Part I.—Original Articles.

THE BODILY COMPLAINT: A STUDY OF HYPOCHONDRIASIS.

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ADOLF MEYER writes, " In the end our task is the amplification and specification of the complaint, expressed in the most factual objective and potent terms ". Robert Hutchison also emphasizes the importance of the complaint when he stresses the presenting symptom in his treatment of medicine. A patient always comes to his physician with some complaint, which it is the duty of the physician to investigate and treat. In the majority of cases the complaint is a bodily one; the patient goes to his physician complaining of an ache or pain or some other bodily discomfort. This bodily complaint may or may not be due to some physical illness. In Sir Walter Langdon Brown's words, " Some are unhappy through illness, some are ill through unhappiness ". This paper deals with those patients who have bodily complaints for which no adequate physical basis can be found. This condition is now known as hypochondriasis.

Hypochondria means originally the regions below the costal cartilages, and as such was used by Hippocrates (Aphorism 64) and is still used in physical medicine. This region was considered to be the seat of the black bile which caused melancholy, and Robert Burton in his *Anatomy of Melancholy* (1611) writes of the windy hypochondriacal melancholy: " In hypochondria melancholia adeo ambigua sunt symptomata ut etiam exercicatissimi medici de loco affecto statuere non possunt " (" In this hypochondriacal or flatuous melancholy, the symptoms are so ambiguous that the most exquisite physicians cannot determine the part affected "). He gives as the bodily symptoms, " sharp belchings, fulsome crudities, wind and rumbling in the guts, vehement gripings, suffocations, palpitation, heaviness of the heart, singing in the ears, and unseasonable sweat all over the body ", and as the mental symptoms, " fearful, sad, suspicious, discontent, anxiety, troublesome dreams, etc.", and

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gives some account of the effect—" Some fear and are not sad, some be sad and fear not, some neither fear nor grieve ". He mentions bizarre hypochondriasis in the following words: " Some by reason of these gripings and rumblings within will not be persuaded but that he has a serpent in his guts, another frogs." Burton gives long accounts of the causes of these conditions, including frustrated ambitions, disappointed love, and solitariness. He recommends as treatment innumerable herbs and diets, the cautery, blisters and setons. In addition, he advises treating it—

1. By using all good means of help, confessing to a friend, etc.; avoiding all occasions of his infirmity; not giving way to passions but resisting to the utmost.

2. By counsel, comfort, good persuasion, witty devices, fictions, and if it be possible, to satisfy his mind.

3. Music of all kinds.

4. Mirth and merry company.

These references to Burton are given in some detail, because it seems that this eccentric Oxford clergyman had more insight into this condition than the medical profession has had until recently. He obviously realizes the psychogenic origin of many of these complaints, in contrast for instance to Nathan Highmore, who, in his paper in 1669 on the Hypochondriac Passion, considers that " the chief cause of this distemper is laxness of the tone of the stomach, whereby vicious chyle and blood is generated that causes a fermentation upon which ensues rumblings and palpitations of the chest ".

Thomas Willis had a long controversy with Highmore in which he maintained that the spleen was the site of hypochondria. Willis, like Burton, made no distinction between hypochondria and melancholia.

In 1730 Mandeville published an interesting account of the vapours and hypochondria, in the form of a conversation between two fictitious patients compounded from his own patients. He describes almost every kind of psychogenic bodily complaint, but makes no contribution to the ætiology or treatment of the conditions. He describes a common approach of these patients to the physician: " I have sent for you, doctor, to consult you about a distemper of which I am well assured I shall never be cured."

James Boswell, writing in 1777, regarded hypochondria as definitely mental rather than structural, in contrast to the purely medical views of his time. He writes, " Nothing characterizes a hypochondriac more than a want of power over his own mind," and he advises cheerful companions and distractions. Boswell, however, confuses hypochondria with melancholy.

Robert Whytt in 1765 put forward a vague nervous theory in which he considered hypochondria to be due to " too great delicacy of the nervous system together with some morbid matter bred in the blood ". He recognized, however, the distinction from melancholy and the close relation between hysteria and hypochondria.

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Austin Flint (1866) says that the hypochondriac is " the victim of a delusion with respect to his condition ", and again, " nervous asthenia is the functional debility induced by excessive activity of the brain function ". This concept of nervous asthenia or neurasthenia grew to include much that would now be called hypochondriasis. George Beard in 1880 wrote an able book on nervous exhaustion or neurasthenia, which he described as a condition with innumerable symptoms, such as vague aches, exhaustion, excessive sweating, flatulence, trembling attacks, palpitations, which were to be distinguished from the symptoms of other diseases chiefly by their variable and fleeting character. He confines the term " hypochondriasis " to cases with a definite delusion of physical disease, and refers to most of the conditions we would now call hypochondriasis as neurasthenia. He believed that the condition was caused by exhaustion or abuse of the reflex centres of the brain, the stomach and the sex organs, whence the injury would radiate by the nervous system to any part of the body: " If a man thinks too much, he will not necessarily complain of his head, but maybe of his legs." Beard used a varied battery of treatment, including sedatives, tonics, rest, and isolation in some cases, work in others, and on many he used blisters. However his conviction of the efficacy of his treatment and his sympathetic listening to his patients procured him excellent results. He held that " by assisting the patient to face the enemy, we can put him into a position to understand that his troubles, serious as they are, are not as serious as he had feared ".

In 1868 Sir William Gull published a very able paper in which he said that hypochondria may follow severe " moral and emotional shocks ", and that " reading on medical topics often frightens men into a hypochondriacal frame of mind." He emphasizes a hereditary insane trait, and distinguishes it definitely from melancholy: " The heightened self feeling of hypochondria does not partake of the despondency of true melancholy." He, like Whytt, considers that it occurs chiefly in men. His treatment consisted of breaking down the patient's morbid self-concentration by active pursuits, careful history taking and reassurance.

In 1875 Sir James Paget also made a very real contribution to the subject. He describes sexual hypochondriasis in the young man, which he treated in a very common-sense way by able reassurance. He recognized it as a very difficult problem to treat, and says that in some cases the hypochondriasis will gradually drift into a more evident insanity. This is consistent with the views developed later in this paper on sexual symbolic hypochondriasis. He states that " A physician's chance of doing good will depend on the skill with which he can influence the patient's mind ". He recognized well the type of hypochondriasis or invalidism that simulates a surgical condition, and he makes an excellent diagnostic point where he emphasizes the contrast in the mental states of those who have real and those who simulate local diseases. He writes: " Few patients with real hip disease for instance think half so much

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about their ailments as they do whose nervous systems simulate those diseases." He did not in fact regard hypochondria as a disease, but as a form of egotism.

Weir Mitchell had a theory that neurasthenia (which included hypochondriasis) was due to exhaustion of the lipoids in the central nervous system, and on this principle treated his patients by rest in a darkened room. The force of his personality was probably the chief factor in promoting improvement in his patients. According to this theory the nervous breakdown was due to overwork of some kind, and naturally it was a very popular idea, as according to this view nervous breakdown became a very creditable, well-earned affair, rather than a psycho-biological maladjustment, which is not nearly such a satisfying belief to the patient. This attitude is still a very prevalent one. For instance, in Price's *Textbook of Medicine* it is stated that the treatment of this condition is physical and mental rest, careful feeding and the administration of stimulants and bromides.

The subject was somewhat differently approached by the psychiatrists dealing with more marked degree of mental disorders. Maudsley in 1880 described some of the anomalous body complaints in melancholia; Kraepelin regarded hypochondriasis as a symptom of very varied mental illnesses. He describes the essential underlying body concern, in which a person seeks to find the origin of every slight body sensation. In his account of the dementia præcox symptoms, he describes many of the bizarre body complaints, such as contraction of the genitals, and in paranoia he makes the point that the hypochondriasis is often connected with the delusional system, i.e., that his body complaints are due to someone destroying his nervous system with electricity. He also refers to the nihilistic hypochondriasis in depression, with ideas of the bowels being stopped, etc.

Bleuler defines hypochondriasis as "the continuous attention to one's state of health, with or without a tendency to ascribe a disease to oneself from insignificant signs". Thus he considers hypochondriasis as a personality trait rather than a medical entity. He says, "We no longer recognize hypochondria as a disease". Bleuler includes all the incurable forms of hypochondriasis under dementia præcox, which seems rather to stretch the definition of dementia præcox. Strangely enough he says that he has not seen hypochondriasis in paranoia, but he describes it as a symptom in dementia præcox, depressive and neurasthenic conditions and in initial stages of organic psychoses.

The psycho-analytic approach was somewhat different to that of formal psychiatry. Freud's chief contribution to the subject of body complaint was his definition and discussion of the anxiety state with its symptoms of palpitations, choking, etc. This he considered to be ultimately due to reflex irritability from the sexual organs. He says that hypochondriasis is the form favoured by true neurasthenics when they fall victim to the anxiety neurosis. Neurasthenia, always an ill-defined term, according to Freud has much the

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same meaning as that of Weir Mitchell, that is, a physical exhaustion of the nerve-cells. Cases of masturbation-conflict with bodily complaint were classified by Freud as neurasthenics, thus somewhat supporting the old masturbation lore. Hypochondria in fact, like neurasthenia, is classed by Freud among the " actual neuroses " or real neuroses, implying an organic basis as opposed to the psychoneuroses.

This organic basis of hypochondriasis he considers to be an increased blood-supply to the site of the body complaint or hypochondriasis, due to a displacement of the erotogenic zone, but there seems to be no evidence for such an opinion. In his analysis of Dr. Schreber, a paranoid patient who had various body complaints, such as plague and softening of the brain, he proceeds at once to the mechanism, which he considers to be castration desires, and quite ignores any analysis of the hypochondriasis. Freud, in fact, does not consider hypochondriasis very fully, as he is more interested in the mechanism than in the complaint.

Schilder considers hypochondriasis as a type of narcissism—" increased self love, but self love turned in such a way that the individual defends himself against his own self love "—and he considers that rectal hypochondriasis is an expression for the anal castration complex.

Adler has no particular contribution to the problem of hypochondriasis. He considers it as a part of the inferiority complex like everything else, and in special relation to the organic inferiority.

Esther Richards in 1919 defined one type of hypochondriasis, the chronic hypochondriasis, merergasic hypochondriasis, or invalid reaction, in which the body complaint is the salient feature of the case. She described 45 cases, in which the hypochondriasis is shown to be a substitution for various life difficulties, mostly of a fairly obvious kind. Robert Hutchison (1925) describes some of the symptoms of this invalid reaction under the heading of " the chronic abdomen ", and stresses the ceaseless complaints, egotism and peevishness. Although this type of hypochondriasis is very common indeed, yet it is by no means generally recognized. The general practitioner often intuitively defines to himself this condition, which comprises the bulk of his regular patients, but yet in the medical schools it is not taught at all, and there is no mention of its existence in the standard medical text-books, such as Price. The result of this lack of medical education on the topic of the psychogenic body complaint is that the physician gives symptomatic treatment for the organ which is the site of complaint. Thus there is a danger of giving digitalis if a patient complains of his heart, or a laparotomy for abdominal complaints, etc., without full investigation of the psycho-biological background of the individual, an investigation which alone will often tend to cure the patient better than any medicine.

Hypochondriasis has thus been taken to cover a very wide field, and many theories have been adopted to account for it. It has been considered under

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the name of "neurasthenia" by Beard, or "psychasthenia" by Janet, as a symptom of depression and schizophrenia by Kraepelin and Bleuler, as an organic or actual neurosis by Freud, and finally as a psycho-biological reaction by Esther Richards and the Meyerian school of psychiatry.

Definition.

Hypochondriasis is variously defined. Henderson and Gillespie define it as a settled conviction of physical disease in the absence of any evidence. This puts it into the order of a delusion. Gillespie, in his review in 1929, defines hypochondriasis as (1) a mental preoccupation with a real or suppositious physical disorder; (2) a discrepancy between the degree of preoccupation and the grounds for it; (3) an affective condition of interest with conviction, but not of anxiety or depression. The latter criterion narrows the scope of hypochondriasis considerably more than is done in this paper. Bleuler, as mentioned, defines it as a state of attention to health. In fact, according to him, hypochondriasis is essentially an attitude of bodily concern which can exist without a complaint. Kehrer emphasizes this enlargement of the sphere of body sensation in hypochondriasis and the constant body awareness of these people. Adolf Meyer defines hypochondriasis as the tendency to exaggerate abnormal impressions or behaviour of special organs, giving invalidism or the tendency to acquire imaginary diseases.

For the purpose of the present paper, hypochondriasis will be taken to be a physically unjustified or exaggerated body complaint. This is essentially an attempt to bring together all the psychogenic body complaints without any distinction into hypochondriacal delusions or attitudes. A distinction of course must be made between normal bodily concern and hypochondriasis. For instance a normal, mentally healthy man may develop a fear of cancer on discovering a lump beneath his skin, but after visiting a physician in whom he has confidence and who reassures him that it is a perfectly harmless lipoma, he thinks no more about it. If he happens to be in a depression he may, however, be quite convinced it is cancer in spite of every proof to the contrary. In this case one might speak of a hypochondriacal delusion of cancer. Similarly, if the patient is in some difficulty which could be solved in some way by invalidism, he may complain vigorously and vociferously of pain in the lump, but leave it to the doctor to interpret. He will travel from physician to physician complaining that none of them understand his condition. In this case one would speak of chronic hypochondriasis. Although technically this is not a delusion, as the false interpretation has not been made by the patient, yet it is often just as difficult to eradicate. In one sense, in that it is a false conviction of physical disease, simple hypochondriasis may be regarded as a delusion. Certainly the so-called simple hypochondriasis frequently blends with a hypochondriacal delusion, and the distinction between hypochondriasis and

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hypochondriacal delusion seems to be a useless one. The field of this paper is not restricted to any one group or diagnosis of patients. The object is to determine whether the body complaint has any special characteristics, similarities and significance in the various psychiatric conditions where it occurs. This topic seemed important, because so often the body complaint is the presenting symptom of any psychiatric patient, as well as of a patient suffering from a physical illness.

Differential Diagnosis.

Obviously the first problem in dealing with a case of hypochondriasis is to determine to what extent, if any, the complaint is physically justified. This was done on all the in-patients by a complete physical examination, blood Wassermann reaction, blood urea, blood sugar, blood-count and any special examination indicated by the nature of the complaint. These physical examinations were made as early as possible so that the patient could be authoritatively and confidently reassured, and treatment of the hypochondriasis could start at once. Frequently this distinction between physical and psychogenic body-complaint is by no means easy. For example, in Case 13, a man, æt. 56, admitted to the hospital for headaches and fits, which were accompanied by champing movements of the mouth, there was for some time a suspicion of cerebral tumour, probably of the uncinate region. He showed some inconsistency of memory, and in addition had partial loss of smell and taste. The character of the fits, however, though superficially resembling epileptic attacks (which he had had an opportunity of observing in another hospital), really were of a hysterical type. On one occasion the cerebro-spinal fluid showed some abnormality of the gold curve. There was a previous history of hysteria-like episodes, and there was a possible motive of avoidance of work. Fully satisfying dynamic factors were not to be obtained from him, but it proved possible to cure his headache and fits, at least temporarily, by hypnosis, and he was discharged free of symptoms. Thus, by the effect of therapy, the diagnosis of a psychogenic complaint was finally established. Various diseases are likely to give trouble in the differential diagnosis of hypochondriasis. Pulmonary tuberculosis, with its symptoms of tiredness, vague aches and pains, abdominal discomfort, headache, is particularly important, especially since tubercular patients are frequently of the type that would tend to be called " nervous ". Disseminated sclerosis, with its emotional instability, may easily be confused with a psychogenic condition. Other physical conditions to be considered are brain-tumour, gastric ulcer, nephritis. Only a thorough physical examination can render a diagnosis of hypochondriasis a safe one.

It frequently happens that a patient is hypochondriacal about a real physical disorder. Such cases are common in the medical and surgical wards of any hospital. They are usually known as " bad patients." Every slight

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ache or pain is magnified into a complaint or topic of concern, and one of these patients will complain more of a cold in the head than another will in dying of a long and painful disease. The attitude of a patient to his illness is a very important factor in physical medicine. This is especially obvious in tuberculosis, when the patient's progress often seems to depend to a large extent on his acceptance of his condition and his fortitude in enduring its discomforts. In all these patients the hypochondriasis has to be treated by reassurance, and explanation that excessive attention to a part of the body can increase its sensitivity and increase the pain to be derived therefrom. Case 38, a woman, æt. 40, in a setting of marital and sexual maladjustment and fear of pregnancy, had a five years' history of abdominal discomfort, backache, and a tendency to relapse into invalidism, and about three months of mild depression with insomnia, excessive worrying and difficulty in making decisions. In the hospital she had innumerable body complaints—" drawing in the head, misery in the back, etc." She showed considerable improvement during her stay, but she developed hæmorrhoids, which caused her some pain, and for a time all her body concern was focused on them. A hæmorrhoidectomy was performed, after which she relapsed into a martyr-like state of intense self-pity about her local discomfort, from which she was roused only with considerable difficulty. The complaint, based on a definite physical disorder, here served the same purpose as the purely psychogenic body complaint she had had previously, and she was prepared to prolong the complaint indefinitely. Probably many cases of delayed recovery from operations belong to this class of patient.

Case 7 is a woman with a life-long history of body complaint, somewhat accentuated since a marriage with poor sexual adjustment. She developed a curious paranoid delirium after a cholecystectomy, which was accompanied by the signs of pellagra and was finally cured by anti-pellagra treatment. The hypochondriasis, with somewhat dramatized complaints of pains all over, burning in the back, etc., was continued throughout her physical illness, which gave some physical basis for the complaints.

Present Investigation.

In order to gain a general idea of hypochondriasis, the records of 226 patients admitted to the Phipps Clinic in 1934 were briefly examined, and a more detailed examination was made of 41 cases of hypochondriasis, 24 in-patients and 17 out-patients, which were personally investigated. The incidence of body complaints in the 226 patients admitted in 1934 is shown in the table. The main points from this are that 45% of the total admissions showed hypochondriasis. The incidence was only slightly more in the females than the males—43% in males and 47% in females. The schizophrenic group showed a higher incidence of complaint in the males (53%) than in females (43%), while in the depressive group the incidence was higher in females (59%) than

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in the males (50%). These figures are not quite representative of all psychiatric patients, as the patients have to be bad enough to need hospitalization, so that the proportion of merergasic hypochondriasis or invalid reaction and anxiety state, which usually is treated outside a hospital, is far too low, and the proportion of depressions and schizophrenics is too high.

Table showing Incidence of Hypochondriasis in 226 Unselected Patients Admitted to Phipps Clinic in 1934.

Diagnosis.	With body complaints.			Total patients with and without body complaints.			Percentage with hypochondriasis.		
	Males.	Females.	Both sexes.	Males.	Females.	Both sexes.	Males.	Females.	Both sexes.
Anxiety states	2	6	8	2	6	8	..	..	..
Merergasic* hypochondriasis	5	11	16	5	11	16	..	..	..
Hysteria	2	..	2	..	..	..	..	..	..
Depressive	20	25	45	39	44	83	50%	59%	55%
Manic	1	..	1	..	..	..	..	..	..
Parergasic†	17	11	28	32	25	57	53%	43%	48%
Panic	1	..	1	..	..	..	..	..	..
All conditions	48	53	101	116‡	110‡	226‡	43%	47%	45%

* " Merergasic " is the term in Adolf Meyer's terminology for part-reaction corresponding more or less with " psychoneurotic ". It is derived from μέρος, part, and ἐργασία, working.

† " Parergasic " is the term in Adolf Meyer's terminology for " twist reaction ", corresponding more or less with " schizophrenic ". It is derived from παρά, by the side of, past, beside.

‡ These totals include the cases which have no bearing on hypochondriasis, i.e. organic nervous diseases, toxic conditions, etc., which are not specifically stated in the table.

Symptoms.

The symptoms of the hypochondriasis, the actual body complaint itself, vary widely in the cases examined, from mild headaches and abdominal discomfort to black plague or reversal of sex. Every organ may be involved in the complaint, or again the complaint may be rigidly limited to one organ, as in Case 33. The hypochondriasis may be the salient feature of the case, or the body complaint may be one feature of a major disorder. Again patients show every variety of affect and attitude to the illness, from intense fear and panic, mild concern, dramatization and self-pity, anxiety, indifference, depression, to an attitude of almost interest and pride, or, as Dr. Richards puts it, " contented never to know another well day in his life ". In classifying and diagnosing hypochondriasis the affect and attitude to the illness is as important as the complaint itself, and especially important is the appropriateness of the mood to the bodily complaint. In addition, from the point of view of treatment it is important to determine whether the patient wishes to be relieved of his illness, or whether he is satisfied with it and is unwilling to relinquish it. Unfortunately, important as these differences in affect are, it is very hard to define them, and the recognition of affect is certainly

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one of the hardest things in psychiatry. For instance, many words could be spent in distinguishing between anxiety and depression. For the present purposes the affect descriptions are used in their everyday, ordinary sense without any effort at verbal definitions. In finding a basis for classifying hypochondriasis, the psychiatric diagnosis must also be taken into account. In these cases the diagnosis was almost entirely anxiety state, invalid reaction, parergasic reaction or depression. Another factor which may be taken into consideration is the ætiology of the hypochondriasis and its mechanism—obviously a very controversial topic. Thus, in classifying these cases of hypochondriasis there are chiefly to be considered:

1. The nature of the complaint.
2. The affect and attitude to illness.
3. The psychiatric diagnosis.
4. The mechanism and ætiology.

Classification.

Examination of the 41 cases of hypochondriasis on the basis of these four features indicated that hypochondriasis might be roughly classified into;

1. Body complaints partly on a physiological or somatic level, usually associated with anxiety.

2. Body complaints which have appeared by substitution or conversion of an affect, usually anxiety, with more or less elimination of the affect.

3. Body complaints with some more or less conscious purpose for the individual—purposive hypochondriasis.

These three types merge into one another and may be variously mixed in the merergasic reactions.

4. Body complaints symbolic of something else, some essential conflict of the personality, usually in the parergasic conditions—symbolic hypochondriasis.

5. Body complaints consistent with a mood disturbance, usually depression.

Anxiety Reactions.

Anxiety is probably biologically the reaction of the body to perception of danger, and is bound up with the reaction of flight. As such it has many physiological accompaniments referable to the sympathetic and parasympathetic systems, such as rise in pulse-rate, sweating, cardiac irregularity, dyspnœa, rise in blood-pressure, together with more controversial changes, such as raised blood-sugar curve, changes in secretion and motility (Wittkower), diarrhœa, vasomotor instability. These undoubtedly give some somatic basis for the anxiety body complaint in the anxiety states, which

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is often described as a definite clinical entity (Freud). The complaints in the 8 cases in 1934 were: (1) Choking, palpitation and sweating; (2) nausea and giddiness; (3) shaking spells, deep breathing, pain in side; (4) abdominal pain and headaches; (5) palpitations, sweating and headaches; (6) palpitation, tightness in throat, pressure on head; (7) palpitation, nausea, flatulence; (8) trembling and palpitations.

