A CASE OF PURE PSYCHIC EPILEPSY¹

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The Dämmerzustand, or twilight state, of variable length and followed by complete or partial amnesia, is a not uncommon phenomenon in several conditions, especially epilepsy and hysteria. The differential diagnosis is not always easy. It is more difficult when the case presents no other certain differentiating phenomena, such as typical and ordinary convulsions, or local and shifting anesthetics or paralyses, or an alcoholic history, for example. The difficulties lessen, however, the more carefully and exhaustively the patient is observed and the longer he is under observation.

To bring out some of the important diagnostic features, the following case will be reported at considerable length. The patient first came under observation some thirteen years ago, and has been seen at different times by various members of this society. I have not had the benefit of their observations, except that in one instance a diagnosis of manic-depressive psychosis was made.

I will say in the beginning that though the attacks to which the patient has been subject have usually been preceded by occipital headache, or feelings of pain, numbness, tension or congestion in the head, increasing in severity, and in some instances by a difficulty in thinking, both the patient and his wife have stated that they could not tell when an attack was impending.

The case is that of a man, born in 1875, and therefore now 38 years old. He is of American birth and parentage, a very large, strong, healthy man, treasurer and managing director of a successful business.

Family History.—The grandparents died of natural causes. The father, an even-tempered man, died in 1883, at 43, of heart disease. He had one brother and three sisters, all well except one sister who was an invalid in the later years of her life. The mother died in 1902 at 57 of enlargement and fatty degeneration of the heart following rheumatism; she was inclined to worry,

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and is said to have had a "nervous breakdown" at 28, two years before the birth of the patient, and to have been "hysterical" at that time. She was one of four children, of whom one died in infancy; her two brothers were reasonably well, but one of them had two tuberculous sons. The patient is one of six siblings, of whom one brother died in infancy of convulsions following a fall on the head, and another died at 7 of diphtheria; a sister is "nervous" and had "nervous prostration" in 1908 or 1909. The others are well. Epilepsy, insanity and excessive alcoholism in the family are denied.

Past History.—As a boy he was normal, rugged, healthy, cheerful, even-tempered, sociable, athletic, and a good average student, with good powers of concentration. He was a heavy sleeper, but did not walk in his sleep, had no nocturnal fears, no nightmares, no wetting of the bed. He had no tantrums. At 10 he broke his arm while playing. At 14, while watching a game of football, he was run into and knocked over, hitting his head. He was unconscious, and when he came to, he was half a block away, by his own home. There were no sequelæ. At 23 he was operated on for appendicitis, the wound became septic, but finally healed well, without further trouble. He has worn glasses for astigmatism since he was 32 or 33. Venereal diseases are denied, and there is no evidence of them. He graduated from the high school at 17, then was clerk in a local bank for 6 years, and since then has held his present position efficiently. As a man he has continued to be normal, having an unusually happy disposition, taking things easily, easy to get on with, yet strong willed, determined and even obstinate. As a young man he was called a "big baby" by his intimates. He is sociable, being a member of a singing society and other organizations. He uses no alcohol or other drugs, and is a very moderate smoker. Except as will be mentioned, he has never been known to have any fainting or dizzy spells, convulsions, periods of irritability, biting or soreness of the tongue, soreness of the body, somnambulism, nightmares, involuntary passing of urine or feces, or petit mal attacks. There has been no deterioration. He was married in 1900, when he was nearly 25, about five months before his first attack. He had been a little more concerned about his business affairs at that time.

First Attack.—About the middle of February, 1901, he was worrying a little more over his business, as the president of the company had gone away on a vacation without telling the patient about the affairs of the company or leaving any instructions. He began to have pain in the head if he kept long at one piece of work; it was less severe if he changed; it was intermittent, entirely occipital, worse in the afternoons; there was no pain in the back or limbs, no nausea or vomiting. He "felt tired" and thought "something must be the matter with him." This con-

tinued off and on till Wednesday morning, March 13, when he felt "a little upset in his stomach." He went to the office, however, and was able to do his work. At lunch at 1 P. M. he felt "dizzy," couldn't order his lunch, and remembered nothing more till an hour later in his office. He was told that he had been unconscious for three quarters of an hour and had been walked back to the office. That evening he felt perfectly well, "better than for some time"; he had no pain or nausea. Nevertheless he stayed at home till the following Monday..

