HYSTERIA

THE LIMITS OF STUDY

It would appear as if Hysteria like diseases with a wide denotation might permit of some liberty in the choice of treatment. That liberty might extend to a doubt as to whether one should take up either some aspect of the disease or whether, one should not try to relate the various aspects in an intelligible manner.

One is forced to conclude with regard to Hysteria that we are not in the position to select at will any one aspect nor does it appear as if one could construct, with the facts we have, an inteligible system out of these aspects.

The Immaturity of our knowledge in all branches of Hysteria determines our choice. Enquiry seems to rest content with the Aetiology , the Symptomatalogy and the Psychology of the disease

To indicate our difficulty take the first of these Aetiology , the family history of this disese affords us very little information, one can shuffle the ancestral predecessors with those of Neurasthenia, Psycasthenia and even definite mental disease.

We may find nothing at all in the family history, but where there are family taints, the variants are too many to permit of a classification sui generis.

This lack of definiteness to some extent indicates an impossibility of finding precise anatomical lesions and ~~th~~ this is borne out by autopsies. Pathological enquiries of this kind are daily in progress in the great institutions for Hysteria, nothing rewards investigation. The finer mechan-

ism is retained, there is no gross brain lesion, nor can we expect it in cases of mental anomolies of this type.

It is the custom however, to make a profession of faith as to the ultimate physical resolvability of all mental ailments and, in passing, to state that the word functional in the phrase "functional diseases" is also ~~xxxxx~~ a phrase of temporary descriptive convenience. According to all authority we seem to be as far from determining the physical relations as the physicist is from deciding what change occurs in soft iron after magnetization.

Most of the enquiry turns therefore on the question of the physiological and psychological aspect, and the task might now be simple, but for the difficulty of circumscribing the disease, and, indeed, of even always diagnosing it. We are not always in a position to say what is and what is not Hysteria, still less can we say what is and what is not hysterical. The errors of medical and surgical, particularly of gynecological

diagnosis and treatment point a warning. The present tendency is to regard with suspicion innumerable complaints and symptoms which were once entirely within the province of somatic specialists. In a recent number of the "Presse Medicale", Mons. Dejerine discusses the special liability not only of the stomach, but of the intestines to hysteric affection. Gastric troubles, acid and atonic dyspepsias, apart from the well recognized symptom of hysteric vomiting, are maladies which he thinks are not to be dismissed offhand as local organic lesions, they must be examined always in relation to the psychological system of the patient. Dr. Robert Hutchison in an April number of the "British Medical Journal" acknowledges much the same thing.

In reference to the question of what is, and what is not hysterical, i.e., in reference to its frequent association with organic disease, it seems hardly possible to determine its limits. The increasing evidence of all the faith-healing bodies indicate the presence of hysteria everywhere. It would be interesting

to know how often the old family practitioner discounts the hysterical taint and discounts it unconsciously in his diagnosis of some of his patients, and how much his success, and the trust placed in him, depends upon this apparently effortless and unconscious elimination.

It is foreign to the vast number of those engaged in general practice to actually recognise this factor in disease. Where they acknowledge its existence they are inclined to ignore its importance, in other cases where they recognize the part it plays, they are disgusted with it as obscuring their work, and still further where they recognize it and deal with it they do so not without some reproach feeling they are treading very near to Charlatanism. The latter feeling is not unnatural, the immaturity of our knowledge, our inability to classify it, with its simulation of, its complication with other diseases, with its astonishing will-'o-the-wisp character of appearing and disappearing and its protean varities, with its unamenability

to the orthodox treatment of drugs and potions and of surgical treatment, all go to make it appear as if no special demand on the skill of the attendant was required. The consequence is that the study appears to have been given up in the past either to specialists or faddists. Now, however, that the foremost of the medical profession, not merely alienists, but nervous specialists are everywhere investigating it and treating it, there is some prospect of obtaining the support of the general practitioner, who will naturally be able to supply a vast amount of useful information. The clinical observation of cases, however, and their interpretation must lie with those who have opportunities of a wide experience.

It shall be my purpose to confine myself to the psycholigical aspects of Hysteria and to introduce other considerations only where relevant to my point of view, I shall use material recorded in the wards of Dr. Alexander Bruce of the Royal Infirmary, Edinburgh, some observations of my own in the wards of M. Dejerine at the Saltpetriére with a view to bringing out the purely

psycholigical aspects. I shall refer to M. Janet's work on this side of the matter and with all respect criticise some of his views, with regard particularly to his interpretation of "Retraction", "Dissociation" and the place of Hypnotism in health and disease. Nothing illustrates the psycholigical aspect of Hysteria so much as a study of, and a comparison with Neurasthenia. I propose to give this point full consideration.

We are usually supposed to deal with something particularly highly organized when we deal with Hysteria, it is thought to accompany a very delicate nervous organization and in support of this we are referred to the frequent association of hysteria and genius, ~~xxxisxxxxx~~ Such a combination is seen to flourish in arts and music. There is no direct causal agency, as far as one can see between the hysterical temperament as such and any intellectual gifts, they are probably coincident features. Nevertheless, something marks the work of hysterical genius and it is the strong affective

tone which linked with other qualities marks his work as "neurotic" and frequently as markedly "original". This affective tone I shall lay stress on later as being the factor responsible for the development of the stigmata and mental dissociation. Hysteria is ~~really~~ rarely associated with what we usually mean by logical, moral and social sanity and the reason is this very preponderance of affective tone, which does not permit of systematised thought and action, it has always a tendency to run to the ~~bazare~~ bizarre, to the unrestrained.

In comparison with psycasthenia and melancholia hysteria also has its fixed ideas, but these ideas are not perversions in the psychic sense; they are usually individualistic, they are never anti-social. The symptoms though they are destructive of self by their persistence as in vomiting to inanition, yet are accidental features, they are not part of the mental content, of the hysteric as they are of the psycasthenic, the melancholic and occasionally of the neurasthenic. In a number of ways ~~the~~ hysteria differs psycholigically from

these diseases but it seems hardly useful to discuss more than one of these, i.e., Neurasthenia.

NEURASTHENIA AND HYSTERIA.

The confusion between Neurasthenia and Hysteria until cleared up will continue to obscure the truly nervous character of the one and the psychic (for want of a better word) character of the other.

Neurasthenia, is often used, as an euphemism by the medical man indifferently to anything with hysterical or neurasthenic features, partly because it is a modern medical term, partly through ignorance of the distinction between hysteria and neurasthenia, and sometimes to avoid ~~the~~ wounding the feelings of the patient and the patient's friends. The popular usage of the word hysteria gives it a meaning which is uncomplimentary to the "morale" of the person to whom it is applied, for it is frequently meant to signify a lack of self-control. Then hysteria has been used with reference to fits or crises only; now, while the crises or the fits are recognised as an undoubted sym-

ptom of hysteria it is perhaps of the least psycholigical interest inasmuch as we are unable to explain them psyiologic-ally. The fit presents an appearance of tremendous physical turmoil, but rarely is it actually harmful to the patient. A patient I observed at the Saltpetriére passing through such a crisis, which always occurred on the inhalation of tobacco fumes, displayed the greatest motor agitation, the gravest dyspnoea, but no ill effects were observed. This patient was discharged cured, illustrating the old adage that

"Natura morburum curationes ostendunt",

for the treatment was nothing but the usual isolation method. Now we can exclude at once the crises or fits and despite our using the term hysteria for such, for no one could possibly speak of a fit as neurasthenic. The difficulty comes in with other symptoms such as contractures, tics, anaesthesias, paralyses and so on, for if neurasthenia is taken to mean nervous exhaustion these symptoms do not indicate that condition in the least possible degree

A continued hysteric contracture, fatiguing and indeed impossible to a healthy subject, is hardly likely to characterise a condition of nervous exhaustion or a disposition, the most susceptible of all to fatigue. Now, irritability and exhaustibility are together a syno nim for neurasthenia, these are not terms which we can apply to hysteria. Some light may be thrown on the nature of neurasthenia if one compares its aetiology with that of hysteria. Is neurasthenia a manifestation of an actual congenital defects or is it the result of a manner of living? This is an important question from the point of view of the prophylaxis of these two diseases. Anticipating, we may say that while there may be a neurasthenic predisposition, it is not the chief feature for we find that neurasthenia can be developed in almost all subjects given the "milieu". Hysteria owes practically nothing for its development to any specificmanner of life or any specific agent, that which has the very remotest association with some emotion the most trivial thing frequently acts as its exciting cause, and so the predisposition is its distinguishing feature

II.

Now the patient who develops neurasthenia may appear entirely free from all mental or constitutional defects; the disease occurs very definitely, frequently after long and fatiguing occupation, after a moral or traumatic shock, and sometimes after acute and chronic affections which render the subject so liable to fatigue. M. Raymond speaks of neurasthenia as a diminution of nervous tonicity "de la tension nerveuse", and that it displays itself as a marked tendency to fatigue, making every effort painful or impossible, by pain in the head and the bones, by insomnia, by various digestive disturbances From the point of view of psychic life it shows itself by atrophy of attention, which prevents sustained mental occupation, by listlessness and morbid introspection.

