RECENT HYSTERICAL STATES AND THEIR TREATMENT.*

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RECENT hysteria is not a disease. Its manifestations represent the pathological exaggeration of a normal protective mechanism. By this mechanism otherwise well-adjusted individuals are enabled to gain time when a sudden reverse of fortune or an overwhelmingly difficult decision presents itself. Its purpose is to ease the blow and thus to prevent that paralysis of effective response which may result from the too sudden realization of the full implication of a situation.

There are three methods by which this flight from immediate realization may be effected: the *flight into activity*, the *flight into non-realization*, and the *flight into incapacity*.

Of these, the first offers but temporary aid, and is seen where the individual, in his distress or indecision, takes refuge in some irrelevant activity. Nero is perhaps the classical example of this, but it is seen in widely varying circumstances. The man faced with a business reverse paces the room, whistles or makes stereotyped drawings on the blotting-paper; the prisoner dresses meticulously on the morning of his execution. In the pathological field, it is seen in the aimless movements of panic-stricken crowds, in hysterical screaming attacks or the frantic gestures of persons distraught. An important variant of this process is the *flight into anger*, where the insecurity and fear engendered by the situation are thrust aside and forgotten in a wave of anger directed against its cause. Such escape reactions can only be of brief duration, and if with their aid it is still impossible to attain an adjustment allowing of normal behaviour, they must soon be replaced by another form of flight. In such moments of panic, as Kretschmer has pointed out, atavistic motor patterns may be released (hypobulic mechanisms), and there is reason to believe that in certain individuals there is a constitutional predisposition for such psychomotor storms to be released by stimuli below the normal threshold.

When misfortune is sudden, few can face its full import in an instant. A period of bewilderment or a feeling of unreality may be regarded as a normal response, whether the ictus be physical or psychological. This period of partial realization will normally give place sooner or later to a fuller grasp of the situation, and with it the development of signs of anxiety in proportion to the threat to the individual's psychic or somatic integration. When he is

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unable to endure this anxiety, whether on account of its intensity, or because of a constitutional inability to do so, the original *mechanism of non-realization* may be perpetuated and developed as an hysterical symptom. Such symptoms vary from complaints of marked depersonalization to twilight states, somnambulisms and stupors. The feature common to all such recent hysterical states is an incomplete realization and a total or selective amnesia for the essential cause of the upset. In terms of the unconscious, a complex with an unpleasant affect is in process of incomplete repression, and the effect of the repressing force on the individual's conscious life is such as to reduce his whole appreciation of his surroundings. Even this group of reactions cannot afford a permanent solution of the patient's difficulties. It is unusual for a twilight state or a stupor to remain unchanged, as such, for a long period. Either the patient's realization of his circumstances must be modified in degree, or a more permanent protection has to be substituted for this temporary retreat. It is common in stupors and twilight states, in which the patient has little or no contact with his environment, for the hiatus to be progressively restricted until it exists solely in relation to the disturbing process. Thus a twilight state may undergo transition into a total amnesia, which gradually becomes selective for the causative event as points of contact with the every-day environment are gradually recalled.

The pathological mechanisms of non-realization contain, however, a new element, in that the patient is by their aid able to withdraw from the situation by virtue of his incapacity to carry on a normal life. It is this *flight into incapacity* which, unless its purpose is purely a temporary retreat, forms the basis of chronic, as opposed to recent, hysteria. As the clouding of consciousness of the fugue or twilight state gives place to full orientation, the individual may find himself still shielded from full appreciation of his difficulties or from the necessity of doing anything about them by the appearance of a protecting symptom, the aetiology of which seems to him a mystery. Such symptoms are the aphonias, amnesias and Ganser states, which are seen almost exclusively in the transitional states of recent hysteria. While they stand as a reason-proof barrier between the patient and his troubles, they also have the effect of rendering him *hors de combat*, and introducing him to the freedom from anxiety available to the possessor of an invaliding symptom. Such patients have taken a further step in the direction of chronic hysteria.

Such a progression to *functional incapacity* through intermediate mechanisms of non-realization is not the most frequently occurring. It is more likely to be seen after the sudden stresses of war, where existence itself is acutely endangered, than with the more delicately balanced anxieties and indecisions of civilized life. Functional incapacity is seen either as a *mode of retreat* or as a *means of adjustment*. In the first case, as seen in recent hysteria, its purpose is to spare the individual the anxiety produced by physical danger or intrapsychic conflicts by allowing of an honourable retirement from the situation

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without great loss of contact from every-day life. In the second case, seen in chronic hysteria, the purpose of functional incapacity is to achieve a more or less permanent mode of life in which the patient is allowed by his symptoms to adapt himself only to that part of his environment which he wishes to face. He makes this adjustment, however, only at the expense of an admitted inferiority to his fellow men. His outlook on life ceases to be that of a normal adult and he becomes increasingly dependent on his symptoms, as a child is on its parents, and his personality tends to revert to an immature and dependent pattern which has, at least superficially, many of the personality-attributes of the child.

There are few children who do not avoid unpleasant tasks by a pretended illness, whether it be a headache to avoid homework or a pain to avoid eating spinach, but the likelihood of such a mechanism being employed as a means of avoiding more serious difficulties in later life will depend not only on the presence or absence of innate tendencies to react to stress in this particular way, but on the extent to which such evasions have been allowed to flourish and become habitual in early life. The process of facilitation by which a conditioned response becomes ingrained in the experimental dog has its very close counterpart in the development of the advantage-of-illness motive.

The opportunity for escape through minor physical disability is of daily occurrence, and few have not at some time availed themselves of it to avoid an unpleasant duty or explain a failing. The difference between the every-day use of this mechanism and its pathological use is one merely of degree, and the transition from its deliberate to its habitual or " unconscious " use is as indefinite as the borderline between malingering and hysteria. Those who have learned to avoid most of their responsibilities in this way will retreat at once from anxiety by the same means, while others of sterner fibre will take refuge in somatic disability only after a severe struggle in which anxiety and mechanisms of non-realization alternate for a long period. In such cases exhaustion is often the factor which finally determines the flight into functional incapacity.

Relationship of Anxiety to Recent Hysteria.

Anxiety is not usually a pathological state. Its normal purpose is to prepare the individual to take action when an unusual decision or situation presents itself. When only one course of action is possible anxiety is minimal, and consists of a physiological preparedness which is noticeable to the subject in proportion to the importance of the situation to him. The subjective sensations of this state, which does not endure for long, make up the state of " wind-up " or apprehension normally felt before important events. When, however, the situation is one demanding a decision between alternative courses of action and this decision is not taken surely and at once, the resulting state of conflict may lead to a state of pathological anxiety having subjective features similar

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to those of apprehension but enduring for a longer period. This pathological anxiety is most likely to make its appearance when the conflict involves the instincts of self-preservation, of reproduction, and of the "herd instinct." In the latter are included the complicated codes of honour and duty whose conflict with the primary instincts is so often productive of the neuroses of civilization.

When to apprehension is added a direct threat to life, the emotion of fear is experienced. When this has persisted for some time the state of lasting fear is indistinguishable symptomatologically from anxiety due to conflict. Acute fear and its extreme form, terror, are exaggerations of the normal reaction of apprehensive preparedness in response to an acute stress. Anxiety is thus necessarily an integral part of the development of an hysterical illness. It will manifest itself in the clinical picture until the patient has either solved his problem or has taken refuge in incapacity. Outward calm is only attained when the conflict has been abandoned, and the individual is prepared to remain aloof from it at the price of an infirmity which sets him apart from his fellows. That this stage has been reached is signalized by the appearance of an altogether pathological tranquillity of mind, the *belle indifférence* of Janet.

Anxiety, whatever its origin, is subjectively unpleasant. Apart from the tremor, palpitations, hyperventilation, epigastric distress and vasomotor phenomena, the feeling of tension may make rest impossible and rapidly bring on a state of exhaustion which, if relief is not found, becomes intolerable. The extent to which an individual will have to experience the somatic components of fear or anxiety will depend on the state of his nervous system, and especially on the sympathetic, which acts as the link between his psychical and somatic components. If, on account of his constitutional type or by reason of some acquired condition (e.g. hyperthyroidism), he is especially sensitized, the strain will be the greater. However phlegmatic the individual, the force of circumstances can always be such as to cause in him an anxiety which is beyond his endurance. Wide as are the variations in resistance before this breaking-point is reached, there can be few who cannot have need of some means of escape. In that the defence mechanisms employed are exaggerations of normal methods of reacting to difficulties, it might be said that anyone is a potential hysteric.

