ment, or from within by rupture of the lung, which again is very liable to result from this treatment, when recurring fluid causes a high intrapleural pressure, and a pleuro-pulmonary fissure may be established. Streptococci, staphylococci, colon bacilli, and many forms of anaerobic organisms have been found. The greenish tint of tuberculous pus now disappears; the effusion is of a dirty yellow colour, is definitely thicker, and has an excess of polymorphs. The effect on the pleura is thickening, by increasing fibrosis of its external layer.

There is no evidence that the prognosis is any worse than that of uncomplicated tuberculous empyema: some observers say it is better; but the literature on treatment is full of contradictory advice, and leaves one with the impression that unlike conditions are being compared, and the individual patient lost sight of in the battle over the comparative advantages of conservative and radical measures.

Conservative Treatments

Conservative treatments range from aspiration, aspiration and air replacement, aspiration and irrigation with so-called antiseptics as saline, gentian violet, acriflavine, and Dakin's solution, up to replacements with gelatin and the various forms of oleothorax. Widely varying results have been reported, each method having its champions prepared with irrefutable arguments for its mechanical and disinfecting properties. Thus Rosenblatt quotes twenty-one cases treated by aspiration and replacement with a saturated alcoholic solution of methylene-blue, and all followed up for from one and a half to eleven years. Eleven survived, but the period necessary for them to become fever-free was five months to two years; in only four did he continue pneumothorax when the cavity was entirely free from effusion, and then re-expansion produced more retraction and mediastinal displacement than ordinary pneumothorax, which may be a not altogether unmixed blessing to the patient.

The same applies to oleothorax. Some writers are still claiming disinfecting properties for gomenol, although Gloyne showed in 1927 that it has no such value, and can act for good only by producing a thickened and therefore less permeable pleura, thus inhibiting or delaying the absorption of bacillary toxins. Bufalini quotes four cases to show its special value; Gullbring, fifteen which were not favourably influenced. Recently, Josevitch has made claims for the oil of cajuput, saying it is less irritant and toxic, while it dilutes the substances affecting the pleural surfaces, but he advocates it as a permanence only where radical treatment is impossible. This is in keeping with the conclusions to be gathered from published results as a whole, where major surgery shows up as far superior to all conservative treatments, and thoracoplasty as the method of choice. Intercostal tube drainage by open or air-tight methods may, of course, be indicated as preliminary by toxicity.

As in pure tuberculous empyema the prognosis is improving with advances in technique. Thus Berry reported of seventy-five cases only fifteen recoveries, but Hedblom has recently obtained obliteration in thirty-seven of fifty-nine, and the Tuberculous Empyema Commission states that of 134 with virulent infection sixty-five were cured and twenty-eight clinically well. These figures are a great advance on Hedblom's result of only six recoveries in sixty-one treated by conservative and minor surgical measures.

Conclusion

We must therefore agree with the finding of the last report of the Committee of the National Tuberculosis Association of America that while no one seems to have found a specific for this distressing complication, we can only hope to follow the method productive of the greatest good, and conclude that while a predominantly tuber-

culous infection may warrant conservative treatment, a predominantly secondary infection or an underlying lesion which renders the empyema a secondary consideration demands major surgery.

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MAJOR HYSTERIA*

BY

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To those who are unfamiliar with the endless variety of physical disturbances which may occur in hysteria the disease presents many diagnostic pitfalls. It is my intention in this paper to give some illustrations of these and to attempt to show how the disease may be diagnosed and how it may be treated. I shall endeavour to use simple terms to explain what seem to me to be the mental mechanisms through which hysterical states are liable to develop.

Evasion and Dissociation

Most of us have the germ of hysterical behaviour in ourselves. Our ability to forget unattractive appointments, and our desire to be deaf to unpleasant facts show a mental process not unlike that seen in major hysteria. In these examples our forgetfulness or deafness relieves us of some mental disturbance or bother. We do not really fail to remember or to hear, but we are able to push unpleasant facts into a corner of our brain which we are able to forget about in everyday life. In achieving this we demonstrate our ability to split our mind into compartments which are almost "watertight." In hysteria this faculty is developed to a remarkable degree, and is described under the term—dissociation of the personality. Both in our own case and in the case of the hysteric, this juggling trick which we play with our minds enables us to avoid some difficulty, and there can be no doubt that the individual who makes a habit of evading awkward situations is thereby cultivating a series of mental processes which, under certain circumstances, may lead to the development of some manifestation of major hysteria.