Of the special cases, No. 2 had attacks of faintness, panting for breath and palpitations, with the complaint: "I'm afraid my heart's going to stop. I feel a thump and a gurgle. Food gives me a pain and forms gas. I feel my blood buzzing through my legs." The somatic findings were, a tendency to flushing and dermatographia, and ventricular extra-systole, which increased after exercise or emotion. When the anxiety state was improved the extra-systoles disappeared, but could be made to return with adrenaline, though not with exercise. Here the extra-systole, probably one of the somatic symptoms of the anxiety, provided much of the content for it. In addition, the symptoms had become a topic of worry as a substitute for his real difficulties, and in this sense it is a conversion or substitution reaction. Thirdly, though anxiety was present from time to time, there was definite dramatization—an obvious desire to impress others with his illness. This dramatization is almost always indicative of some motivation or purposiveness in an illness. The motive here is possibly to gain sympathy and explain his lack of success. Thus there is in this one case body complaint on a somatic level, body complaint as a substitution, and purposive hypochondriasis.

Case 1, with body complaints of indigestion, abdominal pain and attacks of sweating, trembling, dyspnoea and anxiety usually after meals, which he had cut down to an almost starvation diet, shows substitution. The effect between the attacks is tranquil, and there is no suggestion of self-pity, or dramatization or purposiveness in the complaint. The essential fact here seemed to be a fear of cancer after having seen his grandmother die of cancer of the stomach—a fear which was revived by seeing a film of an operation on a cancer, during which his first attack occurred. Recognition of the origin of his symptoms was followed by steady improvement, but he tended to use the body complaints as a substitute for any trivial difficulty which was worrying him, which could usually be reached during an interview. Some sexual maladjustment was present in this case, but as it started later than the onset of symptoms it cannot be regarded as the essential cause.

Case 3 is a girl whose chief features were obsessive, but who suffered from choking feelings in attacks apparently on an anxiety basis. This symptom almost caused her to undergo a thyroidectomy. Although body complaints do not necessarily occur in obsessives as the obsessions themselves are usually a sufficient substitute for anxiety, yet they may occur when the conversion (in Freud's sense) is incomplete from anxiety to the obsessive symptom. Case 15 is another example of hypochondriasis in an old obsessional. The exact meaning

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of the choking feelings in the anxiety states is obscure, but they are so common that one inclines to expect them to be on a somatic basis connected with the parasympathetic system, in line with the symptoms of anxiety.

Case 19 is probably an example of anxiety equivalent—that is a complete substitution of the body symptoms for the anxiety. This man was intensely worried for a month after his brother was certified with schizophrenia, and then developed feelings of a lump in the throat, tired feelings in the chest and back, gas in the stomach, and feeling of his eyeballs expanding. With the body symptoms he ceased to be anxious or worry. A doctor had told his wife, who had told him, that he might go the same way as his brother, as indeed his body complaints might suggest. This at first had upset him. However, no definite parergasic signs were found, and after discussion of the origin of his condition and reassurance the symptoms almost completely disappeared and he was able to continue with his job.

The main factors in these cases were considered to be (1) fear of cancer, medical mismanagement; (2) thwarted ambition, over-anxious, solicitous mother; work beyond ability; sex rumination; (3) worry about a brother's illness and fear of insanity. Further sexual factors might have been brought out by further analysis, but the simple and direct methods served to give some solution of the difficulties. These anxiety cases thus show a mixture of the body complaint on the somatic level, body complaint as a substitution for affect and body complaint with a purpose.

The Merergasic Hypochondriasis; Invalid Reaction or Chronic Hypochondriasis.

In this class, which, of course, is by no means sharply defined, an outstanding feature is the motivation or purposiveness. In accordance with this is the attitude of self-pity and dramatization for the benefit of the environment. It usually is associated with anxiety or substitutive features, and means that the complaint serves some purpose. If the hypochondriasis is well developed, the patient is no longer aware of the purpose, though to others the condition has an air of bogusness. These patients inflict more strain on the general practitioner than any other, but on the other hand no class of patients suffers more at the hand of the doctor than these, through unnecessary operations. In Robert Hutchison's words, "The road to chronic abdominalism is paved with operations". This reaction seems to predominate in women in the present series, contrary to the experience of Gull, Gillespie and others.

Bedingfield, in his review of visceroptosis, describes the mental attitude of the patient with chronic abdominal complaints, who belongs to this type of hypochondriasis: "She seems to find complete satisfaction in the submissive attitude and sympathy of her relatives." He also describes the symptoms of constipation, flatulence, tachycardia, leucorrhœa and abdominal discomfort.

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Bedingfield, however, considers these conditions psychologically on a basis of inferiority complex.

The complaints may refer to any part of the body, they are often diffuse and may vary rapidly. Examples are: Pains in stomach and rectum, headaches and dizziness, abdominal pain and belching, diffuse aches and belching, shoulder pain, headaches and nausea, nausea and shaky feelings, indigestion, eye pain, headaches and hot feelings. Cases 4, 5, 6, 7, 8, 9, 10, 35 and 38 represent various modifications of this reaction.

Case 6, æt. 33, a married woman, had the complaint, " Headache most of the time, my eyes ache, I have drawing feelings in my stomach, my abdomen swells up. I can't bear to be on my feet, I can't rest at night, my female organs are not functioning ". There was considerable self-pity and dramatization and, in addition, much anxiety and agitation. Her trouble had begun ten years previously in a setting of sexual maladjustment and fear of pregnancy. It seems to have started with choking feeling, abdominal discomfort and amenorrhœa, which may have been an anxiety state. Attention was focused on her genitals by local treatment of the dyspareunia, and her bodily complaints increased to their present degree, rendering her a complete invalid. She was able by this means to gain the sympathy of and dominance over her husband and at the same time avoid sexual intercourse. This was probably the motive for her dramatization.

Case 8, with the complaint of pains all over the body and " dropped " stomach, had an attitude of mild self-pity and interest towards her condition, without any suggestion of anxiety. In her case the situation was one of marital maladjustment, but through her illness she had achieved a situation which satisfied her and she had no desire to change, and consequently did not co-operate with therapeutic efforts. She is still a chronic invalid.

Case 9, with complaint of pain in the stomach and noisy belching, the typical " windy flatulent hypochondriac " of Burton, did not desire any treatment at all for his condition, but only compensation for it. It dated from his discharge from the army, and he had already received much compensation, and is likely to receive more. This case is obviously purposive, and almost verges on malingering.

Other complaints in these patients were: Gas in stomach and inability to walk, with irregular sighing respiration (a symptom recently emphasized by Christie. It is really to be regarded as part of the drama rather than any special clinical sign). Two cases, 7 and 38, show the hypochondriasis continuous through, and temporarily focused in, definite physical complaints, in one case pellagra, in the other hæmorrhoids. Case 7 also shows the continuity of hypochondriasis through the delirium of pellagra. Case 39 shows the continuity of hypochondriasis through a hypomanic outbreak (usually only manifested in the depressive phases). Cases 35 and 38 show its continuity through depression. The present view is that this kind of hypochondriasis

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can occur associated with any physical or mental condition, with the exception of the parergasic or schizophrenic conditions. In these conditions the patient does not care sufficiently for his environment to consider it worth a show, which is the essence of dramatization. This view that a hypochondriasis or invalid reaction may be superimposed on any other psychoneurosis or psychosis is supported by Harris.

The occasional body complaints in hysteria are of a slightly different class. Hysteria is a purposive and substitutive reaction, and the affect is usually one of indifference. Sometimes the conversion seems incomplete, and definite pains are complained of as in Cases 12 and 13, with slight anxiety, as in Case 13. The pains are strictly localized and associated with the main hysterical symptom, in one case back pain with hysterical contracture of the back, and in the other headache with hysterical fits.

Another class is the feeble-minded group, in which the complaints are frequently grotesque and absurd, without definitely denoting a more serious breakdown. Possibly in these cases the intelligence is below the level at which absurdities are recognized, and the absurdity of the complaint is not perceived. Thus an absurd body complaint does not seem as grave in a feeble-minded patient as in an intelligent one. Case 6, for instance, with a mental age of 10, occasionally said that her female organs had all gone and the menstrual blood had rushed to her head; Case 4, with mental age of 10, complained of his left calf being drawn up and knotted and feverish pain all over the left side, and syphilis, but is showing no signs of becoming schizophrenic.

Discussion of Ætiology of Merergasic or Psychoneurotic Hypochondriasis.

Hypochondriasis is here regarded as a reaction to a biological difficulty of the whole organism. To develop this reaction there has to be (1) an individual with a tendency for body complaints; (2) a situation of difficulty to provide the occasion. The type of personality to develop body complaints we may call the body-sensitive or body-conscious, and it comprises a great variety of personalities having little else in common. The tendency to develop anxiety states and invalid reaction was found by Esther Richards usually to date back to childhood, and nine out of the ten cases comparable with hers in the series (Cases 1–10) definitely date back to childhood.

The hereditary factor is difficult to assess, as it is hard to separate it from the environmental. Of the first ten strictly merergasic cases, one case (6) had hypochondriasis and alcoholism in siblings, one case (7) alcoholism in a sibling, and one case (9) had epilepsy in a sibling. All the nine cases dating from childhood were under the care of a fussy and over-solicitous female relative, in seven cases the mother. Thus, though this type of relative may be a hereditary factor, it is likely to be a very potent environmental one. The impression

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is, in fact, that the merergasic hypochondriasis is more contagious than hereditary. Any undue fussiness or concern on the part of the mother about her child's health tends to be taken up by the child with great thoroughness. The parent may show excessive interest in the child's bowels or worry about his feeding, or worst of all, suggest to him that he is weak and ailing. The child will, of course, believe that he is an invalid. In addition, he may find that being an invalid gains for him certain immediate advantages that he would otherwise miss, such as the attention of his parents and avoiding school. The bodily complaint will be used whenever the child is in a difficulty. The use of the term "purposive" in this sense does not necessarily imply an adherence to the free-will school of philosophy; regarded as a habit which produces the desired result, it is equally compatible with the conditioned reflex theories. According to this view, then, hypochondriasis in a child tends to be first suggested and then purposive. The notable exceptions to this are the occasional queer symbolic body complaints in schizophrenic children (as in Case 27), when a 13-year-old girl complains of hollow teeth and pain in the side, and Case 7137 (not in special cases), where a girl complains of her fingers dropping off. Kanner emphasizes the purposive and suggestive elements in the development of the chronic complaint habit in children, and Esther Richards comes to much the same conclusion, and her only failures in children occurred in cases where parental co-operation was not obtained. Her conclusions from a study of 22 cases of hypochondriacal children are:

1. That hypochondriasis in children must be taken in hand from the start to prevent development of chronic hypochondriasis and not treated by general medical methods or placebos, which only accentuate the condition.

2. That situational adjustment and improvement of the parental attitude will usually cure the condition in children, sometimes combined with a course of re-education.

It is interesting that one of her cases that failed became schizophrenic, but eighteen did well.

F. Allen approaches the problem of child symptoms from an entirely different attitude—that of giving the child an opportunity for emotional expression, so that the child can adapt to the situation he finds himself in. Allen practises no situational adjustment, but also obtains very good results.

One may, in fact, sum up that hypochondriasis in a child is usually due to a faulty parental attitude, which if not corrected may lead to the much more intractable hypochondriasis of the adult.

Unfortunately the present series shows only one child of this type, Case 5. Here the complaint of gas in the stomach and inability to walk is accompanied by an attitude of self-pity and dramatization. In this case an over-solicitous mother, impressive medical diagnoses and treatment and a possible motive of avoiding school appear to be the main factors, though an additional sexual

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factor may also be present. The actual situation which appears to provoke the hypochondriasis may be almost any of "the thousand natural shocks that flesh is heir to", and there rarely seems to be one causative factor, but a whole combination. No attempt will be made to classify these situations here, but many of them have been mentioned. It is noticeable, however, that the invalid reaction seems to be particularly common in the dissatisfied wife situation. The site of the organ affected seems to be determined mainly by some topical suggestion. Thus, case 1 focused on his stomach after seeing the film of an operation on cancer of the stomach; case 2 focused on his heart because he had extra-systoles; case 6 focused on her genitals on account of the medical emphasis on dyspareunia; case 12 focused on his back because he had had lumbar puncture.

The psychological mechanism involved in the production of the invalid reaction or merergasic hypochondriasis may be summed up as—

1. Suggestion, from relatives, parents, advertisements or doctors.

2. Substitution or conversion of an anxiety affect. It is possible that this may have been a factor in Case 6, where the hypochondriasis seems to have followed an anxiety state.

3. Purposiveness, the extent of which is estimated by the degree of "show" or dramatization.

In any given case of hypochondriasis there is rarely only one of these factors, but often all three operating silmultaneously.

Hypochondriasis in Parergasic or Schizophrenic-like Reactions.

In these cases the attitude to the complaint is very different from that in the invalid reaction. It usually seems to be one of unconcern, sometimes intense concern, sometimes statement of fact without any apparent affect at all. No effort at dramatization seems to be made. The actual body complaints seem to fall into two groups: (1) Bizarre or peculiar complaints, examples of which from the cases of 1934 are: electricity in the genitals, body becoming smaller, poison gas in stomach, body being changed by masturbation, dripping in head, disintegrating with cancer, throat blocked up with something dead, devils in the body, black plague, syphilis, body half a woman, eyes of different sizes, deadness in the head, pain from poisoned food, not enough blood. (2) Vague complaints, examples of which are: tenseness in neck, pain in side, funny feeling in the head, tired feelings, nausea, pains in neck and stomach, etc.

The body complaints in the 12 cases of parergasic-like conditions in the present series were—foggy feeling in the head, pain in the eyes (16), gas in stomach, headache (17), eye and head pains and weakness (18), funny feeling in head, holes in hands, burning in stomach (20), dead feeling in genitals, legs shrinking (22), dead feeling in eyes and cheeks (23), syphilis from masturbation

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(24), face changed, beard weak, loss of manhood (26), headache, hollow teeth, pain in left side (27), left side of body become a woman, pain in back (28).

The bizarre complaints may occur because the schizophrenic can no longer recognize absurdity, but it seems probable that they are always symbolic of something else, though what it is not always possible to find out. This is in line with schizophrenic thinking characterized by forming remote connections, making unusual associations, its tendency for misinterpretations and reading meanings where none exist, and the elaborate undisciplined symbolization.

Case 28, a man, æt. 30, had the complaints: " I've a pain in my back, my stomach has changed its shape ; the fluid has gone from my testicles to my rectum ; I feel as if snakes were in my blood ; my left breast has swollen like a woman's ; the left side of my body is a woman, the right side a man, and my privates are a little boy." He also complained that his beard was becoming softer and that a litter of kittens was coming out of his left breast. It is impossible to understand the meaning of all this, but the idea of losing his sex and changing into a woman is vividly expressed in the body complaint. Kraft-Ebing describes four cases somewhat similar to this, in which the phantasy of sex reversal occurred in schizophrenia, with very peculiar bodily complaints. Some of his cases were able to live apparently ordinary lives in spite of the sex-reversal delusion. This man had also had a delusion of syphilis which he considered had been caused by masturbation, as were all his curious bodily complaints. An important fact in this case is that his first complaint or presenting symptom was a pain in the back. Doubtless this would have meant something peculiar to him, but unfortunately a cystoscopy was carried out which upset him and was followed by the elaboration of bodily complaints. After discharge from hospital he got into difficulties and returned with the complaint of being all to pieces. He complained of his skin peeling off, and the flesh falling off his legs. Here the bizarre complaint seems symbolic of colloquialism (all to pieces). Thus this man's body complaints are probably symbolical of castration ideas and masturbation guilt, but the actual details of the interpretation of all these complaints are not available, nor is it advisable in the patient's interest to try to analyse them deeply. It was interesting that this patient only had body complaints when he was in difficulty, and in the clinic where he was protected, though his mental condition did not improve, the body complaints resolved. It has been observed that body complaints are mainly present at the beginning of schizophrenia, and when the condition is established they disappear. Freud speaks of a " hypochondriacal phase " of paranoia which subsides before delusions of grandeur appear.

Cases 20–28 are examples of this type of hypochondriasis. A common type of symbolic hypochondriasis is the young man who presents himself at the genito-urinary or venereal disease department of a hospital with some

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furtive genital complaint, such as stoppage in the penis, or syphilis, as in Cases 24 and 25. Case 24, a shy seclusive boy of 20, had the complaint of syphilis which on questioning he attributed to masturbation. His attitude was one of intense furtive concern, and he was able to be partially though not fully reassured. He had some ideas of reference, but not a fully developed schizophrenic syndrome, though he led a completely schizophrenic habit of life. Spots on his face and a cheloid he considered to be due to syphilis. The body complaint is here very directly symbolic of the masturbation guilt feelings. Cases such as this may be regarded as cases of anxiety focusing on the genitals, but it is a highly malignant reaction. This patient is being treated by weekly interviews, and is able to show some improvement, but his condition is precarious. It is suggested that this type of case should be treated outside a hospital whenever possible, as the paranoid development may occur very rapidly in an institution.

Case 40 is an interesting example of the usually malignant syphilis-from-masturbation type of hypochondriasis which developed three times in his youth, at ages 19, 21 and 25, and eventually resolved, enabling him to work well for twelve years as a clerk without any symptoms. At 38, in a setting of slight financial difficulty, the same symptoms recurred, with a shallow depressive affect, and show no signs of resolving.

Concerning the ætiology of this type of hypochondriasis, the susceptible personality must be present, but undoubtedly quack literature on masturbation often serves to suggest and set it in operation. Extracts from a booklet published by a quack doctor which had been in the hands of one of these patients are as follows: "A host of results are due to the sinful sexual practice. Nature is bound to punish her violators for this sooner or later. Loss of vital fluid breaks down his strength. His nerve-power lessens and he acts as though he were in a trance. His vital forces wane and his ambition flags. He has pains in his back and his legs give out. Nervous and physical decline becomes manifest and the inroads of the habit on the human body bring about many conditions, such as impotence, lost manhood, wasting of organs and all manner of nervous affections and diseases." As much as possible is done in these booklets to suggest that syphilis is caused by masturbation without actually saying it, and their harmful effects on the adolescent are incalculable. It is possible that many of the sexual body complaints of the parergasic have originally a somatic origin in the body feelings which occur after sexual activity, which, with the patient's intense body concern, is magnified and interpreted in many peculiar ways. It is also probable that anxiety state somatic feelings may occur in the parergasics and provide the basis for misinterpretation.

The symbolic significance of eye complaints is particularly interesting. Jonathan Hutchinson, in 1879, was the first to point out the association of eye complaints with sexual difficulties. He described a condition of weakness

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of vision without any physical disorder, and found that it occurred frequently with impotence. He was able to help some of these patients by discussion of their sexual difficulties. Greenacre has summed up the whole topic of eye complaints from many angles, including that of folk-lore. She describes several cases where the eye complaint was associated with guilt, especially sex guilt. In the present series eye symptoms are present in Cases 16, 18, 19, 23, 26, 33, with the complaints of pain in eyes, eyes expanding, dead feeling in eyes, that the nerve in the eye had destroyed sexual desire, and weakness of the eyes. In 4 out of these it is associated with sex guilt, in Case 19 its significance is unknown, in Case 33 it is associated with guilt following a suicidal attempt in a depression, with some possible sexual factor.

The other body complaints in the schizophrenic condition are tired feeling in chest, foggy feelings, headaches, etc. Gladys Terry finds head complaints very common in schizophrenics, and considers them to be chiefly expressive of the patient's feeling of muddle-headedness. Diethelm suggests that the tension state is possibly the basis of the impure affects. This state is characterized by strained expression, restlessness, tremor, tachycardia, dilated pupils, feeling of tight band round head, etc.; he suggests that it readily proceeds to hypochondriasis. In cases of this series the attitude to the complaint was one of concern, and sometimes (Case 21) the body complaint was considered to be due to enemy influence. The outstanding feature, however, was that these complaints occurred when the patient was in some topical difficulty, when tension or anxiety might be expected, especially in paranoid patients, whose condition constantly provides difficulties.

Case 20, a man, æt. 32, doubting his suitability for promotion to foreman, shows well the occurrence of body complaints in a setting of tension. He got ideas that neighbours were talking about his masturbation. The affect was one of tension and fear. He complained of funny feeling in the head and pain in the left groin. He was able to be reassured after discussion of his difficulties, and after three weeks' rest with frequent interviews his symptoms died down. After a visit from his employer, however, he had a return of his body complaints, " shooting pains in head, as though someone was twisting it "—a typical paranoid phrasing—and his other paranoid symptoms reappeared. In the course of the interview, in which the employer situation was discussed, he was able to lose his body complaints. He had another relapse after seeing an accident, when he became paranoid again, but was able to be reassured during the interview. This man was able to be at work again within six weeks of a serious paranoid psychosis, and so far has remained well. It seemed almost as though there was a kind of conversion of the impure affect of suspicion and tension into the body complaint, similar to the conversion of anxiety into a body complaint in the merergasic hypochondriasis. The importance of these vague body complaints, especially in paranoid patients, is that they are danger-signals that something

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is wrong. The existing cause can usually be found in one interview, and is usually trivial and topical, but greatly disturbing to the patient. Reassurance on this very superficial level after the disturbing incident is discussed is often effectual.

The vague body complaints are also important in that they are usually present in paranoia, as in Case 17, who complained of gas in the stomach and tired feelings. In these cases they are very valuable, as they tend to be the only complaint, and the only condition for which the patient is asking help. They can form the basis of rapport and a helpful physician-patient relationship if they are emphasized rather than the actual delusional material.

Hypochondriasis in Depression.

Bodily complaints in depression are very common, occurring in more than half of all cases of depression. Examples of body complaints from the cases are: Numbness in legs, cancer, fullness in abdomen, rectum stopped up, eye and chest pain, eye and stomach pain, body rotting with syphilis, tight band round head, pain in neck, leg pains, nausea and gas in stomach, bladder pains, abdominal pain and syphilis, no backbone, abdomen full of concrete, eyes and body numb, pressure in stomach and palpitation, pain in heart and stomach, etc. In the present series the depressive hypochondriasis is represented by Cases 29–39.

The essential feature is, of course, the depressed affect. The body complaints may be classified as to whether they are consistent or not with the affect, or whether they have undergone any elaboration on the purposive or symbolic levels.

It is easy to see why a patient with depression develops body complaints consistent with his mood. A depressed patient does feel physically ill, his musculature may be lax and his blood-pressure low, he is constipated and does not sleep, and in fact feels almost as physically ill as though he had just had typhoid. It is then not surprising that any body sensation which may occur either on a physical, tension or anxiety basis should become the object of the patient's whole attention, and provide the hypochondriacal content essentially secondary to and consistent with the primary mood depression. If symbolization occurs, it seems to express the self-reproach (as by no backbone) or sense of disaster (as by cancer, bowels blocked up, etc.), rather than any elaborate sexual symbolization such as occurs often in parergasic reactions.