The modes of flight which have been outlined are by no means always completely successful in protecting the individual from anxiety. When intense anxiety is being avoided by means of hysterical symptoms it is common for somatic components of anxiety, such as tremor, flushing and tachycardia, to be evident even though the patient professes complete unconcern. This admixture of anxiety and hysteria is more especially evident where mechanisms of non-realization are prominent, i.e. in recent hysteria. Where functional incapacity develops rapidly, evidence of anxiety is rarely absent, though the patient may not recognize it as such. It would appear that a time factor is

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frequently involved in the complete removal of the anxiety component from the symptomatology. The admixture is rarely a homogeneous one. The appearance of calm which accompanies an invalidizing symptom by day may give place to terrifying dreams or episodes of somnambulistic violence by night. In recent hysteria in process of transition, anxiety, anger, amnesia and pathological indifference may be inextricably mixed. This shifting pattern of symptoms is the most characteristic diagnostic feature of the condition at this stage. It is illustrated in the following case:

An R.A.S.C. corporal, aged 24, was referred from his unit for multiple symptoms, including severe headaches and vomiting, fainting attacks, bouts of irritability and attacks of pain in the right iliac fossa. His history, elicited in the course of treatment, was briefly as follows:

He was of low average intelligence (I.Q.85), and had been regarded as the nervous child of a family of four. He had had nightmares since childhood, often walked in his sleep and was known for his uncontrollable temper. On leaving school he obtained work as a cook, and at the age of 23 had saved money and could anticipate steady promotion. He played football and boxed, and had numerous friends. He lived with his parents, but had never got on well with them, his father being alcoholic and his mother over-religious. He had only one love affair, which began five years before his breakdown. A year before he had become engaged and had begun to furnish a flat with a view to marriage, but his parents disapproved strongly of the match as he was a Catholic and she a Protestant. He became ambivalent in his attitude to the marriage, wishing to break away from his people and yet doubting if his affection for the girl was sufficient to warrant it. On the day war broke out there was a family quarrel, and the patient smashed all the crockery in the house and joined the Army the same day.

In the R.A.S.C. he was rapidly promoted to corporal, although he did not like the life, but after his transfer overseas he began to have intense nightmares and to become irritable over his work. Following a trivial abrasion he reported sick with intense pain in his leg. This was followed by an attack of vomiting and refusal to eat. After this he developed a variety of symptoms, such as headaches, abdominal and praecordial pain, and was reported to have been in a half-dazed condition at times.

On admission to hospital he was in a dazed condition with an amnesia which varied in its scope from hour to hour. He was unable to remember anything about his parents, or that he was engaged. He refused absolutely to eat or drink, and when tube-fed vomited at once, so that it was necessary to resort to giving intravenous glucose. His pulse was frequently up to 120, and he had attacks of flushing and palpitation, often accompanied by bouts of weeping. He would give no satisfactory account of himself, and such information as he gave was often absurd, corresponding with a layman's idea of the talk of an insane person. At intervals he became angry and threatened or attempted to attack his attendants. At night he had terrifying dreams and would wake up sweating and trembling. At times he would walk in his sleep and fight with anyone who attempted to put him back in bed. He had no memory of these episodes afterwards.

By day his state of consciousness varied. From an apparent coma he would become over-alert, starting at the least sound, but would have no memory of how he came into hospital. At other times he would remember more but was evasive and would avoid answering questions by saying his head ached, or suddenly retching. Even in his semi-stuporose phases he was restless, and when he walked while awake he had a gross staggering hysterical gait. There were no abnormal physical signs in the nervous system, except that the cerebrospinal fluid pressure was a little raised.

During the next few weeks his symptoms continued to show almost hourly

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variations. His amnesia became restricted and it was at times possible to begin to discuss his home affairs. These interviews would be interrupted by attacks of ill-rationalized irritability, for which he was afterwards profusely apologetic. He would ask for interviews with the doctor, as he had something important to tell, and when these were granted he would forget completely what to say, and have to cover his embarrassment by making a petty complaint or a request for leave. He was difficult and irritable with the other men, and was involved in a series of fights. He would eat ravenously for a short period and then refuse food until acetonuria appeared. After becoming more co-operative for a few days he developed acute abdominal pain and vomiting, and his pulse became more rapid. A normal appendix was removed.

After his convalescence he became co-operative again and was able to review his personal affairs. He admitted the need for a decision about his future. It also became apparent to him that the fact that he was in the Army prevented any return to his people. During his irritable phases he would take the part of any patient who had a grievance and say that he was being cruelly treated. When an epileptic was led away by male nurses in an attack of furor he said it was a scandal, and in every way imitated and took the part of this patient, so that they upset the discipline of the ward. Finally he himself had an hysterical fit while in church.

In this case, as the original non-realization symptoms of amnesia and coma became sufficiently restricted to allow the patient a partial insight into his difficulties, severe anxiety appeared, was then lost in fresh amnesia only to appear during somnambulisms. The patient's desire to draw the physician's attention to his case and his complete inability to remember why he was doing so seemed to him to be the cause of the anxiety and irritability which he found himself displaying. As time allowed of no solution of his problems, he took refuge in the invalidism afforded by hysterical fits. Before this final means of retreat became established he alternated rapidly between acute anxiety and flight into activity, anger, non-realization and functional incapacity.

There is no essential dissimilarity between the hysterical reactions of war and peace. The intensity and nature of the strains involved in the former, and the rapidity with which they may overcome the resistance of individuals who would reasonably be expected to be immune from neurosis in time of peace, accounts adequately for the differences in clinical form. By illustrating the effects of more or less standardized strains on a variety of human material, the neuroses of war have given an insight into the recent hysterical states which might not otherwise have been obtained.

Determination of Symptoms in Functional Incapacity.

When functional incapacity without superficial anxiety finally makes its appearance, a number of influences may be concerned in determining its actual form. Many symptoms are determined by some feature of the situation which precipitates them. Some serve a purpose at the time of their onset which becomes obsolete, but is perpetuated and serves as a convenient cause of incapacity.

A woman, aged 50, who had led a sheltered existence was faced with the necessity of earning her own living and invested her whole modest capital in a drapery

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business. This was not a success, but after an initial period of sleeplessness and worry she became calm and slowly spent her capital and ran into debt. When faced with the selling up of her shop and home she appeared unworried and went about her business as usual. One evening she went back to her house and found that a new lock had been put on the door. She raised her arm to put the key in the lock and in a moment would have found that it did not fit. This would have meant a realization that her property had been sold and that she was ruined and homeless. Her hand shook and the shaking spread up her arm and developed into a generalized convulsion. After the fit she had no memory of the circumstances, and stated that she kept a drapery shop and was unaware of any difficulty except that she was a little short of money. After some days she developed an inkling of the true state of affairs, and had a second convulsion, followed by paralysis of the right arm. This responded to a discussion of her affairs, and she was sent to a convalescent home, where she was given much sympathy by the matron. On the day of leaving the home she had another convulsion, again followed by weakness in the arm. She finally recovered when a suitable home and employment were found for her.

In this case the weakness of the arm, the original purpose of which was to preserve the patient's unawareness of her difficulties, was perpetuated as a means of achieving incapacity when this was needed so that she could escape the obligation to adapt herself to her changed circumstances by going to work. This mechanism, by which a symptom which has originally appeared in response to a need for immediate retreat into non-realization or inaction is retained by the patient as a means of providing more lasting functional incapacity, is frequently seen. Thus a paraplegia, the primary purpose of which has been solely to provide temporary immobilization, is commonly retained as the presenting symptom in a chronic hysterical state. Often the original symptom becomes modified to adapt it to its new purpose, an hypersomnia developing into a ptosis, or an aphonia becoming a stammer.

Symptoms may be transmitted or acquired from another person. The patient may be preoccupied with the illness of some person of affective importance to him and may for this reason develop similar symptoms, or he may have in mind the successful evasion of a similar situation by someone with whom he has come into contact, and develop the same symptoms. This is occasionally seen, as in the soldier previously described, where an acutely anxious patient or one who is emerging from a state of non-realization acquires a symptom from a neighbouring patient.

A factor in the choice of symptomatology, which is seen more often in chronic rather than recent hysteria, is the presence in the patient of an organic predisposition to a certain form of disability. The epileptic in whom the pattern of the fit is established and who has had opportunity to realize the retreat afforded by it, frequently takes the hysterical fit as his incapacitating symptom. Since the pattern is already a well-practised one, it is at times impossible to distinguish in these patients between the endogenous and exogenous convulsions. Two of the writer's patients who showed hysterical convulsions of epileptiform type, but who had no previous history of fits, showed

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subclinical seizure-waves when investigated with the electroencephalograph. This would indicate that the pattern chosen by the patient was determined by an organic predisposition, even when it had never become fully manifest as such. Another example of the same mechanism is seen in the not uncommon appearance of tetany or convulsions following hyperventilation in hysterical patients. These patients have the latent tendency to tetany which comes to light when the patient uses hyperventilation as an intermediate mechanism in precipitating it.

An art student who lived with her parents was, while at home, spoiled, dependent and emotionally infantile. At the art school, however, she took pains to give the impression that she was ultra-modern and without fear of adventures, sexual and otherwise. She there formed an acquaintanceship, in which she took great pride, with a young man of advanced views. Her behaviour at one of the noisy parties to which she went became demonstrative under the influence of alcohol and she gave the man the impression that she wished to have intercourse with him. When they were alone, however, she became acutely anxious, and the accompanying hyperventilation brought on an attack of tetany which allowed her to evade the immediate situation.

She did not at first wish to give up the young man because of this contretemps, and they remained friends. On a later occasion she again avoided intercourse in the same manner, and when later she wished to end the acquaintanceship she developed attacks of tetany when due to go out with him. He in turn became sorry for her and she did not wish to tell him to go away, and was unable to escape from him until her attacks became so frequent that she was admitted to hospital. While she was in hospital he tired of her and ceased to visit her, and the attacks gradually ceased. She was able to return to her studies in a different place where her previous life was unknown.

In the same way patients who are in the early stages of organic disorders of movement such as choreoathetosis or spasmodic torticollis will frequently show these symptom-patterns in hysterical illness.