Second Attack.—On Monday, March 18, he was feeling less well than at any time since the 13th, but went to the office as usual, where he found a large mail awaiting him. At 9:30 he felt tired, said he had a severe pain in the back of his head. He kept at his work, but had difficulty in concentrating his mind on it, spoke of feeling dizzy, and could not accomplish much. He called to his brother to know how to form a sentence. He grew more confused and dull, and went home about noon with his brother, going at once to bed. That evening he talked quietly and rationally till about 8 P. M. when he called his father-in-law and said "I'm losing my mind. Take —— (wife) away. I might do her harm." For about ten minutes he talked quietly and sensibly, then asked quietly, "Has the hay been cut?" (Yes.) After a minute or two he repeated the question, then went to sleep and slept till morning. About 6 A. M. Tuesday, March 19, his wife asked him if he were in pain and he replied only "pain, pain, pain." From that time till 5 P. M. on Wednesday, March 20, he lay absolutely mute, his eyes open much of the time but rolling about without fixating anything; he took absolutely no notice of anything about him, even when spoken to loudly. At the end of that period he suddenly sat up, pushed aside his male nurse and shouted "Breakfast! Breakfast! I've ordered it enough! Now bring it! Quick, too!" He at once begun struggling to get up and it took four men to hold him. Effort was made to keep him in bed, but he continued to have frequent periods of struggling, mostly good-natured. He sang songs through correctly, and talked loudly and constantly, often as though he thought himself in the office in the presence of the clerks or of the president of the company, saying "You're a nice fellow to get off and leave me this way," etc. His talk was not incoherent or fragmentary, and was easily followed. He propounded riddles, told stories, repeated the numbers of bonds, figures published by Steel Trust, etc. Laughed heartily at times, especially if he could free himself enough to strike one of his nurses, or propounded a riddle which his apparent hearers could not answer. He was not distracted by events about him, did not pay attention to them, did not recognize his brother, who was with him a good deal of the time, saying when latter tried to identify himself, "No, you're not of this gang of gutter-sweeps,"

referring to his nurses. He was actively hallucinated, telephoning, waiting for reply, then responding in turn. He would sometimes laugh heartily, after listening, then say "Well! that's a pretty good story, John." Sometimes he talked as though he were indulging in horse play with someone not there. He repeatedly addressed an hallucinatory person as "You red-headed lobster," and he prefaced all his struggles by "Well, I'll get up now and split wood." On one occasion he held his breath for a long time, making swimming movements, then lifting his head and blowing as if coming to the surface from having been under water. (Is a fair swimmer.) Throughout his pulse, temperature, respiration were all normal, the pulse not getting above 88 even in his violent spells. He slept poorly, and was given some sedatives without much effect. He took some liquid nourishment. Bowels were regular. He had to be catheterized twice daily.