Case 31, a married woman, æt. 37, showed a constantly changing topic of worry in her depression, but always consistent with the affect. At one time the complaint was of the body being run down, and at another time of insufficient menses. As the depression disappeared, the complaints stopped.

Gillespie suggests that in true hypochondria there is no anxiety, but only interest. Lewis, however, includes all the anxious body preoccupations in

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depression as hypochondria. The present attitude is that just as merergasic hypochondriasis can occur both with and without anxiety, so depressive hypochondriasis can occur both with and without depression.

Case 34, a man, æt. 61, shows depressive hypochondriasis without depression. After a brief manic phase this man had a definite depression, in which he was agitated, suicidal, and developed the idea that he had a cancer of the stomach, and that spots on his back were cancer. This hypochondriasis was consistent with his depressed affect. However, after a year in the clinic his depressed affect resolved, but the cancer delusion remained, though he was able to behave normally and cheerfully. He is now able to lead fairly happily a small-town life, which does not seem to be at all inconsistent with a permanent delusion of cancer. One may here speak of a hypochondriacal rut in a depression, or of hypochondriasis left as a permanent residue of a depression. It seems almost as though a kind of conversion of the depressed affect into the hypochondriacal symptom had occurred.

Case 29, a man, æt. 55, shows some symbolic features in his elaboration of body complaints: "My arms are all flabby, my teeth are like cesspools, I have no strength at all. Impotence is extending over my brain. My blood is full of filth. I am infecting the whole world with syphilis." The depression here was very deep, and these bizarre complaints are in the main symbolic of intense self-reproach and of his impotence. This patient eventually settled to the quiet conviction that he was dead, with much less affect of depression. Case 30, with the complaint of "no backbone", very directly symbolizes in the complaint his own lack of stamina, for which he was reproaching himself. This "no backbone" complaint is a fairly common type of symbolization in depression. Eye complaints are also usually on a symbolic basis as in Case 33.

It seems that hypochondriasis alone does not necessarily give an unfavourable trend to a depression, although it is in Hoch and McCurdy's triad of symptoms of involutional melancholia. If it is consistent with mood, then it tends to disappear as the mood goes. If it is symbolic, or inconsistent with the mood, the course of the illness tends to be more prolonged. The hypochondriasis also tends to be prolonged in a merergasic hypochondriasis, or invalid reaction, complicating a depression (as in Cases 35 and 38).

Case 41, though not strictly a depression, but a panic-reaction, will be considered here, as the essential disorder seemed to be one of affect. He is a boy, æt. 18, in a setting of difficulty in adapting to school. His complaint was: "I've lost a lot of weight, I'm all flabby, my teeth are rotten and full of holes; my heart is weak and I've lost my pep. My eyes are weak; my left side is hollow. It's tuberculosis. I'm going down pretty fast." The affect here was depression and considerable fear and agitation. Bizarre as these complaints were, they did not seem to be symbolic, although definite paranoid features and ideas of reference were present, but they were consistent with the impure affect of fear, which seemed to dominate this case. It is interesting

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that the diffuse hypochondriasis in this case focused eventually on a painful ingrowing toe-nail. When the nail was removed the patient's complaints rapidly abated, and complete recovery occurred.

Later Course of Patients with Body Complaints.

The further course of the 41 patients after treatment (the time being in most cases nine months) is illustrated in the following table. These results in such a small and heterogeneous group are, of course, not subject to statistical analysis. "Recovered" here means symptomless; "much improved" means returned to normal activity, with some symptoms; "improved" means improved, with some curtailment of activity due to the symptoms.

	Recovered.	Much improved.	Improved.	No change.	Total.
Anxiety states (including one with obsessional symptoms)	2	1	1	..	4
Invalid reaction (including two hysterics)	..	3	3	5	11
Schizophrenic group	1	2	6	4	13
Affective group	3	1	4	5	13
Total	6	7	14	14	41

The high proportion showing no change in the depressive group is due to the number of cases of symbolic or severe hypochondriasis, which, as Hoch and McCurdy have emphasized, considerably lengthens the course of a depression.

The Body-Sensitive Personality.

Body-sensitivity and body-awareness is a personality trait which is very common among ordinary people. One type, that on which the invalid reaction is based, has already been discussed. Another kind, shown by intense pride in the body, awareness of body sensations, with a tendency to expect them to be grave diseases, fear of germs, concern over bowel movements, diet fads, patent medicine taking, is particularly common in the paranoid personality, though it may occur in any other. Some allusion in the previous personality to body-sensitivity was present in 7 out of the 12 parergasic conditions, and 11 out of the 13 affective ones. Undoubtedly a personality trait of this kind conduces to the development of hypochondriasis in a psychosis. Concerning the origin of these personality traits of body concern, it is not yet possible to form any definite conclusion. The paranoid type definitely seems to be partly hereditary, with whole families of body-sensitive, proud, rigid personalities. The two especially paranoid personalities—Cases 17 and 36—had parents and siblings of the same tendency. The influence of parents has

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already been emphasized. The race seems to be one factor; Jews appear to have an inborn body-sensitivity and concern, and this is stressed in their whole culture and religious rules. Suggestion, especially from quack medicine advertisements and films about disease, can have a considerable influence in developing these traits; Freud regards this attitude of body concern as one of narcissism, as withdrawal of the libido into the ego. It may be regarded as an attempt to compensate for feelings of insecurity, or else as a method of self-assertion (as in Case 36). It represents an evasion of life and its problems, a flight from the subjective or environmental difficulties into illness. This is in agreement with Noyes, who says that it has its origin in a sense of insecurity which is rationalized as a threat to physical health. Gillespie, speaking of " epidemic hypochondria ", makes the interesting suggestion that the decay of belief in personal immortality has influenced humanity to cling more closely to the present life and to develop an exaggerated attention to health. Probably this is one of the many sources of insecurity which tends to make the hypochondriac or body-sensitive personality such a common one to-day.

TREATMENT.

The general principles of the treatment employed have been very well stated recently by Diethelm. The method is that of distributive analysis, that is to say, the analysis is actively distributed by the physician along the lines which seem most pertinent, and some synthesis or constructive formulation is made at the end of every interview. The patient's complaint is made the basis of the relation between the physician and patient. No special search is made for one factor, such as a sexual trauma in early childhood, which can be made the scapegoat of all later developments, though any such factor is not ignored, but considered in proportion with all other factors which can promote maladjustment in the patient. Definite advice is seldom given, but the alternatives put before the patient and explained, and he is allowed to make his choice. The attitude that it is not the physician curing the patient but the patient learning to help himself is encouraged throughout, and intense dependence on the physician is not sought. In every case a complete history and psychiatric examination and, in suitable cases, a Binet-Simon test is done as a preliminary to more detailed therapeutic efforts, so that one can know as much as possible of the patient and his assets and abilities. Free association is sometimes used, as in Case 23, and hypnosis, as in Cases 12 and 13. If the patient is admitted to hospital, he enters a regular routine of occupational therapy, gymnasium, dancing classes, etc., which occupy the whole day, and he has to adjust to his own group of about 13 other patients. Any topical difficulties are freely discussed and analysed. This provides an environment where the hypochondriasis will not work, and this re-education and discipline alone is frequently able to stop a hypochondriasis in a young patient, as in

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Case 5, who had been living in an environment where her complaints did work, and had been allowed to render her a complete invalid. As the object of the treatment is to enable the patient to live and work in whatever environment is available for him, treatment consists not only in attempting to modify the patient, but sometimes also in an environmental alteration when the patient has entered an altogether unsuitable situation. This is chiefly effectual with young patients, and in the present series was done in Cases 3 and 20, where a change of work was arranged, and Case 41, where the school was changed.

The classification of body complaints suggested in this paper is not intended to be purely academic, but rather to apply in treatment. Various points in the special treatment of types of hypochondriasis are as follows:

In the anxiety cases special attention was paid to analysing the circumstances surrounding the first attack, as indeed this often gives an important clue to the whole reaction, as in Case 1. The whole sexual history is investigated, and in Case 3 the analysis of the sexual ruminations gave a clue to many of the patient's obsessional symptoms.

In the merergasic hypochondriasis or invalid reactions there is sometimes no desire to get better, as in Case 9, and unless this can be produced it is a waste of time to attempt any treatment whatever, and these cases are, consequently, dismissed. On the other hand, this reaction is not as untreatable as many writers have regarded it; for instance, Ross describes it as "a fixed idea of ill-health which is irremovable". If the patient will come to a psychiatric clinic, often an immense change can be brought about by re-education and discipline. If it is caught early, as in Case 5, it can almost always be cut short by putting the patient where the reaction will not work. The purposive factor frequently present in these patients is a very profitable one to analyse. Care is taken not to state the purposive factor to the patient at all directly, but to lead the patient to formulate it to himself by realizing the unpleasant things and situations he is avoiding by his illness. The responsibility is put on the patient by telling him to control his symptoms, as this will not only give him greater confidence of success, but, as Diethelm emphasizes, it often promotes tensity and readiness to talk of the underlying difficulties. Complete insight is, indeed, seldom obtained on account of the rigid make-up of this type of patient, but yet life can be made more tolerable for them, and an unnecessary and expensive series of operations can be avoided.

In treating the schizophrenic group the first step is to attempt to gain the confidence of the patient. It is here, as already emphasized, that the body complaints can be especially utilized in the building-up of rapport, as they are often the only thing for which the patient is asking help. This is particularly important in treating a case of paranoia. The tension type of body complaint, i.e., the headache, funny feelings, tired feelings, abdominal pains, etc., was always analysed as it occurred, and as mentioned, it almost always proves to be a substitute for some topical difficulty, which can often be settled by

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open discussion and reassurance by the physician in one interview. The treatment of this type of patient is fully described in Case 20. The symbolic type of body complaint, i.e., the bizarre complaints of change of sex, shrinking of various parts of the body, snakes in the blood, etc., as in Case 28, on the other hand, was not analysed, as they lead to material which is too disturbing for the patient, the stirring up of which will usually make him worse. If the basis of them was some sexual difficulty or masturbation conflict, the patient was quickly and firmly reassured about it and the subject then left. An attempt to gain complete insight was not made, as even when insight was present, as in Case 24, it was by no means helpful.

In the depressions the presence of a body complaint does not much modify the usual treatment (namely, of regular ward routine, occupational therapy, treatment of sleeplessness and constipation, prevention of suicide, and provision of the reassurance which these patients so much seek). It was formulated to them that their body complaint was an expression of their low spirits, and that as the mood depression lifted, the body discomforts would also leave them. Constant reassurance sometimes seems able to prevent formation of a hypochondriacal rut. In these cases also a fresh body complaint sometimes represents a topical difficulty, which can be settled in one interview. Body complaints in a depression may be on a basis of some intercurrent sexual difficulty, as in Case 38, which can be treated, if the patient is well enough, by freely discussing the sexual factor with both parties and trying to solve the sexual maladjustment. It is notable that bed rest forms no part of the treatment of these patients with a psychogenic body complaint.

One can best sum up this section on treatment in the words of Sir William Gull: "No good can be effected by laughing at his tale of suffering; it is necessary for the physician to be interested and to believe in the reality of the patient's painful sensations. If the patient thinks that the doctor is taking pains to get at the secret of his troubles, he will be inclined to accept the first word of encouragement the latter throws out, and the reflected influence of reviving hope will be certain to assist recovery."

Summary.

The psychogenic bodily complaint or hypochondriasis has been considered in the various types of psychoneurotic and psychotic patients in which it occurs. The history of hypochondriasis has been briefly reviewed to show the evolution of the concept of a psychogenic, rather than physical body complaint, a concept which occurred first in the non-medical writers on the subject. Hypochondriasis is regarded as a reaction of the individual to a life difficulty rather than as a disease. The incidence of body complaints in the 226 admissions in 1934 to the Phipps Clinic was 45%. The nature and ætiology of the body complaints is discussed in 41 cases showing hypochondriasis in

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anxiety and obsessional states, hysteria, invalid, schizophrenic and depressive reactions. These body complaints were classified mainly on a basis of affect and attitude to illness into the following groups:

1. Psychoneurotic or merergasic hypochondriasis:

(*a*) Body complaints which are the physiological accompaniments of the anxiety affect in the anxiety states.

(*b*) Body complaints as a substitute for anxiety without the anxiety affect. This type of hypochondriasis is regarded as one of the types of "conversion".

(*c*) Body complaints in which purposiveness, recognized by dramatization, is a factor. This group comprises the typical invalid reaction chiefly seen in women.

These groups frequently occur in mixed forms. In addition, in the production of any form of psychoneurotic hypochondriasis there is often the element of suggestion.

2. Schizophrenic or parergasic types of hypochondriasis:

(*a*) Bizarre bodily complaints, often considered delusions, which are here considered to be on a symbolic basis, representing the various, often sexual difficulties of the patient in the form of more or less indirect symbols.

(*b*) Vague bodily complaints, such as headaches and abdominal discomforts, which are here considered to be expressive of the affect of tensity, suspicion and anxiety.

The treatment of these cases of vague complaints on a basis of topical reassurance by finding out the usually trivial cause is emphasized.

3. Depressive hypochondriasis:

(*a*) Bodily complaints consistent with the affect of depression.

(*b*) Bodily complaints inconsistent with the affect, forming a kind of substitute or conversion of the previous depressed affect.

(*c*) Distorted bodily complaints on a symbolic basis, usually referring to death or guilt.

A case of diffuse bodily complaints consistent with the affect of fear was described. It is suggested that the course of a depression is prolonged by the hypochondriasis in groups (*b*) and (*c*), but not in (*a*).

The application of this classification of hypochondriasis to treatment has been discussed, and the futility of purely physical treatment emphasized.

It is felt that a great difficulty of this problem lies in defining the meaning of the emotional states, such as depression, anxiety, fear and tension, and in deciding what are the physical accompaniments. It is probable that the body complaints in all these conditions are related, and some kind of classification is necessary in order to help to understand and treat the psychogenic body complaint, which seems to have as many ramifications and complexities as the physical body complaints, which are the province of organic medicine.

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Illustrative Cases.

Case 1: *Hypochondriasis with anxiety state.*

L. A—, male, æt. 32, is a married steel-worker seen in the out-patient department on January 20, 1936, complaining of attacks of palpitation, breathlessness and fear, usually associated with meals. He said that the first attack was in March, 1934, after breakfast, in a setting of no particular significance. These attacks, characterized by fear, sweating, trembling, palpitations, dyspnœa, lasted from ten minutes to four hours, and occurred usually after meals. At the same time he became diffusely hypochondriacal about his whole body, and had difficulty in going to sleep. He attended innumerable doctors, who gave him treatment varying from cacodylate injections and strychnine to luminal and overdoses of bromides (causing bromide eruptions) without any relief, but at

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considerable expense to him. He dieted himself, originally on a doctor's suggestion, and gradually cut down his diet to milk, eggs, one orange and bread, and lost 30 lb. in weight. Following his wife's difficult labour in April, 1935, his symptoms became worse. However, he remained at work during two years of these symptoms. In November, 1935, he had a complete gastro-intestinal investigation, with barium meals and X-ray examination which were all negative. Finally he was referred to the psychiatric clinic.

His parents were English, but little was known of them. His father died when he was 5, and at 7 he was handed over to his maternal grandparents, who brought him over to America. He had one healthy sister. As a child he was spoiled by and somewhat domineered over by his grandmother, who was of a peculiar and hypochondriacal personality, who often kept him terrified by a threat of a tonsil operation. He developed under her suggestion an intense fear of operations, and at 12 he was brought to hospital for tonsillectomy, but ran away. He was at school from 7–14, and did well, reaching seventh grade, but he was somewhat bullied, and his grandmother tried to keep him away from other boys. From 14–16 he did housework for his grandmother, and then took up steel work, at which he has remained fairly steadily, earning from $90–150 a month. His work was mainly clerical, and he is said to be efficient at it. His personality is mild, easily worried, conscientious, hard-working, and with few interests apart from work. In 1930 he married, and the marriage appears to have been successful, apart from the present complaints, which greatly worry his wife, who is very sympathetic about it. There is one child, aged 8 months, and since its birth his wife has withheld sexual intercourse, as she feared another pregnancy, and his sexual desire has also ceased for the same time.

On examination he was a pleasant, mild-mannered little man, extremely wasted, and almost on the verge of self-imposed starvation. His intelligence was fair, with mental age of 15 on the Binet scale. His present complaint was of attacks of palpitation and being unable to eat a reasonable diet. He said that he did not consider it was due to any physical disease, but yet was quite unable to be reassured by his negative physical examination. He produced a diary which told of his life during the past year; the following are extracts:

"Wonder why I have been so bloated and full all evening since eating dinner (2 pieces of bread and butter, 1 cup of cocoa). What food I take seems to stay in my stomach. I know I shall never be my normal self. I should call the past one and a half years "in hell".

"Saturday: Cut lawn. So easily tired must rest every 10 minutes. As usual also bothered with indigestion. Get panicky if I try any foods I should be eating. Started to break out on stomach and back (probably bromide eruption). Had stomach-ache.

"Sunday: Panicky at breakfast. A fear is always with me. I must have very little blood, the way the cold affects me. My hands are numb for an hour or more.

"Tuesday: Getting thoroughly disgusted. Severe pain in left shoulder. Saw doctor. Had shoulder and side bound with adhesive tape, but no relief.

"Thursday: Doctor removed plaster; my back covered with large red pimples.

"Tuesday: Diet has come down to bread and milk except for an orange and an egg at breakfast. More nervous each day.

"Friday: Severe gas pains in stomach. Ate nothing: drank a quart of cocoa.

"Sunday: In addition to being upset, have had what felt like bristles in my throat. It seems I shall never be relieved.

"Wednesday: Terrible pains in lower stomach. Had injection from doctor, also nose treated, but did not do anything about stomach.

"Thursday: Quit drinking cocoa. Believe it may upset me. Refuse to eat any of following: Coffee, tea, cocoa, pepper, sauces, beer, meat, fish, vegetables, nuts, fruits, berries, pastries, desserts, etc. (leaving nothing but bread and milk off the list)."

This diary expresses vividly the miserable life of a patient with this type of anxious hypochondriasis.

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As the history seemed incomplete, he was urged to give more information, and finally, with much hesitation, he said that the first attack of all had occurred at a lecture at which he had seen a film of an operation on cancer of the stomach. In this he thought he was going to faint, and had palpitations, sweating and fear. Since then he has always been careful not to see any other film. In 1926 his grandmother died of cancer of the stomach. " I well remember how my grandmother would have these spells; she would be a pitiful sight. Maybe I have inherited the condition " he said. He had, in fact, an underlying cancer phobia, which he now acknowledged to himself for the first time. After a frank discussion of the cancer fear, which he realized was unfounded, he was much reassured. He was told to follow instructions exactly if he wished to be cured. These were: (1) To stop all medicine; (2) to reassure himself that these attacks could not possibly hurt him, but were the result of his scare of cancer, which he now realized was unfounded, and that they would soon cease; (3) to return at once to a normal diet.

This man appears to have put himself on an anti-cancer diet to the stage of starvation. This hypochondriasis is a substitution for the repressed fear of cancer, about which he was excessively anxious, but the anxiety could not be completely substituted, and returned in attacks at meal-times, which were associated in his mind with cancer and diets for gastric disease. Later discussions with this patient included birth-control advice to himself and his wife, as there was some sexual maladjustment which might have been an additional factor.

CASE 2: *Hypochondriasis with anxiety attacks and extra-systoles.*

G. B—, male, æt. 21, is a German college student, who was admitted to the clinic on March 8, 1935, with the complaint that he was afraid his heart would stop beating.

He first noticed palpitations after being told one and a half years previously of his stepfather's illness, which might have meant that he was responsible for his mother's keep. In September, 1934, he lost a drug-store job which enabled him to work his way through college, and he was forced to live at home. He spent much time by himself, brooded on his frustrated college ambitions, and became very conscious of thumping and irregular action of his heart. He began to lose weight, and went to a library to look up the literature on irregularity of the heart, which much frightened him. In January, 1935, while sitting alone brooding on his ruined career, especially of his hopes of becoming a radio pianist, he reached out to turn on the radio. He suddenly felt faint, his face burned, his heart thumped rapidly, he sweated freely, and was afraid he was going to die. He lay on his bed panting for breath, and called for his mother, who tried to comfort him. The attack lasted about half an hour. After this attacks occurred several times a day and he was afraid of being alone. He would talk about nothing but his heart stopping. After two months of this he was admitted to the Phipps Clinic.

There is no psychopathic family history. He is the only child of his sentimental and over-solicitous mother, who married his uncle on the death of his father, when he was 10. He came to America at the age of 10, and did well at school and business college. He was always interested in his body. At 14 he would watch his bowel movements very carefully, and took daily exercises to keep himself fit. At 16 for several m nths he complained of funny taste in his mouth and thought there was something wrong with his stomach. As a result of reading advertisements he used often to worry whether his breath or his body had an unpleasant smell. He was mainly interested in books, reading philosophy and psychology, but he also organized a jazz band. His ambition was to organize radio programmes. His personality is conscientious and ambitious, with a tendency to worry. He had practised masturbation without conflict since 13, but had had no particular interest in girls.

On admission his complaints were: " It's these loud heart thumps. I'm afraid my heart's going to stop. I feel a thump and a gurgle. I feel my blood buzzing

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through my legs, and puckering and jumpy feelings over my body. Food gives me a pain and forms gas. At night food sticks in my right side. I've a kind of tired feeling; my legs go to sleep. I've white spots in front of my eyes."

He was intensely agitated and worried by these complaints, but there was definite dramatization of them. In addition there was fear of being alone, of insanity, and occasional feeling of unreality. Verbal insight was good, he said. "It arises from too much concentration on my body," but this did not help him. No other abnormality was found in the mental status. The Binet-Simon intelligence test gave a mental age of 17 years 9 months. Physically he is a tall, well-nourished, stooping boy. There was marked dermatographia with prolonged flushing. Blood-pressure was 100/80. Glucose tolerance test five days after admission showed fasting level of ·85 with a rise to ·140 half an hour after 150 grm. glucose, and a level of ·109 at end of one hour, and a return to fasting level after two hours. Extra-systoles occurred about every minute, and about five times a minute during discussion of any sensitive topic. Electrocardiograph on March 29, 1935, showed these to be left ventricular extra-systoles. The normal rate was 68. There was slight left ventricular preponderance, and when sitting one extra-systole occurred a minute. Immediately after the exercise of stepping twenty times on to a chair the pulse-rate was 130, and a ventricular extra-systole after every two beats followed by a compensatory pause of about ·25 sec. Injection of 5 mm. of adrenaline or deep breathing had no effect on the extra-systoles. There was marked sinus arrhythmia.