A post-office clerk, aged 25, following a period of irritability, sleeplessness and depression, developed jerking movements of her head to the right. She had hoped to marry a man who came to see her at the post-office every day, but after a disagreement he had ceased to visit her. She hoped that he would renew their friendship by coming to see her again, and developed the habit of turning her head from the desk at which she sat, to see if he had come in. The turning of her head became at first habitual, and then involuntary.

On examination the pattern of the movement was that of a true spasmodic torticollis. After a discussion with the patient, she was hypnotized and the symptom disappeared. It has since returned, and its spread to other muscles leaves no doubt of its organic origin.

Sometimes the symptom symbolizes an attitude or an affect felt by the patient towards his difficulties.

A girl who was learning typewriting had been advised by her parents to break off relations with a man who had proposed to her. She dreaded the meeting at which she had to tell him that she would not see him again. After a trivial head injury she became stuporose, and then developed an immobilizing paralysis of one leg (the man had a septic foot at the time) and uncontrollable tapping movements of her fingers for which she could not account. When put to a typewriter, these movements repeatedly spelled out the words, " Yes, dear."

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In the same way the affect attached to an incident which has been purposively forgotten may express itself symbolically in the symptoms. The most common example of this occurs where the incident gives rise to disgust expressed in spitting movements or in hysterical vomiting. It is also seen where anger is symbolized in a generally negativistic and truculent attitude.

In acute anxiety hysteria, which does not differ essentially from recent hysteria with functional incapacity, the symptoms appear as a perpetuation of the subjective elements of the anxiety state from which the patient is seeking to escape. It must be emphasized, as has been seen in some of the cases described, that the final symptom-complex may be the resultant of a large number of factors. When, in the course of therapeutic exploration, it is possible to trace the origin of its separate components, material is obtained which is of great value in the subsequent reconstruction of the patient's attitude to his circumstances.

Recent Hysterical States—Classification.

In planning treatment it is very important that the relative prominence of the three factors of *non-realization, anxiety and functional incapacity with pathological calm* be carefully assessed. When the first two are present, the patient is still in some contact with his difficulties, and is not prepared to accept a solution which will leave him inferior to his fellows. The appearance of pathological indifference indicates that this solution has been accepted. Such an adjustment has in common with the conditioned response the fact that the more frequently it is employed the more difficult it is to eradicate. It is therefore necessary to take the patient's previous history into account as well as the duration of his present illness. Non-realization, on the other hand, is of better prognostic import. When by removal of difficulties or by the passage of time the anxiety can be reduced to a point at which the patient can face his environment fully once more, he may always find himself able to adjust to it without the need for a protective incapacity.

For this reason a classification of recent hysterical states is here attempted from which the roles of the three elements can be evaluated for purposes of treatment.

I. *Immediate Reactions.*—Flight into activity or inactivity.

(*a*) Hyperkinetic :

Panic reactions in which relief from acute realization and anxiety is sought by intensive activity of an irrelevant kind. Realization is poor and anxiety thinly veiled. These states are transient and never permanent, and are followed by recovery or transition into other mechanisms. They include

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screaming attacks, aimless wandering, violent undirected anger, repetitive movements, e.g. hand-wringing, hysterical fits.

These are exaggerations of corresponding non-pathological (i.e. socially permissible) protective mechanisms shown in moments of anxiety : Talkativeness, repetitive movements, i.e. drumming of fingers, feeling of resentment against cause of anxiety, tendency to overconcern with detail, tendency to excessive muscle tone with clenching movements, over-alertness.

(*b*) Hypokinetic :

Terror reactions in which relief is sought in denial of consciousness. Non-realization is practically complete ; anxiety may be evident : Fainting, stupor, pathological lethargy, complete loss of motor initiative, hysterical coma, hypersomnia, cataleptoid states (Mira, 1939).

These forms are exaggerations of non-pathological subjective states which prevent the individual from feeling fully in contact with the situation or fully able to act in regard to it : Feelings of mild depersonalization or derealization, feeling of lethargy and tendency to yawn, described in normals under war conditions (MacCurdy, 1918), feeling of lack of interest and motor initiative.

II. *Hysterical Transition States.*

States in which a relative freedom from anxiety is secured by means of symptoms which either prevent the patient from fully realizing his difficulties or relieve him from the obligation to act in regard to them. These mechanisms offer no permanent solution, as their continuance would be incompatible with community life for any length of time, even in the protected position of an invalid. They serve to tide over the period during which anxiety would be beyond the individual's endurance, either until it subsides or until a more permanent solution is found in the flight into incapacity.

The refuge afforded by these mechanisms is very temporary, and they rarely endure for more than a few months at the most, and may last but a few hours. It is characteristic of them that they tend to recover and relapse frequently and to alternate with other hysterical states. In these transition states there is much variation in the degree to which anxiety is successfully avoided. Cases may vary from severe anxiety states in which transient clouding of consciousness or physical disabilities appear, to cases in which gross pathological calm and well-established " conversion " symptoms appear. In order to understand any given case an evaluation must be made of the three variables of anxiety, non-realization and pathological indifference.

Cases tend to group themselves about two poles, which allows of a classification of this group which is of value from the point of view of prognosis.

(*a*) Mechanisms of non-realization, in which a relative freedom from anxiety is attained at the expense of full realization of the situation. Signs

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of anxiety are often ill-concealed, and tremor, flushing and tachycardia may be seen, even though the patient professes complete unconcern. Psychically the anxiety may show itself in nightmares and somnambulisms: Twilight states, fugues, total amnesia, selective amnesia.

(*b*) Mechanisms of avoidance or immobilization, in which the symptoms relieve the patient of the necessity to decide or to act. Here functional incapacity is the principal means of adjustment, but the symptoms in this group are not ones often used as a permanent adjustment, i.e. they are rarely seen in chronic hysteria: Aphonia, astasia, pseudopsychosis.

(*c*) Symptom-groups which are intermediate between (*a*) and (*b*), and in which non-realization and functional incapacity both play a part. No transition state depends on one mechanism alone, but in groups (*a*) and (*b*) there is a preponderance of one or other, e.g. Ganser states, acute regression, amblyopia.

III. *Recent Hysteria with Functional Incapacity.*

In this state, which may develop primarily or may follow acute or transitional reactions, functional incapacity is used as a means of retreat. It is to be distinguished from chronic hysteria by the fact that the end attained by the symptoms is temporary retreat as opposed to permanent adjustment. There is less tendency in recent hysteria with functional incapacity to the personality changes which take place in the course of chronic hysteria. To some extent also the symptoms observed are different in the two groups. Aphonia, for instance, is not often seen in chronic hysteria, while dermatitis artefacta and contractures are rarely seen in recent hysterical states. In recent states the anxiety component is also much more readily detected and mobilized, in contrast to the satisfied indifference of the hysteric of long standing.

Acute functional incapacity is likely to occur where there is some special reason why the syndrome selected should protect the individual from the situation he dreads. In recent hysteria functional incapacity is usually resorted to as an escape from a situation rather than from the anxiety due to indecision or conflict. Since the symptoms are thus directly purposive, those which cause immobilization or an excuse for not dealing with the problem, i.e. paraplegias or aphonias, are the most common. Cases of this group are especially common in military practice, where they afford the soldier an honourable means of avoiding danger. As has been observed, the actual form of the symptoms may be determined by the needs of the situation itself, or by the existence of some organic predisposition in the patient to a particular disability.

While this group differs from chronic hysteria only in the manner and degree in which functional incapacity is accepted as a solution, it is of advantage to separate it from the point of view of prognosis and treatment.

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Importance of Organic Factors.

In any case where the normal adaptation to a situation has failed, the breakdown is the result of the stresses bearing upon the patient being able to overcome his powers of resistance. Organic disease, though not often the principal factor in determining mechanisms of retreat, may frequently serve as an additional strain which makes the difference between adaptation and illness. Constitutional defects of organic origin are frequently the most important cause of the patient's vulnerability to hysterical mechanisms. The fact that the grosser varieties of hysteria, at least, are far commoner in persons of poor intellectual endowment makes this form of organic deficiency of especial importance. Apart from inborn weaknesses, however, temporary debilitating conditions may cause an individual to retreat from a situation which he would face with ease when in good health. Of these, exhaustion, whether due to fatigue or to prolonged anxiety and lack of sleep, is by far the most important. In patients already strained by anxiety due to prolonged indecision or conflict a minor infection such as influenza or tonsillitis is frequently the precipitating factor of an hysterical illness.

There is good reason for supposing that certain diseases of the central nervous system predispose the individual to make use of hysterical mechanisms. The frequency of hysterical disabilities as complications of chronic encephalitis lethargica and of disseminated sclerosis has long been known. Chorea, general paralysis, and the late effects of some head injuries not infrequently commence with the release of hysterical mechanisms which may attract the physician's whole attention, so that the organic background for a time goes unnoticed. The case of epilepsy is a special one. During the periods of irregular cortical activity which may precede or replace the fit, amnesias, fugues and disorders of behaviour may appear which so resemble those of hysteria as frequently to be indistinguishable. It is clear that such symptoms are produced by a combination of factors, and that in epilepsy the organic component is the predominant one.

