

1932

A Modern comprehension of hysteria

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A MODERN COMPREHENSION OF HYSTERIA

By

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A THESIS

Presented to the Faculty of

The University of Nebraska College of Medicine

in partial Fulfillment of Requirements

for the Degree of Doctor of Medicine

Omaha, Nebraska

February 1, 1932

480420

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FOREWORD

On October 14th of this year, Dr. Charles H. Mayo makes the following statement in an address before the American College of Surgeons: "Insanity is the price paid of modern civilization." "Every other hospital bed in the United States is for mentally afflicted, insane or senile persons, and there is an enormous number who are almost fit for the asylum." (See 71), (27). Dr. George W. Crile then demonstrated how emotions, fear, worry, hate and jealousy, affect every cell in the body.

A few weeks later Dr. Willard Stoner, St. Luke hospital in Cleveland, makes the following remarks: "Distorted love life, sex repression and other emotional maladjustments cause most of the nervous disorders. Most great men are neurotic. The list of psychoneuroses include Lincoln, Napoleon, and practically all of the geniuses in arts and sciences. If the extreme energies of this class of people can be held within bounds, much good can be done, but if the defects develop too far they become fanatics, addicts and perverts." (American Congress Physical Therapy, Omaha). (45).

I cite these few examples to illustrate the interest the medical practice in general is giving to the field of psychiatry. From statistics the psychoneuroses are on the increase instead of the decrease. What then, is the future of the situation?

Furthermore, few are the college students today, who pass through a curriculum without seeing one of more of their colleagues fall by the wayside with one of those vague "nervous breakdowns" of which one reads in the daily newspapers. Is there no hope for the future generation? Is the life of this world to be too strenuous for the generations to come? The following paper is written with these questions in mind. One purpose of the paper is to give the reader a modern conception of the mechanisms of one of the vague, prevalent psychoneuroses of the present day, as well as to call attention to the situation that everyone meets in his contact with our more complex, modernistic reality.

The conception that Hysteria is a definite disease entity is of utmost importance, and in the medicine we teach today it should be the general practitioner as well as the psychiatrist, who diagnoses a certain syndrome a true Hysteria, or not a Hysteria.

Perhaps one point that has not been sufficiently emphasized in the following paper is the fact that the psychiatrist often tries much harder and more persistently than the medicine man or the surgeon to locate organic bases for certain expressed symptoms.

Since it is impossible to cover such a large subject as Hysteria in one short paper, the writer has tried to select those things of interest and importance which should be brought before the attention of every physician. The subject matter has been written in as comprehensive a manner as possible; for so many students of medicine say they just cannot grasp certain psychiatric-al conceptions.

An attempt at least, has been made to present to the reader a working, clinical concept of that functional disease, Hysteria.

DEFINITION

Under this heading we wish to convey to the reader a modern-day conception of the term Hysteria; for we remember one of the leaders in this field made the statement that a true definition of Hysteria has never been made, and never will be made. We realize that the term Hysteria has stood for useful concepts varying through many ages. This has meant that the formulation of the precise significance of Hysteria to any age of medicine served a purpose at that time, but later gave way to some other concept. The gradual turning over of the concept and the definition of Hysteria has, however, gone on steadily, responding to the inherent tendency of the human mind to progress, and expand its former limitations.

To define Hysteria adequately is to describe it with reference to the mental and physical phenomena which constitute its clinical picture. The subject has undergone considerable revision since Babinski in 1906, presented his views upon Hysteria at the Society of Neurology of Paris. At this time he proposed the name "Pithiatism," which meant an Hysterical phenomenon which could be produced through suggestion, and cured by persuasion. This definition assumes the psychic origin of the disorder, but gives no intimation regarding the nature of the malady. Babinski also insists upon the necessity of the presence of certain stigmata, in order that one may conclude that the condition under question is Hysteria. Stigmata referred to are convulsive attacks, somnambulism, delirium, paralysis, contractures, tremors, choreiform movements, disturbances of phonation and respiration; disorders of sensibility shown in anesthesia and hyperesthesia; sensorial anomalies and disturbances of the bladder. He further brought out the fact that Hysterical symptoms often exist without the patient's knowledge, indicating the psychic origin of the disease. Often too, the anesthetics, for example, are the result of suggestion produced by the examining physician. Furthermore, it is important

to note that the areas of anesthesia do not conform to any definite anatomical distribution of nerves. (18), (7), (73).

Janet, on the other hand, emphasizes the importance of 'ideas' in the so-called Hysterical accidents; in fact, "With Hystericals," states Janet, "ideas have a greater importance, and, above all, a greater bodily action than with the normal man." Janet is content with retaining only the first part of Babinski's statement, namely that Hysteria is defined by suggestion, meaning that it is the effect of a too-powerful idea acting on the body in an abnormal manner. The fundamental fact--the stigma--is, as already indicated, "suggestion". The suggestion assumes the form of an idea in which, as Janet states, "Instead of confining themselves to thinking the object, they seem to see it in reality, or to hear it. They conduct themselves before our eyes like individuals who have perceptions, but not ideas; they reply to imaginary words; their facial expression is that of a person who hears." Furthermore, what these patients see and hear may be so vivid "that it seems completely to efface the normal vision of things that surround them." (49), (18), (50).

Concerning the mechanism which produces symptoms, be they mental, motor, sensory or somatic, there has not been an adequate explanation in either Babinski's or Janet's theories. The chief distinction between the two theories lies in the difference in the points of view with regard to the importance of suggestion. Janet regards the suggestibility as dependent upon another factor, while Babinski holds that suggestion is the fundamental factor.

Janet believes that, in order that suggestion may have its full play there must be an absence of all ideas antagonistic to the suggestion. This suggestibility is the result of a mental state allied to, if not identical with, absent-mindedness or amnesia, which Janet regards as second in importance to suggestibility. Furthermore, the ease with which one symptom disap-

pears only to be replaced by another--a 'transfer' or an 'equivalent'--is a characteristic. Finally, the general statement with which Janet summarizes the situation places the responsibility upon "retraction of the field of personal consciousness"; that is, impressions gain sufficient importance to leave their effect upon a secondary consciousness, a mental state in which patients can be made to walk, talk and act in a manner unknown to themselves. That the fundamental state is a "moral weakness consisting of the lack of power on part of the feeble subject, to gather and condense his psychological phenomena, and assimilate them to his personality." (49), (50), (18), (84).

Since Janet enunciated this hypothesis, psycho-analytic investigation of Hysterical patients has shown it to be correct; but the investigation has carried us a step farther than Janet.

To Freud must be given the credit of starting a school of thought which has aroused a wide-spread interest in a very few years. His doctrines have been wholly accepted by some, and rejected in toto by others. Freud's studies began with the subject of Hysteria, but were later extended to the study of the psychoses and psychoneuroses. Freud's doctrine requires the acceptance of the conception of the sub-conscious or unconscious psychological processes. The all-important factor is the "complex", which is capable of giving rise to ideas, acting as a force controlling the conscious train of thought, although the individual may not be aware of the nature of the complex. Furthermore, a state of mental conflict is necessary, caused by the presence in the mind of at least two opposing complexes, giving rise to a state of unpleasant emotional tension. The conflict must be settled either by the mind relinquishing or modifying one of the complexes, so that the incompatibility ceases to exist. In some cases the method of the solution of the situation is a pathological one, and gives rise to morbid symptoms, such as are found in Hysteria and in the psycho-neuroses. By the processes of repression and censure the ideas may be kept out of the conscious level of the mind, but

nevertheless may have an effect upon the individual's reactions, especially when one of the complexes succeeds in "eluding the censure", and appears in the consciousness not as the original complex but as a representative which is not recognizable to the patient. The mode by which this complex (regarded originally by Freud as a "wish") can be gratified constitutes the Hysterical symptom. According to the Freudian doctrine, it must suffice to state here that the Hysterical patient is made the object of the activity of repressed complexes concerning the events in the past life of the individual, and that the expression of the repressed complexes gives rise to the symptoms of the disorder. A division of the personality exists individually in everybody, and Freud has shown that the Hysterical symptom represents in symbolic form a compromise between an unconscious wish and its conscious inhibition or repression. For example, an English woman married to a German, who had been interned, was told by him, that after the war, she would have to go with him to Germany and live there with him. As a result she developed Hysterical paraplegia, symbolizing that she could not "go". The paraplegia was a compromise which satisfies both conditions: her unconscious desire to "go with" her husband was inhibited by her conscious desire to remain in England, but her paraplegia satisfied both conditions: for it excused her from "going with" her husband, and also from going away from her native country. (84), (36), (37), (40), (18), (42).

Jelliffe, who has been writing considerable on the subject lately, advances Freud's theories somewhat when he views the human body as an energy system. He says, "Today the progress of medical thought and effort is imbued with the realization that the human organism is constructed so as to capture, transform and deliver energy, which in this said delivery maintains the integrity of the machine itself, and unfolds itself in devious channels in its adaptation to the environment." Hysteria, to be understood and acted upon

therapeutically and prophylactically, must be considered in terms of dynamic or energetic activity; for it represents a compromise adaptation to social formulae which in themselves contain the germ of disease similar to that reacted to by the Hysterical. In one sense it may be said that the Hysterical and environmental reaction capacities are interrelated. The strictly personal ends and self-centered ways of attaining them, are however, not acceptable to the conscious mind, and so there is a blocking of the energy, and a diversion of its output to channels which form a compromise between the two goals.

Social ends are really cleverly circumvented, and the personal goals are also at least partially satisfied by an indirect and concealed mechanism. The personal needs and wishes are unconsciously, though imperfectly, gratified. This is, however, not accomplished without struggle, and the results themselves are far from satisfactory. Disease, then, in terms of the energy system known as man, consists essentially in a conflict between different energy systems. These energy systems, from without or within, may be termed trauma, bacteria, toxins, electrolytes or ideas. Each of these represents simple or complex individual energy systems which, impinging upon the organism, force it to an adaptation. The phenomena of this adaptation are spoken of as disease. Whereas it was well known that blows, falls, bullet-wound poisons, etc., could produce such interaction, it has only been in recent times that "symbolic" energy systems could be considered in the same light. (51), (37).

From the standpoint of present-day psychopathology, it is clearly seen that the striving and the significance of the symptomatic disturbances, are fought out largely in the unconscious part of the individual. The phenomena included under the term Hysteria may be divided somewhat more specifically by extending the same terms of energy to more definite manifestations. It is the extreme variability of such phenomena, and the clinical variety they present, that have led to the many different approaches to Hysteria which have marked the history of medicine. Today we are continuing the classification. Language

which is a most acceptable and indispensable tool, (for not speech alone, but also thought progresses through its medium), must sum up the problem of Hysteria as a large entity, a certain broad type of reactions which present the varied symptoms to view. Thus Hysteria can come to definition only in the fluid terms of moving energy. The question is, what do the symptoms represent as to the personal striving, and the imperfect way of attaining individual ends? In other words, Hysteria, as a 'diagnosis' can never be reached until this concept of the 'purpose of the symptom' be revealed. Until it can be shown that the end attained by the symptom has some foundation in reason, although unconsciously arrived at, diagnosis in the precise sense has not been accomplished. Then therapy is bound to the same question, and must move back along the lines of investigation to discover the exact answer in each individual case. It is, after all, the very nature of human striving to seek the best levels of attainment once these are understood, and so the cure is effected; that is, the individual has found the paths of activity and energy expression which actually serve realizable ends. Hysteria cannot be understood or cured without an exhaustive search through the unconscious to discover the mistaken aims, and the many unsuccessful attempts to reach a better adjustment.

Recent psychopathology also takes into account the two directions of energy. One is outward toward the external world. Here one brings his energies to bear upon the external world interests and its objects, chiefly those represented by other individuals, and his relations to them. If this proceeds without hindrance and confusion, all is well. Reality, however, and the limitations it imposes through necessary adjustment with other objects, particularly persons, sets limits continually to personal wish and striving. Mention has been made of this hindrance as arising from within the energy currents themselves. This means that the wish is stronger than the ability to adapt and conciliate the separate individual wishes. This is far more largely a matter of the un-

conscious than of the conscious choice. (25), (72), (89).

This wish or energy expression, or attempt at expression, is not a simple mental thing, an idea which can be viewed perfectly as objectively apart. The mind knows itself only through the bodily organism. The mind and the body are not parallelistic. They are one, and the soma and the psyche were born at the same time. Psychological activities are but special forms of the bodily activities. Therefore purposeful activity represents or is represented by a definite organic act or action pattern, the wish arising in the organic need, and being again expressed at once through such need and set toward its gratification. When, therefore, the wish, or rather the expression of it, is blocked by external circumstances or by the inability to make such an adjustment that the energy expressions shall be brought into healthy and free relation to the outside requirements, the result is twofold. In the first place, there is psychic and autonomic discomfort, and secondly, there is an attempt, even though an imperfect one, at a readjustment, which however, aims to lessen the original psychic and physical burden. This leads to the creation of the many symptoms which are the outcome of such disturbance and imperfect readjustment of function. This may occur, as Kempf points out, when the individual is "clearly to vaguely conscious of the nature and effect upon himself of his unsatisfied cravings," that is, when he exercises upon them merely a suppression from clear consciousness. The various forms of energy striving, or the wish which causes such experience he has named under the "shrinking from responsibility" or "the liability which the presence of strong affective cravings would occasion were they exercised; a dread of anything which might reveal organic inferiority or lack of power to effect the ends of the real world; with these the definite fears of loss of external things as money, or of honor or freedom, also of receiving pain or injury." There is also a fear of not meeting the expected requirements which tradition and affection have laid down. Often-times, too, there is a positive desire toward some perverse object unpermitted by society

or toward an unattainable or unresponsive object, or hate, shame and disgust for certain objects. This mild suppression of these tendencies results in hypertensions or hypotensions of the various autonomic (visceral) portions or segments of the body, and the long line of functional disorders so commonly seen comes into play. Some of these appear to the patient as mental phenomena, such as distressing dreams, reproach, persistent thoughts which will not be dismissed or neutralized. Others tend to register themselves, at least so far in bodily sensation, that they appear as a decrease of power to coordinate the thoughts, inability to learn or to concentrate, to use the "brain", according to common conscious complaint; or there follows the long line of more distinctly physical disorders, often of course, associated with the foregoing. These grade from what may still be interpreted as errors or accidents, to headache, dizziness, stiffness or weakness of various muscles, interference with secretion of mouth and stomach glands, dyspnea, tachycardia, dysmenorrhea, sexual impotence, hyperirritability of structure otherwise diseased. (51), (54), (56), (57), (87), (42).