The patient did not have any anxiety attacks in the clinic, but on one occasion said he was going to collapse and felt faint. There was no alteration in his pulse-rate. He was told that he had no physical illness, that he must ignore his feelings and behave normally, and that his uncomfortable feelings would go. His ambitions and difficulties were discussed and their connection with the symptoms suggested. He improved considerably in the clinic and was discharged after two months, with definite plans that he would find work. On discharge he continued to improve and obtained work in a store three months later. Though the tendency to anticipate trouble remained, he ceased to worry about his body. Another electrocardiograph was taken in October, 1935. No extra-systoles were present normally, nor after the exercise, when the pulse rose to 120. After injection of 5 mm. of adrenalin, however, he had four ventricular extra-systoles a minute, and complained again of faintness and thumping. In view of his extra-systoles it is notable that he is a non-smoker.

This boy appears to have had definite anxiety attacks on a psychogenic basis accompanied by reaction of the vegetative nervous system in the form of flushing, extra-systoles and dyspnœa. He had always been body-sensitive, and the discomfort from the extra-systoles and vegetative nervous responses he interpreted as being due to grave heart disease. In addition there was a purposive element, as his body complaint enabled him to gain his mother's sympathy, and to excuse his failure honourably. This hypochondriasis is thus a mixture of the purposive and substitutive types with anxiety.

CASE 3: *Choking sensations in obsessive state.*

Miss M. D—, æt. 18, is a farmer's daughter, admitted to the clinic on October 16, 1935, complaining of choking sensations for which she had been sent to a general hospital to have her thyroid removed. On examination she said she had these choking feelings whenever she was worried, and in addition she had a series of obsessive and compulsive symptoms: (1) An obsessive thought of suicide; (2) an obsessive thought that her house would burn down; (3) fear of swallowing pins and pills; (4) a fear of being alone lest she should swallow something harmful; (5) a compulsion to pick specks off her food; (6) fear that something might be on her lips; (7) a compulsion to reread the last line of every page.

The first obsessive symptom, occurring at the age of 13, consisted of an obsessive

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thought that she had not turned off the lights at school. This was in a setting of first going to high school, three months after her father's death, which much upset her. She continued at school, doing well, working very conscientiously and taking the competitive school work very seriously, and was always much worried if she did not head her class. She was of a worrying, over-conscientious, over-cautious personality, and was much fussed over by her mother. In October, 1933, at the age of 16, a girl attempted suicide by taking poison in her neighbourhood, and the patient began to worry lest she should attempt suicide in the same way, by swallowing something. This lasted a few months and then died down. With some weeping the patient said that this girl had an immoral reputation and attempted suicide because she was pregnant. She occasionally told her mother she felt bad, but remained at school during 1934 with an occasional fear of the house burning down. In November, 1934, she began to have choking feelings, and her menses, previously regular, occurred every three weeks. She was told by her doctor she had thyroid trouble, and was given Lugol's iodine. These symptoms did not interfere with her school work. In May, 1935, she was taken out and kissed by one of her boy friends. She felt very guilty about this, and with some difficulty she described her ruminations after this event. They were, first the sexual rumination; " Supposing he had done enough to make me have a baby ". This she considered very wicked—a disturbing thought (she is a strict Roman Catholic). Then the obsessive thought, "I may be pregnant", though she knew she was not, and then " I may commit suicide like that other girl ", and then " I may swallow something ". This occurred in about a week and the obsessive thoughts completely excluded the original sexual rumination; in her words, " It's no sin if you get no pleasure from it ". During the summer, 1935, she developed her other obsessive symptoms, but these did not greatly interfere with her ordinary life until in September she went to a training college for teachers, leaving home for the first time, and taking up work which was really beyond her intellectual ability. She could not sleep owing to her obsessive thoughts of suicide, she could not eat for fear of swallowing poison, and she had constant choking sensations. She went home after a week and was able to do nothing but sit and brood. Her doctor then arranged for her to have a thyroidectomy, but after a week in a surgical ward she was recognized as a psychiatric problem and referred to the Phipps Clinic.

The family history is negative, except that her mother, an ex-school teacher, is very excitable and excessively anxious about and ambitious for her daughter. She is the eldest of a family of seven. On physical examination there was no evidence of hyperthyroidism, no fine tremor, a pulse of 70, basal metabolism of — 2, and slight adolescent enlargement of the thyroid.

There was no real evidence of depression; in the ward her spirits were good. The Binet-Simon test gave a mental age of 16 years, but the Rorschach test indicated a fairly low intelligence from low F plus, M and original answers. This corresponds with the impression of very poor initiative, originality and somewhat pedantic intelligence given by the patient. She was a simple country girl, and obviously unsuited to become a teacher. In three weeks on the ward this history had been elicited, and she eventually was able to accept the formulation that symptoms of choking and fear of swallowing were substitution devices she used, to avoid thinking about what real situations were worrying her, such as sexual desires, and difficulty of becoming a school teacher. She was reassured by a frank discussion of sexual problems. She rapidly lost all her symptoms, worked well in the ward, and was able to be discharged after two months, with a plan of taking up a business course, and has had no recurrence of her trouble. This body complaint of choking, which nearly caused her to risk a serious operation, was probably based on anxiety. The anxiety was not completely substituted by the obsessive thinking, but in addition the choking seemed to have been partly associated with her fear of swallowing, and may be regarded as part of the substitution which occurs in obsessives. It is somewhat uncommon for a body complaint to occur with obsessional thinking, as the obsessions usually occupy the whole of the patient's attention.

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CASE 4: *Hypochondriacal anxiety state with fear of syphilis.*

E. D—, male, æt. 30, for the last eight years has led a life of inactivity at home, and for the last year has not left his house owing to complaints in every part of his body. As a child he was very dependent on his mother. His personality was reserved, quiet and obedient. He had no girl friends or outside interests. He had been a tin mill worker. Eight years ago he attempted intercourse with a prostitute, but was terrified of syphilis and was impotent. Two days later a friend at work blew some cold air jet on his back and he developed a pain in his hip which he thought was syphilis. He had his appendix out without relief, and since then had a variety of pains. He was afraid his legs would go numb and that he might fall, and made a vapour bath for himself to sweat out the poison in his system. He was living on the earnings of his 70-year-old father.

On examination he was a healthy, athletic man. His complaints were: "My shoulders and back get drawn up, knotted and helpless. My left foot is numb and sore. My calf gets drawn up and it seems there's no circulation. When I stand up there's a dull feverish pain in my knees. The trouble is on my left side from the top of my head to the sole of my feet." (The jet of air had been on the left side.) These complaints were given self-pityingly, and he appeared to want to keep his invalidism. He was of low intelligence, mental age 10 years on the Binet scale, and this was undoubtedly a factor in prolonging the hypochondriasis. He was emphatically reassured about the syphilis fear, and the origin of his worries explained to him as simply as possible, and to his relatives, and he was told to go to work at once. He was able to be somewhat encouraged, but as he lived in another State, unfortunately only one interview was possible. This is a hypochondriasis which symbolizes for this simple and suggestible man his intense fear of syphilis, but in addition there is a purposive element—to get off somewhat dangerous work honourably.

Nine months after being first seen in the clinic he was much improved and doing light work, but obviously very hypochondriacal.

CASE 5: *Hypochondriasis in a spoiled child.*

A. J—, æt. 13, a farmer's daughter, was admitted on December 18, complaining of belching, stomach pains and weakness. During eight years of her life she was the youngest child and was much spoiled and pampered by her self-sacrificing and solicitous mother, who always regarded her as somewhat of an invalid after feeding difficulties as an infant. There is no abnormality in the family history. She walked at 16 months and talked at 18 months. At school she did well, and was with girls a year older than herself, but on account of distance from school she had to get up at 6 a.m., seldom went to bed before 10 p.m., and had sometimes expressed a desire to stay in bed instead of going to school. Her personality is described as quiet, home-loving, conscientious and hard working, but obstinate, and she had few friends. She was always constipated, and her mother gave her magnesia several times a week. Menses started February, 1935, and continued every three weeks since. She was at first worried about it, and her mother gave her a book which said that a girl must expect to feel ill at periods. There was no definite sex knowledge, and she is a Roman Catholic. In July, 1935, she was somewhat upset by a petting party at which a man made advances to her elder sister.

The present illness definitely began on September 2, 1935, a week before start of school, when she complained of lower abdominal pain and frequency of micturition. She was put to bed and a doctor diagnosed streptococcal infection of the kidneys. She remained in bed for two months, during which her temperature was normal. She constantly complained of pains to her mother, who waited on her, and she became the centre of attention in the household. After two weeks in bed she started deep sighing and belching, and said she was quite unable to walk. The diagnosis was changed to nervous chorea. During November, 1935, she was at a general hospital, where complete examination was done, including X-ray of chest (normal), gastro-intestinal X-rays, showing ptosis of stomach, lumbar puncture

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(normal), blood-count Hb. 75% and 4,000,000 R.B.C., negative W.R., renal function tests (normal). On one occasion a trace of albumen was found in the urine. During this time she continued in bed, constantly complaining of abdominal pain, and refusing to get up. After three weeks at home, still a helpless invalid, she was transferred to this clinic.

On admission she clung dramatically to the walls as she tottered to the ward. When approached, she breathed deeply, swallowed air and belched noisily. Her expression and whole attitude was pained and self-pitying. Physically she is very tall (5 ft. 8 in.) and much under weight (100 lb.), and has the hair and breast development of early puberty. Blood-count showed 4,800,000 R.B.C., and Hb. of 16 mgrm., physical examination being essentially negative, though there was diffuse tenderness in the abdomen, but no localization or rigidity.

Complaints were: "My stomach hurts all the time; it's awful tight. I have sharp pains in my stomach; it keeps taking my breath. I belch all the time." When specially asked she had complaints for every part of her body. When asked about her chest, "I have pains there"; her legs, "pains in my knees sometimes"; appetite, "I don't feel like eating"; her head, "just dizzy", and again "sometimes it's hard to swallow"; the eyes, "when I look to the side, they hurt". No content beyond the complaints was found, but she said she was afraid she would not get better. The Binet showed a mental age of 10½, but she probably did not do justice to herself. She was told to stop belching and walk properly, and she did so, and in the ward at once began to change her habit of invalidism, and was able to laugh and talk with other patients, but to physicians she still complained of her body. She was urged to pay attention to what she did rather than to her bodily sensations, and at once entered a regular routine of games, occupational therapy, gymnastics, dancing, and is continuing to improve, though insight and understanding of her condition is not yet obtained.

A desire for sympathy, to avoid school and become the centre of attention are probably the main factors in her invalidism. Possibly at first she had a genuine cystitis. During the treatment for this she appreciated the advantages of the invalid condition, and in addition the formidable medical diagnosis may have suggested to her that she was exceedingly ill. This hypochondriasis, with self-pity, diffuse complaints and dramatization, but with some anxiety, is of the substitutive merergasic or purposive type, without any suggestion of remote symbolization.

CASE 6: *Chronic invalid reaction.*

Mrs. L. M—, æt. 33, a housewife, was admitted on September 23 with a ten year history of bodily complaints, which during the last two years have kept her in bed and caused her to take daily sedatives. Her complaints of backache, headache, stomach-ache, insomnia, amenorrhœa, female trouble, pulling and drawing in her womb, restlessness, choking feeling and hot flushes have led her without help through a great variety of medical and surgical treatment, including two operations.

At 22, two years after marriage, in a setting of loneliness, living in a remote country house while her husband worked at night, and marital difficulties, with frigidity, painful and frequent sexual intercourse and fear of pregnancy, she began complaining of gas and gnawing feeling in the stomach and choking feelings. At the same time her periods became irregular, about every two or three months, and scanty. Tonsillectomy was performed without improvement, and she continued under medical and chiropractic care until in February, 1929, appendicectomy and removal of left ovary and tube were performed without relief. Her glasses were changed because her eyes hurt. Unsuccessful medical treatment continued until in 1930 she went to a doctor, who treated her with hormone pills and a medicine, which she says cured her for four months, and her periods became regular again, but she relapsed again to her previous condition in spite of this. In 1933 she had influenza, and after this felt somewhat worse. Her husband sent her to a doctor to treat her for frigidity. This doctor stuffed her vagina with cotton and massaged the clitoris, during which orgasm may have occurred, and in addition he gave her

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hormone injections. She claims that he also attempted to assault her. Since then she has spent most of her time in bed, and said she always felt about to menstruate and that nothing would help but removal of all her female organs. She took large doses of sedatives, including daily injections of sodium amytal and paraldehyde until her admission to the clinic.

Both her parents died when she was 4, and she was sent to the farm of her grandfather who, she claims, assaulted her sexually when she was about 12. At about the same time she had intercourse with an older boy. At 13 she was transferred to the strict religious home of an aunt, where she stayed until marriage. At 15 she was worried by seeing her sister in childbirth. At school she did badly and had difficulty with her lessons. She was often absent with complaints of stomach-ache. At 18, in a setting of worry over whether she would graduate from high school, and whether she should get married, she was at home three months, complaining of stomach-ache after an attack of influenza. She was allowed to graduate from a country high school, and at 20 married a post-office official against her guardian's wishes, in order to leave home and obtain more freedom. This marriage did not turn out as she had expected, for her husband was somewhat stricter than her aunt had been. Previously a cheerful, laughing, sunny girl, fond of company, a good housekeeper, and interested in cooking and gardening, after marriage her social activities and outside interests were almost abolished. There have been no children. Menses started at 11 and were regular until onset of the illness.

Her father died of tuberculosis at 35. Two brothers drink heavily, and one sister became very nervous after an accident.

On admission to hospital her breath smelled of paraldehyde. She was a dishevelled, restless, agitated woman, showing marked self-pity and dramatization, the behaviour being more agitated when she knows she is observed. She showed some depression and marked anxiety, but at times smiled happily.

Her complaints were: "I have a headache most of the time; my eyes just ache. I have drawing feelings in my stomach. My back hurts. Everything I eat rolls over and over. My abdomen swells up. I can't bear to be on my feet. I can't get any rest at night." Her essential complaint was: "My female organs are not functioning at all. When I don't menstruate, my blood all rushes to my head." She also complains of "hot flushes like the change of life", and even says, "My female organs are all gone". All this is told with considerable anxiety, agitation and dramatization.

The Binet-Simon shows a mental age of 10 years.

Physical examination shows a well-built, asthenic woman. The breasts are poorly developed, the tendon reflexes overactive. Gynæcological examination showed a normal right tube and ovary, with the uterus in good position and nothing to account for the symptoms.

Treatment consisted in—

(1) Withdrawal of sedatives, which was done after ten days. This was followed by vociferous clamouring for sedatives, which eventually abated.

(2) The nurses were told not to let her complaints disturb them or the ward.

(3) Continuous baths three hours daily for her agitation.

(4) In the interviews she was led away from giving repetitions of her complaints to considering—

(*a*) Her general life situation, her home life, and her relation to her husband.

(*b*) Her assets and interests, which are quite adequate for her needs.

During a three-months' stay in the hospital she improved considerably, gained weight, and was active with the other patients, but the complaints persisted. No menses occurred. On discharge advice was given—

(1) About birth control (to husband).

(2) Need for developing outside interests.

(3) Need to control her complaints and tell no one of them.

(4) The importance of behaving well in spite of her feelings.

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Since discharge she has apparently become much more active, though she still complains to her doctor.

The essential features seem to be :

1. Constitutional, with an early habit of bodily complaint developed as a schoolgirl.
2. Low intelligence.
3. Marital difficulties and early sexual traumata.
4. Menstrual irregularity.

This case shows a very diffuse hypochondriasis of a somewhat bizarre type, and mainly sexual, but in view of her low intelligence this is not as grave as a sexual hypochondriasis in an intelligent person. Moreover this hypochondriasis seems to be a mixture of symbolic, in which the complaint symbolized her fear of pregnancy and dislike of intercourse with her husband, and purposive, in that it enables her to gain the upper hand over her husband, and to avoid attempts at sexual intercourse.

CASE 7 : *Paranoid delirium in pellagra with long-standing hypochondriasis.*

Mrs. J—, æt. 40, a married woman, the youngest child and only girl in her family, was much spoiled and pampered as a child and used to have vomiting spells, which much worried her adoring mother. She never went to school with other children. She developed a lifelong habit of bodily complaints as a means of attracting attention or avoiding difficulty. She would stay in bed several days with each menstrual period. She was sensitive to criticism, but desirous of attracting admiration, for being different, and never had many real friends. After various romantic experiences she married at the age of 30 a good-natured, heavy-drinking gentleman farmer of whom she became very jealous after several months, and to whom she became frigid. She complained even more of her body, and attended many doctors for various aches and pains. In 1927 she had appendicitis, and had a slight injury to a cervical vertebra in an accident.

These increased her invalidism. In 1930 she suffered from an overdose of allonal. In 1932 in a setting of jealousy against her husband she lost the use of her legs and voice for a few months, probably hysteria. By her invalidism she was able to keep the attention of her husband, who was always sympathetic to a body complaint.

A feeble attempt at suicide with a spite motive against her husband occurred in 1933. In August, 1934, a tooth was removed, and although it healed well she made daily visits to the dentist for a month. She had a dye injection and X-ray of her gall-bladder for abdominal pain, a hæmorroidectomy in December, 1934. Her present illness seems to date from an attack of acute cholecystitis, for which she had her gall-bladder removed on February 7, 1935. Although she says she had an adequate diet, it is possible that she starved herself to some extent after this operation. The bile drainage does not appear to have been considerable, but it lasted on and off from February to May. A rash of brown scales was first noticed on March 21 only a month after the operation. On May 25 she developed an acute delirium, for which she was admitted to the Phipps Clinic.

This delirium showed paranoid features, e.g., that certain doctors were destroying her brain, that others in the ward accused her of sex perversion, feelings of passivity, that her mind was being read, that she was controlled by a machine. She had delusions that she had a million pounds. Orientation was at no time disturbed. The delusional system never became fixed ; it varied from day to day, and was mostly topical and confused.

Physically she was a flabby, asthenic woman. The fauces were injected, there was a slight brown dermatitis of the arms increased reflexes, and œdema of the ankles. On admission the blood-count showed 5,400,000 R.B.C., a sedimentation rate of 36, and 16·9% of Hb. After three weeks she was transferred to the convalescent ward, where she was more exposed to the sun, and a typical pellagra rash appeared and was diagnosed. On July 17 diet treatment was started, but without improvement ; on July 27 daily intramuscular liver injections (10 c.c. extract) were started.

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An immediate reticulocyte response (3%) occurred, and mental improvement began about two weeks later. During the first month in hospital the hæmoglobin percentage fell, the red blood-count fell to 4,000,000, and there was an icterus index of 25, and a direct delayed Van den Bergh reaction, suggesting that some hæmolytic process was occurring.

By September her delirium was definitely over, but thinking difficulty, difficulty in making decisions and mental fatigue remained. At no time was a hypochondriacal complaint absent. Examples of these are: "This very decided nerve in my leg is dreadful. I have a pain in my right shoulder. I am very tired. Supposing my gall-bladder was cancerous. I have a tired brain caused by my gall-bladder, bad bowels and a poor stomach. My back burns. I feel as though there was a space between my brain and skull, that it is full of nerves tingling." During her paranoid delirium she interpreted some of her hypochondriasis on a paranoid basis "I thought that they were burning me alive." In November liver injections were stopped, and there was no sign of the pellagra. Psychiatric treatment was directed to reducing her body concern and increasing her activity. In addition her relation to her husband was discussed so that she could adjust more satisfactorily to the home situation. Her hypochondriasis was definitely diminished on discharge in December, 1935, but still present to some extent, as body sensitivity has been long-standing with her.

This case shows the development of a loosely organized paranoid delirium in a previously hypochondriacal personality, and the continuation of the hypochondriasis through the delirium. The hypochondriasis is essentially of the purposive, merergasic type of chronic invalidism.

CASE 8: *Chronic hypochondriasis.*

Mrs. A. P—, æt. 54, is a married woman complaining of abdominal discomfort, backache, vision difficulty, tightness in throat, exhaustion when doing housework, but not when doing mission work. She had been much pampered and babied in early life and readily treated as an invalid. At 18 her ambitions to be a mission nurse in China were frustrated by her father. At 19 she had an unhappy love affair and developed excessive interest in culture, but her lover died. She married at 24 a fairly steady salesman, and developed frigidity and dyspareunia.

She had two difficult labours 28 and 15 years ago, both unwanted, following the last of which symptoms developed, and she frequently attended homœopaths and drank much medicine.

On examination she was a voluble woman, much interested in medicine and her complaints, and seems happy in her hypochondriasis. Also somewhat worried about finances. There was some insight: "When my mind is occupied, I'm all right."

Her actual complaints were, "My stomach has fallen, my eyes give me trouble, there is a tightness in my throat. I have a shooting under the arm." Her attitude was of interest and mild self-pity, but she had absolutely no desire to lose her complaints. There was no suggestion of anxiety. According to reports, six months after her visit to the clinic she has relapsed into chronic invalidism.

This case shows the chronic invalid reaction of purposive hypochondriasis. The body complaints serve the purpose of giving her an easy life, and avoiding intercourse with her husband, for whom she has no affection.

CASE 9: *Purposive hypochondriasis in a war veteran.*

Mr. M. S—, æt. 41, is a man who spent two years in France from 1915–1917, after having worked as a tailor's presser until the age of 27. In France he saw no active service, but was put in charge of German prisoners and quite enjoyed the variety of experience. While there he had an accident, falling into a limekiln, but suffered no ill-effects from it. On his return to America he could not settle to any job, and began to complain of indigestion, restlessness and insomnia. He demanded compensation from the Government, who gave him $18 a month, and

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then $80 a month for a year, 1920. From 1920–1926 he received no compensation, but he filed numerous petitions for compensation, attended innumerable doctors, took much medicine, and lived on his relatives. He was admitted to various hospitals, with negative physical findings, and was usually discharged for unruly conduct. In 1925 his left eye was successfully operated on for glaucoma, but this had no effect on his body complaints. From 1926–1934 he was given $18 a month compensation, and when this was stopped, became very vociferous for more money. During this time he started about fifty different jobs, but always gave them up because he felt he was not fit for it on account of indigestion. Whenever there was any work he " came all of a quiver ".

Patient is the fifth of a family of ten ; he comes of German parentage. Apart from epilepsy in one brother there is no significant family history. At school he reached the 6th grade at 13. He was rather made fun of and bullied on account of his bad temper. On leaving he took up tailor's pressing, at which he worked on and off until he went to France, earning a very small salary. In his habits he drinks about 12 glasses of beer a week, and since April, 1934, he has taken sodium amytal regularly. Masturbation started at 15 and still continues, and intercourse with prostitutes occurs about every month. His personality is selfish, irritable, with few friends, dishonest and lazy.

On examination the patient is a lean asthenic man, throwing his arms nervously around, and frequently belching loudly. The expression was aggrieved and self-pitying, and he could easily be aroused to petulant and noisy indignation by questioning about his illness. His talk was very voluble, and complaining—all on the subject of how badly the Government's treating him. He had come to the clinic so that his claim for $40 a month should be supported. He complained of belching, pain in the stomach and chest. " I guess it's heart trouble. The doctors can't get to the root of it. I'm nervous, that's all." He said it was all due to his war service, and said he was going to take his case to the Supreme Court. The sensorium performance was well done, and physical examination revealed nothing except diminished sensation to pin-prick over the arms. W.R. was negative.

