Hysteria

Thesis for the Degree of M. D.

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My object in this paper is to deal more particularly with the pathological aspect of Hysteria, and the relation between the mental disorders and the bodily symptoms, but in order to do this it will be necessary to enter pretty fully into the subjective phenomena of the disease. I shall begin by giving an account of two cases of a rather severe nature, which illustrate points on which I shall dwell later on. With regard to the first of these, as the disease developed before I became acquainted with the patient, I have been obliged to rely on the statements of others for the account of the early part of its course, my impressions being her own, and those medical men who at different times attended her.

Case I. A lady in rather straitened circumstances, with a family history of hereditary intemperance on the paternal side, and phthisis on both, had her first hysterical fit at the age of 35. Prior to this she was somewhat sanguine and emotional in character, and subject to violent outbursts of temper. The first fit occurred a few weeks after the death of her husband, who left her rather badly provided for. After this they were frequent, recurring
at the rate of one in two or three weeks. From the
first appearance of the fits a morbid craving for
sympathy was excited, and increased greatly.
This was shown by her continually talking of
herself and her troubles - she could not be kept
off the subject for five minutes, and would talk
in this way to the servant if the world put no
other listener. She consulted a medical man about
the fits, giving a detailed account of her sufferings
during them, and at the same time complaining of
various other ailments, especially violent headaches
and neuralgia. The fits began with clonic spasm
of the muscles of the back, followed by violent general
tremors. They were sometimes, but not always,
preceded by crises mysterious. They recurred at
inconspicuous times, invariably when she had a
visitor, except her medical attendant, before whom
she only once took one.
After this state of matters had continued for about
a year the fits became less frequent, and the lead
an interval of nearly six months during which
none occurred. Then, however, during some domestic
trouble, they reappeared, and became much more
frequent than before, at one time occurring as the rate of
from one to six in a day. She then got into an
excited mental condition, and before a fit used to scream out that the Devil had got hold of her right foot, and was dragging her down. On recovering from the fit she would ask there with her not to mention what she had said to the Doctor.

At this time she used to recount all her acquaintance about her money difficulties. She became very violent in temper, and on one occasion chased her daughter with a carving knife, but she never attempted to do any serious harm, her actions appearing to be intended to produce an effect on the beholders.

She was very theatrical in her conversation, speaking of her broken heart, and crying frequently. She was very neglectful of her household duties, and her house was dirty and untidy, and her children shabbily dressed. She showed absolute disregard for the comfort and convenience of others, expecting persons who were only slightly acquainted with her to put themselves to considerable trouble on her account, and constantly complaining to them of the way in which she was neglected by her relations.

In 1874, when I became acquainted with her, she scratched her face, and by constantly picking off the scales as they formed, kept three open sores on her face for three years, about which she
used to complain greatly to her friends. I frequently saw her picking off the seeds, and when spoken to about it, she always said she did not know she was doing it. At this time she became greatly critical; her temper improved slightly, and the fits became more rare, usually only occurring when anything happened to annoy her. She took to writing sensational and very sentimental stories to newspapers. She was extremely selfish, and while her children had the plainest and scantiest food, she was invariably supplied with expensive delicacies, and spent large sums on pets, dogs, and birds. She complained of want of appetite, but to my knowledge, ate considerably between meals, chiefly sweet biscuits and cake. She was in the habit of reading novels in bed till 12:30 or 1 a.m., and seldom rose before 11. She complained constantly of increasing pains in the back, but looked in excellent health. She had a great tendency to exaggerate—never had a pain but she called it "frightful agony" or something of the sort. She also complained constantly of being tired. Frequently when she said she was scarcely able to stand, a sudden excitement would banish all her symptoms till she remembered them again. Her memory became very defective,
and the forget words, especially the names of things she wanted.

Previous to her husband's death she had taken an aversion to her eldest daughter, and especially appeared jealous of any attention that her husband paid to the girl. This now developed to such an extent as to render it quite impossible for the daughter to live in the house with her. The strangest part of this was that of all her children that one was the most considerate towards her. She was extremely jealous if any man paid the slightest attention to her daughters, always trying to attract their注意 to herself, and interrupting in conversation for the purpose. This was the case whether the age of the man. She observed in a youthful manner.

She continued much in this condition till 1892, when she began to improve. She began to show less anxiety to attract the attention of the other son, took more interest in the state of the house, which had been in a very unsightly state, and complained less of her health. She fits now only occurred under considerable emotional excitement, especially anger. She still showed a morbid delight in dwelling on and exaggerating her troubles,
and discouraged, would talk herself into tears to a stranger. She began to rise earlier and to take more exercise, and to be more regular in her diet.

In 1846, when I last saw her, a further improvement had taken place. She took considerable interest in the welfare of her children, was regular in her habits, a fairly early riser, and usually cheerful in her conversation. No fits had occurred for nearly two years. She complained little of her health, except for shortness of breath, which was due to inactivity. She could be easily led into her former involved mental condition, but recovered from it in a few hours. She was left to think herself obnoxious without cause, and the dislike to her eldest daughter, for which she was given no reason, still remains, though not so strong as before.

At this time she had a visit from a medical friend, and after a few days began to relapse again. She became depressed, and the two would walk in the garden for hours, talking of their ailments, and other troubles, especially the want of sympathy shown by their friends. The laziest part was that while both were improved
With their own troubles and entirely regardless of those of others, they showed the utmost sympathy with one another, and each was ready to listen for hours to the other's woes, while no one could listen to complaints from anyone else without trying to show how much more terrible her own sufferings were.

After the departure of this friend the patient remained depressed, selfish, emotional and extremely theatrical for a few weeks, and then gradually recovered again, since when she has had no relapse. Her memory, however, is distinctly impaired, and she is incapable of long continued close application. She is still very sentimental, and inclined to "play to the gallery." From beginning to end no amnesicia, hypoaesthesia or paralysis has been noticed.

This patient was a lady of excellent education and good taste. It was observed by her friends, however, that after the hysterical symptoms had lasted almost three years, she deteriorated to a considerable extent in these matters. Her conversation became coarser, showing a tendency to vulgar and slang expressions, and her taste in dress,
especially with regard to colours, deteriorated. The most remarkable change, however, took place in her musical taste. She had had a very good musical education, and had formerly a strong preference for classical music. During her illness she gradually took to a lower class of music, principally jangling melodies, which she played rather loud with exaggerated expression. Her singing deteriorated also, and became somewhat crude as to pitch, with theatrical exaggeration of expression in pathetic passages. The same changes took place in her literary taste, indicated by a liking for sensational novels, one of which she became very sentimental. A slight improvement has now taken place in these matters, but a great permanent deterioration remains.
O.D. a female aged 26, unmarried, and in fairly comfortable circumstances. The patient is not that was intemperate, and slightly ascetic. Patient lived with her brother, sister and two sisters.

I was first called to see this patient at night, and found her on the floor, in a typical hysterical fit. I splashed a considerable quantity of cool water on her face, which arrested the fit, but it recurred in two or three minutes, and lasted for nearly five. She had five such fits within two hours, and then went to sleep. I saw her next morning, and found that she had no fits in the interval. She seemed then to be in a normal mental condition, with little depression, but appeared slightly ashamed of herself. She stated that she had been unconscious during the fits, and had no recollection of anything that during occurred during them.

A few days later she consulted me about symptoms pointing to ovarian disease, and hinted at an examination, which, however, I did not perform.

That night I was called to see her at 2 a.m., and found her on the floor, screaming and struggling, and when I approached her with a jet of water, she tried to bite my leg. The water had no effect.
She was lifted into her bed, and presently began coughing and belching. The cough was a series of dry detached barks continued for five or ten minutes, and the belching alternated with this. I was struck by the enormous amount of gas belched up, and found no marked symptoms of distension. I watched her carefully for some time, and discovered that she was deliberately swallowing air, and then belching it up again. These manoeuvres she continued for about two hours, and then took severe spasms of the muscles of the back, which invariably brought her to the edge of the bed till she was on the point of falling out, and was put back in the middle. When this had continued for half an hour, I left the room, taking her relations with me. Half an hour later I went back, and found her in bed and asleep.

A few days later the same thing again about her ovarian symptoms, and this time brought her sister with her. I made a vaginal examination, and found nothing but tenderness of the left ovary. Pressure on this did not bring on a hysterical fit, from this time whenever I saw her she referred to these symptoms, evidently wishing me to make another examination. She also complained of palpitation, headache, and
flatulence. She was somewhat anaemic, and the
beating of the heart was feeble.
I was several times subsequently called to see
her, always during the night, and on every occasion
something had happened during the day to annoy
her, usually quarrels with her mother.
This patient was treated throughout with Bromide
of Potassium and Hyoscymine. She improved consid-
erably, and when I lost sight of her, had had no
fits for about three months.
Before leaving this case, I wish to draw attention
to these points —
The patient stated that she had no recollection
of anything that occurred during the fits. I repeatedly
tried to lead her into betraying a knowledge of
some of the events, but was driven to the conclusion
that what recollection she had was extremely vague.
2. During a fit she evidently recollected what
had happened in previous fits, as shown by
her trying to bite my leg when I approached
her with a jug of water.
3. During a fit her attention could be arrested by
a sudden noise, but she almost immediately
recovered again, showing that there was no
complete loss of consciousness.
While I was attending this case, a servant in the house also became hysterical and hypochondriacal, and took to attending Salvation Army meetings.
Definition of Hysteria: As Prieston says, "It is difficult to describe, still more difficult to define "Hysteria." (Theory and Practice of Medicine, p. 1129). The only point generally agreed on seems to be that it is a functional disease of the nervous system. It is frequently said to consist of impairment of will, but this is necessarily vague and insufficient. Rose (Diseases of the Nervous System, by James Rose, M.D., p. 829) tries to define it as follows: "Hysteria is a functional disease of the nervous system, characterized by paroxysms of convulsions, along with various sensory, motor, vascular, and psychical disturbances, which may be combined in such manifold ways that the grouping of the symptoms may simulate any one of the numerous organic diseases to which the nervous system is liable." This is an excellent description, but not a definition, nor can I discover any more satisfactory. There is a difference of opinion as to whether it is a general neurosis of the whole nervous system, or a psychic disorder of perception. I am inclined to regard it as a state of impaired or abnormal nutrition of the nerve substance, with lowered nerve tension, and consequent impairment of the highest physiological functions, characterized by abnormal preponderance.
of the emotional over the intellectual elements of
mind, defective inhibition, morbid self concentration,
and a tendency to the occurrence of convulsive seizures
of a characteristic nature, and to paralyses of motion
and sensation.