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Hysteria is more common in the female than in the male, and this is probably due to the fact that our social habits tend to protect her from unpleasant situations, and in some ways encourage her to avoid difficulties. By means of this habit of splitting the personality it is possible to evade reality, and many people live in a world of fantasy with the aid of this trick. Such people interpret events in the way which gives them most pleasure. This habit, which is so marked in hysteria, seems to be rather an irresponsible and lazy way of dealing with the hard facts of life. Further, the desire to avoid difficulties leads such people to depend unduly on those with whom they live. This common desire or tendency to fall back on others for help is illustrated by the lady who prefers that notice be given to the cook by her husband.

One remarkable effect of what one may call the evasive attitude to the difficulties of life is that the person who goes through life in this way is of little use in an emergency. Unaccustomed to deal with difficulties she may react to an alarming situation by hysterical screaming or by passing into a state of hysterical coma. The screaming reaction is likely to develop when there is an imminent risk of physical injury—for example, if the house goes on fire. When, however, there is no imminent physical danger, the response to a distressing situation will more often be the development of an unconscious state. An accident may have been witnessed; the experience is very upsetting, and the individual carries out the remarkable conjuring trick which enables her to put the whole of her mental processes into the corner which she forgets. In this way she passes into a state of oblivion, in which she can neither see, hear, speak, move, nor feel.

It is obvious that the hysterical reactions in these examples enable the individual to escape as far as possible from the difficulties of the situation. No one expects a screaming woman to do anything helpful if the house goes on fire; while the scream carries the message "Come and help me!" and illustrates again the tendency to fall back on other people for help which these cases show. Hysterical *fainting* will never occur when such a reaction involves physical danger to the individual, as when the house goes on fire, but in certain circumstances, as in the second example, a period of unconsciousness provides an obvious method of escape from an unpleasant situation.

"Subconscious Malingering"

The reluctance to face unpleasant situations is therefore a common tendency in the community, and is found in all classes of society. An ability to dissociate the personality may be made use of to achieve this purpose, and when it is exercised to an extreme degree major hysteria may result. Now just as we, unless we use unusual self-analysis, fail to realize why we have forgotten about an inconvenient duty, so the hysteric fails to realize why he has become deaf, dumb, blind, paralysed, or tortured with pain. There is always, however, a very definite reason both for our forgetfulness and for the development of hysterical symptoms. By making use of this trick of dissociation, the individual, as far as one part of his personality is concerned, refuses to remember, or to see, or to move; so that a part of the mind is actually exercising deliberate fraud. If you accept this interpretation of the mechanism of the mind in hysteria, then we can conclude that the hysterical reaction is really one of "subconscious malingering." The true conscious malingerer knows what he is doing and why he is doing it, but the hysterical patient succeeds in shutting off the malingering part of his mind so success-

fully that his ordinary or principal personality does not realize that there is anything unworthy in his behaviour.

It should be strongly emphasized that the development of hysterical disturbances always achieves some selfish purpose, and for this reason the patient displays a peculiar state of unconcern at her disability. This *belle indifférence*, which Janet emphasized, will in many cases suggest at once to the experienced observer that the symptoms are hysterical. When a normal person becomes blind or paralysed from the effects of organic disease he is always somewhat concerned. The hysteric often, however, shows little concern, and is usually brought to see the doctor not on her own initiative, but because of the anxiety felt by sympathetic relatives.

Suggestibility

Another feature of individuals subject to hysterical attacks is the extraordinary degree of suggestibility which they show. For example, in a case of hysterical anaesthesia it is quite easy to suggest to the patient that some part of the skin will be very sensitive, say at the base of the nails. In this way a part that was previously anaesthetic may become exquisitely tender.