In this 'suppression group' belong those disorders which the war has brought so prominently to the fore, and which have manifested themselves in what have been called the reflex nervous disturbances, or designated and described more in detail as various contractures, paralyses and parietic states affecting one or more members, muscular atrophy, hypotonus and hyperexcitability of the muscles, changes in skin and tendon reflexes, disturbance of sensation, thermic and vasomotor disturbance, secretory and tropic disorders of various sorts. Such physical findings, for example, are excluded from Hysteria according to Babinski's nomenclature, which reserves the term Hysteria for those manifestations which are caused by suggestion, and cured by persuasion. (77), (80), (6).

Hysteria, then, is any somatic symptom, no matter in what part of the body it may be found, which is the result of symbolic conversion from purely

mental causes; a physical conversion into somatic phenomena. Seen from the psychological side this capacity for physical conversion into psychical phenomena is an index of the growing up of the race. Hysteria here carries the meaning of infantile. Such infantilism may be present as a result of feeble-mindedness in certain of its groups, or may be an index of faulty psychical modes of handling the many complex reactions in daily life. (52), (73).

The Hysterical mechanisms also have a teleological value. The term may be applied not only to the manifestations of energy with the individual, but society as a group of individuals also shows in many of its institutions precisely analogous phenomena which may be termed Hysterical, and which are indications themselves of the infantile attitude of the masses. Le Bon's essay on "The Psychology of the Crowd", shows how wide-spread these actions may be and how the institutions of specialized society tend to show Hysterical traits, the moment a mass reaction takes the place of an individual one. When the reaction of the mass becomes Hysterical, it shows its inferiority to what might be termed aristocratic or individualistic adaptation. The "dancing mania" of the Middle Ages, which sometimes spread through enormous tracts of European territory is a good example of Hysteria in epidemic form. It is occasionally seen today in divers forms in schools, nunneries and remote villages. Such cases bring home to us the fact that there is but little difference between the unconscious desires of humanity, and that we all have the same desire to suppress some of them. When any individual of a community exhibits symptoms which would effect a compromise between his two personalities, what is more natural than that other members of that community, whose conditions are precisely the same, should develop the same symptoms? It must be admitted that there is an element of suggestion in these epidemics, but it plays a minor part. (84), (73).

Hysteria then, still remains a phenomena of such complexity that it has defied complete analysis. We have attempted, therefore, in the foregoing statements to give the reader a modern 'concept' of this disorder.

HISTORY

To write the history of Hysteria would mean practically to write the history of medicine: for Hysteria stands throughout the ages as the type of functional disturbance of the nervous system which, protean in its manifestations, is found associated with all great therapeutic movements in medicine. The "enigma of personality", is the frequent reference of Hysteria. Its descriptions have entered into legends and folklore long before historical records were made. The most ancient books of the East contain in unmistakable outlines many descriptions of the phenomena precisely as we see them today. Historians at all times have had to deal with the Hysterical personality. The poems of Homer and Euripides show it as chief features, as well as the writings of the modern of moderns, Ibsen. Judges and law-makers have been confused by its contradictions and its inconsistencies. Priests, lawyers, philosophers, physicians and laymen have endeavored to understand it in all ages and in all climes. Hypothesis has replaced hypothesis; societies have been disrupted and sects have been rent in twain in expounding its nature. It is interesting to trace the gradual growth of interpretive concepts which have sought to explain the manifest phenomena called by various names at various periods by various physicians of the times. The features which have remained fairly constant are those striking motor phenomena of Hysteria. (44), (68).

The earliest hypotheses concerned themselves with gross anatomical features, and it is said that Democritus first assumed that the wandering uterus brought about the reaction. This conception of unsatisfied longing was naturally connected with the reproductive instinct. It is highly probable that the teachings of the Hippocratic school were faint echoes of previous modes of interpretation. The Hippocratic books labeled convulsive cries of the woman

being due to malposition of the uterus, and for nearly two thousand years the uncritical acceptance of authority hindered any progress being made in our knowledge of Hysteria. Neuburger in his "Medical Lore of the Bible", gives account after account of the existence of Hysteria, along with the healings of Christ and the apostles. His healing with saliva is explained when some of the Roman historians mention that the saliva of great personalities of the day, such as princes, was esteemed to have miraculous healing powers. (65), (73).

Galen more or less demolished the grosser beliefs in a wandering uterus by showing it to be a fixed structure. He substituted a bit of humoral pathology which only slightly deviated from the original standpoint. An unsatisfactory outlet for the humors was the cause. Throughout the Middle Ages and down to the Nineteenth Century one heard of vapors, gases, etc., as causative of Hysteria. (73).

In 1618, Lepois, a physician of Pont-a-Mousson, for the first time challenged the tradition of the uterine pathogenesis of Hysteria, and described similar symptoms in men and young girls; later in the Seventeenth Century his views were accepted by Sydenham and Willis. Sydenham taught that Hysteria is not only common, but shows itself under an infinity of different forms, and imitates nearly all the maladies to which the human race is subject. It was not, however, until Briquet in 1859, described Hysteria as a 'dynamic' affection of those portions of the brain that serve affective states and sensation, that the modern study of Hysteria began. His description was elaborated by Lasague and Charcot, and their pupils conducted a systematic study of Hysterical symptoms which, though it has added much to our knowledge, is also responsible for much that has delayed our arriving at a true conception of Hysteria, by reason of their attempt to constitute a clinical entity without due consideration of its etiology. (69).

Although present-day conceptions of Hysteria may have a beginning with Briquet and a few other physicians, who at his time recognized the mental

origin of Hysterical manifestations, it is nevertheless to Charcot and his school, particularly to Janet and Freud, that the definition of the psychopathology of Hysteria owes its base. The names of Pitres, Richer, and Gilles de la Lourette should also be mentioned at this date. Then the various hypotheses, the various ways of approach and the various aspects in which Hysteria was conceived and defined, began to be brought more consistently together. Since Charcot's day the approach to Hysteria, whether from the more purely psychological standpoint, the physiological or the biological, has made more and more use of the psychogenic idea, and has come to a greater comprehension of its extent and significance. While there is a more unified and comprehensive conception, there is also a tendency to dismember the large conglomerate mosaic of phenomena in order to give them more intelligent and effective therapeutic consideration. (13), (73).

Charcot laid emphasis upon the idea of 'dissociated personality', the psychological disturbance and upheaval which marked Hysteria. Janet elaborated this further with his term 'dissociation', by which is meant the possibility of a process whereby psychical energy could modify physical function, and yet remain as if it were unknown to the performer. The doctrine of the 'unconscious' was a necessary corollary, and the psychology of the unconscious has now become one of the most important of modern interpretation, not only of Hysteria, but of all mental phenomena. Our present-day formula of "conversion of psychical energy into symbolic physical manifestations", will probably have its day, and will then seem crude to the medicine of the future. (73), (52), (20).

Mobius, a follower of Charcot, included the ideational source of morbid phenomena to cover physical as well as psychical manifestations, all having a common psychogenic origin.

Babinski has rendered special service in the dismemberment which naturally and necessarily followed upon the comprehensiveness of Charcot's studies. Having done much to develop his idea 'Pithiatism', he also laid stress upon the

'physiopathic' symptoms which he prefers to split off from Hysteria into the disorders of reflex origin, excluding these not always correctly, (for many reflexes are conditioned and hence are psychical), from psychogenic forms.

(6), (11).

Other writers have dwelt upon the physiological side of Hysteria. The earlier English school tended toward this, and Sollier and Binswanger on the Continent, have given such a definition in physiological terms to the psychological processes. This is spoken of in terms of functional disturbance of the cerebral centers, which then manifests itself in the varieties of disturbance according to the centers disturbed, vasomotor, trophic, visceral sensory, motor and psychic also. The correlation between the psychic and physical processes is therefore interfered with, so that the disturbance manifests itself in both directions. The careful experimental and clinical work of later investigators tends to give such a correlation of mental and physical factors much greater precision and clearness in definite physiological and psychological terms. Both are better explained in terms of the personal craving, wish dynamism, translated into terms of the visceral cravings, and in turn intensified or relieved as the physiological activity satisfies, restrains or aggravates these cravings or wishes. The physiological views which tend to explain Hysteria upon the basis of the reflex action of localized centers, lie also in the field of this close relation of mind and body through the vegetative innervation, though they have tended to separate this form of explanation into two separate compartments. This, for example, is the attempt to explain Hysteria as due to localized or general vascular changes in the brain, or to some other effect chiefly of a vasomotor instability throughout the body.

(37), (13), (26).

The modern psychological conceptions which are based directly on the works of Freud, Janet, Breuer, and Bleuler, whose works developed about 1900, will be referred to under the heading "Etiology".

CLASSIFICATION

Only a brief discussion is presented at this point to clear up in the mind of the reader the position that Hysteria occupies in the classification of mental diseases. A simple form, under which all mental diseases may be classified, is the following:

I. Feeble-minded--Idiot, Imbecile, Moron, etc.

II. Psychoses---1. Organic--Tubes, Paresis, Arterial Schlerosis.

2. Toxic----Alcohol, Drugs, P.A., Pneumonia, Etc.

3. Functional--Manic Depressive, Dementia Praecox,
Paranoid.

III. Psychoneuroses or Neuroses

1. Hysteria

2. Psychasthenia--Obsessional and Compulsive

3. Anxiety Neuroses

4. Neurasthenia

Hysteria, then, being one of the psychoneuroses is a very prevalent disease, this group being the most frequent pathology found by the psychiatrist. Whereas only 1.7 % of mental disease is statistically included under the Psychoneuroses, it really is the most common question met with, and has a tremendous social significance. If it could be reckoned, it would probably be found that the sum total of economic and social liabilities produced by the neuroses would be greater than the amount of damage inflicted on society by the psychoses. (104), (85).

Again, whereas different writers vary tremendously in their definitions of Neurasthenia and Anxiety Neuroses, the modern conception of a definite, clinical entity in the form of Hysteria is fast being recognized. Its final definition, however, remains to be solved.

ETIOLOGY

I. INTRODUCTION

At the physicochemical and the sensorimotor levels it is possible to deal with isolated phenomena of functional pathology. For example, the knee reflex if normal, indicates a normal motor pathway to the quadriceps. At the psychological level, however, it is no longer possible to deal with parts of the individual in this way, but the "whole individual" comes at once under consideration. Thus it may be a question of desire, of failure, of regret, of inefficiency of all sorts, but it is always a desire, a failure, a regret, or what not, of the individual. The individual, as such, has failed in effecting an adequate adjustment. (15).

A few paragraphs devoted to an account of the development of these tendencies of the whole individual before taking up a consideration of the disorders at this level will be useful.

The baby in its mother's uterus has no desires; it has to do nothing for itself, not even to breathe; it rests quietly, far removed from sources of outside stimulation and irritation, every function being performed for it by the mother. After the baby is born an effort is made for this condition to still continue. The baby, to be sure, has to begin to breathe for itself, to eat for itself, to perform the functions of digestion and elimination for itself, but on the other hand there stand about the army of the household, not satisfied to wait upon desire, but with every heartstring of emotion tense to forestall it. He is waited upon hand and foot by all; he is, in the sense that every desire is satisfied, truly omnipotent. As the days go by the development proceeds apace; as the sense organs become more acute, the muscular adjustments more refined, the baby's contact with the world becomes progressively and increasingly complex, and try as they will the loving attendants cannot forestall all of his desires, so there comes times when food is not offered at the instant it is needed, when sleepiness overtakes the baby, but he cannot woo it if he is

in a bright and noisy street, or on a clattering car far from his soft bed. So there arises insidiously but necessarily the mental state of desire, things wished for because they are not had. As development progresses, desires become more and more numerous, because the baby touches reality at more numerous points, and each of these points offers a new possibility for a frustrated or delayed desire, while with such matters as emptying the bladder there soon steps into the situation the social repressions represented by the prohibitions of the mother. (62), (74).

Thus growing up in the life of the baby, beginning even in the earliest days, an ever-increasing discrepancy between desire and attainment takes place, and as the years go on the amoral, egocentric baby must gradually take into consideration the world about him. He is forced to lay his conduct along certain lines which imply a putting off of the satisfaction of desire into an ever-receding future. That is, if he wishes to empty his bladder he has to wait until he gets to an appropriate place; it cannot be done anywhere and at any time. He has to adjust himself to the requirements of society, or run serious risks if he fails.

Conflict is therefore at the very base, the very root of mental life; the adjustment of the individual to the world of reality is by no means the passive molding by external forces, but the individual is constantly and actively, in his mind at least, reaching out and trying to mold the world to suit himself. It is from this basal fact of conflict that there originate two forms of thinking, an understanding of which is of great importance for the comprehension of the psychoneuroses: in fact, for all behavior, sick or well. Thinking, which is dominated by the reality motive, the thinking which is a conscious, intentional effort at efficient relation with reality, is the thinking to which the word 'thinking' is usually applied. But there is another kind of thinking, the thinking by phantasy formation, which is of great importance. In this form of thinking it is not the reality motive that dominates, but the pleasure-

pain motive. The other horn of the conflict is here represented, and in moments of quiescence, when the real world slips away from our vision, and we settle back within ourselves, our thoughts flow without reference to the outside world--they come and go without critique on our part. We are dreaming, perhaps in sleep or perhaps in waking, and the fancies which come at these moments of rumination are all wish-fulfilling fancies, controlled by the pleasure motive, and represent the satisfaction of desires which are either put off, or rendered capable of fulfillment in reality. These thoughts are not only the thoughts that dreams are made of, but the thoughts that psycho-neuroses are made of, and are therefore of immense importance for their understanding. (50), (92), (95).

From the very first the immediate satisfaction of desire is frustrated, to be technical, it is repressed, and some other form of activity has to be substituted. Instead of the immediate relationship that maintains in infancy, a more remote relationship is maintained, and the activities instead of going straight to their goal, take a more or less circuitous and involved path. The original relationship then, tends to be lost sight of, and the more involved and complicated one takes its place. There are, therefore, gradually throughout the period of development, all sorts of desires being repressed which, thus being put out of consciousness, are replaced by other forms of activity. The desires which belong to infancy, and which are thus early repressed and substituted by other forms of activity, constitute the material out of which the 'unconscious' is formed, and the material from which come the activating moments for phantasy formation. The discrepancy between desire and fulfillment then, is compensated in later life by the wish-fulfilling phantasies that have their origin in the repressed material of infancy and occupy the realm of the unconscious. (52), (35), (74).