Pathology - There is no known lesion, microscopic
or macroscopic, associated with hysteria. The conditions
which I believe to be at the root of the disease are these
of abnormal nutrition and lowered nerve tension.
Even if we had frequently to refer to this lowering of
the nerve tension, it may be better at once to
give some evidence in support of the theory of its
existence.

Herbert Spencer has shown that when the pressure
of the nervous fluid is high, pleasurable feelings
predominate, and vice versa. How it is evident that
in hysteria the painful feelings are greatly in pre-
dominance, as shown by the almost constant hypo-
psychiatricism, the concentration of the mind on the
patient's ailments to such an extent as frequently
to conjure up some that have no real existence,
the craving for sympathy, and in all cases with
which I have come in contact by the patient's own
Statements. The fits themselves are unmistakable evidence of the prevalence of painful states of consciousness. The decrease in object consciousness and rise in subject consciousness which are so marked in hysteria, as in all diseases in which the mental faculties are involved, are generally admitted to be signs of abnormally low tension. There is probably in most cases some congenital or hereditary peculiarity.

Causes - The causes of hysteria may be divided as usual into predisposing and exciting. The predisposing causes appear to be much the same as those of insanity and other nervous cases. Race exerts a considerable influence. The Latin races seem much more subject to it than the Teutonic, while it seems particularly common in France. In this country the same forms found in France and Germany are comparatively rare, though the slightest forms are common enough. Among the Scotsmen it is considerably more common than in the south of Scotland. During three years I spent in Lewis I saw numerous cases of the slightest forms, with hysterical fits but no case of hemianesthesias or Paralysis.
The sexual feelings, moreover, are more complex
in the better educated classes. In their lowest
form, as a mere desire for sexual intercourse, this
can almost always be gratified, but with the
higher secondary sexual emotions, such as lie at
the root of most poetry and half the ambitions of
mankind, this is far different. The secondary sexual
emotions and their disappointment, are altogether
much more lasting than the primary, and produce
a greater effect on the mind. Nor is a general rule,
the more highly organized a mind is, the more the
primary sexual feelings are replaced or controlled
by the higher secondary feelings, which through which
a stronger and more lasting influence may be exerted
on the mind. (13, p. 589) 1331-"When the mental
energies are not expended in any healthy mental
occupation, they are often directed inwardly to the
contemplation of the patient's own thoughts and
feelings, and the emotions connected with the grat-
ification of the sexual impulses are then apt to occupy
a prominent place in the thoughts." It is obvious that
this is more likely to take place when the first
place with the secondary sexual emotions, from which
the lower forms are afterwards reached.
This is interesting in view of the close intermarriage prevalent among the Indians, and their well-known hereditary tendencies.

The influence of hereditary predisposition appears to be disputed. Charett and his school hold that this is the only predisposing cause; the others being exciting causes. It is certain that in a considerable majority of cases, the history of hysteria in the parents can be found, but in most cases a history of nervous or some kind can be made out by careful inquiry. It is certain that the daughters of a hysterical woman may more show any tendency to the disease, but this, of course, may be due to the absence of adequate exciting causes. In many cases I have found a history of ancestral intemperance, but this is so common that one cannot attach much importance to it.

Closer to life - it is proportionately much more common in the higher classes. Briitonne (Op. Cit. 1128) explains this by indulgence in idleness and previous amusement, with neglect of healthy exercise and discipline of the mind. It must be remembered, however, that in the more cultured classes the emotions are more acute, have wider and more complex relations and are caused by a greater variety of causes.
Occupation - It appears to be more common in those leading sedentary lives, with insufficient fresh air and exercise.

Discussed in the "Women's System" by James Rowland, M.D. W.C.

Sex - Rowland quotes Briquet as stating that one quarter of all females are affected with decided hysteria, adding that this is a proportion much too high for this country. The proportion of women to men affected in this country is about twenty to one, but Loewenfeld puts it at six to one, and in childhood, two to one. (Hysteria and Hysteria, J. Mitchell Clarke & D. Brain "vol. 50, p. 147").

Row (p. 161, p. 183) states that "advanced age of the parents at the time of birth predisposes to hysteria in the children," and also "all causes which lower the nutrition of the nervous system, as hemorrhage, insufficient nourishment, impeded digestion, and anaemia predispose to hysteria." (p. 161, p. 183). He might have specialized chlorosis, but by some this would be held to belong to the exciting cause.
Exciting causes

The most important of these, and one which may be held to include most of the others, is shock. This may be one distinct shock, as in the Traumatic Hysteria following railway accidents, or a series of shorter ones. "Psychical shocks (traumata) act as the causes of many, if not most hysterical symptoms. Any experience which entails emotions of shame, fear, dread &c. may be a cause, its potency depending entirely on the sensibility of the person affected." (Clarke, op. cit. p. 126.) The shock not only causes a temporary attack, but permanent hysteria, in the course of which any or all of the usual symptoms may arise - fits, paralysis, contractures, anaesthesia &c. The effect of a shock in producing hysteria of course depends greatly on the temperament of the subject, and as Ross says "A slight concussion, as this insignificant injury may cause Hysteria, in those who inherit a strong predisposition to the disease, but a severe injury, such as a gunshot wound of a large nerve trunk, or the shock caused by a railway collision may induce in the strongest man an emotional condition very similar to hysteria in the female, and in which tears and laughter and tears alternate." (Op. cit. p. 682). This statement is
perhaps rather too strong, as such a trifling injury as he speaks of would not, when combined with strong emotional excitement, such as fear, produce hysteria in a subject previously free from the disease, even if strongly predisposed to it. It might, however, bring on hysterical symptoms in a subject who was already suffering from hysteria—a point of difference as distinct as causing epilepsy from causing an epileptic fit in a person already the subject of epilepsy.

A shock, however, does not simply produce by its momentary action a change in the nervous system rendering it liable to hysteria. "The shock and the remembrance of the shock is rather to be considered as a foreign body which can still be potent a long time after its occurrence as an exciting agent." Any of this is to be found in the fact that "if the remembrance of the original cause or cause can be clearly aroused, the emotion which at the time of onset accompanied them is also called up in the patient's mind, and that if the patient then pictures to himself as fully as possible what took place, and describes his sufferings aloud, the hysterical symptoms described disappear and do not return. All varieties of hysterical symptoms may be
"Treated in this way" (Clarke 126-7 from "Helen Ven.
"psychische mechanisme hysterische Phänomene," Dr. Joseph Breuer and Dr. S. Freud, Veröff. k. med. Gesellh. 1893). This however can only be satisfactorily done by means of Hypnotism.

Diseases of the sexual organs. As far as I am aware, all authors agree in admitting the influence of dreams of the sexual organs in producing hysteria, though to a much less extent than previously, when "the womb was supposed to be the seat of the disease" (British J. of Med. 1828). Any disturbance of the sexual functions seems, especially in women, to excite a strong influence on the mind, which is apt to be concentrated on, and to magnify the abnormal sensations. Now says "All uterine derangements, whether "structural or functional, are apt to be attended by "hysteria, and the symptoms are liable to become "aggravated during the menstrual periods in those "who are already hysterical. XXX Dixon of the Xanwes "is most probably a frequent cause of aggravated "hysteria, and local irritation of the other viscera, and "especially that produced by the presence of worms in "the intestine may also give rise to the affection" (p. 143). Sexual disorders, however, are by no means so
Shame and sexual excess have been assigned as causes (Hieronymus, p. 157), and this is what we
would expect from the exhaustion of the nervous system produced. Masturbation, if not a cause, is frequently a symptom. It probably is much more injurious than mere sexual excess, from the sense of moral degradation which it carries with it, though I have seen it stated that it is only more harmful as it is indulged in to a greater extent. Its influence is easily seen in dyspepsia, where it is extremely common, and it is generally admitted that a patient who contracts the habit is less likely to recover. Dr. Blount regards it as a sign of congenital defective inhibition.

Physical overwork is probably a not uncommon exciting cause, especially when combined with bad ventilation and deficient exercise. Perhaps it more commonly gives rise to neurasthenia than to hysteria.

Alcoholism is commonly found in connection with hysteria, and may be either a cause or an effect. Nearly all female alcoholics are more or less hysterical, and I have on two occasions found that patients suffering from hysteria were given to secret drinking, and one of them to opium eating also.
In both those cases, so far as I could ascertain from the relatives, the drinking had begun subsequently to the hysterical symptoms.