At McLean. March 24, about 3 P. M. his expression was alert and natural; pupils normal, eye grounds normal; no facial asymmetry, no tremors of facial muscles or tongue; no scars on tongue; no glandular enlargement, no venereal scars; abdomen and cremasteric reflexes normal; knee kicks prompt, slightly more active on left at first but not subsequently; no ankle clonus. Height 6 ft. 2 in. Weight 230 lbs. He allowed himself to be put to bed and a camisole put on, apparently not noticing what was being done; his expression was calm. He lay quietly till 3:30 when he suddenly began singing, sang three songs through correctly, then lay back for about a minute. Then in a matter of fact tone he remarked "Well, I guess I'll get up and chop wood," and began to throw himself violently about on the bed, shaking his head from side to side, paying not the slightest attention to the nurses who were holding him, but looking apparently at some hallucinatory person at the foot of the bed, to whom he addressed various threatening remarks, calling him often "You red-headed lobster." After a minute or two of violent struggling and talk he lay back quietly, to resume his activity again. After a few minutes, while quiet, he had three momentary "convulsions or paroxysms" as the nurse called them, in which he shook heavily as though chilled, with intervals of about 20 seconds. Immediately after the last one he raised his head, looked around for the first time as though seeing his actual surroundings, and asked with a dazed or surprised look, "Where am I?" (Hospital.) "Have I been sick?" (Yes.) "How long?" (About a week.) "What day is this?" (Sunday.) "What, the 24th of March?" and by succeeding questions he quickly oriented himself perfectly, and from that moment appeared and behaved normally. He was amiable, appreciative, inclined to make the best of everything in a hearty way. The following day he gave a detailed account, with excellent memory, coinciding accurately with the data given by his

relatives, of events up to the evening of Monday the 18th. He told of the attack of the 13th (which his family had not mentioned), and said of the events of the 18th that in the afternoon, while in bed, he had had a feeling of lassitude, didn't want to speak, but didn't feel irritable; that about 8 P. M. he felt himself losing control of his mind—couldn't say how or why. Recalled asking his father-in-law to take his wife away lest he hurt her. "After that I got muddled and can't remember anything more till I came to here." He was unable to give a single detail of the six days.

He went home five days after admission, having been perfectly normal. After a few weeks' vacation he resumed business as competently as ever.

Third Attack.—Having been in good health, free from fainting attacks, changes in temperament, or any physical or mental symptoms of any kind, he had on the following October 26 (1901) a severe occipital pain lasting a few hours. He slept well that night. Next day, Sunday, he rested, but on going out to dinner did not seem in his usual good spirits. He slept well that night. On the 28th he went to his office and worked as usual but in the afternoon felt some return of the headache, and got his brother to take him home. He retired early, and apparently slept all night. At 6 A. M., October 29, he went to the toilet, pulled the chain, and returned to bed. An hour later his wife found him in a stupor, paying no attention when she spoke to him. Seen that afternoon by a hospital physician, he lay in bed, apparently awake, but with no evidence of hearing or seeing those about him, even when spoken to very sharply. He occasionally turned over, or drew up and thrust out a leg, rubbed his head, etc. Pulse, temperature, respiration normal, color good, pupillary, patellar and plantar reflexes normal, heart negative; no resistance to passive movements in any part of the body. The next four days he spent most of the time in bed, with normal pulse, temperature and respiration, requiring enemas and catheterization, frequently rolling out of bed, often with a sudden lurch, lying limp when picked up and put back but sometimes stiffening a little when asked to, and always seeming weak. He would open his mouth to let the nurses swab it, but otherwise apparently paid not the slightest attention to strangers or his family, but kept looking at hallucinatory persons. At first he seemed very dull, squirming in bed a little, throwing his arms up over his head, rubbing his face, etc. But he began after the first day to speak a little, often repeating the same isolated word or phrase many times, such as "Oh, dear," "Hell and damnation," "Hell bent for election," etc., or "Once," "Twilight," "Evening." He sang at times, repeated some poems or parts of them. On November 1 he went through gymnastic exercises with an imaginary "Ned," made motions as though

swimming, crept about butting his head against the wall, and would have hurt himself if the nurses hadn't acted as buffers. On November 2 from 9 A. M. to 2 P. M. he kept up a lively game of football, acting the part of guard, rushing, shouting, kicking, dodging, occasionally falling down for a few minutes, then starting at it again. He talked voluminously in the afternoon of all sorts of topics,—Clayton-Bulwer Treaty, McKinley's speech, the Boston Clearing House, stock market reports, etc.; repeated poetry and uttered such single words as "Evolution," "Gravity," "Procrastination," "Hypodermics."