Dr. Alexander Bruce in addition to this fatigability lays stress on irritability. Now a word in regard to the irritability of neurasthenia and of hysteria, for they are not the same thing. The Hysterique is not irritable, he is hyperaesthetic frequently, hyperaesthetic in the

strict sense. The hyperaesthesia of the Hysterique moreover is not general, it may mark a special or a "general"sense , it is frequently accompanied by a disappearance of one or other sense or a diminution in the range or acuity of one or other sense. Hyperaesthesia is found particularly in the condition of hysteric sonambulism. Hyperaesthesia here in its true sense means an acuity exceeding that of the normal subject, i.e., the sense appreciates what is usually subminimal. A recent and interesting case was reported in the March number of the B.M.J. by Dr. Russell. It is the case of a patient addicted to sleep-walking. In this condition the patient performed feats of crochet, needlework and handwriting perfectly impossible to her in the waking state, for they were done practically in the dark. There is a vast collection of similar cases reported, all showing this curious hyperacuity of someone or other sense. The irritability of the neurasthenic is not hyperaesthesia in this strict sense, the neurasthenic is never known to have acuity as a feature of his disease,

there is with him no increased appreciation of what is usually subminimal sensation. What is present in the neurasthenic is the irritation he feels, when light or sound etc., go beyond a certain degree of intensity, that is, certain stimuli of a certain intensity have a painful quality for him. There is no increasedacuity here, no extension of the field of sensation in some one particular respect . Now this irritibality of the neurasthenic as distinct from the hyperaesthesia of the hysterique is not anything different in kind from normal experience. Most stimuli for the normal healthy subject become painful beyond a certain degree of intensity, and the only difference between him and the neurasthenic is that the painful quality of sensation sets in earlier, in fact inthe neurasthenic we have an actual diminution of the analgesic sensorium, ~~that part of it which is free from pain.~~

The feature of irritability has been called the irritibality of weakness "La faiblesse irritable". The neurasthenic is of course irritable in a complex way, also, he is rendered crazy by a variety of things like the dripping of water, the constant opening and closing of doors and so on, these are not feature of hysteria. The hysterique responds to certain stimuli, not on account of their purely physical ability of causing sensation, a crisis readily occurs on the presentation of a trivial, but specific stimulus, a certain odour, a certain sight or sound.

(The sight of a flame, sometimes of a match only, brings about the fit with all subjects who have been affected by a conflagration; any cry, or name, or sentence, will call it back with others. Our woman with a dog is admirable in this respect; it is enough that a dog barks in the street, she sees a cat pass by, the name of one of the animals is pronounced, or even certain words are pronounced, the use of which she absolutely forbids, as the words "love," "affection," "happiness", etc. It is enough that the date on the calander be mentuoned before her, for the fear of remembering a certain date has caused her to forbid all possible dates. The least thing is enough to bring about an endless fit in which convulsions and howlings mingle together for fifteen or twenty hours.

Observe in passing that there is moreover very little apparent fatigue residue to a crisis, no great physical disturbance afterwards, there is not the stupefaction, the listlessness, the fatigue, one would naturally expect. M. Janet, refers to one hysterique who after, howling for several hours feels rather comfortable. We have an entirely different response to stimuli in the neurasthenic, who responds not only to a specific kind of stimilus when it has obtained a certain degree of intensity, and then the irritability is of the same kind as the irritability of a normal subject, to what is for the latter a too intense light or sound. The neurasthenic reacts

in a normal manner, there is no complicated emotion in the action, he expresses or shows pain, and tries to avoid a repetition of the experience. The hysterique may behave in regard to stimuli except some specific one perhaps just like a normal subject and he may have even less sensitivity to them. The hysterogenetic zones in the hysterique do not confuse the issue between the two diseases for here also there is specificity of sight etc. Now hysteria and neurasthenia are essentially distinct, but that does not imply that they are not sometimes associated in the same person, fortunately, an exact estimate of each is not needed except for purely scientific reasons, and prophylaxis. Of course, the presence of a depressive mental states in neurasthenia would naturally require a modified treatment otherwise the treatment is the same in both. Pure neurasthenia, as such, is a curiously simple disease with really no symptoms which require psychological analysis except when it develops into the more morbid mental conditions. It has frequently been remarked that neurasthenia supervenes on gross brain lesions. Dr Raymond points out that it often supervenes on Tabes, G.P., disseminnated sclerosis, and a curious thing to note is the fact that these diseases are all to a certain degree, confusible with hysteria. A valuation of the parts played by neurasthenia should not however be difficult, in the above cases it must often be due to the emotional arising from a knowledge and fear of the organic

disorder.

Neurasthenic cases when uncomplicated, are almost monotonous, in age, aetiology, symptoms and progress, all show some difference from hysteric cases. Contrast the age, the known causal agencies,—so important in neurasthenia so trivial in hysteria; the symptoms, the onset and progress.

A word in regard to causal agencies I have suggested how extremely difficult it is to understand the relation of cause and effect in hysteria, indicating the reason as being due so much to the part the "personal equation" plays, so little to the part the exciting cause plays. This aspect of neurasthenia can be dismissed in a few words. You can find the symptoms of the neuranthenic almost always indicating the causal agencies, you can tell the neurasthenic clerk, the reader of proofs, for the symptoms are selective and refer to their employment. In women the symptoms are less precise, less localized, she usually complains of "general weakness", pains in the back; these are the statements which fall with monotonous regularity from the lips of, c.g., housewives. The pains in the back have by the way no special significance there are always a symptom of exhaustion even in the healthy. The reason of the difference between these cases is obvious, there is no division of labour for the housewife, her tasks are varied and offer less opportunity to a selective fatigue. Where women do follow depart-

mental work, we find that neurasthenia is made evident with her as with the bulk of men. We have a remarkable number of instances among such selective workers as typewriters. The keys of the machine evade her, she is utterly unable to place her fingers on them, the print dances before her eyes, and this disturbance may not extend to any other task, unless the condition is far advanced. The significance of fatigue in the neurasthenic is extremely important to insist upon here, it is a fatigue of nervous origin, attending tasks which require attention and consequently a good deal of physical expenditure of energy. What happens is that there is an accumulation of fatigue products. There are cases of neurasthenia which appear to be due to other causes. M. Raymond has drawn up a complete list of them in his chapter on neuresthania, in his " Nevroses et Psycho-Nevrose"

(Il peut être aidé, dans son action novice par une série de causes agissant dans le même sens, en modifiant les conditions normales physiologiques du fonctionnement du système nerveux; c'est le cas pour tous les poisons exogènes:morphine, codaïne, alcool, tabac, plomb, sulfure de carbone, etc, pour tous les poisons endogènes, ceux résultant des maladies infectieuses, en particulier de la grippe, de la malaria, de la fièvre typhoïde, de la syphilis, de la tuberculose etc, comme ceux produits par l'organisme lui-même, dans la goutte, le diabète, etc. Il en est de même d'une série de maladies organiques, les unes ayant pour siège direct le

système nerveux: tabes, patalysie générale, sclérose en plaques, etc; les autres ne l'atteignant que secondairement; ainsi, le rhumatisme chronique, l'artério-sclérose, les diverses viscéropathies organiques (ptoses et autres) en particulier celles qui débilitent l'organisme, y compris le système nerveux.) All may disturb the nervous economy.

The most interesting and the most debated question is the causal agency of Shock in neuresthania. Now there is no doubt that a great shock of any discription, as well as any trivial specific agent, betrays the hysteric, some typical hysterical symptom always develops as a consequence. (A man travelling by rail had done an imprudent thing ! when the train was running he had got down on the step in order to pass from one carriage to another When he became aware that the train was about to enter the tunnel it occured to him that his left side, which projected, was going to be knocked slantwise and crushed against the arch of the tunnel. This thought caused him to swoon away, but happily for him, he did not fall on the track,but was taken back inside the carriage,and his left side was not even grazed. In spite of this he had a left hemiplegy.)

Now these cases should be kept apart from neurasthenic cases, the development that occurs indicates whether we have a neurasthenic or a hysteric.

Did neurasthenia develop immediately on recovery from

Shock there would not be no medico legal problem turning upon the question of malingering. It happens however that in a large number of cases an interval elapses between shock and the development of neurasthenia, an interval in which the subject may resume his usual duties. It may be not for a week or a fortnight later, that the patient begins to talk of pains in his back, of inability to do his work, & to keep his attention on his work, of lassitude, in fact all the symptoms we find in the housewife, possibly aggravated.

