ON HYSTERIA IN CHILDREN.
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with 10 Illustrative Cases, - by JOHN PLAYFAIR, M.B.,
F.R.C.P.E.

Most of the diseases of early life have been studied and described more or less completely, either in the excellent text books on Children's disease now at our command, or in the many works devoted to special subjects in this department of medicine. The nervous system in children is specially prone to various disorders; and many of these have been carefully observed and described. Nor need it be wondered at that the nervous system in children is more than usually liable to disease. During this period of life, in the first few years of this period indeed, the nervous system undergoes a marvellously rapid development. The brain, the chief nerve centre, almost attains its full adult size in the first seven years of life. If this extraordinary activity of growth is proceeding in such a delicately organised and complicated structure, it is to be expected that even the smallest interference with its nutritive process, or any sudden jar to the sensitive tissue, will almost inevitably produce very marked signs of disturbed
function. And such does occur. A very slight cause will in some children produce a violent convulsive seizure. The cutting of a tooth, a little gastrointestinal irritation, or the onset of one of the exanthemata, are sufficient in some children to profoundly affect the great central nervous centres, causing loss of consciousness with convulsive seizure. While this is well known and kept in mind by medical men, it is not so well recognised that what are often termed the purely functional affections of the nervous system, in other words the hysterical, are by no means uncommon in children, and even amongst children of very tender age. Some of the text books absolutely ignore the subject altogether, while most merely notice it in a very brief and cursory manner.

It is not difficult to understand why the earlier writers should have failed to recognise Hysteria as a disease of childhood. The name of the affection explains this. So called, because the womb and the development of the sexual organs at puberty were supposed to be its starting point, children were at once excluded.

It is to Charcot and the French medical school that we are chiefly indebted for introducing something like order into the study of a disease which above all is distinguished by the multiplicity and
diverseness of its symptoms, both in the adult and child. Hysteria is marked by very much the same symptoms in childhood as in adult life; and these are characterised by variety and number in both cases; though in the adult, certain of the symptoms are much more pronounced than in the child. For example, the violent contortions and convulsive movements so graphically described and figured by Charcot, are seldom seen in the child. To all intents and purposes, however, the disorder is the same in both adult and child, and distinguishable by the same signs and symptoms.

The following ten cases of Hysteria in children will, I trust, be of interest, and serve sufficiently to illustrate the subject. Eight of these were under my own care in the Children's Hospital. The notes of the other two I have received through the kindness of Dr. John Wyllie, under whose care they were in the Royal Infirmary.

**Case I., A.S.** Aet. 10, Admitted 26th Oct., 1888.

Family history. Father suffers from asthma. Four other children, all of whom had fits when teething. When 1½ years old patient had Scarlet fever, and at that time had convulsions. She also has had whooping cough and Measles, but these were not complicated with fits. At one time had "fainting fits"
without any movements. Lately, these attacks have been accompanied by movements. Her head turns to the left, and her left foot turns outwards, and the arms become stiff. The right leg remains unaffected. After the attack, patient sleeps profoundly. She has severe head-aches localized to the vertex. She has also great difficulty in retaining her water.

Present condition. Patient is evidently of marked neurotic temperament. Many of her movements are quick and sudden and almost choreic in character.

Nervous system. Sensibility normal - Reflexes - Plantars exaggerated slightly - Right abdominal present, but not marked - Left abdominal exaggerated - No ankle clonus - Knee jerk slightly exaggerated - Deglution normal - Bowels very sluggish - Micturition, occasionally involuntary, and she never can control her bladder any length of time, - She knows when she is passing water.

Special senses, normal.
No tender areas in spine.
Heart and lungs, normal.
Alimentary system. Tongue furred - Bowels constipated - Appetite poor.
Urine, normal.
Treatment - Rest in bed.
Nov. 5th. Discharged - never having had any
fits since admission.

Patient was re-examined Nov. 1890.

Patient, since leaving the Hospital, has been troubled with fits. These have steadily become less frequent but more severe. When she left the Hospital she used to have three or four a day, but each of these was slight and lasted only a few minutes, while now they occur only about once a fortnight but last for about 10 minutes.

The last one which the mother witnessed occurred a month ago. For several days she had been heavy and dull and had a severe headache. In the middle of the night her mother heard her scream, and heard the crib shaking violently. She entered the room and found patient convulsed and working her arms and legs rhythmically, but not throwing them violently about. The movements were much more marked on right side of body. The head was turned to the left and the eyes in the same direction. The fit lasted over half an hour and after it she lay unconscious for some time and then fell asleep. She passed her water during the fit. She felt weak for a couple of days and then was better than before.


Family healthy - shows no nervous tendencies.

He had "worms" when a child, but none for some years.
He had Scarlet fever 3 years ago, and soon after this he began to have attacks of shaking in his arms and back. These have continued, and now he generally falls backwards, and once he hurt himself, cutting his eye on a pail. He does not get black in the face, but his eyes look queer. He does not lose consciousness. Sometimes he has six or more fits in a day. He has them also when asleep. For the last 5 days his legs have become affected also with the shakings.

He is a well nourished boy with a placid expression, pupils large.

While his case was being taken, he had what he said was one of his fits. He said afterwards he felt as if he were "dropping." He had no warning of the attack coming. Suddenly his hands and arms began to flap up and down. The movements were not like the clonic spasms of epilepsy, but more like some one imitating the movements of a bird's wings.

He seemed to be conscious, and when slapped on the face began to cry. He had five or six of these attacks in succession. Nothing abnormal can be made out otherwise in his nervous system.

Circulatory and respiratory systems—normal.

The boy was a patient of Dr. Whitelaw of Portobello, who on 26th May, 1891, kindly wrote to me as follows about him:
"D.B. came under my care early in the summer of 1889, suffering from twitching of the arms, and inability to stand steadily when this occurred. For some time I kept him under almost daily observation while treating him for petit mal. He improved under the Bromide for a time, but relapsed, and I sent him to the Children's Hospital. He returned from there in November 1889, and on the 16th of the same month, he developed Typhoid fever, which he passed through without any indication of nervous involvement, even when at the height of the fever the temperature reached 103°.8.

In addition to the twitching in the arms there was a peculiar drooping of the eye-lids when the attacks came on, as well as some alteration in the muscles of the iris.

In the summer of last year he took a fit when the muscles of both upper and lower extremities were involved in the tremors. It took place in the early morning, and when I saw him he was lying unconscious and somewhat cyanosed. This condition lasted the better part of the day and ended in a long sleep. Subsequent to this I have seen little of him, but the same twitchings or whatever they may be termed have continued.

At the beginning of April last, he took another fit. When I saw him he was rigid with a cyanosed appearance, and was for the first time frothing at
the mouth. This condition lasted a good many hours and terminated as the previous fit, in a long sleep.


History.

