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[Reprinted from
Monthly Cyclopædia and Medical Bulletin,
March, 1909.]

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THE CLARIFICATION OF OUR CONCEPTS CONCERNING HYSTERIA.

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The recent discussion at the Paris Neurological Society[1] has done much to give precision to the vague conception so unfortunately attached to the word hysteria. It was in 1901 that the Society, after hearing the astonishing definition of Babinski,[2] began the enquiry which has fructified in the conclusions which now emerge after the elimination of poorly observed cases, clouded reasoning and ill-digested theories.

The suggestions at the root of those symptoms of hysteria formerly believed to be autochthonous and durable, and termed stigmata, are generally, though not always, of medical origin. It is very significant that Bernheim[3] for fifteen and Babinski[4] for ten years have never seen hemianæsthesia, contracted visual fields, dyscromatopsia or monocular poliopia, except in patients previously examined medically. The mode of genesis of these symptoms was first indicated by Bernheim[5]; and the writer has recently presented the theme in a translation of his communication before the Congress of French Neurologists, at Lille[6]. Medico-legal examples in the making have recently been adduced by Brissaud,[7] as, for instance, that where Dupinet, who had found no hemianæsthesia in a workman after an accident, saw it produced by the examination of another expert. It is impossible, however, to prove a universal negative; and to that extent Déjerine and Raymond are justified in believing that undoubted hysterical symptoms may arise independently of immediate suggestion. But it must be remembered that hemiplegia of organic origin is a familiar sight, and that to the lay mind palsy connotes insensibility. Hence it is not astonishing that a man who believes a limb incapacitated, believes it also insensitive; this, however, is a suggestion. The discovery of basal suggestions in hysteria is proportional to skill in psycho-analysis in genuine cases, and to detective shrewdness in cases arising from mythomania.[8]

Many so-called hystericals are, in reality, merely mystifiers, more or less conscious of their deviation from straightforward action. The following cases are examples:—

A young girl[9] announced that on a certain day and hour she would die. When the time came she feigned death, resisting with astonishing fortitude all the stimuli used to awaken her from her apparent state of catalepsy or coma. This comedy lasted three days; then she arose and dressed herself, pretending

to come out of a dream, and amused herself with the stupefaction of her family and friends. When interrogated by her doctor, she confessed her trick and said that she had never been so happy as she was while watching the efforts, threats and prayers of those around her. In spite of the confession the same scene, more or less varied, occurred on ten other occasions, although she appeared to be a young woman of good heart and intelligence.

A second case is that of a man in a hospital who confessed to concealing a hypodermic syringe in his rectum; and this was not all, for in a moment of exasperation, an evacuation revealed two.[10]

Such cases have contributed largely to the confusion of our conception of hysteria. They must be eliminated from a discussion of its nature. So also must be excluded abnormalities of the tendon, skin and pupil reflexes, which are not modifiable by suggestion.

Urticaria, dermatographia, eruptions, œdema, hæmorrhages, ulcers, gangrene, and other circulatory or trophic perturbations[11] arise from chemical or structural abnormalities, whether in suggestible individuals or not, and have nothing to do with hysteria; nor is the temperature modifiable by suggestion; and the urinary, sudoriferous, and salivary secretions[12] are so only slightly rarely and only insofar as the emotional attitude may be perturbed by a suggestion.[13]

The foregoing assertions must not be misinterpreted; for it must be remembered that the tendon reflexes may be suppressed by voluntary muscular contraction, and the cutaneous reflexes, such as that to tickling, may be inhibited by a strong effort of the will.

It must not be forgotten that many intoxicated states which paralyze the neurones which govern the reflexes also necessarily interfere with the psyche, and give rise among other symptoms to many of hysterical type. This by no means means the modification of reflexes by the hysterical symptoms; both are effects of a common cause and either may occur independently in accordance with the preponderance of the intoxication upon one or other part of the nervous system.

Many maintain that psychoneuroses other than hysteria are amenable to suggestion, Déjerine, for example, citing the false gastropaths, whom he calls neurasthenics. The writer has elsewhere[14] endeavored to elucidate this source of error, and to show how a false belief in one's inability to digest, whether implanted by medical suggestion or otherwise (*i. e.*, a hysterical fixed idea), produces asthenia by slow starvation on account of the malassimilation caused by worry that food which has been eaten may disagree. The state induced is a secondary neurasthesia, and, of course, demands the Wier Mitchell treatment; but the initial cause, the false idea, must be removed by phychotherapy, and unless so removed may again cause failure of nutrition.