This suggestibility gives a clue to the method by which the patient produces hysterical phenomena. These phenomena are probably produced by the power of suggestion exerted by one personality on a second personality. The second personality, for example, decides that it is desirable that one limb should become paralysed, and succeeds in suggesting this so effectually to the main personality that paralysis actually develops. The second personality, in fact, hypnotizes the first. It is not surprising, therefore, that the phenomena seen in hysteria resemble very closely those seen under hypnosis. In hypnosis the personality of another person suggests the phenomena which should occur, while in hysteria it is a second personality in the same individual which provides the suggestive force.

The two points, therefore, which I wish to emphasize particularly are that hysterical manifestations achieve some selfish purpose, and secondly that the disturbances which occur are produced by a process of suggestion. These points are of great importance when we come to consider the most suitable line of treatment for cases of hysteria.

Diagnostic Difficulties

The clinical features of major hysteria are so protean that experienced physicians often mistake the resulting clinical picture for that of serious organic disease. In my own experience I have known hysteria to be diagnosed as epilepsy, tic douloureux, encephalitis, brain tumour, migraine, disseminated sclerosis, poliomyelitis, amyotrophic lateral sclerosis, myelitis, rheumatic fever, tuberculous disease of a joint, and acute abdominal emergency.

I propose now to describe a few cases of hysteria which illustrate some of the difficulties in diagnosis which may be encountered.

CASE I

A woman aged 31 years was admitted to the National Hospital for Nervous Diseases in London, suffering from double vision and indistinct vision, which had been present for three years. On examination there was an internal squint with small pupils immobile to light. The movements of the eyes separately were full, and it became obvious that there was hysterical spasm of convergence. The condition was quickly cured, but recurred after leaving hospital. She was then taken to see a brain surgeon, who, after carrying out ventriculography, diagnosed a tumour of the third ventricle. Operation was carried out, but no tumour was found. The patient died as a result of the operation, and at post-mortem examination the brain was found to be perfectly normal.

CASE II

A chemist, aged 21 years, was admitted to Ward 21 of the Edinburgh Royal Infirmary in August, 1933, where Professor Murray Lyon asked me to look after the case. He was then suffering from complete paralysis of the legs and trunk, which had been present for six months. The paralysis followed an attack of influenza. After this illness the patient was admitted to hospital, where he remained for three months without improving. The diagnosis made at this time was that of amyotrophic lateral sclerosis of the spinal cord.

He was later admitted to Professor Murray Lyon's ward on account of slight glycosuria, which proved to be of no significance. On examination the muscles of the trunk and legs were found to be in a state of great rigidity and almost complete paralysis. The slightest attempt to move the legs appeared to cause great pain. The reflexes were normal, and the jerky attempts at voluntary movement made the diagnosis of hysterical paralysis obvious. The arms were quite normal. The patient was treated in the usual way, and he was able to walk quite normally when discharged from hospital. No satisfactory explanation for the development of his symptoms was discovered at that time. After leaving hospital he went to visit some friends in England, where he had massage treatment for his legs. While having this treatment he got steadily worse and was finally admitted to hospital, where his condition was diagnosed as rheumatic fever. He again developed complete paralysis of both legs, and had to be brought home by ambulance. His doctor asked me to see him again, and when I examined him in his own home four months after he left the Infirmary he had well-marked hysterical paralysis of both legs. I questioned him very carefully with regard to anything that could have caused the condition. At first he could tell me of nothing that had been upsetting him, but just as I was beginning to despair of finding the cause he said, "Oh, well, I'll tell you." He went on to say that his heart was in the open air of the country, and that he dreaded the thought of spending his life in a chemist's shop. He had never told his people about this, and they were greatly surprised when I told them. It is probable that his original illness had given him time to think over his future, and the more he thought about it the less he liked it. His evasive attitude to difficulties prevented him from frankly expressing his fears to his relatives, and so his second personality succeeded in suggesting to him that he should remain an invalid in order to get out of his job. The patient is an only child. His father died of alcoholism. He lives with his mother and aunt. The latter is mentally unstable. I attempted to explain to him how his symptoms had arisen, and advised that he should take up some work that was more congenial. A dramatic improvement followed this interview, and within a few days he was able to walk again. His doctor kindly informed me nearly a year later that he has remained well, and that he spends the day looking after his hens. He develops a slight limp if he walks far.