At 6 P. M. (Nov. 2) he kept repeating "Oh! Oh! Oh!" for about 3 minutes then asked, "Where am I?" (At home.) "What makes things look strange?" then quickly oriented himself as before. He continued perfectly clear, though a little depressed at having had a recurrence of his illness. He said he had a confused recollection of visiting the water closet on the morning of the 20th but remembered absolutely nothing till the evening of November 2 when he became conscious of being in his own room on account of the familiar wall-paper, and that then he became perfectly clear as to persons and surroundings in a very few minutes.

He remained well for a year, attending to his business. He then had his *fifth attack*, in November, 1902, when he lost his memory, did not recognize members of his family, threatened to kill his wife, and on one occasion wanted to fight his nurse, but as a matter of fact was not violent. He played golf much of the time during this attack. He thought he was going to build an air-line railway between Boston and Chicago. After 5 days he was tactlessly told of his mother's death and within a few hours regained his normal orientation, with amnesia for the lapsed time.

An interval of six years then intervened before his *sixth attack*, in November 1908, when he lay in a heavy stupor for several days, taking neither food nor drink, requiring catheterization and enemas. He then came suddenly to himself, asked for food and after about 24 hours of apparently normal sleep, he was perfectly normal, but retained no memory of the period of stupor.

His *seventh attack* occurred in 1909; no description was obtained. He may have been for a short time with Dr. Edes.

Eighth Attack.—In February, 1910, one morning he complained of not feeling very well; soon appeared dazed, tried to go to his business, but grew much confused and so weak that he could hardly stand. After a few days he improved, but soon had a relapse and went to Dr. Edes's sanitarium for about 5 weeks. There he was given bromides, and after a time improved, being brighter in the morning; after leaving it was several weeks before he could go back to his business. No good description of this attack was obtained, except that he is said to have had amnesia for part of it.

Ninth Attack.—In February, 1911, on getting out of bed one morning he fell to the floor, was in a stupid, confused condition, sleeping most of the time for about 10 days; during this time he would sometimes speak of hearing running water, and he asked to have an operation performed on his head. He then grew more restless, and more difficult to care for, and after another week or ten days was given a good deal of bromide (at home). After a few days more he got up about 4 A. M., climbed out of a window, fell and tore some muscles of the back and perineum. That noon he became clear, and after his injuries had healed he returned to work as usual. He retained a vague memory for parts of this attack.

Tenth Attack.—On Thanksgiving Day, November 30, 1911, he appeared a little peculiar to his wife. Next day, while trying to write up the stubs of his check-book he collapsed at his desk. His work was nothing but scrawls. Put to bed, he kept talking to an imaginary person, paying no attention to those about him. He would snatch at food occasionally, but ate little. He remained in this condition till December 10 when he became clear, with amnesia. The next three days he remained so, but complained of a drawing sensation in the back of his head. On December 13 he went with his wife to see Dr. Prince, and on the way complained of the auto jarring his head, and he was a little irritable at his wife for going with him. On his return he seemed quiet and depressed, but clear, and after lunch started for a walk alone. He returned at 5:30 P. M. wet to his shoulders, having evidently waded into some pond and ducked his head without immersing his shoulders. His hat was dry, though his hair was wet. He seemed confused, talked in a dazed way of someone coming to get him, but he went upstairs without help, brushed his hair, and then allowed his wife to put him to bed, where he remained for a day or two. Then he grew restless, said he had killed a man, that he was well, and he tried to get out with only a blanket on. He was brought in an automobile to McLean December 15, 1911, where for four days he showed a general dulling of all his psychical and neural processes, hearing a watch only at a few inches, uncertain as to how many fingers were held before him, unable to tell time, only crudely recognizing things in his hands, with diminished sensitiveness to touch and to pain, and with diminished capacity to localize tactile sensations; the pupils were equal, of moderate size, and reacted promptly to flash-light; the left knee jerk was possibly slightly greater than the right, but the test was unsatisfactory; Achilles reflexes slight and equal; plantar reflexes equal, slight; no Babinski reflex. He was weak physically, was slow in his movements and speech, and fumbled in tests for recognition of objects in his hands. He was actively hallucinated, and it was difficult to get his attention from

