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On certain Morbid Fears,
With Remarks on the Influence
of Fear, on Disease.

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The Physiology of Fear.

In order to properly understand the relation of Fear to Disease, it will be needful to briefly enter into the Physiology of Fear.

Fear is one of the most primitive emotions, and is met with very low down in the Organic Scale. Its purpose is essentially protective; it leads the organism to shun danger. It is so to speak a deterring emotion.

There can be no doubt that animals are instinctively afraid of certain things; to cite a familiar example; a cat is instinctively afraid of a dog, and when its eyes are barely opened it will arch its back and spit, upon beholding one; and it is said that the horse will, at sight of a tiger, tremble with fear, though it never had seen one before. In this case there must be an instinctive dread inherited from a remote ancestor, seeing that the modern horse is many generations removed from its wild congener.

Even in man instinctive fear is found. Like animals and many insane persons,

children fear all that is unknown to them; and it is probable that their fear of dogs and cats is hereditary. It may also be observed that when a child begins to walk, it has a decided fear of falling. Whether a child's fear of the dark is always instinctive is doubtful.

In many cases it probably is, but it is certain that the way children are brought up is largely responsible for this fear. From their earliest years they are frightened with dreadful stories of bogies, goblins, and other imaginary monsters. Were children taught to people the dark with fairies, rather than with horrible goblins, their fear of the dark would be much less than is generally the case.

It is scarcely necessary for a medical man to insist upon the absolute iniquity of frightening children with such stories; of unduly resorting to fear as a factor in education, by threatening to call the dog, the chimney sweep, or the policeman, when a child is unruly. A child can be more easily and humanely governed by a system of legitimate rewards, than by

one resting chiefly upon fear. By the latter method not only is the child's life rendered miserable, but its health may be permanently undermined, for any neurotic tendency is thereby necessarily increased.

The whole of the body is profoundly affected in fear, not a tissue escapes. By bearing this fact in mind - a fact, by the way, which scarcely seems to be properly appreciated even today - we shall the more readily understand what an important part fear may play in disease.

The fact, that all parts of the body may be thus affected in fear, shows that those cortical areas which are engaged in the emotion of fear must be in direct connection with the whole of the body. A fact which we shall best explain on Hughlings Jackson's⁽¹⁾ hypothesis, which

⁽¹⁾ Hughlings Jackson. Clinical and physiological researches on the nervous system. London 1875.

regards the nervous system as made up of
 so many different levels, each higher level
 of which is evolved out of that next
 below; the lowest level of all, (the afferent
 and efferent nerves and their end-organs,
 and the grey matter in the Cord, Medulla,
 and Pons from which they take their origin),
 being in direct and immediate connection
 with the non-nervous parts of the body.
 The highest of these several levels constitutes
 the "physical basis of mind;" and, when
 in the various processes of "mentation", the
 nervous agitation in the highest level
 is transmitted downwards to the lower
 levels, the non-nervous parts of the
 body are dynamically affected as the
 result of the mentation. Thus we see
 how mind is able to influence body.
 During intellectual operations the nervous
 agitations have a comparatively low
 degree of intensity, and they are in con-
 sequence (comparatively speaking) limited
 to this area. But in the case of the
 emotions, above all the violent emotions,
 the agitation reaches a high degree of intensity;

they are consequently no longer limited to the highest-level, but lead to an energysing of the lower (efferent) levels; and thus the non-nervous parts of the body are always very definitely affected in emotions, above all in keen emotions, and in no emotion more profoundly than in that of fear.

These dynamic changes we shall now consider. They are briefly as follows:—

Heart: one of the most notable effects is palpitation.

Vaso-motor system, This system is profoundly affected. The brain, as we shall see, becoming hyperaemic; many of the vaso-motor areas on the other hand, notably that of the skin, show arterial constriction. Hence the characteristic pallor of the surface.

Breathing, In slight fear there is a strong tendency to yawn (Darwin⁽¹⁾). In greater fear there may be a momentary suspension of breathing, subsequently, however, it becomes hurried, and there is a tendency to marked breathlessness.

⁽¹⁾ Darwin. The expression of the Emotions

Muscular System. There may be at first over-activity, as no flight from the object of fear; but profound fear has a markedly paralyzing effect. Thus the knees are apt to bend, and the whole body to tremble. Other muscular effects are diarrhoea and diuresis, the erection of the hairs, and dilatation of the pupils.

Trophic. Probably all the secretions of the body are affected, that of the cutaneous glands is increased. This increased secretion, together with the constriction of the cutaneous blood vessels, giving rise to the characteristic cold sweat of fear. As regards other secretions, those of the mouth are dried up. In what way the other digestive juices are affected cannot be definitely asserted; but judging by the effect of fear upon digestion, we may infer that they are all profoundly affected.

Organs of Special Senses. In the slighter degrees of fear, the special senses are probably rendered acuter, but in the intenser degrees of fear they are certainly blunted, so that the individual can neither see nor hear as well as under ordinary

conditions.

Intellect. The same remarks apply to the intellect; in minor degrees of fear it may be sharpened, but in profound fear it is certainly rendered more obtuse.

Some of these bodily effects of fear must now be considered in greater detail.

Palpitation. When the heart-beats violently in fear, it is by no means certain that there is necessarily a corresponding heightening in the activity of the circulation. Doubtless the primary object of the palpitation is to hurry on the circulation, and to prepare the nervous system and muscles for the extra work which attack, defence, or escape, from the dreaded object, might entail. Such, at all events, is the opinion of the Italian Physiologist-Mosso⁽¹⁾; and in this connection he reminds us that at the least noise, the pulse of a sleeping person increases in frequency without his awakening; the object being to prepare the organism for a sudden

(1). Mosso. La Paura. Chap VI. 5.

effort. (Mozzo)

From a physician's point of view, the palpitation of fear is one of the most important of its phenomena; for the heart will leap for a degree of fear which will scarcely affect other parts of the body.

Thus the slightest apprehensions may cause lively palpitation; and it is possible that some cases of more or less chronic functional palpitation take their origin in fear. One can well understand how the continual fright to which a highly nervous patient is subjected, and the consequent repeated palpitation might begot a habit of palpitation.

