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A CASE OF TRAUMATIC NEUROSIS, ILLUSTRATING SUCCESSFUL PSYCHOTHERAPY.

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The pessimism, due to the want of success which has hitherto characterized medical efforts against the hystero-neurasthenic syndrome induced by industrial accidents, and especially those on railways, bids fair to be replaced by a very different attitude, thanks to the illumination of the whole subject of hysteria which we owe to the insight and energy of Babinski[1], who has effectually shown the purely fantastical nature of the hysteria described in the text-books after the traditions of Charcot.

It is unfortunate that some clinicians, and more especially some neurologists, have not taken the trouble to study the mass of evidence about hysteria which has been accumulated since Charcot's day, and continue to write in some such strain as the following:—Thus Church and Petersen (1908 edition) quote only the older article of Dutil, saying "a certain number of elementary phenomena, sensations, and images are not preserved and appear to be repressed in the realm of consciousness." "In addition, there are a number of organic phenomena—disturbances of nutrition, trophic and vasomotor disorders of a neurotic charter." "The stigmata tend to persist as long as the affection lasts." "In the great majority of hysterias the visual field is found concentrically contracted." "The red visual field exceeds the blue." "Both anesthesia and hyperesthesia are usually present in a given case." "Pulmonary congestion, hemoptysis, etc., are not very rare." "The trophic accidents of hysteria are of recent recognition" (an extraordinary statement).

"Even cutaneous gangrene has been recorded." "Neurotic edema usually appears in parts hysterically affected." "Muscular atrophies have been observed by a number of reliable observers."

Worse still writes Saville in a recent lecture published in the *Lancet*. "I cannot agree that hysterics are invariably or especially susceptible to auto and hetero suggestions or are more hypnotisable than non-hysterical subjects." But he gives no facts or reason for this belief, merely stating further that "alternation and tendency to change and evanescence of mental state, called caprice by Sydenham, is the peculiarity *par excellence* by which we recognize a hysterical mind." "When this means of identification fails," he seeks it in "emotional instability, a tendency to abstraction or automatism, especially coupled with certain physical symptoms, as flushing and fainting." He naïvely rejects the observations of both Freud and Janet on the ground that "their studies are carried on in psychological clinics, where patients apply principally or solely on account of mental defects;" and believes they take "too narrow a view, because they do not mention or explain circulatory and somatic symptoms, and also state that they occur much less frequently than do observers engaged in general medicine." Saville can know very little of the Salpetrière clinic in making such a remark, for there the number of persons suffering from physical defects of the nervous system is enormous[2], and it is there that Freud first formulated his theory, and Janet still works. They do not mention the physical symptoms in the same naïf way as formerly, because they have long ceased to regard certain of them as belonging to hysteria, other neuroses (in the true sense) having now been delimited, and other conditions such as palpitations, flushings,

syncope and convulsions being capable of easy production either directly by suggestion or indirectly *via* an emotion. Everyone surely must be familiar with the pallor, cold flashes and syncope of fear and the blush of shame, as well as the convulsive attack of the tantrums of childhood. To invoke a hypothetical splanchno-neurosis to explain such every day phenomena shows great ignorance of well-known data concerning the emotions.

The illustration he uses to enforce a long settled thesis that some hysterical phenomena at least are psychogenetic is unfortunate at least; for the example he gives is that of the tics, the full description of which Meige and Feindell[3] long ago showed to be quite different to hysteria; and as a member of the national hospital staff[3] has translated their book, the knowledge it conveys should be common property.

