HYSTERIA.

In this essay I have endeavoured to collect and describe all the principal symptoms of the condition of the nervous system which we call hysterical, and to draw some general conclusions as to their etiology, pathology and treatment. With the limited time I have had for reading & personal observation, this must necessarily be for the most part merely a compilation; still I hope it will have the virtues of being at least systematic and thorough. Some points will necessarily have to be omitted or only briefly mentioned, because one cannot describe all the bearings of such a subject in the space & scope of a single essay, without prolonging it beyond reasonable limits.

In the first place I would remark that the term Hysteria (ὑστέρα, the womb) is essentially misleading, but has so firm a hold, that it would be useless to attempt to discard it. The disease so designated

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List of Works Consulted.

1. J. R. Reynolds. System of Medicine Vol II. 1872.
2. Buzzard. Quains. Dict. Medicine.
3. Jolly. Von Ziemssens Cyclopaedia. Vol XIV 1878.
4. Wir Mitchell Diseases of Nervous System 1885.
5. Savory & others. Holmes System of Surgery.
6 Gowers . Epilepsy 1881
7. Richer Hystéria

is partly a neurosis, and has no essential connection with the uterus or genital organs at all.

We shall describe the symptoms as psychical & mental, sensory, motor, & organic. By organic I mean such symptoms as occur in connection with the bodily functions of Respiration, circulation &c.

The symptoms of Hysteria are so numerous, & so multiform & even opposite in their characters, that we could not describe them as a single disease, but for the fact that the psychical phenomena are always, in varying degree of intensity, the same, and the other symptoms co-exist, or alternate in such a way, in the history of a case, that it must be a single state of the genital health & nervous system that gives rise to them all.

I. Psychical Phenomena

There is usually something notably good, or notably bad about hysterical persons, something to show an ill-balancing of the functions of the nervous system. Their mental capacity varies just as much as that of ordinary persons.

Sir James Paget. Lectures on Mimicry. Page 186.

J. R. Reynolds Syst. Medicine P. 84.

Intelligence. Not markedly altered, but in proportion to the general mental capacity. Attention however is difficult to retain, because the patient is taken up with her own troubles, and cannot be got to take interest in anything else. Her power of judgment is weakened, and she is liable to be inaccurate, because there is a lack of energy. The reason of this we shall see later.

Buzzard. Quain's Dict. Page. 678.

Memory is often good, but in old standing cases it is likely to become weakened, especially where the symptoms have been severe & acute.

See Weir Mitchell's Diseases of Nervous System Page 230.

Volition. Volition is impaired and also perverted. Three changes chiefly, are noticeable. (1) Patient cannot make up her mind to do anything, but evolves a large number of projects and fails to bring any one of them to completion.

Jolly in Von Ziemssens Cyclopedia. Vol. XIV Page. 542.

(2) Patients cannot do some act because they cannot will it, or else (3) they persist in doing some act to the exclusion of all else. The last two of these we shall see are identical in causation. They are due to a dominant or regnant motive.

There are two doctrines of Volition:- the first, the doctrine of the "Freedom of Will", which is that will is a spontaneous power not governed by any law, forming in fact the exception to the law of universal causation. The second is that of Necessity in which the will is held to be the outcome of motives i.e. states of feeling, the most powerful motive gaining the ascendency and leading to action. The former of these does not aid us in understanding the volitional state of Hysteria, but if we adopt the latter, it renders this state pretty clear.

Now let us ask ourselves what is likely to be the state of the nervous centres in Hysteria? In hysterical persons the general health is below par, & the general nutrition impaired and the higher nerve centres must necessarily share in this. One result of this is instability or increased irritability, coupled with impairment of action or endurance. The result of this is that a multitude of motive is evolved, first one becoming dominant

and then another, and each in turn causing an act of volition. The result of this is the fickleness of will, and inability for sustained effort seen in Hysteria.

If however from internal or external influence any motive makes a sufficiently strong impression, the whole energy of the mind is centred on it and it becomes dominant, to the exclusion of all else. This is what gives rise to all the symptoms which we shall describe as due to a dominant motive or idea. It may lead a patient to feel that her leg is paralysed, and effectually prevent her from using it, or it may lead her to work enthusiastically at some good work, but whichever it may be it will form a hobby, and form a centre for the patients inordinate Egotism which is so common in the hysterical.

Von Ziemssen's Cyclopaedia Vol XIV. p 542.

The condition of the nervous centres engaged in mental processes then, seems to be one in which many motives occur, or else only one. If it be a single motive, it leads to persistent action, but no energy is left for other processes.

Emotional State. Emotions are exaggerated, easily excited, uncontrolled in their expression, and often very inapt to the circumstances causing them. Patients are also rapidly hurried from one state of feeling, to another which is quite the reverse; from a state of melancholy, to one of very lively feeling, and this in turn is rapidly succeeded by some other state. These changes in emotion are caused by what in healthy persons, would be quite inadequate causes.

Buzzard. Quain's Dict. P. 678

Russel Reynolds. Syst. of Medicine Page 89.

Von Ziemssen's Cyclopaedia Vol. XIV. Page 536

The inappropriateness of emotion in these persons is seen in their laughing at tragic announcements, & crying in equally inappropriate circumstances. Circumstances of an indifferent nature may also set them off in either direction.

Wair Mitchell. Diseases of the Nervous System Page 18.

This state of things corresponds exactly with what we have said under volition. The centres engaged in these processes are badly nourished, and instable, so that emotions are easily originated but do not last.

In slighter cases pleasant as well as unpleasant emotions are alike easily roused, but later, as the state is more severe, painful emotions tend to predominate.

As a result patients are bad tempered, restless, & impatient. They become very unamiable & a source of grief both to themselves & their friends. In the end melancholy, varying in intensity is almost constant. This state is also fostered and increased by the various aches & pains to which such persons are liable.

Von Ziemssen's Cyclopoedia Vol. XIV. P. 536 & 537.

Emotion instead of being expressed in the usual manner may cause pain, convulsions, Coma, a paralysis &c. This will be noted constantly in regard to the symptoms.

Bigg and Quains Dict P. 678.

Idiosyncrasies. These seem to me to be dominant emotional motives. Likes or dislikes for certain things are developed. These may be perfectly indifferent, pleasant or disagreable to ordinary persons, but in these persons the pleasure or disgust they cause are excessive. Disgust may be caused by certain odors, colours, animals as frogs, toads, mice, rats, cats, dogs & the like. The presence or even, in some cases, the thought of these things may cause a paroxysm, fainting &c. In one case Mitchell saw a patient have a "death spell or trance", when he talked to her of odours. Excessive partiality may be developed for certain things, colors, odors, sounds, &c, or animals as Dogs, cats, birds &c &c. Also unfounded likes & dislikes for individuals. All of these Idiosyncra-

Von. Ziemssen. Cyclopaedia Vol XIV. P. 537.

W. & Mitchell Diseases of Nervous Syst. P. 189.

crasies may change with a change in the patients emotional state.

The Imagination. Very powerful and lively. This power of Imagination may act for good or evil. It may lead the patient to believe she suffers from symptoms she has seen or heard described, or it may make her believe she can be cured by some particular method. These means are then effectual even in long standing cases. In fact it supplies motives for doing what she has been unable to do, or for checking acts due to a dominant motive.

Von Ziemssen's Cyclop. Vol XIV. P. 540 1.

Moral State. These persons crave sympathy. They consider that they suffer more than anybody else, and are therefore entitled to more attention than people of more robust make". This state of feeling leads to a dulling of the sense of right and wrong. Patients use all manner of fraud to render themselves interesting & deserving of sympathy.

Buzzard. Quain's Dict. Pages 678 & 679.

One form of this is a feeling that their life destiny is a hard one. It is often seen in elderly women, such as old maids & widows, also in women with grown up families, the grievance being that they have to part from their

Von Ziemssen's Cyclopaedia. Vol. XIV. Pages 538 & 539.

grown up children. They also wish to be thought resigned to their lot & protest against sympathy; & state that they are unworthy of regard, while all the time they are craving sympathy, and attention.
In younger persons the same state of feeling is common, but has reference to bodily ailments.
The result of this is that they create new symptoms to keep interest in themselves & their troubles alive. They also mutilate themselves in various ways, by burning, cutting, irritating the skin with ointments &c,. They may also attempt suicide, generally however under such circumstances as to ensure their not being successful. Real attempts are sometimes made & succeeded in, but even success may be accidental & against the patients will, the patients intention being merely to create a sensation.
Vomiting blood, urine, faeces &c. are done in the same spirit, these substances having first been swallowed. They also state in some cases that urine issues from the eyes, ears, breasts, navel &c. This used to be described as a symptom of hysteria, but is of course a fraud. Introducing living & dead animals into the vagina, anus &c. & producing them before the public, stating that they have given birth to them.

Jolly.
Von Ziemssen's Cyclopaedia.
Vol XIV. P. 539.

is another form. Pretended fasting also occurs. They often through their ailments rule their friends with a rod of iron, taking every advantage of the sympathy extended to them, and often complain that they are not cared for. I know of one such patient who is always jealous if any little attention is paid to any other member of the family.

Von Ziemssen's Cyclopaedia Page 5-40.

The great object of all this is to create a sensation. of which they are the centre.

Their moral obtinity may also take the form of intriguing against their friends, stating that they have been persecuted or outraged. They may sometimes deceive the public in this manner, so as to gain their desired sympathy.

Here hysterical disease comes to border very closely on Moral Insanity, just as it borders on, or really amounts to Insanity in other directions.

See Clouston's Mental diseases. Page 347 & 8.

Hysterical Impulsiveness. There is in some profoundly hysterical persons a tendency to uncontrollable impulses. These impulses the patients know to be wrong, and are grieved by them, but have not the strength of will to resist. Certain ideas come before their

mints and do not let them rest until they are carried out. These impulses may be to injure themselves or others, or to destroy ~~anything~~ anything around them, that they can lay hands on. They try and sometimes can relieve themselves by shouting, raving, crying, singing, dancing & the like, of the impulse. Here hysteria passes into Impulsive insanity, the difference being merely in the severity of the symptoms.

Von Ziemssen's Cyclopaedia Vol. XIV. p. 540.

Mimicry of Disease. Mimicry is in all of us marked in childhood, as a normal function, which in healthy persons decreases with years. This mimicry is of an automatic kind, that is to say, it is performed quite or half unconsciously. It is not, I believe uncommon to find grown up, healthy persons mimicking the actions & grimaces of persons whom they see. This is done unconsciously, but as a rule the mimic is aware of what he has been doing afterwards. In my own case this is rather marked, for I often find myself imitating the grimaces of others, especially if I find them a bit ludicrous. Another trick of this kind is throwing back the head unconsciously, if I

Mitchell Diseases of the Nervous Syst. chaps. III & IV.

Paget's Clinical Lectures & Essays. Mimicry chapter I.

see some one drinking out of a glass. If anyone hums a whistles a tune it is often quite enough to start me unless I am on my guard. Listening to a cough very frequently causes persons in the neighborhood to cough. These acts of mimicry are quite within the range of perfect health.

In hysterical people the emotionalism, sensitiveness, timidity, egotism & greed for sympathy all lend a helping hand. Automatic mimicry is also increased. We have already seen that there is a condition where many motions are evoked rapidly one after another. Now given a patient in this condition and suppose she sees a person with a diseased spine, this will cause a great impression, and may lead her at once to feel that she has a similar condition. As a rule I believe this only acts as a predisposing cause, by causing her to dread such a condition, and that some trivial pain in, or accident to the region in question will be required. When such an accident occurs the idea that she has this disease becomes a dominant motive, and so the will is paralyzed as far as

resisting or checking the disorder is concerned. Owing to this, the symptoms being unresisted gain strength.

The vividness of the imagination has a great deal to do with associating any trivial pain or injury with the condition which the patient has seen, or heard described, (for seeing is by no means necessary, in order that the condition may make an impression.), and with the production of symptoms.

Another step in the advance of this state is due to the craving for sympathy, and the patient thus makes the most of her symptoms. Closely connected with the patients craving for sympathy, is a dimness of moral perception, and with this comes a conscious mimicry. Symptoms which have lasted long enough come to be regarded as a matter of course, and hence to hold her position the patient creates new ones. Some go so far as to create symptoms for their own amusement, as in the case Mitchell relates of pretended fasting. Mimicked disease thus begins accidentally, then is unresisted, then cherished for a purpose, becoming all the while more habitual & despotic, and finally the patient wilfully & consciously creates

Diseases of the Nervous System Page 92

new symptoms.

Mimicry is also seen in connection with normally reflex, involuntary processes, such as Respiration, Circulation and the functions of the alimentary canal. These are affected in all to a greater or less extent by mental processes, but how they act is a more difficult question. This is much exaggerated in hysteria. Vomiting is most common. Nausea is normally produced by certain odours, or perhaps emotions of disgust. This tendency is also increased, and vomiting occurs first accidentally, then habitually, & finally it becomes a most despotic & troublesome symptom. It may not be real, the food may be ejected without having entered the stomach at all.

Mitchell Diseases of Nervous Syst. Page. 81.

In other cases again symptoms occur resembling, more or less closely, organic diseases in persons who have never seen such cases, and who have not heard them described, and in persons who could not form such a mental picture. This occurs in children of tender years & in people of low mental calibre. These affections then must be due to derangement of nerve centres. In the former the derangement proceeds from the higher or Ideational centres, but in the latter this is not so clear, though it may be the same.

Pagets Clinical Lectures & Essays. Page. 191.

The nervous local diseases, imitating more or less closely organic diseases, together with the points of diagnosis will be noted later.

In this connection, one ought to draw the conclusion, never to discuss symptoms in the presence of patients of this description.

Organic as well as functional diseases have a mental as well as a physical side. In the former the latter predominates & the former may be almost nil, but of hysterical disorder the reverse is true. The mental side of disease is illustrated in the improvement which cheerful surroundings, & kind, sympathetic words will do, in organic disease, and the disadvantage patients labour under where these are absent.

We will now consider another form of hysterical mimicked disorders viz.

Hysterical Epidemics. In older works called Chorea Major & Chorea Magna, now commonly known as the Epidemic chorea of the Middle ages. The causes were such as reduced the nervous systems of large numbers of people, to a state of increased irritability such as is seen in Hysteria generally. These were probably religious fanaticism, famine, or wide-spread

Jolly. Op. cit. p. 486-488

want. The people were then very ignorant and consequently imaginative. The spread was the same as occurs in sporadic cases, but many persons were in a state to be affected by the sight of those already suffering and consequently it became epidemic. The terror inspired by the symptoms & by their being ascribed to supernatural causes, further increased the tendency to mimicry. We shall now give a brief account of these Epidimics

(1) <u>The Dance of St John</u>. This arised at Aix-la-Chapelle from Germany in 1374 and extended over the region of the Rhine & Moselle & the Netherlands, in the course of a few months. In the cases in which the disease became completely developed, it began with Epileptoid convulsions. Contortions mingled with the dance. In this year troops of men & women arrived at Aix and danced madly until they were exhausted, and fell on the ground, where they lay moaning until compression was made on the Abdomen which arrested or diminished the attack During the dance they had hallucinations & saw visions. Music hurried the attack on & rendered it more excited. "They had an aversion to boots with pointed toes", so much so that an edict was given out prohibiting them

Von Ziemssen Cyclopaedia P. 416. Vol. XIV.

S. Paul Richer Hysteria P. 802.

showing how great was the terror inspired by the malady. They could not bear the colour, red, in this respect resembling what is seen in mad animals (Richer).

II Tarentisme. This dance occured about the same time in Italy. "Some experienced attractions in sight & hearing — others lost their speech and all were insensible to ordinary methods of excitation. The flute & the Guitar could procure them ease. Then as if awakened from a magic dream they opened their eyes, and moving at first slowly & in time; then this becoming quickened they were drawn into a passionate dance".

S. Paul Richer Page 803.

III. Recent Epidemics of Dancing Mania.

Dr. Davy of Cincinnati has described an outbreak which appeared in a convent among the pupils.

Richer P. 806.

Epidemics of "Possession by the Devil"

I. In Germany 1550 – 1560.

There were often called "possessions des Romains". Those afflicted imagined themselves possessed with devils, and presented many hysterical Phenomena.

Richer P. 806

II Possession Des Filles de Saint Ursule à Aix. 1609 – 1611.

In 1609 two women accused de

priest, named Godfrey, of having bewitched them. He was tried & condemned to be burned alive, "and his cinders — not yet cold — were cast to the winds". Their hallucinations, their impulsive movements, their attacks of despair & fury, & rhythmical convulsions were the characteristics of these cases

III Possession Des Ursulines &c.

Loudun 1632 — 1639.

Here again a priest was burnt for witchcraft.

IV. Recent Epidemics.

Hystéro Démonopathie de Morzines 1861
" " de Verzéguis 1880
" " de Plédran 1881
" " de Jara 1882.

In all these cases the priests attempted to exorcise the evil spirits. The ceremony forms the subject of many old pictures. This has led Ruben to devote a long chapter to the influence of hysteria on art. Ignorance and superstition are here shown to have been potent factors in these epidemics as seen in their being ascribed to Witchcraft, & Possession of devils, and also in the attempts of the priests to cure them by miraculous means.

Hysterical Insanity.

All hysteria may be regarded as a psychosis, because the mental side of the disease is always present, and plays an important part. There is no hard and fast line between what would be considered simply paroxysmal hysteria & hysterical insanity. The duration rather than intensity of the attack decides the point. Grave derangements occur during paroxysms of convulsives & other kinds. Such are Hallucinations, delusions, dreamy states, visions & outbursts of maniacal excitement, but these are as a rule only temporary, constituting the hysterical deliria. The patient is quite sane in the intervals.