A realm of 'foreconscious' also exists according to some authors; it lies between the conscious and the unconscious, and from which ideas may be

fairly easily brought into consciousness. The unconscious is of great importance because it represents the region of the deepest repressions, of the thoughts that least resemble the conscious thoughts, and which therefore, when they break through into consciousness, produce symptoms that are so grotesque and strange appearing on the surface, and so non-understandable, not only to the onlooker, but to the patient himself. But to understand the unconscious, certain features in the development of the child, particularly those that are at a later date repressed and substituted by other activities, must be described.

All activities of the individual lead in one of two directions, namely, in the direction of self-preservation, the nutritive activities, or in the direction of race-preservation, the sexual activities. The energy which drives toward these goals may be called the 'libido', and so it may be spoken of as the nutritive or the sexual libido, exhibiting not different kinds of energy, but different directions of energy. Self-preservation and race-preservation are fundamentally opposed to one another, the former implying getting and keeping, the latter giving. The infantile reaction must undergo progressive socialization. The libido has to be socialized, or to use the more frequent term, sublimated. In that proportion in which the individual is unable to effectively sublimate his libido, to break away from earlier, infantile ways of pleasure seeking, to higher social forms of behavior, he is crippled in his capacity to live at his best. This crippling in its milder manifestations we call the neuroses and the psychoneuroses; in the severer form the psychoses, and in its most severe forms the various grades of defect extend to the depths of imbecility and idiocy. It is obvious that the idiot requires the same sort of solicitous care as the normal infant. In the higher grades of personality defect, however, the necessity is clothed in symbols which distort and obscure the meanings in accordance with the mechanisms already as at work in dreams. For example a patient develops the necessity of a particular dietary which can only be provided in the home, and every effort to go out from the home results in a

gastro-intestinal upset because of the inability to obtain it. By this symbolic mechanism the patient is therefore permitted, under the guise of invalidism, to remain like a little child, in the home situation, cared for and protected from the world of reality by the parents. Analysis will further show that there was an early fixation upon the gastro-intestinal ways of pleasure seeking (a so-called partial libido trend) which determines the particular form of the later symptoms. (1), (3), (18), (25), (79).

Then as regards the more distinctly race-preservative or sexual libido: in the early infancy, the child's love is very naturally given out to the father, the mother, the brother, the sister, and perhaps the nurse. This love, contrary to the usual way of thinking of it, is very definite in its direction, and from a very early date presents certain sexual characteristics. Of these sexual characteristics, jealousy of a younger baby who comes into the family and deflects a certain amount of affection is within the observation of most people, while the fact that the love of the child is given out to the members of the family, characteristically to the parent of the opposite sex, is not a matter of such common observation, but it is a matter of great importance psychiatrically. As the child develops, these loves are repressed, and covered into that all-inclusive amnesia for the infantile period, and when adulthood comes along, and the child has grown to manhood and finds his mate, the love which had before been spent on members of the family now finds its true object. It is this infantile love for members of the family that is the root for so many of the incest phantasies of the psychoneuroses. This love for the parent of the opposite sex, for example, if it breaks through into the realm of consciousness becomes a horrid thing, incompatible with the individual's peace of mind. An individual with an unconscious father complex, will get along all right in life, perhaps quite well, until she meets some difficulty. The difficulty drives her back within herself, prevents the outward flow of interest into reality, makes her egocentric, introspective, unable to make efficient reaction, and therefore driven

back to phantasy formation, where things come true, and the difficulties are all removed. The reason for this driving back of the psychophysical energy within the individual under conditions of stress, the reason why this should stir up a particular complex, is because in the life of the individual there has been an undue fixation at that point in the course of development.

(43), (38), (40), (52).

The content of phantasies is best determined by a study of dreams, and it must be remembered that a psychoneurosis, like the dream, is not only a compromise between desire and fulfillment, but it is a wish-fulfilling mechanism that brings to pass both the fulfillment of the wish in the fore-conscious, the wish with reference to the difficulty that caused the introversion in the first place, and also the wish in the unconscious, the wish at the fixation point, which serves as a pullback once the introversion has started. The child therefore, passes through several stages: his first sexual feelings having reference to his own body and being autoerotic; next the sexual feelings are transferred upon someone most like himself, therefore of the same sex (homosexual Narcissistic stage); and finally the period of object love, when fulfillment is had in an entirely different individual, and of a different sex (heterosexual stage). Theoretically, at least, a child may be deflected while passing through one of these stages; for early in life the difference in sex is not appreciated, and the erogenous zones (of which the anus and the lips are important additional ones), are still more or less indefinite. And so the roots of the various so-called perversions are found in these early fixations. The determining factor in the early fixations, the mechanisms that have brought them about, in short, their uncovering, can only be accomplished by fathoming the unconscious. This is the work of psychoanalysis, and the most prominent means at its disposal at the present time is by the analysis of dreams. (78), (36), (38), (59), (51).

MODERN PSYCHOLOGICAL CONCEPTIONS.

The absence of conclusive and indisputable information concerning the causation of the common neuroses may be adduced from the fact, that simply to mention all the etiological theories would consume an unwarranted amount of space. For many years there was bitter strife between organicists and the fundamentalists, and even at this date, the role played by somatic and psychic factors, and their relative importance, has not been definitely settled.

The modern period in the history of Hysteria might be said to have begun with Charcot, whose picturing of the 'grand Hysterie' is well remembered. Although many brilliant workers immediately followed Charcot, one of the most illuminating workers in the field, and one whose theories produced the greatest influence in the study of the disease was Janet. His was a theory of disassociation, and he believed Hysteria to be purely a mental malady. It was due to a poor synthesis of the personality, which enabled certain groups of ideas to drop away from effective association with the main portion of the personality, and occupy a region which Janet termed the subconscious, and there existing more or less independently, produce their results irrespective of corrections from the rest of the personality. The Hysterical manifestations then, were the manifestations of those split-off parts of the personality.

Janet conceived of the Hysterical state as being synonymous with the hypnotic state, and with suggestibility as the prominent characteristic of each state. The followers of Janet, particularly Sidis, White, and Prince in this country, have continued their pursuit of the disassociation theory with greater emphasis laid upon static features, with much description of disassociation, and with some effort to bring the personality back to its healthy synthesis based upon such causal factors. (49), (72), (50), (20).

Binet felt that the mechanism of Hysteria depended on a condition of double consciousness, practically two independent states separated by amnesia periods.

Babinski may be cited as an example of a functionalist. For him Hysteria is purely the outcome of suggestion, and he sought to rename it 'pithiatism'. (85).

Freud, however, has pursued the Hysteria pathology, and studied the separate etiological factors, and given very careful investigation to the mental processes and mechanisms through which the disassociation has been brought about and through which it maintains itself. His investigations, first stimulated by his work with Charcot, were carried on in association with Breuer, who also pursued his investigations in this direction. Breuer had already stated the belief that psychological or physical trauma lay at the basis of the Hysterical symptoms, and as Freud developed this idea, he was led at first to give somewhat exclusive place to genital trauma, or sexual trauma in the narrower sense. Later, however, he extended this conception to exclude the idea of a necessary actual genital trauma, and also widened the concept sexual to include all manifestations of the instinct of race propagation or reproduction, with all forms of production or reproduction that grew out from this, and all forms of personal reaction which are associated with the love life and its wider extension into society.

Freud first tried to reverse the formation of symptoms process by the use of hypnosis, which was classical at the time. He soon replaced this technic by the conscious, rational cooperation of his patients, which he called psychoanalysis. He held that the most important mechanism upon which all the others depended, was that of repression. This is an unconscious, dynamic mental factor which tends to keep out of mind all that is unbearable, all that would interfere with the individual's social position, his own moral or higher personal estimate of himself. All this repressed material, in its direct form, is of an unacceptable nature because it concerns chiefly the individual affective needs, which naturally and instinctively tend to gratification in individualistic ways, and are often in conflict with social demands. The content of the repressed material, or the split-off complexes, was found to be that of this instinctive material

of personal craving, for which Kempf has utilized the term 'autonomic cravings'. Keeping in mind the reasons of the repression, and the difficulties of keeping the repressed elements in the synthesis of the personality, Freud continued his investigations to the very source of the personality, the unfolding of the libido or creative energy. He saw the need for libido expression through the various channels of the personality, and recognized that the most elementary form of such libido expression lay, strictly speaking, in the sex life. Here it has been longest in activity, biologically considered, and so it has all the force and insistence of a primeval function, ineradicably imbedded in the very human constitution. Because of its force and its persistence, it has necessitated a greater control than any other form of impulse, has in fact made necessary, strong repression. This has been in the service of a diversion of the energy and desire represented (the libido) into other channels, which has had for its result the widening of the personality of the individual, and the building up of the complexity and extent of civilization as regards the entire race. Without repression no civilization or culture would have been possible. Yet as no human process is carried out perfectly, this process in the interest of development, individual and racial, has manifested all degrees of incompleteness, and has carried with it grave dangers.

In the censorship of the dream Freud first conceived of the super-ego of the total mental systems. In many individuals, the super-ego is too hard upon one's cravings. No individual yet has acquired a perfect ability for such repression, and for the sublimation of impulse and the adjustment of restrained desire which this implies. The amount of this ability developed in different persons varies with inherited constitution and with childhood experiences. All this Freud studied largely in the field of child psychical development with its many interests, serving the as yet obscure but already present, reproductive instinct. The self-preservative instinct is involved as well, but manifests itself chiefly in the realm of the greater instinct, that of

reproduction. This because of its necessarily greater capacity for biological and social service, has the greater possibility for diversion into many forms and channels, and at the same time the greater possibility of dangerous deviation upon unproductive channels, and the greater danger of repression in consequence. (36), (38), (39), (40), (42), (87), (15).

SEX THEORIES

Freud found that the most outstanding factor leading to the Hysterical conversion lay in the libido realm. Healthy, satisfactory function lies in a gradually developing pursuit of objects with an interest in the external world until the adult love object is found, and an adjustment of mutual progress and workableness is established. It is just this broad psychosexual development which Freud finds interfered with, and it is this interference which he makes the basis of those special manifestations which are termed Hysteria. Even in infancy, the proportional relation of these various forms of manifestation and interest, individually and socially, physiologically and psychically, is disturbed, and sexual activities and psychic attitudes develop, which, if they continue to be manifested in adult life, would be called perversions. They are, however, for biological reasons, reproductive and self-preservative, driven out of the conscious life of the individual, and refused this manifestation so far as the physiological personality is concerned. Psychically also, that is, in their mental interpretation on part of the patient, they must not be recognized or expressed in their direct form. Also men are the prey of the unconscious phantasy which dwells in them, seeking in dreams to obtain the gratification which reality denies. These are unconscious dreams, but often in Hysteria pass over into conscious ones. They so transform and distort, as well as magnify the original needs or cravings, as well as the form in which they may escape the repression and get

out into some form of expression, that there arises all the protean symptomatology of Hysteria. These may then exist in the phantastic dreams, erotic longings, delirium, etc., as well as in all the train of anesthetics, paresthesias, tropic disturbances, etc. (42), (41), (40), (83).

This view of Hysteria may be summed up as that of initial repression, followed by disassociation, and then the conversion of this material into symptoms. These mechanisms belong to the equipment of the mental and physiological life of each individual. There must always be conflict between the elemental individual tendencies, and the needs of that individual dependent upon social adjustment. It follows then that repression is always useful, and to some extent, disassociation and conversion, but it is the degree of these, and the use to which the personality puts the repressed material, the form and content of the complexes constructed from it, and the way these are handled, which constitute reactions that are hysterical, or otherwise psychoneurotic, or that serve the individual well and healthfully. The Hysterical reaction is to split off the material and the complexes, and permit them to function apart, while a healthy use of repression profits by the amount of pressure brought to bear in the personality by the force of the repressed material, to make a new and more effective adjustment of the energy contained in the unconscious desires. In the pathological situation, there is inability to readjust effectively, by bringing about always a new state of affairs in accord with a continuously changing reality, instead of the unacceptable form of action, or one which would cause the individual too severe a deprivation. In other words, in the pathological state, there is inability to make the healthy sublimations by which the individual must continually establish and reestablish his relation to society. This healthy sublimation necessitates the attainment of a level of conduct where the conflicting tendencies and needs can be brought to a workable synthesis, but the Hysterical character has not learned to reach such a higher level with the 'whole nature'.

Certain tendencies remain in an infantile form while there is a compensatory striving, often on the part of the social side of the nature, to maintain a very high level. Thus the breach in the personality tends to widen rather than otherwise, and the possibility of synthesis is more and more displaced by the disassociated form of activity. In order then to neutralize the psychic distress occasioned by such a split in the personality, an artificial synthesis has to be made which is not too strictly in accord with the laws of external reality. The peculiarity of the Hysterical mechanism which effects this, is that it utilizes the pathways of bodily innervation for physically unsocial ends, or those which pathologically compromise with usefulness, and the force of the affect is diverted into the various bodily channels indicated. This force manifests itself in the variety of somatic disturbances, "converted" into these phenomena, and the psychic weight, pain, of the conflict is lessened. (40), (42), (59), (87), (18).

SYMPTOMATOLOGY

The disease has been labeled "the Great Mimic", due to the countless possibilities in the Hysterical phenomena. The symptoms are produced from the unconscious, 'our historical past', any part of which may thrust itself upon some organ of the body to impair, or to bring down its functions to mere primitive levels. Many are the disguises under which the unconscious seeks to find expression. The Hysterical character is chameleon-like in its variations, appearing in all classes, in the intellectual as well as the weak-minded, and badly expressed, shows many resemblances to the childish type of mind. Aside from minor variations, it manifests itself chiefly by emotional instability, by the ease with which it is influenced, in negativism and impulsiveness, a tendency to make sensations, a remarkable egotism, a desire to confabulate, to fabricate, and to simulate. Seen from the standpoint of the psychiatrist, these mental attributes stand in the foreground: the neurological manifestations are dependent upon them, and modern analyses of Hysteria lay stress upon the psychical anomalies. Excessive lability of the emotional life is most striking, viz., happiness along with depression, sensitiveness, quickly changingmoods, and as Sydenham states it, "all is caprice". The males he terms 'hypochondriacs', the spoiled darlings of the household.) Suggestibility is one of the essential traits in the genesis of this mental state, and volumes have been written on the subject. (73), (58), (15).