Chlorosis and anaemia from these causes not unfrequently give rise to hysterical symptoms. Here, owing to the poverty of the blood, there must necessarily be defective nutrition of the brain in common with other organs. I have frequently observed hysterical symptoms in the course of chlorosis in girls not previously hysterical, and in one case a typical hysterical fit which was not repeated. In all my cases the symptoms have passed off as the general health improved. This is also the rule in cases of hysteria following fevers and other debilitating diseases.

Worry and anxiety are common exciting causes, and the same may be said of any thing which causes prolonged or frequent stimulation of the emotional faculties, particularly when the emotions so aroused are of a painful character. The mode of action is probably similar to that of a severe shock, the worry acting as a series of smaller shocks with a cumulative effect.
Clarke quotes (ibid) stating that the abuse of tea, coffee and tobacco may give rise to hysterics. (Op. cit. p.159). Several of my patients have been in the habit of drinking strong tea in great quantities, but I thought this was rather a symptom than a cause, due to the craving for a stimulant common in debilitated states of the nervous system.

Hysteria may arise from association with persons already hysterical (Brustone, op. cit. p.112), in this resembling cholera. There is of course a tendency for any emotional state to be spread by sympathy, but in this case constant association may give rise to a permanent hysterical condition in which symptoms may be developed which were not present in the original case. It is not uncommon when attending a case of hysteria to find that those living with the patient, even though not related, are also more or less hysterical (see case II), and I believe this has at least as much if not more to do with the frequency with which several members of the same family are affected.

Epileptic fits are frequently followed by hysterical
by symptoms, especially by hysterical fits. These also occur independently in epileptics, and especially in the epileptic insane. Other hysterical symptoms are met with, but more rarely. Many of the mental symptoms, however, are common to the two diseases. Gowers says "we must regard all patients who have "true epileptic attacks, major or minor, and present, "often some or all of them, hysteroid phenomena" as "being the subjects of both epilepsy and hysteria." (Epilepsy and Other Chronic Convulsive Diseases, W.H. Gowers. D. p. 174).

"Striking symptoms of hysteria are often seen, "for instance, in cases of tumours of the brain". (Gowers, loc. cit. p. 176). This also applies to many other forms of organic disease of the nervous system.

Symptoms of Hysteria. - These may be roughly divided into bodily and mental, but in some cases it is difficult to decide to which category they belong.

Bodily Symptoms. - A characteristic part of countenance is described, the "Facies Hysterica."
It is "characterized by remarkable depth and fulness with more or less thickness of the upper lip. There is also a fulness and more or less "drooping condition of the upper eyelids" (7th Med. Times & Gazette, vol. XXXIV p. 2). This, however, is by no means constant even in severe cases, especially when the disease is recent. Some development in this direct, you can usually be seen in long-standing cases, but the expression is much more valuable as a diagnostic than any formation of the features capable of description. The drooping of the eyelids is fairly constant, and when combined with tremulous flickering and slight turning up of the eyelids, is a strong indication of hysterical tendency. I have frequently observed it in persons who had never, so far as I could discover, had a hysterical fit, but who had a well marked hysterical temperament.

The hysterical fit, like all convulsive attacks, is an explosive discharge of nervous energy, which discharges itself through the motor centres, giving rise to violent muscular action. It differs from that of epilepsy in the absence of an aura (I mean the status hystericus may be so considered), the retention of consciousness,
though, as I shall show later, probably in an altered form, in the irregularity and want of definite type or sequence of the muscular actions and their more purposive nature, the indefinite duration, and the fact that it never occurs during sleep. In the most typical form the attack is preceded by the sensation known as 'flotting by flashes', and often by a fit of laughing and crying. The patient then screams loudly, and falls violently convulsed. The convulsions are of a more coordinate and purposive character than those of epilepsy. The patient throws his arms, legs, head, or whole body about in all directions, but the motions are more or less reproductions of common acts, as striking and kicking. Occasionally the attacks seem to be accompanied by hallucinations—see Case 1. In the stage of delirium in the fully developed attack, there is an hallucinatory reproduction of the image and memory of the chief injury or group of minor injuries (existing cause) (Clarke pp. 77, p. 128). In the case I have described the hallucination, if feminine, was of a different nature. In some cases the convulsions, instead of being general, are limited to a single movement, repeated frequently—a limited clonic spasm. Such a case in my own practice was that of a Shetland man who was brought to
one by his relations for advice about "spasm of the neck". As soon as I saw him he conveniently took one of these spasms, which consisted simply in repeatedly nodding his head rattler violently for about two minutes. I asked my partner (Dr. Inclinnan, Hamburg) to come and see him, when he very kindly took another fit. He appeared to be very much alarmed about the seizures, and his relations were decidedly so. He had no other bodily symptoms, but had the mental constitution usually considered characteristic of hysteria. Spasm of the glottis, which occasionally occurs in hysteria may perhaps be regarded as a limited fit. With regard to the duration of hysterical fits, I do not think any limit can be laid down. They generally last from one to five minutes, but I have seen one last without distinct intermission, though with several changes of type, for nearly three hours — see case II. The fit is frequently followed by the passage of a large quantity of pale clear urine.

Hysterical Lacertheria — This is one of the most remarkable symptoms in view of the common opinion that hysteria is dependent on weakness of the will,
and is practically a form of swathing. "Anaesthesia in some form or another occurs frequently after a hysterical attack and diminishes in the interval." (Rox. Op. Cit. p. 735.) It may affect only the surface sensibility, or the deeper parts may also be anaesthetic. Mucous membranes as well as skin sometimes suffer. "The mucous membrane of the vulva and vagina may be completely anaesthetic, a condition which is found in highly hysterical married women, and in them there is an entire absence of sexual tactile or pleasure." (Rox. Op. Cit. p. 736.) The most typical form, and one which is practically confined to this disease is hemianesthesia, but the distribution varies greatly. Sometimes it is limited to a single limb, or the distribution of a single nerve. Rox. mentions two cases, one a male, in which both legs below the knee were completely anaesthetic, while in all the parts above the knees the sensibility was normal. (Op. Cit. p.32) Perhaps the most remarkable fact is that anaesthesia may exist without the patient being aware of it, as in those cases where the visual field is contracted. It may affect sensibility to pain alone, or all sensation in the part may be lost. It is usually accompanied by anemia of the part.
affected. It may change its seat, especially after a hysterical fit, and this may be done artificially by means of hypnotic suggestion.

Hyperesthesia - This is a very common symptom, but in some cases it is impossible to distinguish between true hyperesthesia and malingering. (P. 882) says, "Hyperesthesia in one form or another is rarely absent during the course of hysteria," but this, I think, is true only of the more severe forms. It is usually more or less dependent on the patient's attention, so that when a lighter touch will cause him to scream out when the inspects it, he may fail to notice from pressure if his mind be otherwise occupied. Usually there is no increase of pain with stronger pressure, but sometimes a diminution. Certain parts, such as the ovaries and mammae are especially liable to hyperesthesia, and in these cases it may be doubted whether it is a true symptom of hysteria, or due to the sexual disturbances which so frequently accompany the disease. It may affect any part of the body, occasionally the whole cutaneous surface, and sometimes deeper parts. More usually it is limited to certain parts of the skin, especially a limb, or patches of
Akin in any part of the body. It may affect the special senses either as excused sensibility, or as outburst of stimulation. Like paresis, hyperesthesia of hysterical origin may change its seat.

Notably connected with hyperesthesia are the "Paretogenic Zones"—points pressure on which will give rise to "assert hysterical fits." It has long been known that pressure on the ovaries does in many cases give rise to fits, but recent French workers have found that these can be excited from various parts of the body. There is, however, a strong suspicion that these phenomena are a result of suggestion, to which most hysterics are so liable.

Abnormal sensations that occur in great variety. Perhaps the most common is that known as "globus hystericus." This, which has been attributed to spasm of the pharynx, is a sensation of a ball rising into the throat, and causing the patient to feel as if the voice were going to choke. As already stated, it is frequently followed by a hysterical fit. It is often felt to "rise from the throat" (Creighton, op. cit., p. 1832).
Most of my patients, however, have not traced it to fear. Their usual statement being that they were seized with palpitation, and then felt something in the throat. Which was higher till they felt as if they would choke, and accompanied by great difficulty in breathing. Often hysterics frequently occurs in patients who have never had hysterical fits, and I have met with it several times in men. Since commencing this paper I was called one morning at 4.00 a.m. to see a woman aged 49, who complained of an attack of violent shivering, with a sensation of something which began in the left side of face, whence it rose to the throat. She then felt as if something were stuck in her throat and choking her. She said she had great difficulty in breathing. She was unable to give any intelligible description of the sensation before it reached the throat. This patient was neither hypochondriacal, irritable and unstable emotionally, and talked a lot of her ailments and family troubles, and declared she was going to die. Her tongue was florid and slightly furred, and on inquiry I found that she had been drinking for some weeks. I prescribed Dr. brom. 9.8, ipecac. mor. 9.15 every four hours, and assured her she would be all right.
in a day or two. That evening she was much better, and less depressed about herself. She had had no recurrence of the sensation, but complained of slight sickness. The next day she went out for a walk, and when I saw her in the evening, she was cheerful, and said she was all right. On careful inquiry I was unable to discover a history of anything like hysterical fits.