Jolly. Von Ziemssen's Cyclopaedia P. 543, 544.

Hysterical Delirio.

In the more complicated attacks such as Catalepsy, trance, visions & the like, and in cases where the delirio are often repeated, the patient does not become quite normal, but remembers some of the ~~mental images~~ of the paroxysms are thought real. The more frequently these are repeated, & the longer the disease lasts, the greater becomes the derangement, & so after a while other insane ideas occur, besides those of the paroxysms.

Clouston's Mental Diseases P. 479.

Subjects of Delirium (1) Religious (a) Visions of heaven, (b) Seeing the Saviour, (c) Converse with the saints, (d) Prophesy in prose & verse.
(2) Being Possessed. This has been mentioned under Epidemics. Devil & other evil spirits in them, forcing them to strains & cramps, & leading them to utter unholy words, blaspheme God, mock the priest &c. Not always evil spirits. Other spirits may possess them and urge them in another direction.
(3) Others are in fairyland, are very powerful, and are going to be married &the prince, and so on.
Erotic Tendency. Erotic tendencies are present in the "possessed", the prophetesses, & heavenly brides. Still more in those who think they have been ravished, by the persons about them. They are sometimes very circumstantial in their evidence.
Patients in whom these delirias are not very frequent, are quite sane in the intervals, but the oftener the attacks return the more insane they become in the intervals. These persons often conceal their insane ideas, or only show them in their ecstatic behaviour & strange conduct. Hallucinations sometimes lead them to betray themselves.

Continuous Mental Disturbances. These are not marked by paroxysms.

(1) Melancholia. Patients are wretched, anxious, incapable of exertion, unable to enjoy society, and generally desolate and miserable. They also have impulses to suicide or mutilation. These patients also feel a desire to slander, intrigue against, & injure others, to gain a sorry sort of satisfaction for their own misery. These patients are a great source of grief at home, and a great nuisance in asylums.

Von. Ziemssen's Cyclop. Val XIV P. 544 & 545.

J.R. Reynolds System of Med. P. 20.

II. Folie Raisonnante. This disease is almost confined to congenitally hysterical persons. They are completely ruled by their ever changing fancies. They know they conflict with their surroundings, but from the state of their feelings cannot strive against this. Dominant Motives are carried out with great persistency. Sensual appetites are strong and shamelessly indulged. Drunkenness is frequent. They lie, cheat, & steal cleverly & throw suspicion on somebody else. They tend to multiply vices. In this form the egotism, & the moral insensibility attain their acme.

Von Ziemssens Cyclopaedia. Vol XIV. P. 546

They think themselves superior to everybody else, and always have an argument, ingenious & as they think quite incontrovertible to excuse, or palliate their faults. They get at last to believe their own lies, and in this resemble persons whom I have seen, who were quite sane, but having told the same lie so many times came at last to believe it.

More excited states are liable to arise in these either spontaneously or from conflict with their surroundings, such as delirium, confusion & loss of ideas, or acute Maniacal outbursts.

III Primary Derangement. may develop partly with & partly without hallucinations. Closely allied to cases arising from paranoymal delirio. Delusions of Being possessed, magnetized, haunted, Ideas of great importance. These may develop without fits. Sexual Ideas also play some part.

Von Ziemssen Cyc. Vol XIV P. 546.

All these forms may become worse and worse, and end in dementia, but the last form is the most.

These cases cause so much trouble at home, that they are usually sent to Asylums. The result of this seems to be good, for Clouston has seen a cure of 60 p.c. of cases.

Sensory Phenomena

I Those due to increased irritibility in the Sensorium, in various centres (1) Increased Sensibility, not necessarily of a painful nature i.e. true hyperaesthesia. This is comparatively rare. (2) Dysaesthesiae, or painfulness of sensation of various kinds (3) Hyperalgesia or increased sensibility to pain (4) Spontaneous pain.

Few cases occur without exaltation of sensation in some form. This may be general & affect all the senses, or local and confined to the whole, or part of the region of one sense.

Sensations pleasant or the reverse are easily roused, and by slight sensory stimuli, but in severe cases the latter preponderate. In some cases the exaltation of sensibility is only noticeable in regard to special stimuli, and often in the form of Idiosyncrasies. Thus impressions giving indifferent & pleasant sensations to the healthy, may be repugnant, & impressions giving indifferent & unpleasant sensations normally, may be pleasant to them. The psychical feelings of pleasure or repugnance, aroused by sensory stimuli are also exaggerated.

Dalby in Von Ziemssen's Cyclopaedia P. 495

These sensory exaltations are worse under observation & on inquiry & sympathy.

Buzzard. Quain's Dict. P. 679.

Pain especially is often made worse by enquiry, and in some cases it is originated in this way. Moreover, it is often diminished or disappears, when the patients attention is diverted. — J. R. Reynolds Cyct. Med. P. 99.

True hyperaesthesia or refinement of sensibility is commonest in the special senses, but seems also in regard to Touch, enabling the patient to detect colours, odours, tastes, sounds &c, according to the sense affected with a delicacy unattained by the healthy. These refinements must be accepted only, with a measure of reserve because a great deal may be due to the state in which the patient has been living. Thus by living in a dim light she may be enabled to detect slight differences in the intensity of light; or by avoiding all sounds as far as possible, she may learn to detect slight sounds. But after all allowance has been made, a few cases of refinement of Sensibility occur. — Dolly Von Ziemssen's Cyclopaedia P. 496

Russel Reynolds' Cyct. Med. P. 99.

Dysaesthesiae. Pain or annoyance is caused by stimuli of ordinary intensity. This is seen in hysterical photophobia, intolerance of sound, odours, colours & the contact of certain harmless articles.

Hyperalgesia is present in some locality in nearly every case. It may be local or

general. If it be general almost all move-
ments cause pain. It may or may not be
associated with spontaneous pains. Touching
regions so affected causes ordinary pain or a
sensation as if they were pierced with needles
or touched with hot iron or the like.

Von Zeissens Cyclopaedia P. 497-8.

Pain in some part of the body is
constant in hysteria. It is not necessarily associ-
ated with sensory stimuli. When it is associ-
ated with a lesion it is much more acute
than such a lesion would would occasion, in
a non-hysterical person.
The locality is liable to change or the pain is often
variable in kind or intermittent. Pain is
often spontaneous, but may only be elicited
by pressure, however produced it is pecturi-
arly described with a number of stinging
epithets, showing that it is of absorbing
interest to the patient. Not uncommonly a
fulness or puffiness is noticeable after a
time in the painful area.

Russel Reynolds. P. 91.

Savany. Holmes Syst. of Surgery. Vol. I. P. 384.

It is questionable whether patients, of this class,
suffer as much as those with pain due to
organic lesion. Enquiry, sympathy or discussion
will increase or in some cases originate hysteri-
cal pains, while distracting the attention will
often allow of their disappearance. If you notice
the face of a patient describing these pains, (as
present at the time), you will notice a look

Buzzard. Quains Dict. P. 679.

not of torture, but merely of interest in the description she is giving. Mitchell considers that hysterical pain may perhaps bear a relation to pain due to organic lesion similar to that which hysterical paralysis bears to organic paralysis. Diseases of Nervous Syst. P. 64

Spontaneous pains in the hysterical often assume a neuralgic form. It may resemble any known form of Neuralgia. Jolly Von Ziemssen's Cyclopædia. Vol XIV. P. 498.

Hyperæsthetic Phenomena.

Region of Sight.

Refinement of vision occurs at times, but is not common.

Various subjective phenomena occur. These may precede a paroxysm (& especially Ecstasy), sleep or occur apart from either, and that too sometimes in broad daylight. These consist of flashes, sparks, beads, figures & sometimes landscapes &c. Such phenomena also occur in healthy persons at times, but are recognised as subjective, while hysterical patients ascribe them to objective causes. They also cause delusions, because the patient considers them objective, and forms chains of reasoning on them, which are necessarily false, being rested on false premises. The great difference between health & hysteria, is that the hysterical person fails to recognise the subjective nature of these phenomena. Visionary phenomena of Jolly. Von Ziemssen's Cyclopædia P. 495.

this kind may constitute a hysterical paroxysm.

Photophobia is common. The patient darkens her room, avoids all light, and closes the lids very firmly if you had attention to them. I have seen a patient watching me very closely, while I asked her about her symptoms & voice, but she could not tolerate the light at all when I spoke of her eyes.

Russel Reynolds. Syst. Med. P. 99.

Buzzard. Quain's Dict. P. 680.

Intolerance of Colour or certain colours also occurs. Red is most common. Richet mentions the intolerance of Red which occurred in St John's Dance at Aix-la-Chapelle, & compares the state to that of furious animals

See ante. P. 17.

Region of Hearing

Strictly analagous phenomena occur here. Refinement of hearing is more common than that of sight. It is perhaps the commonest true hyperaesthesia. The subjective phenomena are quite analogous to those of sight:— Roaring noises, tinkling, ringing &c. Their relations to other symptoms is quite the same as those of sight. More complex auditory phenomena are rarer than the visionary, and occur chiefly in the more complex hysterical phenomena, as Ecstasy & c. &c.

Russel Reynolds. P. 99.

Dolby. Von Ziemssen Cyclopaedia Vol XIV. P. 496

Quain's Dict. P. 680.

Intolerance of Sound. also occurs. Patients may be annoyed by loud or slight sounds, or by particular sounds. Music often has very marked effect in calming these persons, and also in exciting them. Psych. Clinical Lectures & Essays. P. 182.; Richer P. 803.

Regions of Smell & Taste.

The same conditions are observed as those connected with Sight & hearing, but they are less common. Refinement is seen sometimes. Amann records the case of a lady who could smell cherries in a room, and recognise persons by smell. Von Ziemssen's Cyclopaedia XIV. P. 497.

Idiosyncrasies are common. Patients can thus detect slight traces of certain and especially repugnant substances by their odour e.g. Castor, musk, Assafoetida &c. Also likings & dislikes for certain odours which may be pleasant, indifferent & disagreable to others. Subjective smell & taste phenomena are also observed. These find a parallel in the Olfactory aura sometimes observed in Epilepsy. See ante. P. 7.

Regions of Common Sensibility

Refinement of touch is rare, but cases have occurred where patients have been able to recognise persons & things, by this sense alone, with greater accuracy than ordinary healthy persons. Dolby. Von Ziemssen's Cyclopaedia XIV. P. 494 & 498

According to Eulenburg the perception of pulsation subjectively

shows increase of tactile sensibility. This is observed at times in Hysteria. The power of localization, as tested by the point of a pair of compasses, and temperature perception are also in rare instances increased. But some form of exalted sensation, (rather Dysaesthetic than hyperaesthetic), is almost always observed in some part of the skin. Hyperalgesia is commonest, also spontaneous pain. These may occur together or separately. The distribution is very variable both in locality and extent. It is rarely general. It may be limited to one extremity, affect various parts of the head & trunk, or affect one lateral half of the body (Hemihyperaesthesia). The part affected are often very distinctly defined. In the middle of a hyperaesthetic region, it is not rare to find an anaesthetic patch.

The deeper parts are often affected, along with the skin, with pain & hyperalgesia. Muscles, fascia, periosteum & sometimes viscera are affected. The skin however may not share in the affection. Hyperalgesia of the deeper parts without affection of the skin is apt to be overlooked, unless discovered by some accident eg. a knock or jar.

Local Pains & Hyperaesthesiae

The Head & Neck.

Pains in the head in some form are very common. They are usually intermittent & more or less periodical. Buzzard. Quain's Dict. P. 679.

(1) Clavus Hystericus is one of the most typical forms. The painful area is sharply defined and limited to the top of the head commonly near the sagittal suture. Clavus is common also just over one Eyebrow. The pain is of a boring, gnawing or burning character. It is probably neuralgic, and occurs probably in other diseases than hysteria. Savory. Holmes Syst. of Surgery Vol. I. P. 384.

(2) Diffuse head-ache. This may be only a feeling of malaise over the whole head, or it may be very severe pain. It may & may not be associated with a hyperaesthetic condition of the scalp. Jolly. Von Ziemssen's Cyclopaedia. Vol XIV. P. 498 & 499.

(3) Pain on pressure over the muscles & aponeuroses of the scalp, cervical and temporal regions.

(4) Neuralgia of V & Occipital nerves.

(5) Hemicrania is common. A vague pain extends over one half of the head, which is associated with general malaise, a feeling of faintness, nausea & sometimes vomiting. It lasts generally a few days & rarely a week or two.

Hemicrania & Clavus, according to Jolly, are commonest at or near a menstrual period, or as the result of some emotional disturbance.

Region of the Spine. Pain, spontaneous or on pressure is very common. It is often very superficial, and most commonly cervical or dorsal. It is sometimes associated with spasms, weakness of the legs & contracture in some part. The skin may or may not participate. Skin sensitiveness is sometimes limited to small areas between or over the Scapulae. The commonest phenomenon is pain spontaneous, or on pressure over & about the vertebrae. Sometimes the spines alone are tender, but sometimes also the Dorsal Muscles. Sometimes spontaneous pains arise here, but at others they are not known & exist, until you search for them, and then are only present on pressure. Spontaneous pain is often attributed to some trivial accident, or to over-exertion on some particular occasion. The pain and tenderness vary much in severity & extent & its area is often not sharply defined. It may remain fixed to particular points, but frequently it shifts.

Savory. Holmes Syst. Surg. Vol. I. P. 381.

Buzzard. Quains Dict. P. 697.

Jolly.

Von Ziemssen Cyclopaedia. Vol. XIV. P. 503 & 504

When it remains fixed in certain spines for long periods, it must be distinguished from spinal Caries, or Sclerosis, Myelitis or other Cord disease. It differs from the pain of these diseases (1) in being superficial & excessive (2) In that a light touch hurts more than deep firm pressure (3) Pinching skin more than pressure. Difficulties may arise if these diseases were to arise in a hysterical person.

Savory. Holmes. Syst. Vol. I. P. 381.

Hysterical pain has been ascribed to spinal irritation, if it occur in this region. I do not see any reason why these should lead to this opinion, more than pains elsewhere in the area of distribution of the Spinal nerves. Jolly considers the deeper of these pains due vertebro-periosteal in part, partly muscular & partly neuralgic. In the last the posterior points of Intercostal neuralgia are painful. These are near the angles of the ribs. The more superficial pains are probably simply cutaneous.

Region of the Thorax

Pain & tenderness are common in the mammary regions, most commonly the left. It is often said to be "stitch" in the side and the patient cannot lie on it

Savory. Holmes System of Surgery. Vol. I. P. 384.

The pain or tenderness is generally diffuse & superficial, and without the painful points of Intercostal Neuralgia. On the left side, if vomiting co-exist we may have to distinguish from gastric ulcer. The general characters will help, but one must remember that Ulcer might possibly co-exist, & that great care is required.

Sternal Region. Pain on pressure, tenderness & spontaneous pain of a dull heavy heavy character often coupled with a feeling of mental depression and anxiety is common. The pain is not definitely localized. The heart along with this is generally excited, so that the condition may be due to irritation of the Cardiac nerves. The hyperaesthetic condition impedes respiration & this may account for depression. The condition is allied to Angina Pectoris, a form of which occurs in rare instances.

Jolly. Von Ziemssen's Cyclop. Vol XIV P. 500.

Buzzard. Quain's Dict. P. 679.

Mamma. Great tenderness is often present so that the least touch causes pain. Mastodynia or mammary neuralgia also occurs. Pain here often darts like Schirrus, but the diagnosis may be made by (1) Age of patient, (2) effort of abstracting attention. (3) Absence of tumour. The pain is altogether in excess of that

Savory. Holmes Syst. Vol I. P. 383.

of commencing Schirrus which is almost painless, in the early stages. The pain & tenderness are liable to exacerbations, especially near the menstrual period.

Sir J. Paget. Clinical Lectures & Essays. Pages 248 & 251.

Abdominal Region. General pain over the abdomen occurs in connection with Tympanites. Local pains also are common, but it is often difficult to say whether they are parietal or visceral. Pain & Tenderness are common in the hypochondria. The tenderness is often extreme & often more than skin-deep. It is often attributed by patients to inflammation of the Liver or Spleen. Patients often say they feel a foreign body "moving about the Stomach", and this often causes them anxiety. Another abnormal sensation is hunger after meals, often leading them to take enormous quantities of food. Shifting pains are also common in the region of the Intestines. These are probably due to irritation of the Gastric & Intestinal sensory nerves.

Jolly. Von Ziemssen's Cyclop. Vol XIV P. 600.

Buzzard Quains Dict P. 674.

Epigastric Region. Pains here are referrable to the parieties, near the origin of the Recti abdominales as shown by careful palpation. Sometimes they are probably Diaphragmatic. They cause a feeling of tightness.

Iliac Regions

Pains are common here. Great stress has been laid on tenderness in these regions by the French physicians. Opinions vary as to its frequency and importance. Jolly does not consider it very common. Pain here is often called ovarian, but that it is not always so is shown by cases where it has existed with the Ovaries protapsed into the pelvis (Weir Mitchell). Schützenberger also finds inflammatory state of the ovaries rare in these cases. That pain here, due to inflammation or hyperæsthesia of the ovaries is of great importance is shown by a case where Schützenberger found it, after acute diphtheritis, associated with hysterical convulsions, and compression would arrest them. The nature of the symptom varies. The pain may be spontaneous, elicited by light pressure, or only by deep pressure or even pinching up the skin. The extent of the painful area varies. Beginning at the groin it extends upwards a variable distance, sometimes up to or above the Umbilicus. It may occur on either side, but most commonly the

Von Ziemssen's Cyclopedia Vol XIV. P. 502.