Not only can organic disease *per se* predispose to hysteria, but the sense of disability engendered by it acts as a psychogenic factor in weakening the patient's resistance. The functional psychoses frequently act in this way. Retreat from the sense of inadequacy, of guilt, or of the intolerableness of existence in depressive illnesses into a mechanism of non-realization accounts in part for the frequency of amnesias and states of clouded consciousness at the onset of depressive states.

A middle-aged labourer was found wandering by the police and unable to give any account of himself. There were a number of small cuts in his neck. During hypnosis his memory returned and he gave a history of a depressive illness some years before. He had recently become depressed and lost his employment, had no relatives from whom to seek help, and had contemplated suicide. He bought

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a razor-blade with which to cut his throat and went to a pond, into which he hoped to be able to throw himself. He scratched his neck, stepped into the shallow water, and then wandered away and was found by the police. His illness thereafter took the normal course of a recurrent depression.

A cyclothymic element is always to be suspected when suicidal tendencies are shown during a fugue, or where a severe hysterical illness suddenly appears or clears up suddenly without apparent reason.

A girl, aged 19, who had a good record of work and was known as an active, cheerful person and was engaged to be married, became irritable and seclusive, wept a great deal, refused food, and finally developed an hysterical paraplegia. There were many unsatisfactory features in her home environment, but no real reason could be found for her sudden failure to adjust to circumstances which had previously caused no distress. There seemed no reason for her change of attitude to her fiancé, except that she said she did not feel worthy of him. She was co-operative except when attempts were made to make her eat, do occupational therapy, or to remove her symptoms, all of which were defeated by the appearance of invalidizing symptoms. The true diagnosis was not evident for several months, when the fact that she slept poorly, wept most in the mornings and became much more cheerful and co-operative under the influence of benzedrine suggested the presence of an endogenous depression. Fifteen months after the onset of the illness her symptoms abruptly cleared up and she took up her former activities again. Her hysterical symptoms had evidently been used to rationalize the effects of a depression which had made her wish to avoid marriage and retire into a state of inactivity.

As well as contributing to the onset of functional incapacity, organic disease has an important effect in determining its form. If the situation which the individual wishes to evade or about which he is in conflict does not demand a special symptom as a means of escape, he will be apt, in choosing the form of his incapacity, to fall back on organic patterns which already exist within him. In the same way the expression of suicidal ideas in the course of a transition state may not be determined solely by the desire for attention, but may represent the purposive revival of affects experienced in an attack of depression.

A special case in which organic disease may determine the form of functional disorder is seen in the post-concussion states in which amnesia due to the injury is perpetuated as hysterical amnesia, and the two conditions may be closely intermingled. A complete differentiation between some post-concussion states and hysterical transition states, for this reason, is frequently not possible, and MacCurdy (1918), in discussing diagnosis, observes how one may emerge imperceptibly from the other.

In any hysterical state there are always organic factors, if only those of constitutional predisposition or of exhaustion. In many conditions, such as anorexia nervosa or spasmodic torticollis, it is impossible to decide which is the predominant cause. It is fortunately unnecessary to decide this accurately for purposes of treatment, as both factors must always be taken fully into consideration.

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Examination and Diagnosis.

Diagnosis of the general nature of a recent hysterical state does not usually present great obstacles. The difficulty arises not so much in differentiation from wholly organic conditions, as in the detection of important organic factors when these are present as a background to the hysterical state. A company promoter realized at a meeting that a speculation was about to be a serious failure and that this would inevitably lead to his prosecution. On walking into the street he completely lost his memory. On admission to an observation ward as "Mr. X," he had well-marked signs of general paralysis. There is no doubt that his was a case of recent hysteria, but such a diagnosis would have been glaringly incomplete. His recovery of memory under hypnosis following successful malarial therapy is an indication of the dual outlook necessary in such cases.

The organic background is rarely so obvious. In reviewing the histories of cases of chronic encephalitis lethargica, Huntington's chorea, and other degenerative states which reveal themselves slowly, the frequency with which functional conditions are diagnosed before the organic condition is manifest is very striking. For this reason it is never justifiable to label a case as "psychogenic" and treat it psychotherapeutically without allowing for the need of revising the diagnosis. One must beware especially when there is a very obvious psychological cause for the disturbance. Too often the broken engagement which appears to have precipitated the symptoms has been at the instance of the patient, whose attitude has changed as the result of the onset of a major psychosis.

For purposes of immediate treatment it is not always necessary to know fully the psychogenic determination of a functional illness. It is in fact unwise to pay too much attention to the more obvious motivation, as deeper causes are very likely to be revealed as the patient develops insight. It is, however, important to assess the relative importance of the factors of physical exhaustion, anxiety and non-realization. It is necessary to estimate the patient's powers of recuperation by reference to his previous personality and reactions to stress, and the degree to which he is willing to accept invalidism as a solution of his difficulties. Some estimate of general intelligence must also be made, and this is often very difficult in transitional states, where comparatively intelligent patients are unwilling to use their mental powers, and behave in the same manner as the feeble-minded, in whom the same conditions are more commonly found. In examining a case of hysteria a diagnosis is not enough. It is necessary to gain a preliminary impression of the individual's total personality in relation to his problems.

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Treatment.

The eventual aim in treatment of psychoneurosis is to allow the patient to develop insight into the origin of his condition and to readjust himself in the light of that insight. If this object is attained, the presenting symptoms may lose their purpose and disappear.

While in recent hysteria this general principle must still hold, the introduction of a time factor necessitates modification of the procedure. In the group of acute reactions, very minor therapeutic assistance will often allow of recovery, and it is essential to make the most use of this favourable period and to prevent further retreat. In the same way, as fuller realization develops from a transitional state, it is most important that functional incapacity be prevented or reduced to a minimum, lest the habit of invalidism be established. It is this time factor which makes the removal of symptoms a matter of urgency, and allows at this stage of the legitimate use of the shorter therapeutic methods.

Panic Reactions.

These are not often seen by the physician, though similar states with a large demonstrative element are seen often enough in the course of chronic hysteria. It is perhaps as well that the physician is not at hand, as these states are often satisfactorily aborted by more robust methods than he would care to use. The hysterical screaming attack or fit is perhaps the only occasion in psychiatric practice where cold water and an exhortation to " pull yourself together " is ever legitimate, and if the attack is not part of a chronic hysteria it will sometimes bring about permanent recovery with full insight. In wartime it is well known that a tendency to panic is best controlled by a good example from seniors, and the certain knowledge that return to the base is quite out of the question.

In preventing panic reactions it is important that in difficult situations the individual should be in no doubt as to what to do, and, if possible, should have something to do. Uncertainty as to the immediate future and opportunity to dwell on unpleasant possibilities, if continued for long, are the principal factors in lowering resistance to hysteria. When non-pathological reactions, such as talkativeness, redundant activity, resentment and tension are increasing, they may be relieved if an opportunity is provided to make use of them in shouting, running and hatred, and it is perhaps for this reason that in war preliminary " jitters " is far from incompatible with courage.

When wandering and repetitive movements occur, it is important that those present should give no sign of being impressed, but at the same time their attitude should be a kindly and patient one. Where the reaction is the result of the patient's seeing an unpleasant sight or receiving unpleasant news, the condition will usually clear up rapidly if nothing is done, but where the

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recovery means realization of, or return to, a situation beyond the patient's powers of endurance, it may be necessary to shield him temporarily from his difficulties.

Terror Reactions and Hysterical Transition States.

In their more severe form these states are seen in both military and civil practice, and invariably conceal severe fear or anxiety. They occur usually after severe physical exhaustion or after long periods of anxiety, and are especially found where the individual's future has a certain inevitability. In the writer's experience they have occurred in jilted brides, an absconding slate club secretary, unsuccessful speculators, a mother whose child had been suddenly killed, bridegrooms about to be taken unwillingly to the altar, and even children who could not face an unkindly teacher. In military practice they occur most frequently as a superstructure in men who have been blown up or buried by explosions.

Since such cases are brought for treatment when they have already evaded the situation they dread, the opportunity of returning them to the front line, the altar, or the schoolroom, even if it were advisable, has passed. The object of treatment is now to get the patient to come out of hiding, so to speak, by letting him know that the danger is past. It is first necessary, therefore, to remove him as far from the difficult situation as will assure him that there is no need to face it again. If the symptoms then do not disappear spontaneously, they must be removed by psychotherapeutic means. When this is done the whole situation must be discussed with the patient until he develops insight into the causes of his illness and can form for himself a plan of action for the future. Treatment can therefore be divided into three phases:

(1) Phase of rest and reassurance.
(2) Removal of symptoms.
(3) Therapeutic exploration and re-education.

Rest and Reassurance.

If it were possible to remove all cases of recent hysteria permanently from the situations which had precipitated their symptoms, there is no doubt that practically all would recover rapidly. It is obviously unwise, however, to make this the object of treatment, not only because it is unattainable, but because if the patient is to remain a useful member of the community, he must remain capable of facing without retreat the situations which the average citizen is expected to face. The object of temporarily protecting and reassuring the patient is not to give him permanent shelter, but merely to assure that he is in the best possible condition to face his anxieties when his symptoms are removed. It is essential that this period of recuperation should be accomplished as rapidly as possible, lest the patient be tempted to take permanent

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shelter by means of functional incapacity. The longer the mechanism of retreat has been in operation, the more difficult it will be to replace by a normal attitude.

