Commentary: The Lucid Interval—Coping with Unscientific Terminology

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The authors agree with Shulman *et al.* in their assertion that the term "lucid interval" does not describe what is now known to occur in the fluctuating mental status of some demented individuals. Therefore, its use by the courts to determine competency in such persons can result in an unjust outcome. However, we believe such criticism as Shulman and his coauthors levied at the legal profession should be broadened to consider antiquated and nonscientific terminology in our own field of psychiatry.

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Dr. Shulman and his coauthors[1] present an interesting twist on a long-standing question: does the use of certain incorrect or inadequate terminology, especially across the professions of law and medicine, actually hinder the ability of courts to render a reasonable and fair decision? The term under scrutiny is "lucid interval," as it relates to testamentary capacity. As Shulman *et al.* point out, the lucid interval is not a scientifically accurate term and does not describe what actually occurs in the various forms of major neurocognitive disorder, formerly called dementia. A severely cognitively impaired individual may act in a very compliant manner and be superficially pleasant, but may have very little grasp of his present situation or the identities of his caregivers. This presentation, particularly if the individual is generally loud and disruptive, can be misconstrued by lay persons as a lucid interval. He may seem to be "with it," to use a lay term, for a brief while, but an examination by a skilled expert in geriatric psychiatry shows him to be lacking in comprehension.

As correctly pointed out by Schulman *et al.*, attorneys, even experienced estate attorneys, cannot be relied on to be impartial scientific experts when interacting with these impaired individuals. The authors illustrate that the term lucid interval does not describe the cognitive fluctuations seen in various major neurocognitive disorders. It implies a temporary improvement in comprehension, but research has revealed that cognitive fluctuations are short-lived improvements in alertness and attention.

In the *McPhail* case, Shulman *et al.* demonstrate that the concept of the lucid interval was used to try to uphold a will disinheriting one sibling, while leaving all of a father's assets to the other sibling. Fortunately, the court listened to the medical experts' opinions that the level of the father's neurocognitive deterioration was such that a lucid interval was not possible.

At the beginning of this commentary, we stated that an underlying concern is one of unscientific but commonly used terminology, essentially inhibiting, rather than assisting the courts in their determinations. The inhibition occurs because the terminology is based on inaccurate suppositions.

This problem of unscientific but commonly used terminology unfortunately is also present within our specialty of psychiatry, in addition to being problematic across the lines of psychiatry and the law. One of the primary examples we can think of is the use of insight in the Mental Status Examination. The current edition of *The American Psychiatric Publishing Textbook of Psychiatry*, published in 2014, contains 1473 pages. Insight, which appears in almost every formal mental status examination that we have seen, is listed as one item in Table 1.6 (Ref. 2, p 23) as part of the Mental Status Examination. It is defined as the following: "Insight refers to how well the patient understands her own current psychiatric situation; it does not refer to insightful perspectives on politics,

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sports or the interviewer" (Ref. 2, p 27). That statement is all there is in the latest, purportedly authoritative textbook that residents and medical students read to learn the latest and greatest information in our field. This definition is almost identical to the training both authors of this commentary received 40 years ago into patient insight. Despite all the advances in neuroimaging, neuropathology, neurotransmitters, and neurophysiology of the past four decades, we still lag behind by using early to mid-20th century terminology that is ill defined, questionably scientific, and probably in need of replacement with other concepts that incorporate real scientific knowledge about brain function, and what such a function indicates. A similar criticism can be made for "judgment" which is defined in this same text as: "Judgment is often extrapolated from recent behavior or by asking such questions as 'If you were in a movie theater and smelled smoke, what would you do?'" (Ref. 2, p 27). Again, this statement is the extent of the discussion. To be rather concrete about this definition, many millennials do not go to movie theaters, preferring to get their entertainment online. They may have no frame of reference regarding movie theaters and the appropriate behavior in this venue. Also, "recent behavior" may have to be viewed through cultural norms and socioeconomic class, which may differ between examiner and examinee. Again, this definition is hardly scientific and can lead to confusion and bias toward clinical patients and forensic evaluees. It should be noted that there is a 50-page chapter in this text on laboratory testing and imaging studies. Clearly, however, these tests and studies have not improved our definitions of insight and judgment from the time the authors of this commentary were trained.

Certainly, the most remarkable example of cross-discipline use of inaccurate terms is the term "insanity," which has had little or no scientific meaning in medicine since the early 20th century, before which it was widely used in medicine and law, although not without dispute.[3] As Professor Tighe points out in her elegant article, "What's in a name? A brief foray into the history of insanity in England and the United States," there has been a "transformation of the term insanity from a creature of medicine into a creature of law" (Ref. 3, p 253). As many psychiatrists know, the *American Journal of Psychiatry* was originally the *America Journal of Insanity*. As Professor Tighe so correctly points out, use of terminology derives from function. In law, the function is to aid in legal proceedings; whereas in medicine, the function is diagnosis and treatment. There cannot help but be a dynamic tension between the two. In the use of the term insanity, we see that the law has not caught up with advancing knowledge in brain biochemistry and physiology.

Similarly, the use of lucid interval also does not reflect current advances in geriatric psychiatry. There are four key elements of the "dementia syndrome: cognitive, global, decline, absence of delirium" (Ref. 4, p 101). This concept is not widely appreciated outside of the psychiatric community, not even in some other medical specialties in our experience. Perhaps the concept of the lucid interval originated with the observations of delirious individuals, at a time when delirium was not recognized as a separate entity from dementia, now known as major neurocognitive disorder. Whatever the origin, we agree with Shulman and co-authors that the term lucid interval should no longer be used. Before that is accomplished, however, education of attorneys, judges, and society at large on the nature of major neurocognitive disorder must continue and increase. We must also look within the field, as discussed above and make sure that the standards we set for others are the ones we follow ourselves. Regarding the lucid interval, cultural concepts die hard, and it will take concerted effort on the part of geriatric experts and their supporters before this term is properly abandoned.

References

1. Schulman KI, Hull IM, DeKoven S, *et al*: Cognitive fluctuations and the lucid interval in dementia: medicolegal implications for testamentary capacity. J Am Acad Psychiatry Law 43:287–292, 2015
2. Barnhill J: The psychiatric interview and mental status examination, in American Psychiatric Publishing Textbook of Psychiatry (ed 6). Edited by Hales R, Zudofsky SC, Roberts LW, *et al*. Arlington, VA: American Psychiatric Publishing, 2014
3. Tighe J: "What's in a name?" A brief foray into the history of insanity in England and the United States. J Am Acad Psychiatry Law 33:252–8, 2005
4. Lyketsos C: Dementia and milder cognitive syndromes, in Clinical Manual of Geriatric Psychiatry. Edited by Thakur M, Blazer D, Steffens D. Washington DC: American Psychiatric Publishing, Inc., 2014, pp 99–123