Weir Mitchell. Diseases of Nervous Syst. P. 190. 27.

Bryant. Guain's Dict. P. 679 & 683.

left is affected. It is probably ovarian in some cases, but most commonly it is parietal, and quite the same as pain elsewhere in the hysterical.

Associations. It is associated with anaesthesiæ, paralyses & contractures on the same side. If these change sides the Iliac tenderness also changes with them.

Effects of Compression. Charcot and Schützenberger have observed convulsions follow compression of these regions, but it is rare in England. The results are pain, a feeling of tightness in the Epigastrium, then choking sensations in the throat, then if the pressure be continued ringing in the Ears & loss of vision first on the same side, then loss of consciousness and Hysterioid Convulsions. It will also cut short convulsions. When Iliac tenderness has occurred in England (& it is not common) distress, choking sensations & other premonitory symptoms have been produced, but never convulsions. In a girl of 16 yrs. Gowers observed that it caused pain in the head, a feeling of faintness and drooping of the lids, but nothing more. In another patient æt. 25 yrs. who had marked Iliac tenderness, it caused

Gowers Epilepsy P. 159 2d. ed.

Jolly. Von Ziemssen Cyc. Vol XIV. P. 502.

shortness of breath, flushing of the face and a peculiar thoracic sensation, such as often preceded her convulsions, but nothing more. In still another case opisthotonos could be caused by it during a convulsion, but not at other times. Weir Mitchell has seen it produce vertigo but nothing more.

Diseases of the Nervous Syst. P. 186.

In another case where ligature around the arm arrested the hysteroid convulsions, ovarian compression was tried, at first without effect, but after several trials it arrested the attack, but not so readily as Epigastric compression. Still later it had no effect at all.

Pressure on other painful areas, beside the skin, sometimes produce reflex symptoms, thus it may affect the pulse and respiration & cause other reflex phenomena.

Savory Holmes Syst. Vol. I. p. 389.

The reflex symptoms produced by pressure on the more phlegmatic English, Americans & Germans, are sufficient to verify the correctness of Charcot and Schützenbergers observations, in the French, who are more nervously constituted.

Painful Joints are very common in this country, but does not seem to be so common in Germany. Brodie considered that it formed four fifths of the

Jolly. Von Ziemssens Cyc. Vol. XIV. P. 5-06.

Pepper's clin. Lect. & Essays. P. 204.

cases of joint affections among the women of the upper classes of this country.
The Hip, Knee, Wrist and other joints are affected in point of frequency in the order given. The fingers too are sometimes affected. (Bryant and Quain's Dict. P. 679.)
It often comes on after some trivial injury.
The pain is superficial and in excess of what occurs in organic joint disease.
It is worse on touching, than on passive movement or even succussion. Thus evidently the pain is referable to the soft parts around, rather than to the joint itself. (Russel Reynolds Syst. of Med. P. 89.)
As a rule there is no real deformity.
At most there is slight swelling about the joint, or the joint may simply seem large from disuse & consequent atrophy of the muscles above & below. There may also be contraction from muscular action.
Swelling when it occurs is puffy & confined to the soft parts around the joint & flies from local applications.
The limb is kept rigid in some position and attempts at passive movement often causes spasmodic action of the muscles which are keeping it in that position. (A. E. Durham Holmes Syst. Surg. P. 74. Vol IV) The electric relations of the muscles remain normal.
The general temperature is normal, and the local is normal or may be subject to a periodic & usually nightly rise. In the morning it may be pale, & pimple and almost bloodless (Weir Mitchell. Diseases of the Nervous System P. 218-226)

in the afternoon it gets warmer, and at night it is hot with tinged vessels & shining skin. In a case of Weir Mitchell's the temperature was normal & ½° below during the day, but about 9.30 p.m. the knee became reddened & tense and its temperature rose 1° to 4°. Around the joint was a brawny material. The Hip was flexed on the Pelvis, the Ankle extended & the affected knee flexed. The joint was opened & found normal.

Knee Joint. The Knee is one of the joints most commonly affected in this way. It is often kept rigid instead of flexed as in organic disease, but to this there are many exceptions

Savory. Holmes Syst. Vol I. P. 382 & 383.

Hip-joint. There is pain in the Hip & Knee. This is exaggerated by pressure or motion & hence the joint is kept fixed in one position. This condition remains stationary. The nates do not flatten out. There may be some fulness about the joint, leading one perhaps to think of abscess, but this soon becomes clear. There may be some asymmetry from muscular action. The Pelvis is drawn back at an angle to the Spinal Column, & is elevated on the affected side, leading to apparent shortening, so that the heel does not touch the ground when the patient is standing. This has to be destinguished from

dislocations.

In all the joints the conditions may remain unchanged for years & then recovery occur very quickly.

Diagnosis. From Organic Joint Diseases & Rheumatism. The points to be observed are. (1) Absence of local rise of temperature, or a nightly rise. Sir J. Paget says "A joint which is cold by day & hot by night is not an inflamed joint, that is certain". (2) Absence of swelling & deformity such as occur in organic diseases. (3) Absence of constitutional disturbance. Sleep may be disturbed but not as it is in destructive joint diseases. (4) Character of the pain. (5) Disappearance of rigidity under Chloroform & sometimes during sleep. (6) Progress of the disease. (7) Presence of Anaemia or other cause likely to cause Hysteria, or other hysterical symptoms besides those of the Joint. (8.) Feeble circulation with feeble, irritable quick heart points to nervous rather than organic Disease.

Clinical Lectures & Essays. Page 224.

Paget. Clinical Lectures & Essays. P. 196.

States of Diminished Sensibility

Some form of diminished sensibility is common. Analgesia is commonest. Of the group of skin sensibilities viz Touch, sensibility to pain, temperature, tickling, & localization of points any may be lost and any remain. If muscular sense be lost, there is also muscular anaesthesia. Loss of all of these together is very rare. The affection varies from a slight dulling of any of these forms of common sensibility to their complete loss. It may affect the skin separately or with the deeper structures, or the deeper structures without the skin.

Weir Mitchell Diseases of the Nervous System. P. 26

Analgesia pin pricks often fail to draw blood.

Russel Reynolds Syst. Med. P. 92.

The extent & distribution of these affections vary. It is most commonly limited to small patches of skin. It is common in a limb or part of a limb, & in small patches in various parts of the trunk. The presence of these conditions is often not known to the patient.

Buzzard. Quain's Dict. P. 683

Dolley. Von Ziemssen's Cyclopedia. Vol XIV. p. 506 et seq.

It is common over the back of the hand & foot & over the External malleolus. Sometimes it occurs in the area of distribution of a sensory nerve e.g. an Intercostal.

Buzzard. Quain's Dict. P. 679.

General anaesthesia is rare, and varies in intensity in various parts of the body.

Hemianaesthesia is a common & important

phenomenon, often associated with like tenderness on the same side. It is limited by the median line, near which sensibility sometimes improves on the affected side. According to Chauvet & Briquet left hemianaesthesia is the commonest. It affects the face, trunk & extremities in a varying degree of intensity. It is usually least intense in the face. Commonly one or more of the special senses is affected on the same side. Anaesthesia of the special senses are commonest in this connection. The mucous membranes are also commonly affected on the same side, the conjuction being wide spread in many cases. The special senses connected with them may or may not be lost, but the reflexes are usually diminished & abolished.

Relation to Paroxysms. States of diminished sensibility (1) may exist apart altogether from paroxysms. (2) They are commonest after a paroxysm. A paroxysm may (1) give rise to diminished sensibility. (2) reëstablish it after its partial or total disappearance. (3) change its distribution (4) cause already established anaesthesia to disappear & give place to hyperaesthesia.

Anaesthesia & motor paralysis are often

Jolly. Von Ziemssen's Cyclopaedia Vol XIII. p. 506 et seq.

found together, but either may occur without the other. They represent the same condition in a sensory & a motor nerve centre respectively.

Mutilations is perhaps commoner in these than other hysterical conditions, because pain is not felt. Mutilations is also commonly associated with clinical indifference to pain, the dominant emotion being to create a sensation. Patients of this class like to be experimented on.

Anaesthesia of Bones & Joints occurs at times. Passive movements are not known to the patient if the eyes are closed. Voluntary muscular action is either normal or more or less impeded. If extensive passive movements are not known to the patient the anaesthesia must affect not only the bones & joints but also the muscles & skin. The condition is associated with paralysis & the cataleptic state. One patient with complete analgesia & anaesthesia & flexibilitas cerea of the arm, had no idea what you did with her arm when her eyes were closed.

Jolly. Von Ziemssen's Cyclopaedia Vol XIV. p 506 et. seq.

Local Anaesthesia of Mucous Membranes.

Conjunctiva. Anaesthesia is common especially in the left eye. Touching the Conjunctiva causes reflex movement neither of eyeball nor lids, nor does

Bryant. Dunn's Dict. p. 679.

it cause Reddening or Lachrymation.

Gowers on Epilepsy. P. 156.

Nasal Mucous Membrane. Sometime affected. Tickling with a feather or brush, or the inhalation of powerful irritants does not cause Sneezing. Smell may or may not be affected.

The other means anaesthesiae will be described under the systems to which they belong.

Dally. Von Ziemssen's Cyclopaedia. Vol XIV. p. 508.

Anaesthetic affections of the Special Senses.

The special senses may be affected on one or both sides. When on one side it is usually part of hemianaesthesia.

Buzzard Quains Dict P. 680.

Smell & Taste may be lost together or separately. Hearing is more commonly lost than these, but deafness is by no means common. It sometimes appears after severe paroxysms. Unilateral deafness is usually part of hemianaesthesia, and the affection generally is associated with anaesthesia elsewhere. Deafness is less common than sight affections. The above are all unattended by gross organic lesions.

Dally Von Ziemssens Cyclopaedia. Vol XIV. pp. 509 - 5011

Sight is more commonly affected than any of the other special senses.

(1) Amaurosis. Sight is sometimes lost in both eyes, more commonly in one and as part of Hemianaesthesia.

Weir Mitchell. Diseases of Nervous System 26

(2) Amblyopia is commoner than Amaurosis. The form most commonly met with is partial or complete Achromatopsia or impairment of colour perception. It is especially common in connection with hysteroid Convulsions, with consequent hemianesthesia. Colour perception is lost in the following order violet, green, red, orange, yellow & blue. Blue can be perceived unless the colour-blindness is absolute.

There is sometimes limitation of the field of vision. Hemiopia in one or both eyes occurs sometimes, when sight is lost in one half of one or both eyes. Sometimes vision is merely weak & blurred. Slight colour-blindness & limitation of the field of vision are quite unsuspected by the patient.

Ophthalmoscopic Examination. As a rule nothing abnormal is observed. In one case of Charcot's, Galezowsky found infiltration & capillary reddening of the disc with fusiform dilatation of the arteries. In another Soyres found rapid of the Optic Nerves. It is questionable if these were purely Hysterical cases. Perhaps they were other diseases developing in Hysterical subjects.

Anaesthesiae of the special senses are commonest after severe paroxysms, but this occurrence is not constant after either mild or severe attacks. This duration is very variable. They may remain, pass off suddenly or be replaced by other symptoms. Sometimes they last for years.

Phenomenon of Transfer of Symptoms.

In one-sided hysterical phenomena viz Hemianaesthesia, paresis & Contracture the application of various substances will cause symptoms to leave the affected side, at the same time appearing in the other. This phenomenon is only seen at times & is by no means common in this country. Metallic discs, magnets, Cork, wood or glass all have much the same effect. In two cases Rosenthal & Buzzard found electric excitability, as tested by interruptions of a strong Voltaic current, diminished on the affected side. In Buzzards case improvement in sensibility followed the experiments. The change sometimes lasts for hours. Charcot has seen this phenomenon often. Weir Mitchell & Dr Spitzka have seen slight changes in sensibility & the return of bleeding from the prick of a pin, but never the complete phenomenon of transfer.

Buzzard. Art. Hysteria-Epilepsy Quains Dict.

Weir Mitchell. Diseases of the Nervous System pp. 30 & 192.

Motor Phenomena.

These like the sensory phenomena are divisible into two groups (1) Due to increased irritability in the motor centres viz. Spasmtonic, clonic & tremor (2) Due to diminished irritability viz Paresis & paralysis.

Deliberate voluntary motility is diminished but involuntary motility is increased including ideational movements viz. Movements of the face, grimace, frowning &c. laughing, crying. The face has been aptly termed the index of the mind, and these movements are the outcome of the unstable emotional condition of Hysteria. Movements due to sensory impressions are the same, as seen in the excessive knitting of the eyebrows on the approach of a light, & the excessive start & tremor on any sudden event, violent spasm on the production of pain & the like. This occurs too without hyperaesthesia.

J. Russel Reynolds. Syst. of Medicine p. 92 & 93.

Reflex motility is also exaggerated and changed, so that reflex movements are produced by stimuli too slight to produce them in health.

There is also general muscular unrest. It may be fibrillary twitching in parts of a muscle, in a whole muscle, or in a group or groups of muscles. It is due to increased irritability of motor nerve centres & may be either reflex from sensory stimuli, or Ideational from Emotion.

Dolley Van Ziemssen's Cyclopaedia Vol XIV. p. 516

Clonic attacks are an exaggeration of this condition. Spasms of various kinds also occur e.g. shaking attitudi, cramps, & contractures, all the result of increased irritability of motor nerve centres.

Tonic Spasms may affect any of the muscles of the body voluntary or involuntary. They constitute a leading feature of hysterical convulsions, but occur apart from them also. In two cases recorded by Weir Mitchell on rising from the sitting posture the patients staggered backwards from spasm of the muscles of the legs. In one of them the legs became rigid. Then followed a rotatory spasm of the body generally to the left, the back seeming to take the lead. One of them also suffered from Trismus, & spasms of the neck face & arm. There was also spasmodic pitching to right or left, backwards or forwards. These attacks were unattended by vertigo, or any change of consciousness.

Buzzard. Quain's Dict. P. 680.

Russel Reynolds Syst. Med. P. 93.

Weir Mitchell. Diseases of the nervous system Chap. II. p. 96 to 113.

Globus Hystericus. This symptom is very common, but not invariable. Some form occurs however at some time, in the history of almost all hysterical patients:-

(1) Choking sensation in the throat.

(2) Patient says she feels a ball in the throat which she cannot swallow, & which she fears will choke her.

Buzzard. Quain's Dict. P. 680.

Russel Reynolds Syst. Med. P. 92.

(3) Globus ascendens. This form is less common than the above, but is the one most frequently described. A ball seems to rise from the Epigastrium & stick in the throat. (4) Patients sometime say they can feel a worm (or something of that kind) creeping in the throat.

All these sensations are so distinct that the patient tries to rid himself of it by trying to swallow it, eating & drinking to force it down, trying to pull it out of the throat with the fingers, & tickling the throat to try to vomit it.

These efforts are unavailing, but after a variable time the sensation gradually goes off. The ball seems to flatten out, & in rare instance it descends, & disappears.

Globus is frequently accompanied by tears.

Globus hystericus sometimes arises spontaneously as the forerunner of a paroxysm. More frequently it is due to Emotion.

Sometimes it arises reflexly as the result of swallowing some particular food or drink & from the thought of this: or in some cases as a result of singing or talking. The thought of these acts may cause it. In some cases, where it arises from eating or drinking the annoyance is so great that almost no food is taken, thus being one form of Hysterical Dysphagia.

Jolly.
Von Ziemssen's Cyclopaedia.
Vol XIV. p. 511 & 512.

If we run through the symptoms of hysteria we notice that quite a large number of them are mere exaggerations of what occurs in the healthy, under certain circumstances. Globus is thus allied to the choking sensation children & others feel when they are beginning to cry, or trying to check crying. It is probably due to contractions of the annular muscles of the Pharynx & Oesophagus, partly also of the longitudinal. Eulenburg considers it purely sensory.

Globus Ascendens occurs also in the abdomen. It arises in the hypogastric & iliac regions and ascends towards the throat, but does not always reach it. Patients often talk of it as the womb moving about, which idea is very ancient. Dally considers it due to intestinal peristalsis set up reflexly by some abnormal genital sensation. This I think is questionable. Intestinal Peristalsis often causes the feeling of a body moving about, but it is difficult to see how it should cause this sensation straight up the middle of the abdomen. Is not Globus Ascendens a purely sensory phenomenon allied to the ascending aurae of Epilepsy & Hysterical Convulsions?

Contractures or Chronic Tonic Spasms.

This symptom is not common in women & very rare in men (Mitchell). Mitchells Diseases of the Nervous Syst. P. 123

It may affect almost any part, and is often associated with paralysis, appearing in some cases ~~simultaneously~~ with it & in others the paralysis gradually passes away & contracture supervenes. This may also come suddenly. Contractures may assume a monoplegic, hemiplegic or paraplegic distribution. Contracture often comes on after a paroxysm, so also does the transition from paralysis to contracture. Contracture of one side have, especially, this relation to convulsions. Buzzard Quains Dict. P. 680-683.