As gratuitous and discredited for lack of evidence is his hypothesis that hysterical symptoms must be explained by local modifications, by cerebral anemia due to vaso-motor instability. Science is very far indeed from such hypothesis; and any premature adherence thereto on the part of clinicians only hinders the advance of the real knowledge gained by a study of phenomena, by making them unconsciously distort the facts to conform to an explanation which appears scientific because physiological. The knowledge of neurological diagnosis needed to exclude definite organic perturbations of the nervous system, and an acquaintance with the modern work of Charcot's followers, indicate that there is only one fact certain and indisputable about the reactions of hystericals, and that is that they are "susceptible to production by suggestion and of removal by suggestion-persuasion."[4]

This is not the occasion to refute such notions, nor even to indicate in *extenso* the reasons for dissent; for the writer's recent articles[5] have fully set forth the evidence, and in a communication to the Congress on Industrial Accidents at Rome,[6] the application of the doctrine that the primitive symptoms of traumatic neuroses are hysterical, neither more or less, in that they are each and all "susceptible of production by suggestion and of removal by suggestion-persuasion." I say primitive advisedly; because, although a hysterical contracture for example is produced by suggestion, yet the shortening of the tendons which may follow its prolongation is the result of organic changes due to persistence of a faulty attitude, and cannot be removed by suggestion-persuasion. Again, although the anorexia of certain gastric neuroses is caused through suggestion[7] and removable thereby, yet the emaciation, asthenia and gastric insufficiency which result cannot be thus removed; for they are organic consequences secondary to starvation induced by the fixed idea, the erroneous belief that food will not agree.[8]

Similarly, in the case which follows, the loss of appetite, insomnia, emaciation and unhealthy tint of the skin were secondary to the mental worry concerning the circumstances in which he was placed through his fixed idea, the false belief that he was irretrievably damaged in his spinal cord, and would be unable to earn a living for himself and family; and his whole affective tone thus became morbid secondarily to an idea derived by suggestion, as will appear.

It is that of a railroad brakeman who was thrown by the giving way of a stirrup while his train was traveling about ten miles an hour. He fell on the small of his back against a bank of earth, rolled

over two or three times, and lost consciousness for over half an hour. After crawling about half a mile he was found. He felt sick all over, and brought up blood, which also came from the urine and bowels, only that day, however. After reaching his home town, he was assisted to his house, one and a quarter miles away. He did not sleep that night, but rested the next morning. In the afternoon, he became restless, and sticking pains occurred in the back and lasted several days. He was up and about with a crutch in fourteen days; but shortly afterwards he lost the use of his legs, *having to move them with his hands;* he then walked about on crutches, though he felt faint after progressing two or three squares. On account of anxiety and want of means, he soon after went to live with his mother, his wife going to her father. When questioned, he replied, "Well, yes I missed her;" but he stated that he was *too much pre-occupied with his health* to care much. About three months later, he was able to hobble with a stick only, but varied from day to day in his power to do so.

He says he feels a buzzing and a severe pain in the head as well as in the back; these did not begin until one month after the injury. He worried much over his position and circumstances and the dependence of his wife, in being unable to help her and his mother, who was an invalid with a younger boy to take care of. (He wept while relating this.) He had never worried before his accident, but now he cannot help it, for though he is owed $225.00 by an accident insurance company, they will not pay him anything. He does not know what to think about his health; for though the railroad doctor upon seeing him after the accident declared that he would soon recover and be able to work, he has lost over

twenty pounds in weight, has become very weak, has sore throat, and capricious appetite and sallow skin, and weeps nearly every day. Moreover, about ten days after the injury, two other doctors, called in by his family, each said independently of the other that he had a congestion of the spine, which, though probably temporary, might last a life-time. He had a very severe "fainting-spell" one day after a cold; but when interrogated, he confessed to having eaten a large meal of sweet milk and cold slaw, and this was the only occasion since the accident upon which he had actually vomited, though he had often had a dull sick feeling when over-heated. He wishes he had never seen a railroad, "meaning nothing detrimental to anyone but myself."

He has employed attorneys, who are bringing a claim against the company: he has asked for two thousand five hundred dollars and employment, and has *received much sympathy* from his friends. "I answer a thousand questions a day." When asked his object in this, he replied, "I will be frank with you and all; I was looking forward to promotion. It was no fault of mine that I was injured; if it had been, I would have said nothing. I merely ask for a sum of money and a job I could do. I could get around and do a job I could do, but I would never run railroad again; for in catching a box local, it means heavy weights all day, and I cannot gain promotion except through this." He thought he might do office work, though he dreaded it, for outdoor work suited him better than the confinement of bookkeeping; besides a good brakeman can make a hundred dollars a month.

