The Lumleian lectures on some modern theories concerning hysteria : delivered before the Royal College of Physicians of London on March 19, 24, and 26, 1914 / by J. A. Ormerod.

The Lumleian Lectures

ON

SOME MODERN THEORIES CONCERNING HYSTERIA

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BY

J. A. ORMEROD, M.A., M.D. Oxon., F.R.C.P.

REGISTRAR TO THE COLLEGE; CONSULTING PHYSICIAN TO ST. BARTHOLOMEW'S HOSPITAL AND TO THE NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC, QUEEN SQUARE; FORMERLY FELLOW OF JESUS COLLEGE, OXFORD

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TO

SIR THOMAS BARLOW, BART.,

M.D., K.C.V.O.,

PRESIDENT OF THE ROYAL COLLEGE OF PHYSICIANS OF LONDON

THESE LECTURES ARE DEDICATED

IN TOKEN OF SINCERE RESPECT AND ESTEEM

The Lumleian Lectures

ON

SOME MODERN THEORIES CONCERNING HYSTERIA.

LECTURE I.

Delivered on March 19th.

MR. PRESIDENT, FELLOWS, AND GENTLEMEN,—The first part of my task, and a most pleasant part, is to thank you, Sir, and the Censors for appointing me to the honourable post of Lumleian lecturer. But when one considers the long line of distinguished Fellows who, since the reign of Queen Elizabeth, have delivered these lectures, including the greatest of our Fellows, William Harvey, one may well feel diffident in occupying this place. And perhaps I feel the more diffident because I am simply your Registrar, a person whose chief ambition must now be to keep the annals of the College as accurately as my predecessor—if, indeed, that be possible. But I do not doubt, Sir, that in making this appointment you had a precedent in view—namely, that in 1833 and on several subsequent occasions a well-known Registrar of this College, Dr. Francis Hawkins, was Lumleian lecturer. And I may say, Sir, that I, too, have a precedent for the choice of my subject, not only in the interesting Bradshaw lecture on Hysteria, which you heard last autumn from Dr. T. R. Glynn,[1] but also in the fact that Dr.

[1] THE LANCET, Nov. 8th, 1913, p. 1303.

Thomas Mayo, one of your eminent predecessors in the Presidential chair, delivered in 1842 Lumleian lectures on Nervous Apoplexy, Palsy, and Hysteria. And further, looking to the modern doctrine that hysteria is a kind of mental disability, it is interesting to note that Dr. Mayo wrote a book entitled "Elements of the Pathology of the Human Mind." But I cannot find that he correlated the two subjects in any way.

Hysteria and Neurasthenia.

Between those diseases which are the peculiar province of the alienist, sometimes called psychoses, and those nervous diseases which we call organic and consider to be due to some definite bodily change, there lies a large class of affections to which we apply the vague but convenient term "functional nervous diseases." Sometimes we call them "neuroses," and the people who are prone to them "neurotics." Now this large class falls into several groups. The distinction between these groups is difficult, because in dealing with them we are bereft of the sure support of morbid anatomy. Yet some of these distinctions can easily be made. First, at the organic end of the scale appear several well-known and very definite diseases, which can only be called "functional" in a very qualified and provisional sense, since it seems certain that they have some physical or chemical basis, though we do not yet know it. Such diseases are epilepsy, migraine, chorea, and others. But beyond these as we pass from the organic to the psychical there come two groups of very common nervous affections concerning the bodily nature of which we know so little, that a tendency has now arisen to neglect this aspect of them and to study them chiefly from the side of psychology. These two groups are hysteria and neurasthenia: the first recognised from the early days of medicine, the second modern in name, though I suppose not in reality. Most of us will agree, I think, that we have in them two distinct types of disease, though of course there may be cases in which they overlap. Indeed, tables are laid down in text-books of the clinical points of

difference between them. I will here only mention two of these differences.

1. That in hysteria we expect to find, at some time in the course of the disease, outward and visible symptoms, such as fits, paralysis, anæsthesia, and the like, which are objective at least in this sense that they force themselves on the attention of the physician, whereas in neurasthenia the symptoms are subjective and cannot be verified by observation. 2. That the patients have a different mental outlook; to the neurasthenic his symptoms are always a source of distress and may be a burden to his whole life, whereas the disabilities of the hysterical patient (perhaps I should say the confirmed hysterical patient) tell far less upon her, and she may even bear her cross with complacency; in short, the reality of the disease appears in the one case greater to the observer, and in the other to the patient.

But we must admit that in order accurately to define either of these diseases we must have a theory as to the essential nature of it, seeing that there is no easy physical means of recognising them, like the bacillus in tubercle, or the hepatised lung in pneumonia. I shall endeavour, Sir, in my second and third lectures to lay before you some of the current theories about hysteria.

The Nature of Functional Nervous Disease.