Present Illness. In the morning, on 6th June, Friday, patient had a bad head-ache. On this account he told his master he could not work. It was frontal. It left him at 4 p.m. when he took some dinner. Next day he felt well and worked as usual, but by the afternoon the pain had returned and was very severe. He went home and soon vomited, bringing up part of what he had taken for his dinner. Almost immediately after vomiting he went out with his brother to the Theatre Royal where he vomited freely, and twice again he was sick and vomited. About 9 p.m. he left the Theatre and was standing in the street when he suddenly felt giddy and would have fallen had a woman not caught him. He then had a fit and was unconscious for 10 minutes. The woman carried him to a shop and laid him down. Gradually he recovered and was carried home, where he arrived at 10.30 p.m. He was then put to bed, and in about half an hour he fell asleep and slept well until 7 a.m., when he woke up in a fit. This lasted 10 minutes; and during it, he felt pains in
legs, arms and head, and was in vigorous movement. All day he had fits, one every half hour. Each lasted 10 minutes. He took little food and fell asleep at 11.30 p.m. During the night, he had two fits, and these woke him up. On Monday the 9th, he had a fit every twenty minutes, each lasting 5-10 minutes. He remained in bed that day. From then till Saturday the 14th (the day of his admission), the fits usually came on every 10 minutes and lasted 5-10 minutes. Sometimes, however, one lasted longer; and then the succeeding interval was also longer. On Thursday and Friday nights, he had only one fit each night and slept well. After a fit he always asked for a drink.

Previous health. He had most diseases of childhood. Does not work too hard. Family history good.

Present condition. Well developed, healthy-looking lad with pleasant expression.

During a fit he lies on his mother's knee on his back. His face is placid. His eyes are shut, and his limbs are flaccid; back arches backwards. His chest and abdomen jerk convulsively forwards, causing a sudden expulsion of air from lungs. When the fit is over he looks quite intelligent and only slightly drowsy. Pupils natural and contract actively. Reflexes normal. He is quite conscious during a fit. He took a fit soon after admission. After the movements described had lasted 2 or 3 minutes,
he feebly asked for a drink. This was not given him, and he at once relapsed into another fit. After several such relapses, the battery was applied but only slightly arrested the attack. When he again asked for a drink he was given 3/ Tr. Assafoetida in water, and since then has not had the slightest return of the convulsive seizures.

Patient complained of pains in the head and limbs after the fits, which soon disappeared. He is very quick and intelligent, and sleeps well at night.

Other systems normal, except that the patient is a little anaemic.

27th June. Patient left Hospital to-day quite well. He gained 1 1/2 lbs. in weight.

Case IV. H.M. Aet. 12 years. Occupation - Schoolboy. Admitted 14th June, '90.

Patient on admission was suffering from an affection which caused him to throw himself about violently and cry out.

History. Patient states that, the day before, another boy, during a quarrel, struck him on the head with his fists.

Slight bruises are to be seen on his chin, left cheek and left eye-brow, which he says were inflicted by his opponent.
The quarrel began over a ball with which they were playing. Patient was knocked down and lay unconscious, remaining in that condition for about \( \frac{1}{2} \) hour, during which he was carried home and put to bed. On regaining consciousness, he felt pain over the frontal region. A few hours later, about 10 p.m., he vomited all he had taken during his tea. The whole of that night he was very restless, crying out frequently and throwing himself about violently. Next morning, when brought to the Infirmary, he was in the same state.

**Previous Health.** Patient states that four years ago he had an attack of bronchitis and was laid up for eight months. Six months after, he suffered from measles, after which he had an attack of croup, for which he was admitted into the Old Infirmary and was there under treatment for eight weeks.

**Family History.** Good.

**Present Condition.**

Conformation and development fairly good. Temperature slightly raised on night of admission, but was normal next day. Is confined to bed, aspect cheerful. The face is slightly flushed, especially over the malar regions. Skin moist. No signs of specific disease.

**Nervous system.** When lying on the couch in the Medical Waiting-room, patient's whole body suddenly became flexed, and he began to cry loudly.
When spoken to these symptoms increased. He was given the Faradic Battery which made him cry out more loudly. After a short application of the battery he walked round the room without assistance. He, however, soon relapsed into his former state when the treatment was stopped.

When admitted to Ward he was much quieter and sat on his mother's knee in a dazed and stupid condition.

Pupils normal in size, but somewhat sluggish in reaction.

**Treatment and Progress. 17th June.** Patient is quite well. He remained heavy and stupid for some hours after admission, but now is quite bright.

**25th June.** Patient has had no return of symptoms. He went out today. Gained 1 lb.

**Case V. A.C. Act. 7½.** Admitted 4th Dec. 1883.

Family history reveals no indication of nervous disease. Four years ago patient had German measles, which was followed by the fits from which she now suffers.

**Present Illness.** The attacks began four years ago as stated above. She apparently becomes unconscious, turns up her eyes, twitches all over, and throws her arms about. She sometimes passes her water during a fit. She has never injured herself. Three years ago she was in the Lincoln Hospital,
and improved greatly for a time, but afterwards got much worse. Two months ago, she was admitted to the Infirmary, and remained five weeks. Since her dismissal from there, she has become much worse. Dr. Affleck sent her to the Children's Hospital. Her mother states she has had several fits to-day. She says she does not fall down, but merely throws her arms about.

No abnormality can be detected in any of her systems.

Dec. 11th. Discharged, never having had any fits.

Case VI. M.M. Aet. 4. Admitted 27th Jan. 1888.

Family history unimportant. Father and mother quite strong. Has had measles, Whooping Cough and Scarlet Fever, and Bronchitis.

Present Illness. Four weeks ago she got a fall, striking the right side of her head on a stone. A fortnight after that, she complained of severe frontal head-ache; and between 12 and 1 o'clock that night, had a fit. Face became pale - she squinted and her mouth twitched - hands and legs moved up and down. Since then, every night, between 12 and 3 a.m., has had several convulsive seizures. When coming out of the fit, she screams a great deal. Has complained of frontal head-ache all along.

Present Condition. Child pale and waxy looking

Lungs. Signs of moderate bronchial catarrh - otherwise normal - Heart normal.

Treatment. Jacket poultice and stimulating expectorant mixture.

Jan. 3rd, Chest normal. Ordered a tonic iron mixture.

March 6th. Left Hospital to-day. No fit while in Hospital.

Case VII. H.W. Aet. 11. Admitted 31st May, 1890. Complains of pain and immobility of the right foot. Duration about three months.

Family History - unimportant. His mother is excitable and indulges patient much.

Previous Health. He has had Scarlet Fever and Measles, and made a good recovery from both. He has never had Whooping-cough or fits of any kind, nor has he suffered from head-aches.

Present Illness began with a sharp attack of Influenza three months ago, which lasted about three weeks and left him very prostrate. When he got up he found he could not move his right foot. It was stiff, and immovable for a considerable time before he felt any pain in it. It never was much swollen.
He has now great pain in the foot, especially under the ball of the toe. His ankle has been blistered and painted with Iodine.

Present State. Patient is fairly well built and nourished - complexion somewhat pale. He shows signs of rickets in a marked pigeon breast. Pupils rather widely dilated and equal. Speech slow - manner rather surly at first, but general intelligence and communicativeness good when preliminary shyness overcome. Is a good short-hand writer and takes a great interest in this accomplishment.

Temperature normal.

Nervous System. Is liable to sleeplessness - distinctly emotional, crying readily if much questioned. Complains of severe pain in his right foot. No head-ache. No hallucinations. No evidence of self-abuse. Right leg is markedly wasted from the knee downwards, the anterior and posterior muscles being about equally affected. Measured round the calf it is found $\frac{3}{4}$ in. less than left leg. No alteration in the temperature of the limbs. When patient lies down the leg is semi-flexed and laid on its outer side, and he zealously guards it from being touched even by the bed-clothes. He cannot lean any weight on the leg, but gets about readily on crutches. When patient is in the erect position the foot is extended and the toes pointed. There
is no evidence of organic disease of the ankle joint. There is very marked Hyperalgesia over the whole foot and ankle below a sharply defined line passing round the limb 1½ inches above the malleoli, except over a well defined spot about the size of half-a-crown on the plantar surface of the heel. However much the attention is directed away from the part, the slightest pressure on the foot, causes him to cry out loudly, and even brings tears to his eyes.