In transition states there is usually an element of exhaustion. This may be due to the strain of prolonged anxiety due to indecision or conflict, or, in time of war, to long periods of exposure to danger and fatigue. There is often, in addition, the effect of exposure and exhaustion due to wandering while in an amnesic state. For this reason rest in hospital, adequate nutrition and sleep must be provided before any attempt is made to remove symptoms. Patients after prolonged fugues are frequently exhausted and acidotic and may at first vomit food. They may also in their confused state, and as part of their wish to deny their whole existence, actively resist feeding. In these circumstances there should be no hesitation in tube-feeding or in giving intravenous glucose.

It is often wise at this stage, in cases in which anxiety is prominent, and shows itself in continued nightmares, somnambulisms and anxiety attacks, to encourage an increase of non-realization by the temporary use of drugs. Hyoscine is invaluable in such states, especially when combined with phenobarbitone, or with sodium amytal. It is important for these short periods of narcosis to avoid sedatives which are slowly excreted, as the patients must be clear and alert when psychological treatment commences. It is important to remember that many hysterical twilight and similar states are really acute anxiety states in which a certain amount of protective non-realization has occurred, and that their treatment will in every way be that of an anxiety state. Such cases will benefit often (Mira, 1939) from prolonged narcosis.

Removal of Symptoms.

The object of this stage of treatment is to demonstrate to the patient that his symptoms are unnecessary. When rest and an opportunity to view his difficulties in a more objective manner from an hospital bed without the need to decide or to act at once have improved his resistance, the patient may spontaneously develop a measure of insight. If he is reassured by an understanding physician that he will be protected from the accusation of cowardice or malingering, this insight may become complete and result in recovery. More frequently he develops some insight into his difficulties and shows a great improvement, but retains some part of his symptoms as a demonstration to himself and to the world that the whole affair has not been his fault. Such symptoms may remain for a long time but clear up readily if some forceful and impressive method of treatment is given, which will at once convince the patient of its efficacy and give him an excuse to get well. Such cases are usually very anxious for hypnotic treatment and respond more favourably to it than any others.

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A woman, aged 28, who was making a fairly successful career decided after much hesitation to get married, and re-orientated her life accordingly. Her fiancé, however, ran away with another woman on the eve of the wedding, and the patient developed a complete loss of memory, astasia and aphonia. In the course of some months the aphonia was modified into a severe stammer and the astasia into an hysterical gait. After a year's invalidism she again became interested in her work, and was prevented only by her symptoms from obtaining good employment. At this point she was offered treatment by hypnosis, and permanent relief of symptoms occurred after a single session.

At the commencement, especially with the more intelligent patient, it is advisable to make an attempt to review with him the circumstances of his admission to hospital and to explore the possibility of his grasping the nature of the illness. Treatment by persuasion from the commencement is always preferable to suggestion, and where it seems likely to succeed the patient should be seen frequently and allowed to discuss his condition with the physician until he develops insight with as little interpretative interference as possible. If, on the other hand, the patient clings to his symptoms and allows them to prevent his full co-operation, care should be taken to prepare the way for later treatment by suggestion by giving the impression that cure is inevitable and can be accomplished more or less when the physician wishes.

The principal reason for the more frequent use of suggestion rather than persuasion in the transitional states is that the element of non-realization in the symptoms serves as a screen between patient and therapist, just as it does between the patient and his conflict. It is impossible to discuss the situation with a patient who has a complete amnesia or aphonia, and for this reason the symptoms must be removed first. Their removal will then assist in persuading the patient of their true nature.

While in treating objective functional incapacity the actual method of suggestion used is immaterial, provided that it demonstrates that the incapacity can be removed, in transition states the subjective nature of the symptoms and the presence of amnesia and non-realization often makes hypnosis the only applicable method. It has the special advantage that material discussed with the patient under hypnosis can form the basis of the re-educative treatment which follows the removal of symptoms. This is illustrated by the following case :

A man, aged 38, a labourer riding a bicycle, reported to a police station, having forgotten who he was and where he came from. He was dirty and exhausted and could not be identified. After two days in hospital he was referred for treatment. His vocabulary was full and he was normally orientated. On the first occasion, while pretending to co-operate, he would not fix his attention on the object used and no progress was made. On the second occasion, after similar difficulties, he suddenly became co-operative and almost at once became deeply hypnotized. On being asked where he was going on the bicycle, he said, " To work." He was then told that he was riding his bicycle to work and asked to give an account of his thoughts as he rode. After naming some of the turnings he passed on his way he began to become acutely anxious, evidently dreading going down a particular turning, and on coming to it he rode past it and straight on for 30 miles to a seaside

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town, where he slept out. On the following day, after riding on aimlessly, he realized he had lost his memory. He then described how, when at work on the previous day, he had to dig at the bottom of a deep trench. On seeing some earth falling in from the top of the trench, he was reminded of a similar trench in which he had been buried by an explosion in the 1914–1918 war, and became acutely anxious. He had dreamed of the trench all night, and dreaded returning to work. In the previous incident, after being buried by the explosion, he had lost his memory for several days. While recounting these facts the patient spontaneously woke up and continued his story, until he suddenly realized what had happened.

In this case hypnosis removed a symptom which prevented discussion of the man's anxieties and allowed of a fuller investigation of the case. It will be noted that this patient was by no means co-operative with hypnosis. Many patients in intermediate state, while expressing willingness to co-operate, do not do so, and in fact avoid anything that will bring them in contact with their problems. When this occurs it may be taken to indicate either that the anxiety underlying the hysterical symptoms is too great to be faced, or that the patient is using his symptoms still further to invalidize himself. In the first case further rest and security are indicated before further attempts are made to remove symptoms, while in the latter suggestion must be continued.

While the anxiety component of a transition state is prominent, as is indicated by sudden increases in amnesia, violent nightmares, bouts of aggressiveness, or actual anxiety symptoms, there is little danger that the patient will take refuge in functional incapacity and he can safely be left. Many such cases gradually become clearer in time, and allow of a thorough discussion of their difficulties without the need to use suggestion at all. As is the case with true anxiety states, it is not here possible to abbreviate the treatment.

Therapeutic Exploration and Re-Education.

The treatment of a recent hysterical state does not end with the removal of the presenting symptoms. At the onset of treatment the patient is usually not prepared to accept the idea that his symptoms are not due to physical accident, and will protest against the suggestion that they may be psychogenically purposive. Their removal by suggestion may go far to convince him that they admit of a non-organic interpretation, but it is most important to utilize the opportune moment after their removal to assist the patient in gaining as full an insight as possible. If he is to return to a normal life and avoid further retreats, he must be guided in understanding for himself the mode of development of his illness.

Where the protective symptom has served its purpose and allowed of escape from the threatening situation, and this threat is an obvious one, as is seen in war neuroses, insight is often spontaneous after the symptoms have disappeared. Nevertheless, the physician has not completed his work until he has assured himself that insight has been attained. He must not be

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content merely to remove the grosser mechanisms of non-realization, but must ensure that the patient sees his own position clearly and that he spares himself none of its realism. He must mobilize the patient's anxieties in retrospect and explore the thought trends which preceded his retreat. In this way the patient will learn to recognize in himself the tendency to retreat and will be able, while still under medical protection, to regard his difficulties from a safe vantage-point and decide his future actions in a more deliberate manner. If this is not done the process of retreat will be facilitated rather than guarded against, and may recur when he again faces a similar situation and again is unable to decide how to deal with it.

In guarding against recurrence the patient should either be prevented from having to face again the anxieties from which he has retreated, or he should return to his difficulties with a decided plan of action.

While he is being allowed to review aloud his problems in relation to his powers of response to them, the opportunity should be taken of estimating his potentialities and judging his probable attitude to the problems he is likely to have to face in the future. This aspect of the exploration will be considered under " Prognosis."

Treatment of Acute Functional Incapacity.

When an hysterical symptom has appeared it is often difficult at first to discover its true purpose. Whether the patient is a previously normal individual who has sought temporary refuge in disability under extreme strain, or whether the appearance of symptoms represents a stage in the development of chronic hysterical invalidism, the superficial clinical appearance may be much the same. Although the fuller aetiology will gradually become clearer as therapeutic exploration progresses, it is necessary to decide early certain general questions in order to determine the lines on which exploration will be carried out. It must be determined if possible whether the symptoms represent a temporary retreat or adjustment to stress, or are part of a gradual alteration in the patient's mode of adaptation.

Before proceeding to the removal of symptoms, it has to be decided whether it is justifiable in the patient's interests to disturb the existing state of affairs. It may be possible by means of suggestion to induce a patient to relinquish a symptom which is acting as a comparatively harmless means of adjustment to a difficult life. To do so may be to upset this adjustment and to precipitate unnecessarily a state of anxiety. Among those who suffer from chronic physical disabilities which make it impossible for them to compete on an equality with healthy people, it is common for functional superstructures to be developed which serve the purpose of pointing out to others a disability which otherwise might not be noticed and allowed for. When recovery from the physical state is unlikely, it is unwise to disturb such an adjustment. In the same way

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individuals who are constitutionally inferior in intellect or personality may avoid full realization of their handicap by assuming symptoms which allow of an apparently normal adaptation without inconvenience to anyone. The man of sluggish mentality who covers his slowness in comprehension by pretending to be hard of hearing is employing such a mechanism, and often little advantage is to be gained by insisting on his admitting that he can hear normally.