An interesting feature of this case was that when the extensor spasm of the legs was forcibly overcome, not only was there a marked emotional reaction with weeping, but the patient at once developed paralysis of the arms. His second personality was no doubt determined that paralysis of some sort should persist. We paid no attention, however, to the paralysis of the arms, and it passed off, as we assured him it would, by the following day.

The development of hysterical paralysis following some illness is not uncommon in children. It is often caused by the fact that the child enjoys the extra attention she receives, and therefore determines to continue her illness for as long as possible.

CASE III

A married woman, aged 44 years, was sent to see me on June 20th, 1934. She was suffering from a partial paralysis of the legs which came on six weeks previously. The paralysis came while she was lifting a heavy basket. There was a feeling of great strain in the back, which made her collapse. Her feet then began to go dead, and this dead

feeling gradually spread up her legs. By the time her doctor arrived a few hours later there was complete paralysis of both legs and also of the left arm. Later she became partially blind, and had double vision. She was violently sick every morning, and complained of great pain in the back. Her condition was diagnosed as rheumatic fever, and she was kept in bed, with two nurses in attendance. She did not, however, approve of this diagnosis, and changed her doctor. By the time she was sent to see me she was able to walk a little, but the gait was fantastic and obviously hysterical. Physical examination revealed no change in the reflexes, and the jerky attempts at movement confirmed the hysterical character of the disability. Sensation was not tested, as it is better to avoid testing for sensory loss in these cases if possible. The ocular disturbances, which were no doubt due to a spasm of convergence, had passed off.

On inquiring into her private affairs I learned from her that she had been married for six years to a man considerably below her own social class. Her husband worked in a corporation department, and paid no attention to her at all. She said that he was terribly selfish, and was interested in nothing but his achievements as a golfer. Three years ago, when abroad, she had a similar attack of paralysis, which came on after she found that her husband had been unfaithful to her.

She was advised to go away from her husband for a time and was told that she would soon make a complete recovery. She left home and was soon quite fit again. She has now returned home, and her doctor has recently informed me that her walking is now quite normal. Unfortunately her relations with her husband are still very strained, and there are some financial worries. Her doctor writes to say: "She has made a wonderful recovery, but is surrounded by so many snags that she might go off the deep end again if any of them should trip her up!"

This patient is quite a normal person, just as normal as many of us are, and her case illustrates how hysteria may develop in quite ordinary people if circumstances are sufficiently adverse. This was well seen in the so-called shell-shock cases during the war. These were, of course, cases of major hysteria which had developed in healthy young men under the stress of modern warfare.

Another point worth noting is that in a large proportion of these cases there is a history, as in this case, of a previous breakdown of some sort. Recently, for example, I was asked to see a nun with hysterical paralysis, the subconscious purpose of which was to get out of doing her work in the convent. The history of her case revealed that at the age of 16 years she had had a breakdown following her mother's death. The chief symptom of this was general weakness, but the illness lasted for several months, and during this period her sisters looked after her.

Hysteria is not uncommon in convents, as the decision to become a nun may be due to a desire to get away from the difficulties of life. This, as we have seen, is the type of personality liable to develop hysteria. During the sixteenth century there were outbreaks of hysterical convulsions in many convents. As soon as one nun was attacked it would spread to all of her colleagues.

Hysterical fits are remarkably common, and many such cases are brought into the out-patient departments of a general hospital.