No symptom grouping, no matter what it may be, can be effectually understood or conscientiously treated, without a careful pursuit of each one of the definite features in its origin and meaning. A partial list of some of the symptoms will be here attempted. Space does not permit any interpretation of their symbolic significance, since every patient's unconscious, being his own historical past, makes the disguise a purely individual one. Thus, blindness

may express a wish not to see something definite in the environment; it may signify the desire to be blind to an internal obligation; it may express the lack of desire to see a moral delinquency; or it may be an unconscious portrayal of the blindness which would mean innocence. Each symptom has its own special significance for the individual, although accumulating psychoanalytic experience is showing that broad general trends are capable of being mapped out. (49).

EXHIBITIONISM. A common way of carrying out the affective purposes of the unconscious is the Hysterical endeavor to be always in the attention of others. Here we observe romantic accusations, sensational confabulations, self mutilations and refined theatrical attempts at suicide. The Hysteric unconsciously magnifies primitive attitudes and methods. His ego is exaggerated. He constantly searches for bodily sensations on which to hang complaints, and the slightest sensation is seized upon and magnified. To be sick and to become the center of the stage becomes a life work. The negativistic phase of this self-seeking tendency, a masochistic martyrdom, is a frequent phenomenon. Freud notices that it is always the most wide-spread pains of humanity that seem to be most frequently called upon to play a part in Hysteria.

Pandemic Chorea, or commonly called St. Vitus dance, which has come to us from the Middle Ages, is a good representation of mass exhibitionism. Under the influence of religious fervor there were epidemics characterized by great excitement, gesticulations and dancing. For relief of these symptoms, when excessive, pilgrimages were made to the chapel of St. Vitus in Zebern. Similar epidemics also occurred among the early settlers in Kentucky. (68), (82), (45).

MOTOR DISTURBANCES. Convulsive Hysteria.

The most striking of the motor disturbances are the convulsive attacks, and these have been described since the days when the primitive people set these men and women apart as specially inspired by the deity. We add nothing

new to the description of these attacks, but we now interpret them as part of the mechanism by which the unconscious ends are attained. Their frequency is relatively rare, and in interest they tend to give place in modern neurology to the far more prevalent lesser motor attacks which have occupied much attention, and demanded intensive study during the war. Hysterical manifestations have always been associated with times of religious fervor, and often the religious manifestations of one people are considered major Hysteria outbursts by another. The possibility of such manifestations seems to be always present in all people; the environmental factors alone may be lacking. Contemporary movements which offer plenty of material for study of major Hysterical manifestations may be found. Commonly the convulsive attack is divided into three stages; the prodromal, one of muscular convulsions, and a post-convulsive stage.

The first shows a variety of symptoms, particularly of mental unrest, motor retardation, and a moodiness or feeling of distress. Then occur more special phenomena: localized tensions, palpitations, dizziness, auditory disturbances, all of which may occupy a longer or a shorter period before going into the convulsions. The attack may even end with these, and may never go on to the actual motor discharge. Often with the onset, a 'globus Hystericus', or contraction of the esophagus is present.

The convulsions are extremely tonic in character, the prolonged tonus distinguishing the attack from epileptic convulsions. The face assumes a dream-like expression, and the attitudes adopted often rehearse the phantasy content of the wish. The classical movements of extension and relaxation which pass over the body have always been interpreted as exhibiting a strong erotic element. The theatrical character of the convulsion may be manifested in a variety of individual positions and attitudes, sometimes of a dream-like and ecstatic character. Neurological examination after the attack reveals dilated pupils which usually react to light. The skin and mucous membrane reflexes may be markedly decreased, but the deep reflexes show no marked

alteration, and signs of somatic disturbance are absent. There is only rarely involuntary micturition or defecation.

The post-convulsive stage may be marked by a condition of lethargy, which has given rise to the sensational tales of the "living dead". The lethargic state may continue for hours or weeks, the functional processes going on at scarcely perceptible measures. Others manifest a delirious, dream-like state, which may be of active phantasy type, or a somnambulistic state. Some of the dream states may simulate katotonic types of dementia praecox, or others the mildly confused manic depressive. (44), (68), (11).

All this presents an example of the regression type of neurosis; that is, an effort to escape the struggle, and to retire into gratification through phantasy production and utilization of these phantasy forms of action, the dream-like states. There may be disassociation phenomena, as manifested in play of erotic phantasies revealed in the attitudes and form of activity, the postures and impulsive mannerisms, and in the delirium, confusion and disorientation of the post-convulsive stage. The somatic conversion phenomena which belong to this regressive picture, are shown in the lowered muscle tonus, anesthesia and the retardation, almost suppression, of the functional activities, such as respiration and excretion. Hence it can be seen that in the emotional reaction, as well as in the somatic phenomena, Hysteria may range from the transformation of slightly suppressed conflict, which takes some other than the direct pathway to solution, to the deeply regressive repression of the unconscious material, which is then forced into deeply regressive pathways, ideational and emotional, and into deeply unconscious physiochemical manifestations.

Charcot produced these major Hysterical attacks experimentally by pressing upon the ovarian region, and then stopped them with pressure over the mammae. True 'Hysterogenic' zones however, do not exist; for Charcot had his patients trained. This was suggestion. (20), (30), (87), (57).

RHYTHMIC MOVEMENTS. Tremors.

In regard to the more distinctive conversion phenomena, the conversion of the emotional and ideational conflict into a variety of somatic symptoms, here again the various degrees of suppression of the disturbing material, may be represented with its reappearance in converted form at various levels of the autonomic personality. The Charcot school with its later followers, to whom the war has given particular opportunity for these specific studies, has described very fully the various forms of tremors observable. The polymorphic form of the Hysterical tremor is peculiarly diagnostic. Tremor may be simple, and is frequently seen when the hands are at rest. Intention tremor is rare, while static tremor is sometimes seen. The tremor is usually regular but may be irregular, ataxic, choreic-like. The location is varied, the tremor may simulate that of multiple sclerosis, the hand tremors which are common, are aggravated by emotional shock, but tend to disappear when the hand is in ordinary use as in eating. (21, (73).

Coordinated impulsive movements, such as Hysterical crying and laughing and common Hysterical explosions occur particularly among young women approaching puberty. The histories of most Hysterics show the presence of these emotional expressions in the early stages; and they are generally to be found in the middle grades of the Hysterical temperament. Binswanger offers certain diagnostic and prognostic signs concerning these attacks, and states that they are usually a sign of definite hereditary constitutional inferiority on a basis of the same type of disturbance in the ascendants.

Other motor phenomena which manifest also much of the Hysterical mental attitude are the Hysterical hiccough, coughing, abdominal spasms and stuttering. There are affections of the respiratory organs which are more or less persistent, such as Hysterical asthma, dyspnea, tachypnea, spastic aphonia, known also as laryngismus Hystericus. There is also a classical Hysterical shaking, and a variety of lesser tics. Among all these motor manifestations

can be seen all grades of the Hysterical expression of the suppressed wish content, and the conflict against it. Here, too, there may be a more or less evident conversion of the phantasy content into substitute activities, the source of which is barely out of consciousness, only suppressed from direct activity. Or there may be deep repression, and a completely unconscious return of the dynamic wish through the unconscious reflex paths which activate the sensorimotor pathways of facial muscles, or the vegetative reflex arcs which control respiration and other automatic functions. (13), (9), (18), (30), (87).

ARRHYTHMIC MOVEMENTS. Choreiform.

Sometimes we find irregular, incoordinated movements which so closely resemble chorea as to deserve most careful diagnostic attention, and one should especially be on the lookout for post-encephalitic choreic movements which show a very complex etiology. Rigid neurological examination, however, with attention to the reflexes, cerebellar and cerebrospinal symptoms, and the possibility of infection and fatigue, or overgrowth, should offer a satisfactory insight into the problem. Hysterical tetany may be differentiated from the true today if the etiology is investigated, and Erb's, Trousseau's, and Chvostek's as well as the calcium therapy test be used. Electrical hyperexcitability of the muscles has been reported as a marked feature in the war Hysterias which Babinski and Froment have separated off as disturbances of reflex order. (10), (7), (51), (73).

II. NON-CONVULSIVE FORMS; AKINETIC MOTOR PHENOMENA --Paralyses.

Myasthenia in varying grades is present with most Hysterics, which may signify the beginning of a paralysis, or may simply remain as a weakness. It lies largely in the field of mild suppressions, and represents reaction to a feeling of insufficiency and inferiority, or fear of pain, injury, loss, or a reaction against the sense of unattainableness of desired objects, all of

which exerts a depressing effect upon motor activities. It is sometimes extremely difficult to separate such functional myasthenia from organic conditions. These are multiple sclerosis in the earlier stage, spinal cord lesions of an obscure location, obscure myelitis, tumors, certain toxic conditions and a certain type of pressure neuritis. Paralyses appear in a great variety of forms, but the most distinct types are hemiplegia, paraplegia, and monoplegia. All have been prominent through the war neuroses.

Hemiplegia, which is met with in about half of the cases of the total paralyses is generally incomplete, diplegic, in the arm and leg but without cranial nerve involvement. The presence of the knee-jerk and the Achilles jerk, absence of atrophy, hypotonus, trophic disturbances, etc. , testify to the non-involvement of the peripheral nerves, or of the pyramidal tract. The hemiplegia is almost invariably preceded by an emotional shock; sometimes it develops after a major Hysterical attack. The onset is acute, the paralysis being at once manifest, and often accompanied by a sense of giddiness. As a rule the non-involvement of the cerebro pyramidal tract is shown by absence of clonus, Babinski's or Oppenheim's reflexes, along with no increase of tonus or tendon reflexes. There are a few exceptions, a positive Babinski having been reported in a case with no pyramidal tract involvement. The motor cranial nerves are rarely involved in Hysterical palsy. Hysterical ptosis is fairly common, and facial palsy is seen occasionally. All branches of the facial nerve may be involved. Glossolabial involvement has been noted, and considerable variation exists regarding the position of the tongue and palate--mixture of spasms and pareses seems to be present in most cases. (8), (12), (66), (69), (80), (75).

Paraplegia manifests itself most frequently in the lower limbs. There may be complete or partial inability to move the limbs, or an inability to move them in the vertical position while they can be moved in the horizontal position. This is the well known 'astasia abasia', first described by Blocq in 1888. The paraplegias may be of the flaccid or the spasmodic type, and contractures are often present. Distribution may be extensive, and yet restricted movements be

preserved. These phenomena were common in war cases. (77). Indeed trauma is a very frequent cause of such symptoms, even among children, perhaps on a basis of fatigue of the parts involved. There is often here exaggeration of the patellar reflex. One must be on guard here against confusing a condition due to minute hemorrhages in the spinal cord. (15), (46), (28), (69).

The very frequent Hysterical monoplegias are very irregularly distributed. Perhaps brachial monoplegias are the most frequent, while those of the legs are rarer. There may be affection of the cranial nerves as mentioned, or of individual muscles innervated by a nerve group.

Hysterical contracture occurs very frequently after slight wounds to the extremities, and although it may not be relieved by anesthesia, Roussy and others have placed it beyond doubt as functional, and if treated early, removable by counter suggestion. Hysterical torticollis is of frequent occurrence, though it is never dependent on the contraction of an isolated muscle, such as may occur from an irritative lesion. A convergent spasm and blepharo-spasm may be seen in children, and may be markedly increased by receiving injudicious attention by the parents. (100), (58), (69).

Extreme asthenia is unfortunately often diagnosed myasthenia gravis while in its early stages of Hysteria. In this disease the predominance of the symptoms in muscles innervated by the cranial nerves, for example, fatigue of the masticatory muscles, diplopia due to fatigue, asthenia of the eye muscles, the heavy, expressionless face with some degree of ptosis, will generally furnish a key to the correct diagnosis.

Hysterical scoliosis is of two types, one depending upon a primary contracture of the spinal muscles, the other on a contracture of the hip musculature which causes the pelvis to be tilted. The characteristic hip and shoulder correction of an organic scoliosis is absent in the Hysterical type. Kyphosis and rigidity of the spine, simulating spondylitis deformans, also occur as Hysterical symptoms. (8), (28), (46), (69), (23).

SENSORY SYMPTOMS. Disturbances of Touch.

These consist of anesthesia, hypesthesia and hyperesthesia. Hysterical pseudo-tabes presents some difficulties, especially as Hysterical symptoms may be superimposed upon a true tabes. Purely Hysterical may be pains, incoordinated ataxic movements, analgesia, eye disturbances and other symptoms.

Hysterical anesthetics require much insight and acumen to differentiate. Briquet, in 1859, found it in eighty-five per cent of his cases. Location and degree of the anesthesia are extremely variable. Incomplete anesthesia or hyperesthesia is more frequent than complete loss of sensation. Total general anesthesia as an Hysterical syndrome is probably very rare. Hysterical anesthesia is usually unilateral, or it occurs frequently in patches in isolated areas, or in symmetrical regional areas. Hemianesthesia or hemihypesthesia frequently exists, and the left side is the side more frequently affected. Every left-sided doubtful anesthesia may be held 'sub judice' as one of psychogenic origin, especially in females. Affection of geometrically limited areas, rarely coinciding with anatomical nerve distribution, is well known. This is the stocking or glove type, and has a border line which is usually indefinite. Crossed anesthesia may exist, but care must be taken to distinguish this from the result of possible minute thalamic lesions. The anesthesia is little noticed by the patient as a rule, although occasionally there may be pain, or a pricking sensation, or a feeling of numbness as if the limb had gone to sleep. Anesthesia is usually of a sudden origin, and offers much room for suggestion as an instigating factor. (67), (75), (68), (87).

Closely associated with disturbance of tactile sense is the loss of ability to distinguish heat and cold, though the Hysteric always responds strikingly to cold application. They are rarely burned. Deep sensibility is only rarely disturbed. Disturbance of the mucous membrane sensibility is similar in manifestation to that of the skin.

