BORDER-LINE CASES OF MENTAL DEFECT, WITH SPECIAL REFERENCE TO HYSTERICAL SYMPTOMS.*

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As our knowledge of mental diseases and defects increases and as we gain more skill in recognizing the symptoms to which they give rise, we are able to classify conditions which have not been understood heretofore. There remain borderline-cases which it is difficult to classify, or if they can be classified, for whom it is difficult or impossible to secure suitable treatment. Many times the more noticeable symptoms are those of the hysterical, but careful study reveals a mental defect, a beginning or mild psychosis as an explanation of the person's unusual behavior.

My experience has been gained at the Lancaster State Industrial School for Girls, to which delinquent girls under 17 years of age are sentenced by the courts. Under the present system, few, if any, are so sentenced until other methods have failed: probation by the court, oversight by the Society for Prevention of Cruelty to Children, the State Board of Charity, private charities, etc. Many have been examined by an alienist, who frequently reports that the girl is not normal but that the mental condition does not warrant her being sent to a feeble-minded school or to a state hospital. Frequently girls are sent to Lancaster who admittedly should go to a

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feeble-minded school, but cannot be received on account of lack of room. Many of the normal girls do well on probation or in the care of some society, and consequently never reach us. We have, therefore, at the Lancaster School, a large number of mentally abnormal girls, many of whom are high-grade defectives. The study of these border-line cases is most interesting. Their exaggerated reaction to outside stimuli, to pain and to mental changes, gives us, I believe, an insight into the same reaction, but to a less degree, in more normal people.

We have been able to secure exhaustive family histories in many cases, nearly all of which show a bad inheritance together with a bad environment. In some instances the picture is so dark one wonders at there being such families in existence. The lack of discipline and the means which the child takes to secure freedom to gratify the desires of the moment have to be considered in the final analysis. It is easy to understand how a neurotic, wilful, disobedient child with a lack of self-control, who cannot appreciate the penalty she will have to pay for her transgressions, soon develops into an hysterical offender, especially during adolescence. Dubois says, “An hysterical person is an actor who has lost his head and plays his part, imagining that it is real.” In discussing a tantrum or a convulsive seizure with a defective girl, I have been told frequently that in the beginning she was trying to gain some end, later she could not help it.

Doctor Savill in his “Lectures on Hysteria” has the following to say of the hysterical person: “These patients, even in ordinary circumstances, are easily roused to violent expressions of feeling, to hasty judgments, to impulsive actions, and to passionate exhibitions of various kinds. One moment they are angry because a thing is going to be done; the next moment they may be cross because it has not been done. Sydenham in 1680 described this mental instability well. ‘All is caprice. They love without measure those whom they will soon hate without reason. Now they will do this, now that, ever receding from their purpose.’ Briquet in 1859 dwelt more on the emotional instability as being the chief feature of the hysterical mind, and without doubt it is a very striking feature. But in typical cases there is more or less instability of all the mental faculties—sensation, perception, memory, imagination, feelings and emotion, ideation and connation, attention, judgment and will. The will power is variable and apparently insufficient to control the unruly thoughts, acts and emotions; but it has often seemed to me that this deficiency is sometimes more apparent than real, by reason of the strength and unruliness of the emotions which the will has to control. All the faculties vary from time to time and thus again it happens that the hysterical mind is what we call an unbalanced mind.”

“There is about all their vital phenomena, whether healthy or morbid, a variable or paroxysmal character, a change from day to day which seems quite peculiar to them. Whether ill or well, this is noticeable; and if suffering from some intercurrent malady, one day the patient is so ill as to be hardly able to move, the next day she may be up and about, although the malady has undergone no change. This sometimes brings them undeserved blame.”

“Individually these qualities may not be very distinctive, but collectively—the impulsiveness, the emotional instability, the ready flushing, the excitable reflexes, and the variability of the vital
phenomena—they are so far distinctive as to enable a careful observer to recognize the hysterical diathesis in the female sex.”

I have quoted the above at length as it gives a clear description of a class of cases that are troublesome in an institution and that are unmanageable in the home. Most of the more marked cases of this type that I have seen are mentally defective, and a few, on account of their lack of control and the completeness with which they are mastered by their ungovernable temper, become dangerous to others and should, I believe, be treated as insane.

Malingering, simulation and the production of an abnormal physical state by some means which must cause physical distress, when there is nothing or so little to be accomplished that the discomfort is out of all proportion to any possible gain, seems to me to indicate an abnormal mental state. Threats of, and ineffectual attempts at, suicide, are common with the psychopath. I know of only two cases in which attempted suicide was successful. The first was an apparently normal girl, who had never threatened self-destruction. In going over the case afterwards, there was nothing to be found that might have led those in charge to suspect such an attempt. The other, a syphilitic girl, had had violent outbreaks and had threatened to kill others as well as herself, was probably insane, but we were unable to determine a psychosis. Many attempts have been frustrated, some of such a nature as to leave no doubt that they were not intended to be successful, others apparently so nearly successful as to be regarded as most serious.