Why do not these symptoms supervene immediately? The reason surely is that here we have a nervous disturbance, a molecular change in the nerve cells, and not necessarily an actual expenditure of nervous energy, no fatigue products present to make the individual ~~sensitive~~ conscious to his condition. What happens then on the resumption of work is that the cell disturbed in its economy cannot keep up to the ordinary demands made upon it and ~~so there accumulates the fatigue products~~, there is an increase of nervous Katabolism over Anabolism and which awakens the symptoms precisely in fact the condition we find in typical neurasthenia. The ordinary work may thus be the means of betraying the lack of nervous equilibrium, of nutrition. The usual cause, overwork, is only a longer road to the same goal, the cell is not allowed sufficient time for recuperation, it is in fact lowered in vitality and cannot keep up with the demands made upon it. In conclusion the general symptoms of neurasthenia are immediately due to the

to the circulation of fatigue products.

All these facts point to the essential difference between neuresthania and hysteria. In the one case we have a known physiological cause operating, in the other we are still at a loss to know what is ~~kkk~~ wrong, whether in the cell or associative ~~parts~~ this, but it does not appear in hysteria to be due to an expenditure of nervous energy, of intoxication or lowered cell vitality.

The uncomplicated case of neurasthania shows no dissociation, the symptoms of insommia, gastric trouble etc., are all of the same nature. One must not forget however that neurasthania may be aided in many indirect ways, by the carelessness of the subject in regard to hygiene and food, errors of dietary; hasty irregular and indifferent meals act directly and indirectly, act directly by causing gastric trouble, indirectly by diminishing the available nutrition and reflexly on the stomach again by a lowering of organic tone, in fact a nervous circle.

- I -

THE PSYCHOLOGICAL ANTECEDENTS OF HYSTERIA

The symptoms of hysteria, as distinct from other diseases, are so diverse, so varied in character and degree and locality, that by themselves we could never obtain any symthesis and speak of a hysterical diathesis. Still we find certain common features called stigmata, revealed not always by the patient's complaint, but often only by examination. These symptoms in their local sign cease to have a diagnostic interest upon the general disease, but are interesting in as much as they tell us sometimes something about exciting causes, it may be, suggestion, or accident etc.

There are some symptoms which are seen to be in accord with the mental state of the subject for instance., the frequent resistance to nourishment, associated with the wish to arouse sympathy, or after any accident without trauma, the patient imagines (e.g., his limbs to be paralysed. So often is this the case that some observers like Bernheim, have declared that the symptom is

always the expression of the wish of the patient or what is suggested to him. On the contrary there are such a vast number of cases where it is utterly impossible to see any connection with the volition of the subject and other symptoms of which the patient must be ignorant, that we are therefore disinclined to place much importance on the patient's volition or the conscious expression of the patient's desires. The anesthesias are often discovered by the clinician only, and are unremarked by the patient. Another important fact in this connection is the indifference of the patient when told of some anesthesia. Now if the patinet's mind and the whole of the sensorium (psychological sense) were in organic unity, there would be a distinct sense of failure, of annoyance if some portion of the perepheral apparatus broke down. If a normal subject sees an object, puts out his hand to grasp it and fails to feel that object there is a distinct shock; but in hysterical cases this happens continually, stimuli are observed by the patient to come in contact with an anaesthetic portion of the body and yet no sense of failure or shock occurs. We shall

endeavour to show later that it is due not to a perepheral or known nervous lesion but to a lack of the organic unity between the personal Ego and the sensorium.

A case noted by M. Janet illustrates this point. "A young girl of about twenty had met with a rather serious accident; She fell through a glass door, and a piece of glass cut into her right wrist just below the thenar eminence. The hemorrhage was stopped, and the wound had united fairly well when, a few days after the accident, the young woman presented herself for treatment. She experienced a certain numbness in her right hand, but no paralysis was present. She complained particularly of a persistent sensiblity, most inconvenient, in the palm of the hand; this slight anesthesia about the fingers was in fact complete at the level of the thenar eminence. The case was evidently one of a more or less complete severing of the mediam nerve, and especially of its superficial branches. But while accepting the observation of the patient, we made a singular discovery. She was a hysterical, and on her entire left side she was completely anesthetic, of which fact she had not said a word. "

Note in the above connection the fact, that ehre at any rate, the anesthesia was not likely to have been produced by the examining physician, for we have a definte local anesthesia in the injured hand. If anesthesia were developed by the girl's volition through a suggestion in the sense that Mr. Bernheim uses, the induced anesthesia would be of the same character as in the injured hand, but the girl makes no complaint, suffers no shock, and has no conscious recognition of her new lesion.

These anesthesias are moreover mobile, they disappear suddenly to reappear again, they alternate; it is hardly probable that the disappearance of an anesthesia in one part and its reappearance in another would have anything to do with a conscious act on the part of a subject. To avoid this dilemma, the point is then advanced that hystericals are beyond all people deceitful; how can it is asked, such obvious contradictions such absurdities exist without the patient's being a moral party to it, one might say in reply, is it conceivable that the patient should deceive himself and others in this transparent manner. If contradiction there exists, it is a mental contra-

diction and can have no moral significance.

In all these cases one may fail to obtain any rational cause for the appearance of any given symptom. Mr. Janet has many cases to show some sort of connection. " Malebranche related in the seventeenth century the story of a woman who, because she seen a rider dragged by the foot, had a disease and a paralysis. We continually see facts of this kind nowadays. One patient has an amaurosis in her left eye because she had seen a child with scabs on its left eye, and another vomits incessantly because he has nursed a cancer of the stomach." In another place Mr. Janet refers to the man wounded by a railway engine, this man has a delirium, it is of an engine rushing towards him; eleven years afterwards he sees his wife die, and he recommences the engine delirium; again; another patient has a tic of blowing his nose, it turns out that he had at one time a scab after a spell of bleeding of the nose. He recovers from this tic, but it returns when he loses his fortune, sees his child ill and so on.

Mr. Janet appears to think the quest in this direction a fruitful one. If it proved invariably successful one might construct some working theory but such histories I believe are comparatively rare. I always ventured to ask for the history of any patient at the "La Salpétrière" who looked to have a psychological antecednt of this kind, but all inquiries proved abortive.

Among Dr. Bruce's patients I have noted two or three cases viz:

The case of Mrs R., Vol VI. 3., a patient who presented a mixture of hysteria and neurasthenia . She had much pain in her hip on menstruation.. It appears her hip was injured during an accouchement eleven years before her admission into the R.I.E. Apart from this, she had other interesting features, a prickly sensation down her leg and on her left leg a patch of goose-skin 7"x5".

The case of M. G. Vol. III. I7., This patient I8 years old complained of a pain in her back and one limb, this her left lower limb was kept rigidly extended. The hip was examined under chloroform with absolutely negative results. The patient says her condition was due to a fall and the pain is associated with the

site of fall. This patient presented typical hysterogenetic areas, she used also to vomit after every meal. The patient was discharged cured having been treated by "Isolation"

The case of A.S., Vol III. 36., she experienced much abdominal pain, a floating kidney had been secured and ligatured some years before, but the pain continued. The patient was able to throw the coils ofher Intestine into rigid contraction and this appears partly to account for an obsession she had of an eel in her belly. She was discharged cured. Treatment Idem.

Case of A.D., Vol IV. 20., Patient aged 25 a common type of a hysteric. Among other things patient complained of a sore arm for which patient blamed an accident. No discoverable lesion on examination. Curiously enough during treatment the pain disappeared from her arm to reappear in her right foot, illustrating the condition of " alternation". She was discharged cured, treatment Idem.

Out of a great number of cases, where a few like the above show some kind of historical antecedent, the great bulk show absolutely nothing. The symptoms are not such as to suggest antecedents.

I have noted in Dr. Bruce's wards a large number as follows:

I) Pains across abdomen

2) Pains in the mammary region

3) Dysuria (2 cases only

4) Twitching of hands and leg

5) Shaking and trembling all over (frequent)

6) Swelling of hand and arm (one case)

7) Paralysis (innumerable)

8) Loss of voice (one case)

9) Spasm of convergence (one case)

without counting of course crises.

In all of these cases it is difficult to know where to begin a psychological inquiry, and to know what is the common factor in them all.

T.M., Vol. I5. I9., Patient age 38. Manager of a Lodging House found lying unconscious, he exhibited twiching of left side, he groaned, he clenched his hands and ground his teeth. He allowed pricking and pinching all over without protest. He was dismissed cured and was admitted again owing to another emotional disturbance, the hearing of the loss of a friend; this time he has a spasm of the glottis, on regaining consciousness the whole of the left side is found with diminished sensibility. Discharged cured. Treatment Idem.

Again, in March, this year, a young girl I6 was admitted to "La Salpétrière" complaining of inability to stand. On being placed on her feet she immediately collapsed, she could, however, perform all sorts of complicated movements with her legs, but stand and walk she could not. On examination, her legs appeared absolutely normal, no wasting, no paresis; reflexes normal, electrical reactions also normal. This is one case like

so many others, its history is no less indefinite than others It appears this girl was an involuntary witness of her little dog's destruction by a railway train . She burst into weeping and sobbing and then all at once she found herself unable to stand, the patient was treated by the "Isolation" method in Mr. Dejerine's ward, and was discharged cured four weeks afterwards.