Vaso-motor System. The circulation of the blood in the brain under various conditions has been studied by Mozzo, by taking tracings of the cerebral pulsations in persons presenting some deficiency in the skull; and he has shown that during fear the brain swells, and then its pulsations become more pronounced. On one occasion, while taking a tracing of the cerebral pulse in a woman, The

pulsations became larger without apparent cause; and, on seeking for an explanation, he found that she had at that moment accidentally caught sight of a skull in a cupboard, and this caused in her an emotion which was probably of the nature of fear⁽¹⁾. In another patient the same result was produced by speaking sharply to him, the pulsations being increased to six or seven times their normal size⁽²⁾. Thus we have clear evidence that in fear the brain is more full of blood than ordinarily. Here again the excess of blood is doubtless to prepare the nervous system for an emergency; for it is certain, that in all states of cerebral activity, the supply of blood to the brain is increased. Thus Mosso has proved that not only is it greater during the waking than during the sleeping state, but that it is greater during intellectual effort than during easy thought.

(1). Mosso. *La Paura*. Chap IV. 2.

(2). " " " " " 4.

Like the palpitation, the cerebral hyperaemia which accompanies fear is a fact of some pathological importance; for an individual who is labouring under chronic fear necessarily, one would think, suffers from chronic cerebral hyperaemia - a condition capable of producing quite serious results.

As regards the effect of fear on the other vaso-motor areas, we can only speak positively in respect of the skin which is pallid. Mosso⁽¹⁾ argues that this contraction has for its object the driving of the blood inwards towards the nervous centres.

Breathlessness. In regard to the modifications in breathing which accompany fear, the advantage of the initial suspension in breathing is not altogether clear. The subsequent acceleration in the respiration may, like the palpitation and hyperaemia, be regarded as a preparation to some unmounted effort.

Muscular system. Although a slight degree

⁽¹⁾ Mosso. La Paura. Chap V. 4.

of fright may render the muscular system more active, yet no one of the physical effects of fear is more certain than the paralyzing effects which it produces on the muscles. Thus not only are the knees apt to bend, but in extreme fear (terror), an individual may be completely prostrated. The muscular weakness expresses itself most characteristically in tremor. As we read in Job "Fear came upon me which made all my bones to shake".

Functional Tremor is a very common symptom of nervousness, more especially among women, who suffer more from fear than men, and though this tremor certainly owns many other causes besides fear, one may perhaps not be altogether wrong in concluding that its frequency in highly nervous patients may bear some relation to its connection with fear.

The diarrhoea and involuntary micturition which may attend an outburst of fear have generally been thought to be due to relaxation of the sphincters, but

Mosso (Chap. X. 4) claims to have proved that they essentially result from spasms of the intestines and bladder.

The contraction of the arrectores pili and the resulting goose-flesh, and the erection of hairs, feathers, &c. are well known effects of fear. The primary object of this, according to Darwin, is to render the individual larger and therefore more terrible to his enemies. Mosso, however, rejects this hypothesis, offering in its stead an equally ingenious one. As we all know erection of the hairs and goose-flesh occur whenever the cutaneous blood-vessels contract. Such contractions most frequently result from cold. Thus birds and animals bristle up their feathers or hair in the cold weather; as a result of this, air is able to pass in between these cutaneous appendages, and the quantity of heat lost by the body is thereby diminished. Now during fear the cutaneous blood-vessels contract, (the object of this has already been hinted at), and, as a necessary consequence, the arrectores pili contract.

Therefore Mosso would contend that the erection of the hair, feathers, and other cutaneous appendages during fear, occurs as it were by accident, and has no ulterior purpose. May we not believe that each of these explanations has a measure of truth in it?

Spicklow Brown has often observed the bristling of the hair occurring as the result of fear in the Insane, (see Darwin, "The expression of the Emotions", p. 295), but such bristling is not always associated in the Insane with fear. The hair of the Insane is often very rough, and Spicklow Brown thinks that this is partly due to its frequent erection.

Trophic Changes. None of the effects of fear are more important from the pathological point of view than the modifications of the several secretions. Probably every secretion in the body is affected, and we thus see what grave trophic effects may result in individuals who are the victims of some chronic fear.

The Special Senses and the Intellect. In regard

to the influence of fear upon the mind, it will be enough here to state that, as in all emotions, so in fear, there is apt to be a temporary upset of the entire mental faculties.

We have seen that the essential purpose of fear is self-preservation. It is not a little remarkable that when pushed beyond a slight degree it defeats its own end.

Excessive palpitatio, breathlessness, and muscular paralysis, far from protecting an animal against danger, e.g. the attack of an enemy, place it at a disadvantage, and indeed may render it an easy prey to the foe. I merely allude to the fact without attempting to explain it.

I would point out, however, that fear probably acts largely as an ideal motive, rising up at the reflection of danger. Such ideal fear is not of the same intensity as actual fear. That namely which is excited by the actual presence of danger.

Ideal fear, being less intense than fear in the actual, is, we may suppose, practically

never accompanied by prostration, but is of just sufficient intensity to stimulate to action. It thus plays an important part in causing the animal to shun danger. The paralyzing influence of fear in the actual we must, for the present, be content to regard as an imperfection in the organism. Not only are we unable to explain the paralyzing influence, but we are equally at a loss to account for the profound effect which is wrought on the various secretions of the body.

It is necessary to understand what profound dynamical effects are wrought in the body by fear to realise what a potent influence it may have in disease. Its depressing effects render the body more prone to disease, while at the same time it diminishes the chances of recovery. Thus it has been remarked over and over again that the most fearful are the most apt to succumb to Epidemics, and it is said that the wounds of a conquered army do not heal so well as those of the conquerors.

The following case observed by me clearly

demonstrates this evil effect of fear during the recent Influenza Epidemic.

Mrs B. at 27, the wife of a medical man, in good health, and seven months advanced in pregnancy, unfortunately heard of a woman in her husband's practice who had been seized with Influenza. She also was about seven months in pregnancy; abortion followed, and the illness proved fatal. This made a marked impression upon Mrs B's mind, and she persisted in declaring that she would be attacked, and would succumb to the disorder. And indeed, shortly afterwards, she was actually taken at midnight with Influenza, and from the first the case appeared hopeless. Abortion followed, and, in spite of the ablest medical skill, the patient died in a few days, having constantly before her the dread of the fatal termination of the other case.

A study of the Physiology of Fear, then, impresses upon us the necessity of allaying a patient's fears, and of substituting for

them the stimulating emotion of hope, which by some Physiologists is regarded as the opposite emotion to that of Fear.⁽¹⁾

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Dr. James Ward of Trinity College, Cambridge, to whom I applied for information on this head kindly replied as follows: "In your note you raise a question that I wish I could answer briefly, 'What is the opposite emotion to fear?'"

We might say courage or we might say hope (or if we took the extreme form of fear, terror, we might say there was no opposite). Yet language requires differences, and we set timidity over against courage, and despondency over against hope, bringing out the point that all these are rather dispositions than emotions. Some Psychologists, who make much of contrasts in classifying emotions, pair off fear and admiration (or hope), as when from a neutral state of suspense, we pass to one or other extreme of (pleasant or painful) contemplation or expectation. It is usual too to place fear among asthenic or depressive emotions, and therefore its opposite must be sthenic, or expansive emotions....