Pain sensibility may be diminished or exaggerated. Absolute analgesia occurs only in an occasional ecstatic, dream state. Hemianalgesia and hemihypalgesia occur very much as hemianesthesia and hemihypesthesia, with also crossed varieties. The intact pupillary response to pain stimulus testifies to the unimpairment of the reflex mechanism, even if the pain is not recognized by the patient.

Hyperalgesia is most common. Certain classical points of pressure exhibit marked tenderness, and have given rise to much discussion of so-called Hysterogenic zones. Such points being ilical (ovarian), inguinal (appendical), epigastric, mammary, jugular, supra and infra orbital, and vertebral, are usually those upon pressure of which, physical stimuli are more readily set up in the normal individual. These zones have already been mentioned above, and we conclude that, after all, they have no real relation to the disease, suggestion being the important element. (24), (7), (77), (69).

Localized and spontaneous pains show also a great variability, but are of very frequent occurrence. In the topalgias, there is abundant testimony to the reflex visceral disturbance being brought about by psychic factors. Of course many of those considered as Hysterical, are coming to be more clearly recognized as due to actual visceral disorder acting upon the reflexes. Topalgias are circumscribed painful areas, with no anatomical relation to any known nerve distribution. Spontaneous pains of variable character are to be met with in probably at least eighty per cent of all Hysterics. The neuralgias, particularly, have received much more careful recognition recently as due to organic causes, such as cervical rib, or other anatomical anomaly, or to diseased conditions, such as diabetes.

The ready affect of suggestion therapy would seem to testify to the existence of Hysterical arthralgias, but diagnosis of these has been much restricted since the radiograph has been used in the study of the bony structures.

The existence of Hysterical enteralgia is supported by the frequency of Hysterical vomiting, and several forms of severe visceral pains it is found

are of undoubted psychogenesis. Simulation has been called in to explain Hysterical ileus with pain and fecal vomiting (7), but here again there is a true Hysterical condition which is due to the influence of unconscious rather than conscious factors. The psychic factor also plays an important part in hyperemesis gravidarum. Archaic and infantile confusion in phantasy of the reproductive and nutritive pathways plays a large role in the gastric and other alimentary disturbances.

Hysterical cardalgia is very frequent, and from the standpoint of unconscious disturbance of functional pathways, it can readily be seen that this would be the case. It may occur in a severe form, that of angina pectoris hysterica, or in a variety of lesser symptoms, pains, discomforts, interference with heart action as evidenced by pulse, etc. This belongs among the vast group of gastric, enteric, genital, and other false pathies which are easily seen to be under psychic control; for these functional pathways are not only at psychic disposal, but are also largely concerned in group fashion with the functions of the personality. There may be also a connection here with actual neurasthenic conditions, neurasthenia here being envisaged as a more or less definite somatic syndrome due to toxic action or continuous sexual frustration. (1), (31), (12), (29), (44).

Not enough is known as yet of organic disturbances of the vestibular apparatus to admit of a sweeping inclusion of apparently Hysterical manifestations under the Hysterical diagnosis. Voss has described bilateral Hysterical deafness in combination with Hysterical paraplegia. Binswanger has also reported cases. It is rare nevertheless. (80), (13), (69).

Disturbances of smell and taste have not been satisfactorily investigated. Aguesia may accompany facial anesthesia. Zichen, investigating smell, finds in every case in his clinic great irregularities in smell in the non-hysterical. Voss reports many complete and half-sided anosmias, and says that the left side is most affected.

Unconscious influence upon sight has been strikingly illustrated in a few instances, and in general, tests have revealed the somatic unimpairment of sight, and have proved that it is only psychically affected. Unilateral blindness is the more frequent, although there have been a few cases of double-sided blindness. Diminution of vision, which usually affects the left eye, appears to be a purely psychogenic affection, and largely due to faulty examination. It is a complaint that arises largely out of fatigue, or an inability to concentrate attention.

Scotomata and disturbances in color perception, pupillary immobility and unequal pupillary reactions are sometimes observed among other complaints which the Hysterical reaction is able to produce. (1), (3), (11), (49), (87), (12).

VEGETATIVE SYSTEM CHANGES.

Inasmuch as the vegetative nervous system offers a bridge between emotional and intellectual adaptations, changes occurring in the vegetative sphere should be scrutinized very closely. Newly acquired knowledge of the vegetative diencephalon nuclei, and especially their implication in encephalitis, has offered entirely new view-points for interpretation. Thus suprarenal emotional hyperthermias are quite distinct from encephalitic diencephalic hyperthermias. Here is an opportunity for closer investigation of the relation of the activating wish stimuli, and the automatic pathways over which these operate. (59).

Thermic changes show great variation and an anomalous character. There may be rise of temperature, or there may be localized hypothermia, which was observed in Babinski's cases of so-called reflex disturbances. (62). Oppenheim and Voss say that Hysteria without the aid of other disturbing factors, may cause rise in temperature, although others deny such possibility. (67). Skin changes, urticaria, edema, and other secretory disturbances are all to be considered carefully as manifesting a purely psychogenic origin, or a psychic

activity upon a constitutional condition of skin irritability, trophic peculiarities, or what not. Here again the particular psychic trends of the personality may utilize the physiologic pathways, and at the autonomic level of nervous activity, convert an auto-erotic tendency, an exhibitionistic wish, any primitive self-seeking type of reaction into such definite disturbance, far below the level of conscious choice, or of conscious awareness. Occasionally even the Hysteric aggravates such conditions, or induces some manifestation, as a skin disturbance, by an interference and an activity which is almost clear in consciousness as an impulse or attitude, so that these pathways of manifestation are at the disposal both of the suppressed and the repressed factors of the personality. Although many skin lesions are a result of deceit, there is no doubt that many others are the outcome of Hysteria, superimposed upon the foundation of a slight trophic or vasomotor disturbance. Bullous dermatitis is not infrequently observed as an Hysterical phenomenon, while among the rarer types of so-called Hysterical skin disorders are reckoned acne, psoriasis, urticaria, dermographia, chromidrosis, ecchymoses, vicarious bleeding, etc. Vasomotor symptoms are uncommon when uncomplicated by postural symptoms. Acrocyanosis is a common accompaniment of Hysterical paralysis. Edema, although not of great frequency, is seen in monoplegic limbs, and erythematous patches are seen in areas where the Hysteric complains of painful paresthesia. (47), (52), (44).

A discussion of any secretory activity is similar to the above. There may be increase or diminution of saliva, sweat, flow of tears, while aggravated bronchial and nasal secretion is a most common symptom. All of these are indicative also in the healthy, of the ready conversion of emotion when it is aroused on certain occasions. It must, however, be kept in mind that it is possible in these manifestations to have a disturbance due to multiple sclerosis, syringomyelia or tabes. Polyuria is frequently met with, particularly in major attacks. Anuria, a common symptom in the Charcot school, is

now rarely observed. Hysterical diarrhea is well known. Both the intestinal glands, and the glands of internal secretion are under vegetative control, and are profoundly influenced by the psyche.

Changes in metabolism also fall under the same form of explanation as results of the disturbance of function by the psychic pressure, which has all somatic pathways at its disposal.

Alterations in reflexes are of considerable diagnostic importance. They are frequently present. The corneal, conjunctival, palpebral reflexes are diminished, and there may be loss of the faucial and pharyngeal reflexes. The triceps and radial periosteal reflexes usually are increased. The anal reflex may be absent or show hyperesthetic sensibility, like the rarer vaginal reflex. These two are evident signs of the emotional disturbance of the reflexes. Marked inequality in the reflexes on opposite sides should suggest organic lesions, particularly in the abdominal, epigastric and cremasteric. The knee jerks and Achilles jerk may be lost during or after Hysterical attacks, though they are, as a rule, increased in Hysteria. Here, too, the method of interpretation is not sufficiently clear. (69), (7), (67).

The male sexual apparatus is seldom affected in Hysteria in other form than impotentia coeundi; there is never hyperexcitability. In the female, sexual frigidity and anesthesia are common; vaginal spasm without erotic concomitant may impede sexual connection. (54), (55), (61).

Visceral disturbances are numerous, and only a few of the more important ones will be mentioned here. Esophageal spasm, or the globus Hystericus is very common. Nervous dyspepsia and anorexia nervosa are frequently seen. Vomiting of various degrees, and eructations of gas are often persistent symptoms. Diarrhea and constipation have been discussed. The origin of Hysterical mucous colitis and tympanites is still more or less obscure. (1), (81), (68).

PSYCHOTIC SYMPTOMS.

The strictly mental manifestations have been fully mentioned throughout this discussion, and their close association with the various forms of conversion phenomena. Yet special attention may be given to certain mental states which may mark the Hysterical picture, and which show more or less profound mental alteration as a result of the unconscious striving. Hysteria 'au large' is itself primarily a psychosis, but within its borders are to be found a series of phenomena, at times closely related to the somatic disturbances, to which the term may be more definitely applied. Of these the so-called Hysterical dream state (Dammerzustand) is perhaps the most important. Here consciousness has fallen temporarily to such an extent under the control of the unconscious phantasies that the patient remains or goes about in a state of dreamy delirium, or in a deep reverie, retaining a general orientation, or an ability automatically to engage in ordinary conduct, but with complete or partial amnesia afterward for his acts or for the condition. The dreamy attacks may be associated with a major seizure, immediately preceding the latter or existing during the attack. In this case the patient may be quiet and self-contained but dazed, or there may be the profound lethargic condition already commented upon. In the autonomic activity of the state of reverie, patients may go far from home, and be temporarily or permanently lost from their surroundings; they may commit crime, and even criminal acts which have a motivation in consciousness may be carried over to commitment in this dream state, so that this state is a most important matter of medico-legal interest. Pathological lying, accusations and the peculiar spasmodic, impulsive type of talking, laughing, emitting animal cries, etc., which has been called by Ganser "Vorbeireden", belong to this of twilight state acts. (49), (50).

Care must be exercised to distinguish this state from the similar one belonging to alcoholism, epilepsy, encephalitis, manic states, schizophrenia, or traumatism. The dreaminess associated with an appearance of consciousness, together with the suggestibility, rapid changeableness of conduct, the foolish, childish character of such conduct, and the signs of somatic conversion, distinguish the Hysterical dream state. The presentation of such a variety of symptoms, and also the ready ability to adopt symptoms from any other diagnostic group offer special danger of confusion with other psychoses. (78).

It is becoming more and more clear under penetrating research that there is not in the convulsive seizures the close resemblance to epilepsy once believed. Of course the two syndrome groups may be present at the same time in the individual. Aside from the distinctions which may be observed in the seizures, in which the loss of consciousness and motor control is complete in epilepsy, and partial and incomplete in Hysteria, the attempt to separate the two diseases in the light of the dynamic trend, makes a clearer differentiation between them. At the same time it gives the affective background out of which the impulses arise as a similar one, utilizing however, different mechanisms for taking up the dynamic impulse.

Epilepsy belongs to the malignant type of neurosis, perhaps appearing in a hallucinatory, disassociated form of phantasy, but at any rate representing a drift-back to an earlier biological level, psychic and somatic. This manifests itself in the completeness of the attack in its return of the patient to an infantile or preinfantile level, and in the gradual permanent regression of psychic and physiologic function as the epileptic deterioration proceeds. (35), (18), (84), (87).

Hysterical features may appear in connection with any other psychosis,

since Hysteria manifests a type of reaction in an altered personality. Somatic organic tests are a criterion for a differential diagnosis. In the more evident mental reactions, more difficulty is experienced, but here too, the consideration of the differing mechanisms is a guide. Hysteria is close to dementia praecox in its manifestations, yet as Jung has shown, these two syndromes represent different direction of reaction. In the Hysterical there is still the tendency to activity, to reach reality, although by the pathways of displacements and conversions, while in dementia praecox, the pathways are blocked, and the trend is away from the real world. Or according to Kempf's interpretation of the same distinction, in dementia praecox the patient is unaware that it is the ego's own wish and craving which cause the distress, that the distress has a personal source, while the Hysterical is able to acquire this knowledge. Kempf includes the latter in the 'benign' type of neurosis, and the former in the 'pernicious' type. (53), (56), (69).

PATHOLOGY OR MECHANISM OF HYSTERIA

Although in the following few paragraphs many of the concepts of this disease, as were presented in the Etiology, will be repeated, it is hoped that, following the discussion of Hysterical symptoms, the reader can get a better idea of the present-day conception of the mechanism of this disease.

The possibility of the Hysterical reaction is, of course, inherent in every person, and its appearance depends either upon some direct exciting cause or a change in resistance. Effects vary according to the individual, resistance being due to the inherited constitutional makeup in a more or less degree. (64). The exciting cause is usually some fright, shock or disappointment, but whereas it may take the loss of a husband or child to unloose the Hysterical mechanism of one, the death of a pet parrot is sufficient to keep another in bed for a month with an attack of Hysterical paraplegia.

The theory of psychic repression is well presented by Freud and by Coriat. (47), (25). Repressed thoughts, which in the past have been pushed into the unconsciousness, remain there as wishes and desires, and their nature is such that they act as intruders to the normal course of thinking, or they are not acceptable to our moral or ethical standards. Hence there is a constant effort to conceal them from the consciousness. This may also be an involuntary act to protect the mind from ideas which are unpleasant and painful. A resistance is offered to their entering consciousness again; but they lie in the subconscious like burning coals, and are apt to be presented to the consciousness in disguised forms which we term symbols. In day time the presentation of these symbols would be called Hysterical symptoms, while at night they appear in the form of nightmares or anxiety dreams. Such dreams or Hysterical delirium, repre-

sent a safety valve for the successful escape of our repressed emotions. (25). Hysterical symptoms are then wish fulfillments symbolized. The unconscious exists as a result of a repression, and consists wholly of repressed material. (43).