Mr. Raymond refers to these cases of Astasia-abasia in his"Névroses" - "chez l'individu qui ne peut ni marcher, ni se tenir debout, alors qu'il rampe à genoux, qu'il saute à cloche pieds, etc.,"

These are obviously not anatomical lesions, they refer to certain special coordinated systems, to groups of systematised movements. The psychological analysis of these changes is the only possible one, if indeed we can obtain any result with that. This is a psychological dissociation & doubtless it has its physical basis but for that we cannot employ any intelligent language.

- II -

Freud of Vienna regards the sexual history of hysterics as being of first importance. It is surprising how very often one does find some sexual item in the history. A patient was admitted to the Dumfries & Galloway R.I. during my residence there. This patient complained of pain and like the case above was quite unable to walk. No lesion was to be found, the history related to a trap accident and which naturally pointed to some nervous lesion. Dr.RObson, one of the visiting physicians, suggested hysteria and possibly a sexual antecedent. Skilful questioning led to the fact that there was some "love affair" trouble and of course this would be considered by Freud to need only some shock to bring about some sharply defined hysteric symptom. A great many cases of a like nature are reported, it is difficult not to expect some sexual history in the lot of every patient, but unless we can manage to find in what way it is related to hysterical symptoms we are no better off, no nearer getting a synthesis . Still it is interesting to

observe in how many ways the sexual factor plays a part. For instance, puberty seems the most favourable age for hysterical developments, again, the hysterogenetic areas are usually sexual areas. It is possible and indeed very probable in my opinion that this association of localities has nothing more cryptic, more startling than the fact that the sexual functions have as great or greater affective values than any functions and these are selected by the hysteric in accordance with the affective diathesis.

The synthesis we get is a synthesis of the affective elements.

In the Tripartite division of mind— Knowing, Feeling and Willing, we find the domination in the hysteric of Feeling. We always find the hysterical symptoms appear on some emotional disturbance, that the mental outlook of the hysteric is highly emotional, that the crises themselves are violent exaggerated motor expressions of the emotions and that "stray" emotions are of much more account than systematised and intelligent interests.

HYSTERIC ANOMALIES.

I) A point to note is the uncritical nature of the hysteric mind in the somnabulistic phase. There is the case of a woman who, alarmed in the Zoological Gardens at the time she was "enceinte" by a wild beast, developed a hysteric phase of somnabulism, she went about acting the lion, and , a strange thing is, ate up photographs of children in effigy. Again, there is the case of the patient who in the same condition jumped out of bed, took a pillow, hugged it, believing it to be his child, which he is saving from the mother-in-law.

2) In contrast with this, note the cases where the sense organs are comparatively alert to something not apparently necessary to the controlling idea, take the extraordinary ability of the somnabulist to preserve his equilibrium under conditions impossible to him in the waking state.

3) The fact that the subject sometime shows a curious inconsistency in regard to sense experience, e.g.,

the patient may lose muscular tactile and articular sensations and yet retain the steriognostic sense, the sense of orientation which is itself nothing but a construction out of these individual sensations.

In the first of these cases there is the same condition that we noticed in regard to the induction of hysterical crises i.e. that is the flimsiest pretext suffices. In the above case it is obvious that the bulk of the sense impressions which the patient receives are inefficient to inhibit the progress of her hallucination. First and foremost her stored experience of "photographs" seems quite torpid; the present sensations of size, form, colour, touch etc, etc, are not corrective of that one single feature, viz., its remote resemblance to a living moving child. In normal life we often imagine things which do not exist externally if we are on the tip-toe of expectancy, we seem to see the train move off when the guard has blown his whistle and waved his flag, we bring up with a shock when we find sometimes that the train has not moved, there are numberless instances of

the same kind, the difference between the normal person and the hysteric in cases like the above is that there is a persistance of the idea in the hysteric, the first impression is not afterwards corrected, in fact, the state of the hysteric is a kind of continued tip-toe emotional abstraction, the hysteric has a web of emotional memories round some particular experience, so much so that other things enter his sensorium as things do in the normal individual when much occupied. The second case of an alertness of the sense of equilibrium which seems foreign to the train of ideas which appear to pass through the somnabulitic mind is more difficult. Is it not because the patient is denied the complex knowledge that the waking mind would have of the danger of the situation comprised in the fact of the height of the wall or roof, the danger of a false step etc., these facts to a waking mind are apparently ~~not~~ justly estimated, & yet they seem to have even a kind of pathological significance, they hold by their ease to inspire fear .

In the third case, we are presented not with a simple psychological case of Astasia-abasia cited in repect to the young girl who lost entirely the group of ideas associated with walking, for here a group is retained and is retained despite the fact that we find the individual avenues to the Steriognostic sense an"ideal"group closed. The presumption is of course that these avenues are not really closed, they are closed only in a special manner, they may be so individually to the conscious personal Ego, but, the sensations are and must be nevertheless recorded, but they are not associated directly with this Ego, they only exist for it through the"group" sensation. This naturally raises the quetion of the"sub-conscious" which I propose to leave for the present.

THE SOMATIC LESIONS IN HYSTERIA.

In connection with the psychological antecedents of Hysteria few of the cases ~~discussed~~ showed visible symptoms. Most of the symptoms related to pain, pain in the back, pain in the arm, pain in the stomach and so on; others had to do with what is called functional disease, false paralysis, anæsthesias, hyperaesthesias. In most of these a lack of fixity of the supposed lesion, its fluctuations, its instability, its disappearance sometimes under mental abstraction and particularly in hypnosis or somnambulism and its alternations were all inconsistent with a local organic somatic lesion. These symptoms are nevertheless liable frequently to be confused with such lesions, the swelling of hands or arms, the patch of goose-skin, the contractures, the spasms of convergence, palpitations, vicarious menstruation, vomiting and belching, these are the symptoms which make one pause in diagnosis:

the presence however of other stigmata reassure us when we find no conceivable cause for their presence. Another point to note is that the hysteric lesions show a complete temporary, and often a complete permament recovery. In organic disease Mr. Raymond says there is never an absolute recovery, something is lost, after an organic hemiplegia a loss of the delicacy or the power of movement.

Admitting therefore that there may be nothing to discover in the body of the hysteric, one conclusion comes up very continually and very persistently and that is that if these symptoms are after all nothing but evidences of mental stigmata then the trophic, vaso-motor, sensory and viseral processes are much more en rapport with mental processes than we are in the habit of thinking .

There is another interesting feature in this connection, however, which may point to a physical explanation, it is in regard to reflexes.

41.

In hysteria most of the reflexes are exaggerated, the Babinski is even found after hystero-epileptic crises. Despite the fact that exaggerated knee reflexes are regarded as occaionally functional, one wonders how they can be related to the other symptoms of hysteria.

The Babinski sign is usually regarded as a diagnostic feature of disease of the descending Motor-Tracts The Babinski, however, has been observed to follow a cerebral embolism almost immediately after its occurrence before ~~such a~~ any degeneration could occur.

With regard to the exaggerated reflexes which follow a crises of Hystero-epilepsy one must remember that the cortex is subject to an excessive hyperaemia the Babinski ~~too~~ for the same reason may occur after cases of a like description, after cases of compression either from meningitis or traumatic hemorrhage.

Relating these facts with this association of exaggeration of reflexes and hysteria we might also volunteer an explanation by saying this feature is due also to

a disturbance in the distribution of pressure, it maybe a localised hyperaemia of the cortex and there is much evidence on this matter particularly for instance of blood distribution during sleep and stupor as shown by the balancing experiments of Mott.

Höffding has advanced the idea that attention has its direction determined by blood distribution. Let us presume this is really the case with some of the hysterical symptoms and that the reflexes particularly indicate a disturbance of cerebral blood pressure , then one also might suggest that the affective expressions of the hysteric are due to the same cause. Remark how emotions in the normal subject have a localised effect on the brain, resulting in ~~such as syncope following intense emotions~~ which is of course due to a lowering of cerebral blood pressure.

Lastly vomiting is so frequently a sign of cerebral compression or intoxication that in hysteria too its occurence may refer to some such pressure agency. Granting however that

all these symptoms of hysteria, cardiac, respiratory, gas gastric, vaso-motor and reflexes are due to some local vaso-motor change in the cortex, we are not any nearer in linking up the physiological and psychological functions in an intelligible manner.

Where we do grant some sort of causal connection between cerebration and hysteric symptoms, a connection indeed, more intimate than we find in the normal subject we have not found any particular reason in the psychological antecedents for a "cause d'être" that is, for an association between the mental or psychological aspects and the physical appearances. On the contrary there seems quite frequently a mental and body alienation, also an alienation between the reproductive or memory side of mental life and the sensorium .

- I -

THE RELATION OF VOLITION TO SUGGESTIBILITY.

I have purposely left over the question of suggestion in Hysteria, because it is the most debated, the most interesting of all its features . It is the most difficult and yet the most fascinating of the problems connected with the subject.