The man obviously did not want to be relieved of his complaints, but only desired compensation for them. He was quite unco-operative in any attempt to explain them on a functional basis, and left without any improvement and did not attend again. He was last seen attempting to perjure himself in a law-suit in which he claimed to have been co-respondent in his brother's divorce case. He belongs to a group of men who served overseas, who were never injured, did not amount to much from an adjustment point of view before they left, and since their return have spent their energy trying to get petitions signed to give them something to live on for the rest of their lives. He is typical of the worst kind of " war-veteran ", and he will obviously continue to live on his relatives as long as possible.

His hypochondriasis is mainly on a purposive basis, it gains for him the support of his relatives, it has gained for him money from the Government, it does not interfere with his sexual activities, and in fact it is closely allied to malingering. He shows well the " flatulent windy melancholy " or hypochondria described by Burton, with loud belching, intense self-pity, dramatization, and a tendency to get very angry when the seriousness of his complaint is questioned. Hard work and discipline in an institution might help him, but there is no means of persuading him to take up such treatment, so that the outlook from the point of view of cure for such a case is very poor.

CASE 10: *Feeble minded purposive hypochondriasis with a previous paranoid state, and bromism.*

Mrs. C. B—, æt. 25, is a married woman complaining of " smothery " feelings in the head and diffuse pains over her body. As a child she was pampered and allowed to get off work and school by minor bodily complaints. When she went to factory

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and laundry work, she continued to have bodily complaints and got off a certain amount of work. After a fall at work in 1930 she complained of great pain and inability to walk, and after six months got some compensation, but felt she deserved more. She took abundant bromides, and three months later was admitted to the Phipps Clinic in a bromide delirium with 300 mgrm. blood bromide. In this she was hallucinated, saw snakes and bugs, was paranoid against nurses, and complained of her body. She recovered in a month, but continued bodily complaints. A year after discharge she married a worthy and attentive man, and had two unwanted children by Cæsarean section. Since the last of these she has complained of inability to do any work, and that her heart is big and heavy. She has left all housework to her husband, whom she tyrannizes over by means of her illness. She eats and sleeps well and has a very easy life by reason of her illness.

On examination she was a self-pitying, dramatizing, feeble-minded woman (with a mental age of 8 on the Binet-Simon test of intelligence), with some feeling of being unfairly treated by the relief organizations, and with a bizarre series of somatic complaints and a heavy feeling in her head, which she feels might be a tumour like one of her friends had. Vague hypnagogic hallucinations of faces at night. She comes for medicine and is not really worried by any of her complaints. Blood bromide was 50 mgrm., as she had been taking bromides from her private doctor again.

Bodily complaints were—"My heart feels big and heavy, it quivers; I feel "smothery" and choked in the throat. My head feels as though somebody's squeezing it. I'm better as long as I don't do any work." She was not much upset by any of these symptoms, but she would not accept any formulation that her complaints were not physical, had no desire to change. She was told to stop taking bromides and that she was quite strong enough for housework, but as her husband sympathized with her there is little chance of her doing any.

This is a feeble-minded paranoid personality who has learned to utilize invalidism, and her increase in symptoms is possibly due to her bromide-taking, which previously brought on paranoid symptoms. Her head complaint, "as though someone's squeezing it", is of a paranoid type.

CASE 11: *Feeble-minded bizarre hypochondriasis with paranoid and anxiety features.*

Mrs. T. V—, æt. 34, is an Italian woman seen in the out-patient department in July, 1935, complaining of pains in chest, dizziness and headache. As a child she talked late and cried a lot. She did badly at school and suffered from headaches. She worked in various clothing stores, but often changed work, as she felt people were talking about her, and she got frequent headaches. At 21 she married, but did not get on with her husband; intercourse distasteful to her. She developed abdominal pain. In 1922, at 22, she had appendicectomy, and has complained of numerous pains ever since.

She bore two children, and her husband persuaded her to have two abortions against her Roman Catholic principles. He deserted her after three years of marriage, but she kept on taking him back for a few months, although he was unfaithful to her. She had a third child at æt. 30 and another abortion. Pains occurred during all this time. Living with her parents. In 1929 she complained of seeing faces at night and that people were talking about her. On this visit in 1935 she was agitated because her husband is writing letters slandering her to her children.

On examination she was an excitable, emotional woman, with a mental age of 8½. Her actual complaints were: "I feel real funny in my chest; I could throw everything out. I have headaches and I feel dizzy. My back and side hurt. My eyes hurt, my head goes round like a wheel. I have a cold feeling of dead hands touching my thighs." These feelings were described with much concern and agitation. She was resentful against her husband. Sometimes hears her name called and is frightened. The dead hand that she felt on her flesh she thought was her dead godfather's, who vouched that she would not commit sin,

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and she blamed herself for the abortions. She dreams of dead people and dead babies. She is worried about the letters her husband sends to the children. Insight fair; puts the trouble down to nervousness. She manages her home moderately well in spite of these troubles. She apparently developed these symptoms when she had been dreading a visit of her husband to the neighbourhood. When he went away a week later without disturbing her household all her symptoms began to abate. She was seen at weekly intervals, given barbital for her sleep, and reassured, and in three weeks she had no symptoms, except an occasional stomach-ache.

This incident of bizarre symbolic hypochondriasis in a previously paranoid and hypochondriacal personality is well described by Dr. Richards as a "feeble-minded flurry". In a more intelligent person, sensations of a dead hand, symbolizing previous guilt for inducing abortions, would be grave, but in this simple soul it disappears as soon as the exciting cause leaves the neighbourhood.

CASE 12: *Localized body complaint in hysteria.*

R. B—, æt. 19, is a negro who had meningococcal meningitis May, 1935, with panophthalmitis and removal of right eye. He had had numerous lumbar punctures, which worried him. July 10, two hours after discharge, he had a pain in his back and fainted. He came up to hospital, when he was again given several lumbar punctures and sent to another hospital for two weeks, where he had the same treatment. On discharge he still complained of pain, and was warned to be careful and to watch for symptoms of recurrence. This frightened him, and he continued to have pain.

On August 12 again came to the hospital complaining of backache, and was given another lumbar puncture, with exacerbation of the pain. He was then treated with massage and hot application, with no improvement. Finally he was referred to the psychiatric department as there was no physical reason for his symptoms.

On examination a healthy asthenic negro of mental age of 12, with a base line of 10, of normal family history, somewhat seclusive personality. He wanted to be an artist, but is now a dust collector, and has not worked since illness. There is some history of alcohol. He was sexually active, masturbated since 10 and attended prostitutes until 16, when he had gonorrhœa. He had done odd jobs, and lives with brothers. He now gets 80 cents a week insurance. When first seen he was carried by his brother. He was resistive, and when told to bend forward he extends back to the most difficult position for lumbar puncture. He was not worried about anything definite.

His somatic complaint was, "Pain in my back, running down the leg, throbbing all the time". He had a definite hysterical contracture of his back. His attitude to the trouble was one of indifference. He obviously had difficulty in settling down to work after his illness, and in addition the position of the back adopted was one of opisthotonos such as to render lumbar puncture, which he so much dislikes, impossible. He was treated by hypnosis and suggestion, and was able to walk. After four sessions he was urged to return to light work, which he has done since.

This hypochondriasis is of a simple type localized to the part where he had discomfort during his illness, and recurred in the setting of return to every-day life.

CASE 13: *Head pain in hysteria with the diagnostic problem between organic and psychogenic body complaints.*

Mr. L. A—, æt. 56, is a lodging-house keeper's husband who was admitted on March 8, 1935, with a history of fits and headaches. The first occurred in 1927 in a setting of starting a restaurant business after giving up his previous job as mechanic owing to lumbago. It consisted of a twelve-hour attack of unconsciousness while at work, after which he was able to return to work at once. In 1931 a

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faith-healer cured him of lumbago, which had consisted of sudden attacks of drawing pain in the back which prevented him from standing straight. In 1932 in a setting of financial difficulty he became restless and irritable, and a doctor told him he might have a stroke. In October, 1932, during the night he had an attack of nose-bleeding which was following by twelve hours' unconsciousness, and he again returned to work immediately afterwards. In April, 1933, in a setting of failure of his store, he began to have attacks of sensation of pressure inside his head, after which he would lose consciousness for from ten minutes to four hours. These continued until he sold his store in June, 1933, but started again in October, 1933, when he bought another store, which he gave up owing to the attacks in February, 1934. He never bit his tongue, hurt himself or frothed at the mouth in the attacks. They were preceded by but not followed by headache, and there was no passing of urine in the attacks. He would sometimes throw himself about during an attack, and there were champing movements of the lips and spitting. In May, 1934, a complete examination, including encephalography, was made with negative results, and later he spent two weeks at an epileptic hospital, where he saw true epileptic fits. His wife, who kept him by her work, was very sympathetic towards him in his illness, though previously she had been accustomed to scold him.

The family history is not significant. At age of 16 he started to have the so-called lumbago, which continued on and off until 1927, and for which he attended numerous bone-setters with temporary relief. He married for the first time in 1900, but in 1912 deserted his wife and six children and in 1922 married a widow, who, in his words, " realizes I must not be excited and would work her fingers off for me ". Until 1927, when he took up various unsuccessful businesses of his own, he had worked fairly successfully as a motor mechanic at a good salary. His personality is said to have been cheerful and sociable. Alcoholism occurred from 1902–1912.

On examination he was a fat, anxious-looking man, and gave the impression of being dishonest and evasive. He complained of " terrible pain in the head that never leaves me. I thought there might be a cancer on the brain ". His recent memory was good, but there were definite inconsistencies and gaps in his past memory, about the date of the birth of his children, about his leaving his first wife, and about the various hospitals he had attended. On the Binet-Simon test he gave a mental age of 13·9. He had considerable difficulty in verbalization, in finding the right word to express anything, but never made any definite mistakes.

Blood-pressure was 140/80. Tendon reflexes were brisk; there was no intention tremor; Babinski reflex was flexor. There was complete loss of smell in the left nostril and partial in the right, and loss of taste in the anterior half of the tongue. He said that he had lost his sense of smell for the last four years. Visual fields and fundi were normal. X-ray of the skull was normal. Lumbar puncture showed on one occasion 8 lymphocytes, 50 mgrm. protein % and a Lange gold curve of 333221. The W.R. was negative in blood and cerebro-spinal fluid. The cerebro-spinal fluid pressure was 140 mm. and responded to compression of the jugular veins. The lumbar puncture was twice repeated, giving a flat gold curve and no abnormality. The patient had several attacks in the clinic, preceded by headache, and in none of these did he show any neurological abnormality except anæsthesia to pin-pricks. Pupils reacted normally and the Babinski was flexor. Champing and spitting movements occurred in all of the attacks, with puffing respiration.

In this case there is the differential diagnosis between a cerebral tumour, possibly of the uncinate region, in favour of which are the champing mouth movements and the disorder of smell and taste, and hysterical fits, in favour of which is the patient's personality and the character of the fits. There were no incidents at all resembling uncinate dreamy states; on the other hand hysterical fits rarely start at the age of 51. However the lumbago, which he had had since 16, may easily have been a hysterical manifestation. The matter was decided by the fact that the patient was able to be relieved of both headaches and fits by hypnosis, with direct suggestion of increasing bodily control. The motivation for this

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hysteria is doubtful, but it may have been to save his face when being kept by his wife, and to gain his wife's sympathy.

The hypochondriasis here consisted of head pains. It is somewhat unusual for hypochondriasis to occur in true hysteria, but here some anxiety was present, and the conversion of anxiety into the hysterical symptom had not occurred completely.

CASE 14 : *Post-traumatic hypochondriasis.*

Mr. R. Y—, æt. 42, is a farmer of negative family and personal history, who complains of shaking feelings and nervousness following a blow on the head by a neighbour eighteen months previously in which he was stunned for a few seconds. About an hour after the blow he appears to have had an attack in which he was excited and trembled, and says he was unconscious for six hours, but this does not appear certain, and probably was an hysterical attack. Since then he has had a few attacks in which he felt like falling, and on one occasion did fall by accident, and this was followed by two hours of noisy crying. He has given up work on this account, and in March, 1935, brought an action against his attacker.

On examination he was a healthy-looking asthenic man, fairly contented with his troubles, Knee-jerks increased ; W.R. negative, fine tremor of hands, pulse raised, pupils unequal. He was worried about $600 in debt, and both he and his wife want to have the attacker put in gaol. He was very dependent on his wife, who supplies most of the resentment. His complaints are vague, general nervousness. " My fingers get trembling, my flesh gets numb, I'm aching in the head " ; weakness, insomnia.

This hypochondriasis is to be regarded as purposive, with the object of getting legal revenge for his assault. He was emphatically reassured and the origin of his symptoms discussed, but the resentful and sympathetic attitude of his wife to the condition made the prognosis uncertain. Nine months after his visit to the clinic no improvement had occurred in his condition.

CASE 15 : *Bizarre hypochondriasis developing in a long-standing obsessional.*

Miss E. G— was first seen in the clinic in 1918, when she was admitted at the age of 28, with a diagnosis of convulsive tic of Gilles de la Tourette. Since the age of 23 she had had impulsive outbursts while at confession, swearing at the priest, smashing the confessional and throwing knives, books, etc., at him. Apart from this she was very religious and claimed that these outbursts were caused by the devil. The onset of these had coincided with the birth of her youngest sister, which she greatly disapproved of. After two months in hospital she showed symptomatic improvement, but would give no full account of herself. She returned to work as a nursemaid with occasional outbursts until she was readmitted in 1926 at the age of 36 with an increase of symptoms following a sister's marriage. A full account was obtained during her stay. She had been sex-handled by men on three occasions from the age of 6–9. Mutual masturbation with boys occurred at the age of 11, with terrific guilt feelings. She early became conscious of a conflict between her sex cravings and her repugnance for marriage and pregnancy. At 13 she became a Roman Catholic, and her sexual conflicts increased, as she was unable to confess the sexual incidents. At 23 she said that she challenged the devil (representing the fleshly part of her nature), and said, " Devil, you and I will fight this out ". From then on her personality changed from a sedate, prudish, excessively neat individual and she became very aggressive, hot-tempered and proud. Her impulsive behaviour dates from this time. In the clinic the patient was very evasive and anxious to cling to her view that the outbursts were caused by the devil. Her behaviour was exaggeratedly respectful, perfectionistic and argumentative ; she took satisfaction in being no better. Only on one occasion did she have an outburst. Finally a dogmatic statement that her condition was not due to the devil but to her own impulses which she was unwilling to accept, and that it was up to her to control them, succeeded in improving her condition after a brief reaction of crying and indignation.

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She was able to work successfully as a cook for ten years after this, without any symptoms. She is the eldest of a family of ten; both parents, of German descent, are very excitable; one sister has gigantism due to a pituitary tumour. She attended the clinic again in December, 1935. For six months she had been worried over the care of her invalid mother, and for the last month had had to give up work on account of odd behaviour, such as praying loudly in the middle of the night, excessive washing, collecting innumerable articles in her hands. When seen she had an armful of toilet paper, tin cans, old shoes, etc., and was very dishevelled and resented medical examination. Her only complaints were of her body: "I have a very sore stomach; feels like I have swallowed a tin can; very acute pains in the back and kidney; no strength; pain round my heart; feet hurt." When asked the purpose of her odd behaviour, she would only say, "You're the doctor, you should know". She was sent to a State hospital, as home life was impossible. Her original condition seems to have been on an obsessive and compulsion basis and the hoarding is probably of the same nature. The passivity feeling of being controlled by the devil in her original attacks would appear to have been almost deliberately adopted.

The hypochondriasis in her present condition seems to be a partial substitution for the anxiety and difficulties of her situation, although at the same time obsessive and almost schizophrenic features are present.

CASE 16: *Vague hypochondriasis in paranoid parergasic reaction.*

Mr. E. E—, æt. 26, is a single college graduate who for four years has become progressively more worried, suspicious and convinced of persecution by Jews, Catholics and Masons; determined to find his girl whose letter telling of her marriage he refuses to believe.

In 1929 at the University he became very much interested in a girl, but showed her little attention. He graduated in 1929 and took a post with a gas company, staying with his uncle; gave up his job and returned home when his uncle spoke to him about the parking of the car. He was restless, irritable, unsettled. In 1930, at the State University, he failed one subject and worried. He returned home; restless, lackadaisical and less interested, under a regime directed by his father. Spring, 1933, he got into a quarrel about a tennis court, began to feel discriminated against and seeing it all with some ulterior motive. In December, 1933, he refused to go walking because "the Jews, the Catholics and the Masons" were after him. (He had sneered at Jews at College; and the boy with whom he had quarrelled was a Mason.) In May, 1934, he was arrested for breaking into the tennis court. He regarded the arrest as malevolent "plotting" by club-mates. July, 1934, after typhoid vaccine, he "broke down"; said he had received "the wrong serum", and was afraid he was to be killed. At this time he wrote to the girl mentioned and in reply she said she was married. He refused to believe it and he decided to hire a private detective to investigate. He felt the Jews must have something to do with it (the girl was of Jewish extraction). He again refused to leave the house, being afraid of what might happen. He wrote daily notes: "What damnable fiend organized the Morgantown frame-up and my first breakdown?" "Should you not tell me, as a Mason?" "I have written the girl again—warning—watch, toilet, water, cats." "Could my reproductive powers be threatened?"

Admitted on September 22, 1934, he was restless, suspicious, quiet; at the same time annoyed other patients by his efforts to help them. He spoke of "lack of the usual body strength". At first he felt that the incidents—such as the serum and tennis-court episodes—were designed to prevent his seeing his girl. He had an idea his girl was in Baltimore; he came because "his mother worried him into it". "She makes me nervous in an unmerciful way." Later he decided that everything had been done in his favour in order to spur him on to more aggressiveness. He is still searching for his girl—"I havn't got it quite clear yet."

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He is a tall, thin, undernourished man of asthenic type. There are no physical signs of disease.

He is a " model son ", attached to his mother, quiet, sensitive and solitary. He makes friends poorly, is quiet and suspicious.

He was born in Indiana on October 13, 1907. He has one healthy sister four years younger. At two he had spinal meningitis without residuals. Over-protected by a domineering and solicitous mother. Tonsillectomy at 13. Submucous resection at 15 of nasal cartilage. At 14 his mother left the home with him so that they might attend school in a large city. There have been sex worries, with autoerotism beginning at 20. Concern about loss of sex power.

In addition to the over-solicitous mother, he has a father who required six weeks' psychiatric hospitalization for " worry and depression following financial reverses "; at 58 he recovered, but mistrusts psychiatrists and does not want his son treated.

During his stay in the clinic his condition did not improve. He lost weight, was restless, anxious and suspicious with a high pulse-rate. He did not want to go out as he felt he was being looked at. On about November 1 he developed the idea that he ought neither to micturate or defæcate, as it weakened his sexual organs.

Bodily complaints occurred from time to time, but they were all vague, with no suggestion of self-pity or dramatization, but just casually mentioned without any definite affect. They were, "A sort of dropping feeling all over. I just think some individuals, some groups, might be against me and cause me to lose sleep or get sick or something ". When asked how he is, he says, " Pretty good ; rather weak to-day. My back hurts—don't know why hardly ". This complaint was made in a setting of worry lest he should be visited by his sister, and signifies an exacerbation of his paranoid condition. On another occasion, after meeting a Jew whom he thought was against him, he complained of " a sort of foggy feeling, not quite foggy, but right here in my head "; and again, " my head is very clear—I've a little pain in the eyes ". After a disturbance in the ward he complained of headache and queer feelings in his head. Although his insight was good—for instance, " Of course these are all silly ideas, I'm very egotistical "—he used his insight almost for self-destruction and analysis, and became careless of his appearance, preoccupied, suspicious of everything, and in April, 1935, was discharged to another hospital, where he did badly.

The body complaints were interesting in that they accompanied increase in paranoid symptoms and in their vague unemotional ambivalent character, such as foggy feelings in the head, dropping feelings, little pain in the eyes, and on one occasion it was definitely linked up with his paranoid system, in that the group against him was making him sick.

CASE 17 : *Hypochondriasis in paranoia.*

Mr. R—, æt. 34, is a married man complaining of gas in the stomach, and that an oil company was against him. His family shows rigid strict personalities in both parents, hypochondriasis in one sister and excessive religious and domineering personality in another. He is the youngest of a family of eight, was somewhat dominated by his eldest sister, and was attached to one of his brothers. As a child he was constipated and had enuresis up to the age of 7. His school life was more successful from an athletic than an academic point of view, and he was exceedingly popular with the other boys, among whom he was a leader. After a successful athletic career at Columbia he took a teaching job in a private school in New York. In this he was successful and was hero-worshipped by the boys. He was always fonder of the society of men than of women, and since the age of 20 has been a sporadic social drinker. He had a tendency to form strong likes or dislikes, and at school and at college twice developed intense hatred. His personality is proud, honest, reserved, jealous, sensitive and easily offended, and proud of his bodily development. He always had a feeling of insecurity. He felt that woman's place

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was in the home, but when he married in 1925 had difficulty in keeping his own wife there. His wife's personality was gay, vivacious and friendly, of a type tending to accentuate his tendency for jealousy. In 1933 the school where he worked failed, leaving Mr. R— in debt, and after a period of uneasy unemployment his brother procured for him a job in the Texas Oil Company. In the strain of adapting himself to this completely new work in a setting in which probably some jealousy existed against him, Mr. R— gradually began to consider that the organization was against him. A letter which he had written to his brother complaining of his training he thought had made an enemy of the manager, a certain Mr. P—. Mr. R— began to see innumerable grievances during 1934, some possibly real, such as difficulty in paying expenses, and he linked them all up with the central hostility against him. In July, 1934, an outburst of jealousy occurred against his wife with some slight provocation, and this was followed by masturbation and association with prostitutes and abandonment to spirit drinking. In May, 1934, he was deeper immersed in debt owing to an operation on his wife. In 1934 following influenza he was transferred from an outside to a clerical job, which he considered a degradation. His suspicions of hostility of the office during this year became certainty; people were talking about him at the office, setting spies to watch him, and finally putting dictaphones in his house to listen to him, so that he would be got rid of. Following conflict with a lawyer about debt on his house on April 2 every event was construed as referring to himself, and this developed into an acute episode when he came home terrified, saying that a gang at his office was out to shoot him. At home his suspicions were referred to his wife, who he considered was influenced by the same company, and finally after a threat to kill his children and an attempt to kill his wife he was admitted to the clinic.

