An Address ON THE DIAGNOSIS OF HYSTERIA.*

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Our knowledge of the nature and causes of functional nervous disorders has been revolutionized during the last fifteen years, and more recently the prevalence of the war neuroses has aroused a widespread interest in morbid psychology. Rival theorists contend for the truth of dogmas they have elevated to the solemn position of a religious cult. Moreover, the treatment of the functional neuroses has become a special branch of medical practice carried out by men who see comparatively little of organic disease. At the same time the general physician is scarcely familiar with the psychical aspect of medicine; he and his colleague, the surgeon, rarely consider how large a part the mind plays even in the symptoms of gross structural disease.

But there is one series of phenomena where a knowledge of morbid psychology is of profound importance to every medical practitioner; for no branch of medicine is free from the puzzling manifestations of hysteria. Moreover, during the intensive study of the ultimate causes underlying the functional neuroses, in which group hysteria plays so important a part, many points of diagnostic importance are liable to be forgotten. Much of this knowledge is traditional and cannot be found in textbooks; and yet it may become at any moment of fundamental importance to every medical practitioner, however small his interest in the neuropsychoses. For hysteria is mainly associated with abnormal physical conditions. In fact, it might be defined as a morbid mental state, accompanied by physical manifestations and certain forms of aberrant conduct.

These physical signs are as definite and specific as those of any other disease. Hysteria is sometimes said to "imitate" organic affections; but this is a highly misleading statement. The mimicry can only deceive an observer ignorant of the signs of hysteria or content with perfunctory examination.

For the diagnosis of hysteria it is necessary, not only that there should be no demonstrable organic cause for the symptoms, but that the positive signs of hysteria should be present. It is to these positive signs I am anxious to call your attention; but nothing could be duller than a category of the protean conditions which may accompany this disorder. I shall therefore enumerate and describe them solely in order to lay bare to you the means by which they can be detected and the state of mind which underlies their appearance.

Freud described hysteria as a "conversion neurosis." This term has been widely adopted, and signifies that the conflict in the patient's mind is solved by some aberrant reaction, which removes him from the situation of doubt and anxiety. If a soldier, unable any longer to face the horrors of the front, became paralysed in both legs, he was automatically relieved from the necessity of facing danger without the obloquy of running away.

Physical Signs of Hysteria.

Disorders of speech were amongst the commonest hysterical affections due to the strain of war. Sometimes the patient became completely mute, although he wrote voluble accounts of his condition and understood perfectly what was said to him. This is an example of that peculiar disintegration of some highly developed function so characteristic of hysteria. It is not the physiological mechanics of language that are affected, but the patient is imbued firmly with the idea that he cannot speak; this is no reason, however, from a conceptual point of view, why he should not be able to comprehend what is said to him, to read, or to write—a condition impossible from organic disease. Although his voice might be reduced to a whisper, he could cough loudly; for from a psychological point of view the resonant sound of a cough has nothing to do with articulated speech. Moreover, on examining the larynx the cords are seen to remain widely apart on phonation, although with a cough they close normally.

The so-called "hysterical stammer," more accurately termed a "stutter," exemplifies another aspect of this

disorder. Unnecessary syllables are interjected into the stream of speech; the patient is not held up like a true stammerer by difficulty in reproducing some word beginning with a consonant or labial, but his speech is interrupted by a series of perfectly articulated sounds.

This illustrates the tendency of hysterical phenomena to consist of a positive disorder of movement, which is so clearly demonstrable in the various forms of tremor. Rhythmic unsteadiness, due to structural disease or want of neural control, is shown by defective power to maintain a certain posture steadily. An hysterical tremor, on the other hand, is a positive repeated movement of a high voluntary type, varying in rapidity. It ceases if the patient can be persuaded unwittingly to perform some other movement with the same limb. Thus, a soldier with a severe tremor of the right hand and arm was able to play the banjo perfectly, and I used this musical aptitude for effecting his cure.

Many are the forms of spasm which are liable to appear in hysteria, but they all depend essentially on the assumption of a certain posture. Most of them are local, and affect one limb or even a single joint. Occasionally, both arm and leg may be contracted on the same side of the body, and if the patient does not move them to command, the condition may be mistaken for a hemiplegia. Any attempt to break down a spasm of this kind, to open the closed hand, or to straighten the flexed knee, meets with intense resistance; but in many instances it is equally difficult to alter the position even in the direction imposed by the spasm. If the shoulder and neck are contracted, resistance may be experienced not only in pushing the head towards the normal shoulder, but also in moving it farther in the direction of the affected side.