Almost all authorities are agreed in making suggestibility the chief of the hysterical stigmata. Mr. Babinski defines Hysteria as follows: "

"L'hystérie est un état psychique spécial qui se manifeste principalement par des troubles que l'on peut appeler primitifs et accessoirement par des troubles secondaires.

Ce qui caractérise les troubles primitifs, c'est qu'il est possible de les reproduire par suggestion chez certains sujets avec une exactitude rigoureuse et de les faire disparaître sous l'influence exclusive de la persuasion.

" Ce qui caractérise les troubles secondaires, c'est qu'ils qu'ils sont étroitement subordonnés à des troubles primitifs."

Mr. Janet says that Hypnotism can only be induced in hystericals and in virtue of this very suggestibility. Now while suggestibility can be employed in Hysteria, yet it has an extremely limited province as compared to the extent to which it can be used in hypnotism.

In Hysteria one can never tell exactly whether a suggestion will be operative or not or what conditions are necessary for its operation. Given on the other hand the condition of Hypnosis and the range of suggestion is enormous. Mr. Janet of course would say that you are already dealing with a hysteric, when you are using suggestion on your hypnotised subject, but all I wish to impress is that suggestion has a different potency in the hysteric as compared to the hypnotised(hysteric, to make a concession) subject . There is an actual difference in the mental state of the two.

Mr. Janet devotes much space to the elucidation of the relation of suggestibility in the healthy subject and the subject of hysteria. A great deal of what he says is orthodox psychology, but in one respect, and a respect which obscures the psychological issue, he seems to go back to a forgotten doctrine of psychology, the doctrine of"entities" He makes "will" appear as something separate from "Ideation" something indeed added on to Ideation in order to obtain Motor expression.

In his little book on"the major symptoms of Hysteria " he says : "the idea should seem to develop to the extreme without any participation of the will or the personal consciousness of the subject."

All psychologists are agreed as to the indissoluble nature of that trinity, Knowing, Feeling, Willing and when they do take one term independently of others they make the proviso that they are dealing of course with an"aspect"

I wish to show in this connection that one cannot arbitrarily separate volition in this manner from "conation". Mr. Janet's own theory of suggestibility, as being due to a Retraction of Consciousness, will itself suffer for want of a resolution of this alien element.

It would not therefore be inopportune to do as Mr. Janet does, and that is, to discuss suggestion in relation to the healthy subject. He says that the normal subject is quite unamenable to suggestion.

In regard to this while I should say that though the healthy subject has by no means the same suggestibility as the hysteric, and far less suggestibility than the ~~hysteric~~ hypnotic, he is nevertheless not unamenable to suggestion. And to anticipate, I wish also to say that Retraction, which Mr. Janet regards as rendering possible suggestibility, to an extent must qualify also the mind of the healthy subject. The suggestibility of the hypnotised subject is due to this selfsame fact carried out in an interesting and specific way.

To begin with let us examine the exercise of volition in the healthy subject and show how it is related to the mental content, how it varies with a change or retraction of the mental content. Putting the matter in categorical form thus:

If A commands B to do some menial task, are we to expect B's compliance? The question is of course an absurd one, for how is one to know who A is and who B is. Now suppose we are told A is the master and B the man, is an answer now possible? We must still know a variety of tiresome things what are B's duties, whether B wishes to remain in A's service, whether B wishes to avoid this particular task, whether he can do so without trying A's patience and so on and so on indefinitely.

In this we understand that B's compliance depends not on A but on B's attitude ~~on~~ of mental conception of his own relation to A, we moreover, recognize the fact that B's compliance is not a simple thing it

may be the result of some fairly intricate thinking, it may waver from side to side. We know that there may be some very fine alternatives in one case and there may be a singleness of purpose in others. What it amounts to is that B will do that which seems on the whole most desirable and the mental process may be simple or complex before arriving at his decision.

Examine the state of mind of B who has a master whose orders he can evade, there may be a dozen reasons for doing that particular task, there may be a dozen personal reasons for not, whatever happens B's actual volition positive or negative will signify a harmony in the mental content. Compare with this B's position when he knows that his master A can make his position absolutely intolerable if he refuses to comply. Here there will be a little warring of ideas in B's mind, he will then be said to have"but a single thought" Are these ideas in B's mind merely logical concepts?

Not so, they are all possessed of an affective element, and it is in virtue of this that an estimate can be made of what shall resolve the problem of his conduct. It is observed that some ideas lose their affective tone when ranged alongside others. B's idea of "shirking" with its necessarily small amount of pleasure may cease positively to have an affective tone when B is terrorised say with a threat of dreadful bodily harm or of losing his employment or what not.

The above are circumstances where B has a well endowed, a fairly well educated mind let us say, the alternatives that occur to him are therefore usually many, and observe he seems, except in the last case we mentioned, to be able always to "hang fire", before complying, though of course he may actually comply at once.

Let us now suppose a case C also in the same position as B, but C has a poor mental equipment, has had little education and has a feeble memory.

The range of alternatives is now limited, things, which really have an important value for him, are not appreciated as they would be by B and yet his action does not become for that reason abnormal. We know the kind of things that will weigh with him; they are the same in kind but differing in amount to those that influence B. The difference that we, as observers, would possibly say existed between the two depended upon an inability to concentrate the mind, as if this were something over and above the range and play of ideas, not as is really the case, a sign of a large number of associated ideas.

Now another point; C may have a mental field more attracted, more limited, than many hysterical and yet not be abnormal as I said before. C may possess all his sensibilities but his sensations may have but a small "ideal " nexus, more than that, his senses may actually be limited in their appreciation of the fine differences of the qualities of sensation, his mental

sensibility outlook may be much more contracted than many typical hystericals.

Now there are several points brought out in these illustrations, the first is that the chief thing in a suggestion and a command is to remember we are dealing with the mental attitude of the recipient.

In the next place this person's action, immediate or delayed, depends not only upon the extent of his mental field, but also upon the affective association of his individual ideas.

Thirdly, the concentration and effort mark a delay in thinking of any kind, and lastly, though we have a limited mental field we may not have the condition for suggestion, where a command to be expressed is necessarily acted upon.

This concentration, is it evidence of a new element? It is usually taken as a sign of willing internally i.e. some ideas are it is said, suppressed, others selected and encouraged, as if indeed some independent operator was at work on the mind stuff.

Now "effort" is always a feature of the unstable equilibrium of ideas, it represents a poising and counter-poising of ideas where ideas have their own particular values in reference to the personal Ego. It is not conceivable to think therefore of an effort as diminishing values in ideas, the only thing that could diminish the value of one idea is the exceeding value of another idea.

Taking another illustration, a glass of wine is an idea for two very different persons, for the inebriate, and for the abstainer. Of course, there are certain common features in the idea for the two, colour, etc., but the idea has for each entirely different affective values , in the one it may be called a dominant idea, in the other it may have a subordinate place, so subordinate that it may and does cease to have significance as far as any specific motor expression.

Let us now suppose this abstainer to be also Temperance Reformer, the glass of wine, though it has no specific and all powerful emotional quality, has yet a wealth

of associations which may occupy the mind much more than the ideas which occupied our inebriate unless indeed the latter is a dipsomaniac. In the case of the Temperance Reformer the ideas would succeed each other are not without affective tone they have "acquired ","ficticious" or "indirect" values, and they are, therefore like all ideas acquired by education, for that reason ~~they are~~ none the less powerful.

The ideas and relations of ideas obtained by education are obviously most of them, without direct affective value for a pupil, they are adorned with other, or secondary, ideas of a very high affective value at this stage of life, for instance, it may be the fear of the birch, it may be, later on, prizes to obtain, and finally it may be to succeed in life, but gradually these the primary ideas become detached, in the conscious sense they will begin to exist vicariously and they will thus appear and re-appear on their own merits.

Now ~~for~~ the sense of effort, the hall mark of volition, remains to show, so it is said, the difference between an active and a passive flow of ideas.

All physiological psychologists regard a feeling tone as ultimately somatic in origin, and it has long been a commonplace to say that every idea has its physical representation and that the object or purpose of each idea is only to bring the organism into relation with its surroundings. Now the ideas, as such, do not ~~are not such as to~~ bring the organism into immdiate relation with its environnement, that is left to reflexes. The lower organisms respond immediately to their surroundings, they represent the type of reflex action and of little else. The adjustment of the higher organisms is largely provisional, the experience stored up is represented in ideas, ~~this~~ a capacity ~~of~~ reproducing past impressions. The response to a stimulus, if not immediately performed, in the higher organism is not due to anything other than its inhibition by other responses which exist in ideal association, and the point to emphasise is that <u>all</u> stimuli evoke responses, but they are prevented from becoming specific, reflex if you like, by this inhibition, and the consequence is there is what is called an "overflow",

or diffusion. The sense of effort is this diffusion.

When ideas succeed each other, inhibit each other, the body acts as their indicator and contributes to the sensorium this "sense of effort". The bodily diffusion is a diffusion, an overflow, over several systems viz: cardiac, respiratory, and vaso-motor and visceral .