Upon examination, I found the tendon *reflexes* equal on the two sides and neither exaggerated nor unduly feeble. The cutaneous reflexes were all un-

usually active with the exception of the plantar, in which, however, the toes distinctly flexed upon several occasions, until inhibited volitionally. When I distracted his attention, however, flexion again occurred. *Sensibility:* A pin prick on the lower limbs is called a punch, cold steel is called warm, and the diapason is only felt when in full vibration. Cotton-wool is unfelt in front as high as the groin, and behind as high as the iliac crest on the right side, at first; but after the left side had been examined and found insensitive only as far as the gluteal fold, he confessed to feeling the wool on the right buttock also. When asked to say when he did not feel the wool, he said "No" the first seven times he was touched on various parts of the lower limb, later ceasing to reply. The gluteal anesthetic boundary varied by about two inches at different examinations. In the lumbar region, he was bi-laterally hyperesthetic in a two-inch zone shading off below and sometimes extending on to the buttocks. Posteriorly, the upper border of the zone corresponds to D.12 and L.1, laterally to D.10-11 and anteriorly to D.8-9. The *motor power* was good. When he attempts to use the legs alone, he strongly tightens up the antagonist muscles; but when his attention is diverted, he can maintain powerful extension at the knee, even on the left side, though he declared himself weak there from an old dog-bite. Babinski's combined flexion[9], and Hoover's[10] and Zenner's[11] tests were all negative.

The pupils are equally dilated and respond promptly and vigorously to light and accommodation, but no pain reflex could be elicited.

There was no loss of memory or other intellectual defect, although the affectivity was perturbed as described.

It should be evident that the incapacity of this man arose from the fixed idea, very probably inculcated after the accident by his friends, although contributed to largely by the common belief of railroad employees, that an accident can induce serious nervous disease. The doubtful prognosis of the doctors, evidently unskilled in neurological diagnosis, strongly fortified the man's belief and consequent anxiety. The anesthesia, induced by previous medical examination[12], might have deceived an inexperienced observer; but the wool test, which had not previously been employed as I performed it[13], quickly revealed not only an "uneducated" line of demarcation, but demonstrated that the man did feel by the very fact that he said he did not. Of course, even had I not succeeded in thus demonstrating the incongruity of the syndrome with the neuro-pathology of the spinal cord, the complete conservation of all the reflexes was sufficient to show that the anesthesia did not arise from disease of the spinal cord.

The *diagnosis* then was hysteria, the psychic elements of which were clearly revealed in the foregoing history. The *prognosis* given was favorable; but I first explained to the patient and doctor separately the real genesis of the disorder, showing the former the effects of worry and anxiety upon bodily nutrition, and the role of ideas over bodily activity.

The *treatment* I recommended was the re-establishment of good nutrition, regular exercise, a removal of grief and worry by the assurance of a reasonable compensation for the anxiety and loss he had suffered (for though his ideas were erroneous, and he was in one sense of the word a simulator, he was so unconsciously and because of the environmental beliefs he had acquired), and the declaration that by following my treatment he would be capable

of moderate work in a few weeks, and in a short time would be entirely restored to health. Being asked for a certificate, I gave the following to both patient and doctor:

"This is to certify that I find Mr. V. to be suffering from a condition of incapacity for free walking or mental or physical work from the effects of a fall from a brake car (as I am informed). This state is induced, as a result of the aforesaid accident, by the worry, anxiety and loss of means directly caused thereby. I believe that by appropriate treatment he could be restored to a certain extent within one month, and that within three months he could be fully capable of pursuing any laborious vocation he chose. He is, however, at present in too low a state to be capable of long, continuous labor, even though the incapacity of the limbs were immediately removed. There is, and has been, no disease of the spinal cord or peripheral nerves at play in the induction of any of the symptoms which I find. The erroneous belief that there has been such an injury powerfully contributes to the anxiety which maintains his present state."