The contracture is not under patients control and remains except during sleep or the full influence of an anaesthetic. It can sometimes be overcome by steady extension, but in the more chronic cases great force would be required & this would very probably result in spinal convulsions, or local spasms in other parts. Jolly. Von Ziemssen's Cyclopaedia Vol XIV. p. 621.

The more chronic contractures do not always pass away during sleep, or under anaesthetics unless these are pushed to their full extent. Persistent faradisation will usually exhaust the muscles & so cause relaxation of the spasm.

Localities of Contracture

The Jaw may be locked in either the opened or closed position by contracture.

Mitchell Diseases of the Nervous System P. 124

The head is sometimes flexed on the breast for months in the same way.

Spasmodic Ptosis. This contracture is met with only in women. The lid is quietly shut, but resists passive opening. The patient is absolutely unable to open it. It differs from paralytic ptosis in resisting passive movement.

Mitchell P. 134.

Pectoralis Major. Mitchell has seen a phantom tumor here from contraction of a part of the muscle. Steady extension overcame it, but it soon re-appeared. It came & went fits own accord. It was very tender. Similar conditions are mentioned by Sir J. Paget.

Paget's Clinical Lectures & Essays. P. 240. 2d Eng.

Weir Mitchell 107–108.

Arms. According to Charcot contraction of the arm cause spasmodic flexion of the fore-arm-wrist & fingers. It may also affect individual muscles.

Lower Limbs. Spasmodic Extension of the hip knee & ankle with contraction of the femoral Adductors (Charcot.) is common. Flexion of the thigh on the Pelvis. In one case daily new flexion of the left & extension of the Right leg. The Extension disappeared after a convulsion, but the latter remained. The tonic flexion of the hip & foot (Varus) could easily be overcome

Dolby. Von Ziemssen. XIV. P. 521. P. 522.

Mitchell. Diseases of N. Syst. p. 129. p. 231.

by extension, but the flexed condition of the knee remained except under the full effects of Chloroform.

Mitchell & Paget also relate cases of phantom tumors in the calf muscles. One of Mitchell's cases was of long standing & bilateral. Mitchell. Diseases of N.S. P. 124.

Abdomen. Phantom tumors are commonest here. They may be due to visceral affections, but are most common from contractures in the abdominal parietal muscles.

Course of Contractures. They may be passing phenomena of a few days duration, disappearing & being replaced by other symptoms. On the other hand they may last for months or years without much change. The muscular nutrition & electric relations remain approximately normal. Most authorities speak of their sudden disappearance as common, but Weir Mitchell has not found it so. Most of his cases are old-standing & much exhausted ones, so that one could perhaps scarcely expect it. In many cases after remaining for years they become permanent, remissions having occurred now & again in their history. Then muscular atrophy & change of Electric relations occurs. A case is recorded by Charcot which lasted ten years. Lateral Spinal Sclerosis was found after death. Mitchell has seen such cases but thinks them very rare. Jolly. Von Ziemssen's Cyclopaedia XIII. p. 522. Mitchell. Diseases of Nervous System. Lect. XIV. p. 227. & 237.

The diagnosis between these conditions due to Hysteria & those due to Sclerosis is often very difficult. It is difficult to decide in such cases (1) whether Hysteria is the primary disease, sclerosis resulting from persistent over action of certain centres in the cord; (2) Whether the Sclerosis is accidental to the case, happening to occur merely in a hysterical person. A similar state of affairs has been recorded in connection with the Retinae in hysterical sight affections. I think it very probable that the over-action & mal-nutrition of the nervous system of Hysteria would very likely end in organic lesions, but that such a result is by no means common. The difficulty of deciding these points is increased by the fact that recovery sometimes occurs, after symptoms have occurred which would justify you in diagnosing Sclerosis. Perhaps Sclerosis takes a different course in the Hysterical. The whole of this subject needs further research & study to clear up the difficulties.

Mitchell op. cit. p. 236-7.

Hysterical Clonic Spasms.

Most commonly the clonic movements of hysteria have the character of a fine tremor. It is a characteristic feature of convulsions, but that form will be considered later. Tremor is in many healthy persons a usual result of emotion. The hysterical phenomenon is an exaggeration of this, so that tremor results from any slight cause. It is also an exaggeration of the normal muscular unrest of hysteria. It is often associated with paralysis & contractures just as when these are due to organic lesion. It may be transient or more or less permanent. Its distribution varies, but it is rarely a strictly local phenomenon, but Mitchell has seen a case where it affected both legs below the knees.

Hysterical tremor comes & goes irregularly. It may be constant except during sleep, but voluntary motion, excitement, expectation, & the sense of being watched increase it.

Sometimes tremor comes on & goes on increasing until it ends in a general convulsion. A steady effort of will can diminish or check it for a time. It affects commonly the head, tongue, facial muscles, hands arms & lower extremities. The oscillations are greater in the face than elsewhere.

W. in Mitchell Diseases of Nervous System Lect. VI.

In the cases of Hysteria that I have seen tremor is a prominent feature in the Facies Hysterica. The face is calm & unagitated by emotions, but the muscles are quivering & there are short, quick, regular opening & shutting movements of the lower Jaw.

Many tremors are due to disease of the Spinal Cord, but in this case, from the effect of Emotion, & of an effort of will in increasing & checking it, one would be led to refer its primary seat to the Cerebrum. This is not conclusive for it might still be spinal and due to the removal of some form of cerebral Inhibition.

It is often difficult to determine whether a given tremor is purely hysterical or due to organic disease in a hysterical person. The occurrence of tremor as a symptom of Alcoholism, should lead one to look out for illicit drinking.

Hysterical Paralytic Affections

Paralysis more or less complete & extensive is common in hysterical. It is rarely as complete as paralysis from organic lesion. Its relation to paroxysms varies. Many cases have not been preceded by convulsions, but others have followed it, or been left by it. Buzzard states that about 50 p.c. follows convulsions.

Jolly. Von Ziemssen Cyc. Vol XIV p. 518.

Russel Reynolds Syst. of Med. p. 944.

Buzzard. Brain's Dict. p. 681

It often begins quite suddenly & often spontaneously or after a paroxysm.
Sensory depots, ischaemia & sometimes oedema occur in paralysed parts, but these are not confined to Hysterical paralysis, nor do they bear any constant relation to it. Sometimes anaesthesia gives a case the appearance of paralysis when only slight parsis is present.

Weir Mitchell Op. cit. p. 281. & p. 24-5.

Weir Mitchell. Op. cit. P. 28

Buzzard. Quain's Dict. p. 681.

The Electric relations and nutrition of the paralysed parts are seldom sufficiently altered to indicate organic paralysis. As a rule the Electric relations are either normal or slightly subnormal. In rare instances it is increased & in others abolished. A few applications of the battery usually suffice to render it normal.

Russel Reynolds P. 94.

Mitchell Op. cit. 28029.

Sometimes eccentric relations exist. Instead of the normal or slightly feeble response coming at once, there may be a delay. In one case Mitchell found with slowly & also rapidly broken currents of Induced Electricity 2 or 3 minutes elapsed before the response took place. These alterations in the Electric reactions only come on after the Paralysis has lasted a long time & are in all probability the result of disuse.

Jolly. Von Ziemssen's Cyclop. p 5th 18. Vol XIV.

Diseases of N. Syst. P. 28. 4.

Atrophy also appears from this cause, but is seldom far advanced.

The paralysis may be hemiplegic, monoplegic or paraplegic. It may be confined to the area of distribution of a single motor nerve. This last of General Paralysis are very rare. & the latter very incomplete.
In Hysterical paralysis the face is very seldom affected. Paralysis of the Levator Palpebrarum is common, giving us a second a paralytic form of hysterical Ptosis. In this form there is no constant spasmic opening of the lid. Hysterical paralysis is extremely rare in the areas of distribution of the Facial & Hypoglossal Nerves.
Hysterical paraplegia most commonly affects only the lower extremities. The limbs are generally normally nourished & exhibit normal electric relations. The Sphincters of the Bladder & Rectum are never paralysed, nor are the Ecpulsors. These are sometime affected as a separate symptom, but not as part of a paraplegia.
Patients have more control over their limbs in bed." When you ask the patient to lift her leg she lifts it an inch, insist on effort & it is lifted still higher, and if you get her to use great effort it is lifted still higher, but its upward motion consists of a series of jerks

Von Ziemssen's Cyclopaedia. P. 5-18. Vol XIV

Russel Reynolds p. 94.

Weir Mitchell's Diseases of the Nervous System p. 34 & 35

and paresis" (Mitchell). I have since reading this, had an opportunity to verify it. Russel Reynolds has seen two patients who could lift their legs to any required height, while in bed & the toes could all be moved. When they attempted to walk their limbs seemed to lose all power & they would fall down. No amount of help seems to assist them much, but they fall almost to the ground & then recover themselves. (c.f. Mitchell's Hysterical motor ataxy). In all paraplegic cases equilibration is seriously impaired in the erect posture. Except Multiple Contractures Weir Mitchell considers no hysterical phenomenon more difficult to cure.

Russel Reynolds Syst. of Med. P. 944.

Hemiplegia is commoner than Paraplegia. It scarcely ever affects the tongue & face. The paralysis is as a rule only partial. In walking the patient drags his limb after him without circumduction, & the extensors of the toes are not paralyzed. There is usually some sensory disturbance in the paralyzed parts. The paralysis is in some cases crossed from the first i.e. the arm is affected on one side & the leg on the other. It sometimes changes sides. It may commence abruptly after a paroxysm, Emotion, or an accident.

or come on gradually & insidiously. It is a much more tractable symptom than paraplegia (Mitchell).

The Knee Jerk & Ankle Clonus. Charcot & Buzzard state that the patellar reflex is exaggerated on the affected side, & Buzzard further states that Ankle clonus can sometimes be elicited. Mitchell has seen the Patellar reflex exaggerated in three cases, & diminished in three others. In another the reflex was in the flexors, instead of the Extensors. & in still another it was the adductors which responded on both sides.

Discases of Nervous System p. 26 & 27

In a case with slight contraction of the calf, so that the heel was drawn up, clonus could be elicited, then in a few seconds jerking occurred in the Extensors of the Knee & finally clonus appeared in the other ankle. This points to a curious condition of Instability in the Spinal Reflex centres allowing overflow of the impulse set up, to other centres.

Weir Mitchell analyses these conditions as follows.

(1) Hysterical motor ataxia, purely hysterical & not found outside fit with the same characters.

(2) Paralysis from the rule of a dominant Motive

Discases of Nervous System. Page 16

(3) General Paresis.

(4) Consciously mimicked paralysis (& Malingering.)

The last three fall in the hysterical a

fertile soil, but are not confined to them. A case of Hysterical paralysis is commonly compounded of 2 or more of these forms. Thus it may be partly an ataxy, partly due to a dominant motive, partly weakness & in some cases an element of conscious mimicry is added. This analysis tallies very well with what has been said here of volition & also with Russel Reynolds two cases of paraplegia.

I. <u>Hysterical Motor Ataxia</u>. A form of this has been described by Briquet & Lasègue due to co-existent cutaneous & muscular anaesthesia. Patients can walk readily with open eyes, but on closing them lose control over the anesthetic parts. In severe cases the patient may not be able to tell where the limb, is, with closed eyes, after it has been passively moved. In less profound cases they merely fail to coordinate complex acts with the eyes closed. Mitchell Diseases Nervous Syst. p. 39 & 41.

II. The form Mitchell describes is rare in its most perfect types & is easily mistaken for paralysis & paresis. It is often coexistent with these, but sometimes forms the prominent feature of a case, with little or no loss of voluntary power. In a typical case sensation may or may not be affected, & the patient can use her limbs freely in the recumbent posture

but when she tries to kneel or stand the incoördination makes its appearance. On trying to stand she lunches forward, backward, or to one side & then in trying to recover herself lunches too far the other way. The patient seems to be unable to judge of how far her balance is lost & of how much force is needed to re-adjust it. There also seems to be some disturbance of muscular antagonism. Perhaps there is retardation of the volitional stimulus so that it arrives too late, or perhaps the patient is too slow in learning the necessity to contract this or that muscle in order to maintain her balance. The incoördination is most marked in the head & trunk & is worse on closing the eyes. It is most marked in performing complex acts, least in using a single limb, more in kneeling & most of all in standing. That there is no lack of power is shown by what the patient can do on her back. This condition is common, but is apt to be overlooked, or attributed to paralysis or other incident condition. There may be skin anaesthesia but that is not enough to account for it. It is distinct from Brissaud's ataxy in that patient knows the position of the limbs with closed eyes & in that sensation may be perfect. The only condition with which it might be confounded

is rare. It is alternate spasm in opposing groups of muscles.

Hysterical Paresis. Sometimes in the course of Hysteria the patient falls into an inert condition of mind & body. This Mitchell calls Hysterical paresis. There is intense feebleness without sensory defect. It may be variously combined with the symptoms & be almost pure.

Wm Mitchell. Diseases of the Nervous System. 53 – 54

Patients become feverish very easily. The least over-exertion raises the temperature & quickens the pulse. With & without anaemia all the functions are enfeebled & especially the muscular. If there be pain & this is increased by motion the patient is still more anxious to keep still. This condition furnishes a large contingent of "bed cases".

Respiratory System

Hysterical Disorders of the Larynx & Phonation.

Hyperaesthesia of the laryngeal mucous membrane is sometimes met with so that cold air or a little dust causes pain & cough. Anaesthesia also occurs at times so that touching the Epiglottis & Larynx or inhaling irritating materials causes no pain or cough.

Jolly. Von Ziemssen's Cyclopaedia p. 500

Spasmodic Laryngeal affections also occur. These may come on before, during or after a paroxysm or occur quite apart from paroxysms.

Buzzard. Queens Dict. 680

There are discordant expiratory sounds as coughing, barking, quacking, blowing, meowing, howling & the like. Screaming fits sometimes occur especially in Epidemics. Also involuntary speaking, exclamations, & inarticulate sounds. Hiccup coming on after & apart from a paroxysm is an annoying symptom which may last for days.

Buzzard. Quain's Dict p. 680.

Hysterical Cough is of a sharp ringing character, constant except during sleep and unattended by expectoration. It is powerfully affected by psychical influences; worse under observation and may not occur when the patient is out of hearing. It is evidently due to the rule of a dominant motive.

Buzzard Quain's Dict. p. 680.

Acute Inspiratory Dyspnoea sometimes occurs. It is due to spasmodic closure of the Larynx. It is often associated with tetanic phenomena, but also occurs alone. It is rarely dangerous, being allied to Laryngismus Stridulus, but has been known to cause death.

Jolly. Von Ziemssen Cyclop. Vol XIV. p. 514.

Hysterical Aphonia is the most important respiratory symptom. It may come on after a paroxysm, from Emotion & often after catarrhal sore throat. It is due to a dominant motive in many cases. In old-standing cases where this condition has come & gone several times it may come on without apparent cause.

Mitchell's Diseases of the Nervous System Lecture XII.

Compare Sir J Paget's Essay, Clinical Lectures & Essays. P. 80.

It may pass off as readily as it appeared, but after it has done so several times the disappearance is neither so ready, nor so complete as at first. The degree to which the voice is affected varies a good deal. The voice may be merely a little husky or completely lost. In some cases the voice is only a little weak or husky but breaks if any considerable effort is made with it. In some cases the voice comes & goes, but it is liable to become hoarse, feeble & then reduced to a whisper or lost altogether. This may last for years. Sometimes these persons talk, sing & shout in their sleep. They may be able to whisper, after the larynx fails to act, with the mouth. But in some cases the lips & tongue are in a state of paresis when distinct articulation even in a whisper is impossible.

Aphonia may be produced in the following ways. (1) Bilateral paralysis of the adductors of the cords. (2) Incoördination of the various groups of muscles required in Speech. (3) Habitual spasm or failing of spasm on attempting to speak (Weir Mitchell).

(1) Bilateral Paralysis. In this form the voice is reduced to a whisper or lost. Many can speak in low tones, but if they try to speak louder the voice breaks. Others again

Bryant. Quain's Dict. 681.

A. E. Durham. Holmes System of Surgery. Vol. IV. p. 5-91

Von Ziemssen Cyclopaedia Vol. XIV. p. 577.

cannot speak at all. Sometimes buccal whispering remains after laryngeal speech is lost.

Laryngoscopic Examination. The colour of the cords is normal. The crico-arytenoidei are in a state of paresis or paralysis, so that in marked cases the cords do not come together. The affection is bilateral. The two sides may not be equally affected, but neither comes fairly to the median line. Unilateral Laryngeal paralysis is not a symptom of Hysteria.

II. Incoördination. In this form the Laryngeal, Thoracic & Buccal muscles do not act together. If you introduce the laryngoscopic mirror & tell the patient to sound Ah the cords come together, but do not vibrate, because the expiratory muscles do not act & cause an act of Expiration at the proper time. Some of this patients can still whistle & whisper with the mouth because Buccal & Expiratory coördination is still intact, but this is not always so.

III. Spasmodic Aphonia. The form of aphonia which Dr Mitchell explains in this manner is rare. From emotion, worry & other cause there is a sense of pain and strangling in the Larynx. If the person

he speaking at the time the voice becomes shrill & breaks & the patient is left speechless. Every effort now causes laryngeal distress or pain & results in shrill, squeaky, broken tones. In some cases there is also an upward pulping of the Oesophagus. In a patient mentioned by Weir Mitchell these symptoms were so distressing that the patient would not attempt to speak. In her case dysphagia co-existed. I have seen lately a patient in which I think stammering was produced in this way during a paroxysm. She got worse & worse and finally gave up the effort. Between her attacks she speaks perfectly. This explanation is I think correct, although it cannot like the other two be proved with the Laryngoscope.