On examination he was a pleasant, co-operative man of thick-set, muscular build, florid complexion, and a blood-pressure of 140/100. Mood statement was rather low, but there was no definite evidence of depression. Body concern was shown by his first complaint: "I have a lot of gas on my stomach; I feel physically exhausted and nervous; I have a headache." Emphasis was laid on these bodily complaints as something for which he could receive help in the hospital. Excellent rapport was obtained on this basis, and although he had a well-organized system of delusions against the oil company, it was possible to shed some doubt on his interpretation of the facts, and he definitely had some insight—"It is all due to a feeling of insecurity". Sensorium performance was good; the Housman written absurdities test showed three missed absurdities and five false absurdities recognized, showing a hypercritical attitude. In the clinic he settled down well, and with his feeling of security his bodily complaints again disappeared. Three weeks after admission, however, he complained of headache, and on questioning, his essential trouble was that his watch had stopped, and this he interpreted as due to the influence of the oil company. He was able to be reassured about this, and the bodily complaints again disappeared. Three weeks after admission, on transfer to a convalescent ward where he was unable to adjust, increasing misinterpretations occurred, resulting in an almost successful attempt at suicide. During the next month improvement occurred and he was removed from the hospital against advice by his wife, but was able to adjust to outside life in another part of the country without any recurrence for a year, when hospitalization again became necessary.

This case shows the vague bodily complaints probably representing tension which frequently occur when a paranoid patient is in some difficulty—complaints which tend to disappear in an environment of security. These complaints can often be utilized, as in this case, as a basis for gaining the confidence of the patient, which is otherwise exceedingly difficult to obtain in a paranoic personality.

CASE 18: *Eye complaints in adolescent with sexual difficulty.*

The patient, æt. 19, is the eldest son of a somewhat fussy Italian mother. He did well at a Catholic school until 15 when he changed to a public school, which he

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did not like so well. He got on well with other boys, with whom he tended to be a leader of a delinquent gang and he had been sexually active with girls since æt. 11. One year before he was seen in the out-patient department, when he was within six months of graduating from high school, he had an incident in a motor car when he gave a light to a friend, and since then he felt that people were looking at his hands. He refused to go to school after this and could not bear people to see him. He stayed inactive at home, unwilling to talk to anyone for a year.

On examination he was a lightly built, asthenic boy, very tense, with profuse sweating and dilated pupils and fine tremor of the hands. His complaints were: "It's affected my eyes. It's so heavy on my head I can't stand up. My eyes get real red. It's my head. I put such a heavy strain on my eyes." This was stated with intense anxiety and concern, almost panic. He was afraid of insanity, and heard ringing noises in his ears and an occasional accusatory voice. He also complained of people staring at him, reading his mind and looking at his hands. However he said, "I want to see if I can get out of this crazy habit of mind".

It later appeared that he had done some sexual manipulation in the car with his friend, the memory of which was very repugnant.

Admission to the clinic was suggested but refused, and he was reassured and told to return to a normal life. This he was apparently able to do, and at a later interview was almost symptomless, but as his attendance was irregular he could not be followed fully. When last seen nine months after his first interview he still complained of headache, and real habit improvement could not be obtained in the out-patient department.

This hypochondriasis is in the main a symbolic one, the eye complaint being a symbol of sexual guilt, as in several of Dr. Greenacre's cases. It is interesting that this case showed symptoms which could be considered characteristic of the schizophrenic or at least panic reaction, and yet he was able to make some adjustment after only the most superficial reassurance.

CASE 19: *Distorted body complaints arising in a setting of anxiety in a man with schizophrenic family history.*

Mr. W. M—, æt. 33, is a happily married machinist with five healthy children. In 1932 he was obliged to break up his home, and in this setting would complain of "gas in the stomach", for which he attended his doctor. In 1933 his brother was sent to a State hospital with paranoid schizophrenia, and Mr. W. M— worried very much whether this was justified, and felt his brother ought to have been otherwise looked after. He slept badly for about a month, and then developed a feeling of a lump in the throat, tired feeling in the chest and back, working up to the temples. He was now in regular, skilled work on a lathe, which he did well, but the complaints continued until he came to hospital in October, 1935, with an increase after a visit to his brother in June. After onset of the bodily feelings he found that he ceased to worry about anything. He slept well, but felt nervous and shaky in the morning, was irritated by noises, and was unable to enjoy himself at any time, sitting by himself and brooding on his body feelings.

Apart from the brother, the family history is clear. He did well at school, was popular with others and was trained in engineering, at which he did well. His personality is friendly, hard-working, but with a tendency to ruminate and day-dream when unoccupied. Married life was happy, with no sexual difficulties, and mutual satisfaction in intercourse. Masturbation occurred from 14–16, but without marked guilt, and from 16–20 he occasionally frequented prostitutes.

In the clinic he complained of numbness in the temples, lump in the throat, "makes my throat raw; my eyes feel like they're expanding; so tired in the chest; every nerve in my body in and on the twitter; gas in the stomach feels like it works up to the temples. I feel like the skin of my face is all drawn up".

He also described an occasional obsessive desire to look at his blue prints in work again and again. He said he was worrying about nothing and his manner

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agreed with this statement; he did not seem at all upset by these feelings or by any difficulties, but wore a consistently blank expression. He said he did not worry about his brother any longer. Routine sensorium tests were all well done. No physical basis for his complaints was found. The W.R. was negative.

He was told that his physical condition was excellent, that it was important for him to continue his activity in spite of these feelings, which would diminish, and that his symptoms were substitutes for worries which he had now forgotten. He attended regularly at weekly intervals and steadily improved, under treatment of discussion of his home situation, his work difficulties, his feelings towards his brother, and with reassurance. The eye sensations were the first to go, then the numbness in the temples, but he continues to complain slightly of gas in the stomach—an obviously much less bizarre symptom. He has continued at work throughout the treatment.

In this case the shallowness of affect, the family history and the bizarre character of the somatic complaint give a very schizophrenic-like bias to the picture, but he had absolutely no other schizophrenic symptoms such as ideas of reference. One feels that his complaints of gas and numbness in the temples and expanding eyeballs must have some symbolic meaning for him, but this was not found, and the condition was regarded as a substitution of these bodily feelings for the original worry about his brother.

CASE 20: *Hypochondriasis in paranoid panic.*

Mr. J. A—, æt. 32, is a single pipe-layer who attended the out-patient department on July 26, 1935, complaining of pain in his left groin, and that the neighbours were talking about him. For the last twelve years he had worked well as a workman in a gang under his father, but for the previous nine months he had occasionally been left in charge of the gang as foreman. He had been unable to manage the men, and one of them in particular had made fun of him. He began to be restless and excitable, kept by himself and was afraid of his next-door neighbours. On the night of July 14 (two weeks before seen) he became terrified when his dog barked and thought the neighbours were trying to get at him. Three days later he took some saltpetre because he said he heard the neighbours tell him to, in order to prevent masturbation. After this he felt sick, and was unable to sleep, and spent the nights prowling around the house looking for marauders. He was suspicious of cars in the streets, said the neighbours were peeping at him, and stayed away from work.

In the family history, his father is a morose, moody man, impotent for the last ten years, and gets on badly with patient's mother, who has devoted all her affection to the patient. Patient is the eldest of five siblings, two of whom are out of work and at home, and one sister is described as nervous and irritable.

Patient suffered from meningitis at 2, but recovered without sequelæ. Apart from this he was a healthy child and showed no neurotic traits. At school he did only moderately, reaching the 6th grade at 15, after which he worked at various labouring jobs until he took up his present work. He was a quiet boy, going about mainly with his family, and very attached to his mother and home. He had few friends. His interests were radio and reading about mechanics, as he took his work very seriously. At 29 he was nervous and trembled for a few weeks following contracting gonorrhœa, which was successfully treated. From æt. 20 he had masturbated about monthly with much guilt, and since then had occasionally consorted with prostitutes. He had one love affair eight years previously, but it was broken off as he felt he did not want to marry. There was no history of alcoholism.

On examination he was a tall, asthenic man, very co-operative, and rapport was easily established, as he asked for help. He appeared frightened. The hands were sweating and had a fine tremor, the pupils dilated and reacted normally. The pulse was 70 and no other physical signs. His mood was " all right ". Apart from pain in the left groin, he complained of " a funny feeling in the head " and

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that his hands had holes in them. He had delusions of reference, that people looked at him in the street peculiarly, that neighbours spied on him, that people prowled around his house. His chief complaint against the neighbours was that they thought he masturbated more than he did, so that he had had to sleep with his arms above his head to show them he did not. At night he had hallucinations of their voices saying, " He's at it again ". He said a bad smell came from his mouth. He considered that a man in his gang had put the neighbours against him.

Orientation, memory, retention and judgment were good. When asked what was the cause of the trouble he said, " It might be self-abuse, but I might be just naturally nervous ". He was prepared to accept the formulation given him that the trouble was mainly his own nervousness more than the malevolence of the neighbours. Certification was advised, but as his mother refused, out-patient treatment was continued, while he lived quietly at home with ·5 grm. of barbital nightly.

He attended every three days, and was treated on the lines Dr. Meyer advocates in his paper on paranoid conditions :

(1) Every effort was made to gain and retain the confidence of the patient.

(2) The body complaints were utilized as something for which he needed help.

(3) He was concisely reassured on immediate difficulties such as masturbation, being told that it did not matter whether he did or did not.

(4) Care was taken not to argue with him, or deny his paranoid delusions, but rather to inject doubt in them by suggesting that there were other ways of interpreting the facts. He definitely gained considerable relief from discussing his difficulties even in the first interview.

On July 31 he complained of " funny feeling in my head as though someone had hit me ", and still had paranoid ideas, but during the next three weeks these died down entirely, and he considered the trouble as purely his own nervousness. A Binet-Simon intelligence test gave a mental age of 12, with base line of 9.

On August 20 he had a relapse for three days after visit from his employer asking when he would return to work. In this he suffered from belching, nausea, felt " something in stomach loose, sharp shooting pains in the head as though someone was twisting it, hands and body feel cold ", and he thought the neighbours were talking about him again. He was able to be reassured, and two weeks later returned to work. It was arranged for him (1) to work in a different gang, away from his father ; (2) never to be given responsibility over other men, as he was quite incapable of it.

He did well at work, but had one brief relapse of a day in which he became paranoid and complained of feeling that his stomach was on fire, after seeing a serious accident. Following this he did well, gained insight, and various factors in his personality, such as sex adjustment, relation to fellow workers, his incapacity for responsibility were discussed without agitation.

Thus this man was able to be back at work without symptoms within six weeks of a serious paranoid psychosis. His body complaints are interesting in the following respects :

(1) They are of a typical paranoid form " as though someone had hit me ".

(2) They are diffuse and vague and do not resemble any organic condition.

(3) The complaints coincide with an exacerbation of the paranoid condition. At these times his first complaint was always of his body, then on questioning he gave his paranoid ideas, and on further questioning would describe the upsetting incident. When this had been fully discussed, the body complaint would disappear in the course of the interview. This illustrates very markedly the importance of analysing the body complaints in paranoid conditions, and treating them as a sign of some difficulty which must be discovered and set right during the interview.

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CASE 21: *Hypochondriasis in paranoid panic.*

Mr. F. H—, æt. 32, is a single unemployed carpenter admitted to the Phipps Clinic on January 23, 1935, following a confusional outburst in which he thought he had been attacked by a physician in the medical ward. For the last twelve years he has had a love affair with much frustrated sexual excitement, but no actual intercourse. There had been considerable conflict between his inclinations and his Roman Catholic religion. His fiancée had been very anxious to get married, but he had always put her off on the grounds that he was not earning enough. He had been unemployed since 1931, and had spent his time pottering about his parents' house and meeting his fiancée, who would usually pay his amusement expenses. In January, 1934, his fiancée was admitted to a medical ward for mitral disease and heart failure. She remained in hospital a year and was noticed to be very agitated after H—'s visits. In December, 1934, there was doubt as to whether a thyroidectomy was necessary for her on account of her rapid pulse. Both Mr. H— and his fiancée became very agitated at this possibility, but finally the operation was not considered to be indicated. On January 10, 1935, Mr. H—'s visits to his fiancée were stopped and he became very suspicious that the hospital was doping his fiancée. On January 19 he behaved in a threatening manner and seemed confused on attempting to visit her; felt that he had been hit on the head by the physician and drugged. For the next four days he was in a dream-like restless state; had hallucinations of a voice saying, "You are a dope fiend". Asked people whether they thought there was anything wrong with his privates, and thought that a rash of psoriasis was syphilitic. The family history shows abnormal personalities in both parents: his father is German and has an almost paranoid reaction; his mother suffers from crying spells and is intensely devoted to the patient. As a child he was quiet but stubborn. He did moderately well at school, and on leaving took up his father's trade of carpentry, although he had vague ambitions of going on the stage. He did fairly well at his work, until an accident to his leg in 1931. His personality was quiet, shy and retiring. He did not readily mix with fresh people. He was intensely religious, and was always very careful about his bodily health and cleanliness. He would not go to public lavatories for fear of syphilis. For the last three years he has been concerned about his psoriasis.

On admission he was a flushed, tremulous, asthenic man looking about ten years less than his age. Pupils were dilated, he was sweating freely, and the pulse was 100. He was preoccupied, puzzled, worried about his fiancée, was paranoid against the hospital—"I thought everyone at Hopkins was against me". He was paranoid against his fiancée's physician, and had hallucinations of her voice saying, "I love Dr. B—, and you know it". There were frequent other auditory hallucinations which terrified him. Orientation for time was muddled, and his recent memory for the past two weeks was completely confused though past memory was good. His insight was fair; he said, "I feel nervous and shaky; it all came through worry".

He improved considerably in the clinic and on February 17 was able to give a mental age of 14 years 3 months with the Binet test. Good rapport was obtained and his paranoid reaction against the hospital died down. However he was unable to accept the fact that his fiancée had been transferred to the psychiatric clinic. On February 28 after a walk with his sister he said, "It feels like my legs shrink a bit when I get outside". On questioning he said that he had been talking over his possibility for marriage. He then said that he thought that there were listening devices in the walls to take down everything he said. From this time on he became worse, felt that the food was tampered with, thought that people in the hospital were against him. He developed for the first time bodily complaints in the hospital: "My stomach feels empty; I feel lazy and tired. I had a dead feeling in my privates to-day," as well as the complaint of his legs shrinking. He considered that some "monkey business" of the hospital caused the changes that were coming over him. Reassurance failed, and when in the

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hospital he became exceedingly agitated; he was therefore allowed to work outside, but continued to have hallucinations of a helpful voice ordering him what to do and even telling him where his tools were. No further progress was made in the Clinic and he was discharged home on March 22. Though still frequently hallucinated he is able to remain at his carpentry work, and has not had any outburst during the last year.

The hypochondriasis in this case is probably partly symbolic, as is the "deadness in privates" complaint, and the shrinking legs, but for the most part it is the vague expression of tenseness in a paranoid patient of a body-sensitive personality, as shown by his early concern over his bodily health. Particularly interesting is the fact that the bodily complaint was the first sign of exacerbation of the paranoid condition.

CASE 22; *Hypochondriasis in paranoid personality.*

Mr. G. A—, æt. 45, is a married house-painter, complained of tight feelings in hand, weakening spells, loss of ambition. Of German parentage, he has an alcoholic brother dependent on him. Always seclusive, he had had several grievances in his life. He wanted to be a lithographer, but was obliged to do various labouring jobs. Has earned about $30 a week house-painting and repairing for the last fifteen years, but since the depression he has been worried about business; he is now $100 in debt, with a wife and three dependent sons. His married life is unhappy and his wife is frigid. For three months has got irritable, impatient, with innumerable pains; has had an urge to wander away. Very few jobs. For two months he has felt people were talking about him; unable to sleep; goes long walks at night. He became angry with negroes because he thought they smeared his steps with grease. His children irritate him.

On examination he was a quiet, somewhat sad and resentful looking man. Bodily complaints, heavy pressing in chest, haze in front of eyes, sweating, cold feet. Passivity feeling as though somebody is drawing him. Feels people stare at him too hard; read his thoughts. Indignant against negroes. Sensorium good; insight, "It's due to worrying how to get along". His actual body complaints were: "Something dragging and pressing on my head; my eyes feel as though there was something in front of them; my throat comes up and chokes me; my voice changes and gets rough; I feel all worn out. One testicle is swollen up."

The patient appeared anxious and worried, and there does not appear to be any clear symbolization in these complaints. Although definite paranoid features were present, the body complaints do not seem to be linked up with a paranoid system, but are an expression of his tension or anxiety. They are mainly of the oppressive, of the "something pressing in from outside" type common in anxiety states. The factors in this case are:

(1) Unsatisfactory marriage; frigid wife.
(2) Worry about debts in a conscientious, scrupulous person.
(3) Worry over a drunken brother.
(4) Unemployment.

He improved during several interviews of out-patient treatment, in which his difficulties were discussed and he was emphatically reassured, and was given 0·5 grm. barbital for his sleep.

CASE 23: *Vague body complaints in adolescent with masturbation conflict.*

B. E—, æt. 19, is a framer's son, complaining of headache and dead feeling in the stomach. This dated from a vomiting attack four years ago when he was alone with his brother in a cornfield. On this subject he is reluctant to speak; says it is painful to recall it; will not describe anything that happened. Since then he has had vomiting, headaches, and stomach-ache. His father spent $1000 in doctors and hospitals with no improvement. The family history is negative, but the father is described as short-tempered. Patient is very much

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attached to his mother. He got on well with others; had many friends. His interests were in the farm and he was still working there, but for the last year his father made him take work easily. He did not get on well with his father, who in his opinion did not run the farm well and was able to pay him no wages. He was worried about the farm, which was mortgaged for $500.

On examination he was a very tense, flushed boy, keeping his head averted shamefully during the interview. The pupils were dilated. Speech was very slow, with blocking and evasiveness, especially on sexual topics. His complaints were: "My head bothers me all the time. I've got a dead dull feel above my eyes to my cheeks; it's heated. My stomach's got a nervous feel. My back takes spells too." He stated this quietly without any emotion or dramatization. Mood was "All right". He occasionally heard his name called in his head. At first he thought the trouble was "just nerves". He was definitely antagonistic in his attitude, but at the next interview the Jung free association test was done, giving the connections anxiety—pain—pity—shame—him—abuse—sin, giving a clue as to his sexual content. He gave an acccunt of masturbation from 11–13 with intense guilt; at 13 he tried to stop it, and with the increase of the conflict his symptoms started. During six interviews he was able to be reassured considerably by free discussion of sex. He had thought that he had injured himself by masturbation. He was able to return to work on his farm again, and six months later was still at work.

This hypochondriasis probably started as an anxiety attack, but later developed to the extreme quiet body concern common in some early schizophrenics.

CASE 24: *Sexual hypochondriasis in a schizophrenic.*

L. H—, æt. 20, is a boy of no occupation who presented himself at the venereal disease department complaining that he had syphilis and was referred to the Phipps Clinic on October 29, 1935. He had never been exposed to syphilis; physical examination was quite normal; W.R. was negative. His complaint was "discharge from the penis brought about by dreams of a sexual nature". These occurred about once a week, and he was convinced that they were a sign of syphilis, and was intensely worried about them. At 14 he had learned masturbation from another boy and began to practise it almost daily, with terrific guilt feelings. At 15 his mother found him at it and told him that he would die of syphilis if he continued the practice. He was unable to stop, and from then on was constantly watching his body for signs of syphilis. Any spot on his face he would consider to be syphilis; he read up much quack literature on syphilis and masturbation and was much concerned about his bodily condition. However he did well at school, and graduated from high-school at 19. He was good at academic subjects such as Latin and English, but played no games with other boys, had no friends, and preferred to day-dream alone. His ambition was to be a journalist, but on leaving school in June, 1934, he did nothing about it, living at home reading books on health, psychology and story-writing. Since leaving school he spent much time thinking about a completely autistic love affair with a girl he met at school. He arranged his walks so that he should meet her, but never dared to speak to her. This girl became his masturbation phantasy, but for the last two months he has stopped masturbation with a great effort. His attention then became more intensely focused on his body; he became quite sure he had syphilis, as nocturnal emissions still occurred.

There was no family history of mental illness. He is the youngest of two brothers. As a child he was quiet and reserved. He had nocturnal enuresis almost nightly until aged 16.

In the out-patient clinic he was a preoccupied, ashamed-looking boy, with blocking in speech. He looked suspicious, and had difficulty in concentrating. In addition to the syphilis from masturbation complaint he said people were looking at him on account of a scar on his face which he thought was syphilis. He was uneasy in crowds. He gave the wrong name (James Stewart, a name suggestive of royalty and romance), as he was afraid of his parents hearing of his syphilis.

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The Binet-Simon test showed a mental age of 14½. Sensorium tests were well done.

As the patient was asking for help, rapport was obtained and he was reassured about syphilis and masturbation, but the syphilis delusion remained. Attempts to get in touch with his parents failed.

He again attended the clinic on January 13, 1936, three months later, as he felt he had been helped previously. He gave his correct name, but did not want his parents to know of his attendance. His habit of life had not changed, although he did not seem as fixed in his syphilis delusion. He had been reading much psychology and quack literature on masturbation. His symptoms were auto-erotic ruminations and uneasiness in company. Verbal insight was remarkable. When asked what he thought the trouble was, said, " I suppose it's the guilt reaction from masturbation. Hypochondriasis is my chief trouble; it's imagining I'm going to be afflicted with some bad disease". However, as he spends his time analysing himself, this insight is not likely to help him. He was urged to get work at once and concentrate his ambitions on something he could achieve. In spite of his education this boy's workable assets are extremely meagre, and although the abnormalities are not very obvious he is definitely schizophrenic. The hypochondriasis here is of the purely symbolic, content-determined kind, related to masturbation fears.

CASE 25: *Sexual hypochondriasis in early schizophrenic reaction.*

An unemployed man, æt. 22, complaining of frequency of micturition and feelings of inadequacy. The only child of his mother, his father died paralysed two years ago. At school a behaviour problem; played truant; liked going in country with one boy friend; never went in a group. He was expelled from school at 16 for truancy and poor work. He has done short jobs since—job at printing, also cinema usher, but quarrelled with the boss one year ago, since when he has been unemployed, living at home with mother, reading magazines, no ambition. Particular about food; thinks he needs a lot of sweet things. Masturbation occurred from 13 onwards about once a week with considerable guilt.

On examination he was a somewhat apathetic youth, of shallow affect; does not look one in the face. He was worried about masturbation; feels people are looking at him; he is afraid to go anywhere. Insight poor; thinks it is due to bad circulation; thinks something is wrong with him sexually.

His mental age on the Binet scale was 17.6, with scattering from 12.

His actual body complaints were: " It seems that I have to force myself to pass water. I have been breaking out on my hand. My beard does not seem to grow right. I feel there is an obstruction in my penis. I don't think my erections are as strong as they should be. I am afraid that I will ruin myself with self-abuse. My skin is dry and I have a sharp pain behind the ear."

This hypochondriasis is obviously symbolic of the masturbation lore in which the patient thinks that he has castrated himself by masturbation. These troubles are told without any obvious anxiety or self-pity and quite unemotionally. It is interesting that this man came to the hospital through the urological clinic with the presenting symptom of difficulty in micturition, without any physical abnormality.

