-unconscious, and was taken into a house a few yards distant, where she remained in about the same condition until transferred to Saint Luke's Hospital the next morning. She was in the hospital two to three weeks, and about one week of this time she seemed to be semi-unconscious, but irritable and cranky all of the time. It was learned that there was some bruising of the soft tissues over the occipital bone just to the left of the prominence of this bone. It was thought by the surgeon under whose care she was at the time she remained at the hospital that there was a fracture of the occipital bone, with depression of the fracture.

By order of the Court, Dr. H. A. Lemen, Dr. H. A. Baker, and the writer were appointed to examine into her condition, The examination took place October 17, 1889. Her history, as she gave it to us, was as follows: She said she had always enjoyed

good health up to the time of the accident, but since that time she had lost just forty pounds by actual weight; she had grown nervous; suffered much from pains in the back and head, especially in the occipital region; was sleepless; could not see the largest letters on the street signs, and it was with great difficulty that she could walk. We found her temperature, including that of the surface of the head, normal. The motorial and sensory phenomena showed no deviation from health. The electrical reactions and reflexes, deep and superficial, were good and equal on both sides. Touch, taste, smell, and hearing were well preserved and about equal on both sides. We now came to the eyes. She contended that before the accident she could read fine print and signs at a distance, as well as the ordinary person, without the use of glasses. We found the pupils equal, reacting well to light and accommodation, and about normal in size. The ophthalmoscope showed healthy fundi. The fields seemed contracted, but, on repeating the examination several times, the size of the fields varied very considerably. She was shown a book and professed to be unable to see whether or not there was any print in it. Of large letters, which the normal eye will read at a hundred feet distance, she said she could not see what they were when held only a few feet from her eyes. Glasses, plus 36, about one dioptre, were placed before each eye. She then read fine print at the ordinary distance. The fields of vision were enlarged, and she read at a distance as well as the majority of persons. This was positive proof that she was feigning poor vision. As we had found no evidence of any organic disease, we felt justified in excluding any, especially after detecting her in feigning imperfect vision. She was nervous, irritable, and not very well nourished. After excluding everything except spinal irritation, we next proceeded to test the truthfulness of her statements regarding her health before the accident. We weighed her and found that she was nearly ten pounds heavier than she professed to have been two days before her examination. Upon inquiry of her employer at the time of and before the accident, we learned that she had not been well. He said that she looked as well in October as she did in January before the accident, and that while she was living in his

family she had been nervous, irritable, and poorly nourished, and required to rest in bed one day every week or two on account of pain in the lower portion of the body. The physicians who had treated her before she came to Colorado stated that she was irritable and nervous, and suffered from uterine trouble while under their care. Since our official report we have seen her on the streets of Denver walking as briskly and nimbly as one in perfect health.

Case II.—Mrs. H., aged thirty-three, was a passenger on the Santa Fé train at the time of the Fountain explosion from giant powder in May, 1888. Her face and hands were cut with glass, and she was shaken up considerably. The explosion took place about 4 o'clock, A. M., while the passengers were all asleep. She stated that before the accident she had enjoyed perfect health, but since that time she has been nervous and sleepless, and has suffered from pain in the head and spine. She has brought suit against the railroad, and, as with most persons who are waiting the award for damages, every symptom is exaggerated. The first examination, in August, 1889, was highly unsatisfactory, as she complained of the slightest contact of substances with any portion of the body. After a prolonged examination I could find no evidence of any organic trouble, and so informed her. She presented herself a few months ago, and still no symptoms of any organic lesion were found. On May 16, 1890, she again presented herself for examination, with the following account of her symptoms: She says she has constant pain from the middle of the back, running through to the stomach; has great difficulty in rising from the sitting to the erect posture on account of pain in the back. The pain in the back runs from below upward. Complains of pain and a drawing sensation in the legs and feet at night. She is exceedingly nervous and feels as if something was going to happen. Says she is unable to read fine print, and a bright light is painful; is deaf in the left ear, and can hear only imperfectly with the right. Says that conversation carried on in an ordinary tone of voice she does not hear; complains of buzzing in the head and a dizzy sensation, a feeling likened to lumps in the back of the neck, and a drawing sensation of the post-cervical muscles, causing her to bend her head backward.

Examination.—Gait good; no ataxic symptoms; knee-jerks equal, but slightly exaggerated. All the other deep reflexes normal, as are the superficial reflexes. A thorough and prolonged electric test, both with galvanism and faradism, showed normal reactions. The results of testing the sense of touch were curious and significant. Some time was spent in trying to ascertain the condition of this sense. At one time it was normal; the next minute it would vary greatly from the normal, or she would profess not to be able to feel anything. There was no paresis, paralysis, or wasting of any muscles. She was able to bend the back in various positions without complaint if her attention was kept engaged, but her movements became limited and painful when her attention was directed to what she was doing.