Persons who suffer from hysterical Aphonia commonly have a feeling of fatigue and soreness about the chest which is increased by coughing & efforts at talking (Mitchell).

Interference with Respiration

In rare instances some of the Inspiratory or Expiratory muscles are paralysed. This never affects the Diaphragm, which is sometimes temporarily paralysed in Epilepsy

Selby. Op. cit. p. 5-14. p. 5-18.

The Rate & Rhythm of Respiration is sometimes altered. Extreme quickening occurs & is remarkable in that time is so dyspnoea,

Weir Mitchell Op. cit. p. 198-201.

and there may be no quickening of the pulse or rise of temperature. This phenomenon is nearly confined to Hysteria & might aid a diagnosis. There is not the same relation between the pulse, respiration & temperature in Hysteria, as in Health. Temporary spasmodic pauses sometimes occur in Inspiration & Expiration especially under Psychical excitement. — J. R. Reynolds. Syst. Med. p. 95.

Hysterical Asthma is seen sometimes. In some cases it is due to a physical Examination of the Genital Organs (Asthma Uterinum). Sometimes quite apart from this asthmatic attacks occur showing all the acute oppression, anxiety & expiratory Dyspnoea of Ordinary asthma. In Asthma Uterinum the Bronchial spasm is excited reflexly from the Genital Organs. — Dolly. Op. Cit. p. 5-14.

Haemoptysis is rare in any form. It is very rare with normal menstruation. Its commonest form is in Amenorrhoea without Uterine lesion, when it is a vicarious form of menstruation. These bleedings in hysteria must be closely watched, because they are likely to be mere simulations. Patients may get the blood from the mouth, or sources external to their own bodies & then appear to cough or vomit it up. Genuine Haemoptysis does sometimes occur from Hysteria. — Dolly Op. cit. p. 5-24.

Circulatory System

Some functional disturbance occurs in almost every case. Any part of the circulatory apparatus may be disturbed. As a rule these disturbances are temporary or paroxysmal, but in some cases they are permanent. They are liable to be set up by any trifling emotion and hence it is difficult to cure them while the patient is doing the business of daily life. As a rule these are the last symptoms to disappear when the patient is getting better. They are due probably to altered innervation of the heart & vessels.

Jolly Op. Cit. p. 523

Mitchell Op. cit. p. 184 to 188. & p. 190.

Palpitation is common. It may be purely subjective & due probably to hyperaesthesia in the region of the Heart. There may be tumultuous action with quick pulse, there being evident to the physician on palpation. This is attended by a feeling of oppression, confusion in the Head & Chest & anxiety. The effect on consciousness depends on the state of the cerebral vessels at the time. Palpitation may be brought about by slight psychical or sensory disturbances, digestion, Micturition, defaecation or without obvious cause. The tumultuous action is prone to pass into irregularity & the consequent distress may be very great. Palpitation is common, though not invariable in Convulsions.

Russel Reynolds. Op. cit. p. 95.

Buzzard. Diseases Nerv. Syst. p. 191.

The pulse in this above condition may be 20, 30 or even 50 beats per minute above the normal (Mitchell). This condition is commonest in public patients & in those markedly hysterical as shown by a proneness to tears. It comes on at times when patients are lying in bed & not showing much evidence of disease.

Feeble Action of the Heart.

Feeble action of the heart is common in Hysterical & other nervous persons, who are prone to suffer from mimicked diseases. (Paget). The action of the heart may be slowed. Faintness, fainting & a feeling of dyspnoea unattended by alteration in the respiratory - pulse rate are common. Sometimes a profound syncope occurs which simulates death. There is a stifling feeling & feeling of fulness about the chest, an indescribable sensation at the heart, and the patient becomes speechless, breathless & the pulse almost imperceptible. This state both very precarious, but ends in prolonged sighing & recovery. Weir Mitchell saw a case where formerly certain odours used to cause convulsions but latterly "death spells." This case illustrates very well the Olfactory Idiosyncrasies mentioned at an earlier part of this Essay. On one occasion he talked to the

Clinical Lectures & Essays. P. 196.

Diseases of the Nervous System p. 189 & 190.

patient about 4 hours when she said she was going to have a "spell". The pulse-rate was then 100, but soon became very rapid & countless, & the heart at the same time became exceedingly violent & irregular. Next the pulse began to fall & in 15 minutes it was only 40. Then a beat was dropped here & there, the pulse at the same time getting feeble & feebler, until at last you could neither hear the heart, nor feel the pulse. In this state of seeming death she would lie from 2 to 4 days, pale, still, breathless & without circulation, the state being broken occasionally by spells of furious irregular cardiac action. After this recovery took place. It is exceedingly difficult to explain conditions of this sort, but they illustrate the way in which hysterical symptoms disobey all ordinary laws. These symptoms were due to Emotion & perhaps from an inhibitory impulse going from the Ideational to the Cardio-motor centres. Probably the outbursts of rapid action were brought about by the state of the blood. Remarkable weakening of the Heart's action also occurs in Cataleptic Hysterical states. The highest state of cardiac weakness is seen in the condition known as Trance which lasts sometimes for days. Many hysterical persons

Dalby. Op. cit. p. 524.

apart from paroxysms have an absolutely normal circulation. Anaemia is often the cause of Cardiac weakness in hysteria (Jolly) & the anaemic are consequently most prone to this affection.

Vaso-Motor Disturbances

(1) Want of tone in the surface vessels is common, occurring in the face & extremities. This is not confined to Hysteria, but is common in it. The face is liable to flush on slight psychical Excitement, and the heart's action may at the same time become tumultuous. This is a very annoying symptom. In some the face flushes, & then the general flushing breaks into patches with pale margins. These patches move slowly. This is commonest in the lower part of the face & in the neck. Perspiration often follows. This flushing may be attended with a marked feeling of heat in the head (Mitchell). Sometimes when the face is flushed the feet & hands are cold & bloodless. The lips and conjunctivae also in this state are often pale. Jolly. Op. cit. P. 5-25

Local flushing is often associated with Neuralgia in various parts. Often seen in Neuralgic Head-aches. Buzzard. Quain's Dict. 681

The hands & feet at rest may be cool & pale, but on exertion become red, gorged with blood & break into a perspiration.

General perspiration is common, & perspiration confined to one half of the body occurs sometimes. Local & unilateral flushings are rare. Sally Op. cit. p. 625.

In a case Mitchell records local engorgement with blood, in the legs whenever they were put to the ground. There was partial paraplegia without sensory affection. The engorgement disappeared when the legs were elevated. A similar case is recorded by Sir J. Paget in his Clinical lectures on Mimicry. Whenever this patient walked for a past his feet became "cold, white & numb" & then when he rested they flushed red & hot & were turgid with blood distending even the veins of the leg. These cases go on for years without causing organic change. The condition is one of paralysis of arterioles with consequent lowering of the blood pressure. In another case there was permanent unilateral flushing of the face, the whole face becoming flushed paroxysmally. A spot of colour would come & go, then others appear & these would coalesce & the flushing would extend to the ear & scalp. This gave the patients face the appearance caused by habitual toping. The Retinae were not affected. There was a feeling of heat & fulness but no pain. The heart was scarcely affected. Cold water spray caused the vessels to contract. Considerable improvement followed the administration of digitaline

Mitchell Op. cit. p. 195-6.

Clinical Lectures & Essays. P. 184 & 185.

Mitchell Op. cit. p. 196 & 197.

and measures to improve the general health.
In another case the abdomen was the site of this paroxysmal vascular paralysis.
It would fill with blood until the abdomen had the appearance seen in an 8 months' pregnancy. Most of the patients blood was withdrawn to the abdomen. A slight thrill & humming sound were audible over the abdomen. Pulse 165, almost imperceptible. If she attempted to sit up she fainted. The only sensations complained of were abdominal tension & pulsation.

States of Local Ischaemia.

Hysterical persons often suffer from cold hands & feet. These parts may be pale or purplish, the latter often being in association with paralysis or sensory defects. It is due to lack of blood from local constriction of arterioles or feebleness of the heart.

Dolley op. cit. p. 525.
Paget. op. cit. p. 146.
Mitchell. op. cit. 195.

The face is liable also to become pale from psychical causes. The heart may be quickened or slowed at the same time. Ischaemia of the conjunctivae & eyes, as we have seen accompany flushing of the face. Flushing is commoner than pallor in Hysteria. Both are exaggerations of the normal blush of shame & blanching of anger.
Local patches of pallor may affect any part of the body & are especially associated with anaesthesia.

Ischaemia is very common in anaesthetic areas & especially in Hemianaesthesia. So marked is the condition that pin-pricks do not bleed. There may be no analgesia, but there is some sensory defect present. As the anaesthesia goes off, the Ischaemia also becomes less marked. If transfer be obtained by means of a magnet or metallic plate &c, the Ischaemia also is transferred. It is seen also occasionally in organic paralysis of sensation. Mitchell has seen it after section of the Sciatic nerve & in cases due to cerebral lesion. Hence there is some causal relation between them. Probably the interference with *afferent impulses cuts off some reflex inhibition of the muscular coats of the arterioles, so that they contract on slight irritation. The pin-prick causes local spasm of the arterioles & hence no bleeding results.

Buzzard Quain's Dict. p. 680.

Mitchell. Op. cit.. p. 1920 193.

*Mitchell.

Cutaneous Haemorrhages.

These curious phenomena must be very rare. The descriptions we have are probably partly founded on fact, partly on the credulity & superstition of the observers, & partly on wilful fraud. These phenomena are supposed to be miraculous reproduction of the "bloody sweat" of Gethsemane, and hence are invented or if they occur, used by priests & others to further their ends in obtaining money and influence.

Hysterical patients may also fraudulently simulate these bleedings & create a sensation of which she is the centre. Making every allowance for the fraud which probably accounts for most cases, we have a few left which are described on good authority. These are bloody sweat & tears, and bleedings from small cutaneous areas. (Stigmatization). Stigmatization is commonest on the Hands, feet, fore-head & chest. What is said to occur is (1) Formation of a serous bulla. (2) This becomes bloody. (3) The Epidermis breaks and flattens out. (4) A variable quantity of blood flows away, the haemorrhage continuing for a variable time.

Jolly. Op. cit. p. 527.

Cases.

Parrot saw in one case during a hysterical convulsion a blood coloured fluid flow from the fingers, knees, thighs, chest & conjunctivae.

In another Case Astley Cooper saw subcutaneous extravasation take place. Laycock also saw this phenomenon, accompanied by bleeding. Magnus Huss saw a case of bleeding from the Scalp.

Alimentary System

Mouth. Hyperaesthesia & anaesthesia occur in the mucous membranes of the mouth & fauces as elsewhere. Jolly Op. cit p. 509.

Tongue. The same sensory changes occur here as in other parts. Taste may be refined, diminished or lost, & subjective phenomena may occur as in other special senses. Jolly. Op. cit. p. 512. 517.

Spasmodic affection of the tongue occurs sometimes so that its actions are disorderly. As a consequence articulation and deglutition may be interfered with.

State of the tongue. I have noticed that in most of the hysterical patients I have seen the tongue has been clean & normal. This might be of diagnostic importance, because very few serious organic maladies occur without a fur on the tongue. Hysterical patients are of course liable to the same diseases as others, so that it might be found, while many of their symptoms were really due to their nervous condition. Paresis & Paralysis of the tongue occur. They are more associated with Hysterical Hemiplegia, sometimes occur alone, but most frequently they are associated with affection of the throat.

Mastication. This function is sometimes paralysed. Patients allow the food to drop out of their mouths, or get the nurse to remove it. In one such case Weir Mitchell advised the Mitchell Op. cit 240

patient to work her jaw with her hands, and her condition soon improved.

Salivary Functions. Sometimes perpetual salivation occurs after a paroxysm, more rarely it occurs independently. Sometimes it is only apparent from loss of the power to deglutition. Diminution or suppression of the salivary secretion also occurs. The mouth is dry and as a result large quantities of fluid are drunk. Jolly. Op. cit. p. 528

Affections of the Pharynx, Oesophagus. Deglutition.

Spasms, Paralyses or Anaesthesia occur, but the last is rare. In all cases directing attention to the throat aggravates the dysphagia.

Dysphagia may be due to (1) Pharyngeal spasm, (2) Pharyngeal Paralysis. In the former the food seems to irritate the pharynx to a spasmodic, disorderly response results, so that swallowing does not occur. The difficulty is commonest in regard to solids, but may be in regard to fluids or both. Patients can often get on all right if they are alone & no notice is taken of their symptoms. Paget. Clinical Lectures & Essays. p. 85-086.

(2) In Paresis or Paralysis of the pharynx the difficulty may be only slight or such as to render deglutition almost impossible. Weir Mitchell Op. cit. p. 240.

In other cases the difficulty is Oesophageal. Spasm of the oesophagus occurs and the food is quietly or violently ejected. These symptoms may be so persistent as to render patients perpetually miserable. They sometimes lead to Emaciation and the Jolly. Op. cit. 517.

necessity to feed with the tube. As a rule this passes without difficulty.
Dysphagia & Aphonia rarely co-exist, but Mitchell has seen them alternate. Op. Cit. p. 212.

Gastric Troubles

Appetite. Sometimes the appetite is increased and patients eat large quantities of food, even when they know they cannot retain it as is seen occasionally in Hysterical Vomiting. Jolly. Op. Cit. p. 507. 518.
Great thirst is sometimes present in cases of Vomiting.

Anorexia or loss of appetite is a very common & important symptom. In the worst cases the appetite is annihilated and there may be aversion to all kinds of food. Weir Mitchell Op. Cit. Lect. XV.
This leads to violent spasm on the sight or even thought of food in the worst cases. Thus feeding is very difficult, and sometimes ends in long fasts. Anorexia is sometimes constant, at others only at the menstrual periods, & in still others it is exaggerated at these periods.

Pica or depraved appetite occurs sometimes. Buzzard. Nuem. Syst. p. 681.
It is one of the Idiosyncrasies of Hysteria.
Patients eat all sorts of strange & non-nutritious things, as Hair, cinders ashes &c.
Seen often in connection with pregnancy.

Hysterical Vomiting. Vomiting is one of the most troublesome symptoms, and is

liable to persist for long periods in spite of all you can do.

Typical hysterical vomiting is a simple regurgitation without nausea. The food is returned with a gulp after each meal. It is sometimes reflex like that of pregnancy (Dally).

Less frequently mucous & bilious matters are vomited.

It may cause emaciation, but this is less than one would expect, and Mitchell has seen the patient grow fat. He explains this condition in this way. (1) Little food is ~~required~~ by a person at absolute rest in bed. (2) Regurgitation is not always immediate or complete.

Weir Mitchell p. 242. El. Sey.

I think if much vomiting occurs and the patient does not grow thin, that the chances are she helps herself when nobody is near, & does not vomit.

Mitchell's patient who became fat & flabby used to take opium, which perhaps helps us in the explanation. Death almost never results. When emaciation becomes extreme, the vomiting ceases and rapid recovery ensues.

In many cases the appetite remains good, and the patient takes & vomits her meals regularly. If the case lasts long

and anorexia sets in emaciation follows. This accounts the statement given above explaining the comparative slightness of Emaciation in hysteria.

Vomiting with Nausea & Eructations is not uncommon. It is often due to injudicious diet & drinking.

Russel Reynolds. Op. cit. 95.

Eructations are commonly due to flatus, but also occur without much distension

Jolly. Op. cit. P. 513.

Gastric Secretion is sometimes much increased and even when the patient is fasting large quantities of fluid may be ejected.

Haematemesis is rare. It is sometimes due to vicarious menstruation, but also occurs when no menstrual irregularity is present. The vomiting may be copious and occur perhaps once or twice daily, or every other day. The blood may be more or less altered - bright, dark or as "coffee grounds" - thus depending on how long it remained in the stomach. Malaena may also be present. Great care is needed in diagnosing between this & gastric ulcer. In two cases of Jolly's there was (1) pain in the stomach (2) fulness & weight in the Epigastrium (3) Vomiting of blood (4) Sense of relief.

Jolly. Op cit. p. 526

In a case of Ferrari's there were severe fits,

Gastralgia becoming very intense, then tinnitus aurium & Vertigo followed by a swoon, which was recovered from & followed by haematemesis with violent retching.

Vicarious Urination. This rare, but very interesting phenomenon, is associated with Anuria. Charcot & Fernet each describe a case. Dally also has seen vomiting associated with partial anuria. Fluid is secreted by the stomach, containing a large quantity of urea. This urea was not demonstrable in Dally's case, but the anuria was not complete.

Dally. Op. cit. P. 529.

Intestinal Symptoms.

Hyperaesthesia can sometimes be diagnosed when the abdominal walls are anaesthetic.

