A Lecture ON PSYCHOPATHOLOGY AND DISSOCIATION.*

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HYSTERIA AS A DISSOCIATION.

THE following case illustrates the conception of hysteria as a dissociation, involving mental conflict and repression, in a specially clear way, and seems worth reporting in some detail.

A soldier, aged 47, unmarried, had had three hysterical attacks in his life. The first attack occurred at the age of 26, the second at the age of 36, and the third attack a month or two before I saw him. When he came to me he was suffering from extreme loss of memory, and could remember very little of what had happened during the war. He was suffering also from weakness of the legs, a tendency to anaesthesia, especially in the right leg, and a very definite tendency towards dissociation—towards dreamy states, states of mental distraction, when he is unable to concentrate on what is before him.

I will consider the case in the order of my gradual insight into his mental condition. All that is emphasized in the medical case-sheet is that he has recently had an hysterical attack, in which he lost consciousness for some time, and has since suffered from paralysis of the right side, with anaesthesia of the right leg below the knee. In talking to him I do not at first get very much help. He does not tell me very much about himself. And so I proceed to use the method of word association which Jung was the first to introduce into psychology—that is, I draw up a list of words and call them out one after another to my patient. (One calls out the word and starts the watch going, after first instructing the patient to reply with the first word which comes into his mind. If one calls out the word "house," he may reply with the word "garden." Thus:

Stimulus Word.	Reaction.	Association Time.
House	Garden	1.8"
Grass	Green	1.2"

So one goes on, calling out one word after another, interspersing words which one thinks may bear upon the earlier associations of the patient, and may be connected with his dissociation.

I called out the word "death," and the subject remained absolutely silent for twenty seconds, then gave the word "geranium." He smiled as he gave the word, and said it seemed a curious word to give—he did not know why he gave it, but it was the first word that came into his mind. This was all that I got of value from the association test in my case.

I question the man further, and get a certain amount of information from him. He tells me that the first hysterical attack he had was at the age of 26, as I said before. He had just recovered from an attack of influenza, and had walked out to visit a great friend of his. By some mistake he was shown by his friend's sister into a room where the man lay dead in his coffin. His friend, whom we will call J., was dead—had died suddenly after an accident in the football field. My patient had not heard of the death, because of his own illness. This was about eight o'clock at night. My patient staggered out of the house, noticing, however, to his surprise, that he felt very little. He felt shaken, but very cool. He was surprised and annoyed that he felt no grief. Then he lost consciousness, and evidently wandered about London until he came to himself, about four o'clock next morning, in a part of London which he did not recognize. He tried to find out where he was. He met a policeman, who, of course, imagined that he had been drinking. He could not remember his name or address, or anything about himself, but they searched his pockets and found out where he lived, and then took him to a hospital. He lay there for several days, suffering from pain down the right side of the

head, over the right eye, pins-and-needles down the right side of the body, weakness of the right leg, giddiness and nausea. At first he had very vivid dreams which he could not remember. Later on he began to get better, however, was allowed up, and finally left the hospital. That was at the age of 26—that is, twenty years before I saw him.

Ten years later he happened to be walking from Boscombe to Bournemouth along the parade, when he suddenly felt giddy again, and had to stagger to the side of the esplanade and support himself against the wall. He nearly lost consciousness, but pulled himself together, got home, and was seen by a doctor. He was again suffering from the same pains and the same tendency towards a dreamy state of consciousness. He went into a hospital on the doctor's advice. (This time, too, he had just recovered from an attack of influenza.) He recovered after he had been in hospital some weeks.

His third attack occurred in October, 1917. He had just had a bout of sciatica, and was thoroughly tired out by drill and all the routine of a soldier's life. This attack resembled the two previous ones, with similar pains in the head and body. He was taken to a military hospital and afterwards transferred to another, where they treated him in a masterly way with electricity and massage and got him on his feet again, so that when he came to me he had roughly recovered from most of his symptoms, but had this extensive loss of memory. He could remember very little that had happened during the war.