CASE IV

An unmarried woman, aged 25 years, was sent to see me in November, 1932. She had suffered from fits for eight years. These had been very frequent recently, but had stopped while she was in a nursing home. A neurologist had diagnosed her condition as being due to petit mal. This diagnosis seemed the likely one until her mother informed me that as she was coming out of the attacks she always said, "Oh, Daddy!" Another suspicious feature of her history was that after being away for a holiday she had repeated attacks the very day she arrived home. This patient's father died of alcoholism a few years previously, and the mother's devoted care of her only

child was unable to protect her from witnessing some scenes which must have been very distressing to the girl. While it was difficult to be certain that the fits in this case were entirely hysterical, I thought it wise to try the therapeutic test. I therefore discussed the problem with her on two or three occasions, stopped the luminal she had been taking, and assured her that she would have no further attacks. I think she came to realize that the attacks had probably been started by the strain of having to face her intoxicated father, and she was delighted to know that they were of no serious significance. It is obvious that the examiner must show to the patient no trace of any doubt he may have with regard to the diagnosis. She was encouraged gradually to resume her full activities, which included dancing and many games. It was also important in this case to attempt to lessen the girl's dependence on her mother, so we advised her to get into the habit of making her own decisions, and of facing her difficulties without having recourse to her mother's help and advice. There have been no further fits since that time, which is now over two years ago, and the patient's general health is excellent.

There is no time to refer to many other forms of hysterical disturbance, which include deafness, blindness, aphonia, amnesia, blepharospasm, contracture, tremor, and spasms of various types. They are usually easily diagnosed by anyone familiar with the signs of organic disease, who remembers and realizes that hysteria may cause an endless variety of symptoms. Considerable difficulty in the diagnosis may arise when hysterical manifestations develop in a patient suffering from organic disease. For example, a patient with slight optic atrophy may, by means of a hysterical mechanism, become quite blind. This combination of organic and functional disease may lead to claims of "cure" of organic disease made by any variety of treatment from osteopathy to a visit to Lourdes.

Practical Points in Diagnosis

The diagnosis of hysteria becomes almost a matter of instinct. There is something very characteristic about these cases. As has been already mentioned, there is an attitude of unconcern with regard to the symptoms. In addition to this the patient shows an absence of frankness in describing her symptoms, and may appear to be watching you out of the corner of her eye, so to speak, as though she expected to be blamed for her incapacity. With regard to the motor disturbances which may occur, the diagnosis is based on the failure of the type of disturbance, combined with the physical examination, to agree with the symptoms and signs of organic disease. Irregular and jerky attempts at voluntary movement are very characteristic of functional weakness. The tendon reflexes are often very brisk, but the abdominal and plantar reflexes are normal. The brisk abdominal reflex is particularly useful in excluding organic disease in cases of spastic hysterical paralysis. It is important to remember that hysterical symptoms may include great pain, a symptom which often misleads the physician. The most useful weapon of all with which to diagnose these cases is experience of nervous diseases, both functional and organic.

Principles of Treatment

Treatment is usually highly satisfactory if it is directed to combat the factors in the aetiology of hysteria which I have put forward for your consideration. As I have mentioned, the hysterical manifestation gives subconscious satisfaction because it has enabled the patient to evade some difficulty or to achieve some selfish purpose. We must also remember that the symptoms have been produced by a process of suggestion, and that the patient's suggestibility will often enable the symptoms to be cured by the same means.

In the first place, it is wise to approach the problem with great sympathy and understanding. We must never scoff at symptoms, and must not use terms such as hysteria or nerves to the patient or relatives. Having concluded that the symptoms are largely or entirely functional, we adopt a quietly confident attitude. We can explain to the patient that the nervous system becomes overstrained and sensitive, or, in a case of paralysis, that the muscles are working against each other. We go on to explain that with suitable treatment the condition will quickly get better. If the cause of the symptoms is apparent then the removal of the circumstances which caused the breakdown will suffice to effect a cure. In order to avoid any recurrence we have a talk to the patient on two or three occasions and, by explaining how the symptoms have arisen, indicate that prevention of future attacks rests with herself. If the case is severe and of long standing we insist on removing the patient from her environment, which is usually responsible for perpetuating the incapacity. We explain that a complete rest is necessary, and take the patient into a home or hospital. We keep all visitors and letters away, and the patient is not allowed to read. She is visited only by the doctor and one or two nurses accustomed to deal with such cases. Endless trouble is caused by people seeing the patient or treating her (masseuses, for example), who, instead of distracting the patient's attention from the disability, draw her attention unduly to the affected part. After the first examination no further examination should be carried out except for the purpose of demonstrating improvement. It is better never to test for hysterical anaesthesia, but to ignore it.