Shifting pains are often complained of in the region of the Intestines. These are probably due to spasmodic contractions in different parts of the Intestines, but it is often difficult to distinguish whether a pain is intestinal or parietal. Colicky pains occur with Tympanites. Anaesthesia probably occurs, judging from the way in which the contents of the bowel collect, but we have no means of diagnosis. Powerful peristalsis often occurs, giving a sensation of something

moving about. To the patient this is often a foreign body, a the womb.
Spasmodic stictures are common. These along with tympanites or faecal collection cause local or general abdominal swellings which may resemble tumours o especially the latter because the faecal collection gives a dull note on percussion.
Paralysis of the intestines also occurs. It may cause faecal collection or tympanites though not expelling the intestinal contents. Paralysis may also result from excess of intestinal gas, perhaps dammed back by a spasmodic stricture or else in such excess that the gut cannot rid itself of it. In either case the gut becomes distended o finally paralysed. Intestinal paresis o paralysis often result in obstinate constipation.
Tympanites. Many hysterical persons are troubled with flatus. This may arise from (1) Excessive secretion of normal intestinal gas (2) Formation of gas from fermentative changes due to indigestion, from injudicious feeding. (3) Failure of the Intestine to expel gas present in normal quantity. (4) Possibly perhaps from swallowing air.
It results in noisy passage of gas

per anum or per rectum, borborygmi, colicky pains, and local a general abdominal distension. Sometime a collection of gas is imprisoned between two spasmodic strictures causing localised swellings, fuely movable, tympanitic on percussion, and perhaps suddenly resolving either spontaneously or on pressure. Sometimes when these conditions have lasted some time the intestine gets weakened or paralysed, and is no longer capable of expelling the gas, so that it becomes necessary to use pressure, electricity or possibly the Intestinal tube.

Diarrhoea. Sometimes profuse, watery, diarrhoea occurs especially as the result of psychical causes. This is rarely so profuse or constant as to cause exhaustion. Jolly. Op. Cit. 5-29.

Rectum and Defaecation

Pain about the region of the anus is not rare. It is unassociated with organic lesion. It comes & goes, and varies much in severity. Patients ascribe it to a tender ovary or retroflexed uterus or the like. It may or may not be associated with the act of defaecation. Mitchell. Diseases of Nervous System Lecture XVI

In such cases a thorough rectal & genital examination should be made to exclude organic lesions. Then the subject had better be dropped (Mitchell) the patient being assured that all will be well.

Rectal Irritation may be slight or severe. It may result from emotional causes, occur without apparent cause or be associated with menstruation. There is no diarrhoea, but there is increased irritability of the rectum. It is often associated with a similar vesical state. It may be a trivial annoyance or the dominant feature of a case. In some cases it is so annoying that patients habitually wear a towel or napkin. The difficulty of dealing with it depends on the patients mental capacity. If you can impress on the patient that it is a bad habit which she must break, and can break, the condition will pass off. If you cannot, the treatment is extremely difficult. In recent cases a morphia suppository may do good, but is not as a rule desirable. Mild laxatives & a daily washing out of the Rectum also aid, but the patient must be given to understand that these are not essential, but mere accessories.

Paresis or Paralysis of the Rectum and Faecal Collection. In this paralysis the higher portion of the Intestine do not share. Faecal collection is chiefly in the Sigmoid flexure & Descending Colon. It is brought about in this way:- (1) Patients are disposed to humour every symptom. From some cause they become constipated, and then case to make the

Bigg and Quain's Dict. p. 681.

effort to get the bowels moved at the regular time. Then they get a dominant motive that there is something seriously wrong and begin to use purges and Enemata, which they gradually increase in quantity. These tend to distend and weaken the walls of the Rectum. The weakened will or inattention, or desire to be thought ill increase the evil. As a result fissure or piles may occur and then the pain attendant on movement of the bowels increases the difficulty. In some cases anaesthesia of the Rectum aids in increasing the Evil. Patients have a notion that there is a local cause such as a pouch in the gut, or the "womb is turned back blocking up the whole passage."

The several forms of faecal collection are caused by (1) Rectal Anaesthesia (2) Rectal paralysis (3) Incoördination of the Muscles concerned in defaecation.

(1) Anaesthesia ▽ loss of heat-perception occurs in the rectum ▽ skin about the anus. The reflex is lost with it, and the rectum may be filled enormously full, without any desire to defaecate. It is such patients who get their bowels moved weekly, fortnightly or even monthly.

(2) Rectal Paralysis is rarely if ever associated with Hysterical Paraplegia, but sometimes occurs alone.

You may be able easily to introduce the hand, without causing any pain, and the sphincter may remain open for hours afterwards. As a rule when there is faecal collection it is above the rectum. Since the Descending Colon & Sigmoid Flexure must share in the paralysis. Large quantities of purgatives may fail to rouse the gut to action. Jolly. Op. cit. p. 576.

(3) Incoördination may occur here. Mitchell describes this. Paget alludes to it but has not described it. According to Mitchell it is often associated with slight pareisis and anaesthesia of the bowel. Alone it is rare. The Intestinal & Rectal peristalsis & the Sphincters may act properly, but the accessory abdominal & Expulsory muscles fail to aid them. Their action may be feeble, unsustained or at the wrong time. Sir J. Paget Op. cit. p. 86.

The rarest form is where all is right, except that the Sphincters do not relax. The spasmodic state may or may not be due to fissure. If you attempt to dilate with the finger spasm occurs, with a cramp-like pain lasting for some time. If Enemata are given they are expelled again through the narrow opening, without the faeces. The best means of overcoming the difficulty is to dilate the sphincter to its full extent. Unless there is a fissure division is not required.

Affections of the Genital & Urinary Systems.

External Genitals. Hyperaesthetic states and pain are not uncommon. Some have irritation and burning sensations at the orifice & ostium vaginae with venereal desire. This is commonest at the menstrual period but not confined to it.

Anaesthesia is sometimes found alone, but these frequently escape in general anaesthesia.

The genital & urinary mucous membranes are sometimes profoundly anaesthetic. Russel Reynolds Syst. Med. p. 92.

Sometimes the Vulva & Vagina are affected and all venereal desire lost. Seeligmüller found this in only four cases. In three of these it was the only symptom & in the other three was besides only occasional blunting of sensation over the backs of the hands & feet. Jolly. Op. cit. p. 509.

Amann found it more frequently.

Spasmodic Affection of the constrictor vaginae is sometimes seen, especially with hyperaesthesia. It is perhaps always reflex. It is the hysterical form of Vaginismus.

Uterus. Pain & hyperaesthesia are not uncommon. It may be due to disease, spasm or more rarely it is a purely nervous subjective phenomenon. Jolly. Op. cit. p. 503.

Menstrual Functions.

These are normal in at least 50 p.c. of hysterical patients.

(Jolly). Be this as it may I do not think Genital disorders bear that relation to hysteria which it is generally held to bear. Jolly. Op. Cit. p. 525.

Haemorrhage may be increased as the regular periods, come on too often, or be scanty or regular, or at too long intervals. Amenorrhoea is not uncommon and often is due to anaemia which is probably a most important cause of hysteria. In it the anxious symptom of vicarious menstruation is sometimes seen. The bleeding may be from various surfaces. The most important forms are Haemoptysis & Haematemesis. Menstrual irregularities may be (1) due to the same causes as the hysteria (2) Due to local lesions in the uterus, which may or may not bear a causal relation to the disease. (3) Due to altered innervation from hysteria, without uterine lesions.

Uterine & Vaginal Secretions (1) Leucorrhoea is common from the constitutional weakness causing the hysteria (2) Nervous leucorrhoea coming on after Emotion or a paroxysm. Jolly. Op. Cit p. 530.

Bladder & Urination.

There is sometimes a condition of irritability of the Bladder, sometimes associated with Rectal Irritation. This causes frequent desire to Micturate. It is analagous to Rectal Irritation. Weir Mitchell Op. Cit. p. 264

Retention of Urine is common. It may be due to one of three causes (1) Anaesthesia of the mucous membrane, so that desire to micturate is not indicated. (2) Spasmodic Closure of the neck of the Bladder. (3) Vesical paralysis. Savory. Holmes' Syst. Vol III. p. 382.

By far the most frequent is Spasmodic Retention. It may be reflex from a local painful state, or spontaneous. The desire to micturate is often increased, but efforts are unavailing. The bladder may become enormously distended. There may be considerable difficulty in passing a catheter through the sphincter vesicae. Jolly Op. cit. p. 675.

Paralysis of the Bladder is most commonly due to distension, but is sometimes a primary affection. Jolly. Op. cit. p. 567.

Besides these urination may be rendered difficult through Incoördinations. These symptoms bear probably a higher ratio in hysterical men than women because of the greater complexity of the urinary apparatus. Paget. Op. cit. p. 81-2.

Before passing a catheter in these cases it is advisable to try the effect of a hip bath warm or cold, and waiting. But awkward consequences may arise from paralysis if we wait too long. If we pass a catheter the danger is that it will become necessary or at least habitual. Other means should first be tried & if these and waiting fail, we must pass one. Jolly p. 515-518. Op. cit. p. 81.

Hysterical Retention is to be diagnosed by the absence of local lesions, the normal quality of the urine & the sexual state of the patient. Savory. Holmes Syst. Vol II. p. 382

Urinary Secretion. Urina Spastica. A large quantity, limpid, ~~of~~ low specific gravity. Also seen in other nervous diseases. It is often the result of psychical causes. J. R. Reynolds. Op. cit. p. 96.

Anuria or Ischuria ocur sometimes. The latter condition is due probably to fall of blood pressure in the kidneys, because the quantity of urea is almost normal, while the solid constituents are very greatly reduced. Anuria or absolute suppression occurs sometimes. It is bloated because vicarious urination occurs in the gastric mucous membrane & probably by the intestinal mucous membrane also. This anuria may be due to renal Ischaemia, such as accompanies anaesthesia. All these alterations in secretion of urine are nervous or functional, and probably brought about through the vaso-motor system. Dalby. Op. cit. p. 629.

Paroxysms.

I shall begin this section of the subject with a short account of a curious phenomenon I believe pretty common between sleeping & waking. It is minutely described by Weir Mitchell & I have recently seen a case. Just as the patient is falling off to sleep & sometimes during the day she feels:-

1. An aura consisting of (1) Something rising from one or both feet or hands (2) Merely a tingling in some part. (3) A sense of terror from the feeling that something is impending. This aura passes to the head if of the first kind, as in the case I saw. Then there is a sensation of one of the following kinds (1) a blow on the head (2) An explosion e.g. pistol shot, or something bursting. (3) An auditory sensation as the Clang of a bell or guitar string (4) A visual sensation, as a flash of light. (5) An olfactory sensation, an odour of some kind (6) A vague feeling of uneasiness over the head. (7) A psychical form culminating in the approach of a nameless dread. These forms may be variously combined. At first these attacks cause considerable alarm, but after a time this is much diminished. The attacks can usually be checked by turning over or some other exertion. This phenomenon is not rare in men, especially heavy smokers, & in hysterical women whether anaemic & puny or apparently robust. It is more like petit mal than anything else. Consciousness is never lost even momentarily.

Weir Mitchell. Op. cit p. 163 to 180.

2. **Hysterical Convulsions**

These vary very much in severity from the common fit of "hysterics" to severe convulsions with tetanic phenomena of great violence and nearly complete loss of consciousness. Some of the severer convulsions are hardly distinguishable from Epilepsy.

Modes of onset. There may or may not be an aura. The fall is usually less violent than in Epilepsy. It is often merely a sliding down, and the patient does not often fall where she will hurt herself. The convulsive phenomena do not usually commence until after the attack is fairly begun & the fall completed. In some cases however tonic rigidity begins before the fall which is then more sudden & violent. If the patient fall violently and remains ~~still~~ for some time before tonic spasm begins we have to deal with Epilepsy followed by Hysterical convulsion (Gowers).

Aural. The aura may be epileptic the attack beginning with petit & grand mal and Ending with hysteroid phenomena, but often no Epileptic Element is discernable. (Gowers). The following are Hysterical aural.

(1) General feeling of malaise and illness.
(2) Epigastric sensation.
(3) Palpitation.

(4) A Cephalic sensation of some kind, giddiness &c.
(5) A bilateral ascending foot aura.
(6) Globus Hystericus → Globus Ascendens.
(7) A "psychical aura" as delirium.

An initial scream is common and is often repeated again & again during the attack. In this connection we have loud screams, singing, shouting, ejaculation of particular words, fits of laughing, of crying & the like.

Dally. Op. cit. P. 533.

(1) Tonic Spasms. In this stage the lower limbs are usually rigid in extension with the toes pointed. The arms may lie at the side of the body or at right angles to it. (Crucifiement of Charcot). Sometimes the elbows are flexed, & the fists clenched. The wrists may also be flexed. But there is never the "interosseal position" of Epilepsy in which the fingers are flexed at the metacarpo-phalangeal joints with the fingers straight (Gowers).

Gowers' Epilepsy P. 146 & 147.

Larynx. In some cases there is extreme dyspnoea. This forms constitute the choking fits or Hysterical Strangulation of French Authors. In a case of this kind Gowers noticed the breathing over 80. The patient was a little girl. She hypnotized him and it fell to 26. When she awoke she breathed rapidly, crowed as in Croup, the face became cyanotic

Gowers Op. Cit. P. 153.

See also the reading part of this Essay under respiration.

and occasionally the "hawked" up bloody mucus. This is probably an extreme form of bulbar (Gowers).

Pharyngeal spasm also comes on paroxysmally. It is often accompanied by tormenting thirst. It is called Hydrophobic Hysteria by French authors. In a case recorded by Raynaud Laryngeal & Pharyngeal paroxysms co-existed. Patient died in one of the paroxysms. The condition has already been described. Gowers. Op. cit p. 153.

Tetanic Symptoms. These constitute a very characteristic feature of the more severe paroxysms. Opisthotonos, the "Arc en cercle" of the French is rare at the commencement of an attack, but may follow either the tonic or clonic stages. It may be only a slight arching, or the patient may rest on the head & heels. Sometimes the legs push the body upwards so that the neck is dorsi-flexed but utmost extent & the patient rests on the heels & forehead. If thus occurs when the patient is on the side we get the Arc en Cercle latérale, with the knees flexed, the neck dorsiflexed & the back arched. The patient may relax & bound back several times during an attack with great violence. Gowers Op. cit p. 147. Sally. Op. cit p. 532 - 533.

Emprosthotonos sometimes occurs, and is especially characteristic of those forms Gowers. Op. cit. p. 176 et. seq.

of convulsion where consciousness is lost and we hardly know whether to call them Hysteroid or Epileptic.

Clonic Spasms. These are quick, regular, & small in range. Tremor better expresses the condition. Sometimes it is confined to the lids. Sometimes opening & shutting of the hands occurs at the same time. Patients often try to bite others, their own fingers, & lips, but rarely bite the tongue. In the intermediate forms (or truly Hystero-epileptic) the tongue is thrown into spasm and occasionally bitten.

Gowers Op. cit p. 148 to 150.

Jolly. 532 et seq.

Coordinated Movements. These have a purposive aspect, and are perhaps due partly to mental state arising during the attack. Patient may for a time remain in a forced attitude from tonic spasms, then wild movements & distortion occur, following each other rapidly. These movements are mostly wild & irregular & without order of sequence. Sometimes the movements are rhythmical. The arms & legs may be thrown into the air, rapidly flexed & extended. They may beat the ground or the body. The fists are rapidly clenched & unclenched, & patient may tear her hair. The legs are commonly rigid in extension, while the arms are rapidly flexed & extended alternately.

Gowers. Op. cit. p. 150 - 154

Jolly. Op. cit. p. 531 & 532 —

The patient may be lying on her back and then heading movements occur in the legs, propelling her head foremost across the room. This is sometimes seen in Hydrophobia.

In one case Gowers saw tremor lasting 15 to 20 seconds, then flexion of the fingers, then of the wrists, then of the elbows, then the arms so flexed were flung backwards at the shoulders & finally they were flung forwards in extension. This process was repeated several times.

Another form, seen especially in post-epileptic cases, is digging the fingers into the face, sometimes producing severe scratches.

The head is wagged rapidly from side to side or nodded & flung about. The face is distorted with peculiar expressions, a jovial grin, then a wrathful expression & so on. Peculiar gestures may also be performed with the fingers. There are a few of the principal gestures & contortions, but others, too numerous to mention, may occur in various parts of the body.

Condition of the Eyes. The lids may be open, but are often firmly closed.

The eyeballs often strongly converge, or are rolled upwards or to one side. The pupils are often dilated, but vary during the attack.

Sometimes the pupils are contracted when there is convergence, or from spasm.
The reflex action of the Iris, to light is generally preserved, but it is difficult to test, because the pupils are rolled away from the light.
The Conjunctival reflex is usually much diminished or lost, during the height of the Convulsions. Sometimes it is unaffected. When it is anaesthetic it is frequently part of a general condition.

Mental State during Attacks

This is perhaps the best index by which to judge of the severity of attacks. In the milder forms consciousness is only slightly impaired, patient can dispose himself so as to fall without injury, hears what is said, and may perhaps remember what has occurred. But in the more severe attacks patient is far more unconscious. The power of reproducing the events that have occurred, when the fit ends, is not retained, and the patient may not be aware that one has occurred.

Mental aberrations may occur varying from mere emotionalism to outbreaks of maniacal violence. Some talk incessantly & unnaturally throughout the attack. One little girl used to count rapidly backwards! Screaming is also common.

Dalby. Op. cit p. 52-3

Gowers Epilepsy p. 139 p. 140. p. 171 & 173

Gowers.

Theromimecry occurs, meowing, barking & biting. These are partly due to hallucinations but biting is probably due also in part to an innate tendency which is now let loose. Biting occurs apart from hallucination. Mental disturbance is characteristic of the more severe attacks. It is very pronounced in the French cases. In them Emotional disturbance & hallucination often precede & follow attacks. These are common in this country also but the type is different. In the French Erotic Ideas are common. In England they are practically unknown.