Somatic influences play an important part. The large number of physical defects found in mental defectives and psychopaths is astonishing to one who has not had the opportunity of examining a large number. The list includes ear, eye, nose and throat defects, defects of the circulatory system, including functional and pathological heart conditions and vaso-motor instability, defects of the gastro-intestinal tract and the genito-urinary system, skin diseases, weak and fallen arches, asthma, glandular enlargements, poor teeth, poor nutrition, lack of resistance against infections, etc. Menstrual abnormalities are frequent, incontinence common. I have wondered if the internal secretions were not oftentimes out of balance. Many of the girls have enlarged thyroid glands, but as there is a physiological increase in the size of this gland during adolescence, and as I have seen a number of abnormally large thyroids in public school girls, who are otherwise apparently normal, I should hesitate to say that this was more frequent in the class of cases under discussion, without definite data.

I have been much interested in the theory that vaso-motor defects may be the cause of hysterical manifestations. I have often been able to observe vaso-motor changes preceding and during an attack and have been able to get a history showing this defect in many others. The feeling of cold or heat on the surface of the body, the flushing or pallor of the skin which often precedes or accompanies an attack is very suggestive. Mottling of the skin has been so well marked in a few cases that I have had to watch the condition come and go in order to satisfy myself that the patient did not have a rash. The most profound vaso-motor paralysis I ever observed was in a girl who practiced self-abuse excessively, which I considered to be the cause. Whether or not we consider sexual trauma to
be a cause of hysteria in the average person, it seems doubtful if it can be of great significance etiologically in a girl who will discuss her sexual indiscretions as freely and with apparently as little feeling as she talks about her school work.

The physical symptoms of which these girls complain are often most confusing. Many times slight discomforts and pains are magnified until they assume the proportion of a serious condition. Past illnesses are remembered and the patient apparently suffers as much from a second and a third attack, for which there is no pathological cause, as from the original illness. I have seen girls suffer from repeated attacks simulating appendicitis after the appendix has been removed. A girl repeatedly comes to the hospital, bent over, crying from a pain in her left side, to be cured in five minutes by being put to bed with a hot-water bottle. A history of the case shows that she had convulsive attacks several years ago, later, cyclic vomiting. At one time a girl would come to the hospital every few weeks with a febrile attack for which we could not account. The matron watched her very carefully and found that if she did not get an answer to a letter she had written within a certain time she would begin to worry, stop eating, and would have to come to the hospital. Twice she came to the hospital with a temperature over 101° as predicted after the letter was sent and no answer received. I asked for a report on a girl who had repeated attacks of acetonuria and in reply got a statement that at certain times she would begin to worry, lose flesh rapidly, and after a few days have to go to the hospital. It often happens that a girl who has been menstruating regularly up to the time of coming to the school will not menstruate for months. At times the bowel functions seem to be in abeyance for days and occasionally the kidneys do not secrete for three or four days.

In selecting the following cases to report, I have taken those which best illustrate several different types that, in my opinion, need custodial care, and for which, with one exception, we have been unable to secure permanent treatment in a suitable institution. The first four cases are included to show the physical symptoms of which the defective delinquent may complain. If I have not given sufficient data to demonstrate the defect it is because I wished to keep the record within reasonable bounds, not because the material is lacking. One case, No. 6, is included to show the development of a psychosis in a mentally defective person.

Case 1. A. M. Born August, 1892. A foundling, adopted from the State Board of Charity. Character of home, good. Her mother by adoption, respectable, but little force of character. Mother's second husband died when Alice was thirteen years of age, since which time Alice has been unmanageable. Alice associated with low boys and girls. Worked for a short time in four places. Ran away from home and hired a room to which she brought men.

Committed to Lancaster in May, 1907. Examination showed eye and ear defects. She was infected with syphilis and gonorrhea. Has had diphtheria and appendicitis. Reflexes normal. At the School, was always in trouble; no violent outbreaks or tantrums, but always doing foolish things and getting the other girls into trouble. Dared a girl to eat the eyes out of a frozen cod fish and when the dare was not taken, did it herself. Would get food out of the kitchen and eat an enormous quantity. Stuck needles into herself until we refused to cut them out. At one time claimed to have got glass in one eye; we picked out pieces of glass for several days.
We finally told her that if she put any more glass into her eyes it might stay. At another time she said her bowels had not moved for two or three weeks. More recently she has complained of “blind stagger.” Has fainted.

October, 1911, was given neo-salvarsan at the Boston Dispensary. Following this her arm and hand were swollen and gave her a great deal of pain for six or seven weeks. Examination and x-ray negative. There were suspicious marks above the elbow. She was accused of cording her arm. This she denied, but soon after told of falling out of a chair and striking on her elbow, after which she felt “pins and needles” in her hand. The hand got blue and the swelling subsided—recovery immediate. June, 1913, was given neo-salvarsan intravenously. She became delirious, then unconscious, these states alternating for several days. There was no secretion from the kidneys for thirty-six hours. The nurse reported that while in a hot pack her breathing stopped and her pulse became very weak.

At another time she developed some trouble with one knee—pain, redness and stiffness, and at times slight cartilaginous crepitation. The redness looked very superficial, as if it had been encouraged. This lasted for several months; part of the time she was in bed.