the voices he heard and the man he saw. He was dull of comprehension, and was completely disoriented. He gave his name, but thought he was about 50 years old (36), that he was not married, that he had never done any work; he didn't know his address, or whether his parents were living, etc. Simple subtraction was poor, multiplication was better. He had a crude appreciation of the fact that he wasn't well. (Memory good?) "I guess not." (Head clear?) "No." (Feel blue?) "No." (Feel happy?) "I don't feel much of anything." (Why slow?) "I don't know. I guess something's the matter with me." He kept constantly talking to an imaginary person, having chiefly the ideas that he had killed a man, and that this hallucinatory man was urging him to do something that he didn't want to do—probably commit murder. There was some tendency to perseveration in his replies both to the hallucinatory voices and to the examiner's questions.

On December 19 he was seen in the morning by four physicians for about 15 minutes. At 3:45 P. M. he got out of bed as though just awake, looked about in amazement, asked where he was, and on being informed, told the nurse of his being here several years before. He was depressed at having had another attack. At 4 P. M. he was pretty clear and well oriented, but still a little retarded; he could recall vaguely that several men had been in that morning, but not what he had eaten for dinner, nor whether he had eaten it in bed or in the dining-room. He recalled being rather depressed Thanksgiving Day, and its being hard to concentrate his mind on his work next day and having visited Dr. Prince one day, but not what advice had been given him. He recalled vaguely having gone for a walk after lunch that day and having got wet, but he could give no details or reasons. The rest was a blank, except that he remembered vaguely riding in an automobile. When asked leading questions he said he could recall thinking he had killed a man. He was much depressed. Sensory examination showed a little dulling, but not nearly so much as before. For the next 3 days he had at times active auditory hallucinations, occipital pain and headache, variable moods, especially depression and irritability, and some thinking difficulty, but he was approximately oriented.

On the morning of December 22 the pupils were equal and normal in reactions: the knee reflexes were moderate, the left being a trifle larger; the Achilles reflexes equal and moderate. Tactile sense not appreciably diminished; localization of points only slightly diminished; hearing slightly impaired; no narrowing of the visual fields. He was retarded, and it took him $2\frac{1}{2}$ minutes to make continuous subtraction of 7 from 100 with paper and pencil; while doing this he said aloud two or three times "Do it," without being aware that he did so. When asked why he said it, he replied that he had not said it, but that someone had

said it to him. At a quarter past four that afternoon he suddenly announced that he felt like a new man, and asked to see the examining physician. At that time he had a rather confused recollection of the examination that morning, and of the events of the preceding three days, with the hallucinatory voices. On the morning of December 23, he was alert, not depressed, was fully oriented, prompt in replies and accurate in memory for all but the periods of complete and partial amnesia. For the latter, the things he could recall were accurate, but there were gaps, and the details were not sharp. (Remember thinking you had killed some one?) "It seems as though—it's like a dream. It seems as though there was a struggle and that I killed him. That's all." 100—7 in 15 seconds. Sensory examination was normal. He made a perfectly normal impression.

From December 24 to December 31 he was again much confused, threatening, talking of having killed a man, etc., with a few brief periods of sudden clearing in which he had only fragmentary recollections of the confused periods. He then remained clear and oriented, but a little suspicious, critical and depressed.

He went home, and on January 7 following he again became quite depressed, then confused, in a stupor, neither eating nor urinating, and was brought back to the hospital in an ambulance on the 10th; for three days he was quite disoriented, talked fragmentarily of burning fires, of cremation, of the Himalaya Mountains, etc., and at 5:30 A. M. on the 13th cleared suddenly, with good orientation, and amnesia for the 6 days, except that he remembered indistinctly his being brought in a van (ambulance) and struggling with the nurse on the way. Association experiments with the standard list of 100 words, followed by free associations with the most notable responses led to no "complex indicators." The only noteworthy event during the tests was that when the word "sheep" was given him, he seemed abstracted for an instant, then asked if "sleep" were the word, and on being signalled to go ahead, gave the association "move." This whole reaction took only 5.4 seconds. It is possible that this was a momentary *absence*, the only one observed. But such episodes occur sometimes with normal persons.