Let us consider the war neuroses here. The difficulties presented in such cases, increased and precipitated by special circumstance, a wound, a sudden overwhelming threat of injury, as in an exploding shell, form the final cause why the fatigued personality no longer reacts vigorously toward the outside environment, and retreats into pathways of less effectual activity; for these at the same time serve the unconscious, or barely conscious ends, such as, for example, a desire for release from the extreme difficulties of warfare, consciously unknown and unacknowledged to the individual. This reaction may activate any of the pathways over which the wish may bring a direct or indirect fulfillment. The roads to fulfillment might be those ordinarily called voluntary ones, which may interfere with certain ordinary voluntary functions, but they can just as well, by the same mechanism of mental stimulus of any physiological pathway, find their way into expression through the reflex arcs controlling tendons, skin, heart, vasomotor system, trophic conditions of skin, hair, nails, etc., or by those which adjust muscular states. In short, the patients have consciously or unconsciously, the whole range of bodily activity, sensorimotor or autonomic, at their disposal. The reflex vegetative arc has not been sufficiently taken into account, although this is possibly older in development than the more easily recognizable sensorimotor reflex arc and its response, and even the often observed reactions of the latter type really take place over such arcs. When research has brought to light more facts in regard to the establishment of such arcs, and their continued func-

tion in autonomic activities, the concept of Hysterical conversion will tread on surer ground, and its mechanisms will be seen under greater illumination. (29), (59).

The foregoing approach to Hysteria is made still more logical by pursuance of the idea of 'repression', as originally outlined by Freud. This works in the same fashion as the suppression, but with more profound effect upon the individual's personality; for the repression signifies that the individual tries, as Kempf puts it, to "prevent the autonomic cravings from causing him to be conscious of their nature, or needs, or influence upon his personality. He succeeds in this by maintaining a vigorous, incessant, defensive coordination (concentration of attention) of his 'egotistic wishes upon a course that compromises, as a resultant of converging forces, with the repressed cravings." Here the individual not only prevents the affect which represents his craving from passing over into unacceptable forms of action, but he also does not permit himself to be conscious of its existence, or the needs it expresses. In the mere suppression, on the other hand, he permits himself the awareness of the needs for which the affect stands, but prevents the expression of those needs in overt acts. (56), (47).

The symptoms which such a state of affairs causes can be seen as far as Hysteria is concerned in sensory disturbances, anesthasias, specific, localized and general, hyperesthesias and paresthasias, and in craving for certain forms of stimuli, perhaps sexual, perhaps esthetic, often for painful or semi-distressing masochistic. There may be amnesias and misinterpretations according to the buried affect and misrepresentations. Convulsions may occur, but without loss of consciousness. There will be interference with segmental functions, incoordinations, spastic and postural tensions, with also simulations of postures. (32). There will be in-

crease of muscular tension, of blood pressure, of exophthalmic tensions with hyperactive functioning glands of internal secretion, or there may be interference with these functional activities with lowering of their tone and tension, according to the form of unconscious attitude; for this may be that of a compensatory striving, to discharge the concealed emotion, or of a retrogressive tendency which tends to draw the personality further back into the realm of phantasy production and activity. (85).

These physiological reactions may be accompanied by, or substituted for, in a large degree, by corresponding mental attitudes, overcompensatory in nature, such as excessive zeal in reform or good works, sense of inspiration and exaltation of mission, exhibitionistic tendencies in dress, voice, manner of behavior, or they may represent the regressive attitude with evasion of responsibility, indifference, inefficiency, absorption in childish dreams. There may be even marked disassociation conditions manifest in definite and sensory disturbances, in an ungoverned exercise of excretory functions, more or less plainly erotic in character. There will be an uncontrolled, or a more systematic striving to compensate; there will be apprehension, panic over loss of self-control, anger and rage as an unacknowledged defense against the affective cravings, impulsive action, postural effects, and also phantasies as a substitute for denied reality. There may be also severe visceral distress and motor derangements. (18), (84), (59).

Starting with disassociation as the most fundamental descriptive term applicable to the Hysterical state--the doubling of the personality, in the sense of Janet, (50),--it has been shown that there is at the basis of this process of disassociation, an active process called repression, which has as its function the splitting off of inaccessible idea-constellation 'complexes' from the main body of the personality, and thus, so to speak, put-

ting them out of the mind. These complexes continue functioning, independent, more or less, of the balance of the personality. This process of repression and disassociation, following upon conflict, is a very general one, and is found in divers mental states, and is, in fact, a normal process. It is not these processes or mechanism which are characteristic of any particular mental disorder, but it is the way in which the split-off complexes manifest themselves that produces the different types of mental disorders. If the individual of the psyche be considered as being a complex of adaptive mechanisms which is always making an effort to come into closer adaptation with the environment, then the meaning of a conflict is that there enters into this mechanism certain factors to which it cannot make sufficient adaptation. This results in repression and splitting, but the whole tendency of the machine is to readjust effectively by bringing about in some way a new state of affairs.

In the conflict, there are two groups of tendencies in the psyche which are diametrically opposed to each other. No solution of the conflict can possibly be brought about by a fulfillment of one of these groups, because the conflict would still remain. Therefore any readjustment that takes place must in some way bring to pass the tendencies of both groups. Inasmuch as these groups are opposed to each other, such a result cannot actually be brought to pass in a world of reality, at the level of the conflict. Therefore, unless an adequate adjustment can be brought about, by an all-inclusive synthesis at a higher level, an artificial world which is not governed by the strict laws of reality has to be brought into existence, wherein those opposing forces can both, as it were, allegorically find their ends attained. In different mental disorders, this end is brought about in different ways. The Hysterical mechanism is different, inasmuch as while it is a general rule that the painful affect of the split-

off complexes is drafted off by various channels and thus finds expression, and while the expression is usually not consciously associated with the idea content of the complexes themselves, yet the patient is saved from a realization of the true nature of the complexes. He is thus conserved from an appreciation of the pain that would result if they were understood at their true value. In Hysteria the painful affect is drafted off into bodily innervation, so producing the somatic phenomena of hysteria. This is the process of conversion and is characteristic of Hysteria. The so-to-speak strangulated, unreacted-to emotion of the split-off complexes manifests itself as the physical symptoms of the psychoneurosis, and in this way the strong affect of the split-off complex is weakened. The complex is robbed of its affect, which is the real object of conversion, and hence its value to the individual. It is the fundamental Hysterical (conversion) mechanism which throws upon the body (and makes a scapegoat of it) the responsibility for our moral failures. And yet it does more than that. It produces suffering and pain, which here as elsewhere, point the way of relief by making the wrong path as unattractive as possible. Unconscious egotism provides the push, the repressions which demarcate lower from higher social values, distort and fashion the outlets, which finally emerge as the variegated mimicries of the Hysterical mechanism of conversion.

Many mistakes have been made by judging the Hysterical individual from the attitude of conscious logic, whereas really to comprehend we must see the illogical consistency of the unconscious. Herein lies the bewildering confusion of the symbolism of the unconscious. (52), (73), (84).

Freud concludes that: "1. The Hysterical symptom is the memory symbol of certain efficacious (traumatic) impressions and experiences.
2. It is the compensation by conversion for the associate return of the

traumatic experience. 3. It is, like all other psychic formations, the expression of a wish realization. 4. It is the realization of an unconscious fancy serving as a wish fulfillment. 5. The Hysterical symptom serves as a sexual gratification, and represents a part of the sexual life of the individual. 6. It, in a fashion, corresponds to the return of the sexual gratification which was real in infantile life, but had been repressed since then. 7. It results as a compromise between two opposing affects. 8. It may undertake the representation of diverse, unconscious, non-sexual incitements, but cannot lack the sexual significance. The mental symptoms of Hysteria are explained on the basis of elaboration and development of hypnoid states or erotic day dreams." (47), (85).

DIAGNOSIS

Little will be said at this point concerning the actual differential diagnosis of Hysteria, for this has been extensively discussed throughout the preceding text. That is, we have already described the Hysterical reaction type, the importance of 'suggestibility' in the make-up, the typical stocking or glove type of anesthesias found, and the diagnostic difference between an epileptic and an Hysterical seizure. It has been shown how Babinski, Oppenheim and others have given us the neurological tests to differentiate Hysterical sensory and motor involvement from true nerve lesions. We have discussed the types, and the importance of the Hysterical stigmata. There remain, however, a few factors in the general diagnosis of Hysteria which should be discussed.

Although in Charcot's time diagnostic errors were common, the newer signs of organic involvement of the nervous system provide an unfailing means for the recognition of Hysteria, and indolence has little excuse for diagnosing as Hysterical the organic disorders which may lie at the back of these symptoms. In his "Psychopathology of Everyday Life", Freud has related his confusion in overlooking an abdominal lymphosarcoma in a fourteen year old girl, who also had manifestations of Hysteria. But no one is immune from making such mistakes; for there is no disorder of the human body which has not been mimicked by Hysteria, and the diagnosis of Hysteria has been incorrectly attached to practically every known somatic disorder. A complete differential diagnosis therefore would range over the entire field of medicine and surgery.

If we take the attitude that Hysteria should be a diagnosis arrived at only after the most rigid exclusion, we have a method which will least

likely to lead to disaster, even though it may seem a great waste of time. Most of the mistakes wherein organic is termed Hysterical are due to carelessness in examination. (58), (73).

The Hysterical patient must be viewed from a different light. Man is not a physiochemical mechanism alone, nor a sensorimotor reacting device, nor yet only a human being in a human society seeking psychical adjustment to the needs of self-protection and race propagation. He is all three. His psychical needs rank the highest, else he would have remained at the lower levels, an earthworm perhaps. Hence the most vital questions with which the physician should occupy himself, if the question of Hysteria arises, are those of the human interests of the patient. The patient is not physically sick because his digestion is disturbed, or his sleep is interfered with, or his liver working badly, but because his psychical needs are upsetting his digestion, his sleep and his metabolism. The diagnosis of Hysteria will for some time no doubt be reached by the method of exclusion. (5), (14).

The psychical conversion hypothesis, moreover, does not apply to all Hysterics. In fact, most patients with predominant Hysteria show other symptoms. Thus practically, one has a mixed psychoneurosis in each and every case; some with pronounced neuresthenic symptoms; others with compulsive thinking, phobias, obsessions, tics; others with even psychotic admixtures, hallucinations at times, traces of delusional interpretations, etc. Just what any particular medley shall be called is a secondary matter after all. When one considers an individual patient, one does not care to give a name to a series of processes, one should understand the why and whither. A child may understand the name given to a choo-choo car, but this knowledge does not enable him to manage one; so to name a series of processes going on in a sick body, Hysteria, psychasthenia, etc., is of no particular service to the patient. It should be observed that it is another matter when technical hypotheses are sorted and compared in a society of those using these logical tools. Then diag-

ORGANIC.

nostic word symbols have a value. (29), (73).

Hysteria from the mental aspect, represents a mode of escape by the patient from reality. This mode is symbolically expressed through the symptoms. These are unconsciously developed in accordance with the character traits which are fundamental to the individual. These fundamental character traits are in course of formulation from earliest infancy, and their chief features are apparent in the very young. Heredity plays some part in creating or imparting somatic structures to carry on the work with reality. Environment, family, society affords educational features, cultural restraints, and outlets for the physical striving, the libido of the individual. This libido, working with better or worse organic structures, in accordance with well or badly managed repressions, gives the characteristic type of the ego, which striving for antisocial, associal, or social ends determines the value of the individual, that is, his sickness or his health. Inasmuch as the conversion or defense mechanisms are subversive of social value, they are called diseased, and also when of a special type, Hysterical. (43), (94).

In the 'neurasthenic' syndrome of older authors, many conversion mechanisms were included, but a preferable way of looking at neurasthenia is to regard it in the light of a very definite somatic disorder. It is a fatigue due to definite organic factors. Such factors are seen after acute or chronic exhausting diseases, after poisoning, after great grief or shock, or continued worry. Here the patient is unable to meet reality, but tries to do it, not by a side-tracking of his libido, but by means of a mismanaged repression through conversion. The neurasthenic really has little energy free to convert because of the exhaustion or toxic process. He is not trying to dodge reality. It is thrust upon him, and he cannot handle it. He may in addition run away, and may superinduce Hysterical phenomena. Rest and food cure this neurasthenia, if not complicated. It is somatic. (15), (19), (87).

Another somatic syndrome very frequently called Hysteria is multiple sclerosis. One should keep in mind the early fatigue of this disease and later Charcot's triad. Intention tremor as an Hysterical monosymptomatic sign is very rare.

Disease of the mid-brain frequently leads to a faulty diagnosis of Hysteria, especially when the sensory pathways are first involved. Here amnesia and peculiar irregular movements are carelessly termed Hysterical. Syphilitic disorders of the mid-brain are not rare.

Similarly early cases of paralysis agitans with pronounced emotional disturbances, which very frequently precede the motor changes, are called Hysterical.

The differential diagnostic signs of epilepsy may be categorically enumerated. Thus, the ordinary signs of epilepsy are, aura, loss of consciousness, complete amnesia, involuntary urination or sometimes feces, pupil immobility, clonus or Babinski at the end of the attack, exhaustion and sleep. In convulsive Hysterical attacks we have no aura, no loss of consciousness, partial amnesia, little or no injury to the tongue or body, and absence of involuntary discharge of urine or feces, absence of ankle clonus and Babinski, no pupillary disturbances, absence of fatigue, no desire to sleep, and often the attack lasts for hours with intermissions.

Acute cerebrospinal meningitis is generally readily diagnosed with the utilization of lumbar puncture, bacteriological and cystological examinations. (67), (81), (15), (44).

Organic brain lesions such as gummata, trauma, syphilitic meningitis, septic encephalitis, tumors, cerebrospinal carcinosis and hemorrhagic meningitis may be diagnosed Hysteria. Careful examination and developing symptoms should eliminate these lesions.

PSYCHOSES.

As might be expected, Hysterical symptoms are found in many of the non-hysterical psychoses. This is especially so in the manic depressive group, and in the early stages of dementia precox, and in the presenile and senile depressions, and is occasionally true of general paresis. Care should be taken in differentiating the dream states of epilepsy, alcoholism, manic stupor, catatonia, and traumatic dream states.