Occasionally her work was satisfactory, but most of the time she was not interested in it and needed constant supervision. She was easily discouraged, impressionable, and was always looking for excitement.

When placed on parole she did not do well. In one place she left the baby alone, took clothing and disappeared. Was found living with a boy. After this, several unsuccessful trials. Was arrested for larceny. When she became twenty-one she went to live with a man whom she had married at some previous time, and of whom she had claimed to be very fond, but she soon tired of him and went to live with another man. When last heard of, was at the State Infirmary awaiting confinement.

Diagnosis. Although she passed the Binet test for fifteen years, I believe she is a defective delinquent and should have custodial care. There is a probability of cerebral syphilis and the knee may have been organic.

Case 2. E. B. American parentage. Born November, 1893. Committed Dec., 1908. A police officer reports: “The father is poor stuff and has been on our books and graced our docks many times for drunkenness and non-support. Husband and wife living apart. They move frequently, either the house does not suit the B’s or the B’s do not suit the landlord. The mother is in poor health; her character has suffered on account of her fondness for men. E’s sister is noted for her indifference to her marriage vows. The home is very unattractive and on the whole E. cannot be good and nothing can be expected of her people to aid her future.”

A report from the Associated Charities: “From first to last the church has done a great deal for Mrs. B. We have dealt with three families related to her; very poor stock, epileptic, feeble-minded and drunkards.” The mother’s sister, who lives with the B’s, is a notorious character.

Before coming to the Lancaster School E. had lived a disreputable life—a sexual offender, drank, smoked and probably took drugs. As it is the influence which her mental state had over her heart’s action which I wish to bring out, I will not take time to go into her mental history, excepting to state that she is a high-grade mental defective, and is very susceptible to her surroundings. She passed the Binet test for eleven and four-fifths years when she was seventeen years old. She can and does do her work very well when interested in it. When not interested, her work is far from satisfactory and she complains of heart pains, weakness, dizziness.

She had rheumatic fever in August and again in December, 1907. Chorea, lasting one month, the same year. Has had follicular tonsillitis, measles, and scarlet fever. She has a double mitral lesion.
an hypertrophied heart and evidence of kidney involvement. After coming to Lancaster she did not menstruate for six months. She complained a great deal of pain in the region of her heart, shortness of breath and dizziness. June, 1910, she was in the hospital suffering from failing compensation. There was considerable cyanosis, dyspnea, and a small irregular pulse. The heart, which was very large at best, seemed to be increasing in size. No treatment was of any use. The condition seemed so serious that I advised the authorities to allow her to go home provided she should improve sufficiently to be able to stand the journey. She was told that she could go home when she got better. The result was that within a few days she was sitting up, apparently as well as ever. The authorities were suspicious that I had over-estimated the seriousness of the case and withdrew their permission. Within a week or ten days she was back in bed with all her old symptoms. Her condition became so serious that she was again placed on the dangerous list. This time I told her, myself, that if she got better she should surely go home. The result was nearly as prompt as before, and she was allowed to go.

She remained at home for a while, then ran away and lived in a very dissolute way. Was returned to the School. She did not have as bad attacks after this, but was not able to do any work. Was in bed a great deal. She was sent to the State Infirmary for treatment. She improved and was returned to Lancaster. She was better for a time, then became discouraged and lost all she had gained. We took her into the hospital and after a short time began to have her help in the kitchen. This seemed to interest her and soon she was doing as much as any body and continued to work until she became of age and left the School. I believe the care which she received at the house in which she lived was as good as that at the hospital, but she did not like it. No treatment with drugs seemed to relieve her to any great extent, and at times heart stimulants made the pain worse.

Remarks. If I had not had this experience and watched this case for several years I should not have believed that the mental state could affect the action of a diseased heart as it apparently did in this case. It has made me hesitate to join in the criticism which we frequently hear of physicians who, from the subsequent outcome of the case, have apparently overestimated the seriousness of a prisoner's physical condition, thus securing his release.

Case 3. E. B. French Canadian. Born May, 1895. Father alcoholic, abusive, sex offender, has court record. Mother tubercular. Brother and sister said to be "unusually smart," have but little respect for parents. A brother arrested for breaking and entering. Emma said to be stubborn and unmanageable at home, lies continually, out nights with questionable girl friends. Is a trouble maker, tells one girl what another one said about her and so on, until she makes a complete tangle and confusion. She has stolen twice and frequents cheap dance halls.

Committed to Lancaster, September, 1911. Physical age, sixteen years; Binet age, ten and one-fifth.

Physical History.—"An attack of heart failure one year ago." Sick two weeks. No other illness. Heart normal at time of first examination. On Sept. 22 she came to hospital complaining of difficulty in breathing, pain in pericardium and across upper part of chest. This of several days' duration. Respiration very rapid (90). While waiting to see the physician she became faint and had to lie down. There seemed to be considerable prostration, hands cold, pulse rather compressible, but not rapid; examination of chest was unsatisfactory on account of the rapid respiration. She had times of coughing and choking. A tendency to general convulsions, hands clinched, arms and legs straightened out. She did not seem disturbed mentally. Said, "If I could eat I would be all right." Reflexes nor-
mal. Test of sensation not satisfactory as she would say she could or could not feel, apparently at random. Urine normal. A possible cause of the above attack was that her plans to run away had been frustrated.