Sensations of local heat, and of the blood rushing to the head, are commonly complained of, and are usually accompanied by various motor disturbances. Sooner or later, not normally represented in consciousness, sometimes rise to such prominence as to cause great uneasiness; the patient may become conscious of the peristaltic movements of the intestines. Other abnormal sensations which occasionally occur in connection with hysteria are too numerous to individual mention, in fact there is no limit to their variety.

Pain of various kinds may occur in hysteria. One of the commonest forms is that known as chlorine - a feeling, as if a fluid were being driven into the skull, usually above the eyebrows. This occurred occasionally in Alice, but usually in the temple. It is dependent on
the patient's attention, and a woman who has apparently been suffering the most acute pain may be drawn into conversation till she shows no sign of pain whatever. I have at present under my care a woman aged about forty, who is subject to severe unilateral headaches, worst at the vertex, with tenderness over the scalp, but not particularly over points of exit of nerves. With these headaches she complains of a sense of creeping in her brain, as if there were some live thing moving there. This begins at the parietal eminence, and spreads, chiefly forwards. She is a thin nervous woman with an anxious expression. The headaches last for weeks if untreated, but subside in a day or two under Bromide and hyoscyanum. This patient also complained of feeling a swelling just inside the vagina, but a careful examination revealed nothing. Local application of ice vaccination produced considerable improvement. She admits that this becomes worse when she thinks much about it. She has never had a hysterical fit.

Hemalgie in various forms frequently occurs, and has nothing to distinguish it from hemalgie in other subjects.

Pain in the lumbar region is often complained
frequently of an intermittent character, or a full
form with regular exacerbations once or twice
a minute. This possibly may be associated with
uterine disease. Pain in a joint, such as the well
known hysterical knee, is a most characteristic
form, and dependent entirely on the patient's attention.

Paralysis - Briquet, quoted by Ross (Op. cit. p. 539)
found that "out of 436 cases of hysteria, 120 suffered
from pains or paralysis," and Landray, quoted by
the same author, "out of 593 cases found 46 thus
affected." In this country, even the latter proportion
is too high. Paralysis may occur suddenly or gradually,
beginning in slight weakness and going on to complete
loss of power. It may be paralytic, hemiplegic, or
limited to a limb, or simply inability to perform
some particular motion. "It seldom implicates the
muscles of expression, or the larynx (Stern, p. 1183),
though one or both levatores palpebrae may be
paralyzed. It may, or may not come on after a fit,
and is frequently associated with anesthesia. Ross
(Op. cit. p. 539-40) says, "If the hemiplegic form takes the
form, which may last for several days, or that
the hemiplegia resembles the result of organic lesion of the brain. * * * There is no deviation of the face nor deviation of the tongue or protrusion. It may be accompanied by rigidity and contracture, but in this differing from paralysis from cerebral hemorrhage. It is liable to change in its seat, especially after fits, or under the influence of hypnotic suggestion. It is rarely accompanied by pain, contract of the bladder and rectum is seldom if ever lost. It is usually stated that it is not followed by muscular atrophy or degeneration, but this view is, I believe, abandoned.

Now (p. 640) says, "The irritability of the paralyzed muscles to both the parasympathetic and sympathetic currents remains unaltered even when the paralysis has existed for years, a circumstance of great importance in establishing a correct diagnosis." Later writers disagree with this. Thus Lowenfeld (Clarke, q. cit. p. 154) says, "The actual occurrence of muscular atrophy in hysteria is no longer open to doubt. In the diagnosis from atrophy of organic origin, the degree and extent of atrophy, loss of electrical irritability, and presence of fibrillary contractions give us aid. The states, however, that it comes on quickly, and reaches a certain degree
in a short time. Rigidity frequently occurs in extension, which is rare in paralysis from organic disease. The reaction of degeneration may be present (Douglas) - Clarke q. cit. p. 154.

Here is present under my care a woman aged forty-seven who is suffering from paralysis of the seventh nerve, which I believe to be of hysterical origin. She was first seized with paralysis of all the branches of the facial nerve on March 25th, 1896. The next day she had also incomplete anaesthesia over the right side of the face and scalp, extending into the neck, with considerable swelling. There was severe lancinating and circumvallate burning. On March 28th, both pain and anaesthesia were diminished, and she continued to improve slowly till April 4th, when she was seized with giddiness, and vomited a quantity of green fluid which I did not see. I found her face drawn to the left side, the right completely paralyzed and still partially anaesthetic with some pain. The pupils reacted normally. The tongue was protruded straight, but when retracted went to the right unparalyzed side. The uvula and soft palate were symmetrical. The eyelids were not paralyzed. On the next day she had severe diarrhea, which
lasted about twenty-four hours. She had no paralysis in paroxysm of any other part. Since then she has improved slowly, but the paralysis still persists, and the left side of the face is affected.

The tongue is now protruded towards the paralyzed side very slightly, but in the mouth has the same deviation. The vertigo has diminished, and sensation is returning. The woman is very nervous, and has suffered greatly from headaches and neuralgia. There is no head trauma. These facts together with the remarkable tongue symptoms incline me to regard the case as hysterical, though there is considerable room for doubt.

Contracture may occur simultaneously with paralysis, or may supervene later in the paralysed part. The amount of atrophy varies greatly, sometimes being very slight, and under a strong strain, such as a severe mental shock, the paralysis and contracture may suddenly and permanently disappear. In such cases atrophy is marked and rapid, with loss of electric irritability, and sometimes reaction of degeneration. In the frightful forms it may be overcome under an anaesthetic.
Hysterical contracture with paralysis, tremor is sometimes observed, especially on attempting any movement, first as in contracture arising from "sleeping of the cord," the patellar tendon reflexes are often exaggerated, and even ankle clonus may sometimes be elicited. (From op. cit., p. 442).

Aphasia is a not uncommon symptom in hysteria, and varies considerably in type and duration. Complete aphasia, I believe, is always of short duration when of hysterical origin. I have met with two distinct types, central and peripheral, the one due apparently to physiological incoordination, owing to which the patient when wishing to speak could not select the words, and either remained silent after opening her mouth to speak, or used wrong words which conveyed no meaning; the other evidently due to incoordination of the muscles of articulation. Both forms, especially the first, were extremely fleeting, lasting only a few seconds. Stammering is not uncommon.

Aphonia is another paralytic symptom. It is unusual in case 1, who could be started out of it. It is due to paralysis of the vocal cords. From the same
cause dyspepsia may occur, according to Bristow (op. cit. p. 133) to such an extent as to require surgical interference. It occurred in case II, but appeared to be voluntary, and surmounted under neglect. The hysterical cough was also well illustrated in this case.

Vomiting is a very common and persistent symptom in hysterical subjects, and frequently resists all treatment. The vomiting may take place the moment the food is swallowed, or at an interval of from five to twenty minutes. In the latter case it may or may not be preceded by pain or nausea. These cases have occurred in my practice, two of which recovered, though I hear one has since relapsed, while one is still under treatment, after seven months, with occasional hematemesis. Other cases the symptoms in all were the same - severe pain shortly after taking food, followed in a few minutes by vomiting the food almost unchamped, when the pain ceased. In these cases there was little or no nausea. There was tenderness in the epigastrian region, not strictly localized. In none of them did the kind of food taken seem to make much difference except that potatoes
foods were retained rather better. In all the appetite was good, but the patients were afraid to eat on account of the pain. All cut flesh, but not so much as would be expected, as two of them said they vomited every time they took food. In the case now under treatment, two sudden intermissions have taken place, each lasting three or four days, during which she did not vomit and went about doing her work and saying she was quite well, but each time she relapsed as suddenly. Many cases simulate gastritis very closely, and haematemesis may occur, as in the case mentioned above, but this is probably due, at any rate in some cases, either to vices of menstruation, or to inconstant gastritis ulcers. 

Pallor may also be present.

Hysterical vomiting has been attributed to reflex irritation from diseased ovaries, and to the general irritable condition of the nervous system. It is, however, more probably due to local hyperesthesia, such as occurs in other parts.

Various other disorders of the alimentary system are met with in hysteria. A craving for unnatural or unusual articles of food is not uncommon.
in Ulcers, raw oatmeal is often consumed in large quantities. Frequently there is a desire for food at all times between meals, and a tendency to eat sweet cakes and other delicacies at odd hours. These habits are usually concealed or denied.

Habitual dyspepsia is commonly present often with chronic constipation. It differs both from the ordinary forms of atomic dyspepsia, the symptoms being chiefly sensations of fulness and swelling, increased after meals, with turgid pains in the abdomen. The tongue is usually pale and flabby. In many cases the appetite is unimpaired.

Polyuria occasionally occurs, and according to Dr. Albert Matthews (Clarke, q. v., p. 162) generally affects men. The urine is pale, and contains neither sugar nor albumen. The condition is accompanied by thirst, and usually large appetite. It may be brought on or removed by suggestion (Clarke 162).

Retention of Urine is very common, and Brody (q. v., p. 1135) states that "doubtless it sometimes depends on paralysis of the bladder." Personally, I have seen many cases, have never passed a catheter, and in the end the patient invariably
resumed normal evacuation. I have never seen the trickling away of urine which occurs in a truly paralysed bladder, and am inclined to regard the affection as spasmodic.