When there is a series of fits the patient may appear rational in the intervals, with perhaps just suffecient peculiarity to lead you to expect further attacks. There is generally some emotional disturbance & often delirium. They may talk unnaturally, & have distinct hallucinations. Wrong interpretations are put on events happening before them. Their ideas are often dominated by incidents which have impressed them during the fit. Their mental state is often dream-like rather than insane.

Sometimes the activity of the Encephalonal centres is such that the states of feeling are too rapid for the development of any mental purport. This condition is known as Compressed Mania. It is an exaggeration of the state described under Volition.

Gowers has observed no difference between simple & post Epileptic attacks in this respect. The condition is closely allied to post epileptic mania, In the post-epileptic form the circumstances & its occurrence are almost the same.

Sometimes these mental phenomena occur without motor or sensory symptoms. Grave mental phenomena sometimes arise sd. Cases of Hysterical mania are often paroxysmal.

Duration of attacks. Attacks may last only a few minutes, or perhaps an hour or so, but in other case with more or less marked intermissions it lasts for days. It ends in either lassitude, or deep sleep for hours, or in delirium more or less marked for a day or two. In other cases the fit ceases & leaves the patient in her normal condition.

Types of Hysterical Convulsions.

(1) Ordinary attacks of "hysterics". Rythmical tonic & clonic convulsions of the extremities & head, Respiration quick & irregular. Face grimacing. Patient's consciousness only slightly impaired. She hears what is said & sees what occurs. She can be roused by powerful moral impressions, & irritants.

(2) Severe attacks with tonic & clonic spasms, tetanic symptoms present or absent,

wild coordinated movements. Consciousness considerably impaired, so that patient does not remember what has occured. Often grave mental phenomena present.

(3) Attack scarcely distinguishable from Epilepsy. Consciousness completely lost. Emprosthotonos frequent. Alternate clonic & tonic spasms. Spasm of the tongue, which may be bitten. A foam issues from the mouth. Breathing slow & stertorous. Jolly considers the brain condition the same as in Epilepsy. Sowers considers it due to a discharge of a different kind occurring in the same locality as Epilepsy usually appears.

(4) Mental attacks without motor convulsions

(5) Cataleptic attack

(6) Hysterical Trance, Ecstasy, Somnambulism, & Hypnotism. These last two groups are associated with the most profound hysterical condition. They are characterised by dreamlike mental symptoms. They are usually described as separate diseases, and so I do not think it advisable to discuss them further here.

Jolly Op. Cit. 533 & 536.

<u>Relations to Epilepsy</u>. These are so clearly and concisely given by Sowers that I think I cannot do better than give a short resumé of what he says, as these

done to a considerable extent throughout these sections.

(1) The occurrence of hysteroid after Epileptic attacks is only occasional, not constant, & only under certain conditions.

(2) Neither the Epileptic, nor the Hysteric attack is materially altered by the associations.

(3) The Epileptic is followed by the Hysteric attack in those presenting the constitution, age & sex in which Hysteria is common.

(4) The conditions must be present which ordinarily produces hysteria.

(5.) Both Epileptic & Hysterical attacks may occur alone in patients who at times present the combination. But the tendency to hysterical convulsion may be so slight, that the attacks never occur except in the post-epileptic state.

(6) Patients having major or minor Epileptic attacks, followed by Hysteroid attacks are the subjects of both diseases.

(7) Hysteria is due to an abnormal condition of the nervous system.

Intermediate attacks. Trousseau regarded some convulsions as of this nature. Now we usually regard all fits as belonging to one or other category. (1) Many attacks deviate considerably from either type. (2) The initial stage of Hysterical convulsions which closely resembles that of Epilepsy (aura) must be

due to a discharge of nerve energy in the same locality, tho' differing in kind from that of Epilepsy. (3) Some undoubted Epileptic fits show hysterical tendencies, such as coördinated initial phenomena as visual aura, running, hopping &c.

(4) The chronic occurrence of Hysterical fits may render the general disorder more & more like Epilepsy. The pseudo-epileptic stage of a purely hysterical fit must be due to a liberation of Energy in certain centres & consciousness is more & less impaired. Repetition may so increase the tendency, that in spontaneity & suddenness the fits which were at first purely hysterical, come so closely to resemble Epilepsy that we are almost obliged to regard them as partly Epileptic.

Gowers. Op. cit. P. 176 —.

We may be able to judge somewhat by the effect of Bromides which affect Epileptic, but not Hysteroid convulsions.

Diagnosis from Epilepsy

Epileptic convulsions arise without apparent cause: Hysterical as the result of emotional disturbance. In Epilepsy the aurae are various but especially the Epigastric and unilateral ascending aura in the Extremities. In Hysteria general malaise, globus hystericus, Palpitation, and the bilateral ascending foot aura.

In Epilepsy there is often an initial scream: So also in Hysteria but it is often repeated, or screaming, talking or the like. Never repeated in Epilepsy, never any talking or screaming.

The onset is usually sudden in Epilepsy but gradual in Hysteria. The fall in Epilepsy is sudden & violent. In Hysteria it is usually gradual & not violent.

Convulsion is tonic followed by clonic convulsion in Epilepsy. Abrupt & "shock like" in character. In Hysteria there is often long continued tonic spasm, clonic spasm & tremor, coordinated movements and ataxic phenomena.

Tongue-biting is common in Epilepsy and a foam issues from the mouth. Rarely often in Hysteria, but patients bite their lips, fingers, bedclothes or other persons.

Micturition & defaecation sometimes occur during an Epileptic fit, never during a hysterical convulsion.

Duration. In Epilepsy a few minutes, In Hysteria from ½ to several hours.

Consciousness. Quite lost in Epilepsy. Usually confused in Hysteria, but rarely altogether lost.

In cases of post-epileptic hysterical convulsions the beginning of the attack show the characters of petit or haut mal & the end those of Hystria.

In the intermediate forms we diagnose the case as Hysteroid or Epileptoid by the general characters of the convulsion. If fits are brought on by emotion, cease when patient is alone, are affected by change of surroundings & the like we consider them Hysterical. If they are not affected by these, and are controlled by Bromides they are probably Epileptic in spite of inter-paroxysmal hysterical Symptoms.

If attacks are not witnessed it is well to ask the leading question "Does the patient struggle or merely sink"? (Gowers). Struggling points to Hystria.

Control is necessary in bad cases of Epilepsy to prevent accident, in Hystria to check violence.

Methods of Arresting attacks.

1 Patients can often by a mental Effort, or bodily exertion, ward off an attack for a time or altogether. Gowers. op. cit. p 146.

2 Slighter cases can often be arrested by stopping the mouth & nose with a towell for 20 or 30 seconds (Gowers) Gowers op. cit. p. 298.

3. Cold Water. May be used to cut short attacks. A little poured into the open mouth is often effectual (Lowers). Cold douche is often effectual if used freely. It should be poured on the face from a height. For a few seconds it has no effect, then the patient gasps and tries to get away. It often diminishes the frequency or stops the attacks. It probably acts by changing the patients "motives". or states of feeling. It has the obvious disadvantages of being a rough proceeding, making a big mess, and it may give the patient a cold. Besides this it occasionally happens that it simply makes the convulsion more violent. In fact these abrupt proceedings may influence the patient either way, for good or evil.

Lowers Op. cit. p. 298.

Buzzard. Quain's Dict. p. 682.

* Dally. Op. cit. p. 570.

4 Powerful irritants held to the nose such as strong ammonia are sometimes effectual.

Buzzard Op. cit. p. 682.

5 Ovarian Compression, or the effect of applying metallic plates &c. may be tried where there is iliac tenderness on one side, but not much good is to be expected from them, at least in this country.

Buzzard. Op. cit p. 684

6 **Faradization**. The persistent application of powerful inducted currents, applied to any part of the body will often cut short attacks

Gowers Op. cit. 2 vol. 298. Buzzard Op. cit. p. 684.

7. **Apomorphia**. Gowers has observed that nausea however produced has a powerful effect in warding off or cutting short attacks. Taking advantage of this he has used apomorphia very successfully. After the hypodermic injection of $\frac{1}{12}^{th}$ gr. of apomorphia he has found that spasm ceases & consciousness becomes normal in three or four minutes. In six minutes she will sit up & in eight she will vomit and there are no bad symptoms remaining except slight nausea. $\frac{1}{20}^{th}$ gr. produces the same effect but takes longer. The finds that this is more than a palliative, because after a few administrations, in many cases the attacks cease altogether. This has the advantages certainly of portability, absence of pain & apparent roughness, and if it does all he claims for it, is certainly well worth trying.

Gowers Op. cit. p. 298 & 299.

Aetiology

1 The first question is that of the nervous organization which predisposes to hysteria. This constitution, especially when unmarked might almost be considered a mild degree of hysteria itself. The line of demarcation between health & hysteria is here not defined. This is marked chiefly by the prominence of the emotional functions, fickleness of ideas, with consequent weakness of will & instability of purpose. All circumstances favouring this condition of the nervous organization tend to produce hysteria. (Russel Reynolds op. cit. p. 84.)

Persons with high-strung nervous systems are not specially liable, provided that this condition affects all its functions equally (Reynolds), to become hysterical. (Jolly. Op. cit p. 481 – 482.)

No degree of intelligence seems to affect the liability to hysteria. It occurs with equal frequency in the intelligent & educated & in the weak minded and ignorant (Jolly).

2 **Sex.** Hysteria is most common in females, because from their nervous organization, habits & surroundings they are more liable to develop the nervous condition above described. (Russel Reynolds Op. cit p. 83.) It is also more common in males I believe than is commonly supposed. (Savory. Holmes Syst. p. 385.) I do not think a reliable numerical statement can be made as to the relative frequency of hysteria in the two sexes.

Age. Hysteria is commonest at the times of Crisis in a person's sexual and general life. The evolution o involution of the sexual organs are attended by nervous changes, and during these the hysterical state is very prone to arise.

Russel Reynolds. Op. Cit. p. 83-4.

In both sexes hysteria is not uncommon before the twelfth year. It is common in females o occurs in males sometimes, during puberty o the decade following. The climacteric period, or period of sexual involution is commonly marked by hysterical symptoms. Afterwards it is rare in women.

Jolly. Op. cit. p. 478. p. 548.

Not uncommonly a girl becomes hysterical during sexual evolution, and then the symptoms disappear, to break out afresh during sexual Involution. The completion of this is often the turning point towards recovery. During the last year I have seen many cases of hysteria during the Climacteric. They are usually rather mild, resembling hypochondriacs but unattended by its gloom and foreboding. Most commonly they have a number of aches o pains shifting from place to place, without any objective symptoms whatever.

In males it is common before the

twelfth year, and during puberty. Convulsive attacks are pretty common at this time. After this it is rare until 30 years, and is sometimes seen up to 45-50 year. It is during this, the active period of responsible human life that over-work & mental strain tell on the constitution. It is also not rare to find hysterical phenomena between 60 & 70 yrs. during the period of commencing senile atrophy. In all cases it is women & men of emotional organisation that are affected. The robust man & the hearty masculine type of woman are never affected.

Relation to Sexual Health. If you can keep the blood, circulation & digestive processes up to the normal standard hysteria is next to impossible. Dolley. Op. cit. p. 481 482.

I classify states of sexual health likely to produce hysteria as follows:—

I. Causes producing primarily exhaustion of the nervous system & through it producing depression of the sexual health. Mitchell Op. cit. p. 15.

Such are: Over-work mental or bodily, worry, anxiety, & excitement connected with business. Also want of definite aim & rational employment, the exactions of society, bereavement, unhappy love affairs

and the like.

II Causes primarily lowering the general health and as a consequence the tone of the nervous system. Such are exhausting diseases as the acute fevers & diseases generally. In this way act also pregnancy, childbirth & lying in. Also anaemia either acute from haemorrhage or chronic from any cause. I believe few hysterical women would give a normal blood count. Many appear delicate & pale but others are stout & sometimes apparently not anaemic, but they are as a rule flabby & incapable of much exertion.

III Causes Reflexly producing symptoms in persons whose nervous systems are already debilitated. Such are uterine diseases especially flexions, ovarian diseases and displacements & genital disorders generally. Wounds also occasionally act in the same way (See Holmes Syst. Surg. Vol. IV. p. 190-191), & also tumours & the like. Holmes Syst. Vol IV. p. 190-191.

Circulation. Persons whose circulations are weak, who suffer from cold hands and feet are specially liable to hysteria & in particular nervous affections resembling organic lesions. (Paget.) Paget. Cl. Lec. p. 198.

Relation to the Sexual Organs. This has been much exaggerated. The connection is by

no means a necessary one. We have already seen that sexual crises are times when hysteria is rife, but this is due to changes taking place in the nervous system. The same may be stated of Menstruation. Hysterical symptoms are commonest at these periods, because of the functional disturbance that then takes place. Besides, many have no trace whatever of genital disorder or irregularity of menstrual function. Jolly thinks no genital disorder can be proved in 50 p. c. while in many of the cases where it occurs it is merely a concomitant complication. In still others it is merely a reflex cause of particular symptoms in a person already hysterical. Many cases occur also when the sexual functions do not act viz. before puberty & after the climacteric, and in cases where the ovaries, uterus or testes are absent or rudimentary.

Russel Reynolds p. 82.

Jolly. Op. Cit. p. 482 to 484.

Menstrual irregularities are common in hysteria, as in all conditions where the general health is depressed. Menorrhagiae & Metrorrhagiae may cause anaemia & so hysteria. Hysteria & Amenorrhoea are commonly due to a common cause viz. anaemia. Possibly the effect of amenorrhoea on the circulation causes those cases where vicarious menstruation occurs.

Sexual excesses & Masturbation are likely to cause hysteria, because they depress the general health and also primarily depress the nervous system at the same time. They also act through the emotional functions. Jolly Op. cit. p. 480.

Occupation. This has an effect, because some callings depress the general health through want of fresh air, and exercise. The worst occupation however is to have nothing to do & no aim in life but to please one's self & kill the time. Russel Reynolds. Op. cit. p. 85-6.

Station in life has no necessary influence, but often acts by the personal habits it leads to.

Climate Temperature & Season. The disease is said to be commonest in Warm Climates: in summer & in spring, why, we do not know. Russel Reynolds. Op. cit. p. 85-6

× Jolly. Op. cit. p. 480.

Race. Every race has probably its own types of the disease. This depends on the national temperament, mode of living & thought, and on the methods of Education in vogue. In France the violent convulsions, checked by ovarian compression; the occurrence of transfer of symptoms; & the occurrence of marked Ecstasy are common. In England they are very rare. Again Mimetic joint diseases are common in England, but almost unknown in Germany. This subject would be worthy of study, but is not well known. Sowers. Epilepsy. p. 159 et seq. p. 171-173. Jolly. Op. cit p. 505.

Heredity & Education. The condition of the nervous system which predisposes to Hysteria may be inherited or acquired. The causes above enumerated may produce this condition and then Hysteria, but are far more likely to act where the condition has existed from birth, or has been acquired as the effect of bad bringing up. Russel Reynolds. Op. cit. p. 84.

The conditions likely to give rise to Hysteria are. (1) Various neuroses, as Mania, & Insanity in its various forms. (2) Various Scleroses, Epilepsy and especially Hysteria. Also debilitating diseases in parents and especially Phthisis. Want, debility apart from distinct disease & advanced age in parent also have an influence. Sometimes the tendency is so strong that the disease begins in infancy. Lally. Op. cit. pp. 479 - 481.

Probably however as much depends on the home influence, education & example as on heredity. Thus Hysterical mothers not only morbidly watch every trifling ailment in themselves & their children, but train, by their example, their children to do the same. The consequence is that they never learn the self-restraint, which is so essential in fighting successfully the battles of life. In this way Hysteria descends from

mother to daughters.
Too much indulgence tends to produce hysteria by failing to impart moral & physical strength, while too much severity by reducing the child's physical strength & nervous stability. These are equally bad, but worse than either is the condition in which some children are brought up where their education rushes from one extreme to the other. This is what marred the character of Byron.
The foundations of Hysteria are often laid in Boarding schools. The causes are (1) an unnatural mode of life, (2) over-work from ambition which receives every encouragement. (3) Want of open-air exercise. (4) In many instances the evils of masturbation are super-added. Another, perhaps necessary evil, is training all the children in the same way, & making all do the same work, in spite of their mental & physical differences. From these causes Hysteria sometime becomes Epidemic in such Institutions.

Pathology.

Of the physical causes giving rise to hysteria we know nothing. That there are physical changes in the nervous system is certain, but if we examine the brain of a hysterical person no morbid changes are found. This is what we mean by saying Hysteria is a functional disease.

Dolley. Op. cit. p. 488-493.

Whatever the change may be, it gives no reactions, or physical signs microscopic or otherwise by which we can recognise it. If we make a post-mortem of a person who has been hysterical, we find no peculiarity whatever, that would enable us to say that Hystera had existed. Russel Reynolds p. 99 & 101.

The condition given rise to is one of increased irritability, or instability i.e. a condition in which the nervous system responds with more than normal ease to external or internal stimuli. The response moreover is liable to be disorderly.

Most or all of the symptoms can be referred to the Hemispherical ganglion, but it is probable that lower centres are also affected. The mental symptoms are all referable to this ganglion.

To increased irritability of sensory & motor centres we refer hyperaesthesia, pain & abnormal sensations of all kinds subjective & objective, convulsions, & spasms clonic & tonic.