Prof. Willima James of Harward refers to this tendency of ideas to realize themselves and illustrates how their diffusion is observable as e.g., in the leaping of the pulse (eg when a band is heard), which he has registered and shown on tracings.

Furthermore, the play of ideas, continued for some time accompanied as it is with effort, will in the end spell fatigue.

The next point to raise in relation with this is the association of another element which will prove important in our discussion of somnabulism and of hypotism and that is the matter of belief. Prof. W. James goes on to say that belief indicates the willingness

to act, and that, of course, belief has nothing to do with some obscure agreement between ideas and reality, but that belief is the internal agreement of ideas. Relate this with what we have said in regard to volition, in regard to the illustrations we have used on the subject of alternative action, that if there is an incomplete agreement in ideas, action and specific volition is delayed. Now that delay, we can say, in addition to being accompanied by a sense of effort has also the characteristic of the absence of belief.

The law of ideo-motor action then, is that all ideas have their motor accompaniment, but whether they have a specific motor expression is another question, and it is this specific response we usually understand to be a volition.

Comparing volition with reflexes and instinctive action, the latter are part of our birth-right and which we cannot dispose of readily, and which remain because they serve us in a specific way, always the same

way, and rightly in 99 times out of the I00, they would indeed cease to be reflex if they failed us too often, for another system would arise to inhibit them and these reflexes would no longer be reflexes, but curiously, instead of being degraded they would be elevated to a place in the mental plane, for they now still have some value but not an invariable value and they become ideal because of being provisional.

What are the reflexes which have no particular sensorial accompaniment? They are: cardiac, and alimentary reflexes etc., these are ever present needs, superior to changing conditions and so need no ideal associations, they are never provisional.

Passing from these direct reflexes to modified reflexes where there is some mental association we find the respiratory functions are partly conscious and why? Because sometimes the respiratory function needs modification.

It is sometimes useful to break the reflex rhythm of respiration, that is to suspend breathing temporarily,

e.g., when inhaling noxious fumes. So there is a measure of control given in the only possible way because of this sensory accompaniment.

The rest of the body which brings us into relation more immediately with changing conditions, develop the ideal association to such an extent that some lose entirely their reflex character. Take for instance the muscles of the larynx which have to do with such an infinite variety of provisional needs which therefore are thus entirely under the control of the will, but better still, to avoid the ambiguity of the word "will", under the control of the ideal complex, the personal Ego. Now all these ideas act only mediately through their ideal associations, but they may lose these if they act too often in a certain specific way, then they become "habitual" then degenerate into pseudo-reflex action as in group systems like walking, piano playing and typewriting. In such instinctive and habitual action the actions are hardly willed, though they are not entirely set free from their ideal associations, in walking, each step may not be

willed but each has sufficient ideal association to be inhibited if need arises.

Now I have purposely analysed this aspect of normal psychology to show how often we see morbid states in a healthy subject and how a suggestion may act in absolute conformity with physiological laws. (1) A spectator at a foot-ball Match is often known to kick his neighbour by mistake he is obviously engrossed in the Match, he is quite unaware of what he has done, until some sense stimuli brings him to a sense of his position, it may be e.g. his neighbour's voice, it may be the resistance his foot meets, what matters it, the point is he is in a condition practically of monoideism.

This person is a normal person, he is regarded as having excellent self-control let us say, and he is aware that here he has done something out of accord with his personal social Ego.

2) It is a wellknown fact that some people are unable to look over a precipice, they feel sure they say, that will throw themselves over and it often happens that they actually do, with no suicide premeditated.

Their personal individualistic Ego is now at a discount with all its strong affective associations.

Inumerable instances of the same kind are readily recalled.

In the first place, the obvious thing of course is that the spectator at the Foot-Ball Match is entirely occupied with the game, he is oblivious of his surroundings, the sensations these give rise to, have little or noaffective tone for him, his interest is occupied with the player who is about to kick a ball, he identifies himself with that player the idea passes into action and he kicks his neigh-

bour.

In the next place the person who unfortunately throws herself over a precipice is temporarily obsessed also, fear is the factor, and how does it manage? This emotion of fear sets in motion a train of thought which begins with a picture of slipping, falling, and these are vivid because of their immense affective values and they become dominant, providing the conditions of idiomotor action.

In all these cases the ideas, to be efficient, must be always highly effective, other ideas must dwarf because in comparison, they have little emotional tone, what is more, the circumstances may themselves contribute partly that affective tone.

Let me now quote Mr. Janet.

"While I am paying attention to what I am reading, I abstract myself from the noises in the street, though I still perceive them. This abstraction exists in hysteria

in an astonishing degree. It was noticed early that it presents itself in regard to the sensations and to ideas. These patients appear to see but one thing at a time, and you become aware that they have no notion of another object, though it be very near the first. When they speak to one person, they forget that there are others in the room. They forget them so entirely that they would tell all their secrets before them with indifference. When they express some idea, you notice that their conviction is childish. It seems very strong because it rests on an astonishing ignorance. Objections, impossibilities, contradictions, do not reach their mind in the least."

And again: "The exaggeration of this disposition will bring about the phenomenon of subconsciousness: a great many things will exist outside the personal consciousness. You will be able to make the patients walk and act unknown to themselves. If the ideas you express do not attract their attention and if they remain in that

domain of absent-mindedness, it will result
~~would break the windows, kill myself. I fall into an idea~~
in mediumship, as we saw before that the
~~as down a precipice, and the declivity is hard to climb again."~~
developments of the ideas resulted in great zeal and devotion.

There is no ultimate distinction between these cases of Mr. Janet's and the illustrations which I employed with reference to the healthy subject.

The normal individual does act upon suggestion which is not distinct in kind from the suggestions used on hysterics, perhaps the one difference is that difference of continuity of idea.

The normal subject, under some circumstances, so like the subject under hypnotism is unlike the psycasthenic, whose obsessions are frequently at variance with his personal habits and manners, in fact, they are critisised by him, he may be quite conscious of their absurdity.

Compare this condition with our Foot-Ball spectator again whose obsession is not in conflict with the rest of his mental content, the obsession of the psycasthenic is in open contradiction and yet does not disappear and for this last reason it is regarded as pathological.

Alienists have always made it a matter of surprise that these obsessions of the psycasthenic are so rarely impulsive and yet a reason is ~~in their~~ seen from the very analysis and statement of the case as I have shown, the ideas are declared to be in the psycasthenic out of accord with the rest of the mental content.

Why is the psycasthenic able to critisise these"ideas " or obsessions? In more exact language, how do these ideas persist in spite of their inability to be reconciled with the rest of the mental content? Is it not because of their relatively small affective value, i.e. while sufficiently strong to retain a place in consciousness, they are not able to dominate consciousness.

The psycasthenic is indeed nearer the normal individual in this particular respect than he is either to the hysteric or the hypnotised subject, and why, because they are both in possession of all the avenues of sensations and associations (ideal) .

Let us say our psycasthenic is a victim to an obses-

sion - the wish to commit sacrilege, he is always worried with this idea. Place him in the circumstances where it is possible to give a motor expression to this obssession, does this obssession become impulsive? Not necessarily, the flood of sensations which may pour into his mind when he is in those circumstances e.g. in church, may have so many ideal associations, so many specific systems that the persistent idea ceases to have sufficient affective power and therefore becomes inefficient. In the above manner I have tried to show under what circumstances the normal person is allied on the one hand to the Hysteric, on the other to the Psycasthenic.

HYPNOTISM IN ITS RELATION TO WILL.

It is quite impossible to define exactly what is meant by consciousness, it means more than mere sentiency but it does not mean on the other hand an ever present recognition of the relation of sensations or external reality to a personal Ego, i.e. selfconsciousness. Selfconciousness is only one among several ideal relations which the mind may form.

Consciousness as such, is distinguished from mere sentiency in that it does refer to an ideal complex i.e., any idea does not rest on itself, it is always related subconsciously to a personal Ego or consciously to an ideal complex.

In the consideration of volition we indicated this mental complexity, that the mind in fact had a content, and that a particular idea did not necessarily become invested with its own particular motor expression,

though, we pointed out there is such a tendency with every idea but being inhibited it spends itself in "overflow" or diffusion.

Now volition is the test of the existence of the idea, of consciousness; the mind of course may be conscious and yet the body quite passive, but the observer cannot know of the existence of consciousness until there is some motor expression and then the observer has to decide whether that expression is an expression of volition, whether in fact it is more than an immediate response, whether, it is more than instinctive reflex or habitual action, in other words, whether it is "provisional".

Now the hypnotic state is the most interesting of all mental conditions because it is the simplest mental state we can possibly study, it is the nearest approach to mere sentiency, but with this difference that while the sentient being reacts on simple stimuli, the hypnotic subject is moved by a complex of sensations, in fact,

an "idea".

The hypnotic subject is told to stand, up there is no hesistancy, there is immediate performance, the state of doubt and the pause, which we have seen to indicate a complex associative content, is absent.