As I said, the first thing I discovered about him was that the word "death" gave a long reaction time, and produced as a reaction the curious word "geranium," which he himself could not explain. I then proceeded to hypnotize him, which was of course very easy. He at once passed into a very emotional state, and began to remember things which he had not been thinking about for some years. "Geranium" he then knew to correspond to the nickname of a girl he had known over twenty years before. She had been called the "Geranium Girl" after an advertisement for cigarettes. She was like the girl in the picture which appeared as part of the advertisement. He proceeded to tell me a rather dramatic story of his early life. He had been extremely fond of his friend who had died, whom I have called J. They had been close friends for years, when J. became engaged to this Geranium Girl. While he was at college he asked my patient to help amuse this girl, to take her out to theatres, etc., as she was very lonely. The result was that the girl fell in love with my patient, though he was not in love with her. (It was on his friend J. that his own affections were fixed.) The situation was a very difficult one. He felt disloyal to his friend. He obviously thought much more about his relations with his friend J. than about his feelings towards the girl. His friend never knew the facts, but a coolness sprang up between them, which was intensely painful to my patient. As a result he shot himself, but was taken to hospital and recovered. He saw less of his friend, however, and then the friend died. This was a definite mental wound to my patient, and set up a mental conflict, the result of which seems to have been an amnesia, a loss of memory. There was a tendency for his mind to split up. The memories were not absent from his soul, however, but remained below the surface to produce these attacks in which he went through all these disturbing experiences again—through all this time of mental conflict.

What can one say of his earlier history? As a boy he was fairly normal, except that he noticed that he always had a great desire to sleep in the middle of the day. He would find that the sight of anything bright, like a field of snow, would make him drowsy. The candles in the chapel of the Benedictine monastery, where he was at school, had the same effect upon him. He was at school at this monastery from the age of about 11 to 17, and formed a friendship there with a much older boy. In the course of this friendship an event occurred which disturbed him very much. (I cannot tell you what it was.) It was his duty as a good Catholic to confess, but he did not do so. He tried to put it out of his mind instead. He knew that if he confessed it would be serious for his friend, but if he did not he would be committing a sin. He preferred to commit the sin. The result was a state of mental conflict, followed by repression and amnesia.

These, roughly, are the main facts about his life. He had never known what it was to fall in love with anyone

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of the opposite sex, but all through his life he had had strong feelings of friendship towards certain people, especially feelings of loyalty. Although he was a private soldier, he was a most intelligent man. He was an inventor, and struck me as being very able. By hypnosis, you see, I brought up some of these facts which he had himself forgotten. I urged him to attempt to synthesize his own mind—to try to improve his memory. And his memory *did* improve. Under hypnosis he worked off a good deal of emotion. (His three hysterical attacks had all been cases of what Breuer and Freud call "abreaction"—the working off of emotion—but an abreaction which was imperfect and incomplete.)

He now began to dream. He dreamed night after night that he was trying to get to a certain village in Sussex, but that briars and thorns and thick hedges kept getting in his way, and he could not cut his way through. At last he met an old man in rags, who was about to tell him something about this village, when he woke up. I tried to interpret the dream for him, but things did not go very rapidly, so I again had recourse to hypnosis. At once he had the same dream again, and could tell me who the old man was; he was a man who used to clean windows in this village in Sussex. He also knew the reason of the dream. He was very anxious about the fate of a young friend of his who had gone to France during the war, and whose name had been posted among the missing. This boy had been in the habit of going to this village. My patient did not know why he went there, but he had guessed that there was a romance going on. He therefore thought that his friend, whom I will call C., would, if he wrote at all, be likely to write to someone in this village, possibly to the window-cleaner. That was why he was trying to get to the village. Now, there were certain reasons why he had tried to disguise the intensity of his feelings even from himself. The result of the analysis of the dream was, therefore, that he became much more communicative, and could tell me very much more. His friend, he said, was many years younger than himself, and, years ago, they had been in the habit of going fishing together a great deal, and had had a very pleasant friendship. They had thought a great deal of one another.

This dream ceased after it had been interpreted, but a few days later he walked in his sleep. He could not tell me what he had dreamt that night, but what actually had happened was that he had walked from the ward, which was upstairs in the hospital, downstairs, and had awakened to find that he was carrying his pillow case. I discovered under hypnosis that he had been back with his young friend. They were fishing together, and his friend had sprained his ankle. My patient had taken a canvas bag and had fetched cold water and bathed the ankle. The pillow case was the canvas bag. The curious fact was that he did not remember the dream. But that is typical of somnambulism. I have never met a case where the somnambulist remembered the dream, though hypnosis will bring it back. There is always a mental cause for somnambulism.