Allied to fear is Anxiety which Hughlings Jackson has defined as "fright-spread-out-thin". The dynamical effects upon the body are therefore very much the same in the two cases. And this thought-enables us to understand what profound bodily effects may be brought-about-through Anxiety.

While Hughlings Jackson's definition is in the main true, it must not be forgotten that Anxiety may attain to a very considerable degree of intensity. I have seen a patient quite prostrate by anxiety.

Fear plays an important part in the aetiology of the neuroses. Thus long continued fear in the shape of anxiety has a most pernicious effect upon the nervous system, and predisposes to the functional nervous disorders, amongst which may be mentioned Insanity, Epilepsy, Hysteria, Migrain and Asthma. Sudden fear or fright must be regarded in the light of an exciting cause. Epilepsy, Hysteria, Chorea and other nervous disorders, and certain forms of Insanity such as

Melancholia stuporosa are known to be thus excited.

Among the nervous disorders which may be provoked by fear, not the least interesting is absolute loss of voluntary power over certain muscles such as those of the lower extremities. Russell Reynolds⁽¹⁾ published such a case in 1867. Analogous cases have since been recorded by Ichiriew,⁽²⁾ Charcot,⁽³⁾ and Lovelöw.⁽⁴⁾

The influence of fright upon the heart must not be forgotten. Undoubtedly a person may die from fright, and in such cases death is presumably due to cessation of the heart's action. Such a result is only likely to happen to those with weak hearts, such as the old and feeble, and those suffering from some organic cardiac affection.

⁽¹⁾ Russell Reynolds, Brit. Med. Journ.: 1867.

⁽²⁾ Ichiriew, Med. Messenger, 1884.

⁽³⁾ Charcot, Le Prog. Méd., 1885.

⁽⁴⁾ Lovelöw Archiv: Psych.: Vol III. 2.

Morbid Fears

In this Thesis I propose to consider more particularly the so-called Morbid Fears. These have been termed the Pathophobias, and the better to understand them we must first consider Fixed or Impulsive Ideas.

Fixed Ideas.

One common fact is noticed in all the several varieties of Pathophobia. The patient is unable to escape from the Thralldom of a fixed idea. One idea, a group of ideas, takes up its stand in the field of consciousness, and tyrannises, as it were, over all the thoughts.

Fixed Ideas, (*Zwangsvorstellungen* = idea or notion of compulsion or of being constrained), have been ably described by a number of German authors - notably by Griesinger⁽¹⁾, Meschede⁽²⁾, Berger, Müller, Stricker and Westphal.⁽³⁾ Among recent authors who

⁽¹⁾ Griesinger, "Arch. f. Psychiatri.," Vol. i., No. 1.

⁽²⁾ Meschede, Brit. Med. Journ. Vol. i., 1879.

⁽³⁾ Westphal. Ueber Zwangsvorstellungen. (Archiv. Psychiat. 1878)

have treated this subject in a masterly way are Buccola⁽¹⁾, Krafft-Ebing⁽²⁾, Emminghaus⁽³⁾, (who first applied the term "Zwangsvorstellungen" to fixed ideas), Wille⁽⁴⁾ and Ball⁽⁵⁾.

Fixed ideas are due to an alteration in the intensity of certain ideas. A similar tendency may be observed under perfectly normal conditions. After having heard a tune, it may run in the head for days with aggravating persistency, so that the person will complain "I cannot get this bothering tune out of my head". In a similar way certain lines of poetry will recur to the mind again and again, in spite of oneself. In like manner a piece of ill-news will

⁽¹⁾ Buccola, *Le idee fisse* Reggio 1880.

⁽²⁾ Krafft-Ebing, *Lehrbuch der Psychiatrie*. Zweite Auflage, 1883, T. II.

⁽³⁾ Emminghaus, *Allgemeine Psychopathologie*, 1878.

⁽⁴⁾ Wille, *Zur Lehre den Zwangsvorstellungen*.
Archiv für Psychiatrie 1881

⁽⁵⁾ Ball, *Des impulsions intellectuelles*. *Encephale*, 1881.
et. *La folie du doute*. *Encephale* 1882, No. 2.

take possession of the mind, and will refuse to be dislodged by any effort of will. One may also call to mind, in this connection, the persistence of certain emotions such as anger or revenge. We hear of men harbouring revenge a life time.

The current of thoughts depends upon the principle of Association. One idea will give rise to another, and thus continual series of ideas are perpetually travelling over the field of consciousness quite independently of the will. The will, however, is said to have some control over the thoughts. By an effort of will, the attention can be concentrated on some idea or group of ideas, and these by the law of association call up cognate ideas. Thus, if an individual is tormented by a group of ideas, and desires to dismiss them from his mind, he, by an effort of will, attends to something else.

Individuals differ considerably in their ability to do this. It would appear, therefore, that the prevalence of fixed ideas depends upon two things: -

2. The intensity of those ideas.

3. The strength of the will.

The more intense the ideas, and the weaker the will, the more will the individual be dominated by them - the more will they tyrannise over his thoughts. Each of these factors plays a part in the causation of morbidly fixed ideas.

That the morbid idea is abnormally intense is very evident; while as regards the strength of the will, the patients who are the victims of fixed ideas are essentially weak-willed. There is evidently marked mental dissolution in all these cases; and just as in the development of the will, we pass from the most automatic to the most voluntary, (Herbert Spencer); so in the dissolution of the will, we pass from the most voluntary to the most automatic. (Spencer, Hughlings Jackson). It is therefore evident that those who suffer from fixed ideas are weak-willed and that the weakness of the will is partly a cause of the morbid condition.

How are we to explain the undue intensity

of fixed ideas? We must assume that for some reason or other, a group of psychical centres is unduly excited; and just as a long continued spasm of a group of muscles may be due to a persistent over-action of the cortical voluntary centres, so we may suppose a fixed idea to be the resulting over action of a group of psychical centres; in which case the fixed idea may be regarded as a spasm or convulsion, so to say, of Thought. Why such over-action should take place we are no more able to explain in the latter case than in the former (in many instances at all events).

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- Fixed ideas fall naturally into three classes.
- (1.) Those of only moderate intensity, which, while they tyrannise over the thoughts compelling them to revolve round about a fixed point; do not in any notable degree influence conduct.
 - (2.) Those of greater intensity which influence in a very emphatic way the conduct of the individual. Under this

head are included the morbid fears of which we shall presently treat—such as Agoraphobia, Claustrophobia &c.