The rapid respiration continued for about four weeks; some days she seemed better, others not so well. Attempts to catch her breathing less fast while asleep and off her guard, failed. She complained of a varying amount of pain in the pericardium. There was a very sensitive area near the apex of her heart. She complained of "pin pricks" in her fingers and toes. There were no convulsions after the first few days. She was up for a time but seemed so weak and miserable she was put to bed. Her appetite was variable. She gained in weight.

Oct. 22, she began by having a slight cough, then screamed with pain, clutched herself over heart, pulled and tore clothing. Stiffened out with paroxysms of pain. Respiration 92 and irregular. Cried out for her mother. It was rather difficult to make her answer questions. Hands and feet were cold, left lower chest very sensitive to touch. A consultation was called and she was etherized for diagnostic purposes. Under ether respiration became normal. Heart sounds were normal. During recovery from the ether she vomited an enormous amount of partly digested food, two hand basins nearly full. She was given a severe talking to on the error of her ways. There was no recurrence of the difficulty. We have no further history because she ran away, and, although she has been heard from several times, she has succeeded in keeping out of the way of the officers.

**Diagnosis.** An unusual hysterical manifestation, with acceleration of respiration to an extreme degree, occurring in a mental defective.

**Case 4.** E. B. Italian. Born April, 1896. Father alcoholic. Mother a spiritualist, in good health before E. was born. E. weighed four and one-half
pounds, normal infancy, had measles, chicken pox, German measles, whooping cough and hemorrhage from nose. Was not considered nervous. A friend of the family said that she remembered Elsie and that her bold actions were a menace to the neighborhood. She said she had fits in school. This is the only evidence that I have been able to get that E. had any convulsions, fears or hallucinations before she came to Lancaster.

Committed to Lancaster June, 1912. Was syphilitic, had gonorrhea and acne vulgaris. At this time gave a history of having had fits since she was fourteen years old. June 25, 1912, had tonsillitis. July 1, was found in a chair with head resting on window, unconscious. She remained unconscious for one-half hour, then had a convolution which left her dazed. She slept most of the afternoon. Following this she had one or more convulsions every day for seventeen days. As convulsions come on there are clonic spasms of the arms and legs, hands are clenched, thumbs inside; feet extended; her head is suddenly jerked back and to the right shoulder, the left shoulder drawn up. Her muscles then become set in the position in which she happens to be. One day her head was hanging off the bed when she became rigid, and when moved back onto the bed she was in opisthotonos. Left cheek is drawn in. When convulsions begin to pass off, patient swallows, hands and feet relax, eyes look first one way then another. She goes from one convolution into another. Has had three in forty minutes. During convulsions eyes are closed, pupils rolled up out of sight. When pupils can be seen they are dilated. When she recovers she begins asking questions. One day asked what time it was. When asked to say what time she thought it was, the patient answered correctly, although she had been having convulsions for two hours. At other times she seems dazed, mistakes people. One night fell and struck her head during a convolution. At another time her face was contorted and she looked diabolical.

July 17, during the rigid state of a convolution, ether cone was filled with ether and put over her face. After what seemed to be a long time the patient began to struggle. She was told that if she would straighten out, put head on pillow, and lie quiet the ether would be removed. This she did. She was given a long talking to, told that she could stop the convulsions and that she must or the nurse would give her something that would make her very ill. Every day for about a week she was told what would happen if she had any more convulsions. She has not had another and it is now eighteen months. Reflexes rather dull. Stands with eyes closed, but there is some unsteadiness, area of anesthesia varying, circulation poor. Passed the Binet test for ten years when she was seventeen years old.

Patient's own story. She does not know her father. Her mother has times of being dizzy, "is rotten inside," has had an operation. There is no one else in family who ever had fits. Since she was eight years old she has had attacks of nausea and vomiting. Since she was ten years old she has had cramps in abdomen once, twice or three times a week. She has had sexual relations with landlord since she was ten years old. He told her that she could get anything she wanted, at home, if she would have a fit. She did not know what he meant until one day she was picking lilacs, when a dog came up behind her and barked; this frightened her and she threw up her hands over her left shoulder. Her mother came to the door and cried out "Elsie is having a fit." She had her first fit the first day of her first menstrual period. She stooped over to tie her shoe string, was unconscious one-half hour. She was anointed by a priest. After this she had a fit nearly every day. Days she did not have one she was sick at night—buzzing in ears, dizzy, nauseated and, if she got up quickly, was faint. Attacks were worse and more frequent before and during menstruation. She was dismissed from school and lost places in which she worked on account of fits.
She does not usually know when an attack is coming on; occasionally her head gets dizzy, she feels as if everything was going around and as if she was going around herself. She feels as if she was going to fall forward but does fall backward. Once she fell on a stone wall and cut her head; at another time she bit her tongue. She has cut her nose and hurt her knees. At times she gets cold, at others hot, before an attack. She does not cry out, but occasionally tries to talk, this she is unable to do as her tongue is numb.