Anuria also, though much more rarely, occurs in the course of hysteria. A patient of mine this winter had a hysterical fit, and two days later told me that she had not passed urine since I had her carefully watched, but she passed none till the fifth day, and then only three or four ounces. Percussion above the pubes showed no signs of a distended bladder. The suppression was due to no symptoms whatever, and the urine when it did come showed no abnormality. Partial suppression may continue for months without apparently any injurious effect. Chavert has shown that this curious phenomenon depends not upon a spasmodic condition of the ureters, but upon some disorder of the kidneys themselves, probably due to muscle contraction of the renal arteries (Proc. Br. p. 151). It may be accompanied by vomiting, and in a case observed by Chavert, a considerable quantity of bile was detected in the vomited matter.
I have already referred to affection of the sexual organs as cause of hysteria, but functional derangements of these organs frequently occur in the course of the disease. The affection most commonly met with is hyperaemia of one or both ovaries. I have generally failed to find any objective signs of disease, but they may be enlarged. They are usually tender on pressure. Hysterical patients are very apt to complain of pain and other symptoms in the region of the genital organs, but it is probable that many of these are due to suggestion, either from within or without, which is facilitated by the proportionally large part of the mental field occupied in hysteria by the sexual functions.

Hysterical oedema is a not very common symptom. It usually accompanies paralysis or contracture, and is generally confined to one foot, hand or limb. Oedema is occasionally artificially produced by suggestion, but there is no doubt that it may occur spontaneously. The peculiar point about it is that it does not put on pressure. The skin over the affected part may be normal or cyanotic. It is usually accompanied by a lowering of temperature, Cheyney has produced it by suggestion (Clarke op. cit. p. 154).
It is said to be most marked in the evening.

Pyrexia occasionally occurs in hysterics for which no physical cause can be found. The temperature may be higher on one side of the body than on the other. It may or may not occur in connection with hysterical fits. It is probably of purely nervous origin, and analogous to the mysterious fever to which the insane are liable.

Flavell (q. v. p. 158) compares it to the high temperatures which occur after the status epilepticus, but hysterical fever may be entirely independent of the occurrence of fits, and may even occur in subjects who have never had hysterical fits, but who are of the hysterical temperament. It may be paroxysmal or continued, and is apt to be of an irregular hectic type. Ross (q. v. p. 84) mentions a case in which a temperature of 116° F was reached. In this case the most extraordinary variations occurred—on one day 110° at 6:45 a.m., 108.2 at 10:30 a.m., and 99.2 at night, and on another 116 at 4 a.m., and 98.6 at 8 p.m. It is probably due to impaired inhibition of the heat centres.
Mental Symptoms. - The mental peculiarities common in hysterical subjects form a fairly characteristic group, easily recognised in a short conversational. The fully developed hysterical temperament may, however, be met with in persons who have never had a hysterical fit, or may also some of the bodily symptoms. Clarke (op. cit., p. 140) quotes Friedenwald as stating that "the traits of character which have been ascribed to hysteria by most writers until recently are the exception, not the rule". This, however, is quite contrary to the usual experience in this country. In some cases, however, these symptoms are not constant, usually occurring in connection with various other attacks. Emotional instability and defective inhibition are the groundwork of the hysterical temperament. The patient's emotions are aroused to an abnormal extent by slightest causes. She is easily carried away by the emotion of the moment so that she will laugh or cry on any slight provocation, and when she has begun, continues or alternates between the two after the cause has ceased. Her temper is also easily aroused, and fits of unprovoked passion and acts of violence are not uncommon. There is almost invariably a marked amount of self-consciousness, and desire to attract the attention of others, with frequently great
and ill concealed vanity. There is an air of exaggeration in all her words and acts, which is easily recognized, but difficult to describe, and which is most marked when she is talking about herself, as she is apt to do. With this there is evident a want of energy and application. The patient is seldom capable of prolonged exertion, physical or mental. She has a tendency to begin tedious undertakings which she never finishes, and is apt to neglect her household duties. She is hypochondriacal, continually complaining about her health, and shows an inordinate desire for the sympathy of others, which in many cases, leads to selfish mendicancy. This craving for sympathy is perhaps the most constant of all the mental symptoms, and at the same time hysterics show a marked want of sympathy for others, and a strong jealousy of any attention paid to any real sufferer. In some cases it is difficult to avoid the conclusion that the patient actually believes herself to be in extreme bodily weakness, when she looks a picture of health. She is frequently utterly regardless of the feelings or conveniences of others, and is quite unable to take a dispassionate view of her own conduct, so insincere that she is selfish, or that she is not so ill as the doctors say.
assume the different resentment, and probably to
aggravate all the symptoms.
There is usually running through all this a
certain element of mental depression, which is
sometimes so marked as to border on actual Mel-
ancholia. Threats of suicide are very common, and
according to Blackie (op. cit. p. 41) may be carried out. In
some cases attacks of mental excitement are apt to
break, usually brought on by some emotional dis-
traction, as disappointment or anger, and which may
even simulate acute maniacal condition, and may
as in case I be accompanied by hallucinations or trans-
vent delusions.
The patient is usually extremely religious in an
emotional manner. The religion, as in Epilepsy, the
most closely allied condition, is of an extremely personal kind, and is made to suit the
patient's wishes. As Browne Lewis (op. cit. p. 242) says
of Epileptic Insanity, "The present animal passion,
find their gratification and pass with this one
"display of pietistic favour, with a sanctimonious
"bearing and a purpose indulgence in religious cant,
"and with apparent consistency in the Epileptic's
"mind. The realisation of the religious life in action xx
"is as fault. xx hence he finds no difficulty in
"Reconciling these feelings with the continuous gratification of love and depraved instincts." In many cases of hysteria this would hardly be an exaggeration of the mental attitude with regard to religion.

Loss of memory usually occurs to a greater or less extent in severe and prolonged cases. The memory is variable, and so in the amnesia of dementia, is usually much better during mental excitement than at other times.

A certain amount of degradation in the mental type usually occurs, and here I think the aesthetic and moral faculties are more apt to suffer than any others. The loss of moral sense has long been recognized, and I have found that it affects not only the patient's judgments of herself, but also, though to a less degree, her standard of morality for others in affairs with which she has no concern. The degradation of the aesthetic faculties was well shown in case I.

Without passion is a very common characteristic. Emotion, to a certain extent, is always present, the patient not only magnifying her sufferings, but giving a strong colour to all her conversation. Especially is she apt to dwell upon and exaggerate the deficiencies of persons she does not like, putting the
Most unfavorable construction on their actions, and taking every possible opportunity of informing people of their real or imaginary misconduct. A slight injury is brooked over till it assumes extraordinary proportions, and in the patient's account is twisted out of all possible recognition. At the same time she has the appearance and manner of one who is perfectly convinced of the truth of what she says. Frequently wholly imaginary charges are brought against persons who have fallen under her displeasure, and are made with an elaboration of detail which shows that they must have been brooded and thought over for weeks before being brought out. It is impossible not to believe that after a while the patient regards these stories as true.

These tendencies are so present, and there is usually a clearly perceptible sexual element in the behavior of hysterical women towards the other sex. Sometimes very marked advances are made, and the rejection of them arouses the most vindictive resentment. The summation which are so frequently resented by hysterics are usually of a sexual nature. On the other hand, complete indifference may exist. Masturbation is common.
Like Epileptics, Hysterics sometimes appear to have a certain sympathy for one another, and like each other's company. (See p. 27.)

Hallucinations have already been referred to in connection with hysterical convulsions.

Somnambulism sometimes occurs in the course of Hysteria. In true hysterical somnambulism (for it is occasionally simulated) the patient on waking has no recollection of what has occurred during the somnambulistic state, or at most, a dim remembrance of single events, but when in that condition remembers what happened in previous attacks. The same actions are usually performed over and over again in successive attacks. By throwing the patient into the somnambulistic state by means of hypnosis, she can be made to give an account of the actions in previous attacks, a fact of great importance from the medical-legal point of view.

Catatony also is usually a symptom of Hysteria, though it occurs in the course of other diseases, notably Adolescent Insanity. This, like Somnambulism, is far too wide a subject to be fully discussed here. The essential symptoms are partial or complete loss of consciousness, with plastic rigidity of the muscles.
So far I have treated the symptoms from the objective point of view, and I shall now proceed to the more difficult matter of dealing with the subjective side.

I'll recently there has been a tendency to regard hysteria as a condition in which a person of weak will contracts a habit of wilful or semi-wilful masquerading for the sake of sympathy, and a great deal of the treatment has been founded on that conception. To suppose that symptoms such as total anaesthesia can be wilfully simulated by a patient with unfeigned will is, however absurd, as the amount of inhibition required to keep up the pretence of non-sensation while a limb is cut or burned, as may be done in many cases, is much greater than most persons possess.

I have already referred to mental depression as a symptom of hysteria, and on consideration, it will be seen that many of the mental symptoms point unmistakably to the presence of painful emotional states. Such are the hypochondriacs, the tendency to imagine nearly ill used and the lack of energy shown by the patient, while the hysterical fit itself resembles nothing so much as the tumultuous struggle of painful emotions.
To find an outlet in silent muscular action. Now according to Herbert Spencer (Principles of Psychology, Vol. I, p. 239) "when the pressure of nervous fluid is low, the diffused discharges will be in distributed that the finely varied feelings of pain will correspond cont. and vice versa. Hence we may assume that in hysteria the nervous pressure or tension is abnormally low, a point to which I shall refer later. The mental depression carries with it its invariable accompaniments, a fall in object-consciousness, and a rise in subject-consciousness. The condition is not unlike that occurring in the early stages of melancholia, of which B. C. Lewis (Op. Cit., p. 117) says - "he [the patient] finds himself up to introspective states in which he dwells upon the present contents of his mind, broods on his morbid feelings, and falls into long reveries, the subject matter of which partakes of the same gloomy colouring." The early melancholic, however, except perhaps in the premonitory stages, fiddles the presence of others so much as the hysteric fiddles solitude. The representational faculties are impaired, with consequent impairment of volition, for if the will is admitted to be the result of the conflict between sets of ideal motor changes which usually tend to become real, and one of
which eventually does become real (Herbert Spencer, Op. cit. VI. I. p. 396) it is evident that unfoiled representation of these ideal bodily changes must interfere with the process. As Browne hints (p. 170) "Then paint summation of vital movements which are aroused as the incident to vital action may mutually antagonize each other; and their very want of vigour will of itself neutralise that distinctive quality which enables the one group to preponderate and overcome the other in action." Hence we have that very prominent symptom, impaired rotation, a loss of "will power.