(3) In this group are included those cases where the fixed ideas attain the highest pitch of intensity. The individual is impelled, in spite of himself, to commit some terrible crime. Frequently he is the victim of the homicidal impulse, and so conscious is he of the unfortunate condition, that he will entreat his friends to put him on a straight-jacket, to incarcerate him, or in some way to control his actions until he regains self-control.

Causation of Fixed Ideas. The causes are (1) Hereditary, and (2) Acquired.

1. The influence of Heredity is all important, and is admitted by all writers on the subject. Thus in every one of 16 cases Willé discovered evidence of a family history of nervous disorders. Hence, most, if not all, the victims of fixed ideas, have a congenitally weak mental

organisation. In some of the cases we can clearly discern what Maudsley has termed an eccentric disposition, and at other times there is deficient intellectual development.

2. The acquired causes include all such as tend to perturb nervous action, such as

a, strong emotions, intellectual fatigue, excessive worry, &c.

b, Anaemia, exhaustion through bodily disease, lactation &c.

c Menstruation, The critical periods of life, (puberty, climacteric), pregnancy &c.

Frequently the fixed ideas take the shape of some morbid fear, and we then have the condition produced which it is now proposed to describe in some detail. There is naturally no end to the number of fears from which an individual may suffer.

The nature of the fear is very largely accidental - doubtless depending very greatly upon the particular mental organisation of the patient, but is

also dependent upon external events - These naturally may to a large extent determine the nature of the fear. Already a large number of morbid fears have been specially described, and not a few have been learnedly named. To dignify each particular fear by a special name, as though it constituted a separate and independent disease, is as useless as it is absurd.

— . A List of the Chief Morbid Fears. —

Acro-phobia (Verga), or Hypsophobia (Arnold)	= Fear of heights
Agora-phobia	= Fear of open spaces
Atremia ⁽¹⁾	= Fear of moving from one seat or getting out of bed.
Astro-phobia (Beard)	= Fear of lightning
Anthropophobia	= Fear of crowds
Anthropophobia	= Fear of men
Botrophobia	= Fear of cellars
Claustrophobia, (Chitophobia of the Italians):	= Fear of enclosed spaces
Claustrophobia	= Fear of leaving a room
Hysso-phobia (see Mosso)	= Fear of having Hydrophobia

⁽¹⁾ Reflex. Meber Atremie, Virchow's Archiv 1883.

Gynephobia	= Fear of women
Monophobia	= Fear of solitude
Mysophobia (Hammond) or Rupophobia (Verga)	= Fear of contamination
Nosophobia	= Fear of contracting disease
Oicophobia (Kovalevsky)	
Panophobia	= Fear of everything
Pathophobia	= Fear of contracting disease
(This term is sometimes used in a general sense to include all the several varieties of Morbid Fear.)	
Sitophobia paradoxica (Cougnet ⁽¹⁾)	
Spermatophobia	= Fear of nocturnal pollution
Syphilophobia	= Fear of Syphilis
Utophobia (Salemi-Pace)	= Fear to return home

Nevertheless there are at least three kinds of Morbid fears which are attended by highly characteristic symptoms, and which are therefore worthy of being denoted by special names. These are Agoraphobia or fear of open spaces, Claustrophobia or fear of enclosed spaces, and Mysophobia or fear of contamination.

⁽¹⁾ Cougnet, Archiv. di psichiat. Torino 1885, vi, 213-217.

Agoraphobia

A careful clinical description of this disorder was first given by Westphal.⁽¹⁾ Flemming⁽²⁾ contends that it was already described in 1832; while Höring⁽³⁾ ascribed the first account of it to Alexander Balbinus Lombardus who wrote in 1512. Amongst French authors Legrand du Saulle⁽⁴⁾ has treated this subject in a masterly way.

In the same year that Westphal described the disorder, Cordes⁽⁵⁾ published 27 cases of it. He regarded the term Agoraphobia (as suggested by Westphal) as too exclusive, suggesting in its stead Topophobia or Platzangst; that is to say "fear of places," instead of "fear of open spaces."

Since this time several cases have been recorded,

⁽¹⁾ Westphal, "Archiv für Psychiatrie und Nervenk"
Vol III 1872 p. 138

⁽²⁾ Flemming, Allgem Zeitsch f Psychiatrie Vol XXIX No 2

⁽³⁾ Höring, Allgem Zeitsch f Psychiatrie Vol XXIX

⁽⁴⁾ Legrand du Saulle, "Étude Clinique sur la peur des espèces," 1878

⁽⁵⁾ Cordes, Arch Psychiatrie Vol III 1872 p. 521

and at the end of my account of Agoraphobia, I have appended a list of all, or nearly all, the authors who have written on the subject.

The victims of this disorder have a fear of space or emptiness, and the more unbounded the space in which they find themselves, the greater is their fear. Thus it would be worse in crossing a large square, especially if quite deserted, than in a narrow street; particularly if the latter were thronged with people. In like manner it would be more likely to show itself in a church than in a room. The fear has been excited under the following circumstances.

In the country, in squares, in the streets, especially in such as have no shops, or in streets whose shops are shut up, in the theatre, in church or concert-room, in an omnibus or cab, or on a bridge, or in a room having a window overlooking a large court; In all these cases it would appear that it is the sense of emptiness which causes the fear. The patient becomes suddenly filled with great fear which he is powerless to control, though he may be fully aware of the absurdity of it.

He is seized with a feeling of oppression at the heart which palpitates violently. The whole body trembles, the knees bend causing a staggering; the vaso-motor system is much perturbed, the face becoming pallid or red, at the same time the surface breaks out into a sweat.

There may be a strong tendency to cry out: (These symptoms, it will be observed, are the chief bodily accompaniments of fear)

The patient is afraid to go backwards, or forwards, being apparently terrified by the emptiness around him, and it sometimes seems as if space were widening out indefinitely before him. Anything which tends to remove this sense of vacuity, and which offers a means of material support; suffices to calm him, notably the presence of a companion, and in some cases even the arm of a little child.⁽¹⁾ Similarly the support of a walking stick, or the approach of some vehicle, or the light of a lantern, (*Le grand au Sautle*), may remove the fear. His courage returns as he approaches houses, if for instance he turns down

(1) Cordes, "Arch Psychiatric" Vol iii No 3.

a narrow busy street. In order to obtain a good picture of this curious disorder, I shall now relate a series of cases which I have selected from a large number that have been recorded, and with them I shall include one that I have myself observed. It will be advisable to describe them in the briefest possible way.