CASE 26: *Sexual hypochondriasis in schizophrenic.*

A man, æt. 31, who complains of innumerable bodily pains, dating from losing sex desire with a woman who wanted to marry him two-and-a-half years ago. In 1934 he lived at home doing nothing but keep snakes as a hobby, to watch people's reactions to them. Attended many hospitals, wandering over the continent, and hitch-hiked from Texas to Maryland for treatment. Nothing remembered of early history previous to probably hysterical attack at 16, in which he lay still for five days, on setting of sex difficulty. For next two years attacks of losing memory, especially when in car or train; first attack when driving to see mistress's child.

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On examination a vague, smiling young man; some scattering; feels tired and disgusted; complains of loss of sex power; feels people looking at him, saying he is crazy. Insight: thinks it all due to meningitis. Ambition to keep pets. All his working life has been spent doing odd jobs; fireman for short while in boat; wandering and doing any kind of labour until onset of illness.

His actual body complaints were: "Dizzy head like something buzzing; terrible headaches; it's the eyes and the nerve alongside my eyes. It's taken my passion away from me. My face is changed, my hair is grey and weak. My teeth are just like enlarged stones; there is not enough room for them; I have tried to pull them out."

This is a diffuse vague hypochondriasis, but in the main it symbolizes loss of manhood and is essentially sexual.

CASE 27: *Hypochondriasis in parergasic reactions.*

The patient, æt. 13, is the daughter of an extremely fanatical Minnanite Dutch woman of very rigid nervous personality who is constantly hostile to her husband on account of religious differences. The patient was admitted in August, 1935, with the complaint of irrational behaviour for three months. She was healthy but backward at school, where she went by the nickname of "Grandma". She got on well with other girls, but her interests were in the home, in needlework and housekeeping rather than at school. She was fairly obedient, but tended to be stubborn with her parents. Until a year ago she tended to side with her father in the home, but then she went to a revival meeting where she confessed her sins, and since then has been completely obedient to her mother, who now believes she is a true child of Christ. Her personality changed and she became a model girl. In March, 1935, she went to visit some friends, where she met a boy with whom some sexual incident occurred. In May, 1935, after a visit to a party where girls discussed going to high school she became preoccupied with the idea of high school, and became slow and obstinate. On one occasion she tried to light a lamp without a wick, saying, "I can make wicks". She would slowly smash windows, saying, "I can make windows", and similarly with fountain-pens. When told to tidy up, she would further disarrange her room. For several days she would not stop talking. She said that she wanted to lie in her aunt's grave, and that her mother's eyes were like those of someone dead. She would put her father's screw-driver to her left side and try to screw it in.

On examination she was a quiet, suspicious-looking girl, smiling to herself. There was much blocking before she answered questions. She felt children at school talked about her, and that people looked at her. She felt she was guided by the Holy Spirit and heard a quiet gentle voice of God and also that of the boy saying indecent things. Her bodily complaints were: "My teeth have been hollow; my head hurts; I guess it's my brain. My stomach gets gas on it; my feet go to sleep nearly all the time, and my left side hurts" (pointing to the left inguinal region). Absurdity recognition was poor. Her ambition was to become a nurse in order to help suffering.

This girl was probably somewhat feeble-minded before the onset of the present illness. The factors in the present condition seem to be (1) the conversion experience, (2) the family quarrels between the mother and father, and (3) the sex conflict. The diffuse hypochondriasis is almost impossible to analyse, but the pain in the left side in view of her peculiar behaviour with the screw-driver possibly has some symbolic sexual significance.

CASE 28: *Bizarre hypochondriasis in schizophrenic reaction.*

The patient, æt. 30, is a single engineer who, following marked concern over a rash which appeared on his legs after an evening in New York where sex play occurred at a dance, developed marked preoccupations of a bizarre, hypochondriacal nature, became dazed and anxious and heard voices talking to him from great distances.

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According to him, his difficulties began with his concern lest he had contracted venereal disease in May, 1934, though he had indulged only in sex play. A few days later a rash appeared on his body, and though it soon disappeared, he worried about it until the end of July. He changed his work to a more strenuous type. At this time the only girl he had been interested in refused him. He developed pain in the back, which spread into his abdomen and groins. A physician cystoscoped him and washed out both kidneys. This procedure disturbed the patient in a very unusual manner. He began to worry about his sexual capacity. His work seemed like a dream. On September 12 he began to get an idea that the two sides of his body were different, the right side strong, the left weak. He felt that he was changing his shape and becoming a woman. He felt he was composed of three people, one part a man, one part a woman and one part a boy. He felt that his mind controlled the possibility of choosing which of the three to be, but felt unable to make the choice. On September 15 he woke following an emission and felt desperately disturbed because he felt himself turning into a boy, his hands becoming immature. He gave up work; wandered around the streets. He became muddled and confused. He heard a voice talking to him which promised him he would get well. Dreams stirred him greatly. Following one on September 26, he felt his body become stiff and knew that he was dead. He thought the blood whirled around his body like a wriggling snake. He entered the clinic willingly on October 2. He immediately began to improve, said he no longer had any of his ideas and insisted on being released on October 28. On November 4 he went to a dance and again began to feel queer. Immediately all his preoccupations overwhelmed him. He saw visions at night. He returned to the hospital on November 8, feeling all in, hearing the voices of friends in New England advise him and read his letters. He thought his body was falling apart, the skin had rolled off his arms, and people were influencing him by prayers. Since admission he has again shown immediate improvement. There is at present no further talk of hearing voices.

He was born in New England in 1904. His mother died nine days after his birth, and he was taken into the home of an uncle and aunt, who spoiled him. He rarely saw his own father again. As an only child he had few playmates, and developed the capacity to amuse himself by imaginative and solitary games. At 14, following the onset of masturbation and severe guilt reaction, he had a six-months' period of imagining his blood being turned into a snake, etc., but never had to drop out of school. At a polytechnic college he failed his second and third years and had a recurrence of exhaustion and peculiar sensations all over his body, which subsided in a few weeks. He obtained his engineering degree in 1926. He went to work with a railroad, and had at the same time the care of his helpless, paralysed foster-mother, who had become exacting and querulous. He invented a wheel-chair, which he sold with some success. When he refused to give up his foster-mother, the girl with whom he was in love would not marry him. In 1932 he lost his job. In January, 1933, he had influenza and transmitted it to his foster-mother, who died suddenly. He felt ill and depressed following the funeral and found himself very much alone, without friends. In February, 1934, he secured work as a skilled labourer. It was in the setting of a change of work to a railroad in Baltimore that he became acutely upset.

He was found to be a tall individual of asthenic-athletic habitus. Speech is somewhat slurred. Abdominal reflexes absent. Blood bromide 60 mgrm. Slight right facial weakness.

The patient's father was emotionally unstable. He disappeared on his wedding-day and was not heard of for some months, when he was found suffering from amnesia. The father is still living and re-married, and shows no interest in the patient. A maternal grandfather had a mental breakdown, and was hospitalized and recovered. One cousin is very nervous.

The patient throughout his life has been untidy, clumsy, easily led and easily becomes preoccupied. He day-dreams a great deal. Although friendly in nature, he has few friends.

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This is a particularly interesting example of hypochondriasis. The chief complaints were: "I haven't been feeling good. I have a pain in my back; my stomach has changed it's shape. The fluid has gone out of my testicle into my rectum. My private parts have turned numb and pink. I feel as if snakes were running all over me. My left breast has swollen like a woman's. The left side of my body is a woman, the right side a man and my privates are a little boy." He also complained that there was a snake in his belly and that he had various pains in his head and chest. He said his voice was changing, that his beard was becoming softer, and that his hands were becoming less square. On one occasion he said that a litter of kittens was coming out of his left breast. All this was told quite unemotionally without any suggestion of self-pity or dramatization. It was obviously content determined, and appears to a large extent to be symbolic. Thus the ideas of losing his manhood, expressed so vividly in the hypochondriasis, are probably part of the common masturbation lore in which the individual thinks he injures himself and loses his potency as a result of masturbation. It is interesting that at the age of 15 when he started masturbation he developed to a small extent the same type of hypochondriasis. At 20 in a setting of difficulty with examinations he developed burning sensations all over his body, and he appears to have expressed his difficulties always in the form of body sensations. Particularly important is the fact that his presenting symptom was pain in the back spreading throughout his whole body, which lasted for two months, in a setting of changing his job and loneliness. Doubtless at this time a psychiatric examination would have revealed the fact that this pain was psychogenic rather than physical in origin. Unfortunately he was examined by means of cystoscopy, which the patient obviously interpreted as a sexual assault.

CASE 29: *Depression with symbolic hypochondriasis.*

Mr. S. F—, æt. 55, is a lawyer, with a family history of depression in his mother, and a past history of a depression at the age of 29 for one year, who developed depressions with delusions of poverty and guilt, with vague bodily preoccupations after marrying for the first time in June, 1934, in which he proved impotent following an indefinite period of depression after the death of his closest friend. Previous to this his interests had been those of a fairly settled bachelor, with an especial affection for his nephew. Alcoholism lasted many years, and stopped in October, 1934. On admission he showed depression without retardation, considerable eloquence, delusions of poverty and guilt, preoccupation with his body and impotence. Since admission he has shown a crystallization of his preoccupations, first into a fear of syphilis, and finally certainty of syphilis. Bodily preoccupations predominate over all else. His complaints were: "This is the end of me; my arms are all flabby, my face is altered, my teeth are like cesspools; I have no strength at all. Impotence is extending all over to my brain. I have allowed my blood to get rank; it is full of filth. Someone must answer for my syphilitic infection; I am infecting the whole world with syphilis." In addition he was suspicious of other patients tampering with his property and believed that the food was drugged. In the clinic he did badly, and on discharge to another hospital showed no signs of improving.

This hypochondriasis is in part consistent with the mood of depression, but to a large extent it symbolizes his impotence. The syphilis delusion probably represents guilt feelings, but this is also consistent with the self-reproach of depression. A year after discharge he regards himself as being dead, but is not particularly anxious, agitated or depressed, nor has he any other hypochondriasis.

CASE 30: *Nihilistic hypochondriasis in depression.*

Mr. E. M—, æt. 47, a married decorator, admitted on November 25, 1934, complaining of restlessness, constipation, insomnia, depression, hopelessness. He was deeply depressed and suicidal. For the past four years business had done badly, and in March, 1934, after a few months of depression and anxiety, he felt

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that something snapped in his head, after which he felt quite hopeless. " The sky, the ground, nothing looks the same for me. There is no hope at all; I am just dead inside. I am cursed by the Almighty." During three months at a hospital he became paranoid towards other patients, thinking that spies were set to watch him, but in this clinic no paranoid features were seen. The family history is not significant. His personality was sensitive, over-critical of himself, perfectionistic and easily worried. At 24 he had had a previous depression for six months, but without the " deadness " of the present one, in a setting of financial difficulty. He was never able to stand responsibility, and responsibility of starting a business on his own six years ago was the chief factor in ætiology. He is happily married, with two children, and there were no sex difficulties.

In the clinic he was agitated; his mood statement was " Hopeless; I just think of failure ". The depression was of a smiling kind, he was suicidal, and there was no retardation. He had from time to time definite hypochondriacal complaints such as: " I have pain all down my backbone; there are no nerves in my spine; a constant pain. It is because I have not faced my troubles with sufficient backbone. Something is gripping my heart. The Almighty has punished me." These were all appropriate to the depression, and may be called nihilistic body ideas—common in cases such as this which have the features of involutional melancholia as described by Hoch and MacCurdy. The " no backbone " idea, in which the pain in the backbone symbolizes the patient's self-reproach for having no backbone in facing his difficulties, is also a very characteristic depressive form of symbolic hypochondriasis, consistent with the mood. The bodily complaints were present with considerable anxiety and agitation. This patient was discharged after six months in the clinic somewhat improved, but still nihilistic and depressed. Since discharge he has been able to work adequately on a farm for psychiatric patients.

A year after discharge he was able to live at home and almost return to his normal life and personality. It is possible that in time his recovery may be complete. The nihilistic tendencies here seem to have prolonged but not rendered permanent the depression.

CASE 31: *Hypochondriasis consistent with mood in depression.*

Mrs. S—, æt. 37, is the wife of a successful southern merchant, and was admitted to the clinic on November 8, 1935. There is a family history of depressions in her father and one brother. During the summer of 1935 she became worried lest her child catch infantile paralysis and she began to lose weight. In October she developed temporary fear of cancer following cutting her finger. On October 20 she became intensely worried about the school promotion of her child. She became frankly depressed with symptoms of insomnia, increased constipation and general bodily preoccupation. The youngest in her family, as a child she was somewhat spoiled and regarded as ailing by her mother, without any obvious cause. Her personality was cheerful, but easily worried by small difficulties, reserved and with no interest apart from her child, and she was always concerned about her body. An uneventful school and college life was followed by an intense fear of tuberculosis at the age of 22, in a setting of deciding whether to become a teacher. At 23 she married a very kind and indulgent man who has preserved her from all responsibility, and the married life has been happy. At 25, when pregnant with her only child, she had pernicious vomiting of pregnancy, and she had a delayed convalescence from the labour. At 35 she stayed in bed for a month to gain weight.

In the clinic she showed at first self-pity, worry about her child, antagonism to the hospital and home-sickness, and a mood statement of feeling blue. Her complaint was: " My body is run down; I don't digest well. I can't sleep at all." She stated her complaints with much weeping, anxiety and depression. There was definite increase in depression in the mornings. She had some depressive ideas of reference that other patients were saying unpleasant things about her

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and her poor health. Her topic of worry varies from day to day. For a few days all her attention and complaints were focused on her slight hæmorrhoids, but when these were treated her attention became concentrated on her menstrual period, which she considered was not as profuse as it should have been. These gave place to equally intense worry about home-sickness. Under treatment of reassurance, occupational therapy and ward routine she improved steadily and was able to recognize her own improvement. Later treatment is being directed to increasing her interests and enabling her to control her mood swings.

This hypochondriasis is entirely consistent with the depressive mood, and did not become fixed in any symbolic system. Her previous personality was obviously very body-sensitive. In addition, there was an element of using the hypochondriasis as a means to gain sympathy.

CASE 32: *Persistent hypochondriasis in depression.*

Mr. J—, æt. 50, is a Jewish clothing designer, admitted in March complaining of difficulty in swallowing, weakness and rectal preoccupation. He is the eldest of five siblings, two of whom have had depressions in setting of financial difficulty. He had gonorrhœa at 20, and an operation for fistula-in-ano in 1926. He had a successful business career, earning about $500 a week. He married at 26, and does not appear to have got on well with his wife, as sexual promiscuity occurred after marriage, the last episode, four years previously, being followed by impotence. His personality was conscientious, secretive, hard-working, perfectionistic, pessimistic, suspicious, interested in and particular about his body. His interests apart from work were mainly club life. There was alcoholism for fifteen years, greatly increased in 1933. In January, 1933, following a financial loss he became anxious, worried and irritable with insomnia. He became frankly depressed with an episode of agitation in November, 1933. This was followed by many bodily symptoms and medical consultations. The depression lessened in intensity and he became afraid of germs, suspicious that people were injuring his business, very faddy about food, and diffusely hypochondriacal. He improved greatly during a short stay in an institution in the fall of 1934, but relapsed at home under the inefficient and fussy treatment of his wife. In December, 1934, he became preoccupied with his rectum and dirty in his habits. On examination he shows a diffuse hypochondriasis, depression of a dry type, no retardation, intense rectal preoccupation, worry about impotence, fear of germs and association with other patients. The paranoid features were not as marked as they had been previously. Sensorium performance was good.

Physically he showed a healed fistula-in-ano, and a raised blood-sugar curve. He objected to washing, was partially incontinent of fæces, and constantly belched and passed flatus. His complaints were: "My fistula is corrupting my privates, it has corrupted my whole being. I have not got the strength to swallow. I feel pretty weak round my heart; my blood is very poor; I always have a saliva taste in my mouth; passing urine is not controlled."

His mood was—"I feel a bit depressed"; however his behaviour was not deeply depressed, and his original mood of depression was almost completely lost in the condition of interest in his body complaint, but there was still some anxiety present.

This hypochondriasis is partly symbolic of his impotence, as in his complaint of the rectum corrupting his genitals, but it is also a diffuse, nihilistic body concern consistent with his previous personality, and with original depression. In the hospital, cleanliness and routine occupational therapy were enforced, and in addition he was given relaxation exercises and direct suggestion, which controlled his incontinence for a while. On discharge after four months, however, his mental condition was essentially unchanged, and no real improvement has occurred since.

CASE 33: *Eye complaint in depression.*

The patient, æt. 48, is a married Jewish business man, admitted April 6, 1935, in his fourth depression. In 1921 worried about his business; he was depressed

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about one year and made a suicidal attempt. Following this he was elated for one year. In 1924 he was depressed for six months. In 1926 he was depressed for eight months. In 1929 became elated for three years.

The present illness began early in 1934, following promotion to a position of responsibility in 1933. Although fulfilling his duties excellently, he had misgivings about his capabilities. In February, 1934, he seemed quieter than usual; talked only of business. In May, 1934, following a reprimand he feared he would not hold his job, became depressed and anxious, and slept poorly. In October, 1934, his firm was involved in a lawsuit. When advised by his lawyers to perjure himself, he became exceedingly agitated, worried and depressed. He turned to Christian Science and improved throughout November and December, but in January, 1935, became worse, indecisive, restless, lost confidence in himself, said he could not think and that his memory was poor. In February he consulted a physician, who diagnosed glandular insufficiency and gave him daily injections of testicular extract. He became worse, and in March drank rubbing-alcohol with suicidal intent. He then reproached himself for the attempt and insisted he had ruined his eyes by it. On admission he said, "My melancholy is so deep that I feel hopeless of recovery". He was deliberate, worried, and reproached himself for having left work and for his lack of sex drive. He claimed he had injured his eyes. Sensorium tests were well done.

Physical examination revealed a spare, asthenic man who lacked muscle tone; sluggish reflexes. The eye consultant was able to reassure him to some extent, but he still complains of his eyes. He feels better toward evening; is somewhat agitated in the mornings. He has slowly improved, pulse is more regular, sleep is better, but there is still early morning awakening.

He was born in 1885, the fifth of a family of six. He was his mother's favourite. She impressed early upon him the need to be ambitious. At school he did well in all his subjects, was good at athletics, and became president of his class. He worked in the evenings to save money for college and graduated from law school at 22. Since the age of 17 he has had occasional periods of fear of choking. At 22 he became a salesman, and did so well that in four years he was promoted to vice-president. At 30 he rather impulsively married because he felt he should be married. Premature ejaculations and occasional impotence marred his adjustment. They were unable to have children. At 35 (1920) he set up his own business, and became elated for a year. He did the work of a superman. After a year, 1921, he lost confidence in his business, was depressed, wrote letters of apology to his previous boss, and almost succeeded in hanging himself. After a year of this he became elated for one year, during which time he built up a successful business, became interested in the League of Nations, wrote letters to the rulers of Europe. Again in 1924, when business was bad, he became depressed, was out of work six months, and hospitalized four. In 1928 in his third depression he was out of work six months, after his business had gone into receivership. In 1929 while still depressed he was given a good job and rapidly became elated. He remained elated from 1929–32, doing excellent work, and was well from 1932 until the onset of the present illness.

His personality is over-conscientious, industrious, scrupulously honest, egotistical, could not endure criticism, rarely confided in anyone.

His father died of a stroke at 84. His mother, æt. 82, has always been tense and worrisome. An older brother had a depression lasting several months at 27 following financial worries. Another brother had two depressions, one at 22 following a hand operation, one at 40 following financial worry, and lasting a few months. One sister has phases of extreme worry and agitation at her menses. Two other sisters are highly-strung and worriers. Two maternal aunts committed suicide in depressions.

The eye complaint was the only hypochondriacal feature in this case. He said that his suicidal attempt had injured a nerve in his throat, and this had affected his eyes, and that the eye condition stopped him sleeping. He said that his eyes have changed and become weak and that others noticed the change in

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his eyes. About this eye complaint he said, " Perhaps I have mutilated myself in some way; I'm afraid my mentality is broken down and my eyes won't function ". He was obviously much worried by this eye complaint. Several accounts may be given of this:

(1) He may logically fear blindness in view of the known toxic effect of methyl alcohol on the eyes, but his explanation was much more indirect than this, and moreover, he was unable to be reassured by the eye consultant.

(2) The eye complaint may represent his guilt reaction to the suicidal attempt.

(3) It may be in relation to some sexual guilt reaction as well, as he uses the strong expression, " I may have mutilated myself ", and moreover, impotence is definitely one of his complaints. Dr. Greenacre in her paper on the eye complaint emphasizes that it is often an expression of guilt, frequently of a sexual kind, and here the eye complaint is curiously linked with the throat. During a year in the clinic the depression improved somewhat, but the fixed idea about his eyes remained. The eye complaint cannot be said to have been fully analysed, but it seems probable that it is symbolical of a guilt reaction either to the suicide or something else.

CASE 34: *Persistent hypochondriasis in an elderly man following a depression.*

Mr. P—, æt. 61, is a man in a depressive rut with inability to recognize improvement.

For the past three years he has been under heavy strain of responsibility caring for his deceased brother's family. He felt at times unable to carry the burden. His appetite and sleep became poor and he resorted to large quantities of alcohol. In June, 1933, he had shingles following a period of rather heavy whisky-drinking. He was out of work for three weeks, then became overactive, elated, in high spirits, profane, spent money freely, endorsed notes for all who asked, travelled a lot, neglected his work, slept very little and was always on the go. Six months before admission he became "blue" and miserable and complained of feeling tired out. He appeared depressed and brooding. He believed he had a cancer and that he would not get well. He became more and more agitated and was unable to work. He complained of feeling dazed and crazy, was afraid of the dark, expressed the fear that his food was poisoned and threatened suicide.

When he entered the hospital he was agitated, restless, could not sleep, insisted that he had a cancer in his stomach, was constipated and worried about finances and his job. Throughout his nine months in hospital he has shown objective improvement; sleep has improved. The patient himself is unable to admit any improvement. In spite of evident improvement he has developed the idea that grease is put over his face at night, that something is put into his eyes, that his face is changing due to vaseline that " they rub on my face ". Although he has become progressively more cheerful, he is convinced that he has cancer and that the skin of his face is falling off. He believes he is given ether at night to make him sleep. In the past month he has shown less concern about his body and more concern for the family situation.

He is of athletic habitus. At first he was under-weight, but he has gained considerably and is now over-weight. There were coarse tremors of the outstretched fingers, hyperactive knee-jerks. Blood-pressure 144/80. Mild peripheral arteriosclerosis. Eye-grounds showed evidence of slight arteriosclerosis with hypertension.

He had a normal childhood. From 13 until 22 he complained of pain in his side, which was diagnosed as chronic appendicitis and an appendectomy performed. Subsequently a hernia was repaired at the site of the old scar. He has had a good work record, has steadily advanced and makes a comfortable income. Throughout his life he suffered from constipation, and showed considerable concern about his gastro-intestinal tract. For forty years has consumed steadily a considerable amount of alcohol, although he has never been drunk. He has never married.