In hysteria the disorder lies in maladaptation and not in the symptoms themselves. Unless, therefore, the underlying condition is given full consideration, the removal of one set of symptoms will only be followed by some other form of pathological adaptation.

In some cases of hysteria the maladaptation does not appear to arise as the result of environmental stress, but occurs as a primary and progressive lack of urge to continue as a normal individual (progressive or degenerative hysteria), and in such cases, as has been observed, symptoms develop after trivial stress or apparently from sheer ennui or desire for attention, the latter being a part of the characteristic personality change in the direction of a child-like dependence, which may be detected long before overt symptoms appear. In this type, if the process has not advanced beyond hope of readjustment to normality, the symptoms can only be removed as part of an attempt to get the patient to reorganize his whole life. Where there is no constitutional or organic inferiority which will render the end-result unworthy of the means, psychoanalysis may here be the only practicable mode of treatment. Often the most that can be done is to make use of the suggestibility shown by such patients to clear up superficial symptoms.

As has already been indicated in the case of mechanisms of non-realization, it is often advisable first to attack the symptoms of functional incapacity by means of suggestion, and the underlying maladjustment afterwards. This is especially so where the symptom itself (e.g. paraplegia) has outlived its usefulness and is now merely retarding the patient's return to normal pursuits. It is similarly necessary where the symptom (e.g. defect of speech) impedes the physician's access to the patient's mental content. Even where more thorough therapeutic methods are employed, suggestion may be needed for the final removal of symptoms, although their continued existence may seem quite unreasonable to the patient. In these cases the principal symptoms seem to be retained by the patient on account of a sort of spurious pride which prevents him from admitting demonstrably what he has already admitted in principle, i.e. the purely functional origin of his disability.

While the use of suggestion should be restricted in favour of persuasion in fully co-operative patients, it may be used more freely and often with greater success on those who are incapable of gaining full insight, even in the most favourable circumstances for treatment. Treatment by suggestion alone is often very successful in persons of low native intelligence. It is

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especially effective in treating hysterical symptoms which appear as superstructures on chronic disease of the central nervous system. Where hysterical personality deterioration has reached a point where non-dependent existence is out of the question and insight unattainable, modification of the symptoms is often easily obtained by utilizing the suggestibility which is one of the outstanding features of the advanced hysterical character.

If it has been decided that removal of symptoms is to be carried out, it is unwise to resort to methods of suggestion until the patient has been given some incentive to respond to them. If recovery from a protective symptom will at once lead to the patient's return to the situation he is avoiding, he is unlikely to be very responsive. The patient may be urged into recovery either *a fronte* or *a tergo*. On the one hand the necessity for the symptom may be removed and its psychogenesis made obsolete. This is often done by affording the patient the refuge from the harassing situation afforded by admission to hospital or, in military cases, by removal from the line. On the other hand, the immediate advantages of being well and the disadvantages of remaining disabled must be brought home to the patient. It is here possible to take advantage of the tendency in the more infantile hysterics to alter their symptomatology for immediate ends, and in some cases partial recovery will occur merely to gain for the patient some minor privilege from which his symptoms debar him. No opportunity should be lost of letting the patient know what a nuisance his disability is to him. In intelligent patients who have developed some understanding of the causation of their illness in the course of the preliminary exploration, the incentive to recovery has to be created by developing an urge to attack their problems in the new light in which they appear after discussion. In such cases the symptoms will come to be regarded as an impediment to this urge, and the patient will eventually be only too glad of the excuse offered by suggestion to relinquish them.

When the use of suggestion is finally decided upon, the attitude of the physician towards his patient must undergo a radical change. He is no longer the patient's friend and confidant who is prepared patiently to encourage his understanding of himself; he must now become firm to the point of hardness and must convey to him with confidence that his cure is inevitable. He must be prepared to practise a deception on his patient in his interests, and must carry this out in spite of any pleas for a more kindly approach. The difference in attitude is so great that a physician who has revealed to the patient that he is as human as he is may be unable to take his new role in a convincing manner, and will have to send his patient to a therapist who specializes in suggestive treatment. If, however, he can carry out this part of the treatment himself and successfully, his rapport with the patient in the later work of reconstruction will be enormously enhanced.

With these principles in view, the patient who is to have his symptoms removed by suggestion should have his liberty restricted by isolation in bed

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and should be allowed to associate, if possible, with patients who have lost their symptoms in a dramatic manner. He must be allowed to observe the privileges and social life in hospital enjoyed by those who have responded to treatment. The attitude of his attendants must be such as to convey to him in a casual manner that now that he has been selected for treatment by suggestion his recovery is inevitable as soon as the physician cares to carry it out. The latter should see his patient seldom and briefly, and his manner should be distant and impressive. Even the most intelligent patients can be made to feel that the powers of "the psychologist" or "the hypnotist" are a little more than human, and however unpleasant this attitude may be to the physician, the testimony of recovered patients bears out its success in inspiring confidence.

As soon as it is felt that suggestion is likely to succeed, an appointment is made and the patient is allowed to dwell on his treatment as the hour approaches. In the writer's experience the interested co-operation of a nursing staff who understand the principles of the method contributes enormously to its success.

In most cases it is advisable to use a method of suggestion which has rapid effects. Some classification of the methods within the writer's experience is here attempted. Some methods employ more than one of the principles described.

(1) Simple demonstration.
(2) Re-education.
(3) Conditioning out.
(4) Suggestion with vehicle.
(5) Dissociative suggestion.

(1 and 2) *Simple demonstration and re-education.*—This is the method of choice where the patient is unable to carry out some normal function, e.g. walking or sleeping. It consists first of demonstrating that the affected function is present and then of re-educating it until it approaches normality. For instance, if a patient who is unable to make sounds is asked to breathe deeply and a fairly strong faradic current is applied suddenly to the neck, a cry of surprise will usually result. This has the effect of demonstrating to the patient that his voice is still present, and he can usually be encouraged with further faradic applications to produce simple vowel sounds and gradually re-educated in normal speech. In the same way the patient who cannot use his legs may be put into a swimming bath where, in the urge to self-preservation, his paraplegia will be forgotten. His kicking movements can then be re-educated into walking at first in the water, and then on terra firma. Similarly the deaf patient can be made to look into a mirror while a pistol is let off behind him. His sudden start will demonstrate that he can hear, and he can then be made to hear sounds of gradually decreasing intensity. It is more pleasant to remove a symptom by re-education alone, and this is often possible when the patient has been partially convinced of its lack of physical reality

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by a process of persuasion ; but the demonstration is frequently indispensable, and must not be evaded if necessary.

(3) *Conditioning out.*—The methods in this group include the more barbaric treatments of hysteria, and it is fortunate that they are becoming less popular, in this country at least. The principle of the treatment is to ensure that any manifestation of the hysteria is followed by an unpleasant stimulus, and that recovery is rewarded by relief from it. Thus paraplegias are driven to walk in order to escape the application of faradic brushes, and cases of hysterical vomiting are tube-fed after each occasion. The same principle is employed very unsuccessfully in the giving of unpleasant medicine to cases of chronic hysteria. The disadvantage of this type of treatment lies in the poor rapport which is obtained afterwards, the patient usually recovering temporarily and relapsing where he is out of reach of the physician. Nevertheless, the principle has some value when used in conjunction with other methods, and its use has already been referred to in the restriction of privileges of patients awaiting removal of symptoms. It is often useful, for instance, when an hysterical aphonia is proving difficult to re-educate after the first sounds have appeared, to apply fairly painful faradism to the throat at regular intervals. The patient will then not waste time, as to do so would prolong the application of the painful faradic stimulus. It is important, when removal of symptoms has been obtained by such coercive methods, to make the patient demonstrate his recovery in front of others, even if he asks for it to be kept a secret so that he does not look foolish. If this is not done he may relapse at once and deny any recollection of temporary recovery.

(4) *Suggestion with vehicle.*—This type of suggestion is indicated where the symptoms are subjective and their removal is not susceptible of objective demonstration. The principle consists of making the patient take a medicine, submit to a diet, make a pilgrimage or carry out some other procedure, and at the same time making him believe that it will result in cure. In its simplest form it consists of giving harmless drugs, together with strong suggestions as to their effects. It is often possible to use treatment in which the patient already has some belief, and whether the suggestion is applied in the name of Christian Science, Raja Yoga, autosuggestion, osteopathy, colonic lavage or will-power, the result may be excellent. The weakness of the whole method lies in the fact that when the symptoms have gone the patient still believes in their physical origin, and recovery cannot act as a demonstration of their true nature. The subsequent discussion may take the form of an effort by the patient to convert the physician to the successful medicinal cult.

(5) *Dissociative suggestion.*—The use of hypnosis has already been advocated in removing non-realization symptoms. As the most direct form of suggestion it is applicable to most types of incapacity provided that the patient is willing to co-operate or can be convinced that he cannot help doing so. It has the advantage that after the symptoms are gone the patient may be made to

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relive affectively important incidents under hypnosis, and to discuss material which would be acutely embarrassing in a normal state of consciousness. It has the disadvantage that the patient may use the hypnotic state as a retreat, and may either become dependent on it or become prone spontaneously to other dissociated states, e.g. fugues. The technique will not be discussed here.