To diminished irritability we refer paresis, paralysis & anaesthesias of various kinds. Perhaps no change of this kind exists in the Cortical centres of the brain, but the changes are due to

interference with the passage of
afferent & Efferent impulses in
the lower nerve centres or peripheral
or intercentral nerve trunks.
This seems more probable because
we find no condition of the centres
concerned in mental processes corresponding exactly to anaesthesia or
paralysis. The close resemblance of
certain hysterical affections to
spinal diseases (Sclerosis &c), and the
possible passage of the former into
the latter also point to affection
of the Spinal nerve centres. This
might be referred to primary change
in the centres themselves or to the
influence, excitor or Inhibitory as
the case may be, of the higher over
the lower nerve centres.

In anaesthesia reflexes are often
diminished or lost, which shows
failure of the centres, cerebral or spinal
where the reflexion normally occurs
to act. This might be due to primary
change in these centres, or to an Inhibitory influence exerted by the higher centres.
The increase of the patellar reflex & the
presence of Clonus, in certain cases
points to the spinal centres as being

too irritable either primarily or as the result of a central efferent influence acting on them.

In Hyperaesthetic conditions reflexes are increased, sometimes beginning at the spot stimulated and then spreading & leading to general spasms or convulsions. This also points to the spine.

With regard to the peripheral nerve trunks & end organs, I know of no means of determining whether or not they are affected.

That portion of the nervous system governing the action of the circulation both cardiac & vaso-motor is certainly affected as shown by the various changes that occur. This may also be primary or due to the influence of the highest cerebral centres.

To conclude, Seeing that General depression of health, however arising, is the most important factor in producing hysteria, I think that the whole nervous system is affected, and that while all the symptoms can be referred to the Sympathetic Ganglions, yet the lower centres are almost certainly affected.

Diagnosis. If the condition is well marked this presents no difficulty.
The following points should guide one:-
(1) The presence of the hysterical nervous state, with its mental peculiarities.
(2) Increase of symptoms under observation & their diminution when the patients' attention is distracted.
(3) Absence of physical or objective changes sufficient to account for the symptoms complained of.
(4.) Presence of characteristic symptoms as globus, clavus, sensory changes &c.
(5.) Absence of the rise of temperature which marks all acute general diseases, & local inflammations.
(6) Loss of the usual ratio between the pulse-respiration, & temperature points of Hysteria.
(7) Course of the disease. Hysteria does not impair the general Health like organic diseases of equal severity. (Savory). Holmes System Vol I. p. 386.

The More fixed & isolated the symptoms, the more difficult the diagnosis. (Dolby). In cases of local pains the absence of lesion points to Hysteria, but great care is required to exclude organic causes. The greatest difficulty is presented when both co-exist. Here the hysterical state causes the symptoms to be much exaggerated. Dolby. Op. Cit. p. 5-5-1. Savory. Holmes Syst. p. 386. Vol I.

Hysteric symptoms are more commonly mistaken for organic diseases than vice versa, because (a) they are commoner (b) they simulate organic diseases very closely. (Savory op. cit).

Paralysis. (1) Hysterical paralysis is usually attended by anaesthesia. In Apoplectic paralysis this may occur also. But Sensibility returns first, in Hysteria last. Mitchell op. cit. p. 20. p. 25-26.

(2) The paralysis is always incomplete. The Hemiplegia is often crossed, may change sides several times. It also varies more in degree from day to day than Organic paralysis. Jolly. Op. cit. p. 5-20 p. 5-3.

(3) Electric Relations. — muscular nutrition remain approximately normal. Brissaud. Op. cit. p. 681.

(4) In Hemiplegia due to Hysteria the face & tongue are not affected, & the neck only very rarely. Reynolds. Syst. Med. p. 94.

(5) In Paraplegia the sphincters are not affected.

(6) In Hemiplegia & Paraplegia the mode of progression differs from that of organic paralysis.

(7) Unilateral Oedema may occur as in Organic Hemiplegia, but in this it is constant, while in the Hysterical paralysis it varies greatly from the influence of Menstruation, Emotion & exercise. It also differs in character from that of Organic paralysis. In some places the swelling is clearly oedematous, but in others it does not pit on pressure, or only on prolonged pressure (Mitchell) Weir Mitchell Op. cit. p. 28.

Hysteria and Spinal Cord diseases.

(1) Local pain & superficial hyperaesthesia are rare in Sclerosis; common in Hysteria.

(2) Psychical conduct different.

(3) Aetiology different as a rule.

(4) Electric relations altered more in Sclerosis.

(5) Progress. Hysteria remains stationary and changes symptoms more than Spinal diseases. Dalby. Op. cit. p. 552 553.

(4) Affection of Speech & deglutition are rare in Hysteria. Common in advanced Cerebro-Spinal Sclerosis.

(5) Gait different. The patient with Sclerosis tires his best, the hysterical patient makes the most of the symptoms & watches her observers.

It is often most difficult to distinguish between these affections of Hysteria. If you get paraplegia with sensory changes, exaggerated reflexes, & contractures it may be almost impossible to decide whether these are mimic or due to local Sclerosis & Myelitis.

Favourable cases of Landry's Paralysis are also extremely difficult to diagnose from Hysteria. (Dalby). In Multiple Cerebro-Spinal sclerosis there are shifting paralyses, paroxysmal exacerbations & intermissions, Convulsions & affections of Consciousness. Here diagnosis is only possible after minute examination & prolonged watching. The difficulty is increased by the fact that

there is reason to believe that mimicked disease leads to Sclerosis in certain cases. The exact relation is not known, but perhaps long-continued stimulation of certain tracts leads to degenerative changes in them.

In these cases we can only watch our patient, bearing in mind the differences noted above, & watching the effect of treatment.

The diagnosis of other conditions has already been given.

Prognosis. Fatal Hysteria is so rare that the question of death seldom need enter into our calculations. Still a few cases have proved fatal and it may be as well to give some account of how this has come about.

1. Violence of symptoms, as convulsions, cyanosis, collapse & Coma &c. (Wunderlich's Case) [illegible] Jolly Op. cit. p. 530.

[illegible] (2) Pharyngeal & Laryngeal Spasms as in Rullier's Case, (Thèse de Paris 1808). Raynaud's Case, (L'Union médicale, March 15, 1881, p. 433.) Gowers. p 155-161.

(3) Danger to life may occur from burning on the face. (4) Apparently paralysis of Vagus. (Mitchell's case (1).) (5) Acute congestion of the Kidneys (Mitchell Cases 2 & 3). Mitchell Op. cit. p. 22.

(6) In chronic cases danger to life may arise from extreme marasmus due to fasting, or vomiting. This rarely happens however.

As a rule the duration of life is not affected. The most serious consideration is

that although the patient's chances of living are not affected, she is rendered utterly useless, if the disease becomes fully developed.
Another danger especially seen in cases with marked heredity is grave mental derangement, which is very prone to end in mental enfeeblement.
The following are the conclusions I have come to: —
1. The more a patient has changed, in becoming hysterical, in her mental temperament, otherwise the better the prognosis. Hence it is better in acquired cases than in inherited; & better when attended by grave anaemia than when the patient is stout & rosy (Mitchell).
2. The longer the morbid condition has lasted, & the more habituated the nervous system is to abnormal habits, the worse the prognosis. Hence cases of long-standing are more difficult to treat than recent ones.
3. Cases with anaemia or general weakness rapidly improve, as a rule under proper management, and this gives you a good opportunity to impress the patient with the importance of checking bad habits. This gives you an advantage which is not seen in robust patients.

(4) In some cases the prognosis is bad because you cannot raise the level of the patients health to the normal. These patients soon relapse. They closely resemble those cases of Anaemia in which there is supposed to be smallness of the vessels, and which cannot be quite cured, and soon relapse when treatment is discontinued.

(5) The prognosis is also affected by the degree to which you can win the patients confidence, and remove her from baneful influences, home or other. Unless you have or gain the patients confidence, & can remove her from hurtful sympathy or surroundings, it is quite useless to undertake to treat her.

(6) It is easier to deal with intelligent patients who wish to recover, than with stupid ones, because you have a better chance of supplying a motive for effort to overcome morbid habits.

Prognosis as Regards Symptoms.

Reflex symptoms often disappear on removal of the cause e.g. righting a uterine flexion or the like, but if they have lasted so long as to become deep-rooted habits, this result does not always follow. The prognosis is bad

Selby. Op. cit. p. 562. 561

where these are chronic & incurable. They not only keep up the reflex symptoms, but by this means prevent such a rise in general health as to cure the general condition.

Particular symptoms may disappear at any time from some cause moral, emotional & physical. This is the opinion of Jolly & most writers on the subject, but Mitchell has not found it so in Hystero-palsies, contractures & the like, except when these are purely due to a dominant Motive. These are not under patients' control as some suppose, because Mitchell relates a case of a baby caught in a fire, who could not get away, but only fell down.

Jolly. Op. cit. p. 556.

Mitchell Op. cit. p. 35.

Any of the symptoms sensory or motor can be recovered from, but we have no means of telling which will go off & which will remain. If they recur several times they become more persistent & difficult to get rid of.

The worst bodily symptoms are (1) Multiple contractures. (2) Paraplegia. The worst mental are (1) Melancholia, (2) Folie Raisonnante & moral perversity.

The prognosis is influenced more by the duration & persistence than by the violence

of the symptoms. The more deep-rooted mental symptoms are very prone to end in more or less profound Dementia.
In paroxysmal forms the prognosis is better.

Paroxysmal Hysteria. Hysterical fits are more favourable than Epileptic. If they coexist you can often cure the Hysteria, but the Epilepsy remains. The Intermediate or truly hystero-epileptic forms are the worst because in many cases neither Epileptic, nor Hysterical remedies do good. The ultimate prognosis is good, because the convulsions usually cease sometime sooner or later. Generally the prognosis is the same as in other forms. Gowers's Epilepsy p. 249.

Treatment

Prophylaxis. If children were properly fed, clad & educated we should hear very little of Hysteria. The following remarks apply to all children but especially to children who have inherited neurotic tendencies.

Dietary. The diet of children should consist for the most part of milk & vegetables. Lean meat should only be allowed with great moderation, but fat may be taken freely. The meals should be at regular times, and over-eating prohibited. Children should be Jolly Op. cit p. 56-58 — Russel Reynolds 163 - 164.

taught to eat what is provided for them, and not allowed whatever they ask for. In order that this may be carried out, the same must be observed by the grown up members of the household. Persons who grumble at this, that & the other will have to contend with similar habits in their children.

Clothing. This should be loose & warm, flannel being worn next the skin.

Education. Should be such as aims at the formation of character and self control, rather than mere personal accomplishment. What is done should be done thoroughly. All cramming is injurious. Regular working hours should be pursued strictly. Regular hours for open air exercise should also be observed every day. Games, fun and frolic ought to be encouraged at proper times & in proper places. Moping indoors should be prevented.

Children should be treated with firm kindness, always the same. They should be kindly led to suppress personal peculiarities of emotion, fear & various little tricks which children commonly have. They ought never to be ridiculed, because this makes them feel hurt and tends only to accentuate their peculiarities.

The general health, state of the bowels and bodily functions, should be looked after & kept right in a firm quiet manner of both manner.

Sleep. Children should go to bed early, sleep long, and get up when called in the morning. Reading in bed must not be allowed. Here also regular hours should be observed.

Puberty. Special care should be taken at this time. Precocity should be carefully guarded against. Anaemia which is common at this period must be carefully treated.

Treatment of Hysteria.

In the treatment of Hysteria very little is to be hoped for, from so-called anti-hysteric remedies. Valerian & its preparations seem to do some good in climacteric, spasmodic cases, in alarming symptoms. Assafoetida & Galbanum are useful in flatulence, but they do not improve the patients general health, & their effect is evanescent.

Drugs generally are to be looked upon as aids to treatment, not as a means of curing the disease.

The following are the lines on which I think Hysteria should be treated:—

(1) The physician must have a win the confidence of the patient & her friends, or he can do no good.

(2) The patient must be removed from her invalide habits & harmful home influences. These are (1) worry & annoyance; (2) unwise solicitude on part of friends. (3) Too great sympathy which makes the patient rather enjoy being ill. (4) She is liable to be fatigued by too many callers. Before you can do much good this must be rectified & the patient left entirely under your control.

(3) The next consideration is to find out & treat any physical ailments which are keeping up the hysteric state, either reflexly or by depressing the general health. If surgical operations are required, they had better be undertaken if the state of the patients health permits.

(4) The next steps consists in carrying out measures to raise the patients' health above the level where hysteria is possible. If you can do so you get a cure, if not you get amelioration but a tendency remains & the disease breaks out afresh, when the patient is exposed to its exciting causes.

The measures required here are

(1) Accustoming the patient to a nutritious healthy, non-stimulating diet.
(2) Securing exercise for the muscles, if the patient is well enough by open air exercise, if not by massage & electricity. (3) Patients should always stop short of fatigue, go to bed early & be out early in the mornings.
(4) If there is anaemia great good can be got from Iron in any pharmaceutical form, but more especially the ferrous preparations. Also from bitter tonics as Nux Vomica, Quinia, Gentian &c.
As a result of these the general state of the patient improves & she eats more & sleeps better.

7. Moral Treatment. This should consist in (1) trying to make the patient understand that she is curable, but that a great deal depends on her own efforts. In this way you must try to supply her with a new motive, so that she can try to suppress her symptoms. If you have got her into a state of improving health this fact should be impressed on her (Mitchell) that she is getting better & that more is possible than before. In this way you should go on increasing your demands, but never

making them sufficient to fatigue her, because this throws her back and makes her lose confidence. If possible you should never allow any effort to fail entirely.

These are I think, the most important indications. In milder cases they can be carried out by sending the patient into the country, to the sea-side or the like, but she must be given strict instructions. More severe cases may be managed at various hydropathic or other institutions where the indications can be carried out.

In severe cases of chronic invalidism Weir Mitchells treatment best fulfils the indications. It consists of seclusion, which must be absolute, rest, careful feeding, massage & the use of electrical stimulation. The last are to take the place of the normal exercise of the muscles. This renders a fattening process possible, which is considered so essential in treating mental affections. For the details I must refer to Mitchells works. Mitchell Op. cit. p. 265

In concluding this paragraph I may add that no condition has to be considered so much on its own merits as that of a hysterical patient, and none

makes a greater demand on his skill, patience & ingenuity. In this disease above all others we have to treat patients each according to their condition of body & mind, and not merely disease.

Treatment of Symptoms.

As a general rule the symptoms of hysteria should not be made much of. The general treatment should be carried out and as the patients' health improves these will gradually disappear. Still some good can be done by local & special remedies.

1. Fainting. As a rule no special notice need be taken of them. But if they continue long it may be necessary to rouse the circulation with counter-irritants as mustard, or by electricity. In trance, catalepsy & like conditions artificial feeding may be required either per rectum or with the stomach tube. Irritants may fail to rouse the patient. If so we must keep on the feeding & wait. Jolly. Op. Cit. 5-73.

2. Paralyses. Electric currents sometimes aid the general treatment, but sometimes fail. Transitory benefit occurs, which becomes more permanent after each application in favourable cases. Strong faradic currents

are best as a rule. Sometimes constant currents are more effectual.

Paraplegic forms are most obstinate. Galvanization of the Spinal cord is sometime useful. Patients must be encouraged to use the paralyzed parts as much as possible. Massage & passive movements of the paralyzed parts also do good. Jolly Op. cit. p. 574 575.

It is often necessary to lift the patient on to the floor and teach her gradually to kneel & then to walk with or without the aid of various crutches & other appliances. Some weakness often remains after the patient is up & about again. Mitchell Op. cit.

<u>Tongue, Pharynx, Larynx</u> &c. Local Electric treatment is very useful here. The poles may be external or one in the throat & one on the skin over the Larynx. In the throat & especially the Larynx relapses are common, I suspect because the local is as a rule treated without considering the general condition.

Passage of the stomach tube or oesophageal probang often does good in dysphagia.

Laryngoscopy also often cures aphonia. Asking the patient to sound the vowel Ah, often surprises her with a noise & takes her off her guard. External compression & manipulation sometimes cure the aphonia. See Holmes Syst. of Surgery Vol IV. p. 592.

Contractures. The following are the heads of treatment as described by Weir Mitchell. (1) Extension by pullys & Weights or pressure. (2) Firing out the muscles by electricity (Buzzard. op. cit. p. 684).

(3) Hypodermic injection of atropia into the contracted muscles. Often the means of greatly doing much good. (4) In severe cases where other means have failed section of tendons may be tried. Mitchell has seen good results in three or four cases.

Blisters every three or four days are often useful (Buzzard). — Quain's Dict. p. 684.

Any of these means succeed if the general management succeed, but fail if it fails although they may give temporary relief.

Convulsions It is of great importance to get the patient properly secluded, because under excitement patients easily work themselves up into a state where convulsion is almost certain.

Great judgment is required in managing the patient while in a fit. Too much should not be made of it. — Lowes. Epilepsy p. 297.

Restraint often increases violence. Just enough should be used to prevent the patient from injuring herself or others and no more. Of the methods of cutting short the convulsions I have already treated.

A great deal more could be said of the treatment of symptoms, but sexually the sexual treatment is more to be relied on & will give better results.

As a rule Opium, Chloral, Alcohol & anaesthetics should only be used with great caution, because the patient is only too liable to add more bad habits to her already large stock, but each Case must be treated on its own merits, and the physician must use his own judgment in these matters.

In dealing with hysterical patients one must always be on the watch for fraud, because finding a patient out and learning something of the motive underlying their condition often does much towards curing it.

John B. Bowden