The dynamometer registered R. 80; L. 80. On requesting her to try the instrument again, it registered, only a few minutes after the first trial, R. 110; L. 104.

The examination of the special senses was not completed when I had to postpone it until the next day. As yet, two weeks having elapsed, she has not presented herself.*

Whatever real trouble the outcome of this case may result in, it is now evident that she is hysterical and feigning, and thus, by her over-anxiety to appear injured, she may be preventing the detection of some organic lesion.

Case III.—Mr. M., a nervous, slenderly built man, about forty-five years old, was injured on the Denver Tramway Road by being struck on the back by a wagon while in the act of getting on a car. He was knocked down and rendered unconscious for some hours. He remained in bed about a week. About six months after the accident Dr. Parkhill and I examined him at his request, for the purpose of testifying in court. He professed to have considerable pain in the back throughout the entire length of the spine. He complained of the slightest touch on most of the spinous processes. He had a limping, halting gait, walked with a cane, and said he had most pain in the lower portion of the back and in the left leg. After two pro-

* Her suit has since been decided in the U. S. District Court. She sued for $25,000, and was awarded $750 damages.

longed and thorough examinations we found movement much more free and extensive than he had stated. Sensation in every portion of the body was normal. The reflexes and electrical reactions showed no deviation from health. We could find no positive evidence of any organic lesion, and one of us, the other not being called, so testified in court.

In conclusion, I will discuss only a few of the points suggested by the case histories that form the foundation of this communication to the society :

First, the detection of feigned epileptic convulsions. Under ordinary circumstances, the dilatation and immobile state of the pupils, the insensibility of the corneæ, the character of the muscular contractions, the onset of the attack, the stages of the seizure, and the subsequent sequelæ will serve to distinguish the true epileptoid or epileptic fit from the feigned. But we must remember, as Romberg long ago pointed out, that there may be some reflex irritability in true epilepsy, such as to produce winking when the cornea is touched. During the past year I saw an account of the observations of a German physician, whose name I have forgotten, on the detection of feigned epilepsy in criminals. This observer had detected simulated epilepsy in several hundred criminals simply by pressing with the ball of each thumb over the supra-orbital nerves. His position is behind or at the head of the "suspect," with his face looking toward the simulator's feet. In this position one can exert considerable pressure on the supra-orbital nerves, and if the patient is not unconscious he is unable to bear the pain, and soon endeavors to free himself from the operator's grasp. I have not had the opportunity to try this test in attacks of true epilepsy, but here a corrugation of the forehead would not be sufficient to pronounce the case feigned, because there may be some reflex action of the muscles even when a person is unconscious. I have had the opportunity of

employing this method in detecting feigned epilepsy in four malingerers, and in each the attack was cut short, and the simulator exerted himself voluntarily in order to get relief from the pressure.

Before leaving the subject of feigned epilepsy I wish to utter a caution—viz., that because a person is caught feigning epilepsy we must not at once conclude that he does not suffer from real epilepsy. Real and feigned epilepsy, I think, were exhibited by at least one of the persons whose cases have just been narrated.

Feigned Insanity.—In the majority of cases of simulated insanity the deception is comparatively easy to expose. It is self-evident that the task is made easy in proportion to the familiarity of the examiner with the different types of insanity and their differential diagnosis, and in proportion to the amount of clinical study he has given to the insane. It sometimes happens that an asylum superintendent is a poor diagnostician of insanity, because, in many instances, of the large amount of executive work devolving upon him, thus leaving him insufficient time to devote to the intelligent and systematic study of minute peculiarities of individual cases and groups of cases. It is rarely that a simulator of insanity is sufficiently informed in regard to the diagnostic symptoms of the different varieties of the disease to prevent his confounding them. His task is especially difficult when he attempts to simulate mania, melancholia, or dementia. In mania or melancholia the patient may be boisterous or quiet, but in the former the delusions are always of an expansive character, while in the latter they always take a depressive form. In dementia, a form of insanity probably one of the most difficult to feign, the failure of memory is just the opposite to what the ordinary layman, when he attempts to simulate, will assume. In this form of insanity memory for recent events is first lost or

affected, while that for occurrences which took place before the mind became impaired is often retained with great minuteness for details; and this holds good until the mind becomes almost a total blank. The patient is usually quite talkative unless harassed by depressive delusions. Recent events, unless of an extraordinary character, make no or but little impression. He is unable to tell what occurred the day before, or what he ate the previous or probably the same day. Any one who has studied the diagnostic symptoms of dementia and is at all conversant with the symptoms exhibited by T. must realize that by deception this criminal has thus far cheated justice.