It has already been emphasized that no case of hysteria has been adequately treated if, in addition to removal of the presenting symptoms, the patient is not assisted to gain some insight into the mode of their causation. Unless purely symptomatic treatment is aimed at, the process of therapeutic exploration must be continued until this has been done. Very frequently, as the aetiology of the illness becomes clearer to the patient, the need of making some important decision as to future conduct becomes evident to him. Realization of the need to decide may cause the patient to retreat from the decision by a temporary relapse. Often he will try to place the onus of decision on the physician. If he is to become independent the patient must make his own decisions, and the appearance of a decided attitude to future problems is a sign that he is becoming fit to take a normal place in the community. It is only when the patient is to be regarded as constitutionally inferior and in need of permanent assistance that it is justifiable to give direct advice.

The difficulties encountered in urging a patient to decide for the future are illustrated, with other therapeutic points, in the following case:

A nurse, aged 30, of superior intelligence (I.Q. 140), good education and attractive appearance, had been listless and unhappy for four months. Following an attack of influenza she suddenly developed uncontrollable choreiform movements, worse on the right side of her body, together with a slurring dysarthria and a tendency to weep on slight provocation. At the same time an intermittent diarrhoea, which had appeared at the onset of her illness, now became much more severe.

She was an only child of rather severe Scottish parents, and apart from extreme fussiness over food, which at times had her family in despair, she was a model child, and was universally admired for her saintly behaviour and her prowess at school and especially at Sunday school. In adolescence, when her mother died, she became greatly attached to her father, kept house for him and restricted her contacts to relatives and to friends met at the church. While not without a romantic belief in love, she had a severe attitude in moral issues.

Her first acquaintance with sex matters was made during a friendship with a boy she met at church. While the sex-play which resulted aroused in her feelings of guilt, the possibility of other modes of life than that she was living was opened up to her, and she felt she would like to marry if it were not disloyal to her father. In the course of the affair the young man developed disseminated sclerosis and had gross intention tremor, a left hemiplegia and dysarthria. When eventually personality changes occurred in him she returned to her father and once more had no thought but to devote herself to him.

Five years before the onset of her illness she again fell in love, and was in doubt whether or not to accept the young man and leave her father. She decided to remain with her father, but a year later, after a painful illness, he died of carcinoma of the rectum. Throughout this illness, in which he had severe diarrhoea, she devoted herself to him, and at his death she was exhausted and depressed.

After an interval, however, her attitude changed, and she ceased to be religious,

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went out to parties, and again became friends with the young man who had proposed to her. By this time he had developed severe rheumatic heart disease, and during their renewed acquaintance commenced auricular fibrillation and was given a hopeless prognosis. She again became depressed and anxious, but after an interval decided to get away from her old surroundings and take up nursing in London. She worked hard and her career was regarded as a promising one. While in London she developed a very profound friendship for another nurse and with her became converted to the Catholic faith. After some months, however, she met some friends, including a man, from her home town, and began to wish she could return. She became anxious, slept poorly and frequently suffered from diarrhoea. While in this state she was nursing a case of chorea in a young man resembling her first love. At this time she was obliged to go off duty on account of an attack of influenza, and on recovering she developed the symptoms described.

On admission to hospital she was dysarthric, tearful, sullen and unco-operative, and at first said she could not remember her relatives' address. On examination she had choreiform movements which were worse on the right, had a slurring dysarthria which became an anarthria when questions were asked about her illness, a gross intention tremor of the hands, and sudden urgency of defaecation. At first all attempts to discover the aetiology of her symptoms were defeated by her attitude. Direct questioning resulted in aphonia, and when driven into a corner she would have an urgent desire to defaecate.

She was isolated in a single room, and after a thorough physical examination was given a sedative and allowed to sleep. On the following day she became more co-operative and entered into a discussion about her symptoms, resenting hotly the suggestion that there was a functional element and showing in her rationalizations considerable intelligence and medical knowledge. After two weeks most of the facts already described had been elicited and checked by reference to relatives and friends. There was still, however, no insight, and she declared that her sole anxiety was as to whether she would be able to continue her nursing career. She said she had never worried over decisions and had never felt any strong interest in sex. In view of her good intelligence and the fact that she had apparently not retreated until she had experienced a great deal of anxiety, it was decided not to attempt to remove the symptoms by suggestion, as there was a good possibility of her gaining insight.

In the course of the next six weeks the symptoms were not discussed, and the patient gave an account of her life up to the time she entered nursing. She began to show an increasing amount of emotion in discussing her early love affairs. When the relation of her symptoms to those of individuals of emotional importance to her was pointed out, she at first insisted that the similarity was due solely to coincidence, even though by this time she realized that her symptoms were not due entirely to physical disease. Finally she was in the position of being able to formulate her own case and to realize the purpose of her symptoms. They did not, however, automatically disappear. No attempt was made to remove them, as she still had before her the most difficult decision of all, and she was quite unable to face the fact.

The next stage was reached when the patient asked the physician to decide whether she should return to her old life or continue nursing. This advice was refused, and she was told she must decide herself. This resulted in a renewal of anxiety dreams and reduced co-operation for several days. At the end of this time she said she must decide, as she could stand it no longer, and announced her intention of returning to work as soon as she was well. Her whole case was then reviewed with her, and she expressed surprise that her symptoms remained. She was told that if she stood up and held out her arms her tremors would go. They did.

On the following day she had relapsed completely. Her decision was reviewed, but she insisted on returning to work, though she seemed undecided. Her symptoms were again removed by suggestion, and she was sent home for a month's holiday, and told that her decision could always be reversed in that time.

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A month later she rang up the writer from a telephone booth at one of the main London termini. She had arrived to continue her training as a nurse, and her symptoms had relapsed at once on leaving the train. She made her final decision in the telephone booth. She has remained well.

Prognosis.

The prognosis of a case of hysteria is the prognosis of the individual's success or failure in normal adaptation. It is impossible to form an opinion as to the future on a basis of symptomatology alone. If a reliable impression is to be gained, consideration must be given to the strength or weakness of the patient's physical and personality resources as a whole in relation to the social and cultural milieu to which he must adjust himself, and to the stresses he is likely to be called upon to face. If he is to assess the patient's capacity to resist flight into illness, the physician must, in the course of his therapeutic exploration, endeavour to build for himself a living mental picture of his patient's reactions to past and present problems. This will allow him to foresee to some extent his future conduct, at least in response to predictable stress. While emphasis must be laid on this total view, there are certain aspects of an hysterical illness which are of especial importance in prognosis.

If the stress which appears to have determined the patient's illness is not an overwhelming one, or one that has continued beyond normal endurance, the reason must be sought for his retreat from a situation which the average individual is expected to face. Further inquiry may reveal that there are other difficulties and anxieties which have weakened his resistance, and that retreat has only taken place after a genuine effort to overcome them. If, on recovery, return to a less trying environment is possible, the outlook for adaptation to average stress may yet be good. If, on the other hand, the patient has to return after his symptoms have cleared up to a situation as difficult as the one that wore down his resistance and forced him to seek refuge in hysteria, relapse can be expected, however full the insight that has been gained during treatment. It is only when it causes the patient to see his difficulties in a way which allows him to dispose of them that insight is of value and is likely to be retained.

In the same way, if he suffers from some native handicap, physical or intellectual, for which he cannot compensate, which has prevented him from taking a normal place in the community, normal adaptation cannot be expected on his return to it. Such cases do not present themselves with symptoms of recent hysteria unless some sudden additional strain has brought their deficiencies into relief. Even where a solution of the immediate problem is possible, each retreat may, unless some compensation is found, increase the possibility of a permanent adjustment through functional incapacity. Handicaps such as these are more likely to acquire chronic functional superstructures if they are such as not to be easily discerned by others. The blind man is not only excused his ability to avoid collisions, but he is suffered to be more

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bad-tempered than the man who can see. The simpleton of intelligent appearance, on the other hand, has his failings attributed to malice, and can hardly be blamed if he learns to explain them to himself and to others as due to his "nerves." Where the disability lies in incapacity for social adaptation it is often difficult even for the psychiatrist to detect and to make allowance for, even though it is a constant, though unsuspected, handicap to the patient. There can be no doubt that, even apart from the group of psychopathic personalities in which the tendency to hysterical mechanisms is the presenting feature, functional illness is common in psychopaths and prepsychotics of all kinds. The presence of such a personality argues a poor prognosis in proportion to its degree.

Since there is much in hysterical illness that is comparable to faulty habit, it is helpful to inquire into the way a patient has been accustomed to deal with minor difficulties. To those who have been able from childhood to postpone and evade their daily responsibilities on pretexts of physical indisposition, the extension of this mechanism in the face of larger issues may come easily. Those who have been encouraged in youth to believe the world at their service may feel the need of retreat more acutely when exposed to the stresses of adult life. The adolescent who has refused to give up his childhood dependence will find himself unprepared for the traumata inevitable at his age, and will be forced to blind himself to their existence, as is seen in the denial of sex knowledge so common in the female hysteric. The frequent occurrence of hysterical illness in the daughter who has stayed with the parents while the other members of the family have made themselves independent is generally recognized. It may be that she has stayed because she was constitutionally predisposed to hysteria and therefore to dependence. The converse is, however, absolute, i.e. that a dependence which has not been sought by the individual predisposes him to make use of hysterical mechanisms.