My patient now tells me other things about his friend, about whom he is still very much worried. He remembers that, years ago, he himself noticed that he could tell fortunes by looking into a black polished stone, and on one occasion, when his friend was 14 years of age, he saw him in the stone bleeding at the mouth and at the point of death, and he now feels that his prevision has come true, and that his friend has been killed by the Germans.

A week or two later he came to me and asked me to have him confined to the hospital, as otherwise he was afraid that he might break away and go down to this particular village. I offered to let him go, but he said he felt that he ought not to go. He wished to get well first. However, a day or two later I hear that he is missing, and he comes back a few days later and tells me this story: He was having his hair cut when suddenly he had seemed to lose consciousness, and the next thing he had remembered was that he was right in the country, not very far from this particular village. He could not remember how he had got there, but, being in the neighbourhood, he had thought he would go to the village. He had done so, and to his great joy he had discovered that his friend C. had escaped from the Germans and was now safe in Egypt.

He is unable, then, to tell me how he did this. Under hypnosis, however, he tells me that he had an impulse to go, ran the gauntlet of the military police, and took a bus

into the country. He was taken up by a motor car and given a lift. Then his consciousness changed. That was the point at which his main consciousness resumed its sway. The result of all this is that his mind is at last at ease about his friend C., and he makes a good recovery. All the time his memory for earlier experiences during the war has been improving.

Such a clinical history illustrates, very typically, the nature of hysteria. This flight from hospital is what the French call a "fugue." It was a symptom frequently observed in France. A number of my patients were in danger of court-martial and death for flight from the line. (Many others pretended loss of memory, but it was quite easy to distinguish such malingerers. Genuine cases are always extremely easy to hypnotize.) This case also illustrates dissociation. It is just the sort of case that Janet quotes by the dozen in his writings. It is similar to hundreds of cases one met in France immediately after the men had been under shell fire. It also illustrates mental conflict, the prolonged reaction-time of Jung, and the ignorance of the main consciousness as to what is going on below the surface. It illustrates the significant character of dreams—their symbolic nature—and how, in many cases, apparent clairvoyance is merely hysteria. This man was convinced that he had clairvoyant powers, and was (wrongly) convinced by this that his friend was dead.

Another thing I ought to have mentioned was that, just after his last attack, he was allowed in the grounds of the hospital, and suddenly thought that he saw his friend C. about twenty yards in front of him, walking along. He was delighted to see him, and hurried after him, but then noticed that he made no sound in walking, although he was wearing heavy service boots. Then he disappeared. It was a hallucination. (Extreme cases of hysteria show hallucinations of this kind. They are curable.) His dreams were of the same nature. After all his attacks he dreamed very vividly, but he could not tell me what his dreams were about, except under hypnosis. I became rather tired of hypnotizing him so often, and sometimes tried talking to him for a long time, but progress by this means was slower, and there seemed to be no theoretical or practical reason why I should not use hypnosis to accelerate the analysis. His ultimate recovery was due to this analysis and resynthesis.

Before I turn to another part of my subject I should like to make it quite clear—or as clear as I can—in what respect one may consider hypnosis a justifiable method of treatment, and in what respect not only the ordinary popular, but the ordinary medical, idea of it is wrong.

Unfortunately, the members of the Nancy school, who undertook to criticize Charcot and his disciples of the Salpêtrière, whilst making a great advance in the subject of suggestion, have hopelessly confused the question of hypnosis. I am probably speaking in a minority of one, or perhaps two, in this matter, but, as a result of my experiences in hypnotizing five or six hundred patients out of about six thousand shell-shock cases seen during the past five years, I have come to the conclusion that Pierre Janet is absolutely right when he says that only the hysteric can be hypnotized, and that hypnosis is an artificially produced hysteria. More than that, I agree with Janet that the word should be limited to the production of artificial somnambulism. (If we do this we shall get a clear system of ideas without necessarily distinguishing things which ought to be kept together.)