During an attack she does not know what is going on about her. One day she thought she saw her step-father, who is dead, in a casket of plaster of paris. She sometimes wets herself and occasionally her bowels move while unconscious. She bites her left cheek. She has been told that she frothed at the mouth, and that she gets yellow and black in the face. She never has a headache excepting when coming out of an attack, then there is a pain which feels as if something was pulling from one side of her head to the other, pressure causing it to become more severe. It is because of this pain that she grabs her head at this time. After the attack passes off she sometimes knows what is going on about her, at other times she feels dopy, numb or nauseated. She has had as many as four in one day. She woke up one night and thought there was a statue in her room; she tried to grab hold of it and grabbed the door. Another night she thought her sister came into her room; she tried to grab her, caught the lamp and set fire to the house.

She now says (eighteen months after the above was written, during which time she has not had any convulsions) that she had no fits before coming to the school, only faint spells; that her landlord had told her that if she did not like the place to have fits and she would get sent somewhere else. At first she made the fits, later she could not help having them.

Matron reports that she has improved. At first had tantrums, would swear, talk obscenely and threaten suicide if things did not go as she wanted.

Would take things which did not belong to her. She is an inveterate liar; she can do housework if she wants to, but requires a great deal of directing.

Diagnosis. Hystero-epilepsy occurring in a mentally defective, syphilitic patient.

Remarks. In taking the above history I tried not to suggest anything to the patient, and some of the questions I put in such a way as to draw out the opposite answer if her answer were suggested. I believe the history she gave me at first to be the correct one. This case shows, I believe, the evolution of the convulsive attacks, which were more or less deliberately induced at first, later becoming sufficiently established to require outside assistance to stop.


Family History.—Parents, brothers and sisters, intelligent and respectable. Father is much upset and discouraged by actions of A. Loses his temper when dealing with her. Strikes her and pulls her hair. Home conditions good.

Past History. She was put on probation between April 29, 1910, and June 6, 1911. A report of her probation covers fourteen pages. There were seventeen people interested in her besides the Children's Aid Society. She was entered at the Emerson College of Oratory as a special student, given lessons in music, instructed in voice culture, work was found for her in stores, etc. She was allowed to return home. She ran away, was with a theatrical company. She was restless and discontented, would not stay in any one place and her conduct with men was questionable.

She was finally sent to Lancaster on June 6th, 1911, as there seemed nothing else to do. Our experience with her was simply a continuation of what had gone before. At the School her conduct was good. She was intelligent, clean and neat. Seemed
quite superior in her manner. Was not much of a
worker. Cheerful at first, then became depressed,
feared she was going insane. Had times of being
apprehensive. She complained of nervous tension,
that she lost her self-control and said things she did
not intend to. At times she was told of things
she had said that she did not remember saying. She
frequently forgot what had happened during certain
periods of from one-half to three hours or more.
Never forgot her name. She found letters which
she had written that she did not remember writing
and that were not sensible, that is, they were about
things which had never happened. At one time, before
coming to the school, she thought someone was try­
ing to poison her by putting something into her food.
Soon after coming to Lancaster she was visited at
night by a lot of people, some friends, some other­
wise. She said that she attempted suicide once by
jumping into a river. Physical examination nega­
tive.

She was sent to the Psychopathic Hospital for
observation July 30, 1912. They report: “While
here she conducted herself in a fairly normal man­
er and observation revealed no evidence of any psy­
chosis, neither did she show any definite mental de­
ficiency. She impressed us as a rather peculiar, un­
stable girl and that her difficulties have been due to
her unusual temperament rather than to definite
mental disease. Her stories in regard to her deal­
ings with men of which you spoke seem to us un­
reliable and it would seem to us that untruthfulness
on the part of the patient would explain her sup­
posed difficulty much better than mental disease.
Our diagnosis was psychopathic personality.”

Sept. 26, 1912, placed at housework. Did very
well for a while. Began to be very moody and
depressed, at times hysterical. Expressed strong feel­
ing that the Almighty had planned her life work,
which was the stage. Dec. 13, 1912, place changed.
Started in doing very badly. Seemed to be dream­
ing most of the time. When asked why she did not
do better, said she was on the stage most of the
time acting heavy parts. When she played a happy
part everything went well. Her play at that mo­
ment, she said, was one in which she had become
engaged and her engagement broken, which meant
that she could do nothing well.

Feb. 17, 1913, home. Claimed to have been bitten
by a dog belonging to employer’s neighbor; brought
suit which she won.

May 9, 1913, threatened suicide at her place of
employment. November 29, 1913, permission was
given A. to go from town to town as a “crew man­
gager” for a periodical circulating company. Later
had an attorney arrested for seduction on promise
to marry, claiming that she was six months preg­
nant, and that he was responsible. Evidence was
given that she had been with other men, one of
whom she had attempted to blackmail; that she had
used morphine and been in the habit of drinking ab­
sinthe. A letter dated August 21, 1914, from a
commissioner of charities of a city in another state,
states that an examination disclosed that she was six
months pregnant and suffering from gonorrhea. He
also writes that she has no visible means of support
and in his opinion is a menace to society.