The so-called paralysis of the tongue is another good example of this rule. On protrusion it deviates, say, to the right; with organic disease this would signify loss of power in the muscles of the right half, and the tongue would in consequence be withdrawn to the left. If the deviation is due to hysteria and the tongue is thrust out to the right, this position is maintained, even when it is returned to the mouth.

Sometimes movement is positively inhibited; the patient says, "I cannot move my leg," and it hangs inert, or is dragged behind him like a log. If, however, he is laid upon the bed and asked to kick his leg into the air, you will be able to determine, by placing your hand under his heel, that it is pressed strongly into the bed. Turn him over on to his face and ask him to bend his leg so as to raise it in the air; you will now find that the toe is strongly thrust downwards. On each occasion he responded to your command by an exactly opposite movement. In the milder examples of loss of power or inability to stand on one leg, the nature of the affection is revealed by the following trick. If it has been determined to the satisfaction of the patient that he cannot support his weight on the right foot, tell him you are quite satisfied that the right is affected, but that the left is his "good leg." When he is standing steadily, give a sudden command, "Kick out your good leg"; this he will do, although it necessitates balancing himself upon the affected foot. On the other hand, follow this quickly with the order, "Kick out your bad leg," and he will fall, although he is supported on the normal limb. Sometimes the patient is completely unable to stand or to walk, but judicious examination demonstrates that he can make all the necessary movements when lying on his back.

Inco-ordination of movement, apparently due to lack of recognition of the posture of the affected limb, is a not uncommon manifestation in hysteria; but it usually differs fundamentally from ataxy of organic origin. Suppose a cerebral lesion has made it impossible to touch the nose with the forefinger of the right hand, when the eyes are closed, you will find that the normal (left) hand has, as a rule, greater difficulty in finding the tip of the affected forefinger than vice versa; for it is the position of the right hand which is unknown, and it is this which leads to the difficulty. The defect is the opposite in hysteria; for since no good action can be carried out by the affected part, the right (affected) forefinger makes wild attempts to find the left hand, whereas the normal hand is rapidly brought correctly into contact with the part whose position is nominally unknown.

Again, when the patient attempts to touch his nose with the forefinger, it may deviate widely from the mark and always pass to the same side of the head; but if the head is pushed over in that direction, the finger will now deviate still further, as the goal is brought closer to the position usually reached by the hand.

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Not infrequently, if he is allowed to stand comfortably and the eyes are closed to command, the patient tends to fall; but if he is placed in exactly the same position and is told you are about to test his pupils, you can place your hands over both his eyes without the least sign of instability. He knows he cannot stand with his eyes closed, but this has nothing to do intellectually with testing his pupils.

No phenomena of hysteria are more instructive and at the same time more misleading than its sensory manifestations; pain, or rather oversensitiveness to manipulation, is extremely common. A weight falls upon the foot of a workman, and from that time he complains of pain and tenderness. The distribution is not that of any peripheral nerve or posterior root, and can only be explained by mental considerations. A similar law governs the form assumed by hysterical anaesthetics. It is undoubtedly true that loss of sensation of this character is mainly due to suggestion on the part of the medical man; but once this has occurred the form it assumes is significant. It occupies the foot below the ankle, the hand bounded by the wrist, or it may be limited by a line round the elbow, the shoulder, or the knee. The belly may be affected without the back; the face exclusive of the cornea and the lips. Moreover, the outside of the cheek may be analgesic, whereas the sensation of the buccal mucous membrane is intact. It is possible for a physician by examination to produce other forms of sensory loss; but it seems to me that the usual distribution is due to the following reasons. When I say to you, "hand," those of you who visualize strongly will see a picture corresponding to all the parts below the wrist; in the same way, if I say "foot," there is a tendency to call up a picture of all below the ankle. If I say "belly," you see the abdomen between the pubes and the ensiform with the navel in the centre; but, anatomically and physiologically, the belly is nothing but the anterior half of a column of which the back and loins form the posterior portion. When therefore sensation is disturbed from structural or physiological causes the distribution of the abnormal areas extends both in front and behind. On the contrary all forms of disordered sensation of mental origin tend to affect the front without the back, or the spine without the chest and lateral parts of the trunk; for this is the way we normally think of the surface of the body, and in hysteria we are dealing with paralysis by idea.