Jung's studies on the psychology of dementia precox, and those of Bleuler on negativism, emphasize the enormous difficulty in separating this symptom grouping, in its earlier stages, from Hysteria. Jelliffe believes that the symptoms, though identical, are indicative of different stages in the break-up of the personality. He argues that just as one reaches the same point, and sees the same view, in going up or coming down a mountain, so the disassociations of personality in the loose 'synthesis' which we call Hysteria, may show the same, or nearly the same, pictures as we find in the disassociation of a 'disintegrating' personality, which we name dementia precox. Often the history is the only aid in deciding between a catatonic stupor, and an Hysterical dream state. Sudden onset after a psychical shock points to Hysteria, while a longer, slower course implies catatonia. Both conditions share in foolish conduct, negativism, catalepsy, amnesia, grimaces, analgesias, etc. Refusal to take food, and long-standing negativisms are indicative of catatonia; unilateral pressure points, and disturbances of sensibility of Hysteria. Hysterics, even in the dream states, are less likely than catatonics to be uncleanly. Stupor, preceded by changes of character, such as emotion, stupidity, or disinterestedness, by hypochondrical ideas, ideas of influence, and menstrual disturbances should make one suspect catatonia very definitely. The emotional apathy of the dementia precox patient evidently

parallels the indifference of the Hysterical. Both are the result of covered up, hidden or repressed complexes, which are much more difficult to dig out in the case of the dementia precox patient because of his mental disintegration. In the Hysteric, the mood is broken up by an explosion, violent crying, muscular contortions, or some analogous outburst. Both disorders show a disease, an exaggerated phase of the normal disposition to repress the unpleasant, and to bury it deep down. In the Hysterical, following psycho-analytic investigations, we find conversions and transmutations; in the dementia precox patient, we see particular transpositions and blocking, which prevent adequate reactions to reality. The Oedipus complex appears baldly in the open in dementia precox, and in the paranoid form the tendency of father indentifications become very marked phases of the picture. If too much importance is not attached to them, the terms 'Hysterical character', and 'dementia precox character' are very useful concepts. All types of temperaments may be found among Hystericals, yet it is characteristic of these personalities that a powerful emotional complex is present, which is incompatible with the ego complex. Such emotional complexes, which are also present in dementia precox patients, show themselves in studied and pretentious behavior, artificial gaits, philosophical enthusiasms, religious originalities, etc. Delusions of social elevation in dementia precox manifest themselves in exaggerated manners, studied speech, bombastic expressions, affected eloquence and high-sounding phrases. Hysteria and dementia precox show themselves alike in quasi-religious schemes. (14), (22), (49), (73).

In summary, the mental stigmata are: outbursts of laughing or crying, an infantile reaction to reality, passionate sexually though impotent, somatic conversion symptoms, anxiety, and easily influenced by suggestion.

The practitioner has constantly to bear in mind the strong tendency in Hysterical patients to practice deception.

PROGNOSIS

It is probable that a small number of the mild cases of Hysteria recover without treatment of any kind, but the prognosis generally depends on the treatment. In the great majority of cases, the physician may look forward with hope to effecting in a few months a cure which, in view of the apparent severity of the symptoms, frequently causes much surprise to the friends.

Unfortunately, however, Hysteria may sometimes tend to relapse in home surroundings, but the tendency decreases with advancing age. The duration of the disease does not materially affect the prognosis, provided there have not been previous serious attempts at treatment which have failed. Such failures only further suggest to the patient that he is incurable. Previous treatment by hypnotism and suggestion is, for some reason or other, inimical to the success of subsequent treatment by psychoanalysis.

It must not be forgotten that a few cases of Hysteria end fatally, especially those suffering from dysphagia, anorexia and vomiting.

It is fortunate, of course, that the Hysterical patient usually retains enough insight into his own condition to permit a cure to be effected. The dementia precox, having practically no insight into his mental status, is faced with a poor prognostic future. (84), (15).

TREATMENT

Prophylaxis and individuality should be the slogans in dealing with Hysteria. Complete knowledge of the history of each individual case is essential.

Just as the conception of Hysterical manifestations has passed through many stages, so has the practical approach to it. Its dynamic nature, as that is understood today, explains also the method of sensational, 'Miraculous' cures which has not yet passed out of possibility. Anything that will suddenly or slowly alter the form of striving for the active cravings, and through confidence, 'faith', open the personality into outgoing channels, such as a trusted or loved object offers to every human being, can make an occasion for a cure. This is in essence the 'transference' phenomenon of Freud. Such a redirection of energies gives at least a partial, and often a most striking, relief of affective cravings, by which, healthy function has been restored.

Psychotherapy is the best, one might almost say, the only mode of treatment. Psychotherapy is capable of wide definition, and includes the use of every means by which the patient may be helped to the attainment of self-control, from the word of command which may relieve the child of an Hysterical paralysis, to the use of pragmatic philosophies and tactful dialectics, or the wise and careful psychoanalysis required in the treatment of a college professor, or a refined and intellectual individual. General laws are impossible of formulation; the means must be suited to the individual, and his social milieu, always bearing in mind that moral re-education is an absolute necessity, if one would have permanent results. Nevertheless the ideas expressed by psychotherapy, naturally fall into loose, overlapping groups, the principal of which are hypnosis, suggestion, and reeducation. (29), (79), (73).

HYPNOSIS.

Suggestion and hypnosis have the same basis for their affect. They also represent the readiness of the unconscious self to expand, to open up to outside objects through the stimulus of emotional response, to the physician or other medium of healing, and thus an alteration takes place in both the goal and the mechanism for reaching that goal. The change in all these cases is really in the patient himself, and effected only by him, although by means of his unconscious self, where after all his dynamism lies. Thus suggestion, hypnotism, the presence of a 'divine' person or a sacred spot, or a sudden event, tragic or otherwise, which changes the trend of the striving, are all only opportunities for this personality to assert itself in new ways, ways which better fit the demands of the real world upon the personality.

Hypnosis has been modified considerably, and now implies a form of suggestion in which ideas are impressed on the patient's mind while in a state of modified consciousness known as hypnotic sleep, and which is induced by some trick method. Not every patient can be hypnotized, and also it is doubtful if suggestion effected by this means is of much value in the case of the weakminded, or for those whose Hysteria is due to constitutional mental inferiority. It is in these subjects that absolute evil can be accomplished by hypnosis in the hands of the unscrupulous. The type of patients in whom hypnosis seems to work some real value are those whose susceptibility is an expression of the Hysterical personality. It may be an aid in gaining a foothold with those patients, but it is not sufficient to cure severe Hysteria. It should be used merely as a preliminary to re-education, lest in place of eradication, perpetuation of the reactions may be the result. The use of hypnosis as a means of therapy has lost ground greatly, and has been rejected by many of those who were at one time its warmest advocates. It remains a strong card in the hands of Indian fakirs,

SUGGESTION.

and charlatans of many brands. (16), (17), (34), (87).

Suggestion as a definite means has also lost ground as being unsatisfactory. As here used the term means the bringing about of an affect state by influences which are not apparent to the individual. It consists in inducing mental associations leading to the modification of the patient's emotional, and therefore psychical, state that will cause actions that will make for better adjustment. Suggestions enter consciousness, either perceived on the threshold, or on its margin, awaken ideas and associations, and bring about action which has a compelling force on the individual, who is probably quite unaware of the source of the influences. The wise suggestor knows how to appeal to every idiosyncrasy of the individual, and combines with suggestion persuasion, and in some cases makes use of the word of command.

There exists a danger in all these methods of only partial alteration of the personality. A seeming cure may be effected in regard to a portion of the personality, while other trends, others cravings still conceal themselves. Some childish pathway is still overcharged, and over it the wish bursts forth later in a new symptom or group of symptoms. This is particularly evidenced in the 'brutality' methods, so dear to anal erotically conditioned therapists. These medieval and barbaric ways of 'chasing the devil' out of the patient by command, etc., get rid of only certain forms of behavior; they really do not cure the patient; they drive the disorder into other more settled forms. (30), (4), (9), (87).

Freud recognized this together with the need to reach the more persistent symptoms, which were not accessible to the methods mentioned. He therefore instituted and developed the slower but more thorough method of 'psychoanalysis'. He bases it upon the same principles which underlie the forms of therapy discussed, only he carries it through the analysis to the point where the aims and strivings of the personal cravings are brought to the clear knowl-

edge of consciousness, so that the patient has a conscious control and choice of methods of reaction before him, and he is no longer unconsciously driven to utilize the ineffective and distressing ones of the Hysterical mechanisms. Also the patient is left with such a wholesome knowledge of the mechanisms once employed, and the manner in which they are built up and employed by the unconscious, that he can avoid their domination, and so control his own life without the need of such indirect 'symptoms'. (35), (40).

Freud's chief medium for bringing the patient to a knowledge of the hidden affective cravings, as well as their manner of transformation over into substitution and somatic symptoms, is the dream. (41). He examines this in the light of free association with which the patient surrounds it in the conscious telling and contemplation of it. In this way a knowledge is gained of the whole personal trend and aim, with those individual factors which have been pathologically developed. It is out of this background of understanding and approach, that modern psychopathology aims to make more clear the dynamic trends which the autonomic affective cravings of the personality have taken. In this way not only can the mechanisms be understood, but they can be followed out therapeutically with the patient. Thus other more effective mechanisms can be substituted, and the craving or wish brought again into a form of activity which satisfies both the personality, and its relation to social environment. This, of course, is the process of 'sublimation', and removes the barrier erected by the faulty mechanism, and through the phantasy form of the wish. It finds an adult method of direct gratification in many forms, instead of in the impossible and unacceptable one which was harbored in the infantile phantasy. (51), (53), (40).

This sort of classification gives also the best understanding of the

PROPHYLAXIS. PSYCHOANALYSIS.

prophylactic possibilities in regard to Hysteria. Freud has made it plain that these lie chiefly in the period of childhood, and consist, most simply expressed, in the aiding of the child to develop in a free and unhindered attitude toward the world of reality in which he must live. This is not the unguided and untrammelled following of individual impulse; for this would only increase the introversion upon the interests of self, and the intensifying of these interests, to the exclusion of relation to other selves and the outside world. Then when the child in its earlier or later years finds that these interests must be altered, and adapted to meet external conditions, it is driven away from the difficulties which these conditions present, and back into an unconscious (in the Hysteric a partly conscious) indulgence in phantasy gratification, instead of the efforts and often hardships of reality. Then the struggle continues between the cravings and the phantasy form they have taken, and the conscious world, so that the conversion or substitution pathways are resorted to. (43), (40).

It is therefore important that children should be treated with that wholesome neglect which does not set them in the limelight of importance, from which it is so hard for the immature adult later to free himself, and which makes the hard contrast between the ideals of phantasy, and the actualities of the world of environment. On the other hand, a too great actual neglect may foster in the child a sense of deprivation and abuse, a negative or masochistic sense of self-importance also productive of phantasy exercise rather than reality. In either instance, account must be taken of the inherited constitution including possible inferior physical constitution, and of other handicaps which make the adaptation to the external world more difficult, and phantasy production easier. (24), (98), (103), (102), (92), (95).

Most important is it to watch the attitudes which the child builds up to definite questions and situations of life. The child is confronted with

facts and situations which, in the light of his experience, ignorance, and comparative helplessness present to him far more serious and weighty problems than adults usually remember as belonging to their own history. (98), (99), (86).

Chief among these, or forming the center interest of all his problems, is the sex problem. Here again Freud has not only brought to attention what children themselves clearly enough reveal to us, when we have eyes to see it or courage to believe it, that the sex problem is always with the child, and is of paramount interest. Moreover, Freud has taught us to recognize it, not in a simple, unified, adult form, but in a polymorphous form in the many appeals it makes through the child's own variety of interests in its own body, and in its different relations of adjustment to the objects and individuals, chiefly the parents, by whom it is surrounded, and its love response to them. It is a variable problem also because the child is passing through various stages when one form of sex interest or another is paramount, on its way up to adult maturity. Here more than anywhere, the judicious but candid presentation and treatment of facts aid the child to develop in the realm of reality, rather than in phantasy. This makes a wholesome attitude of handling these facts, and building up reactions which are free and self-expressive, and do not necessitate the roundabout, pathological mechanisms of substitution, conversion, etc. (24), (38), (42), (43), (48).

The prophylaxis of Hysteria chiefly concerns childhood, since the reactions are deeply laid, and for the most part dependent on a life-long attempt to adjust ~~the~~ sick and perverse family conditions. Hysteria rarely develops in healthy family surroundings. In the sense of mild suppression Hysterias, such for example, as war conditions produced, they might be avoided by avoiding conditions of extreme hardship and fatigue, without which

the individual might always maintain a healthy reaction. In many cases, however, there would be found an already imperfect mechanism brought more prominently into activity by the difficulties encountered, and the temporary personal disability. (62), (63), (69).

A definite outline of treatment should be followed, consisting of first an exhaustive history. We have not space here to mention all the environmental and social facts, etc., that should be included in the history. The next treatment step is the physical examination, which must be complete to rule out any somatic pathology. According to an outline as developed by Riggs, the physician then enters into a frank discussion with the patient concerning his difficulties, and the reasons for his maladaptation. The patient is then informed of the plan of treatment, and is given a daily schedule to meet his individual needs. It consists of exercise, diversion and rest. The key-note of the treatment is re-education. It stresses the importance of dominating the emotions, and of utilizing the intelligence to guide conduct. Efficiency is emphasized. The patient is impressed with the necessity of making clear-cut decisions. The harmful effects of worry, unnecessary hurry, inattention, and self-pity are elaborated; they are manifestations of inefficiency. The patient is instructed concerning rest, which is not synonymous with sleep, and is chiefly the temporary and volitional abandonment of responsibility. (16), (85), (50), (30).

The "cathartic" method, as first termed by Breuer, and later worked out as Freud's "Psychoanalysis" method, can now be used if the case needs such. It may, in short, be described as "talking it out", an unburdening of the patient's mental troubles; a scientific application, one might say, of the principles of the confessional. By gaining the patient's confidence,

and permitting him to see his unconscious mind, the analyst seeks to overcome the resistance, to bring back to consciousness the disagreeable memories curtailed by the Hysterical reactions, and thus throw light on the repressed wishes of which they are the realization. When this has been done, the first step on the road to a cure has been made, and re-education becomes possible. Great tact, patience and concentration are required, as well as the power to gain confidence. Every symptom has some meaning which it is the task of the analyst to reflect back to the patient, as in a mirror, that he may see himself. Every act, symbolic expression or action, lapse in speech, mannerism, needs to be carefully noted, and its bearing coordinated. Besides this 'free association', dream analysis is of tremendous importance. (63), (41), (53), (51).

It is of great importance to trace back the patient's emotional life to his earliest years; for frequently some childish experience, the memory of which has been repressed and forgotten, is the foundation for the Hysterical reaction. Forgetfulness is the normal means of blunting the pain of an emotional strain, especially when the stress is great, or when such reactions as fears, anger, impulsive acts, etc., lie at the base. The shock caused by the loss of loved ones, cannot be removed by discussion; social relations may make mention of the shock impossible, or there may be something which the patient wishes to forget. These things are not given voice to, but are thrust back, repressed and overlaid by some Hysterical reaction. The experience itself may be forgotten, but the emotional scar remains.