Reflexes. Plantar - excessive on the right side - present on the left. Patellar. - Almost absent on the right - Distinct on the left. Other reflexes well marked, but not exaggerated. No loss of control of sphincters. No difficulty of swallowing. No paralysis of sensation or motion, other than noted. Special senses unaffected. The effect of heat and cold on the foot could not be ascertained on account of the extreme pain caused by the slightest touch.

June 1st. Being allowed to get possession of his crutches, and to go out, he made off to his friends in the Town. His mother was requested to bring him to Hospital next day to have chloroform given to him, so that his foot and ankle might be thoroughly examined. He was brought evidently very much against his will, and at once said he was better now and could walk without his crutches. He immediately gave a demonstration of his ability to
do so, by walking and standing about unsupported. The fear of the chloroform and the dread of being left in Hospital had evidently worked the cure, and much to his relief he was taken home by his friends.

Three months after his return home, Dr. Aymer of Bervie, whose patient the boy was, kindly wrote giving me some account of his condition and progress. Dr. Aymer says "Yesterday I found him walking about with a slight limp, and using a stick which his parents can't get him to discard. The muscles of the leg are still considerably wasted, but all trace of the hypersensitive condition has gone." After stating some of the symptoms with which the case began, Dr. Aymer farther says, "The pain and sensitiveness were therefore the primary factors. That they were purely hysterical manifestations, is now perfectly clear, but the case was very puzzling."


Father and mother quite strong. One child died from cerebral mischief.

Family History - otherwise unimportant.

Patient has had measles, whooping-cough and bronchitis. Always been delicate - has also had slight rheumatic pains with palpitation.

Present Illness. Began 18 months ago with pain in back and legs. At this time some prominence of lumbar spines was noticed, and she was ordered a poro-plastic jacket which she has worn since; un-
til a week ago she has been able to go about. Since then she has been quite unable to walk, and has complained of pain in back, neck and right side and down legs.

Present Condition. Child pale and thin - pink flush on cheeks - emotional - laughs when saying that any motion or touch is very painful. Complains of pain in back of neck and across lumbar region and on right side below angle of scapula.

When in sitting posture there seems some undue prominence of vertebral spines in lumbar region, which disappears when patient lies on her face. When asked to sit up, patient hoists herself up with her hands, and apparently only with great difficulty manages to rise up. Her head hangs downwards with an inclination to left. When asked to raise her head does so slowly, and sometimes assists the movement with her hands.

Noticed that when she thought no one was watching, she could rise up easily, and almost without assistance from her hands.

She is unable to walk unless she is supported. Gait is uncertain and staggering.

Complains of pain if slight pressure is made on back of neck or lumbar region. Also says pressure anywhere on her body is painful if her attention is directed to the act of pressure.

Heart. A systolic murmur heard in mitral area,
but not in axilla. Heard also in aortic and pulmonary areas. No enlargement of organ. Urine normal. 

**Treatment.** Massage and over-feeding. In about a week a severe attack of Diarrhoea and vomiting came on, with high fever. This soon subsided.

On 15th Jan., she had an attack of follicular ulceration of the throat, with severe inflammation. She had quite recovered from this by the 19th.

On 31st Jan., Weir Mitchell treatment was resumed. Diarrhoea with slight fever again came on. By 9th Feb., temperature was again normal.

On Feb. 20th, Weir Mitchell treatment was resumed, no further complication.

On 20th March report is: - "sitting up and going about - walking very well indeed, especially when she thinks no one is looking.

May 3rd. Sent to Convalescent - cured.

In March 1891, patient was again seen and examined, when the report was as follows: -

After leaving the Convalescent 3 years ago, she remained a week well and then got as bad as ever, and was in bed for a week quite unable to walk. She then quite recovered. She has had no paralysis since; but several times has felt "too tired to walk."

She gets very easily over-excited and laughs or cries immoderately.

Sleep very much disturbed, and she walks about
in it often. She is always very much done up after any excitement.

Her features twitch occasionally involuntarily. She walks well, and with no dragging of the legs.

Knee jerks a good deal exaggerated. No painful or anesthetic areas anywhere. There is some undue prominence of all four lumbar vertebrae but no tenderness here and it is no worse than it has been for years.

Slight impurity of first sound at apex and in pulmonary area. No bruit de diable.

Menstruation too profuse, but not often enough. Has been established a year.

Case IX. C.A. Act. 10. Admitted Oct. 28th, 1887.

Father and mother alive and healthy.

Family History - unimportant.

Patient has had measles and whooping-cough, recovered well from both.

Nine months ago began to complain of right arm feeling tired after doing anything with it. This has gradually increased. Takes his food now even with his left hand. Has has no injury. His mother thinks his left arm is weak also. Has complained lately of pain in his right upper arm, and of feeling as if "it were all drawn and something were inside it."
With strong galvanic current, all muscles of both arms re-acted normally.

Arms somewhat thin, equal in strength, muscles contract normally and do not seem at all flabby or degenerated. He is seen occasionally to use his right hand quite as freely as his left.

Other systems - normal.

Left Hospital, Nov. 14th. Condition same.

He was seen and re-examined in March 1890, and the following report made:-

After leaving Hospital he got stronger, the medicine which he was taking seeming to do him much good.

He left school last June, and has been much better since.

His arms improved in strength greatly and he never complains of them now. His arms are rather thin but strong, and feel hard. He is excitable but never had anything like fits.


Complains of chronic vomiting. Duration one year.

Family History. Father and mother alive and healthy, though father is a nervous and excitable man. Eight brothers and sisters alive and healthy. No syphilitic or tubercular history.
Previous health. Patient has had measles and whooping-cough, and is subject to bronchitis during the winter months. She has never had fits or other disorder of her nervous system.

Present Illness. About a year ago, she began to have uneasy feelings about her stomach. On account of these feelings she would rise from table during meals and vomit. Immediately after she would return and eat heartily. This went on for about 9 months. For the last 3 months she has vomited everything except milk. All kinds of food have been tried, but with the same result, and milk has accordingly been her sole food. She has had no jaundice or headache. Her bowels are constipated, motions pale in colour.

Present State. Patient is fairly well nourished - Not anemic - Tongue covered with a brownish fur, but moist.

Circulatory and Respiratory systems are normal.

Alimentary System. Abdomen lax. No pain, or tenderness, or swelling. No enlargement of any organ.


Treatment. 3 grs. Calomel at bed-time, followed by 20 m. Liq. Ext. of Sagrada in the morning. 1 m. Vin. Ipecac. every hour.

July 25th. Vomited at 3 a.m., and again at
5 a.m. The vomited matter was brownish in colour, alkaline in re-action, and under the microscope was seen to contain blood corpuscles, and numerous fat granules.

July 26th. All medicines stopped; and she was put on a special diet, consisting of Brand's meat jelly, minced raw meat between thin slices of bread and butter, peptonised milk, and cream and hot water. Small quantities every 2 hours.

There was no further vomiting. The food was gradually changed to ordinary diet, and she went home cured on August 23rd 1890.

Further particulars supplied to me by her ordinary medical attendant, Dr.T. Fraser of Berwick-on-Tweed, on 11th August 1890.