Neither by this method nor by asking direct and leading questions, could any memories of the completely amnesic periods be aroused, and only vague, hazy and disconnected ones of the partially amnesic periods. He gave, however, a very full and detailed account of the normal intervals, and showed no evidences of deterioration.

We have then a man, now 38, whose personal make-up and whose heredity have been unexceptionable, except that his mother is said to have been at one time "hysterical" and whose sister has had "nervous prostration." Without any evidences of con-

vulsive seizures he has had since the age of 25 several attacks characterized by the sudden onset of a condition in which there have been, in one or more, automatic and somnambulistic acts, a fugue, narrowing of the intellectual field, general diffuse dulling of the psychic and sensory activities, even to stupor, complete disorientation, vivid auditory and visual hallucinations, delirious ideas different in the different attacks, a tendency to perseveration and to stereotyped repetition of words or acts, flighty associations, hilarity, depression, psycho-motor retardation, muscular weakness, and fumbling movements, but no localized anesthetics or paralyses.

These attacks have usually been preceded for a few hours or a day or two by an unmotivated depression, a thinking difficulty with feeling of confusion, and especially by an occipital headache growing more intense. But these have not been pronounced enough to be regarded by the patient or his family as indicating an impending attack.

Following the attacks there has been sometimes complete amnesia, beginning and ending at a definitely determinable time or event, at other times an almost complete amnesia, but with a few hazy patches of recollection, and somewhat less definite onset and emergence. It has not been possible to revive a memory of the events of these periods. There has been a period of depression lasting a few days or even weeks after the attack.

In the intervals between attacks the patient has had an unusually accurate memory for details, and has shown no mental deterioration.

Since he has had then in one or more of the attacks some of the symptoms which may be seen in epilepsy, hysteria, manic-depressive psychosis, alcoholism, dementia præcox, and prison psychosis, each one of these conditions must be considered in making a diagnosis.

Although he has not had any known convulsions, unless the chill-like episode of his first attack can be regarded as such, he has not shown any symptoms which may not be seen in the psychic states of idiopathic epilepsy.

Twenty-five years ago Féré showed that there was frequently dulling of the different senses and slowing of response to sensory stimuli in the quarter or half hour following a convulsive seizure, and Spratling demonstrated a dullness of the pain sense and of

hearing during a fifteen minute twilight state. Féré also showed muscular weakness to be not uncommon. Delirious ideas, disorientation, "reduction" of the psychic field, automatism, somnambulism, fugues, preverberations and stereotypies are well known phenomena. Depressions are not unknown, and Spratling speaks of cases with laughter and hilarity. Flighty associations are not so common. I have not seen them mentioned, nor do I recall any instances in the cases I have seen, but they occur in so many different conditions that their diagnostic significance taken by themselves alone is not very great, and there is no *a priori* reason why they should not occur in epilepsy.

It is probable that a continuous series of cases could be shown ranging from those having only convulsive seizures, through those with many convulsions and an occasional *dämmerzustand*, and those with few convulsions and many *dämmerzustände*, to those with only the psychic states. The latter, of which some have been reported in the literature, are cases of so-called pure psychic epilepsy; Kraepelin quotes Starr as finding in nearly 2,000 cases of epilepsy only 0.8 per cent. of purely psychic cases, and Spratling finds even less—four cases out of 1,325 epileptics.

Most of the investigations on the psychic state of epileptics have been made either just after—within 15 or 20 minutes—a convulsion or in the comparatively normal state between convulsions. In a hasty and superficial glance through the literature I find very few made during a so-called psychical equivalent. A general psycho-sensori-motor dulling rather than a limited or localized dissociation seems to be the type of change, which is that seen in this case.