As in all states of impaired nutrition of the brain, the highest and latest acquired functions suffer first, and as these are lost, so is their inhibitory influence on those below them. "When the nervous system is not fully charged, these latest and highest structures are the first to fail. Instead of being "instant to act, their actions, if appreciable at all, "come too late to check the actions of the subordinate "instincts," (Herbert Spencer Op. cit. I. 605). The tension being low, the nervous discharge aroused by a stimulus favours off by the older and more patent channels, without forcing the more recent ones of higher devel-
opposite. In addition to this, whether owing to the impaired nutrition, to the loss of inhibition from higher centres, or both, the nervous action acquires an explosive character, owing to which the result of a stimulus may be altogether out of proportion to its cause.

It follows from the above that while reasoning, which implies the forming of new channels of communication, is likely to be greatly diminished, the emotions, due to faint revivals of past and ancestral feelings by conduction through old channels will be much less apt to suffer, and owing to the diminution of the higher inhibiting influences, will take an abnormally large share in the total consciousness.

Following the rule that the latest developed functions suffer first, we find a marked absence of altruistic sentiments, in the Spencerian sense of the term. The wish to benefit others with no advantage to self is almost incompatible with hysteria. So altruistic sentiments are more common, such as the desire to evade approbation by openly benefiting another, and especially religious sentiment. The more severe and lasting the case, however, the more purely egotistic the patient becomes, till she will without compensation destroy the character of another for the sake of being considered ill-used. So we find the
religion of hysterics assuming a markedly personal form, in which the patient's want which acts are justified, and every thing is wrong or right as it seems matters her or otherwise.

The misconception of the representative functions already mentioned has a large share in the creation of the mental symptoms of hysteria, by diminishing the mental field, circumstances which largely influence the actions of healthy-minded persons, remote consequences, etc. Frequently do not appear to enter into the mental processes as anything like the normal extent. Much of the sickness of hysterics appears to me to be due not so much to selfish disregard of the feeling and convenience of others, as to the fact that these circumstances do not enter into the patient's consciousness at all. In the same way her conduct may be extremely inimical to her own prosperity and their interests, but these things being comparatively feebly represented in consciousness, are overcome by the emotion of the moment.

The relation between the consciousness of the patient and some of the symptoms of hysteria is one of the most difficult points in connection with the disease. The fact that many of the symptoms,
such as the convulsive attacks, often appear to come on at the will of the patient, at the time when they are convenient to produce an impression on others, and the undoubted tendency to deliberate malingering, before one to consider the whole thing as an elaborate system of malingering, while on the other hand the existence of anaesthesia and other symptoms of which the patient has no knowledge are positive proof that some, at all events, of the phenomena are beyond the patient's control. But for the frequency with which the two classes of symptoms are associated, one would be inclined to regard them as belonging to two distinct diseases. Through the study of closely allied conditions,—petition, sleep and waking and hypnosis, being the only plausible explanation yet put forward—there is a double consciousness, or rather division of consciousness. The theory is, briefly, that hysteria is due to physiological misdirection of impulses, owing to which the normal summing of impulses does not take place, some failing to take their part in consciousness, and forming one or more separate groups, which under favorable conditions may rise in consciousness to the total or partial subversion of the principal groups.
"The essential character of this "disease of disaggregation" is the formation in the mind of two groups of phenomena, the one constituting the ordinary personality, the other, capable of further subdivision, forms an abnormal one, different from the first, and injured by it" (Clarke, Jr. cit. p. 132). Janet, quoted by Clarke (p. 133) states that the incomplete state of the normal personality constitutes the "hysterical core," and permits the disorderly action of the second personality. The second existence is often a rudimentary psychological "existence, in which a few sensations and ideas exist, not controlled or modified the one by the other (Clarke cit. p. 132).

This condition is evidently closely allied to that of hypnosis, in which, though the higher parts of the consciousness are suspended, the subject retains a form of consciousness by which he is able to receive certain impressions and to act on them, though on returning to his normal condition he has no recollection of what has passed. That is to say that the consciousness existing during hypnosis is dissociated from the aggregation forming the normal ego.

A strong confirmation of this theory is found in the frequent occurrence of somnambulism in hysteria. Here we have a condition of consciousness of which
the subject has no recollection in the waking state, while frequently during the somnambulistic attack he has a recollection of what occurred during previous ones. Here we have two complete series of phenomena, two separate existences, mutually exclusive, but in which each period of either existence is closely related to consciousness with others of the same sort, a much more complete doubling of the personality than is required for the theory under consideration.

In this point Clarke (op. cit. p. 122) says "By throwing the patient into the (hypnotic) somnambulistic state and prompting by the memory he has of the phenomena of the attacks whilst he is in this state, and only whilst he is in it, it is found that some emotion, in terror, anger, despair, always initiates the attacks. All hysterical attacks are of the same nature, and consist in a more or less complete reconstruction in a "second existence of a past idea, adventure or emotion, that is, of a more or less rudimentary somnambulistic state."

In hypnotism we find a parallel of these independent or "fixed" ideas, for as it is well known, a person can, when hypnotised, be so influenced as to cause him, without knowing why, to do a given thing some time after he has returned to his normal conscious-
Here there must be a fixed idea, not present in consciousness, but nevertheless influencing the eye. It is evident that such division cannot be without result on the nature of the eye or principal group, and while the temporary displacement of the principal by the minor group in consciousness may explain the consolative phenomena, the alternation in character of the principal group, and more especially the presence of the minor in the subconscious strata may explain many of the interparoxysmal mental symptoms. This defective coördination of psychical phenomena will also account for the apparently physical symptoms. Thus anaesthesia would appear to be due to the fact that apparent impulses from a past fail to become connected with the eye, either communicating instead with the minor group of phenomena, or being inhibited by it in some part of their course. In the same way paralysis would be due either to the inhibition of motor centres by the secondary group, or to their implication in the group. The paralysis in this case is cortical or psychical, but as real as if the connection were sudden come down by division of the nerve or spinal cord.

In hysteria a paralysis may be induced by suggest
in while the patient is under the influence of hypnosis, which will persist when that is removed, exactly as it may change its seat during a hysterical attack. If hypnosis persist in the new situation. This is evident by the case of an idea, not forming part of the principal group of ideas which constitute the ego, persisting when the field of consciousness is occupied by the principal group to the exclusion of the rest. Here we have some light thrown on the paralyses and other symptoms which appear after hysterical fits, for assuming the mental condition in which the fits occur to be that in which the secondary group of phenomena has become so active as to replace the primary in consciousness, a theory strongly supported by the absence of vagaries of unconscious in the part of the patient of what occurs during the fits, it is evident that this increased activity must favour the development of fresh ideas associated with the secondary group. Again, there is an analogy with that form of hypnotic suggestion in which a subject is made to perform a given act at an interval after the hypnosis. In each case there is introduced during the temporary suspension of part of the consciousness an idea, which is never perceived by the ego, but which afterwards acts on it as an outside influence.
Concerning these fixed ideas, Clarké (op. cit. p. 130) quotes Charcot as saying: "Under certain circumstances paralysis may be caused by an idea. By reason of the noteworing ease of the ego produced in one case by hypnose, in another by nervous shock, an idea once implanted, fixed in the mind and "ruling through without control, will further develop, and acquire sufficient force for objective realization." The great susceptibility to suggestion in hysterics, and its power in causing, transferring, and removing symptoms, indicate a closer resemblance between the hypnotic and hysterical states. In this same way these symptoms can be temporarily produced by suggestion under the influence of hypnosis, or more hysterical subjects. Now in hypnosis there is a suspension of a part of what normally constitutes the ego, while the remaining part acts separately, free from the inhibiting action of the rest—a condition closely resembling that in which from any cause the coordination of parts fails, and each acts separately. The paralysis produced in hypnosis is due to the inhibition of certain psychical processes by an idea artificially introduced during the suspension of a part of the consciousness, while in hysteria the same action is assumed by
ideas or groups of ideas, not forming part of the primary group, but acting and developing independently of it - a foreign body, a Torsion of the mind.

While the above theory may be accepted as fitting in well with the known facts of the disease, and as by far the most rational yet put forward, it must be admitted that it requires almost as much explanation as the disease which it explains. The question at once arises - why does this state of incoordination arise in one nervous system, and not in another under similar circumstances? or while the shock, for instance, of a railway accident may cause hysteria in one person, many others undergoing the same experience are unaffected. To explain this, some individual defect of the nervous system must be assumed to precede, and this I think will be found in an abnormal state of nutrition of the nervous system, due to heredity, or to unhealthy habits such as those mentioned among the predisposing causes. This abnormal state of nutrition I believe to be one of insufficient formation of the nervous fluid, comparable to the deficient formation of blood in Chlorosis, and leading to a state of low nerve tension,
Combined with, and depending on this, as is found in other forms of malnutrition of the nervous system (liver asthenia, epilepsy) there is an abnormal irritability arising to which the central nervous discharge may be altogether out of proportion to the external impulse provoking it.