For this reason the tender spots, which may be present on the surface of the body, tend to react in a peculiar manner. Let us imagine that the patient has a tender area in the right iliac fossa, simulating that caused by the appendix: he will complain that the point of a pin dragged gently across the skin causes exquisite pain. So far there is nothing to show that the condition is not due to an organic cause. Having once established the extent of the area within which the patient complains of tenderness stimulate him over this part with cotton-wool and he will not uncommonly react excessively, although a touch with cotton-wool is not potentially painful. It is the position of the tender spot, and not the physiological nature of the stimulus, which dominates his consciousness.

Sometimes the distribution of the sensory disturbance may be determined originally by an organic lesion. I saw a sergeant in whom a bullet had passed through the front of the ulnar aspect of the forearm. An hysterical analgesia extended from the site of this wound, and occupied one half of the palm and the little and ring fingers. Behind, it not only affected the ulnar half of the hand and forearm, but ran up to the elbow-joint; for here there was no transverse wound, as on the anterior surface, to limit its extent.

The use of a large tuning-fork will not infrequently dispel the idea that a loss of sensation, apparently following an ulnar distribution, is due to the destruction of the nerve. Place the strongly vibrating fork on the anaesthetic area of the palm and the patient will deny that he can appreciate it until it passes on to normal parts; and yet the vibration, widely conducted on the palm, is evident to the hand of the observer far outside the boundaries of the loss of sensation.

Limitation of the field of vision at one time occupied an important place amongst the signs of hysteria. But, since Babinski's statement that it is due to suggestion on the part of the examining physician, it has fallen into undeserved disrepute. For the very fact that a condition of this kind can be manufactured in a patient is striking evidence of the nature of the disorder from which he suffers. The normal field of vision consists of a central portion where colours can be accurately distinguished; outside this lies a zone of considerable extent, which is colour blind, although all shades from white to black are clearly visible. Here coloured

objects are appreciated according to their luminosity and not their chromatic value. Green is said to be "light" or "whitish," red "dark" or "greyish"; this response is heightened by mounting the green object on a black background and the red on a white square twice its size.

During the earliest stages of optic atrophy, for instance in disseminated sclerosis, vision for red and green is frequently diminished and the colour field may be reduced to minute proportions. But outside it still lies a large area of retina, over which these colours are appreciated as "light" or "dark" and the form of the test objects is clearly recognized. In hysteria, on the other hand, they are said to be coloured or are not seen at all, whatever may be the limits of the visual field. This is ample proof that the defect is of mental origin, and experience shows that it is usually suggested by the observer or by his methods of examination. For separate appreciation of luminosity and colour is a physiological phenomenon of which, like the blind spot, we are normally unconscious. But, over a field restricted in consequence of psychical causes, we either recognize or do not recognize an object; vision is not broken up in terms of physiological function, but follows strictly mental lines.

Diagnostically, the visceral manifestations are by far the most misleading. Occasionally the intestines become inflated with gas and simulate a tumour of the abdomen; but such a swelling is resonant to percussion, it does not shift from side to side according to the position of the patient, and the physical signs alter if the head is lifted from the pillow so as to tighten the rectus. If you are in doubt a whiff of chloroform will settle the matter.

Retention of urine sometimes forms a troublesome complication, for it is not wise for you to pass a catheter. Let this operation be performed by a careful and judicious nurse. It is well to remember that incontinence of urine never occurs in uncomplicated hysteria.

Seizures and Fugues.

I have left till the last consideration of the seizures and convulsions which may occur in hysteria, because, to an observer on the spot, they offer fewer difficulties in diagnosis. They are essentially emotional outbursts; the patient makes violent movements, arches her body, and may even simulate tetanus, but the muscles of the abdomen and back are never contracted at the same moment as in this disease. I once was called to a servant maid who had scratched the base of her thumb. Her jaws were tightly clenched, and every few minutes she was thrown into violent convulsions, in which her back was strongly arched. She had already received a dose of antitetanus serum, but observation showed that the movements in no way resembled those of tetanus. Moreover, subsequent investigation elicited that she had been seduced under promise of marriage by a chauffeur, who had embezzled money and fled the country. In her state of anxiety a word by a fellow servant as to the probability that a scratch between the thumb and index finger would produce lockjaw was sufficient to precipitate the attack.