Since it seems to be a fair inference from the association of the convulsive attacks with the psychic states that they are both due to a common underlying cause or condition, and since the symptoms seen in this patient have the characteristics seen in the psychic equivalents of epilepsy, the inference seems fairly well justified that the condition underlying his symptoms is the same as that underlying the seizures and the twilight states of idiopathic epilepsy, and on this ground I make the diagnosis. That this underlying condition is unknown and that the condition underlying the other diseases (some of whose symptoms some of the patient's symptoms resemble) is also unknown, does not signify that they are therefore identical or not differentiable.

If I may digress a moment I would like to say that I think we lose much when we give up the conception of disease entities or underlying conditions, and try to make diagnoses on the basis of clinical pictures or symptom-groups, as we are apt to do in psychoneurology and psychiatry. Diagnostic effort is directed to finding out what is the matter with the patient. If we make our diagnosis on the facts that he shows this or that symptom-complex or shows this or that clinical picture, we shall often err. For any given symptom-complex or clinical picture (as mutism and resistiveness) may be found in widely diverse conditions, and on the other hand any given condition may give rise to widely different clinical pictures (for example, the wide diversity of clinical pictures in general paralysis). To seek then for a diagnostic symptom or symptom-complex is a vain and fruitless search, and leads only to misunderstanding of the relative importance of symptoms, and to waste of energy.

Diagnosis should always be regarded as an *inference* from the facts *as to the underlying condition*. This attitude sets the definite problem of finding out this condition, of differentiating between cases which present symptom-groups which are superficially similar but which arise from different causes or on different grounds, and leads to greater accuracy. It is the attitude of general medicine and surgery and should be that of psychiatry. If this conception had been kept in mind, it would have been impossible for a writer to have said, as was done in this Society within a year "While the sufferer from obsessive psychosis may drift into chronic hypochondria or into manic-depressive insanity, he will become a case of dementia præcox only if he has the inherent brain defect which limits development and predisposes to deterioration."

I would like to continue my digression to speak of nomenclature. Just as we need the conception of disease entities or underlying conditions, so we need names for them. And it is better to keep the old, long-used, familiar names for a given disease-entity, even though the latter be a quite unknown *x*, in order to distinguish it from another different but perhaps equally unknown *y*, or from a known *a* or *b*. And it is better to keep them to denote the clear-cut conception, even though later knowledge shows the theory embodied in the name to have been fallacious. Modern medicine is full of such terms—such as malaria,

measles, etc. It does not trouble us now-a-days to speak of malaria, even though we know it is not a "bad air" disease. Neither does it trouble us to speak of general paresis in the absence of paresis. It should not then trouble us to speak of manic-depressive psychosis in the absence of a manic or a depressive condition, or to speak of a dementia præcox which arises comparatively late in life. It would not trouble us if we recognized that each of these terms should signify a disease entirely different from that denoted by the other names; many of these names having been given under a mistaken theory of the origin or essential nature or characteristics of the disease. It is when names like those are used purely symptomatically, to denote a symptom-complex, that unnecessary difficulties of diagnosis arise—there are enough unavoidable difficulties without adding avoidable ones. If what should be diagnostic terms are used symptomatically, we lose them for diagnosis, make unnecessary synonyms, and create confusion.

On these grounds it seems to me more helpful and more scientific to keep the term epilepsy for the cases having a presumably common unitary underlying condition, and to name the so-called "symptomatic epilepsies" epileptoid states or conditions—just as in general medicine we differentiated typhoid fever from typhus fever, or now speak of rheumatism and the rheumatoid diseases, and in psychiatry differentiate paranoia and paranoid conditions. To give up "epilepsy" and speak only of "the epilepsies" is to make the word a blanket to cover essentially different things, while the general trend of scientific advance is to narrow and sharpen the conceptions connoted by words.

But to return from the digression.