The result of low tension is that the discharge caused by the reception of an external impulse is able largely to expand itself locally, and those channels of distant communication which are forced will be the least and most patent, and connecting least with the higher centres. Also, the amount of discharge along these passages will be less than normal, and from long continued comparative idleness, they will become less patent, till only an exceptionally strong discharge will force the communications at all.

This being the case, it is evident that new channels of communication are not likely to be formed, so that whatever nervous action takes place is likely to depend itself locally, or through different nerves connected with the tract. In this way tracts of the nervous system may become shut off, under ordinary circumstances, from communication with the rest, though during exceptional activity they would be able to force communications. But in the meantime
The main part of the nervous system would have grown accustomed to receive impressions from the affected tract, and the result of a sudden re-
emption of communication would be a disturbance of function. Thus, suppose the function of the tract concerned to enter normally into conscious-
ess, a sudden renewal of communication after long
function would be comparable to the rite to cons-
sciousness of a function normally subconscious,
such as peristalsis—it would effect consciousness
as an outside agency, a part of the non-ego.
Moreover, the control normally exercised over the
activity of one centre by its relation with the pro-
cesses going on throughout the rest of the nervous
system being lost, there would be a tendency to
occasional over-action. The result would inevitably
be the forcing of communications with other centres,
and in this way the isolated process would be
brought into relation with the general body of
psychical processes—the isolated idea with the
coordinated body of ideas forming the ego. But here
instead of ideas developed and increased in complex-
ity in constant relation with the rest, there would
be an irruption of already complex and organized
ideas, having no previous connection with the ego.
This would evidently affect consciousness as part of the non-epic. The effect would vary with the strength of the impulse received from the isolated tract, and so we know consciousness may be entirely occupied by an extremely strong sensation to the exclusion of other elements, it is easy to conceive that the sudden, violent excitation of these ideas may dominate consciousness in the same way to the subversion of the series normally constituting it. An impulse of less strength, being an accretion of formed ideas, would take the form of suggestion, similar to that communicated from outside under hypnosis.

Let us now consider the probable effect of a severe shock on a nervous system in this condition. The first effect would, of course, be an enormous expenditure of nervous energy, forcing communication throughout the whole nervous system, and resulting in a great exhaustion of nervous substance, with consequently further lowered tension. The forcing of nervous channels would set up secondary activity, connected in consciousness at this time with the shock, in various parts of the cortex. The vivid sensations of the shock will be followed by faint revival of the sensations, but these, being of much less force,
and acting as first in a state of still lower tension, can only force a comparatively small number of the communicating paths during the vivid sensation. It is consistent with our knowledge of the nervous system to suppose that the stimulus given by the shock to numerous parts of the cortex will be followed by action at the centres stimulated, but the representative sensations being insufficient to force all the channels forced during the primary sensation, the activity at some of these centres is not reflected by that caused elsewhere by the faint survivals of the original stimulus.

The ultimate result of the forcing of a channel of communication is to make it a more easy road for future impulses, but the immediate result is exhaustion, proportional to the strength of the discharge, and in the state of malnutrition supposed, the waste will not be made good so rapidly as under normal conditions, so that the period of exhaustion with further lowered tension will be abnormally prolonged. Hence the activity set up at one of these centres will be transmitted rather by other channels to connected centres, which would thereby be rendered more patent, while the discharge being comparatively trifling, the local exhaustion would be less. So, by
by the time the channels by which the original impulse was received, and the resulting impression passed on, the other channels would be moreurry, and representations of little force would not be brought into relation with those occurring elsewhere. Thus we should have psychic phenomena, originally connected with the vivid sensation, elaborating and forming new connections, which are not connected with the psychic phenomena set up elsewhere by the same cause — ideas connected with the original shock, not brought into relation with and controlled by the general body of ideas associated with the shock, but liable at a later stage of development to come into relation with, and modify it.

How the immediate result of a severe shock on consciousness is purely emotional — strong fear, grief, etc., and it is to be expected that the representation in the incoordinated group of ideas resulting from it will be of the same character. Hence the influence of this group on the ego will be of a painful emotional kind, and for the reasons already mentioned, may be altogether disproportionate to the original cause; and as I have already shown, this is exactly the influence of hysteria on the mind of the patient.
The conditions given above—malnutrition and irritability of the nervous system—are very much what are supposed to give rise to neurasthenia, and as a matter of fact the two diseases often overlap so that it is sometimes difficult to say whether a patient suffers from hysteria or neurasthenia or both. But hysteria is very much commoner in females, while neurasthenia is commoner in men. Here in women the emotions form a larger part of the total nervousness than in men, hence the greater likelihood that in the abnormal state under consideration there will play a large part in the disease. Low, subdued emotion, and the results of disorders of emotion form a great part of the symptoms of hysteria, while a considerable further part is common to the two diseases. Again, neurasthenia is more common in brain workers (Clarke, op. cit., p. 148) that is to say among those in whom the intellectual faculties are highly developed in proportion to the emotional. So the diseases would appear to be the result of similar conditions in differently constituted nervous systems.

Hysteria, then, is a state of defective nutrition of the nervous system, with irritability and low tension; and consequent incoordination of psychical phenomena, owing to which some fail to take their part in the
Aggregation of physical phenomena normally constituting the ego, and from one or more separate groups, uncontrolled by but acting on the principal group, and which under favorable circumstances may rise to consciousness as the total or partial subversion of the principal group. It is characterized by emotional instability, with a tendency to the prevalence of painful emotional states; marked self-concentration; defective inhibition; a morbid craving for the sympathy of others, with a tendency to gratify this by soliciting; a tendency to the occurrence of convulsive seizures of a characteristic nature, and of paralyses of motion and sensation.

Diagnosis: This is sometimes rendered difficult by the tendency of hysteria to simulate other diseases. The hysterical temperament is rarely recognized, but the possibility of coincident organic disease must not be overlooked. Thus, hysteria occurs with great frequency in epileptics. The hysterical fit is actually seen can hardly be mistaken for anything else, and even if it has to be diagnosed by description the patient's account is usually sufficient. No bruises or other marks will be found, such as might be caused by the fall in an epileptic fit. The tongue is never
Hysterical fits may simulate paralysis from organic disease, but usually there is sufficient discrepancy to render the nature of the affection pretty clear. The principal points are, (1) the tendency to the occurrence of disorders of sensation, (2) tendency to incompleteness, (3) irregularities of distribution, (4) loss of the muscles of the face and tongue, (5) freedom of the bladder and rectum, (6) sensibility of loss of knee-jerks, (7) electrical reactions in most cases unaltered, (8) tendency to alternation in character and sudden disappearance, (9) the influence of hypnosis and other suggestion, (10) the occasional presence of rigidity from the joint, or in the position of extension.

Hysterical joint affections are distinguished by the absence of redness and swelling, the superficial nature of the pain, and the insensibility with which the joint can be handled and moved when the patient is distraction. In most cases there is little or no atrophy of the muscles, though this may occur. Hysterical vomiting is perhaps the most difficult of all hysterical affections to diagnose, with certainty,
the resemblance to the symptoms of gastric ulcer
being sometimes very close, while it may be almost
the only symptom of hysteria present. The occasional
occurrence of haematemesis in hysteria complicat-
ing matters would further . As a rule, the pain on
pressure is not so strictly localized as in gastric ulcers, while in hysteria, blood is much more rarely
found in the stools. Haematemesis from gastric ulcer is almost invariably preceded by pain and
symptoms for a considerable time, whereas in hysteria the haemorrhage may be the first symptom . Where
there is any room for doubt, the existence of gastric ulcer must be assumed.

It is often difficult, and sometimes impossible, to know
whether a symptom is real or simulated. Thus, true
haematemesis is occasionally found in connection
with hysterical vomiting, but it is more common for
patients to simulate it by making the inner bleed,
swallowing the blood, and afterward vomiting it.
In most cases of this kind, a careful physical
examination will reveal the source from which
the blood is obtained. The forms of malingering which
occur in hysteria are innumerable, but many of
them are so subtly constructed as to be quite tran-
parent, such as vomiting urine (1809 p. 195 p. 853) producing
fruits from the vagina etc.
Lastly, a history of hysterical convulsions is not necessary to establish a diagnosis of hysteria.

Prognosis - As regards life the prognosis is very favourable, though deaths from hysteria have been recorded. With regard to recovery it is not very hopeful. It is not uncommon for a patient to suffer from slight hysteria when in a generally debilitated condition, as after a severe illness, but to show no further symptoms on returning to good bodily health. Except from this, and especially when the symptoms have persisted for more than a few weeks, the tendency is for the disease to become permanent, and frequently progressive. With removal of the cause - worry, sexual disorder, etc. especially after the climacteric, improvement may take place, but the disease has left its mark indelibly on the mental constitution of the patient. While the best remains abnormally emotional and selfish, with a certain degradation of type. There is usually some or loss of memory. The whole condition is comparable to that occurring after recovery from acute insanity. There also remains a strong tendency to relapse, especially under depressing
circumstances. The occurrence of any of the more permanent symptoms, such as paralysis or anaesthesia, influence the prognosis unfavourably, and the same may be said of unusual severity and frequency of hysterical fits.