The physician, working by this method, aims to bring the underlying factors into the open, and remove the cause for the reaction. There is no doubt that the method is of greatest value in the great majority of cases, especially in those patients whose intellectual powers enable them to follow the process with intelligence. (90), (79), (70), (51).

A critical point in the treatment is the management of the transference, which is soon manifested by the patient, and which is a sign and measure of resistance. In one sense, 'transference' is the unconscious misidentification of the analyst, so that the patient may behave and feel toward him in a way which satisfies the experiences and impressions which refer to another (love or fixation object). The measuring rod of the analyst, which in a way is a prognostic indicator, is the Oedipus complex. In its character and strength should be determined the potentiality of breaking away from the father or mother fixation, and entering into true heterosexual life. More broadly, it is a gauge of the degree of sociability or adjustment which is possible. The final stages of psychoanalysis concern themselves with the overcoming of resistance, and the leading of transference by the analyst into safe and useful channels, so that when the patient is ready for explanation, sublimation may be expected. If sublimation, which may be regarded as the erection of a higher goal, not a sexual one, to obtain which the energy of unattainable wishes is utilized, is achieved eventually, then the cure is complete. (4), (16), (22), (29), (53).

The wise psychiatrist also insists upon a follow-up treatment.

The field of treatment can scarcely be touched in the space here allotted. Weir Mitchell has contributed tremendously to the treatment of Hysteria. Volumes have already been written upon the relations of the endocrines to the psychoneuroses (33), and at present, the Massachusetts General Hospital seems to be doing the most work along this line.

An excellent summary of treatment has been prepared by Janet (50) in two volumes, in which he thoroughly discusses treatment by suggestion, hypnotism, rest, isolation, mental liquidation, education and re-education, by excitation, by psychophysiology, and by moral guidance.

CASE HISTORIES

CASE I. (Anxiety Hysteria). 33426.

Jennie Zlotky, Jewess, saleslady, single, age 36, was in the University Hospital from 11-5-30 to 11-14-31.

Entrance Complaints-- Fear of heart trouble, fear of becoming insane, and inward nervousness, all beginning one year ago, three weeks following the death of her father who dies of heart failure. She had to quit work six months ago because of the nervous attacks, and believes that exertion strains her heart. Soreness of left ankle, toes and sole of foot, is also complained of.

Past History--Born in 1894 in Poland, but came to the United States when one year of age. Family history is essentially negative.

Has had the usual childhood diseases. Her school work was poor, and she left the first year of High School, at the age of seventeen. She was sensitive as a child. In 1918 she had influenza and pneumonia. When eighteen she had an appendectomy and an ovary drained. A year later an operation for abdominal adhesions, and a year after that, a nasal operation. The past year a vaginal discharge has accompanied her nervous spells.

Present History--Has good morals and no desire for sex relations. Did not marry because she felt too weak to do so. Likes attention, but is embarrassed before others. Is a good mixer, but tends toward lethargy attitude and feels inferior. Is easily upset by argument, and has emotional displays. Lost confidence in God since the death of her father. Seems to enjoy poor health.

Mental Examination--Fears death, yet wants to die. Complains of a feeling about the heart. Complains of sore abdomen, pain and disability of

of left ankle and foot. Has headaches and demands relief of all her pains. Is sensitive to praise or criticism. No delusions, hallucinations or flight of ideas, or paranoid trends. No retardation, negativism, or ideas of reference. Is pre-occupied by her condition, and worries over her death. Is easily distracted, has hypochondriacal delusions, the orientation, insight and judgment are good.

Physical Examination--Pulse, temperature were normal throughout her stay in the hospital. Pelvis was checked several times and was negative. Has an intact hymen. Was tender over both ovaries once. Urine and blood was normal throughout. Cranial nerves negative, reflexes normal, virgin breasts, mitral murmur but heart well compensated. No cause could be found for the abdominal or ankle and foot pains.

Progress--Anal fistula was repaired, psoriasis of the arm was treated, X-rays of sinuses and ankle revealed no pathology. An attempt was made at psychotherapy, to make her rest, cease her worrying, and occupy her mind with other things. A gradual improvement was the result, and she was dismissed on 7-14-31, being fairly well adapted to her problem.

CASE II. (Acute Hysteria) 33553.

Mrs. Leona Hawkins, white, American housewife, age 30, was in the University Hospital from 11-19-30 to 12-3-30.

Entrance Complaints--Fainting spells with no aura, beginning five weeks ago and was incapacitated for three days, though had not head injury. Someone was always present during the attacks, particularly her husband. Now has three attacks quite often with no increase in symptoms, or relation to anything in particular.

Past History--Usual childhood diseases and had draining left ear. Had lues eight years ago and was treated. Family history negative. No children though married ten years. Reflexes are increased with decrease of pain sense in Achilles tendon.

Mental Examination--From her statements on history she is inclined to know too much about what is wrong. Is not alert, yawns, tired, desires attention. No flight of ideas, mutism or retardation. Is not exalted, sad or fearful. No delusions, compulsions, or hallucinations. Is worried over finances. Has good orientation and memory. Insight good.

Physical Examination--Temperature, pulse and respiration are normal throughout. Blood and urine normal. X-rays of chest and heart are normal.

Progress--Has dizzy spells in which she falls to the floor. The last attack was 11-14-31 and lasted two days. Some friction with the husband is suspected. He leaves on week-ends on hunts. Three months ago she met a young man, 'Al', at a show, and he took her home. She constantly feared this information would reach her husband. This is told to her husband with her knowledge, and she obtained a better outlook on the situation. She went home much improved on 7-3-30.

CASE III. (Hysteria with Sex Basis) 33997.

Mrs. Katie Sallee, American housewife, 27 years of age, was in the hospital from 1-10-31 to 2-28-31.

Entrance Complaints--Pain in chest; tired, aching legs; dizzy spells; nervousness; smothering spells with dyspnea; all since the birth of her first child six months ago. The spells are caused by over-excitement, and have increased to four times a week. Pain over the heart has also been present at these times.

Past History--Has had the usual childhood diseases; measles seven years ago, and has been weak since. In the family history we find that

one sister cries easily. Has lost some weight and sleeps poorly.

Physical Examination--Temperature, pulse and respiration are normal throughout with a few upshoots in the pulse rate. X-rays of the chest, sinuses and teeth are negative. Blood and urine were constantly negative. Cranial nerves, reflexes and pelvic examinations were all negative.

Mental Examination--Patient seems to worry about something. Is very modest and self-conscious. It was discovered that she had absolute lack of libido since marriage. She had always had the idea of modesty concerning sex, an outgrowth of girlhood which is so pronounced as to make the sexual act seem immodest and obscene. The husband was not a good provider, but the patient was very faithful to him nevertheless.

Progress--Patient adjusted well to the ward, and gained weight readily. Psychotherapy with enlightenment upon a proper sexual concept was attempted, and the patient was released much improved.

CASE IV. (Hysterical Hiccoughs) 32798.

Mrs. Elizabeth Sterling, American housewife, age 25, was in the hospital twice, from 8-21-30 to 8-28-30, and 1-1-31 to 1-12-31.

Entrance Complaints--Continuous hiccoughing.

Past History--Usual childhood diseases, no important family history, a brilliant girl, finishing High School in three years, at the age of seventeen. In 1925, she had a nervous breakdown during which time she tried three times to kill herself, by cutting her wrists, jumping out of a window and tying a cord around her neck. She was married July, 1927.

Physical Examination--Absolutely negative in all tests.

Mental Examination--Has had the hiccoughs five times in the past six years. She is very sullen. She cries easily, and says that the nurses are mistreating her. This is an old case, improperly handled perhaps the first time seen; for it is probably one with a sexual complex at the base which has resulted in the repeated attacks of hiccoughs.

Progress--Patient conformed readily to the routine of the ward, and soon behaved well enough to gain dismissal. It is felt that the case should have been carefully psychoanalyzed.

CASE V. (Anxiety Hysteria) 34238.

Mrs. Amelia Werner, a German housewife of 37 years, entered the hospital on 2-5-31 and left on 3-6-31.

Entrance Complaints--Tonsillitis, pain over sinuses, extreme nervousness, numbness in arms especially the left, smothering painful feeling in the chest, frequent colds, crying spells. All of these have been increased during the past three months, and this was the date of birth of her last child.

Past History--Family history negative, had the usual childhood diseases, and says she was always a nervous child. Had her appendix out when she was 19, and had the influenza in 1918. She quit school as a sophomore in High School. Three miscarriages, coitus interruptus by husband.

Physical Examination--Blood and urine examinations normal. Tonsils out on 2-6-31. Pulse, temperature and respiration normal throughout. Teeth are poor.

Mental Examination--The phobia state is due to the sequence of the following emotional shocks: a nervous temperament all her life, a scabies episode three months ago after the birth of her first child, (fears and very emotional at this time), Chicken Pox followed this, and Scarlet Fever after this. She then became Hysterical over a supposed rat poisoning to the child. She was afraid of lightning shock. She feared phenol after treating herself for Poison Ivy. She then developed a phobia for all odors. Mood, sensorium and intellectual capacity were all right.

CASE VI. (Chorea-like Hysteria) 54758.

Miss Arlene Kennedy, white, single, age 22, was in the hospital from 4-3-31 to 8-31-31.

Entrance Complaints--Extreme nervousness; spasms of muscles of legs, arms, hands and feet; inability to relax; worries about her health.

Past History--Since the age of eight, has shown twitching contractions or choreiform movements, and was always a very nervous child. She was under many doctors' care, and showed temporary relief. The past year the attacks have been more frequent, and worry and nervousness have increased. In March had an acute appendicitis, but this subsided. The past month she has been very nervous, and the muscles all seem tense. She could not work the past six months, and now she cannot sleep. In the family one sister has fainting spells.

Physical Examination--Tonsils, adenoids and teeth all out six months ago. Has frequent sore throats though. Pulse, temperature and respiration were practically normal throughout, although the pulse shot up occasionally. The blood and urine remained negative. She has a chronic cough, and has a feeling that her heart is beating forcefully. She has frequent burning with nocturia, and worries about self and health.

Mental Examination--Patient says that her only worry is her health; home life exists, and has no particular emotional shocks. Has cared for some men, but never let it worry her when she could not go with them. Has a spastic contracture of left arm, hand, leg and foot. When excited, the patient has a constant spasm of one or both hands. Occasionally the entire group contracts at one time. Face and trunk are free from muscle involvement. When asleep she has no contractures.

Progress--Some sodium amytol was given in the treatment, but the treatment consisted mainly of introspection about complexes, sex, etc. No true pointers were elucidated along this line, but during her confinement the patient got gradually better, and was dismissed on 9-1-31, with only occasional twitchings.

CASE VII. (Globus Hystericus) 24440.

Miss Dorothy Marr, white American, age 15, was in the hospital from 1-10-28 to 1-22-28.

Entrance Complaints--Choking sensation, increased pulse rate and nervousness. These began September 26, and occurred three times a week, lasting about three hours.

Past History--Patient had the usual childhood diseases. No family history of importance. The first attack began while playing, and later on followed other activities, and was characterized by dyspnea and increase of pulse rate. Attacks occurred every month at premenstrual period and also about three times a week.

Physical Examination--Thyroid slightly palpable, though B.M.R. is -5, W.B.C. 9200. X-rays of chest negative. Bad tonsils and palpable cervical glands. Pulse 136. Other laboratory tests negative. Heart, lungs, G. I., G. U., symptoms negative.

Progress--Choking spells were the only complaint. She had a spell on 1-20-31.

These felt like a ball in the throat. The patient was put at rest, and alkalinized. The attacks gradually disappeared. Tonsillectomy was advised.

CASE VIII. (Anxiety Hysteria) 26886.

Mrs. Hill, white, American housewife, was in the hospital from 11-3-28 to 11-19-28.

Entrance Complaints--Extreme nervousness, occipital headache, pain calves of the legs and in the back, on exertion.

Past History--These symptoms began four years ago. Since she was 26, she has had a series of operations with little relief. 1. Right ovary removed when she was 26, and it took eighteen weeks in the hospital to recover. 2. Tonsillectomy on her own accord when she was 27. 3. Teeth pulled six months later. 4. Right tube was taken out at Mayo's, when she was 28, although she went there with the idea of a goiter operation. 5. Cysts in ovary operation when 30 years of age. 6. Appendix a little later, and then an operation for adhesions following the appendectomy. 7. The next year she had a hemorrhoidectomy. 8. This was followed by an ulcer of the colon. 9. When 32 years of age the hemorrhoids returned. 10. One year ago when she was 39, the left tube was removed. She has lost forty pounds in the last four years. The past two years she has had night sweats, and coughing spells with the sweats. Six weeks ago an abscess of the right labia was removed. This has been present for fifteen years, and has drained of its own accord. She has had bronchitis twice in the past two years. She has dizzy spells with blurred eye vision. The heart is negative, except for tachycardia attacks.

Physical Examination-- In the past ten years, attacks of pain over the heart with pleurisy were relieved by pressure over her side. Those now come

once a month. G.I. is negative. Menses are ceasing, lasting only a day or two now. Smokes and drinks some beer. Has been using allonal to excess the past month. Family history negative, except for a strong strain of tuberculosis. Pelvic examination negative.

Progress--With rest, psychotherapy and restraint of drugs, the patient gradually resumed a fairly normal reaction to reality. General dissatisfaction, overwork, worry and family trouble were the main offensive agents in this case.

CASE IX. (Hysterical Vomiting of Pregnancy) 34223.

Mrs. Gabrielle Wilson, white, housewife of 31 years, was in the hospital from 2-3-31 to 2-5-31.

History--A case whose last period was on December 5th, complaining of morning vomiting since that time. She has been unable to hold anything on her stomach, especially during the past four weeks.

Physical Examination--Was entirely negative throughout its complete routine.

Progress--The vomiting was finally ruled of a Hysterical nature, rather than one of toxic origin, when the following history was obtained. The patient really did not want to carry through with the pregnancy. Financial difficulties were at the basis of the problem. The mother wanted to be sterilized, and rid of the present pregnancy. Encouraging advice was given the patient after she had been put on a strict rough-dry diet, and she finally reconciled to carry through with the present pregnancy.

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