Discipline and Co-operation

While the avowed purpose of this type of Weir-Mitchell treatment is to rest the patient, the real value of it is that it removes the patient from sympathetic relatives, and that it also removes any factors which allow the hysterical incapacity to give satisfaction. The patient soon begins to ask for the regime to be relaxed, but we sympathetically insist that we can afford to take no risks and that complete quiet must be continued until the incapacity is *cured*. This trifling discipline is a splendid stimulus towards recovery, for by insisting on the strict regime we remove the last trace of satisfaction derived by the incapacity, and substitute a strong suggestive force, which conveys the thought, "The sooner I get better, the sooner I'll get out of this." However much the patient complains, the doctor must be quite firm. This has the added benefit and tonic that, for the first time for probably a very long while, the patient is having to do what she is told to do, whether she likes it or not. Most patients will co-operate without more than a few mild protests, but a few will become frankly abusive, either to the doctor or, more probably, to the nurse in charge. In such circumstances it is the doctor's plain duty to speak very frankly to the patient and to indicate that she is making no effort to co-operate in effecting a cure, and that the patient's whole attitude is one of extreme selfishness. He can also say that if she does not want to get well she had better go home. A little frank exchange of opinion along these lines has sometimes the most pathetically dramatic results. The patient often realizes only too well the truth of your accusations, and, after having been given time to consider the position, decides to do anything advised and apologizes for what she has said. This type of hysteria, which requires a little firm talking to, is fortunately not common; usually the whole treatment can be carried out with the preservation of cordial relations between the doctor and patient throughout. The following was a difficult case of this type.

CASE V

An attractive woman aged 34 years, the wife of a clergyman abroad, began, three years ago, while recovering from the effects of tonsillectomy and otitis, to suffer from pain above the left eye. No physical cause for the pain was found, and injection of the Gasserian ganglion with alcohol was attempted on two occasions. This, however, made the pain much worse, although considerable anaesthesia of the left side of the face was produced. In August, 1934, she came to this country as the pain was still very severe. The pain seemed to be very genuine, and was associated with twitching of the left side of the mouth. It was therefore considered advisable to divide the sensory nerves to the face on that side, and the fifth and ninth nerves and the nervus intermedius were divided in succession. Severe pain, however, continued to be complained of.

There was little evidence in this case that the pain might be functional. At the time the pain began, however, the patient, who had been ill, had been finding her duties as a clergyman's wife very tiring, so much so that she felt she could hardly face her responsibilities at that time. Another noteworthy detail was that her husband had become excessively fussy about her during her illness, and this might have caused considerable subconscious satisfaction. We accordingly decided to admit her to hospital, and to treat her as a functional case. Professor Bramwell kindly admitted her to his ward for the therapeutic test to be carried out. It was obvious that no half-measures would suffice in this case, so, with the patient's full approval, we instituted a strict regime. We sent her husband away, although he protested strongly that she would be much worse if he were not there to comfort her. A strict Weir-Mitchell regime was arranged, and the patient was left quietly to herself, except that the doctor and sister-in-charge visited her occasionally, to give her a few words of encouragement. As usually happens in these difficult cases, complaints began in a few days, and the patient's apparent charm became less obvious. She went out of her way to say unpleasant things about individual members of the nursing staff to their colleagues. After a week she became very difficult, and said she was no better and that she might as well be sent out. This gave the opportunity which should never be shirked in cases of this type. We firmly told her that she was making no attempt to co-operate and was behaving in a very selfish way, etc. We also told her that if she did not wish to get well she could go out whenever she wished. The effect of this frank talking-to was remarkable. After thinking it over she decided that she would stay in hospital, and apologized for what she had said. The pain disappeared in a few days, and she left the ward after a stay of two and a half weeks in all. For the first time for three years she was free of pain. I shall quote from a letter received recently. "I must thank you just ever so much for all you did for me. Only you and Sister know just all you did do for me. I can only look back on that two and a half weeks with a feeling of deep humiliation and remorse, and yet I am grateful, really grateful for it. My husband is looking so different already, he was so thrilled to find me so much better." Further letters show that the improvement has been well maintained.