Often, before breakdown has occurred, the patient will think consciously how his difficulties would be solved by the fortuitous appearance of a disabling wound or illness. It is frequently possible, in the course of treatment, to revive the memory of these thoughts, and to find out to what extent disability was consciously hoped for. In cases in which incapacity has appeared early, it may become evident that since so little effort was made to prevent a thought from becoming a reality, the same process could easily occur again.

During treatment the appearance of a zest to return and deal with the old problems in a new way is a welcome sign. It is more easily mobilized where the patient has ordered his life to some definite end in which his interest can be renewed. Where he has led an aimless, day-to-day existence without a central ambition, his prognosis is the worse. A history of previous hysteria with each attack, precipitated by a decreasing stress, and preceded by a decreasing amount of anxiety, suggests that unless a radical overhaul of the whole personality is possible, relapse is likely.

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The presence of signs of acute anxiety is an indication that solution of the patient's problems by means of functional incapacity has not been too placidly accepted. A history of a fairly prolonged period of anxiety preceding the development of symptoms argues a good prognosis if this anxiety can be mobilized in the course of treatment. In cases where mechanisms of non-realization are prominent anxiety is nearly always evident, and in these cases the outlook is usually good. In general, the prognosis of panic and terror reactions, unless they occur in the course of chronic hysteria, is excellent, while that for transition states is not quite so good. In recent hysteria with functional incapacity anxiety is never so overt, and *belle indifférence* may have made its appearance. Such cases have much in common with chronic hysteria, and their outlook is the less favourable for that reason.

Anxiety is not always readily recognizable as such. It is often masked by aggression, and for this reason the appearance of a belligerent attitude and of resistance to treatment in the early stage is by no means a bad sign. It has been seen that aggression is common in alternation with true anxiety and with non-realization symptoms in transitional states. This favourable aggression has to be distinguished from that seen in psychopathic personalities, and especially in the epileptoids, in whom chronic and progressive hysteria is common. In the same way true anxiety has to be distinguished from the perpetuation of long-inactive anxiety symptoms as a means of functional incapacity (anxiety hysteria). A useful indication of the presence of true anxiety in retrospect is a history that the patient has wished for death rather than disability as a solution of his difficulties.

Perhaps the most important part of this prognostic estimation of the personality is to decide whether or not breakdown has been the reasonable result of stress. If it has, then recovery may be expected. If it has not, the cause may be found in constitutional inferiority, or inquiry may reveal a deteriorative character change which has been taking place for some time before the actual appearance of symptoms. Some patients appear to have an inborn weakness in their resistance to such a change and, in a favouring environment, drift into the habit of blinding themselves to and evading their responsibilities until the evasion amounts to hysterical non-realization and retreat. Others of greater native strength may be forced into the habit of retreat by acquiring some disability, whether it be an injured brain or a cruel husband, for which they are unable to compensate. In a special group, to which the name degenerative hysteria may be given, patients, often of previously good personality, rapidly develop the grossest hysterical mechanisms, many of them closely akin to malingering, together with irreversible personality change. Many such cases follow head injuries and others prove later to have chronic encephalitis, epilepsy or some other organic insufficiency. This group will always need partial protection and a useful life is rarely possible.

The detection of the signs of personality deterioration associated with

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progressive hysteria is of great prognostic importance. If they were absent before symptoms appeared, there is always hope of complete readjustment and the effort of treatment will be repaid. The chronic hysteric develops gradually a childish egocentricity. He covers his lack of interest in the common good with showy protestations of self-sacrifice. His affects are shallow, but he attempts to deceive himself and others with displays of emotionality. He is unambitious and is guided by the whim of the moment, and will mobilize all his pathological resources to obtain it. He is shamelessly dependent on others, and demands his full rights from a community to which he contributes little unless it incidentally satisfies his own self-esteem. He seeks by identifying himself with the child to gain his privileges while retaining the dignity of an adult. His facility in such inconsistent identifications is an indication of the development of a chacteristic suggestibility which can at any time change abruptly to negativism. In such a personality hysterical mechanisms flourish, and if it has been present before they appear, the prognosis is less favourable. In recent hysteria similar characteristics may appear while the symptoms are present, but they have not then so serious a significance as when they have been present before.

Though often misleading until all the causative factors are known, the nature of the actual symptoms, apart from their general type, is of great prognostic value. If the form of the illness is that of a true recent hysteria, the immediate outlook is always good. Amnesia and aphonia invariably clear up, and on the first occasion of their appearance are not usually replaced by functional incapacity. A pseudopsychosis, on the other hand, though it usually responds to treatment, occurs in a poorer type of personality, and the form of psychosis imitated may indicate an underlying trend in that direction. In the group with functional incapacity there are a number of symptoms which rarely occur unless there is considerable personality deterioration. Symptoms which bear a strong resemblance to malingering (dermatitis artefacta, puncture abscesses, pseudopyrexia) indicate that this deterioration is a progressive one unless they occur in a setting of prolonged physical illness or severe anxiety.

Patients who appear at first sight to be dull and degenerate may alter rapidly with relief from strain and a knowledge that an attempt is being made to understand their difficulties. In the patient's interest he must be seen at his best, and this may not be possible until a good deal of effort has been spent in therapeutic exploration. If there is doubt as to whether the patient is deserving of an intensive therapeutic attack he should be given the benefit until he is proved undeserving of it. If, however, it is seen that chronic hysteria is inevitable, the effort spent in treatment should be kept for worthier material. The aim in such cases can only be to improve the patient's adjustment to his life rather than radically to alter him.

A relatively small number of cases of recent hysteria become chronic, and of these only a few become complete dependents. The partially dependent

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group is, however, a large one, and includes many of the permanent supporters of hospital out-patient departments. These individuals are a permanent burden on the social institutions which must aid them, and mar the happiness and restrict enterprise in the families to which they are attached. In preventing chronic hysteria, the physician is acting at least as much in the interests of the community as of the patient.

Summary.

The manifestations of recent hysteria are due to the retreat from a situation which is beyond the patient's endurance. Reduced awareness of the situation is an essential feature. It is the pathological counterpart of a normal protective mechanism.

Retreat may be attained by flight into—

Irrelevant activity or anger.

Non-realization symptoms.

Functional incapacity.

In recent hysteria the retreat is a blind one. In chronic hysteria the patient has a fuller awareness of his circumstances, and adjusts himself to them by selectively purposive symptoms. This is only possible at the expense of loss of independence as a social unit and of personality changes consonant with permanent dependence on others.

Anxiety is most commonly the state from which escape is sought. This anxiety may arise in fear or from conflict. Signs of anxiety are very frequently in evidence, if in disguised form, among the symptoms of recent hysteria.

Classification of recent hysterical states :

(1) Immediate reactions.

Hyperkinetic—panic reactions.

Hypokinetic—terror reactions.

(2) Hysterical transition states.

(3) Recent hysteria with functional incapacity.

Constitutional and organic predisposing factors are of great importance, both in lowering resistance to hysterical mechanisms and in determining their form. Recognition of such factors and of that of exhaustion is a necessary background to a psychotherapeutic approach.

In recent hysteria the nature of the symptoms themselves is such as to hinder inquiry into their causation. For this reason, and because there is a time factor in preventing further retreat into functional incapacity, it is often advisable to remove the presenting symptoms at an early stage in treatment.

Panic reactions recover spontaneously or respond to reassurance or redirection of the patient's excessive activity. If they do not they may become transition states. Terror reactions and transition states need rest

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and security before symptoms can be attacked. Their treatment may be divided into three phases :

Rest and reassurance.
Removal of symptoms.
Therapeutic exploration and re-education.

Suggestion is of great use in recent hysteria. In the group with functional incapacity, especially, preparation is necessary, as unsuccessful suggestion has an adverse effect of rapport. There must be an incentive to recovery, if only an immediate one. The methods of suggestion include :

Simple demonstration and re-education.
Conditioning out.
Suggestion with vehicle.
Dissociative suggestion.

These methods are used in combination rather than separately.

Removal of symptoms does not mark the end of treatment, but it may greatly assist rapport and the development of insight. In the therapeutic exploration which is made at all stages of treatment a vital study is made, with the patient, of his life. Prognosis can only be based on a review of the total personality and equipment of the patient in relation to the problems and stresses he may be called upon to face. A poor prognosis does not threaten life. Lifelong neurosis, the worst result, is a handicap, not so much to the patient as to those upon whom he is dependent.

The main features to be reviewed for prognostic purposes may be summarized in four groups :

Physical and constitutional factors.—Intelligence. Constitutional or acquired organic deficiencies, especially gross disease of the central nervous system. Exhaustion and debilitating factors.

Previous personality.—Presence or absence of drive and ambition. Evidence of personality deterioration. Extent to which mechanisms of retreat were used unchecked in early life. Psychopathic personality. Exclusion of degenerative hysteria.

Nature of stress upon patient.—Its intensity and duration, and whether the patient has attempted to overcome it. Ability of the patient to adjust to it if given help. Extent to which patient can be shielded against similar stress on recovery.

Form of the reaction.—Intensity and duration of anxiety period before breakdown occurs. Acute changes from previous personality, such as panic and terror reactions, have best prognosis. Transitional states usually good if it is the first attack. Acute functional incapacity less so. Non-realization symptoms are of good import. Symptoms resembling malingering occur in poor personalities unless in exhausted states or degenerative hysteria.

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