The subject is furthermore told to eat something noxious, he is told it is pleasant and the patient does respond, manifesting pleasure. We know this subject to be possessed of an organism similar to our own, ~~it~~ which responds, ~~it~~ with reacts as our own does, and so we know that his palate and its reflexes therefore are such as to provide a noxious sensation and the motor response, repulsion. But our subject continues to eat and manifest pleasure, he is not brought up with a shock against reality. He does not feel like a person does who misses a step, or who mistakes soap for cheese, in fact, his reality is constructed for him, his own physiological nature is temporarily divorced.

Is this reality, a reality as we understand it? Is it a body of systematised associated perceptions? We cannot answer the question definitely; to judge, by our subject, that small portion of reality given him by the operator is self sufficing, if it becomes more than that, the addition is in organic relation with it.

In this condition then we find the clearest, finest illustration of idio-motor action, there is a direct transition from idea into action because the distinctive function of the hypnotic ~~condition~~ state is to suppress all that which might inhibit the idea, that is, it suppresses all sensations, all ideas which are not in harmony with the suggested idea. The ideas suggested are dominant ideas for the subject, circumscribed, doubt and hesitation are not possible, for these would signify other ideas,

The great problem connected with hypnotism is the question how this contraction comes about, it is impossible to say , we can merely state the existence of

this contraction and it is this which makes the person respond to suggestion; if other ideas entered, then the person would be conscious, - in the ordinary sense of the word, and a suggestion could not then become an effective idea. An example of idio-motor action, because the particular suggested idea would have to stand in compatibility with them.

Reflex and instinctive action resembles hypnotic conduct, has the same automatism. An automatism which characterises a great deal of the life of the healthy subject. Not only , however, is the normal subject like our hypnotic subject in respect to this automatism, he resembles him sometimes in another respect occasionally, e.g., our Foot-Ball spectator with a dominant idea, in both cases an idea passes directly into action and this action is not what is ordinarily called "willed". It is a curious case of a physiological reflex anachronism, a linking up of the idea directly with its own specific motor expression in a kind of primitive reflex way.

A phenomenon in no way removed from the phenomena we have just been considering is that condition of deep dreaming, with one difference, there is no realisation in a motor sense of the dream images. The feature in common is that the person believes in his images, they are for him a portion of unquestioned reality.

It is the experience of most to pass through experience in dreaming, the most ridiculous adventures, the most terrifying experiences, the most horrifying spectacles, the subject sees the dead and relates them with contemporaneous events, see figures move on the same platform whom the Poles separate. Is the reality of these images doubted? Never in deep dreaming. There is the same actuality, the same reality as in ordinary waking life. These images pass uncritised, their truth goes unquestioned, they are <u>believed in</u>. In the waking state subsequently only are these ideas adjusted to reality and found to be false; but mark you, not in dreaming. What is again the reason for the existence of the belief

in the reality of the dream images? Are we not here presented with the same answer as before? It is because the there is a retraction of the mental content, ~~only~~ the dream images exist and exist unqualified. If other ideas, other sensations entered, these would put a measure on the relative reality of the dream images. In "day-dreaming" in "castle-building" and in light dreaming there always exist a qualification of the reality of the ideas which occur, because the sensorium is not closed to opposing impressions.

The difficulty that is left over from this question of the condition of mono-ideism in dream life is the problem of the non-realisation in motor expression of the dream images. The conditions appear to be precisely the same as those of our hypnotised subject and somewhat similar to the state of mind of our Foot-Ball spectator. Remember there is in all these cases no mental conflict, there is a suppression of all ideas which indicate doubt, how is it therefore that dream life is so distinct in the matter of motor response from these afore-mentioned

cases? All we can say is that in the condition of dreaming there is this annihilation of specific motor expression, in fact, of idio-motor action . This annihilation is an actual physiological inhibition such as we would expect in a mind fully conscious. We know of this inhibition by the undoubted fact of "diffusion". This diffusion we know to pass off in cardiac, respiratory and visceral and vaso-motor disturbance, [illegible] Here we have hypnotism more nearly related to the laws of physiological and psychological reaction than we have in these dream images, the hypnotised subject's ideas realise themselves and represent the law of idio-motor action in all its simplicity.

In regard to Hysteric Somnabulism the point to note is a certain resemblance with dream life, in this one respect it is distinct from induced somnabulism, the ideas proceed from within, you know not how,

The course of the dream images pursue a sort of (indepen-
dent) course to all external suggestion, perhaps the one
difference usually between the recorded cases of Hys-
teric Somnabulism and dream life is that usually the former
is more iron-bound. Mr. Janet has enumerable instances
of cases which pursue again and again the same conduct.

It is difficult to understand why
Mr. Janet keeps hypnotism so jealously within the sphere
of Hysteria, as if suggestibility was the fundamental defect.

There is a feature more fundamental than
suggestibility, without it suggestibility has no potency,
it is the retraction of the mental field,

What is to be said of dreaming where there
is unmistakably a retraction of the mental field?
Is dreaming a feature therefore also of Hysteria? This
seems to be a Reductio- ad-Absurdum.

It is interesting to see that Dr. Sollier
has had his definition influenced by some such considerations

as we find above. In his Genèse et Nature de l'Hystérie

(L'hystérie est un trouble physique, fonctionnel du cerveau, consistant dans un engourdissement ou un sommeil localisé ou généralisé, passager ou permanent, des centres cérébraux et se traduisant, par conséquent, suivant les centres atteints, par des manifestations vasomotrices et trophiques, viscérales, sensorielles et sensitives, motrices et enfin psychiques, et suivant ses variations, son degré et sa durée, par des crises transitoires, des stigmates permanents ou des accidents paroxystiques. Les hystériques confirmés ne sont que des vigilambules dont l'état de sommeil est plus ou moins profond, plus ou moins étendu.)

- II -

HYPNOTISM AND HYSTERIA.

Finally we discuss the relation between the action of suggestibility on the Hysteric and the Hypnotised subject. All along I have tried to show the identity of this phenomenon of suggestibility in the pathological as well as the normal subject and the difference is a matter of degree merely though it would appear to be a difference in kind.

All observers are agreed in regarding suggestibility as one of the chief features of Hysteria I have only to refer again to Mr. Babinski's definition. Mr. Janet says that suggestibility is a feature of Hysteria only and so "hypnotisability" is merely another symptom of hysteria, for Hypnotism is merely a condition brought about by suggestion.

However that may be, for the time being the point is that the subject in hypnosis is differently suggestible to the Hysteric, the Hysteric does not respond to any and every suggestion, does not believe his

wine milk, that he is strong and vigourous, we cannot determine the limits exactly nor can we state what circumstances there are to make any suggestion active.

Mr. Janet states his point of view illustrating his case with what seems to me an utterly futile illustration.

" If we take a person of that kind (normal) and if we state to him that there is a little dog at the corner of the table where he is sitting, he will laugh in our face and experience no hallucination."

Might one ask would one expect the realization of the same suggestion in the case of a Hysteric?

The only purpose of such an illustration must be to point out that there are conditions necessary for the realization of a suggestion.

"A dog in the corner" is confronted with other presentations in the healthy subject the avenues of which are not closed.

The normal subject is not devoid of suggestibility but the suggestion must be in harmony with

the patient's mental content, I say a word like Castle, and it may arouse a train of associations or it may not. There is nothing in the mere word to conflict with any part of his reality and it may therefore exist obviously without a specific motor expression for that would introduce an association with the rest of his mental content. Now with regard to the Hysteric, some avenues are still open and so he is not completely suggestible, he is only suggestible in so far as there is no conflict, for let there be a suggestion made in conflict with the sense presentation whose avenues are still open and he will react like the normal individual, i.e., a train of thought may be pursued as in the normal subject. or, if the idea possess great affected tone, it too, as in the case of a normal person , a Foot-Ball spectator e.g., will perhaps invade reality and substitute it.

There is certainly less opportunity, less room for a suggested idea to dominate the mind in the healthy subject than in the Hysteric for in the latter there is a

smaller array of conflicting ideas, but we are not dealing with different psychological conditions for suggestibility.

Mr. Janet's ideas about Hypnotism being possible for hysericals only is at variance with most observers. The view of the latter might be modified by saying that while all are potentially suggestible, few actually are so. There is nothing in it that a normal individual resists.

The fact of the matter is that the conditions for Hypnosis cannot always be obtained. The object of the operator must always be to obtain the belief of the subject.

How is this belief usually likely to be induced? Our knowledge of Hypnotism in its early history indicates that this belief was procured by the most trivial, banal, methods; the appearance of the operator was of great importance, the old mesmerist used to cultivate a kind of weird appearance. The methods employed though utterly

silly were found by experience of value.

The transition from the methods of older school to the present school in the matter of sleep induction shows more and more that the external apparatus, the various methods, the appearance of the operator were of the most complete indifference as far as explaining the nature of Hypnosis.