11th Aug. 1890. She has been ill for about a year, but has had no particular symptom except difficulty of swallowing and immediate regurgitation of any food she tried to swallow. I prescribed various remedies and diets, without any good result, and she went on bringing up everything and getting thinner.

I made her, while I was present, try to eat some bread, and from the choking convulsive attempts she made to bring up the food, I came to the conclusion, rightly or wrongly, the trouble was in her gullet. On one occasion she brought up about 3/4 of blood.

Dr. G.W. Balfour saw her with me one day and
recommended me to feed her on small quantities of milk frequently repeated, and on this diet she got a great deal stronger and stouter.

On 16th July 1891, Dr. Fraser kindly wrote to me again as follows: -

"C.A. is now plump and ruddy. Her appetite is very good, but her mother states that she often still regurgitates a portion of her food after meals. Her mother also informs me that she has a morbid craving for food, and often asks for more soon after she has indulged in a full meal.

On two occasions, I made prolonged and deliberate attempts to pass bougies into her stomach, but did not succeed; though she submitted to the manipulations with great patience and courage.

I am not prepared to say there is any stricture. It may be hysterical spasm. She has not brought up any blood since she was in Hospital.

Her father is, as you have guessed, a very nervous and excitable man. He has suffered from asthma for many years. Her mother is a big, healthy, strong woman. None of the members or connections of the family have suffered from hysteria or insanity, or other nervous affection."
These ten cases naturally divide themselves, according to their most prominent symptoms, into three classes.

I. A class in which convulsive movements of various kinds were the most marked symptom.

II. A class in which symptoms of paralysis were most marked.

III. A class in which persistent vomiting was the distinguishing feature.

Six of the cases belong to the first class, three to the second, and one to the third.

Let me now take up the consideration of these groups or classes somewhat in detail, and in the order in which I have stated them. Of the six convulsive cases, two, Nos. 1 & 2, though diagnosed as hysterical when in Hospital, developed symptoms afterwards, which were more those of Epilepsy than Hysteria. They were retained, however, in the series, to illustrate the great difficulty there often is in distinguishing between cases of Epilepsy and Hysteria.

Case I. was thought to be Hysteria, because of the child's marked neurotic temperament and family history, the localization of the movements to the head, left foot and arms, the right leg remaining unaffected, and the cessation of the movements during her stay in Hospital. When she was seen and
examined again in Nov. 1890, her fits had assumed a much more epileptic-looking character. A glance at the account of her case then shows this at once. The dull heavy look, and severe head-ache, for several days before the fit, look very like an aura. Also, the absence of violent movements, the involuntary passing of her water during the attack, and the unconsciousness and heavy sleep after the fit, all point to Epilepsy. Whatever the case was at first, it was certainly more like Epilepsy than Hysteria as it was latterly seen. The more marked symptoms of Epilepsy as distinguished from those of Hysteria will, however, be referred to later on, when I come to discuss the question of diagnosis.

Case II., though to all appearance an example of Hysteria when admitted to Hospital and during his stay there, and diagnosed as such, eventually came, like Case I., more to resemble Epilepsy. It also serves to illustrate the difficulty of diagnosis between Hysteria and Epilepsy. The peculiar flapping, flying-like movements and his apparent consciousness during the attacks when in Hospital gave rise to the decision that the case was one of Hysteria. It was after he left Hospital that his fits became more epileptic-like in character. It will be remembered that Dr. Whitelaw's report of him then was, "At the beginning of April last, he took another fit."
When I reached him, he was rigid and cyanosed, and was for the first time frothing at the mouth. This condition lasted for a good many hours, and terminated, as in the previous fit, in a long sleep."

Dr. Whitelaw looked upon the case as one of Epilepsy; and as he saw it, I must say, it would have been difficult to come to any other conclusion.

Case III., one of those kindly supplied to me by Dr. Wyllie, was specially well-marked and interesting. The convulsive seizures were no doubt preceded by head-ache and vomiting - symptoms which might have indicated real brain mischief. The description and course of the attacks, however, leave no doubt as to their true nature. The fits, though numerous, evidently had no depressing effect upon the boy's general condition. For three days he had more or less constantly recurring convulsive seizures, sometimes as often as one every 10 minutes; and yet, when admitted, he is described as a "healthy looking lad with pleasant expression."

Clearly, he had none of the dull, dazed look of the epileptic, and which would have been certain to have been strikingly present had the attacks been epileptic. He took one of his fits soon after admission; and here again the description is very characteristic. He had no premonitory symptoms, such as loud screaming or laughter, as is often the case in hysteria; but the peculiar movements of his body, the
"jerking forwards of his chest and abdomen," and "arching of the back," were entirely symptomatic of the hysterical convulsion.

This, the so-called "arc de cercle" movement, is laid great stress on by the French writers. The boy's limbs did not participate in the movements; nor did his facial muscles, as his look is described as placid during the attack. He was said also to be quite conscious during a fit. The recurrence of an attack immediately on the refusal to give him a drink, and the sudden permanent cessation of the convulsions following the administration of the nauseous draught of Assafoetida, at once confirmed the diagnosis, and cured the disease.

Case IV., had a history and some signs of brain concussion. He was knocked down in a fight, was said to have been unconscious for half an hour, and vomited some hours after. On his admission to Hospital the day after this occurred, signs of Hysteria only remained. His violent movements, the flexing of his whole body (arc de cercle), his loud crying, were all characteristic of hysteria, while the cessation of the convulsive movements, and his ability to walk round the room after the application of the Faradic current confirmed the diagnosis. His rapid, permanent recovery could also, I think, only have followed a functional affection of the nervous system.
Of the remaining two convulsive cases, no special notice need be taken. Neither of them was seen in an attack, though before, and up to the time of their admission to Hospital, both patients were said to suffer from frequent and severe fits. In neither did a single convulsion occur after admission. This sudden cessation, due simply to their removal from the sympathetic influence of relatives, makes it probable that their convulsive seizures were hysterical and not epileptic. One or two other points also helped to establish the diagnosis.

Case V., is said, during a fit, to turn up her eyes, twitch all over, and throw her arms about. Also, the report states, "she does not fall down, but merely throws her arms about." Such a description could not, I think, apply to a patient in an epileptic attack, but gives strongly the impression of one in a convulsive hysterical seizure.

Case VI., has a history of a fall on the head. This may have shaken the child's nervous system, but had apparently no other connection with the fits which developed a fortnight later. Her face becoming pale during the attack, the up and down movements of the hands and legs, the recurrence of the fits at the same hour every night, and the screaming at the termination of the attack, all point to Hysteria.
I now take up the group distinguished by paralytic symptoms. As illustrative of it, three cases have come under my notice; and of these Case VII. is the best marked and most interesting. His symptoms were at first those of disease of the ankle joint, and must undoubtedly have been very puzzling, as Dr. Aymer found them. When seen on his admission to Hospital, the diagnosis was not so difficult; though the tenderness on pressure over the joint, and the wasting of the limb were very striking. The sharply defined, acutely sensitive areas, the non-existence of swelling or redness of the joint, the boy's marked emotional nature, and lastly, the rapid cure, brought about entirely by the fear of chloroform, and of having to remain in Hospital away from all his relatives and friends, stamped the case as one undoubtedly of hysterical paralysis. It is interesting to note that this case of nervous derangement followed an attack of Influenza, the nervous system having been, according to my observation during the late epidemics, often profoundly influenced by that disease.