She was brought back to Massachusetts, and again
sent to the Psychopathic Hospital for observation.
They report as follows: “Mental examination—Pa­
tient is nervous and impulsive and inclined to worry.
Seems to lack ambition and sense of duty to other
individuals and the community. Psychological ex­
amination: Actual age of patient, nineteen
years; according to Binet, twelve and two-fifths years;
according to point scale, fifteen years. Patient
passes tests like any normal person, and gives no evidence
of deterioration or mental defect. Comprehension,
reason, judgment, planning and discrimination good.
Patient has well-developed learning ability and
remarkably good comprehensive memory. Construc­
tive and analytical ability is good. Planning is
very quickly done. Perception of form is adequate.
Apperception is good. Patient is well oriented, has
good general knowledge, and appears able to profit
by experience. Reads quickly and shows strong interest and good attention. As brought out by examination, the only mental quality that may possibly functionate to the disadvantage of the patient is a slight suggestibility. Diagnosis: Not insane, not defective."

Remarks. I believe that the diagnosis of psychopathic personality describes this case as well as any. Although, as is stated, she appears able to profit by experience, she does not seem to have so profited. I would like to raise the question of there being a moral defect in this case without there being an intellectual defect. I believe that this girl needs treatment, and that she should have custodial care. Attempts were made to secure treatment in sanatoria, but these failed as the authorities did not feel that they could control her.


Hereditary—Paternal: father and two paternal uncles, somewhat lacking in energy, but family shows an average of fair ability and industry. Maternal: mother hysterical, tuberculous; one uncle, sex offender; three uncles, tuberculous; one uncle and three aunts, neurotic; two great uncles paralytic; four cousins, sex offenders; thirteen cousins, tuberculous. All highly nervous and overbearing.

B. was from an early age very peevish and wilful, and everything that her mother and aunt could do to spoil her was done, partly because of their fondness for her and partly because there was no living with her unless she could run things. She was stuffed with candy and rich food, overdressed, and the household ordered completely according to her whim. They abetted her in deceiving her father and the teacher. In school, patient showed herself slightly below average in ability, was surly, deceitful, and cordially hated for her overbearing ways; usually chose rough and younger companions whom she could dominate. She had convulsions while teething, and later a severe attack of pneumonia. Later, when she grew very fat and clumsy, she was laced tightly in order to give her a trim figure. She then began to have fainting spells.

Her mother became very ill and they moved to a large farm, where she ran absolutely wild. Her mother died and she went to live with a married aunt, whose husband undertook to give patient some much needed discipline. She was a big, hoydenish girl, crazy to be on the streets with boys and rough associates, and refused to do anything at home but outwit and tantalize her uncle in every possible way. She kept the whole place in a state of upheaval; matched his profanity with her own, or, this failing, had a fit and thus got the desired indulgence. Her father sent her to his sister's in the country. Here they failed utterly to control her; she slapped them and pulled their hair or fell in a fit if corrected, and even threatened suicide. Her father married and tried to care for her at home, but she wanted to rule everything and everybody, refused to work or dress properly, exposed herself and talked foolishly. She canvassed several streets in Boston, begging. She represented herself as an orphan child, eldest of six.

Committed to the Boston Society for the Care of Girls, November, 1911. In the first place her conduct improved in every way. Transferred, because she proved "too great a strain." Tried in two other families, she showed herself irresponsible, bad tempered, subject to fainting fits and feigned attacks of acute indigestion. Imagined herself the victim of hatred and persecution on the part of her father and stepmother. Wrote letters to newspapers to arouse public sympathy. When reasoned with or corrected, threatened suicide. It was felt that she might be mentally unbalanced; was examined and pronounced sane.

Committed to Lancaster, January, 1912. At first she showed signs of improvement; was obedient,
neat in person and room, and worked well without supervision. After a few months all her old tendencies reasserted themselves. She was stubborn, incorrigible and disagreeable. In her violent fits of temper she once attacked an officer with a broom and another time bit an officer in the breast. She assumed a stiff shoulder. She was tried in several cottages, but her fits of insubordination became more and more frequent. In December she had a number of outbreaks, when she kicked and screamed for hours. These outbreaks increased in violence, she swore, scratched, bit and spit at the officers, kicked out the panels of the door, and used the vilest language imaginable. After some of the attacks would seem penitent and at times would go several weeks without an outbreak.

May, 1913, attempted suicide by hanging. May 18, 1914, was much disappointed because she could not fulfill a desired whim. Cried during the night. Seemed all right the next morning. Without warning she attempted to drink household ammonia; her mouth was badly burnt. After this was quiet until the next day, May 20, when she began to talk irrationally. Tore the shades from the windows, tore her clothing, made a mess of her room generally. Screamed, cried and laughed alternately. Passed into a state of sexual excitement as shown by her talk and actions. Said she had on a gown of Irish point lace, the material of which had been brought over from Paris by a friend. That she had made money to pay for it during the past few days by prostitution. Did not seem to know where she was, the month, the day of the week or the time of the day. The next day was quiet, would not talk, did not appear to know those about her; had written obscene words on the window. Taken to the Westboro State Hospital for observation and treatment; on the way seemed to come to her senses, recognized and talked with the nurse who was with her. Physical examination negative.