As to the outcome, a letter from the doctor a few days ago stated in reply to my query: "We compensated V. by a sum of six hundred dollars; and he went back to work *on time,* just as you predicted." *Naturam morborum curationes ostendunt.*

The replacement of this morbid feeling tone by another cannot be direct; but must be accomplished by replacement of the causative idea by another, and this is what indeed the psychotherapist does in the gastric neurosis.[14] But in traumatic cases, the litigious element prevents this, for the patient is suspicious of everyone who does not accede at once to his fixed idea that he is incapacitated, and medical

men as a whole are not noted for the psychological finesse required in approaching such cases. Hence, access, even if gained, is quickly lost, except by the medical men whose belief concords with that of the patient; and these, believing as falsely as he, are as helpless to cure him.

It must be remembered, too, that mere affirmation may prove a very poor appeal, for a cold, intellectual acceptance is not enough to change an attitude or mood which has been assumed for any considerable time. Intellectual acceptance must entrain immediate action, whether emotional or not, for the whole bearing of the patient's mood must be orientated towards a desired idea, that of disappearance of the hurtful idea-emotion complex. Thus, I obtained the *active* consent of my patient, and he was invited to dine with his doctor that night, made to feel optimistic, and then taken home, and the settlement clinched at once.

It is clear that the return of this man's functional capacity was the result of the enlightenment and skillful persuasion he received during our interview, seconded by his physician, who saw that immediate action followed an intellectual conviction which might not have been maintained against the counter-suggestions he would have again received in the environment of invalidism which had grown up around him. It must be remembered that patients with a fixed idea become aboulic where other matters are concerned. Thus Brissaud[15] remarked of a patient who went into a fit when they gently attempted to extend the contracture of a limb which had lasted five years since the railway accident, "this contracture is his life." Misoneism,[16] the impossibility of adaptation to unusual conditions, is

common enough, and its intensity is proportional to the length of time during which the mental habit has persisted, as well as to the affection, so to speak, with which one's habit or defect has been cherished and the age at which they have been acquired; and in such persons conviction soon becomes inert if allowed to sleep.

The effects of an emotion such as fear quickly pass away unless they are maintained artificially ideationally, as by suggestion, which need not necessarily be made after the event, but may be latent, as in the following case:

A girl was brought to Babinski[17], having become monoplegic upon receiving an electric shock while crossing a tramway line. This seemed like paralysis not caused by suggestion, but after the symptom had been removed by persuasion, further inquiry elicited the fact that the patient had overheard some months previously a conversation between some electricians who were speaking of the dangers arising from electric shocks of the above description. It is evident that upon experiencing the shock, there had flashed into the patient's mind a datum learnt from the conversation she had overheard and apparently forgotten, and that this memory furnished the suggestion at the base of the palsy she developed.

A suggestion need not even be explicit, but is often implicit in the whole conduct of those who surround us. It may occur in consequence of manifestly insincere attempts to minimize what the patient sees that from their very manner those who surround him believe to be gravely dangerous. Alarm is difficult to conceal, and is very contagious, but it is soon dissipated when a reasurring idea is successfully implanted. Some theorists believe that

the trauma of fright increases susceptibility to "neurosis" by creating new physiologic dispositions in the spinal and lower neurons; but we have no evidence to show that such dispositions are modifiable volitionally. The true neuroses, that is functional affections of lower nerve paths the physical basis of which is at present unknown to us, can be neither acquired nor removed by psychic means. To telencephalic anomalies the word psychosis[18] should be applied, and the traumatic neurosis is of this type; for, to explain the reactions of these patients, we must invoke the labile differentiability of neopallial, psychic adaptation rather than the inherent neuric arrangements which are disposed toward the precurrent and consummatory reflexes phylogenetically organized, which we call instincts.

Hence, traumatic neurosis is only one form of suggestion psychosis; for suggestion is sufficient and efficient, and no other alleged cause is even essential; that is to say, the condition is pure hysteria, for its primary symptoms are each "susceptible of production by suggestion and of removal by suggestion-persuasion."[19]

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