Case VIII., besides being of interest as a case of hysterical paralysis, merits notice also as showing some signs of spinal disease. It was all the more readily admitted to the series as it serves to illustrate the difficulty of diagnosis.
when along with slight spinal curvature there is apparent powerlessness of the lower limbs. The curvature might readily have been associated with her inability to walk, and indeed evidently was so before her admission to Hospital. A careful consideration of her case, however, did not justify such a conclusion, and revealed besides signs and symptoms which marked it as one of Hysterical paralysis. Her evident emotional nature, her apparent inability to move her head, which could not have been due to a lesion of the cord so low down as the lumbar region, and her freedom of movement when she thought she was not observed, all indicated hysteria. The favourable result of the treatment also, and the after history of the case, made the diagnosis of Hysteria certain, and showed that the prominence of the lumbar spines had nothing to do with the weakness of her lower limbs.

Case IX., was a clear example of hysterical paralysis. Any weakness of his right arm, if it did exist, was only occasional, as he was seen at times to use the arm freely. His description of the sensation in the arm also "as if it were all drawn up and something were inside it," was characteristic of an hysterical disorder. The report of his condition, three years afterwards, was also confirmatory of the diagnosis. I now pass on to
the third of the classes into which I have arranged my cases, but of which I have only seen one example. It is, however, very interesting.

I am quite aware the diagnosis is open to question. The presence of blood at least twice in the vomited matter is the symptom which points most strongly to some organic disease of her stomach or gullet. Notwithstanding the blood, however, there were good reasons for supposing the case was purely nervous. There was never the least sickness accompanying the vomiting, and she could return to table and eat heartily immediately after emptying her stomach. Milk was supposed to be the only food she could swallow for some weeks prior to her admission to Hospital. She had, however, free access to other kinds of food, and was not watched in any way, so that she may have been diversifying her diet liberally, for all that was known. At all events, it is very extraordinary that within two days after her admission to Hospital she was without difficulty partaking freely of a diet by no means confined to milk, and which included bread, the substance which Dr. Fraser had seen her so entirely unable to swallow. It is most probable, I think, that her removal to Hospital, away from the too lavish sympathy and attentions of her relatives, was really what caused her vomiting to cease. She evidently had some spasmodic condition of her esoph—
agus, and it is not improbable that she could voluntarily induce this contraction of her gullet. Whether voluntary or involuntary it could scarcely have been organic. Otherwise she could not have so suddenly begun to take a diet composed, in part at least, of food as solid as raw meat sandwiches.

Henoch (Lect. on Dis. of Children, New Sydenham Soc. Vol.I. p.230.) mentions a case of a girl of 11 who for several evenings regularly about 8.30, had a violent attack of retching with haematemesis and which he diagnosed as purely hysterical. The patient was ordered to leave her bed and drive every day, and the vomiting ceased at once. Some months after she had a slight recurrence of the haematemesis, which was treated with Ergotin injections. A few months later the vomiting returned with traces of blood, but an immediate cure was effected by the mere threat to repeat the subcutaneous injection.

Peugnier, in his very full and exhaustive treatise on Hysteria in children (De l’Hystérie des Enfants, p.101.) states that spasms of the pharynx and æsophagus are common in children, and that the "Hysteric ball" is probably due to a spasm of the æsophagus.

The occasional presence of blood in the vomited matter in these cases is not easily explained. The violence of the retching might mechanically
cause it. Henoch (Op. cit p. 231) while admitting the difficulty of explanation, suggests that it may be due to irritation of the vaso-motor nerves of the stomach causing hyperaemia and hemorrhage in the same way as sudden blushing is caused by mental emotion.

Having discussed some of the points which seemed to me of most interest in the cases of Hysteria in children which I have been able to bring together, let me now make some general observations on the subject. These I would group under the heads of aetiology, diagnosis, prognosis and treatment.

As regards the Aetiology, the element which seems to play by far the most prominent part in the production of Hysteria in children is Heredity. It is a matter of regret that in the cases related the family histories have not been gone into as carefully as they might have been. Most writers on the subject, however, are agreed as to the causative power of Heredity. Either the parents or some near relative or relation are sure to manifest signs of hysteria or other nervous affection, such as chorea, epilepsy or insanity. The tubercular diathesis seems interchangeable with the neurotic, so that hysteria is frequently met with in the children of consumptive parents. As in adults, so in children, sex plays an important part as a predis-
posing cause. Girls are more frequently attacked than boys, though it would appear that boys are proportionately more frequently attacked than men.

With nervous systems so susceptible, it seems extraordinary that children do not suffer more from hysteria than they do. Their cerebro-spinal system is in a condition of excessive growth and activity. All is sensation to them, and but little controlled by the intellectual powers. Profound impressions are therefore easily made upon the child's nervous system, and it might be expected that children generally were most likely subjects for the exhibition of hysterical symptoms. Probably they are so, but the very impressibility of their nervous system saves them. The impression left by one event or set of events is soon succeeded, and, partially at least, effaced by another; and so their nervous system is not injured by any harmful impression, if it is not too prolonged or too often repeated.

Of other causes of hysteria in children, masturbation probably holds a place. Jacobi in a paper on "Masturbation and hysteria in young children" in the American Journal of Obstetrics, Vol. VIII, p.595., points out that any irritation of the genito-urinary organs may be a cause of hysteria in children. He quotes several instances, and records the case of a girl of 3 who seemed addicted
to the vice of masturbation by rubbing her legs together, and who developed convulsive hysterical attacks. Mills (Keatings Cyclopaedia of the Diseases of Children, Vol.IV) also mentions masturbation as a cause, but only after the habit has been long persisted in.

A long tight prepuce, catarrh of the bladder, and irritation of the rectum as from constipation or worms have also been noted as causes of hysteria.

Besides such peripheral nerve irritants, moral influences have also an undoubted causative effect, such as improper educational methods, bad example, ill-treatment, jealousy, too much reading, and effeminate kinds of play in the case of boys.

Briquet (Traité clinique et Therapeutique de l'Hystérie, 1859) found that in 79 cases of Hysteria in children, 18 were caused by bad treatment inflicted by the parents, 8 by sudden fright, 3 by ennui, 3 by anger, and 2 by moral emotions. In the remaining 46 cases no cause could be determined.

The cases given by me scarcely show one cause more common than another. Nos. 2 and 3 seemed to originate in fright. In Nos. 1, 5 and 7., the nerve trouble followed rapidly acute illnesses, namely, German Measles, Scarlet fever and Influenza. No.4 had violent head-ache and vomiting before the hysterical attack occurred, and in the other cases no cause could be assigned.
As regards the age in children most liable to Hysteria both Briquet and Landouzy found by far the greatest number of cases to occur between the ages of 7 and 15. Peugnier states that no age in childhood seems specially liable, but that Hysteria is rare before the age of 7. The present ten cases show ages ranging from 4 to 12, the majority of them (six) happening between the ages of 10 and 12.

The Symptoms of Hysteria are, as has already been stated, far too numerous and diverse to admit of even an attempt at description or even enumeration. A classification of the cases according to their symptoms is even difficult and unsatisfactory, as the same case may, at short intervals, manifest nearly all the symptoms of the different classes. And yet a classification, however imperfect, is useful as it assists in giving a general idea of the affection, and in fixing the attention on the more prominent symptoms.

Peugnier divides Hysteria in children into three kinds.

1. Hysteria without convulsions.
2. Hysteria with convulsions.
3. Hysteria with various intermediate nervous symptoms, a comprehensive enough classification assuredly, as any case not included in 1 and 2 is bound to come under 3.