It is a fact that hypnosis is not the same thing as suggestion. It is a fact that one can hypnotize a patient again and again and find him no more suggestible than he was before; indeed, generally speaking, one may find him less suggestible in certain respects. It is a fact that, if one finds a patient suffering from a functional amnesia—that is, a loss of memory, of greater or less extent, due to an emotional shock—if there is no sign of physical injury, and if one has no reason to suppose that he has sustained a definite physical shock, one may then be absolutely certain of being able to hypnotize him. On the other hand, if one turns to cases, equally free from organic lesion, which do not show this tendency towards "functional" dissociation, one will find that hypnosis fails. The Nancy school—Bernheim and his followers—say that it should be possible to hypnotize 98 per cent. of one's cases, and that anyone who fails to hypnotize 90 per cent. does not know his work. Personally, I should there again agree with Janet in saying

that these people are calling by the name of hypnosis something which is very different. It is true that, in cases of shell shock seen immediately after the shock has occurred, where there is amnesia and dissociation, one can almost always hypnotize one's patients. Literally 100 per cent. of these cases could be hypnotized if one took the trouble to draw the proper distinctions and did not attempt to hypnotize cases that belonged to another category—that is, if one made one's diagnosis first; but, on the other hand, if one turns to what have been called "anxiety states"—cases of obsessions or ordinary cases of neurasthenia—these cases are not hypnotizable, if one follows Janet in his use of the word to signify the production of a second state, where the patient does not remember what has previously occurred and will again fail to remember what has just been going on unless one gives a post-hypnotic suggestion that he will. It is true that in 98 per cent. of cases one can, by using certain means, get a state of increased suggestibility, so that, if one suggests that the patient's eyelids will get heavy, that he will lose feeling in his limbs, and so on, all this will come about; but if, in cases like this, one succeeds in producing the hypnotic state, then one has either to do with a case of hysteria or one has made the patient hysterical.

Is it possible to make a person hysterical who is not so originally? That is a doubtful matter. Personally I should be inclined to disbelieve it. A person who is hysterical has probably been hysterical from his birth—it is probably an inherited form of mental weakness.

Suggestion, then, is different from hypnosis. It is used, or may be used, for a different purpose. We have advocated the use of hypnosis as a means of recovering dissociated memories, functions, etc., and also as a means of giving outlet to bottled-up emotion, to use a rather popular phrase which will have to be defined more clearly in a subsequent paper. We have not used it as a means of applying suggestion. One certainly finds, in many cases, that the more deeply one hypnotizes the patient the more suggestible he becomes, but, in other cases, one may find that suggestibility is not increased. More than that, one may find that people who are not hypnotizable may be suggestible, and that their suggestibility may be increased without any sign of hypnosis coming on. One can use suggestion without using hypnosis at all.

This view is certainly different from that of the Nancy school. It is nearer to Charcot's view, for Charcot worked extensively with hysterics by methods of somnambulism artificially produced, which is definitely the hypnotic state. Charcot was misled, however, in his ideas of the regularity of the phenomena. He thought that he could distinguish definite stages in all cases of hypnosis, including, for example, the "*attitudes passionnelles*" of major hysteria. The question of suggestion with him was mixed up with that of hypnosis, although his own cases mainly illustrate the facts of hypnosis itself.

Finally, the question arises with these cases of artificial somnambulism, might not the same curative results be obtained by longer methods without having recourse to hypnosis? To a certain extent this is possible, but the results are not quite the same. In the first place, if you are going to use the ordinary method of questioning your patients again and again, and encouraging them to tell you more and more of what comes to their minds, you will certainly find that their dissociated memories will tend to come to the surface, and, as the investigation proceeds, the recovery of these memories may become more and more complete. But the method requires a much greater expenditure of time, and the memories are seldom recoverable thus in all their details. In the second place, you do not obtain the hallucinatory vividness of emotion obtained under hypnosis. The abreaction under suggestion is not so vivid. If anyone objects that by hypnotizing a patient you are making him hysterical, the reply is that he must be hysterical already, otherwise he would not be hypnotizable, and that one is justified in using a pathological state to assist a cure, if it really does so. There are medical instances of the use of vaccines, etc., which are perhaps analogous. Anyhow, the final test is the test of results, and one finds in these cases that if the hypnotizing is not repeated too frequently, and if it is carried out by someone who understands to a certain extent what is going on, and who knows that the subject is suffering from dissociation, that he must resist this tendency in the

subject, and must help him more and more to a resynthesis of his personality, then the results justify its use. You do not get recurrences of the dissociation. Pierre Janet¹ has reviewed nearly two hundred of his earlier cases of major hysteria, and shows that in the vast majority of them there is no recurrence. In the cases where relapses did occur, Janet found that he had not gone deeply enough into the causes of the dissociation, that he had not brought all the causes to light.