Treatment. If the patient be seen in the first appearance of hysterical symptoms, she will often be found to be in worse bodily health, and anaemia, the rest, change and change may be sufficient to arrest the development of the disease. Rest, of course, should not be silence, but rather a change of occupation, such as a few weeks sculling, with moderate exercise in the open air, and sufficient amusement to keep the mind occupied and prevent brooding.

In the more severe and long-continued cases, however, especially those who have been more or less hysterical since childhood, it is a much more difficult matter. The first point, of course, is to remove the exciting cause where that can be ascertained. Unhealthy occupations must be abandoned, and bad hygiene surrounding remedied. If any disease of the sexual organs be present, that should be attended to. In many cases, however, the exciting cause, such as worry, is beyond the reach of medical treatment.
Hysteria being a disease which affects the body through ideas, it is to be expected that treatment of a psychical nature will have some influence, and so we find one of the most efficacious methods in the "moral treatment." This includes, first of all, the removal of the patient from injudicious friends, thus by making much of the symptoms, and giving way to the patient's desires, later to the already abnormal craving for sympathy, which grows with gratification. The nature of the disease should be carefully explained to the patient, the functional as opposed to organic cause of the disease being especially dwelt on, and a hope of ultimate recovery encouraged. Above all no doubt must under any circumstances be impressed on the reality of any of the symptoms, the first sign of malingerering being usually sufficient to aggravate the disease. This of course does not apply to undoubted wilful simulation, but to the more false symptoms of hysteria. Much depends on the medical man possessing the confidence of the patient. She should be under the care of trained nurses, and should not be allowed to associate with other hysterics. Indeed it is better that she should see no one but the nurses and medical attendant. A regular and easily digested diet is necessary, as eating between meals being
allowed. Regular exercise proportionate to the patient's strength, and when possible in the open air, will usually be found to benefit both the mental and the bodily condition. The patient should not be allowed to sit still doing nothing, every effort being made to break the habit of seclusion and brooding. Reading will do no harm if the sentimental and erotic elements are excluded. Implicit obedience to all the rules laid down, to the smallest detail should be insisted upon, and will usually be easily obtained after a week or two if the treatment be sufficiently firm at first. At the same time anything like harshness will have a harmful effect, and is quite unnecessary. Before any improvement can be expected the patient's own wishes must be insisted on in that direction. By the removal from the usual surroundings, the hope of recovery, the careful diet and exercise, and the occupation of the mind many of the influences which tend to keep up and aggravate the disease are cut off, and the exercise of some healthy habits of thought, besides excluding the unhealthy, tends with time to become habitual. Short of this elaborate system of treatment, a change of air and surroundings is often of benefit. Sea air is said to be unsuitable for severe
lens of hysteria (Lewinsohn, quoted by Clarke, op. cit. p. 312) but the essential point is not so much the aid as the separation from accustomed surroundings. The influence of hypnosis in the treatment of hysteria has attracted considerable attention, as would be expected from the influence of suggestion in causing, transferring and removing hysterical symptoms. Hypnotic suggestion has that power to a very marked extent. It has been objected to on the ground that the repeated exercise of hypnosis tends to increase the susceptibility to suggestion, which is already abnormally great. Unfortunately, the action of hypnosis is somewhat uncertain, and some hysterics cannot be hypnotized at all. Lewinsohn (Clarke, op. cit. p. 173) says — "...more capable of influence through hypnosis are hysterical symptoms of the more violent character, paralysis, anaesthesia, hyperaesthesia, contractures, and frequently recurring convulsions. The symptoms removed in this way are very liable to recur, sometimes in another situation. It appears that though special symptoms can in many cases be removed, hypnosis is useless in the treatment of the disease itself — the hysterical condition cannot be cured by its means.

I shall not enter into the treatment of symptoms
by the application of magnets, as the grounds for regarding the results, if real, as due to anything but suggestion are wholly insufficent.
Colds baths and douches are said to be beneficial in some cases, probably by the tonic effect on the nervous system. Many hysterics, however, are in such a weak state of physical health that one would hesitate to adopt this treatment. The mild rub and walk is also recommended. Massage is very useful, especially in the paralytic affection.

Numerous cases are recorded in which severe cases of hysteria have been cured by shocks, especially by fright. It is very doubtful, however, whether hysteria really is ever actually cured in this way, though individual symptoms, especially paralyses, are often removed. It is probably due to the forcing of already faulty nerves of communication. This treatment is not to be recommended, as the effect not unfrequently is to seriously aggravate instead of improving the disease.
The treatment of hysteria by drugs is not very successful, and where it succeeds, it probably owes much of its efficiency to suggestion. If the physician shows the entire confidence of the patient, any drug will have a benefical effect, but none will cure the disease. I have
Myself had good results in several cases with burnt sugar, syrup and water, which in the mouth of one patient who suffered from hysterical headaches, "acted like magic." The drugs usually recommended seem to be selected principally for their nauseous taste and smell, as if the patient were malinger ing, and would rather give it up than swallow such mixtures. So I find Farrell (Materia Medica and Therapeutics p. 307) saying: "Some physicians have even doubted the value of the Valerianic Acid, but it can hardly be conceived that such a powerful smell inger body as the acid is devoid of antispasmodic properties." I have tried this drug and its salts, and have used it repeatedly, but seldom with any good result. On the other hand, when recourse to N. J. Ennism in Lewicki, I found it had a wonderful effect in curing simulated illness among the prisoners. The vegetable tonics and iron sometimes appear to produce some improvement. Bromide of Potassium is valuable during exacerbations, especially when fits are frequent, and seems to be more efficacious when combined with Thoracium. Daily large doses must be given - 30 gr. of Bromide and 30 dr. of Thoracium every four hours is not too much. The effect, however, is usually temporary.
Electricity, too, probably owes some of its efficiency to suggestion, and some also to shock. With massage it is useful in the treatment of properly isolated and supervised cases; but otherwise it is not of much use except in the treatment of individual symptoms, especially paralysis and anesthesia.

Hysterical fits, if unusually prolonged, may call for some treatment to prevent arrest. The sudden unexpected blowing of cold water on the face is often sufficient to arrest this, but the effect may be only momentary, the fit recurring as soon as the shock and surprise have passed off, and a repetition is seldom successful. Also (p. cit. p. 87) states that if the patient be held down firmly, it is to prevent any struggling, when once the fits that she is thoroughly restrained the normally losses to struggle. I cannot believe that this method is beneficial. If the epileptic expenditure of force which occurs in a hysterical fit is not within the voluntary control of the patient, and is not allowed to find vent in muscular action, it must expend itself in other ways, probably in an emotional direction, and the result, like that of mechanical restraint in acute mania, must be to aggravate the mental condition.

Syringes are sometimes recommended, but their adminis-
natomis attended with some difficulty. I have on several
occasions tried the effect of simply leaving the patient
alone in the room with the door shut, and the sounds
of struggling have invariably lasted in one or two
minutes. The presence of others seems to bring the
mental condition in which fits occur, by acting on
the diseased craving for sympathy.
Headache is usually relieved by bromide and hy-
sciums, but in many cases any medicine will do.
Thus a patient of mine in Norwich, aged about 50,
and markedly hysterical used to suffer from severe
headaches whenever she heard from her sons, who
were her great anxiety. I treated her first with
bromide of potassium, which removed the headaches on
the first three or four occasions, but then lost its effi-
cacy. I then gave her sulphonal, which acted in the
same way. Finally I gave her a mixture of the two,
which still retained its power when I left Norwich
a few months later, and the afterwards asked my
permission to procure the prescription from me,
as nothing else was of any use. It is hardly likely
that bromide of potassium and sulphonal (v. 109 each)
preserved any inherent power after the affection which
another had when used separately.
Vomiting is usually best treated by bromide
intake of (given dry) and easily digested food. I generally advise nothing but Benger's Food. Rest in bed is generally essential. This régime proved as effective as any other form of treatment, and it is free from danger where there is any suspicion of Gastric Ulcer. Bow (op. cit. p. 873) says "Sometimes the patients retain highly seasoned food better than bland diet, and the vomiting may cease if they are allowed to eat raw ham." A raw minced meat well prepared, can however "should be taken that the nature of the case is clear." The last condition is a very necessary one, as the diagnosis from Bacteria with Ectodermic Gastric Ulcer is often a very difficult one.

I can find no recommendation as to the treatment of Hysterical Nervous, and have had no personal experience of this symptom. I should, however, in cases requiring treatment, be inclined to use a graduated bath, or tepid sponging rather than antipyrine drugs, especially those like antipyrine which act powerfully on the nervous system. I have had some experience of a high temperature in the Paroxym, apparently due to nervous causes, but have never interfered with them, nor seen bad results.
Hysterical dyspepsia is usually best treated as the same form of dyspepsia in non-hysterical subjects. Carassina sagrada, thymolmnia and intestinal antiscorbutics are valuable, and also a mixture containing Khrab and Diphosphate of soda. Considerable relief may be obtained with bromide and hyoscyamine. Retention of urine, if clearly hysterical, does not in my opinion call for treatment. Anything tending to attract the patient's attention to the part will make matters worse.

Amnesia usually has no bad consequences, but the possibility of its being due to organic disease must be borne in mind. If this cannot be excluded, its presence must be assumed, and treatment directed accordingly. Complete sudden amnesia from organic disease, not complicated by other symptoms, such as pyrexia, is however very improbable.

Fred. W. Skene, M.D., F.R.C.P.
I hereby declare that this Thesis on Historia
is written by me.

Frederik He 1843.