Case 1. Commercial traveller, aet 32, suffered from palpitation, tremor, and peculiar feeling of uneasiness in the head when he attempted to cross a square. A stick would not help him, but walking arm in arm with a friend in conversation is of great service. The same symptoms are experienced if he has to walk along a blank wall, or besides shops that were shut. He supped in a restaurant, and would wait till he saw someone going in his direction, and then he would follow them home, or he would follow closely behind some vehicle. He described the unpleasant feeling experienced as different from giddiness.

Case ii Woman aet 44, since ascending the Rigi, when 15 years old, has not been able to cross alone any large square or street such

as the Champs-Élysées without fear and trembling. Felt her legs bending under her as if the pavement were moving. She is quitted if she can take her husband's arm, or even the hand of a child. Experiences a similar feeling if she goes to an empty church, especially if there are no forms or chairs in it. Has her sitting room over-crowded with every kind of furniture to do away with the sense of emptiness. Reasons to herself on the absurdity of her fear to no purpose.

Case iii Infantry Lieutenant, at 27. One day while traversing a large empty square in uniform was suddenly seized with intense fear; he hesitated whether to retrace his steps; a cart then appeared, and this enabled him to continue his walk; but he did not regain his ease until he arrived at a narrow street. The same symptoms were afterwards experienced under the same conditions, but he felt quite at ease picking, or when walking with his sabre at his side. He afterwards experienced an uncomfortable feeling upon looking out of a window from a height, and in church. He changed his lodgings several times to the surprise of his friends, and finally hired a shop, and put up the shutters. Here he continued to live for some time.

Case IV. A man, act 23, is seized with great anxiety and palpitation if he tries to cross a public square. Is calmed as he approaches houses; is much less troubled if he is pre-occupied, if he can take the arm of some-one, if he has a walking stick, or if a carriage is near. He has a great dread of long walls, shut shops, or barracks. Has the same trouble in a Theatre or church. He fears space. When leaving his café of an evening, he waits till some-one goes in the same direction as himself, and then follows him step by step. The red lamps of restaurants are a great help to him.

Case V. Man, act 24, Cannot traverse squares or streets with shops shut. Cannot remain in Theatre, or concert room. Has a strange agony, palpitation, and trembling when traversing a square. Space seems to widen out indefinitely before him. He cannot reason himself out of this abnormal state.

Case VI Man, act 26, when traversing an open square suffers from a peculiar tightness at the heart, is terrified, he blanches and reddens. The ground seems to rush in torrents under his feet. The arrival of a carriage stops his troubles. The fear vanishes when he has once crossed the space,

but returns when he looks behind. Iron. Trees are a great help.

Case vii Suddenly seized with an undefinable emotion, weakness, and colic when crossing a bridge, wide space, or street. Finds a stick of great help.

Case viii Woman, aet. 30, she feels as if she were lost in space, and as if she were going to fall forwards or backwards. much less troubled if accompanied by somebody.

In none of the above cases (all from Legrand du Saule) was vertigo present.

Case ix. Man, aet. 40, manager of a paper mill. He suffers from palpitation and tightness at chest in attempting to cross alone the market-place or common of his town. The mere thought of expansive country weighs him down. He describes his sensation as if the land was moving away from him in all directions, and he expected to sink into the vacuum. (This patient came under my own observation.)

Case x. A clergyman was seized with terror when there was nothing between himself and the sky. In the country he would walk under trees, and if there were no trees he would put his umbrella up. (This case was com-

municated to Westphal by Brück)

Case XI Man, aet 23, One day while walking on the streets he was suddenly attacked by palpitation, dimness of vision, trembling of the limbs, and a feeling as if he were going to fall. After this he took to his bed where he was obliged to stay for 6 weeks, for whenever he got up the unpleasant-symptoms returned. For 6 months after this he could not bear open spaces or streets; preferring those streets where there was most traffic. Felt himself again when taking the arm of a friend, or using a walking stick, or even when in company of his little brother 6 years old. Sometime afterwards his disorder underwent a sudden change. He lost all fear of deserted places, and developed instead a great fear of heights. He thought that his apartments were situated in an upper story game him no rest day and night: (from Cherchewsky⁽¹⁾). Sometimes this fear is experienced rather in crowded streets than deserted ones. Legrand du-Sault, Cordes, and Cherchewsky have recorded

⁽¹⁾ Cherchewsky - Contribution à l'étude de l'agoraphobie.
Rev. de Méd., Paris, 1885, v. 909-934

such cases. The following case is taken from the last author.

Case XII. Man, *æt* 31, is seized with "painful anguish" in the cardiac region, with prostration, when in crowded streets, ball rooms, restaurants, &c. He has to go every day from St Petersburg to his regiment situated in a neighbouring town, but owing to his fear of crowded places he chooses the very earliest trains in the morning for the journey. Directly any person or carriage appears he is filled with an indescribable anxiety. In places where he is well known he suffers from none of these troubles, because, if he fainted, or became unconscious, he would not then be mistaken for a drunkard. The above cases are examples of pure Agoraphobia. Many cases recorded under this name are not instances of this disease at all.

In most of the cases I have quoted it is expressly stated that the unpleasant feeling experienced by the patient is not one of giddiness. Westphal was most careful to distinguish Agoraphobia from giddiness. Before him (1870) Benedikt had described the

disorder, and had attributed it to ~~ocular~~ vertigo. But although Westphal has drawn a distinction between ordinary giddiness, and the uneasiness of Agoraphobia, Grainger Stewart⁽¹⁾ contends that the feelings in both cases are closely allied. This physician appears to me to give the most philosophical description of the disorder which has yet been offered. "Various explanations," he writes, "of the condition have been attempted, but none of these seems to me quite satisfactory. A reasonable explanation of one element of the trouble lies, I think, in the supposition that these patients with the nervous system morbidly sensitive, have from some peculiarity, acquired the habit of guiding themselves in their equilibration by reference to near vertical lines; and that, when these vertical lines are wanting, they feel, as others do, when standing on the edge of a cliff. Notice the fact about the methods they devise for getting across squares. If they can get behind some vehicle, they can walk well enough; the vertical lines of the vehicle suffice to guide them"

⁽¹⁾ J. Grainger Stewart: Clinical Lectures on Important Symptoms, "On Giddiness." Edinburgh, 1884.