Patients suffering from mental debility, dream-like states, hebephrenia and other forms of dementia præcox, mental confusion, states[15] of emotional perversion, etc., insofar as they are suggestible, are hystericals; but the whole syndrome cannot be removed by suggestion, as it can in cases of uncomplicated hysteria. For the differential characters of such states, I must again refer the reader elsewhere.[16] The victims of what has variously been called cerebral

neurasthenia, idio-obsessive psychosis, *maladie de doubte, délire de toucher* and latterly, psychasthenia are the antitheses of the hysterical, though many of their symptoms may be imitated by suggestion, and so removed. The essential psychasthenic characters, however, do not accompany a symptom simulated in this way. I cannot better contrast these characters than in the following extract from *International Clinics*:[17]

"The very important diagnosis between hysteria and psychasthenia depends upon the following: First, as to fixed ideas, their duration in hysteria tends to be long; for, though they are easily buried and forgotten, they are resuscitated with great ease and infallibility, whereas in the psychasthenic the fixed ideas are very mobile, but keep recurring voluntarily, and indeed become cherished parts of the individual, and are far more difficult to eradicate than those of the hysteric. Second, hysterical ideas are evoked by well-defined and not numerous associations, 'suggestions'; in the psychasthenic, they are often evoked by apparently irrelevant associations, which are searched for by the patient: thus the 'points de repère' are very numerous, cannot be predicted with certainty, and are often mere excuses for crises of rumination or tics. Third, in the hysteric, the ideas tend to become kinetic; whereas the psychasthenic's constant state of uncertainty causes him to oscillate between 'I would' and 'I would not.' Inhibition is too strong to allow an act, but not strong enough to dismiss the obsession.

"The anorexia in hysterics is derived from a simple idea not to eat, suggested by imitation, extraneously or in a dream. Cases of true loss of the feeling of hunger are not hysterical, but accord with the 'anorexia mentale' of Lesègue,[18] in whose days hysteria was poorly differentiated. The anorexia of the psychasthenic is secondary to an obsession, usually of shame of body, of being fat, or of the act of eating, and is accompanied by numerous stigmata of the psychasthenic state."[19]

It must, however, be remembered that the neurasthenic state favors suggestibility, though it is not of the dynamic kind, which the hysterical manifests, but is of a passive, aboulic character.

From the foregoing considerations it follows: (1) that from hysteria must be eliminated cases of trickery, simulation and mythomania; (2) that to the syndrome of hysteria do not belong modifications of reflectivity; (3) that the vasomotor and trophic neuroses have nothing to do with hysteria and (4) that other psychoneurotic states such as psychasthenia, neurasthenia, cenesthopathia, mental debility, and confusion, the early phases of dementia præcox, dream-like states, and emotional perversions must not be confounded with hysteria.

Having eliminated these negative characters, there remain the very definite conclusions which I quote again from *International Clinics*:[20]

"1. That all the symptoms which may legitimately be included under hysteria are imposed by suggestion.

"2. That the state of suggestibility derives from (a) faulty education, tending to perpetuate and fortify the natural suggestibility of the child; (b) cerebral modifications due to organic causes, the action of which necessarily varies among individuals in accordance with (c) the hereditary constitution."

For clarification of the issue we are indebted to Babinski and the discussions which his pertinacity has inspired in the Paris Neurological Society; and for a full account of the data, the reader is referred to the reports of these.[21]

Space forbids even a statement of the therapeutics and medico-legal corollaries of these conclusions. The latter were alluded to in the MONTHLY CYCLOPÆDIA of November last.[22] The former should clarify our understanding of much of the pseudo-scientific psychotherapy now becoming so rampant.

A clear conception of the psychological mechanism of hysteria will add enormously to the power of medical men in controlling the psychoneurotic element present in so many diseased conditions.

The hit-or-miss psychotherapy-of-encouragement in many cases does more harm than good. It is as dangerous therapeutically as digitalis or the knife in hands ignorant of pathology. The delicate judgments upon which the treatment depends certainly cannot be entrusted to the untrained. However supple-witted may be a pedagogue, priest or mental healer, he lacks the broad training in the fundamentals of clinical medicine in which, unfortunately, some men who specialize too early in their career are also deficient. Accordingly, the therapy of hysteria as well as of the other psychoneuroses can be intrusted with safety only to the physician, and he in turn must rise to the occasion by studying the pathogenesis of these as he now does that of arteriosclerosis or glandular insufficiency. In the meanwhile, he must have recourse for advice, and sometimes for direction, to the few men who have already devoted themselves to this study.

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