As regards the many hundreds of cases that I myself sent down from the casualty clearing stations, it was, of course, difficult to get after-histories, but I was able to get such after-histories with thirty extreme cases of hysterical dissociation. These patients had all suffered from loss of voice and hearing, paralysis, intense tremors, and extensive amnesias. In all of these cases but one the reports that have come to me from the base hospitals in England admit that there have been no relapses at all; that the cure has proceeded still further under the later treatment at these hospitals; and that there has been no tendency for other symptoms to appear. In one case alone a hysterical tendency remained. It was the case of a boy whom I had treated for loss of voice, and who showed weakness of the legs at the time when he reached England. I saw from the analysis of the case, however, that he was suffering from a shock received in early life. In such cases one had not time to go fully into the past histories of the patients, as one can do now in England; one had not always the opportunity of using the method of hypnosis to discover more deeply buried memories. In the large majority of cases the patients seemed to be naturally predisposed to hysteria, but to have been quite healthy before the shell shock, and in such cases the working off of the bottled-up emotion and the resynthesizing of the mind was quite sufficient to produce a permanent recovery.

Hypnotism is a method which should only be used in cases of definite loss of memory combined with loss of other psycho-physical functions. Such cases are easily hypnotized—anyone should be able to hypnotize them. You do not need to hypnotize them deeply, only just sufficiently to recover the lost memories and produce abreaction. Then, later, you should resynthesize the patient, and always, as a matter of course, you should investigate his past history and endeavour to link up his dissociated stretch of memories with his past, and also with his more immediate present. If you do this you will find that you have made him less hypnotizable than he was when he first came to you. That is, after all, the test. If you have done real good to your patient he should leave you less hypnotizable than he was when he came to you. This, however, is not always possible. In some cases the patient is so hysterical and suggestible, his powers of mental synthesis are so weakened, that this character of hypnotizability persists unabated. In many cases, on the other hand, one can observe its gradual diminution, and, corresponding with this, one finds that the patient's general mental condition improves.

NEURASTHENIA AND COMPULSION NEUROSIS.

We come now to a consideration of other forms of functional disease which are described under the names of neurasthenia and compulsion neurosis. Compulsion neurosis comprises the different forms of phobias and obsessions. Pierre Janet describes these cases of compulsion neurosis, along with others, under the heading of psychasthenia, and, although his clinical descriptions are very detailed and very valuable, they do somewhat confuse the question, because he has not made a very clear distinction between what the Germans and some of the French have designated compulsion neurosis and other forms of neurosis.

First, let us consider neurasthenia quite briefly. Dejerine points out that the neurasthenic suffers from preoccupations and increased suggestibility as regards personal health. He has become worried, perhaps, by some mental difficulty in his life which he cannot adequately grapple with. He worries about it more and more—finds himself spending more and more time in thinking about it, and thinks about it in an emotional way, in a personal, subjective way. He is unable, through lowering of his powers of mental resistance at the time, to take an impersonal, objective view of the situation. He identifies himself with it more and more until it becomes a pre-occupation—not an obsession; an obsession is something

that is past a certain stage towards abnormality. The emotional character of the preoccupation perhaps itself tends, on the one hand, to fatigue the patient—there is nothing so fatiguing as emotion, continual anxiety and worry—and, on the other hand, it makes him more suggestible in reference to anything bearing upon the preoccupation. If his health fails, as it is almost sure to do, if his digestion, etc., gets out of order, his attention will be directed towards this inadequate functioning of his digestive organs, and this attention will be of an emotional nature, and will increase the disorder. Thus a vicious circle is set up. The rate of digestion may perhaps be slowed down, owing to the patient's fatigued condition, with the result that the process of digestion is itself disturbed, and this disturbance then produces real intestinal disorders. The beginning of it all, however, was mental, and the cure is again mental. In order to break through that vicious circle you must attack it in the right place—namely, on the mental side. If you attack it on the physical side, you may get a temporary improvement—you may be able to reduce the acidity of the stomach, etc., but the worry will still be going on all the time, tending to set up the same condition again. Once the body has given way in any particular function, as a result of a mental trouble, that particular part of the body has become weaker, and as the mental trouble increases again it will break through in the same place. Dejerine points out that the neurasthenic is more suggestible even than the hysteric. One is inclined to agree with him. The neurasthenic is very suggestible with regard to his health.