When Hypnotism was little understood, when its induction seemed to rest on a certain manner of manipulation, the Hypnotist believed largely in externals, in the precise manner of waving the hands, in all sorts of paraphenalia later, it began to dawn upon experimentors that the precise manoeuvers adopted mattered little, for there were on record such a multitude of methods, all of which were efficacious. And now the idea entered their minds that it depended upon the personality of the operator or upon the possession of some magnectic force, but whatever it was, that he was all powerful..

To Braid and to Charcot we owe the new conception of Hypnotism. "Fluids" and Magnectic personalities were meamingless, Hypnotism depended upon suggestion.

Have devices on the advent of this new conception disappeared? There is no school of Hypnotists which does not rely on some device and the reason is that it is stated these devices are used for convenience. The patient is said to pass into sleep more quickly. It is agreed that there is no potency in the revolving mirror etc., they have no special virtue in themselves, they are often explained to be of service sometimes to obtain the attention of a subject, sometimes on the contrary to empty his mind.

If we gather all the facts together we must come to one conclusion that there is a virtue in every device, every method no matter how foolish so long as we induce Hypnotism, and are we not referred back really to the mental state of the subject, what his attitude is towards these things, whether he believe in them.

This belief may be what is called unwilling belief, the patient may deny the possibility of his susceptibility, but whatever conception he may have on the subject, if he passes into sleep it is a declaration that his belief has been secured.

Why are some men more succesful than others in inducing sleep? It is always because of the ability to convince the patient of their ability to do so. The one thing produced by the suggestion "sleep," tempered and prepared by any device you use is the limitation of the mental field which under the condition of belief procures the domination of one idea, that idea being sleep? It is necessary always to prevent disturbance in the first attempt of sleep induction so the avenues of sense are circumspectly closed, the field by this method is closed to a considerable number of distracting correcting impressions.

One cannot suggest to a normal subject certain specific things, small portions of reality which

would conflict with the rest of reality and at the same time expect belief. "The Dog in the Corner" of Mr. Janet's illustration is incompatible with the stream of sense impressions, that is, this attempt at constructing a small portion of reality, which conflicts with the reality which pours in by the avenues themselves, is doomed to failure.

Compare with this the suggestion of sleep, that suggestion is a concept, it does not conflict with any part of reality, it stands in no immediate sense contradiction, it is an idea merely and it may find however many things which will give it an opportunity for finding a footing, the associated interest of the subject, its weirdness and so on. Now, one may suggest many ideas which not only have no associative interests, except indirectly, but you may find arranged against them whole systems of organised ideas, as e. g., when one is told the world is flat, though we have no contradictory sensation the idea is as strongly combated by a whole system of related ideas.

For any suggestion to be active you must have either the dimunition of the mental content or you must have the elements of that content in agreement, this condition is brought about when Hypnosis is induced, the mental field is contracted, there is no possible means of being contradicted.

It was agreed that sometimes the Hysteri is in a condition to accept some specific suggestion without being hypnotised . Apart from the immense bulk of information collected in verification of this, there is another sphere from which we obtain supporting evidence, all we know of"faith healing" holy wells, holy relics, of the Miracles performed at Lourdes, the"cures"of christian science point every one to this selfsame fact, that they are one and all able to inspire belief in a certain the conditions of type of person, if you will, Hysteric. The religious factor is particularly able to obtain the greatest success, it has the greatest bulk of ingrained teaching, associations to procure a ~~condition~~ suitable soil & so when associated with a strong

affective element vix: the promise of cure, it is likely to provide the condition of mental harmony and by that of mental retraction. Remembering all we have learned in regard of the influence of the mind over the body in the condition of Hysteria and Hypnosis we can see that we are obtaining here also the condition for a like linkage. we are brought to the Conclusion that we have the ever present factor of suggestibility - & we can never be quite sure in our treatment how far we may not be relying on its aid

It is no longer possible to refuse a recognition to this factor the only dispute is in reference to the scope & extent of its action & the introduction the question of the Somatic lesions It is cannot be gone into at any length we are all agreed to accept the relation between broken legs & marked hysterical anomalies

THE RELATION OF SUGGESTIBILITY TO THE SUBCONCIOUS SELF.

The word retraction has been used for the conscious mental state of Hysterics more particularly and we have seen that it can be applied also to the normal subject in conditions of extreme interest, and also in a condition of deep dreaming. Does retraction mean the emptying actually of these unassociated, conflicting ideas? That is, do they cease to be?

All the facts which have accumulated with regard to double personality, all the information we obtained by experimental Hypnosis point to their continued existence.

In the healthy subject the sensations which pass unperceived are not lost, most of the sensations have been shown to give rise to what is called the"organic self", they are said to be sub-conscious. This organic self is the referendum for all the impressions

consciously recognized or received.

In Hysteria if we therefore declare, that all these anomalies we find in regard to sensibility, are after all due to the fact that they are not referred to this personal self, it is because they must be dissociated. More than this, the portion cut off sometimes assumes an individuality of its own and so we have the facts of double personality.

It thus appears it is better to use the word dissociation than retraction in order to indicate that there is a portion of the sensorium, it may be, or a portion of the system of ideas, which go to form a personal Ego, cut off. "You find the Hysteric forgets suggestions as soon as ended, he appears little conscious of these when they are executed, he often executes them without knowing, quite sub-consciously." Now we have two important facts here, the one the fact of dissociation, the second that suggestions are not apparently effective because of their appeal to one particular portion of the

subject. It would appear that the majority of suggestions in Hysteria depend upon this ability to be seized on by this cut off portion of mental life.

The number of cases to show the conscious character that this bit of self may assume are as I said too numerous for individual mention. They often explain the presence of tics, contractures, anaesthesias.

Take a case mentioned by Mr. Janet in his "Névroses et Idées Fixes":

"Un jeune homme de 25 ans que j'ai eu l'occasion de soigner il y a quelques années était atteint d'un tic à la face. Toutes les deux minutes il soufflait violemment par une narine en faisant force grimaces et ce tic durait depuis six ans sans que le pauvre garçon pût comprendre ce qui déterminait ce mouvement déplorable et sans qu'aucun traitement ait pu avoir la moindre influence. Ce malade, ainsi que j'ai été amené à le constater, présen-

tait de l'écriture automatique et du somnambulisme.

Dès qu'il fut dans cet état il s'expliqua très clairement: " Mais c'est bien simple, dit-il, j'ai une croûte dans le nez depuis un fort saignement de nez que j'ai eu il y a six ans, elle me gêne et je souffle pour la chasser." Inutile de dire qu'il n'y avait pas de croûte dans le nez et qu'il s'agissait simplement d'une idée fixe de forme subconsciente comme cela arrive si souvent chez les hystériques. Il suffit de modifier cette idée fixe pour faire disparaître le tic comme par enchantement. Sans parler de ce traitement et de cette guérison, constatons seulement que le somnambulisme rendait au malade le souvenir d'idées fixes qu'il ignorait pendant la veille.

Apart from experimental hypnosis we find that sleep itself may induce this suppressed part of the dissociated personality to come to the surface, so the case of the Hysterical girl whom Mr. Janet mentions, who was a hemianaesthetic on her left side. Pinched on that side in her sleep, the patient winced in her dream, crying out "you are pinching me" -"how stupid"- .

From these illustrations and from our reflections is it impossible to explain the presence of tics, contractures, hysterical vomitings etc.?

We have seen in the case that we have quoted from Mr. Janet about the youth who suffered from a tic of snuffling that though we see an apparent consistency between the appearance of a tic with the history which the sub-conscious self supplies in Hypnosis, yet, as Mr. Janet himself points out, there is an absolute want of intelligibility in the explanation.

This is surely another instance of the mistakes and absurdities which retraction gives rise to but here curious to relate it refers to the cut off portion

We have seen the conscious part of the hysteric subject suffer from a want of complete unity of its sensorial and ideal life i.e., the portion cut off was really necessary for a true appreciation of its relation to the world of sensation. Is it not conceivable too, that the detached portion suffers in a like manner but now in a complementary way from the fact that the conscious waking life of the hysteric ~~being~~ was closed to it. Suffering by its cleavage from the total personality it too will have its own obsessions and thus we have all the various mental accidents which qualify the one portion of the total personality qualify the other also.

To conclude (I) The Hysteric has an unstable mental nature, all the mental accidents which befall him are due to the dissociation that he is so liable to. The curious mental features which we associate with the Hysteric, the double personality, the

curious bodily affections are all expression of this dissociation and make possible the obsessions which may relate to both sides.

2) This instability which is at the bottom of those disturbances , what is it due to? It is certainly due to the excessive affective quality of the mental life of Hysterics. Mr. Bernheim has remarked this feature as being the distinguishing feature of hysterics.

" L'Hystérie n'est donc pas une névrose primitive; c'est un réflexe émotif exagéré chez des sujets hystérisables."

All we know in reference to Hysterics manifestly points to the excess of the expression of the emotions and we know also that the hysterical dissociation is always to be dated to some form of emotional disturbance