Not uncommonly the patient falls into a dissociated mental state; memory of the occurrences during the seizure may be absent during the waking condition, and consciousness is therefore supposed to have been lost. Such attacks of alternate consciousness are frequently associated with otherwise inexplicable conduct and during the war were sometimes accompanied by extreme violence. This brings us to those remarkable seizures known as "fugues."

A lieutenant in the R.F.A. was wounded in France, but the injury was not severe. Whilst in hospital in England he obtained leave to spend a week-end with his parents. On Sunday afternoon he started on his motor bicycle, intending to return to hospital, and disappeared, but was found several weeks later on a farm where he had worked as a pupil before joining the army. He arrived there on Monday morning, occupied his old quarters, and set to work at once. When the surprised farmer asked him how long he intended to stop he said he had been discharged from the army. He subsequently confessed to me that during the ride he began to think with pleasure of his life on the farm; from that time he had only a hazy recollection of what happened, until he was discovered by his brother three weeks later.

These "fugues" are commonly attributed to amnesia, and the patient is said to remember nothing that happened. This is true in certain instances; but I am convinced that, during some of these inexplicable disappearances, memory is not completely lost, and sometimes a fairly coherent account can be obtained from the patient of how he spent his time. He loses all appreciation of the cogency of the reasons against the line of conduct he adopts, and his personality may have

undergone a subtle transformation. But he can often remember the desires which lay behind his mental conflict, and give some account of his disappearance. Such fantasy building was responsible for many aberrations of conduct in young officers during the war, and lies at the bottom of those curious cases, met with in civilian life, where a woman for a time leads a purely fantastic existence.

Mental Causes of these Physical Manifestations.

When we attempt to express these morbid phenomena in general terms we are struck by their positive nature. There is nothing negative about the manifestations of hysteria; even the anaesthesia is due to refusal to accept impressions, which otherwise run their normal physiological course. Amongst the disorders of motion, the tremor is due to actively repeated movements, rather than to failure of static tone; spasm is the assumption of a definite posture and not the reflex over-activity of some lower function; the so-called hysterical paralysis is the effect of direct inhibition, an active expression of the conviction in the patient's mind—"I cannot move."

Closer analysis of these positive phenomena shows that they depend on three mental factors—proneness to auto-suggestion, a negative attitude to orders from without, and a tendency to the state known as "dissociation." There has been much dispute concerning the extent to which these patients are suggestible; hypnosis frequently fails lamentably to remove their disabilities, in spite of the ease with which a suggestion is accepted that falls in with their morbid state of mind. Many hysterical joint affections start in some remark by the medical attendant, and the nature of the anaesthesia, or the form assumed by the fields of vision, are all examples of antitherapeutic suggestion. Associated with a ready acceptance of some morbid idea by the hysteric is an instinctive opposition to external commands. Place your hand lightly around the arm, so that the fingers cover the biceps and the thumb is in contact with the triceps; tell the patient to bend his arm, and the first muscles to contract are the extensors. Give the opposite order, and instantly the biceps can be felt to tighten. This "negativistic" attitude, as it is called, permeates the whole mental activity of the hysteric. Thirdly, there is a profound tendency to what is called "dissociation." This expression was employed by Pierre Janet to indicate a state in which some aspect of mental activity had become split off from the conscious functions of the mind and lived, as it were, an isolated life. He used the conception to explain not only the lapses of memory, fugues, and dual personality, but also the anaesthesias and hysterical paralyses. Now, there is no doubt that we possess the power of refusing to accept impressions, even under normal conditions. Experts at the direct method of ophthalmoscopic examination keep both eyes open; but the one which is not applied to the back of the mirror is, for the time being, psychically blind. In the same way, when shooting, both eyes remain open, but alignment on the bird is made with the right alone. The hysteric, like the hypnotized person, has this power in a still higher degree. He can shut off all impressions arising from one limb so that they do not disturb consciousness; and yet his reflexes are normal and, with hysterical blindness, he can avoid obstacles in the room. Automatic acts are performed with ease, though voluntary responses are inhibited or obstructed.

If these are the factors in hysteria, how is this remarkable state of mind induced? It is essentially an irrational answer to a conflict. A young woman, who is a candidate for an examination which she feels is too difficult for her powers, can solve the problem illegitimately by spasm of the right hand. A soldier suffering from fear, knowing he cannot run away, finds a perfect and honourable solution in hysterical paraplegia.