How is a neurasthenic patient to be treated? Obviously by reasoning with him—not by ordinary moral reasoning, but by inquiring into the original cause of his symptoms. He may tell you that his stomach gave out, etc., etc., a year or two before, but you must not stop there in his history. You must go back to what happened years before, for there is often a long period of incubation with these disturbances. Then you may get a history of an emotional shock—not necessarily a sudden shock—though sometimes a sudden shock which with an hysteric would perhaps have caused a dissociation straight away, will in these cases produce an aggravation of that tendency to worry and to feel anxious that we all have. This tendency to experience anxiety is a normal tendency; it is a very important one, because in these mental cases it is so frequently exaggerated. Anxiety is an emotion which stirs us up and makes us really investigate a matter. Let us consider the typical example of an undergraduate who is preparing for his finals. Perhaps he has not been working very hard, but as the examination draws near he begins to get into a panic and really feels too ill for anything, and does not seem able to do any work. It is a very good thing for an undergraduate to experience anxiety of this sort, as it makes him take stock of his knowledge and find out what he really does know. His mind is thus worked up to meet the situation. If, again, we are faced with any definite peril, physical or mental, we have this same feeling of anxiety, which wakes us up and makes us more alert, though if it is too intense it defeats its own end. It is a different emotion from that of fear. The French have described it in very great detail (cf. *Les Anxieux*, par Devaux et Logre, Masson et Cie, 1917). This state of anxiety is exaggerated in the neurasthenic. He fails to pass on to a more ordered form of mental activity, to grapple with the situation (as, of course, all these psycho-neurotics fail to do, in one way or another), and he expends the energy which he should be using to deal with the situation in intensifying the idea still more, in keeping up the worry, and finally disturbing the state of his physical health.

If you go over the matter again with him, if you talk over his past with him and get him to look at it from his present point of view, to take an objective view of it as if he were considering it as someone else's history, you will find that he will recover. One might suggest that the result is partly due to a diminution of suggestibility—that at least is my own view. What analysis does in helping neurasthenic patients is, I believe, to diminish their suggestibility. The better they understand how their symptoms arose, and what exactly was the sequence of their mental experiences, the less suggestible they become, not only as to their own past but also as to the future. You have made them stronger personalities altogether. That is why I have suggested a word to sum up the matter—the word "autognosis," self-understanding.

(The Germans talk of "Krankheitseinsicht.") What you do in these cases is to help the patients to understand how their disease arose and to understand their symptoms. Autognosis is simply a word corresponding to such insight. This does not comprise the whole method of cure, however. The patient has in many cases to be re-educated. You have not only to get him to understand how and why he went wrong in the past; he must have practice in using his energies in a different way in the future. This is the case with physical disabilities, and it is the same with mental disabilities.