A writer in the Brit. Med. Journ. (May 3, 1884, p. 863) offers a very similar explanation. "In walking in a street we are continually guiding ourselves by the horizontal lines of the pavement or houses, even though our eyes be fixed on a newspaper, or our mind abstracted from all surrounding circumstances. In passing from a street into a wide open place, we have at once to abandon the horizontal guidance, and steer by the vertical lines of the houses on the opposite side. It is the absence of horizontal lines, the absence of visual impressions received from both sides which would seem, on this view, to be the determining cause of the peculiar uneasiness of Agoraphobia." These writers attribute the phenomenon of Agoraphobia to some disturbance in the process of equilibration, rather than to the psychical disturbance - to a morbid fixed idea as Krafft-Ebing contends. And the fact that the arm of a friend, the use of a walking stick, or even the hand of a child sometimes suffices to remove the morbid phenomenon, is evidently in favour of this view. Nevertheless the psychical

element in the case must not be wholly neglected. In practically every case of Agoraphobia, the patient is of highly neurotic descent; and manifests some form of mental obliquity, and it is certain that the morbid dread of open places sooner or later assumes all the obstinacy of a fixed idea.

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Claustrophobia

Claustrophobia (Clitophobia - a term we owe to Verga⁽¹⁾) is the very reverse of Agoraphobia. In it the patient has fear, not of wide open spaces, but of closed spaces; above all does he fear to be shut up in a room or in a house from which he cannot at once escape. The thought that he is thus shut up induces a panic, a mental anguish, we may assume very much of the same nature as that which would be produced in a perfectly healthy individual who suddenly found himself locked up in a small cupboard. Claustrophobia appears to me, in fact, to be an exaggeration of a normal fear; it is a pathological state which grows out of a state purely physiological. In this respect it differs from Agoraphobia in which I am unable to discover any physiological counterpart. Meschede contends however that this disorder should be classed with

⁽¹⁾ Discorso col quale il Prof. Andrea Verga inaugurò l'anno 1875-76 nell'Ospedale Maggiore di Milano Estratto dal Giornale dei Tribunali. Milano 1877 Vedi anche l'Archivio italiano per le malattie nerv. Nov. 1876.

Agoraphobia, because in both cases the patient is unable to properly appreciate the dimensions of space⁽¹⁾. Beard⁽²⁾ is of the same opinion, and proposes to group the two under the head of Topophobia, or fear of places, closed or otherwise. It will be seen that according to my view, Claustrophobia is essentially a psychosis; while Agoraphobia depends, in large degree, on some disturbance in the muscular sense.

The Claustrophobic, (if I may be allowed the term), prefers the wide open country to indoors. If compelled to remain indoors he is most careful to secure for himself a ready means of egress. He will get up in the night to lock the doors, and he will throw open the windows of his bedroom.

This disorder has a very scanty literature. Among them I select the following as typical instances of the complaint:-

Case 1. Man, aet 80. Had suffered for some years

⁽¹⁾ Meschede. Brit. Med. Journ. Vol I 1879.

⁽²⁾ Beard. Neurasthenia. London, 1890.

from fits of depression. Has an intense horror of enclosed places. If shut up in a small room, or one affording no means of ready escape, he would, he avers, be driven to suicide. One day his nephew shut him by accident in a closet. He shrieked out for help, and was seized with fury, madly striking the door with his feet and fists in order to break it down. Fortunately help soon came. He would not have hesitated, he declared, to jump from a high window if he found no other means of escape from a closed room. Sometimes he would be seized at night with the fear that he could not get out of the house, and would go down and test the door returning tranquilly directly he found that he could actually escape if he wished to. (From Raggi)⁽¹⁾

Case II Lady, aet 40. If by accident she finds herself in a closed room, she is seized with frenzy, and, if long detained there, would commit suicide. The landlady of her house insisted in having the hall-door locked

(1)

A. Raggi, *Ile casi di Clitrofobia*, Bologna, 1877.

every night; and the thought that she was thus shut up, and could not escape should any danger arise, prevented any sleep. She would throw open her window, and wander through the house, thus preventing others from sleeping. Her friends prevailed upon the land-lord to let her have a key so that she might go out if she chose. The key she kept safely under her pillow, and it enabled her to sleep in peace. (from Raggi).

Case III. An artist, act 30, had a great dread of staying in closed rooms. Always had his bedroom window wide open; would get up in the night, and wander in the neighbouring fields. When competing for a prize at an Academy of Art; on finding himself alone and shut in, he was suddenly seized with a panic; so intense was this, that he was compelled to escape by the window on to a neighbouring roof, whence he was able to reach the ground, and to wander into the fields. This patient subsequently became insane, his peculiar fear becoming more and more pronounced. Eventually, however, he drifted into complete

dementia (from Raggi)

Case IV. A man. is seized especially during the night with panic at the idea of being shut up alone. Keeps the windows open, has had to get up in the middle of the night, and wander about the streets till morning. (from Ritti)

Case V. Woman, aet 36, One day while ascending a tower was seized with terror at the thought that the door was shut below, and that she could not get out. She was compelled to push down, and when she reached the open her trouble vanished, as if by magic. After this she gradually drifted into unmistakable Claustrophobia. (from Ritti)

I have made inquiry by means of a circular letter as to existence of Claustrophobia among inmates of prisons and public Asylums. The information thereby obtained was unfortunately meagre, but is sufficient to show that this disorder is at any rate very rare in prisons.

Thus Dr. O'Keefe (of Mountjoy Prison) writes, "My

experience is that-Claustrophobia does not exist to any extent amongst the inmates of prisons." The medical officer of a large convict prison observes, "From my experience Claustrophobia does not exist among prisoners."

On the other hand, according to Dr Gilbert, (H. M. Prison, Holloway), "Claustrophobia does occasionally exist, but very soon wears off; and it is almost entirely amongst the better class of prisoners"

Perhaps the most emphatic answer I have received on the subject is the following from Dr Price, (H. M. Prison, Birmingham), "I have not found a single case of Claustrophobia among the 40,000 to 50,000 prisoners that have been under my charge. I have heard that in the old days, when prisoners were subjected to long terms of solitary (in its true sense) confinement, that upon release they feared open streets and places. "Solitary" confinement does not now exist, and in the so-called "separate" confinement, convicts exercise in association for at least one hour daily. With regard to Claustrophobia,

interpreting it as suffocation in a small space, or impending calamity therein, we must remember that in the vast majority of cases, the prisoner is removed to a cell which itself is, or may be, larger than the room he habitually occupies.... "

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Mysophobia

In 1849, Hammond⁽¹⁾ described a disorder characterised by the dread of being contaminated, calling it - Mysophobia; Verga⁽²⁾ in 1880, described the same disorder under the name of Kupofovia. But Legrand du Sault⁽³⁾ in 1875 had described the disease as "the madness of doubt accompanied by delirium of the touch." He collected the cases that were first described by V. Fabret⁽⁴⁾, the elder, in 1866 under the name of "the diseases of doubt", and by J. Fabret⁽⁵⁾ under the title of "partial alienation with fear of contact." It has also been called Mania contaminationis, Melancholia with filth dread, (Russell)⁽⁶⁾, & 2nd stage of the madness of doubt.