Adopting, for the present, Peugnier's method of
dividing cases of Hysteria, I should like to make some farther remarks on the cases composing his second division, Hysteria with convulsions.

Cases of this kind may present endless variety, from the example presenting all the symptoms of the classic form, the Hysteria Major, with its aura, and four periods or phases of Epileptoid seizure, great movements, passionate attitudes, and delirium, to the case distinguished only by a slight epileptoid seizure or spasmodic movement of the arms as in Cases Nos.1 and 5.

Although convulsive hysterical seizures of various kinds are common enough in children, fully developed Hystero-Epilepsy or Hysteria Major is very seldom seen in them. We owe much to Charcot for his graphic descriptions of such cases. In a well-marked example of Hysteria Major, there are usually some prodromal symptoms such as a sudden burst of joy or rage with laughter or tears. The aura then commences. It consists of a painful sense of constriction, and is named from its point of origin, cephalic, epigastric, ovarian etc. The epigastric is the most common. This horrible feeling of constriction causes the patient to struggle and clutch at the neck. Unconsciousness soon now supervenes, and the convulsive seizure proper comes on. It begins by first a tonic spasm in which the face is congested, and the neck characteristically swollen. A
little foam gathers on the lips, the teeth are clenched, and respiration is suspended. On this follows a period of clonic spasm. The limbs are spasmodically moved at regular intervals. The facial muscles participate, and the mouth is drawn from side to side causing the most hideous grimaces. To this phase succeeds a period of rest and quiet. A loud inspiration occurs, the livid colour of the face subsides, and the patient seems as if asleep. Soon, however, a period of other movements is entered upon. This is the period of great contortions or movements, in which, amongst irregular violent jerkings, the characteristic feature is the position of opisthotonos (arc de cercle) which is assumed. The patient also moves the arms and legs violently about, throws himself from the bed and rolls on the floor and beats himself. During all this he utters loud cries, but does not attempt to speak.

These violent movements are followed by a phase characterised by emotional or impassioned attitudes. The patient is evidently now under the influence of some strong hallucination, and the attitude assumed is determined by the nature of the hallucination.

To the phase of impassioned attitude, succeeds a period of delirium, in which the patient looks around him, and begins to laugh and talk in a disconnected manner. Occasionally, he is gay and lively.
but more often sad or frightened. Gradually, his laughter or tears, and rambling talk subside, and that attack is over, having lasted altogether from a quarter to half-an-hour.

The fully developed classic hysterical convulsion has therefore four distinct, regularly succeeding phases, thus:-

1. Epileptoid seizure, comprising,
   c. Resolution.

2. Great Movements.

3. Emotional Attitudes.

4. Delirium.

Though convulsive hysteria is common enough in childhood, as already stated, the classic form, the Hysteria Major, is seldom seen. One or more of the phases is almost invariably wanting; and the phase most usually absent is the third, that of passionate attitude. This is probably because the emotional centre is not developed in the child's brain. Dr. Clouston, in his admirable and most suggestive lectures on Neuroses of Development (Morrison Lectures for 1890), points out that it is the re-productive function which rouses the keenest emotions, and most vivid imagination, and at the same time often disturbs the motor, sensory, and trophic functions of the brain. It is therefore
not unreasonable to suppose that the phase of impassioned or emotional attitudes does not occur in the Hysteria of childhood, because the brain centre giving rise to passion and emotion has not yet developed.

Of the six convulsive cases here presented, only three, Nos. 3, 4 and 5, were seen in an attack. The removal to Hospital had such a beneficial effect apparently on all the others that no opportunity of observing a fit presented itself, and a relative or guardian had to be relied on for a description of the seizure.

Even the three cases in whom the attacks were seen and noted, got well so soon, that little time was given to observe and record them carefully. None of the cases presented all the symptoms of a fully developed hysterical convulsion. The only attack in which No. 3 was seen occurred in the waiting-room. The flexure of his whole body, the arc de cercle attitude, was however characteristic.

No. 4 also, in his attack, assumed the symptomatic attitude of opisthonos. The sudden jerking forward of his chest and abdomen also marked his convulsion as hysterical.

The curious flapping movements of the arms presented by No. 6 were certainly more the convulsive movements of Hysteria than of Epilepsy, though the case probably afterwards turned out Epileptic.
The occurrence of hystero-genetic areas in cases of hysterical convulsion is also of great interest. In none of my cases was such a symptom discovered, but in some cases of hysteria in children, areas or spots in different parts of the body are found, light pressure on which will at once produce a convulsion. M. Fère, in a paper on Hystéria in boys in Le Progrès Médical for 1882, Nos. 50 and 51, relates the case of a boy who had three of these hystero-genetic points, one on the bregma, one in the left iliac region, and one in the lumbar region. The least touch on any one of these produced a fit. His playmates discovered this interesting pathological phenomenon, and amused themselves by the production of a fit when a favourable opportunity offered. The ovarian region in women is a common hystero-genetic point, and while light pressure on such a region will produce an attack, strong pressure, as is well known, on the same region will often arrest it. Dr. Dunsmure some years ago published the case of a boy, who, whenever he was touched on certain parts of his head, fell down in a convulsive seizure. The nature of the convulsion was doubtful; and I believe it ultimately became more like Epilepsy than Hysteria; but in many points it much resembled M. Fère's case.

Let me now pass on to hysterical paralysis as seen in children, leaving, in the meantime, the various
disturbances of special and common sensation which often accompanies it.

Almost any variety of hysterical paralysis may occur in childhood; but para- and hemi-plegia seem to be the most common forms. The muscles of the face are rarely affected, though occasionally hysterical ptosis has been noted. Jacobi (Op. cit) mentions the case of a girl of 9 who had right ptosis, with external squint and dilatation of pupil of the right eye. All these symptoms followed a convulsive attack, and all disappeared in a few weeks. They re-appeared after another convulsion, but suddenly were removed by Dr. Jacobi telling the girl in a decided tone of voice he could cure her, and making firm pressure over the right orbital nerve. Hysterical paralysis in children, however, as already stated, most frequently takes the form of para- or hemi-plegia.

Goodhart (Students' Guide to Diseases of Children, p.476) relates the case of a boy of 11, who had complete functional hemi-plegia with hemi-anesthesia. Jacobi also mentions the case of a child of 10½ who had complete paraplegia with sometimes hyper-aesthesia, sometimes anaesthesia in various parts of his legs. Riegel in the Zeitschrift für Klinische Med. Vol.VI. 1883, p.445, relates the case of a boy of 12 who was admitted to Hospital suffering from loss of power of his legs.
Sensibility seemed much exaggerated, but when his attention was withdrawn his legs could be laid hold of and straightened without any evidence of giving him pain. The application of the Galvanic current caused the boy to jump from his chair and run to the window, and he remained cured of his paralysis from that time. Reigel also records a similar set of symptoms in a boy of 15 which came on after an attack of fever. Electricity, in this case also, produced an immediate cure.

Dr. Barrs, in the Brit. Med. Jour. Feb. 25th, records the case of a boy of 12 who, on Nov. 23rd, 1881, was admitted to Hospital with loss of power of his lower limbs which came on suddenly seven days before. The legs were well developed and held in a position of full extension. He had complete anesthesia, sharply defined, from the level of the patellae to the roots of the toes. Two days after, the anesthesia had entirely disappeared, and on 6th Dec., he left Hospital cured of his paralysis.