Now, a method like this is obviously far superior to the method of hypnosis. No one who understood his business would dream of attempting to hypnotize a neurasthenic. In the neurasthenic, as in the hysteric, there is certainly bottled-up emotion. It seems to be a tendency in everyone's life for emotion to cling to experiences. We must all have noticed this. If we hate a person we find that the feeling of hatred clings to all sorts of things connected with that person; it links them up with the experience itself. If we make it up with the person afterwards, it is not easy at first to get rid of the emotional feeling connected with him. The same thing happens, as is well known, in the experience of falling in love. If we fall in love we experience certain sentimental feelings in regard to a certain person, and we extend this feeling to some degree to a great many things connected with him. If we afterwards fall out of love again, these sentimental feelings will continue to be connected in our mind with certain experiences, and this association only dies out very gradually. In these cases of neurasthenia too much emotion has been linked up with certain experiences, too little with other experiences. This has tended to produce conflict, strain. The more this has happened the more a person is repressed and unnatural, or mentally awkward. Certainly this characteristic of repression, of awkwardness of the mind, is definitely reduced to a minimum by an autognostic working over of past experiences, affording an opportunity for the dammed-up emotion to flow out along association channels to other thoughts, to come out in talking things over and explaining past experiences. This does not mean, however, that in the end you will have drained off all the emotion from a person's past—that certainly does not happen—you do not by releasing bottled-up emotion leave the experience without emotion at all. (You can test this quite easily in hypnotic cases.) The patient works off a lot of surplus emotion, but if you return to the same experience again later on, you will find that there is still emotion there though it is not so intense. You can test this again and again, and, after the first one or two times, you will find that the amount of emotional reaction remains constant—it will not be absent. You can go back to certain memories as often as you like, but you will always find some emotion there. It is my view that all memories of one's past life carry their own emotion with them, but it is additional emotion that has to be worked off in the neurasthenic as in any other form of psycho-neurosis.

OBSESSIONS AND PHOBIAS.

I now turn to obsessions and phobias, called by German writers compulsion neuroses, because the patient feels compelled to think or to do certain things. A very common symptom which most of these patients exhibit is a feeling of doubt and uncertainty as to what they have just done. Perhaps they are going to bed at night and are not quite sure that they have turned off the electric light or the gas downstairs. This is a very common symptom indeed. Another very common symptom is the feeling that they must be continually washing their hands. Another is that they must read everything that is in the newspaper, or, perhaps, that they must read every advertisement that they see. I knew one man who used to read all the advertisements that he saw on his way home from work. On one occasion he decided that he would give this up, and he did manage to reach home without reading any of them, but he could not be happy until he had returned and had read them all carefully. That is, of course, an extreme case. A very simple tendency which one may find in a great many people is the tendency to walk along the pavement in such a way that, at each step, their feet avoid touching the line of demarcation between the paving stones. It is a tendency that people who are quite sane and normal may have, but

it is an incipient form of the same sort of thing. These are obsessions—the patients are obsessed by a tendency to think or to act in a certain way.

Then there are phobias, or fears—pathologically intensified fears. A very common phobia is the fear of heights. A phobia seems sometimes to be an exaggerated fear of the ordinary type, but in other cases one may find people fearing things that no ordinary person would dream of fearing.

Before turning to explanations, one ought to describe in a little more detail the state of mind of these patients. Besides the actual obsession or phobia, one has to attack in these patients a constant feeling of anxiety. Constitutional anxiety seems to be intensified in them, to be continuous throughout their lives, and to become more acute under certain conditions. To anticipate what I shall say later, one usually finds that, if one succeeds for a time in curing a patient of his obsession or phobia, he will return to this mental tendency. One of my patients felt a constant anxiety lest he should return to an obsession of some kind or other—a feeling which could not be allayed. Freud has a very interesting theory as regards compulsion neurosis. He says that the patient is really obsessed about the wrong thing. What has happened is that in the past, at some time or other, something has gone wrong with the development of his psycho-sexual life. He has done something that he is ashamed of, and which was charged with an intense emotion of a painful nature which he has tried to repress and to drive out of his mind. He has only succeeded in dissociating the emotion from the memory. The memory thus becomes harmless and walks quietly into the unconscious, but the emotion has still to be dealt with, and finds its way along association channels to other less suspicious ideas and memories. The patient, who should be worried about some guilty thought or act of the past, is now worried about something which is obviously innocent and harmless. Thus the obsession is really disguised vice. In certain cases this does work out according to theory. You do sometimes find that you gradually bring up past experiences which are out of harmony with the patient's general character, and which have been repressed. When these memories are recalled, they and the obsessing emotion link up together again, and everything is all right once more—the patient is no longer obsessed. In the case I referred to just now, my patient, who was a bank clerk, had an obsession of infection. He used also to tear up circulars, and then worry as to whether he ought to have read them before tearing them up, etc., etc. He was a homo-sexual, and I discovered that, at the age of 15, he thought that he had led a younger boy astray. He described this incident to me with great emotion, with the result that the obsession disappeared, permanently as far as I know, but there remained a general feeling of anxiety. My further treatment naturally was to carry my analysis still more deeply into his past. This analysis definitely helped me to trace back his tendency to homo-sexuality, and to bring out many other emotional experiences of his past life, and, as far as I can make out, he recovered. Some Freudians hold that all such cases are homo-sexual, but this does not seem to be correct, though it is true that a great many of them are.