As you can well realize, cases such as this may be very difficult and exhausting to deal with.

Many forms of treatment are useful according to the degree of suggestive force they can convey. Strong faradism can be used very effectively as a suggestive measure in cases of flaccid paralysis, aphonia, and hysterical gait. The forceful overcoming of contracture is most effective if accompanied by the suggestion that the procedure will cure the condition. This manipulation is accompanied by considerable apparent pain, but the main reaction is emotional, and the patient invariably weeps as she sees her treasured stiff leg bending. A sudden fright, a thunderstorm, or a visit to Lourdes may also cure hysterical paralysis in a most dramatic way. Some doctors treat cases of hysteria successfully by methods which appear to be brutal and, while one prefers to avoid such methods, the results achieved are often very

satisfactory, and permanent. Some years ago the Medical Committee of the National Hospital for Nervous Diseases, London, gave me permission to follow up a series of cases of hysterical paralysis which had been treated in the institution. One of these gave an interesting report of her previous treatment.

CASE VI

A single woman, aged 25 years, was admitted to the National Hospital in 1927. Her legs had been weak for three years and completely paralysed for a year before admission. She was treated with massage and faradism by one of the nurses, but made little progress until Dr. X treated her for two hours with faradism and exercises. When I saw her nearly two years later, she said of Dr. X's treatment, "He was awfully cruel, but it was he who cured me, and I have remained well ever since. I felt very bitter and unhappy after leaving hospital, and did not feel a bit grateful when people said, 'How lucky you are to make such a good recovery.'" She said that Dr. X made her lose her self-respect. He told her that her breakdown was due to not wanting to work. She was so upset by this that she made up her mind to recover her self-respect. She therefore started an arts and crafts studio with £2 capital, refused to borrow any money, and succeeded in making her business a success. This was a remarkable achievement, and restored her self-respect.

That case is quite a good testimony to what one may call the bullying line of treatment.

Prognosis: Prophylaxis

The prognosis in major hysteria is always very good if the case can be dealt with adequately, and, particularly if the circumstances which encourage a hysterical retreat from difficulties at home can be adjusted, the cure should be permanent. Complete recovery from even long-standing paralysis may often be achieved in two or three days, and should not take more than two or three weeks. Under trying circumstances, however, the symptoms may recur as long as forty years later, as in the following case.

A married woman, aged 60 years, had been paralysed for eight months before admission to the National Hospital on January 24th, 1930. This paralysis proved to be hysterical, and was quickly cured. This patient at the age of 20, forty years previously, became paralysed following her mother's death, and remained paralysed for six years. Recovery then occurred spontaneously, and she remained fit for a very strenuous life, including very hard work during the war.

Hysterical paralysis is not uncommon in old people, and is usually diagnosed as due to organic disease. There is a charming old lady (aged 75 years) at present in the Longmore Hospital for Incurables whose legs have been quite paralysed for five years. Occasionally, however, she gets up and walks in her sleep without any apparent difficulty.

Prevention is, of course, better than cure. Children should be educated to make their own decisions and to face up to difficulties. On no account should they come to feel that they can get their own way if they make enough fuss about it. If, as is often the case, devoted parents are quite incapable of exercising even a little kindly discipline, then the child should be sent to boarding school if possible, and every effort should be made to educate the parents to adopt a more reasonable method of bringing up their children.

The Cambridge University Press will publish shortly an annotated list of *Medical Practitioners in the Diocese of London, 1529-1725*, licensed under the Act of Parliament 3 Henry VIII, cap. 11. The object of this short book is to show in what manner the Bishops of London handled their great and serious responsibility respecting the licensing of medical practitioners.