In stuporous insanity malingering is sometimes hard to detect. A case of feigned stupor reported by Field in the *New York Medical Journal* for May 3, 1890, will illustrate this:

"Since his admission he had not spoken or made any voluntary movement; would follow where he was led; if put in a chair, would remain there; would not partake of any food or water unless they were put in his mouth; would swallow mechanically. Sometimes he would wet his clothing or the bed. He had a fixed, staring expression, only occasionally winking. He was not cataleptic, although two physicians had so certified to the District Attorney. Nothing would startle him out of his condition—neither pricking, nor dashes of cold water, nor pressure on the supra-orbital nerves. He lost thirty to forty pounds of weight. Subsequently he was sent to the Jefferson Market prison, from which he escaped by sawing out a bar in conjunction with another prisoner. His associate was recaptured and told how he had aided the malingerer in his deception. The feigning of the prisoner had been carried on for three or four months."

Real or Pretended Traumatic Cerebro-spinal Affections, especially such as follow Railroad Accidents.—That cases

of severe and permanently disabling nervous injuries follow upon and are caused by the physical and mental strain incident to severe railroad collisions are as well attested as that cases claiming such injuries have been suddenly and permanently cured after damages for the same have been settled by the company sued. In the few remaining minutes for which I crave the society's indulgence I shall not attempt to discuss the positions taken by three classes of writers on the so-called "cerebro-spinal shock." One class, represented by the railroad surgeon, who often becomes in these suits for damages railroad advocates, contend that most of the symptoms are simulated. The second class is formed by Charcot and his disciples, who at one time maintained that all of the symptoms might be accounted or on the theory of hysteria, especially the class which he designates traumatic hysteria. And the third and last class is composed of the over-enthusiastic so-called medical expert, who is too apt to accept the statements of the patient implicitly and attribute all of the symptoms to some obscure organic disease of the nervous system. Practically we meet with applicants for remuneration the symptoms of whose injuries are mostly, if not entirely, feigned; and others whose ailments are purely of an hysterical nature, and yet others whose symptoms are due to organic disease of the nervous system. On the other hand, it is not infrequently that we may find the simulated, the hysterical, and the organic symptoms combined in the same patient at the same time.

We may ask, What should be the testimony of the medical witness when called upon to testify in regard to nervous injuries, real or feigned, alleged by parties suing for damages? He should be unbiased, and base his testimony on demonstrable facts and not upon possibilities. It is well to bear in mind that the central nervous system may

have sustained permanent injuries and no objective symptoms be manifest to the most careful examiner until several months, or perhaps one or more years, after the accident. This should teach the claimant caution. In such cases, if the patient's health is not being injured by delay of legal proceedings, the suit should be deferred as long as possible. The examinations should be made jointly by at least two physicians—one for the plaintiff and the other for the defendant—and these should consult together simply to arrive at the truth. The examinations should be thorough, and repeated sufficiently often to prevent erroneous conclusions. The patient's body should be bared, the spines of the vertebræ and the muscles of the back carefully examined—the former for tenderness and deformity, and the latter for tenseness or rigidity. We should look for wasting of muscles. Next, the patient should be required to bend the back in different positions, and the freedom or restraint of motions observed and carefully noted. The gait of the patient should be scrutinized, and all of the tests for ataxic symptoms carefully employed. The reflexes, deep and superficial, should be thoroughly investigated, after which a careful electrical test for the condition of the nerves and muscles should be used. The tactile, muscular, temperature, weight, and pain senses should be carefully examined and compared on the two sides of the body. This is sometimes of the greatest importance, especially when hysteria or feigning is suspected. I have some cases of organic lesion of the cord under my care at present in which, in certain portions of the body where the senses of touch and pain are present, the sense of temperature is abolished. There should never be less than two thorough examinations, and the results of the second examination should be compared with the first. The condition of the special senses should never be neglected. The patient's own story of his sufferings should be

duly considered, but only in connection with the results of the examination. In other words, we should never be led into the error in these cases, where heavy damages are claimed, of making a diagnosis on subjective symptoms only, as has occurred in a recent case in this city. The health of the patient prior to the accident should be ascertained, if possible. If, after careful and repeated examinations, we find no objective evidence of disease of the nervous system, it seems to me that the only thing left for the medical witness to do is to so testify; for, if we have to base the diagnosis entirely on subjective symptoms, unaided by physical signs, we are placing the companies sued, so far as our testimony is concerned, on the honesty of the claimant for damages. Some of our courts of this city have decided, and it seems to me properly, that if the medical man has to base his opinion of the case entirely upon what the patient tells him, such testimony in those cases is inadmissible, and the claimant's statements must go direct to the jury without being interpreted for them by a physician.

I wish to say, in conclusion, that the physician who has carefully studied these cases and compared the results of different examinations will soon be able to sift the truth from the feigned symptoms of disease. Especially is this true when the physiognomy of the patient is studied during the examination and compared with its appearance when his attention is not absorbed by the examiner's method of procedure.