In other cases the results were not of a similar nature. A case occurs to my mind of a well-educated patient, also homo-sexual, who had obsessions about the technique of his own particular work. I traced this back to a feeling of intense respect for his teacher and worry as to whether his views were out of harmony with those of his teacher. We traced this back for many years to a moment in his past, at the age of 8, when his sister, who was two years older than himself, had told him that God would punish him for every single little act of wrong-doing he committed. She told him that God was everywhere, and that He could see all the wrong things that he did. He remembered very vividly that he had gone up to his bedroom and had wept bitterly. His imagination, which was very vivid, had helped him to realize what such a situation would mean, and, as far as I could make out, that was the most important of his memories. I took him back earlier still to memories of intense affection for his mother. He had also appreciated her great affection for him, and he was always on the look-out for a love which should be as intense and as spiritual as his mother's love for him had been. This particular case has recovered from his obsessions completely,

but the mechanism seems not to be quite the same as the Freudian one. There was no question of his ever having reproached himself for any specific sexual or psycho-sexual actions. The conflict was of another nature. Other mechanisms seem often to be at work. It seems to me that one cannot well lay down a single definite generalization about such cases, but one is certainly tempted to believe that a very important factor in compulsion neurosis is great exaggeration of the innate tendency towards anxiety which these patients possess. That is why analysis sometimes does not help the patient much—may even make him worse—and why suggestion treatment often does make the patient better. In the past people have often claimed to have hypnotized such cases and to have made them better by this method. Janet, however, says in his latest book that he does not understand these reports, and my experience bears him out. I do not think that these cases are hypnotizable, though one may temporarily increase their suggestibility by making them passive, and thus help them to fight down their fixed idea and also to get rid of this general tendency towards anxiety. One may keep them in this attitude whilst they regain their physical and mental health.

Nevertheless, in many cases a course of autognothetic treatment, with little or no suggestion, is sufficient to produce a cure.

REFERENCE.

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Observations

ON

SUBACUTE INFECTIVE ENDOCARDITIS.

BY

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(A Report to the Medical Research Council.)

THERE are in the United Kingdom about 80,000 men receiving pensions for some cardio-vascular affection. In the London Area there are, roughly, 8,000 pensioners with some cardiac disability, and 1,200 to 1,500 of these have structural disease of the heart. All of them come before the Resurvey Boards for re-examination and assessment at intervals of nine to twelve months. They are called up on special days, and all those with signs of structural disease are seen by a heart specialist. During the past year and a half I have acted as heart specialist at two Resurvey Boards. Such cases as required treatment or further examination I have referred to the Cardiographic Department at University College Hospital. At this clinic they receive out-patient treatment or are admitted to the wards of the hospital. Here I have been able to observe during the past year and a half a large number of selected cases presenting signs of structural disease of the heart.

The most striking clinical feature of this clinic has been the large number of subacute infective endocarditis cases that have been under observation.

From September, 1919, to June 1st, 1920, there were admitted as out-patients 159 pensioners presenting signs of aortic regurgitation, 136 with signs of mitral stenosis, and 65 with mitral stenosis and aortic regurgitation. In 30 of these the diagnosis of subacute infective endocarditis was made, and 11 were suspected as having this disease—that is, 8 per cent., and possibly more, of 360 patients with gross valvular disease had subacute infective endocarditis.

The observations which follow are based on a clinical study of 15 of these cases, together with a larger group of 40 patients with subacute infective endocarditis, whom I had under my care while in charge of the clinical services at the Sobraon Military Hospital, Colchester. Both at Colchester and at University College Hospital the conditions have been most favourable for making a careful study of the symptoms and signs which these patients presented; and through the Medical Research Council I have been able to obtain full after-histories of nearly all who were discharged from hospital. I hope to show from a study of these cases that subacute infective endocarditis is not an uncommon disease; that infection plays a most important, if not the most important, part in a certain number of patients with chronic valvular disease; that the signs of