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- (1) Hammond, Neurological Contributions, New York, 1879
 (2) Verga, Archivio delle malattie mentali 1881
 (3) Legrand du Sault, La folie du doute avec délire du toucher, 1875.
 (4) Fabret, V. Delasiaume & Discussion sur la monomanie raisonnante. Ann: Medico-psycholog: 1866
 (5) Fabret, J. de la folie raisonnante, 1866.
 (6) Russell, Mysophobia. Melancholia with filth dread, &c (Alienist & Neurologist - 1880)

The patient afflicted with this malady has a morbid dread of touching anything for fear of being contaminated, poisoned, or otherwise injured. He is continually washing his hands, (one of Hammond's patients performing this operation no less than 200 times a day) and avoids touching anything with bare hands as much as possible, and to this end will go about with gloves on.

In some cases he will carefully observe what objects, such as door-handles and furniture, are touched by other people, and for fear lest he may be contaminated, he will carefully wash them over where they have been touched; and if compelled to touch them, he suffers from palpitation, cold sweat, and other physical manifestations of fear. This fear frequently originates from an instinctive aversion to certain animals - mice (as in Tamburini's case) cats, dogs - in this case dread of Hydrophobia playing an important part.

Tamburini. Sulla Pazzia del Dubbio &c.
Rivista Sperimentale di Freniatria 1883.

(1)
Morel mentions a case in which the patient, a woman, on account of the fear she entertained that every object might have been contaminated by the foam of a mad dog, not only abstained from touching them, but would not allow any linen to go near her person except such as had only just left the factory. (2)
Marce in 1862 described a still more characteristic case of the same fear in a country girl, where the delirium, little by little, so grew on her, that she regarded as dangerous, not only contact with the objects themselves, but even the exhalations they were supposed to emit. - There may be intermissions in the course of the disease for months or even years; but at the slightest cause (especially returning to the same surroundings) all the morbid phenomena reappear. Exacerbations are likely to occur at the menstrual periods.

(1)
Morel, Du delire émotif, Archives générales de médecine 1866

(2)
Marce Traité des maladies mentales 1862

It is a curious fact that these patients, at first so scrupulous as to cleanliness, often afterwards become dirty in their habits, persistently refusing to change their linen.

As in claustrophobia, so here, the morbid dread is probably an exaggeration of a fear, which, kept within due bounds, may be perfectly physiological. It is eminently sensible for a person to wash his hands carefully before sitting down to eat a meal, or after handling patients, or any dirty objects. The possibility of being contaminated by neglecting to do this might well occur to the mind of a perfectly sane person. When, however, the idea of contamination attains the intensity and persistence of a fixed idea, dominating all the thoughts and acts of the individual, the condition is manifestly pathological.

In all these cases the mental balance of the patient is, no doubt, unstable. There is an undue tendency to fixed ideas, but what particular idea shall dominate the individual is very probably, in great measure, accidental.

The possibility of contamination was, by reason of some accidental circumstance, suggested itself, and this determines the nature of the fixed idea.

The following are selected cases of Mysophobia:-

Case 1. A girl, at 18, ~~her~~ uncle had died of cancer of the nose; for fear of infecting herself and others, she continually washed herself. Would carefully wash her hands every 5 minutes, spend an hour in the bath, using a dozen towels, and would go about the house with gloves on, and would stand in the middle of the room to avoid touching persons or things. She admitted the absurdity of all this, but could not help herself (from Sequin⁽¹⁾).

Case II A man, suffered from the fear of contaminating his hands, and avoided touching anything as much as possible. On going to bed at night, he spent from 10 p.m. to 2 a.m. in washing every object he had touched, using for this an abundance

⁽¹⁾ Sequin, A case of Mysophobia, Arch: of Med: August 1880.

of towels. (Russell).

Case III A woman, in puerperal state, got into her head that one of her parents had touched a corpse, then followed the desire to have everything washed, and to perpetually wash her hands, lest; by chance, she had touched any of the objects which the contaminated parent had touched (from Verge)

Case IV Woman aet. 30, By degrees developed the notion that everything she touched was filthy; and, when anyone came to the house, she carefully noticed every object that was touched by the visitor, and afterwards washed it (from Samburgini).

Case V. Boy, aet. 15, goes about holding his arms and hands away from his body, as he is afraid of touching his clothes. Is afraid, if he touches anything with his hands, it will poison him. Thus one day he remarked "I have been touching the paint on the wall, do you think it could come off and poison me?" (from Shaw⁽¹⁾)

⁽¹⁾ Shaw. A case of Mysophobia, Archives of Medicine, 1881.

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Madness of Doubt.

It must here be mentioned that Mysophobia is sometimes preceded by what has been termed the "Madness of Doubt". Indeed some writers would appear to assume that it is always thus preceded, and that, on the other hand, the Madness of Doubt⁽¹⁾ always goes on to Mysophobia. Writing on this belief, Legrand du Sault has described (Mysophobia as now known) "Folie du doute avec délire du toucher."

There can, however, be no doubt that, while these

⁽¹⁾ Prof. Kovalevsky of Karcov thinks the relation is 1st Stage, Neurasthenia, 2nd Stage pathophobia, 3rd Stage "La folie du doute."

two may occur together, the one passing into the other, nevertheless either may exist independently.

Seeing that the madness of doubt is often associated with Mysophobia, it will not be out of place to very briefly consider its leading aspects here.

Questions are continually and persistently presenting themselves to the patient against his will. These questions are often of a highly abstract and problematic, and sometimes of a very ridiculous, nature; while the mind remains in constant doubt regarding them, so that they recur again and again to the mind.

Sometimes metaphysical questions present themselves as to the existence of a God, at other times curious mathematical problems, so that the patients will be perpetually engaged in working out some calculations. Or again they will continually ask themselves why such and such a thing is as it is.

As an example of this "Mania of why" which has come under my observation I may cite the following: -

A girl at 20. She was under the dominion of Why? She would come into a room and want to know why people came in by the door and not by the window? Would spend 10 or 15 minutes asking herself why should she put her right stocking on before her left; or her right foot before the left: &c. She ultimately became dangerous, and, making a murderous attack on her mother, was removed to an Asylum.