Case 9 is an example of an hysterical paraplegia, though the prominent lumbar vertebrae gave it an appearance of a real paralysis due to pressure on the cord. That the paralysis was merely functional, the result of the treatment showed. Her sudden relapse on going home, and her as rapid recovery soon afterwards were also significant. She had also well marked disturbances of sensation.
Case 7 was an admirable example of hysterical motor paralysis. It affected only the right leg, but so complete and prolonged had the paralysis been, that there was marked wasting of the limb from the knee downwards, simply owing to disease. The disturbance of sensation was also very marked and characteristic, the increased sensitiveness of the foot, except the little spot over the heel, being very acute and sharply defined. There was no question of simulation in this case. The pain to the boy was very real and sharp when his foot was touched, and was not lessened by distraction of his attention. It is interesting to note that one of Reigel's cases, like mine, followed an acute feverish illness. Mills (Op. cit) states also, an acute fever seems a common fore-runner of functional paralysis of the lower limbs.

Case 8 was not a very well marked case of hysterical paralysis, in so far as there were no accompanying hysterical symptoms noted, such as disturbances of sensation, etc., and it was uncommon in that only the right arm was affected. The healthy condition of the boy, a few months after he left Hospital, with both his arms equally strong, conclusively proved the loss of power in the right arm to have been purely functional.

It is unnecessary to dwell farther on the various hysterical paralyses of children, except to state
that aphonia is not unfrequently met with.

In contrast to such cases, we have also in children various spasmodic hysterical conditions. Case 10 was an example. In her case the spasm was sometimes in the stomach, sometimes in the aesophagus, producing vomiting, or difficulty in swallowing, according to the level of the spasm. To the same class also belong cases of spasmodic cough, the cough often resembling the barking of a dog. These are often most troublesome to deal with, and very annoying and irritating to those living with the patient. The sharp, hard cough goes on incessantly, causing no pain or inconvenience to the patient; but every one near him is nearly driven distracted. A patient of mine, a highly nervous, but physically strong little fellow of 8, developed an affection of this kind. The noise he made was exactly like the sharp yelp of a small terrier, and was to be heard all over the house. Certain strong measures which his Father was driven to by the irritating noise, caused a speedy cure when all other gentler means had completely failed. Wilks (Diseases of the nervous system, 2nd Ed. 1883) mentions one or two such cases. One of a boy who had a paroxysmal cough, and who barked like a dog. Another of a boy of 12 who had a fatty tumour in the side of his neck. If this was touched even by a feather, he instantly lost consciousness, and had a violent tetanic spasm. He
also barked and crowed. The removal of the tumour effected a complete cure.

Various hysterical spasms of the intestines also take place, causing constrictions at various points. The bowel between the constrictions is sometimes in a condition of paralysis, and becomes enormously distended, and thus the so-called phantom tumours are produced. So also we get spasms of the respiratory organs and breathlessness and asthma set up. Cardiac spasms and palpitations are also not uncommon in children, and though more rarely, spasms of the neck of the bladder of an hysterical nature. Henoch (Op. cit) alludes to these spasmodic Hysterical conditions in children and divides them into two classes:—A class in which convulsive symptoms predominate, and a class in which the symptoms take the form of co-ordinated movements, such as jumping, running, climbing, occurring spasmodically. In the latter class, the movements, he says, are, though rhythmical, choreic in character, and the cases are accordingly known as Chorea Major. Such cases are apt to spread by imitation; and thus all the girls of a boarding-school have become affected with movements of various kinds, and similar symptoms have been known to develop in all the members of a boys' school.

The dancing manias of the Middle Ages, related by Hecker (Epidemics of the Middle Ages – Sydenham
Society, 1844) are examples of the same kind of hysterical affections. Hecker states that in 1237 about 100 children were suddenly seized with dancing mania, and proceeded, dancing and jumping from Erfurt to Arnstadt. Many fell exhausted there and some died.

Leaving now the many affections of movement seen in the Hysteria of children, we come next to the disturbances of sensation which so frequently also are to be noted accompanying other hysterical symptoms.

First, as regards common sensation. This may take the form of either hyperaesthesia or anaesthesia; and both may, and often do exist in the same subject. The latter is probably most frequently seen in the child; and it usually is distributed in small, sharply defined areas.

Case No 7 was a good example. His whole foot was hyperaesthetic, except the small area over the heel, which was anesthetic. In the adult, it is most frequently seen as affecting the entire half of the body—hemi-anaesthesia. A characteristic of anaesthesia, both when it occurs as affecting the whole half of the body and in small areas, is that it moves from one part of the body to another. Thus the right side will be insensitive one day, and the left next day; and so also when small areas are affected, they vary from day to day.
Areas of increased sensitiveness are also found over the body in the hysterical child. These hyperaesthetic areas affect certain regions by preference. The ovarian region in girls, and the testicle and flanks in boys, are the most frequent seats of hyperaesthesia. In many cases a slight touch in such a spot will produce a convulsive attack, and the sensitive area is then called an hysterogenetic zone. Strong pressure on the same spot will often cut short an attack. It is not uncommon to find several hysterogenetic zones in the same subject as in Fère's case already mentioned. The special senses are also frequently affected in children as in adults. Sight, hearing, taste or smell may be diminished or altered. The eye is most commonly affected. Amblyopia is frequently met with. It is rarely double, but usually accompanies disturbances of common sensation, and occurs on the same side. Complete or partial colour blindness is also met with, and diminution of the field of vision is not uncommon. It is impossible to discuss all the manifestations of hysteria which have been noted in the child. Almost all the symptoms of the disease in the adult have been seen in the child, though many of them are not so pronounced in the latter. It must suffice merely to mention some of these. Joint affections are often met with, and their diagnosis is occasionally attended with
great difficulty. Case 7 was an example in point. His ankle was thought to be diseased, and it was blistered accordingly.

Hysterical club-foot is also common. Psychical disturbances of various kinds are also met with, such as pavor nocturnus and diurnus. Cases of catalepsy or ecstasy or trance are not infrequent; neuralgias affecting the head and other parts of the body, and many forms of trophoneurosis.

Let me now, with a view of helping to distinguish between cases of hysteria and cases of real organic nervous disease, point out some of the chief characteristics of Hysteria. And first, it seems to me necessary to state that all cases of Hysteria are not cases of Simulation. In the child, as in the adult, cases are met with where the symptoms are to a great extent Simulated; and in a greater number, I believe, the patient is really hysterical, but the symptoms are exaggerated to obtain sympathy and notice for which the hysteric has often an abnormal craving. No doubt children are met with whose one object in life seems to be to deceive. They will feign convulsions and almost any other symptom of illness if it will suit their purpose, but they are also adepts at deceiving in every relation of life. Such children have a distinct want of mental equilibrium and are more nearly insane
than hysterical. Though, therefore, simulation may, and frequently does, play an important part in cases of Hysteria, it is certainly not present in all. The marked alterations of sensation, and their remarkable sharpness of definition could scarcely be feigned; and many of the convulsive cases are unquestionably real.

To come now more particularly to the question of diagnosis. There is often great difficulty, in the convulsive cases, in distinguishing between hysteria and epilepsy. It must be admitted that it is extremely difficult and even impossible to distinguish between the two diseases in some cases; and it has also to be kept in mind that some hysterical patients are also epileptic. The following four characteristics, as pointed out by Charcot, will often serve to distinguish Hysteria.

(1). The existence of hemi-anesthesia or other disturbances of common sensation.

(2). Affections of sight (Amblyopia, Achromatopsia).