But in many cases the underlying cause is far more subtle. Many of you know the evil effects of not answering promptly a disagreeable letter. Perhaps it remains unopened in your pocket, and all day you feel that some unknown misfortune is about to befall you—you are "off your game," you are certain that you are in for influenza, or at least for a bad cold. All these ills are an expression of the unresolved emotion evoked by that unanswered letter.

This is an example of the evil effects of repression, or an attempt to shirk some unpleasant experience by expelling it from consciousness. But fortunately we can sometimes forget even disagreeable facts without harm. In order that repression may produce evil consequences the idea, charged with emotion, must have been thrust out of consciousness; the patient dislikes it with such intensity that he refuses to

face it squarely. The emotion accompanying such an idea may then appear in some substituted form, such as vomiting, headache, or paralysis. If, for example, a patient expresses to you a moral repugnance to taking food, it is well to consider whether her statement does not hide some real cause for moral doubt and anxiety.

Fear is the most potent reason for repression. All children and animals experience fear; this is suppressed in the adult, who, under normal conditions of civilized life, experiences anxiety only. But deep down lies fear, ready to spring into being when inhibition is removed—as, for example, during sleep. Now in civil life fear of disease is extremely frequent. Some are so subject to this form that they dread each disease in turn, as it becomes the fashionable centre of discussion in the popular press. Such fears, dismissed from consciousness without reasonable consideration, are liable to work havoc in the underworld of our minds.

Some relationships are by their very nature liable to be highly charged with emotion. "No man," Bacon said, "can speak to his child but as a father"; and parental fear is the basis of many anxieties. Conversely, however, adoration of a son for his mother, or a daughter for her father, underlies many of the difficulties which may arise subsequently in marriage.

Marriage without physical affection is an impossible human relation; one of the simplest methods of escaping from such difficulties is the development of a physical illness. In the present day many women embark heedlessly on associations that are bound to lead to emotional trouble; the so-called "friendship" with a married man, whose wife "does not understand him," is a state of unstable equilibrium. Fears in women of marital relations, or of pregnancy, can usually be traced back to some terrifying experience in childhood or adolescence.

A very important element in the production of a conversion hysteria is a want of capacity to face failure. The schoolboy cribs to save himself from disgrace; the hysteric loads the dice to produce an effect that would have been impossible by honest toil. Hence the frequency of direct malingerer—as, for example, the production of factitious sores. To be interesting is to be endowed with power; a paralysed girl with a charming and modest manner can attract universal attention from the simpler sex.

Treatment.

I cannot close this discourse without saying a few words about treatment. If possible, the patient should be removed from the usual surroundings and new influences brought to bear. An attempt should be made to switch the dissociated part into the continuity of the patient's mental life. Every form of persuasion should be exercised to convince the patient that he is able to carry out the action he is convinced to be impossible. Never bully him or accuse him of dishonesty. No one is a greater failure than the medical officer who wishes all hysterics could be shot at dawn. On the other hand, the firm diplomatist with subtle and demonstrable reasons why the patient can stand, walk, or feel, often produces miraculous cures. But it must never be forgotten that in a large number of cases, especially in civil life, removal of hysterical symptoms is only a prelude to the discovery of an anxiety neurosis. The causes for the suppressed emotion must be investigated, or the patient may be left in an even worse condition than that in which you found him.

To the medical man I would say, see that you do your patient no harm by antitherapeutic suggestion; carefully prune your conversation, and do not think out your diagnosis aloud. Purge your mind of vague phrases, and avoid such words as "neuritis." Some diagnoses, such as "floating kidney," are more deadly than the disease. Avoid thinking in terms of surgery when dealing with functional neuroses. When you find that a patient is vomiting, do not let your mind at once leap to gastro-enterostomy. Be natural, but on guard; you will then be ready to deliver your blow at the moment required. At the same time, remember that your most brilliant conversation is useless with an hysteric; she is interested in herself, not in you.

Nature's moral code, under which we work, is cruel and unrelenting. There is no forgiveness of sins; but, in the medical man, this knowledge should be tempered towards the patient by clinical curiosity and human sympathy. In conclusion, I would say to all who have to deal with these morbid conditions, be as honest in thought as you would be naturally in deed. Act without fear and never lose courage; finally, call nothing common or unclean.