Not only is there doubt as to the why and wherefore of things: there may be equal doubt as to actions which the individual has himself performed, as the following case, observed by me, shows -

D, a medical man, abt 27, was first taken by this doubting condition when a student:

In dispensing he would be doubtful whether he had put an overdose or some poison into the bottle. After adding water he would frequently take a dose himself, and would even then probably empty the bottle, and make up the prescription afresh. On some days he was entirely free from this uncertainty. He would read and reread the directions, and often would

tear off the paper wrapper for one more read.
 On turning off a gas jet, he would place his hand
 over the burner to detect any escape, would feel
 the stop-cock to be sure it was turned, would
 strike a match and hold it over the burner,
 and then would perhaps turn the gas on and
 light it. The whole process had thus to be
 repeated, and sometimes for 3 or 4 times.
 Even after such careful precautions he
 would lie awake in bed in order to detect
 any smell of gas, and has been forced to
 get out of bed to see all was safe with
 the gas. There were many other similar actions
 in connection with this patient. He gradually
 got rid of these doubts, and is now quite
 free from them.

The delusion of doubt was known to Esquirol,⁽¹⁾
 and has also been described by Falret, (père
 et fils) Parchappe, Trelat, Baillarger, and
 others; and Legrand du Saulle⁽²⁾ and Prof. Ball⁽³⁾
 have given complete clinical investigations of
 this disease.

⁽¹⁾ Esquirol, "Maladies Mentales"

⁽²⁾ Legrand du Saulle, "La folie du doute"

⁽³⁾ Prof. Ball, "L'Encephale," 1882, No. 2.

Syphilophobia

This is a comparatively common Morbid Fear.

This is not to be wondered at; seeing how many put themselves into the way of acquiring Syphilis, and seeing moreover what a serious disorder this latter is. In some cases, however, it would appear that Syphilis is feared even though there be no pretext-whatsoever for the fear. Accordingly P. Diday⁽¹⁾ divides Syphilophobes into two classes (1). Those in whom there is no pretext for the fear. (The disorder he then terms Syphilomania). (2) Those who have some cause for their alarm.

One of his methods of treatment is to put the patients under the antisyphilitic treatment. If they do not improve, he can assure them that they are not suffering from Syphilis, and that there are accordingly no grounds for their fears.

Syphilophobes are, as we should expect; most frequently met with in Lock-hospitals, and this morbid fear is much less common in women than in men.

⁽¹⁾ Diday, P. Gaz. mèd de Paris 1861, 3^è Sér., XVI p. 530

The following case is an instance of the disorder occurring in a woman.

Case. Woman aet 61. Said to have been parished years before. Has for some time been continually haunted with the thought that she was then inoculated with Syphilis. At one time she imagines it is localised in the eye, at another in the ear, at another in the nose. She complains of a nasty smell in the nose; This compels her to get up in the night constantly to rinse her mouth. All the facts of the case, however, tend to show that the unpleasant smell is anthelmintic. There are no evidences of Syphilis. (from E. Chambard).⁽¹⁾

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XXXVI. 189-194

Acrophobia

Acrophobia or Fear of High Places is in a minor degree an exceedingly common affection. Most people experience an uncomfortable sensation when looking down from some great height:

(see Gspangen Hewart "On Giddiness" p. 10)

By practice, however, the disagreeable feeling thus caused can be overcome, as we see in the brick-layer, sailor, and rope dancer.

As with the other fears, so with this, the condition becomes aggravated when the individual is out of health. It is well known that bricklayers and others whose occupations compel them to ascend great heights, find themselves unable to do so without risk when their general health is upset:

Andrea Verga⁽¹⁾ was the first to describe Acrophobia as a special morbid fear, and his description derives a peculiar interest and importance from the fact that he himself is a victim of the disorder.

The following is the description of his own case:

⁽¹⁾ Verga, A. L'acrophobia, Archiv: Ital: per le mal: Nerv: Milano 1888 XXV. 92-98

"I have never succeeded in overcoming the more or less painful feeling, which my organism undergoes when it is in elevated places. I find that I am essentially a terrestrial and a pedestrial animal. Though not a giant, I realise the fable of Anteus, who could never be raised above the ground without feeling himself lost. It is a long time since I took my first riding lessons; I preferred an humble donkey, from which I could scratch the ground with my toes, to the finest looking horse, be he ever so docile and gentle. I have sometimes journeyed on the dicky of a stage coach, or the box of an omnibus, but the pleasure of the grand and varied scenes presented to my view, was always smothered by the disquietude caused by my elevated seat; and the fear of being instantly pitched off. Every time I have passed over a river, in a wagon or a carriage, along a high and long bridge, I have never known when I reached the end of it; fearing that at any instant the bridge might break down, and I should be tumbled into the water and suffocated. I have not a bit of taste for looking out of windows, even if only from the first

story, for I am seized with a sudden apprehension
 lest the wall may give way, and myself go
 down with it. When I have reached the top
 of a tower or a belfry, I always prudently stand
 in the centre, and I do not attempt to look
 down, for it seems to me that I must be
 hurled into the abyss that is gaping for
 me below; and what is very curious is
 that whilst I am ascending a tower or a
 belfry, I experience a painful sensation,
 just as if my belly was being dragged out
 of me, and no argument by myself or by
 others, as to the solidity of the edifice, and
 my personal safety, succeeds in quieting me.
 I am naturally always ashamed of this
 weakness, and yet, on some occasions, I
 have not refused, in company with others,
 to visit heights generally regarded as very
 pleasant, superb, or enchanting, because of
 the fine prospects to be enjoyed there, but
 I must not tell you the internal distress
 caused to me by the sacrifice. To me
 the ascending of a scaffold is a heroic enterprise,
 be it ever so well fenced in, the timbers ever
 so strong, and near to each other, the footings ever

so thick and well arranged, and the whole constructed according to the instructions of the most skilful director.

It is not necessary that I should actually see others in perilous positions; it is sufficient that I but imagine them.

Sometimes an incipient giddiness and a nausea assail me on the mere reflection that the globe, on which I exist, is rotating with great velocity in the immense vacuum of space, and it appears to me that the force of centrifugal projection of a body in very rapid motion may, sometime or other, overpower centripetal gravity."

One fact stands out very prominently in considering these varieties of morbid fear. The particular fear from which the individual suffers is not the sole manifestation of psychical abnormality. Careful observation discloses the evidence of mental peculiarity; indeed, it is my belief that the entire mental organisation is at fault. A strong

tendency to fixed ideas never, so far as I know, shows itself in a mind normally constituted, and such a tendency is, as we have seen, an essential factor in these cases of morbid fear.

For this reason I have come to regard the prognosis of cases of this kind as very unfavorable. Something may be done by attending to the general health of the patient; by the administration of drugs such as Bromides, and by modifying the mental environment of the individual; but even though temporary benefit may often be thereby obtained; sooner or later the fear is apt to return, either in the same or in a modified form, and it is of some importance that these facts be represented to the friends of the patient.