A report from the above hospital, dated Dec. 4, 1914, states that: "She has continued to have frequent outbreaks when she is very much disturbed, and these outbreaks seem to come regardless of outside circumstances. She showed many mental symptoms suggestive of dementia precox, as, for instance, recently during a disturbed period she repeated certain phrases over and over again in a stereotyped manner."

They made the diagnosis of imbecility, with psychosis.

Case 7. E. G. Irish. Born October, 1896. Father shiftless, alcoholic, insane. Mother alcoholic, sex offender. Two of mother's sisters alcoholic, sex offenders. Older brother has been in juvenile court and a younger brother in parental school. Home materially and morally bad. Hardly a week passes that the police are not called in.

E. worked in a store, was given a week's vacation on account of poor health, did not return. She arranged to go on the stage, but was prevented. She ran away from home repeatedly. Stayed for a time with an immoral woman; later went to a house of ill fame where she was found. She had had nothing to eat for several days. Her clothes were in a deplorable condition. She was found to have diseased lungs and was taken to a hospital. She was placed in several families, in all of which she was very rebellious and discontented.

She was sent to a trade school, went one day but would not go back. Drank the contents of a bottle said to be poison; was taken to the Emergency Hospital where she was unconscious about four hours. She made several attempts to take her life while at the House of the Good Shepherd, and at their request was examined by an alienist and sent to a hospital for observation. She worked at the Carney Hospital as ward maid for a few days. She left without telling anyone and carried off the key to the ice chest. Was found, brought back, given another trial, but only remained a short time. She was taken to the Boston City Hospital for observation; reported to be normal.
Committed to Lancaster, August, 1912. An attractive, ladylike, well-appearing girl. Seemed much superior to most of our girls. In sixth grade of school. We had been warned that she threatened to kill herself if she came to Lancaster; precautions were taken to prevent this. The second day she scratched her arms in what she said was an attempt at suicide. A few days later she was found in her room with a wet towel tied tightly around her neck. Was reported black in the face and unconscious. All attempts to arouse her failed. She lay quiet in bed with eyes open, occasionally winking but apparently not seeing. There was no response to any outside manipulation. Would not swallow. As her condition remained unchanged for a considerable time she was sent to a state hospital. Observation failed to reveal any psychosis and she was returned to Lancaster.

She was placed in a family, but did not do well. Was arrested for being drunk and disorderly. The officers were frightened by her repeated attempts to take her own life and her irresponsible behavior. She was sent to the Psychopathic Hospital for observation and for the fourth time declared not insane. Sept. 10, 1913, was discharged by the trustees of the Lancaster School as an unfit subject. Returned to care of her guardian.

A report from the Psychopathic Hospital states that: "Probably her suicidal attempts are not due to a psychosis, but result from an emotional crisis. She is not insane. Psychological examination: Binet test, does the twelve and fifteen year old series. This is better than you would expect, because the most noticeable thing about her is her inability to learn from and profit by experience. She is suggestible, follows the path of least resistance.

"Diagnosis. Not feeble-minded, but subnormal. Within the border-line of defective delinquent."
On her arrival at Bedford she used the same tactics as at Lancaster, immediately barricaded her door and broke everything possible. Everyone worked with her and for her, but she grew more unmanageable and finally, considering the case a hopeless one from their point of view, she was committed indefinitely to the Matteawan Institution for the Criminally Insane.

She was returned to Massachusetts and sent to the State Infirmary for observation. In response to a letter of inquiry, I got the following: 

"She was seen by alienists and considered non-committable. While in the insane ward she was quiet, indolent and lazy, but caused no special trouble. She very frequently had outbursts of temper. Used profane and obscene language as well as attempting violence. As far as I can ascertain she would seem to come more directly under the classification of moral or constitutional inferiority."

Case 9. S. N. Colored, illegitimate. Born January 23, 1901. Was committed to Lancaster November, 1911, on complaint of principal of school. She did not do well in her studies, disturbed the school; a very bad influence on the boys and girls in her room. Would run away and frequent disreputable places of amusement, continually stole. She has shown immoral tendencies since she was three years old. December, 1911, passed the Binet test for ten and one-fifth years (was eleven years old). A small, undeveloped child, has a congenital cataract and weak arches. In the school she has been a very difficult child to manage. She has lived in four different cottages, in each of which she caused so much disturbance and was so insubordinate that a move was necessary. She is very unclean, even filthy; a constant bed wetter. She has an extremely violent temper and invariably when corrected threatens to commit suicide.