(3). Existence of hystero-genetic zones, and slight or strong pressure on these provoking or arresting an attack.

(4). Bromide of Potass given in progressively increasing doses has no effect on the hysterical convulsion, but has usually a marked beneficial effect on the epileptic. If opisthotonos (arc de
cercle) occurs during the convulsion, it is almost certainly hysterical. The condition of the patient at the end of the convulsion is also important. However violent the movements, there is no sign of exhaustion in the hysterical; whereas the epileptic is in a state of both mental and physical collapse. Henoch remarks on the enormous amount of muscular exertion exhibited by the Hysteric and without any appearance of fatigue. Fere also mentions the case of a child of 13 who in less than a year had 582 convulsions without any apparent diminution of intelligence or muscular activity.

An emotional nature with a tendency to laughter or tears, and a family history showing nervous instability will also mark the hysterical.

Two of the cases brought forward, Nos. 5 and 6, illustrate the difficulty of diagnosis between Epilepsy and Hysteria. When first seen, they appeared cases of Hysteria; but the accounts of their subsequent attacks, as related by Dr. Whitelaw from personal observation in the case of No. 5, and as obtained from the mother of No. 6, pointed much more to Epilepsy than Hysteria. In No. 5 the long continued twitchings of arms and legs, the complete loss of consciousness, the cyanosed face, and long profound sleep at the termination of the attack, were all strongly suggestive of Epilepsy.

The epileptic symptoms of No. 6, as described
by the mother, were the dull, heavy look present for several days before the attack, the scream at the commencement of the attack, the rhythmic movements of arms and legs without any violent throwing about, and the unconsciousness and deep sleep at the close of the scene. So much then for the distinguishing features of the hysterical convulsion, and the difficulty of diagnosis between it and the epileptic seizure.

To pass on now to the prominent symptoms of hysterical paralysis. These are:–

a. Accompanying disorders of sensibility.

b. The sudden appearance of the paralysis and the rapid manner in which the loss of power often passes from one limb to another.

c. Ability to move the limb in bed, though quite unable to stand.

d. No loss of faradic contractility nor of knee jerk.

In joint cases, it is often very difficult to determine whether they are hysterical or organic. If hysterical, the stiffness of the joint will vary from day to day. There will be disturbances of sensation, probably hyperesthesia. The patient's general condition will be that of health - no fever and good appetite. Under chloroform, the joint will be straightened without difficulty.

Hysterical spinal cases often give great diffi-
culty in diagnosis. Chloroform will also be of
great use in their determination, while they will
always lack one or two of the symptoms of real
spinal disease, and will probably also manifest some
of the more prominent signs of Hysteria, such as
disturbances of sensibility or affections of sight.

The Prognosis of Hysteria is distinctly fa¬
vourable - much more so than in the adult, though
it should be kept in mind that relapses are not un¬
common. [Little need be said of the Pathology of
Hysteria, as practically nothing is known about it,
either in the child or adult. That there is some
definite change in the tissues of the nervous cen¬
tres, is most probable; but we have not yet the means
of detecting it. Dr. Clouston (Op. cit) lays great
stress on the want of proper relationship in the
development of the brain centres as the great cause
of the Developmental Neuroses, and states that bad
heredity is the important factor in the production
of disturbed growth and development of the brain
centres. Blocq also explains hysterical manifes¬
tations in children as due to imperfect development
of the cerebral centres, and particularly to the
want of inhibitory action of the cortex on the low¬
er centres. The actual tissue changes in the cere¬
bral centres in hysterical cases, however, have as
yet not been demonstrated.
Treatment. The main indications are: -

1. Removal of the patient from all morbid sympathy, and bad example.

2. Careful attention to bodily and mental development without causing undue fatigue. There can be no doubt that isolation forms a most important element in the treatment of all hysterics, whether adults or children. All other treatment, without isolation, often fails. Fere relates a remarkable case of a Jewish boy who was subject to well marked hysterical convulsions, and who resisted all treatment until he was entirely removed from the foolish sympathy of his Father. It was only after much persuasion that the Father would consent to isolation. The boy discovered, after his removal to Hospital, that his Father continued to haunt the neighbourhood of the building in order to get news of his son's progress; and it was not till this was stopped, and the boy felt himself completely cut off from the parental sympathy, that real improvement took place, and a cure was effected.

In most of the cases recorded in this paper, removal to Hospital was practically all that was necessary in the way of treatment. In an affection like Hysteria, where imitation apparently is often a great factor in the production of the symptoms, the importance of removing the patient from the bad example of a nervously weak and hysterical mother,
or perhaps choreic brothers or sisters, can scarcely be over-estimated. All foolish sympathy should also be withheld; and this can often only be attained by an entire change in the surroundings of the patient.

The second main indication for treatment, careful mental and physical development, is best carried out by judicious educational means, and good food, tonics, and properly regulated gymnastics and out-of-door exercises. Hysterical children are often bright and clever, and fond of giving an exhibition of their cleverness. This should be discouraged, and their lessons should be on the lines of subjects they do not know well, and in which they do not shine. This will help to strengthen their self-control, and prevent precocity in other directions.

Their physical training will be best carried out by exercises in the open air, such as walking, running, riding and games.

Well regulated gymnastic exercises will also be of great benefit. Of course, care will be taken, in both mental and bodily training, not to induce more than a healthy amount of fatigue. No specific action need be expected from any tonic or other medicine, but they are often helpful. Of tonics perhaps arsenic is the most useful, either alone or combined with iron. [In the distinctly anemic cases, most reliance should be placed on iron. If
the nutrition is poor, cod liver oil should be given, or maltine, when the oil cannot be borne.

In the convulsive cases, anti-spasmodics and sedatives will occasionally be required. Valerian, Belladonna, Hyoscyamus, Bromides, Sulphonal, Chloral and Morphia.

Henoch states that he has found Chloral and Morphia the most useful of all the sedatives. The latter he gives by the mouth or subcutaneously. While admitting the power of these two medicines, Chloral and Morphia, to control the convulsive seizures, they should, I think, only be given after much deliberation, and after other less powerful drugs had failed. You may undoubtedly subdue the convolution by one or other; but after the sedative effect of either chloral or morphia has passed off, the patient always seems to me in a more or less nervously limp condition, and in just such a state indeed in which a renewal of the convulsive attack may be expected. Before using Chloral or Morphia, therefore, the other sedatives such as Hyoscyamus, the Bromides and Sulphonal should be thoroughly tried and found wanting. These have little or no reaction, and they can be given freely and for a long time with safety. Sulphonal especially seems to suit children well, and may be given in doses of 5 grs. to a child of 3 or 4 years.
As general tonics, hydropathy, electricity and the Weir Mitchell treatment will be found useful. In case though the massage, and over-feeding seemed at first to produce untoward symptoms, the treatment ultimately succeeded well. Electricity acts no doubt as a tonic in some cases, but it unquestionably also has a psychical effect. It is unpleasant, and rather than have it repeated, the patient, by an effort of the will gets well. So also may act cold baths and douches, though the water-treatment is usually better liked, and has justly, therefore, more the credit of tonic action. Excellent results will usually be obtained from the treatment as indicated; but, while carrying it out, care must be taken to remove or prevent all sources of peripheral nerve irritation or depression, such as worms, or any irritation of the lower end of the bowel, any bladder irritation, or a long, adherent prepuce. Masturbation must also be watched for, and if detected, strong measures at once taken to eradicate the bad habit.