Hysteria must be considered in this case, because there appear attacks of mental "reduction," with automatisms, somnambulism, fugues, perseverations, hallucinations, delirious ideas, disorientation, with sudden onset of and emergence from the attack, and amnesia for it. But the manifestations of hysteria are almost if not quite invariably initiated by some strong emotional cause. The hallucinations and delirious content are apt to be reproduced in successive attacks, perhaps more often in hysteria than in epilepsy, and are usually capable of being brought to memory in the normal state, while in this case they were different in each attack, and could not be recovered, though not all

methods by any means were tried. Indications of special complexes are comparatively easily elicitable in hysteria, while here none were found. In hysteria the sensori-motor disturbances are apt to be localized and more or less shifting and variable while in this case they were general and diffused, and not shifting so far as observed, and there were no localized anesthetics or paralyses. Janet speaks of the hysteric patient usually being quite comfortable and normal on emergence from the attack, while this patient was usually depressed and not up to par for a few hours or a few days.

From the absence of some of the characters that seem essential to hysteria, there is not sufficient ground on which to base that diagnosis in this case.

In manic-depressive psychosis we see at times mental confusion, even to the point of stupor, with hallucinations, and sometimes with a certain degree of amnesia for the period of confusion; we also see psychomotor retardation, thinking difficulty, disorientation, depression, or exhalation with flighty associations and over-activity; and occasionally we see sudden changes, such as sudden lifting of a depression—"the cloud lifted at 9.25 this morning"—or sudden temporary clearing in rather confused manic states, with efforts at orientation.

But the confusion and stupors never come on suddenly, out of a clear sky, the muscular weakness occurs only as the result of exhaustion, and there is no sensory dulness, except in profound stupors which are rarely seen. The amnesia, if it exists, is usually less patchy, and never begins and ends sharply; when depression lifts suddenly there is never any amnesia for the preceding state.

The depression in this case is a rather normal reaction to the appreciation of the fact that he has had another attack, that he doesn't know when to expect another, nor how many he will have, and that he is liable to be incapacitated for work for an indefinite time. It is not a fundamental one. The excitement and flight of ideas were more automatic and mechanical, and not the free labile activity of the usual manic case, and at no time did he show the distractibility that goes in manic cases with as much flight and hilarity as he had. The rather sudden temporary clearings in manic cases I have no explanation for. It is very rare that the

manic state ends in that way, as the recovery is usually gradual, even in cases having such remissions.

Thus there are lacking sufficient evidences to warrant the inference that the manic-depressive condition underlies the symptoms in this case.

For dementia præcox there is little except the stereotypy, the perseveration, and the fugue. But these symptoms, if they occur in dementia præcox, do so during full consciousness and without amnesia. In the presence of mental confusion it is dangerous to make the diagnosis of dementia præcox, anyway. Besides, in this case there is no dementia at the end of 13 years. In reality, nothing speaks for that diagnosis.

The clear history of non-use of drugs or alcohol is sufficient to exclude the possibility of a psychosis due to them.

The fact of the patient's never having been under such conditions as give rise to the prison psychosis would rule out the consideration of that condition, even if it is to be considered as an independent disease entity, which I think is doubtful. Many of those cases are in defectives, and in that class not only is epilepsy not uncommon, but also anomalous psychotic episodes arise which are with difficulty classified. And the histories of some of the reported cases strongly suggest hysteria, and of others dementia præcox. So we probably have to deal in the case of prison psychosis with anomalous and atypical cases of some of the comparatively well-known psychoses.

There remains to be considered the possibility of different psychoses in different attacks, especially as the patient showed some over-activity followed by depression, probably in his seventh or eighth attack. But the onset of every one was said to have been sudden, and he had amnesia for a part of each, while his mental confusion does not appear to have been great enough to have been followed by so complete and sharply limited an amnesia, if the attack had been one of manic-depressive psychosis. Furthermore, the patient and the family describe the attacks as being all alike in general nature. It seems a fair inference, therefore, that in spite of some excitement and some depression (symptoms which may be found in almost any psychosis) the same underlying condition was responsible for his symptoms in all the attacks.

Hence, not only on positive grounds but also by exclusion of other conditions, I have felt justified in making in this case the diagnosis of pure psychic epilepsy.