Her language at such times is most profane and obscene. She will throw herself on the floor, kick and scream. On several occasions she has spit in the faces of officers. At one time she bit the neck of a girl who came to the assistance of the teacher she was attacking. When shut up in her room during one of these outbreaks she looks more like an animal than a human being. At times she crouches in a corner of the room, her small shining eyes following whoever may be in the room, as if ready to spring on them, her hair pushed up until it stands from her head in disorder, her expression demoniacal. During these times she will not answer questions. The room is in disorder. Everything that can be has been smashed and the litter strewn about; windows broken, hooks pulled from the walls, base boards smashed, her clothing torn, curtains, bedding, etc., in shreds. Again she will pound, scream, shout obscene sentences and make everyone within hearing uncomfortable. She usually has to be carried to her room. She will kick, scratch and bite while being undressed. Without provocation she will hide under beds, in dark closets, in the coal bin or the ash bin and refuse to come out. She will not comb her hair, brush her teeth or clean her room without strict and oftentimes strenuous supervision.

One report reads: "She is extremely disagreeable and insolent, in both manners and speech. Not a day passes but that she refuses to do things she is told to do, but when told not to do the same things she will immediately do them. Sometimes she will refuse to obey and will go and lie under a table or go into a closet. She is often reported from school for various misdemeanors. At times she refuses to answer to her own name and will only answer when called by her teacher's name. Whenever punished she will refuse food in any form for days."  

Another report says: "She is mean and deceitful, is a continual tale bearer and so a constant troublemaker among the girls. Her work is slack. Shows no interest or desire to learn to do better, is very untidy and dirty. Mentally—average, but slow. She
usually has an outbreak just before the menstrual period; during the period she is more amenable than at any other time."

The superintendent writes: “There is very animal-like in all her habits and has shown absolutely no improvement since she came to the school, so that we feel it would be impossible to place her. On the other hand, she has a most demoralizing influence in the institution and we have accomplished absolutely nothing by way of reform in the three years she has been with us.” I have never been able to satisfy myself that she has any false ideas. She can be made to behave for a short time by telling her that she will be sent to an insane hospital or that some surgical operation will be performed on her if she does not mend her ways.

*Diagnosis.* Defective delinquent of the explosive type.

There is no question in my mind but that in our work with mental defectives we have an irregular development to deal with. In many cases there is a defect of all the mental faculties; in others, many of the mental faculties are sufficiently developed to pass for normal, while other faculties are defective or have never been developed. Many intelligent people find certain things much more difficult to master than others,—language, mathematics, music. Many masters of finance do not have the same idea of right and wrong as does the average person. How much more marked may the unequal development be in the unintelligent and the defective? We should not expect a child brought up in a family where promiscuous sexual indulgences are common, and where getting caught is the only crime connected with thieving, to have the same standards of morality as one differently situated. It is oftentimes difficult or impossible to determine whether we are dealing with a defect or whether the apparent defect is due to a lack of development, and if the latter, whether there is a possibility of developing the desired faculties.

The Binet and other psychological tests fail, I believe, to differentiate many of the high-grade defectives. The defect has, in some cases, to be determined by observations of some length. A carefully kept history of the transgressions is, I believe, important in determining whether a defective delinquent should be allowed to live in the community, or not. Engrafted upon, or because of, the defect we often have a psychopathic condition.

The above cases differ one from another in many ways, but they have certain qualities in common:

First, they are all delinquents. They have been judged and committed as such by the courts.

Second, they are only partially responsible for their acts, and have no relatives or friends who are able to control them.

Third, the hysterical symptoms, the exaggeration of symptoms due to physical defects and the simulations of disease oftentimes increase their inability to compete with other more fortunate individuals in earning a living.

**Conclusions.**

First, they are a prolific source for the spread of venereal diseases.

Second, their children will undoubtedly be as abnormal as the mothers, or more so.
Third, they do not belong in a reform school, as they cannot be reformed. They upset the discipline, and are a detriment to the best interests of others who can be helped.

Fourth, they do not, with one exception, belong in an insane hospital or a feeble-minded school. This, I believe, has been proved by the repeated terms of observation in insane hospitals and wards which the more questionable cases have been given.

Fifth, the expense of proper custodial care would be much less to the state than under the present unsatisfactory system when we consider the time taken by the courts, probation officers, police, their intermittent control in more expensive state institutions, etc.

H. G. Wells, in his book entitled "Marriage," makes the leading character refer to what he calls a "Gawdsaker." When asked what a "Gawdsaker" is he says, "He's the person who gets excited by deliberate discussion and gets up wringing his hands and screaming, 'For Gawd's sake let's do something now!'" Without being a Gawdsaker, I believe the time has come when we should ask for custodial care of the more definite cases of the type given above, and if we decide on some definite plan and all work for the same plan, I believe we can get what we ask for.

Note.—Chapter 595, Acts of 1911, providing for the maintenance at the Reformatory for Women, the Massachusetts Reformatory and the State Farm of departments for defective delinquents. Section 12. "This act shall take effect when the departments named in Section 5 are ready for occupancy. The prison commissioner and the trustees of the State Farm shall notify the Governor when said departments are in a suitable condition to receive inmates; and the Governor may then issue his proclamation establishing such departments as places for the custody of defective delinquents."