He has been pleasant, honest, courteous, sympathetic, sensitive and apt to hold grudges; very apprehensive at the prospect of new responsibilities.

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Father died at 75 of senile gangrene of the foot. He was an alcoholic. A paternal aunt spent one year in a hospital with a diagnosis of melancholia. The entire family have had hypertension. One brother is described as nervous and despondent.

This patient appears to have been hypochondriacal since the age of 14, complaining of vague abdominal pain, which caused him to have three abdominal operations. He was always very particular about his diet and the care of his body, being of the body-sensitive type of personality. When his depression occurred he interpreted his discomfort as body pain, which in turn he considered to be cancer—a hypochondriacal content which was consistent with the mood.

During his stay in the hospital the depressed mood disappeared, but the fixed idea that he had cancer not only in his stomach but over his back remained, and on noticing a little exudate round his eyes in the mornings, interpreted it as drops put in by other patients to make him blind. These paranoid and hypochondriacal ideas became quite fixed, but did not seem to interfere with his enjoyment at all. He remained a neat, well-behaved old gentleman, and was able to be discharged home, where he lived a leisurely club life in a small town, perfectly adequately, though when asked how he was, would always reply with a smile that he had cancer. This case shows how the hypochondriasis occurring in a depression at the so-called involutional period, may long outlast the depression, but with the decline of the mood disturbance may still be consistent wlth normal life. In the depression a body sensation becomes a pain, a pain enters the content as a cancer, consistent with mood, but once having entered the content and the hypochondriacal delusion being formed, it becomes established independent of the mood, and the cancer delusion may persist even with a completely inappropriate mood of cheerfulness.

CASE 35: *Long-standing hypochondriasis with a depression.*

Mr. B. R—, æt. 48, a farmer, was admitted to the Phipps Clinic on September 7, 1934, complaining of depression, restlessness and agitation and many body complaints. In the family history a paternal aunt committed suicide. As a child he was much attached to his mother, who was replaced when he was 14 by an unsatisfactory stepmother. He had nocturnal enuresis up to the age of 11. Following promiscuity with negresses, at 20 he made an unsatisfactory marriage with a woman ten years his senior. No sexual intercourse has occurred since 1935, as his wife refused it, and since then he has practised masturbation.

His personality is described as miserly, conscientious, hard-working and irritable. He was an efficient farmer.

At the age of 30, following pneumonia, and in a setting of disagreement with his wife, he felt weak and depressed. He attended many doctors, was admitted to eight different hospitals, and was treated by tonsillectomy, appendectomy, excision of varicocele, bromide medication and many cystoscopies. After three years of this he was admitted to the Phipps Clinic in 1921 complaining of pain in the back, aching all over, pain in the root of the penis, shortness of breath, and he was diagnosed as suffering from an anxiety state. His hypochondriasis at this time was mainly centred on his bladder and penis. After a month he discharged himself, but worked well on his farm with one interval for cystoscopy, which he seemed to like, until 1933. In 1933, at age of 46, he became very depressed after an attack of " flu ". For this and his hypochondriasis he was re-admitted in March, 1933, but was discharged somewhat improved. In October, 1933, he started another round of hospitals for his genito-urinary and abdominal complaints. He was usually fairly happy in the hospitals, but relapsed as soon as he returned to his wife. His gall-bladder was removed in March, 1934. He made a delayed recovery from this. When admitted on September 7, 1934, he was tearful and depressed. His talk showed no spontaneity except about his complaints. His spirits were " pretty low ", and worse in the mornings. The only content was hypochondriacal, pains and aches in arms and hips, terrible pain between the

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shoulders, gas in the stomach, pains in the head, and pains at the base of the bladder. These were all mentioned with self-pity and dramatization. Sensorium tests were well done. The Binet-Simon test showed (when the depression had subsided) a mental age of 10 years. Physically he is a pyknic, well-nourished man. There was œdema of the ankles, but no cardiac signs or abnormality to renal function tests so that it probably was local.

In the hospital the depression diminished and he slept and worked well, but had no initiative for any but routine occupations. When his return home was suggested his hypochondriasis became more marked, and he had an attack in which he lay on his bed, said he could not walk, complained of terrible pains in the back and in his bladder. This was intensely dramatized, and even resembled a hysterical attack. When reassured and told to get up he did so. On another occasion after return was suggested he had a temper tantrum and tried to throw a chair at an attendant. This behaviour and the hypochondriasis had become definitely purposive, in order that he should still appear ill and remain in the hospital. As no progress was being made, and return home was out of the question, he was transferred to a State hospital, where he has worked fairly happily.

This hypochondriasis seems to have originally been on an anxiety basis, with sexual maladjustment, and then it provided the appropriate content for a depression, and finally when true depressive features disappeared, it remained as a purposive or merergasic hypochondriasis, serving the purpose of ensuring hospitalization.

CASE 36: *Hypochondriasis in depression with paranoid tendencies.*

Miss F. W—, æt. 61, is an unmarried ex-dancing teacher admitted in June, 1935, in her fifth depression. Her first had occurred at the age of 43, following an unhappy love affair, and the others had occurred in various settings of financial and family difficulty. The present one occurs in a setting of looking after her invalid aunt. In the family history there are three very proud independent, reserved, suspicious, siblings, and similar personality in her father and the patient, but no definite mental illness. She led a fairly leisurely life, interested chiefly in riding, until æt. 35, when she took up teaching dancing. She has always been concerned about her body condition. Her depressions have been characterized by a paranoid attitude, feeling that people have been doing things to irritate her, that others were talking about her, and each depression lasted about a year.

The present illness, dating from April, 1935, showed insomnia, constipation, depression, inability to concentrate and make decisions, loss of weight, extreme irritability. She was a tall, well-preserved, lean, haughty-looking woman, with very little arteriosclerosis and no evidence of senility. Her bodily complaints were: "My kidneys don't work right. Nothing about my body is good. I never have a natural movement. I'm worried about my stomach. The inside of my mouth and lips is raw. I feel the doctors are not doing as much as they should for me." These complaints would be aggressively stated, in her more depressed periods, and she definitely adopted the attitude that it's the doctor's job to put these right at once, otherwise he's no good. Her whole attitude was slightly paranoid, that other patients tried to irritate her, that everything was made difficult for her and no one took any trouble to help her. It was put to her that her more cheerful periods when she had no complaint would steadily increase as she took more part in ward activities. Gradually her aversion to the hospital and peevishness died down, and during eight months in the hospital her normal fairly cheerful personality was regained, and the body complaints ceased.

This hypochondriasis is interesting in that it is a depressive body complaint, consistent with the mood, but in addition it is used as a form of self-assertion against the hospital in accordance with the somewhat paranoid tendency of her personality. The tendency for an exaggerated body attitude has probably existed since her youth. This case shows hypochondriasis, and peevishness in an elderly woman, and yet recovers perfectly, contrary to what Hoch and MacCurdy's definition of involutional melancholia would lead one to expect.

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CASE 37: *Depression with anxious hypochondriasis.*

Mr. K. I—, æt. 49, is a married Jewish store-keeper, with a family history of depression in his mother and uncle, who has led a fairly smooth successful life until his father's death in 1928 and his own bankruptcy in 1930, since when he has had more responsibility and business worries. He is anxious about his son's education, but unable to spare him from business. In September, 1934, he became unable to make decisions, lost sex desire, became depressed, preoccupied with his mother's suicide, and afraid of getting what he called the " blues ".

His previous personality was secretive, reserved, hard-working, with no outside interests. He was never able to express himself in letters. On examination, he was profoundly depressed, but smiling, and able to slur over his depression, very evasive and reserved, with various bodily complaints, such as headache, stomach-ache and feelings of general weakness. Preoccupied with suicide and with his mother's death and business worries. His bodily complaints were: "Head feels as though I had a tight cap on; I have a pain in my heart; something is wrong with my body. I feel bad; nothing is worth while ".

During the year at the Phipps Clinic he showed no change or improvement, possibly because his business went bankrupt and he had heavy sickness insurance. The body complaints here are secondary to the mood of anxious depression. The feeling of a tight band round the head seems to be a fairly common statement in very tense patients.

CASE 38: *Hypochondriasis in depression, on a basis of sexual maladjustment.*

Mrs. F. F—, æt. 40, is a farmer's wife admitted to the clinic August 15, 1935, with the complaint of feeling blue, and of pains in her back. The family history shows one sister with numerous bodily complaints and a worrying disposition and a maternal uncle with depression. Early history was uneventful. She was the sixth of a family of eight, and did well at school. She developed an over-conscientious, worrying personality, very neat and orderly, seclusive, sensitive and reserved, but with a few friends. At 18 she married a hard-working farmer whose only interest was in making money, and since marriage she has done little but look after the home very efficiently and worry about her children. Menses were irregular all her life, usually painful, and started at 14. Sexual intercourse was satisfactory until the birth of her last child, four years before admission, during which she had considerable difficulty and vomiting. Since then she has been frigid; at the same time she began to complain of various bodily aches and pains, such as pain in her side, feeling weak, and occasionally attacks of breathlessness and palpitations. This continued until the fall of 1934. Meanwhile she worked conscientiously and excessively about the house. She then began to attend many doctors, faith-healers and bone-setters, without any improvement. In May, 1935, following a bone-setter's manipulation, she said she felt weak and sick, and that she was paralysed. She remained at home as a complete invalid. She became very depressed, tearful, lost weight, was easily irritated, unable to make decisions, suffered from early morning wakening and was constantly worried about details and finances. On admission to the hospital she was a prematurely aged, worried, depressed-looking woman, and intensely self-pitying. She gave a mood statement of feeling blue and nervous, was worried about her home and children, and somewhat resentful against her sister, who she felt did not sympathize with her enough, and against her husband, who she considered bossed her too much.

Complaints were of pain in the stomach, eyes feeling swollen and heavy. " A kind of drawing in my head; misery in my back; my heart seems to bother me. I've not been strong since my child. My heart seems to beat so fast; the leaders hurt in the back of my neck. I have a lot of gas in my stomach; it chokes me. I worry about everything." Memory, orientation and calculation were normally performed. She considered the trouble to be due to some physical illness, and said that she needed quiet and rest.

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On physical examination she was a thin, athletic woman, blood-pressure 110/76; there were internal and external piles. W.R. was negative, blood-count and blood-chemistry normal. At first she was given continuous baths and 0·5 grm. of barbital nightly for her sleep, and persuaded to take part in the occupational therapy with the other patients. In a month her depression was considerably improved, and she was able to sleep without sedatives. The hypochondriasis, however, persisted, varying in intensity from day to day, being markedly worse whenever she was worried about anything, such as not receiving letters from home. In the discussions she gave with some reluctance a history of her sexual difficulties since the birth of her last child. She had been afraid of pregnancy, and her husband had practised coitus interruptus without any satisfaction to her about four times a week, after which she had been accustomed to lie awake in an agitated and resentful state for the rest of the night. She had grown to resent her husband's domination of her and his not allowing her any outside interests. In addition, she gave an account of a family quarrel with her sister. She had from time to time dreams of catastrophes of her children being killed, or her husband, and sometimes of throwing herself over a cliff. There were also some suicidal thoughts. After three months in the clinic she began to complain of her piles and to focus all her bodily complaints on them, which she considered the source of the trouble. These were successfully removed by operation under avertin and gas on December 5. After the operation she showed a very great reluctance to recovery, and adopted a martyr-like attitude, craving sympathy from everyone. Her bodily complaints were not diminished, and the depression returned with suicidal ideas. On December 23 after some improvement she was taken home against advice, but was given birth-control and sexual instruction.

Here the hypochondriasis seems to have arisen in a setting of anxiety about her sexual ill-adjustment and her fear of pregnancy, together with a slightly purposive element, in that this was the only way she could dominate and gain the sympathy of her husband. Definite anxiety attacks with palpitations and breathlessness appear to have occurred at the beginning of the hypochondriasis. Though the depression here was undoubtedly a mild one, yet the previous existence of hypochondriasis appears to prolong the depression. The effect of the operation here was particularly interesting, in that she took the opportunity to relapse again into complete invalidism, although the need for distracting her attention from her own body was emphasized to her as a means of avoiding pain and uncomfortable body sensations.

CASE 39: *Hypochondriasis in hypomanic reaction.*

Miss P. A—, æt. 24, is a music student who was admitted on August 3, 1935, with the complaint from her parents that she was over-talkative, overactive and indiscreet.

She is the eldest daughter of a successful lawyer of aggressive personality and a past history of alcoholism, her mother is very voluble, fussy, excitable and hypochondriacal, and once had to be admitted to a psychiatric hospital; her parents constantly quarrel.

As a child she was much attracted to her mother, until when she was 8 a sister was born and she had a violent jealousy reaction, hated her mother, and began to lie, steal and have temper tantrums. She stole first from her sister's nurse, then her mother, and finally at 15 from other girls at school, with the motive of buying cosmetics so that she should not be considered a child. At school, however, she did well, was very bright and intelligent, and showed special musical talent. She often stayed away from school for various aches and abdominal discomfort, which her mother would make a great fuss of. However, she annoyed other girls by her aggressiveness and bad temper. At 15 she simulated an abdominal pain in order to avoid athletics in a summer camp. It was diagnosed as appendicitis, a laparotomy was done and her ovaries were suspended. Since this she

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complained of dragging pains in the abdomen, and had frequent attacks of nausea. Nausea would occur in any difficulty, such as an examination at school, which she was able to avoid by this means. After leaving school at 20 she had two years as a debutante, during which she had an unsuccessful love affair, and at 22 went to a New York music school, where she did well, but after six months, in April, 1934, was tearful and complained of nausea before an examination, which she passed. In June, 1934, complaining of abdominal pain, she was put to bed for a month. From September to January, 1935, she became depressed, tearful, had no confidence in herself, and was fitted with a special corset for her abdominal complaints. In October, 1935, her spirits began to rise, her voice was better than ever before, and by June she was giving innumerable parties, talking loudly entirely about herself, not sleeping, over-drinking and over-smoking, was sexually excited and indiscreet, had several love affairs at once, including one with another woman, and finally had to be admitted to the clinic.

On admission she presented a typical hypomanic picture with press of talk, activity, restlessness, aggressiveness, distractibility, rapid association of ideas, constant boasting. She was facetious, with frequent giggling infectious laughter. Sensorium performance was excellent and she was obviously highly intelligent. Her mood showed very rapid changes, from elation with laughter to sadness and weeping, and frequent anger outbursts. Although definitely hypomanic, she showed as much depression as elation. Bodily complaints were frequent; she was very body-sensitive and constantly watched her body sensations. These consisted of (1) a feeling of her insides falling out: this was generally an expression of vaginal sensitivity and excitement when she wished for a vaginal examination; (2) pain in the left shoulder; (3) pain in left breast; (4) headaches; (5) intense dramatization of menstrual cramps. These complaints occurred usually in her depressed periods and seemed to have mostly the motive of attracting attention. On one occasion they occurred before a dancing class she wished to avoid. The complaints were always made dramatically and self-pityingly. There was no physical basis found for them, and she was usually fairly easily reassured for the time, and would forget them for considerable periods. The hypomanic phase gradually died down and the emotional instability improved during six months in the clinic, the hypochondriasis becoming less marked. Treatment has been directed to attempting to lessen her extreme attention to her body.

This is an almost purposive hypochondriasis, a habit of complaint which developed when the patient was a child, and persisted through a hypomanic attack, but is not to be regarded as a symptom of it. She early seems to have learned to use a body complaint, many of which must have been suggested by her mother. As she is young and intelligent her faulty body attitude is definitely improvable by psychotherapy.

CASE 40: *Malignant hypochondriasis.*

Mr. R. B—, æt. 38, is a married clerk, in his fourth mental illness. Family history shows a dominant mother, excitable, worrying sibling, and schizophrenia in a cousin. The youngest child of his mother, on whom he became very dependent, and has remained so all his life. After a strictly religious upbringing, he masturbated from 12–17 with great guilt feelings, and appears to have encountered suggestions that syphilis, masturbation and insanity were connected.

At 19 he had a breakdown at college in a setting of worrying about being a preacher. In this he thought he was losing his mind from masturbation, but he recovered after a few months. At 21 when starting work as bank clerk he had a similar illness, and again at 25 when trying to start business for himself he became intensely worried about his bowels. From 1921–1935 he worked successfully as clerk in an office. He married in 1923, with no great marital difficulties. His personality is shy, quiet, hardworking, conscientious, easily worried, dependent on his womenfolks, with no close friends. He is religious and of rigid moral code. He always regarded himself as a weakling. Since 1929 he lost his own and friends'

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money on the stock exchange, and reproached himself on this account. In 1933 he attempted to atone for this by taking up sick-visiting, Sunday school and sending birthday cards. In May, 1934, he became depressed and started fear of cancer. In September this changed from certainty of cancer to certainty of syphilis.

On examination in the clinic on April 26, 1935, he was seen to be a well-behaved, co-operative man of asthenic habitus. Blood-pressure was 110/70, his muscles were flabby, and tendon reflexes sluggish. His mood statement was low, but his expression and behaviour was by no means depressed. He had a varied series of bodily complaints. "I feel that I am going to die; I have no kidneys; my rectum is as tight as a drum; when I open my bowels there is no volume. My flesh is all flabby. I used to have a cancerous growth, but that has been corrupted away by syphilis. My sexual organs are shrivelled away; I have lost my manhood. My whole body is greasy, and what I eat comes through the pores of my skin. There is something wrong with my blood. I have no pulse. Syphilis from masturbation, that's what it is." All this was told with a pleasant smile, and his affect seemed shallow and by no means appropriate to such content. His sensorium was good, but insight completely lacking. Performance in the absurdity test was poor. He was unable to recognize any improvement, and his content remained essentially the same during four months' stay in the hospital. He was treated with occupational therapy and ward routine, and in the discussions he was urged not to reiterate his complaints, but to concentrate on performance and utilization of his assets, which had been considerable. On discharge after four months there was essentially no change in his condition.

This case may be regarded as a hypochondriacal rut-formation in a depression or as a recurrence of a schizophrenic reaction which he had in his youth, and in which the content was much the same as in the present illness. However, the central feature of the case is the hypochondriasis, which is in the main symbolic of castration through masturbation, although in part, as in the cancer delusion, it might have been consistent with a depression at the onset of the illness. It seems unnecessary to attempt to fit this case into the group of either schizophrenia or depression, but rather to regard it as a very rigid hypochondriasis, which tends to get neither better nor worse.

CASE 41: *Acute hypochondriacal panic with depressive and schizophrenic features.*

This patient was admitted in February, 1935, complaining that he had tuberculosis, and that every organ in his body was diseased.

He is a school-boy, æt. 18. In April, 1932, his father killed his mother and committed suicide. Although he fainted at his mother's funeral he recovered from this shock and returned to boarding-school. He did moderately well, although the work and discipline was hard. In the fall of 1934 he was somewhat bullied by the boys, on account of his fatness and egotistical disposition. In December, 1934, he caught a cold and thought it was tuberculosis, and said that he felt the left side of his body was hollow. Whenever he passed a mirror he would open his mouth and look at his throat. He returned to school, however, in January, and on arrival was in bed six days with influenza. After this he complained of loss of strength and general malaise, that he could not concentrate, and that he was behind in his studies. He took his work very seriously, kept away from the other boys, but was unable to study. He ate very little, thought that the food was tampered with, and that others were talking about him. On February, 14, 1935, he was sent home to his aunt, and on arrival followed her about the house weeping, saying his teeth were full of holes, and that everyone was against him.

In the family history his father was a prosperous Jewish merchant, whose personality was highly strung, irritable and jealous. His non-Jewish mother was a selfish and impulsive woman, fond of gay society. He has one healthy younger sister. There is an early history of finger-biting and night-terrors. His previous

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personality is described as very sensitive. He was easily upset, proud of his body, and would frequently look in the mirror and say how handsome he looked.

Since 1926 there had been quarrels between his parents, and in 1931 he had a depressive and restless episode for about two months after an injury to his left leg, coincident with the start of his mother's infidelity. He was then moved in order to be away from divorce proceedings, from public school to a military boarding school, which he did not like much and where he was bullied. In 1932 his father sent for him to be present in Baltimore while he shot his mother.

On examination in the clinic he was tearful, agitated and depressed, saying that he would not get better, reproached himself for having given up, felt that he had lost all his money, and was terrified of the hospital. He suspected that an electric light was used as an electric machine to make him worse. He had innumerable bodily complaints: " I have lost a lot of weight; I am all flabby; my legs are weak. I don't get any sleep; I have lost my appetite. My teeth are rotten and full of holes; my left side is hollow. It is tuberculosis isn't it? I feel funny in my throat; my heart is very weak and I have lost my pep. My eyes are weak; will I go blind? I am going down pretty fast." These complaints worried and agitated him considerably. Orientation and memory were good.

Physically he was a very fat boy (210 lbs.), with a feminine distribution of pubic hair and an almost Fröhlich type of obesity.

In the clinic his intense agitation and restlessness were treated by continuous baths. On one occasion he said that he heard his people's voices pleading for him. He also became afraid of catching syphilis from one of the other patients but this did not become a fixed idea. He remained depressed and puzzled, but was somewhat better towards the evenings. He continued to believe that he was going to die, saying, " I want to be buried next to my father ", until March 27.

On March 20 he developed an enceedingly painful ingrowing toe-nail with suppuration under the nail-bed. This was left for a week, during which all his complaints were of the pain in his toe. On March 27 the toe-nail was removed, with relief of pain and almost complete relief of the hypochondriasis.

For the first time he said that he felt better. During the next month he steadily improved. He was able to discuss without any agitation the onset and causes of his illness, his attitude towards the parental tragedy and towards sex. There had been a history of masturbation for the previous two years with some guilt feelings, and he was reassured about this. He was discharged on May 22 in a very cheerful, almost elated state, he showed a mental age of 14.6 with a base line of 9 on the Binet-Simon test and was obviously unsuited for a college career. He was seen at regular intervals during the summer, and in September, 1935, it was arranged for him to attend a somewhat easier school while he lived with his foster-parent. Here he took a full part in athletics and enjoyed the work, at which he was quite as good as his school-mates. He plans to take up a business course rather than go to college with indefinite purpose, which had been his previous plan. Two months after discharge he was seriously cut in the arm by a motor car, and had to have an operation under general anæsthetic (under which he almost died). Though at first terrified by the injury, he accepted it and complained no more than any other surgical patient.

The causative factors for this condition seem to have been (1) his constitution; (2) the feeling of insecurity at a boarding-school where he was worked beyond his ability, and not liked by the other boys; (3) brooding on his parental tragedy; (4) some possible sex conflict; (5) physical disability resulting from the initial attack of influenza.

This hypochondriasis is particularly interesting in that it was bizarre and yet ran a benign course. The reason for the hypochondriasis may possibly be to some extent his Jewish parentage. It is interesting also that his bodily complaints by no means provided an escape from his fear, but only provided the content for it.

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