Now the first difficulty in theorising about these diseases is to settle whether we are to look on them as mental or as bodily affections. I do not propose to discuss neurasthenia in these lectures, but perhaps I may be allowed to say a few words about it in illustration of this difficulty. Under this general term "neurasthenia" are included several groups of cases. There are the patients described by Beard—perhaps we may call them simple neurasthenics—who suffer indeed from subjective feelings of exhaustion and incapacity, but whose principal symptoms—pains, headaches, backaches, giddiness, palpitations—might well be, and

generally are, ascribed to physical causes. Then there are the neuropaths described by Dejerine, whose physical functions appear to be deranged, for they are unable (it may be) to walk, or sleep, or swallow, or micturate properly, yet no organic disease can be found in them, and Dejerine traces their complaints back to mental and moral causes. Lastly, there are the psychasthenics of Janet, in whom the psychical element is obviously preponderant, who are tormented by obsessions, doubts, crises of mental agitation, phobias, or by inarticulate and inexpressible feelings of distress—so-called borderland cases, though they do not always cross the border so as to become insane. Are all these classes of neurasthenics suffering from the same disease? And if we say, as appears incontrovertible, that the psychasthenic is affected mentally, then what of the simple neurasthenic? Why cannot he face his day's work? Has he some physical affection—say, malnutrition or toxæmia (if you like these words) of his nerves and muscles, or is he, too, a psychoneurotic, who is suffering from a mental depression, and has forgotten the truth of the song of Autolycus—

> A merry heart goes all the way.
> Your sad heart tires in a mile-a?

Now while the clinical delimination of hysteria is more easy than that of neurasthenia, because it is a more definite type of disease, yet there is the same difficulty in discussing its nature. Is it a mental or a bodily disease? There are those who look on it as a problem in physiology, to be solved by knowledge of the anatomy, chemistry, and functions of the brain. There are those who would solve it by psychological methods. I think it is no contradiction to say that both are right. It is a question of difference in their points of view, their methods of work, and perhaps their predilections. As to the point of view, if I was to hold up to you, Sir, say half a crown, you might say it was heads, I from my side of the table should have to say it was tails. Not that I should be contradicting you, Sir, unless indeed I forgot that the two faces are indissolubly connected, just as there is some

unknown but certain connexion between mind and matter. And as to the method, the physiologists and psychologists are like two gangs of workmen excavating opposite ends of a tunnel; they may hope to meet some day if they have a due regard to the direction of each other's work. But I am afraid the physiologists are apt to think that the psychologists' work is child's play, mere beating the air; whereas the psychologists retort that the physiologists have reached a stratum much too hard for them to work—namely, the task of exhibiting mental phenomena in terms of nerve cells and nerve fibres.

Symptoms of Hysteria.

Anyhow there exist these two ways of regarding functional nervous disease, and probably it will be a long time before they are satisfactorily combined. Now I propose, Sir, to defer for the present the consideration of systematic theories of hysteria, and in this lecture merely to review some of the symptoms of the disease in such a way as to show that it is not always easy to choose between the physiological and psychological explanations, or to adopt one to the exclusion of the other. And if in so doing I travel over familiar ground, I must plead in excuse that for the purpose in hand the common symptoms are perhaps more valuable than the less well known.

Hysterical Fits.

The hysterical fit or paroxysm has always been considered one of the most characteristic features of the disease. The points of diagnosis between the fits of hysteria and those of true epilepsy or of Jacksonian epilepsy are so well known that I need not repeat them. But, indeed, there are as great differences between the varieties of hysterical fits *inter se*. Consider the simple hysterical fit as described by Briquet, corresponding to the popular "fit of hysterics," in which the patient feels a lump in the throat or some other odd sensation, sinks into a chair, gives a mild emotional display of gesticula-

tion, tears, or laughter, and speedily comes to again, having never lost consciousness of her surroundings or passed beyond the reach of help from her friends. How greatly does this differ from the hystero-epileptic fit as described by Charcot, in which the patient loses consciousness and unfolds a regular panorama of striking, one might almost say terrible, events, in the four stages of epilepsy, meaningless contortions, dramatic display, and delirium. One might well suppose that these two varieties of fit had nothing to do with each other. There is, however, a third variety, which stands between these two extremes, common enough in this country and elsewhere; to which Sir William Gowers gave the name of "hysteroid." In this type of fit there are loss of consciousness, though this may vary in degree in different cases. rigidity of the limbs, and very frequently opisthotonos, and movements of a purposive or coördinated character, in which, however, it may be impossible to trace any one dominant idea.

It is difficult to see what single explanation will fit these three kinds of attacks, not to mention the other forms, small and great, such as hysterical petit-mal, swoons, prolonged sleep, ecstasies, and so forth. For the simple kinds of fit some simple physical explanation, such as variation in the cerebral blood-supply, might perhaps suffice, and there is a fact, rather lost sight of nowadays, which seems distinctly of the physical order, I mean the copious secretion of watery urine which may take place after a fit, to which Gilles de la Tourette added a variation in the chemical composition of the urine. The psychological explanation, on the other hand, takes for its starting-point the dramatic stage of the hystero-epileptic fit. The patient appears to be transported to some scene of her past life; it absorbs her whole consciousness, and she acts it out regardless of her present surroundings. This can be demonstrated in cases where this phase of the fit is well developed. It is reasonably argued that the same mental process is going on in the other kinds of hysterical fit, where the patient, however, does not do the acting so well. This may be so with our own countrywomen, who are not, perhaps, histrionic by nature. But it is diffi-

cult to construe in this way the meaningless movements and rigidities which are so common, especially the frequently recurring opisthotonos. The particular (sexual) significance that has been ascribed to the opisthotonos does not apply to its extreme form the "arc de cercle" or to some of the varieties of this position.

It must be mentioned, however, that serious doubts are now thrown upon the genuineness of Charcot's hystero-epileptic fits. I believe that they are not now seen in Paris, and are considered by some Parisian authorities to have been a piece of display on the part of certain well-trained patients who knew what was expected of them, and did it. There may be truth in this, but I can scarcely think it is the whole truth, for the reason that in this country, and in patients who have been subjected to no sort of suggestion, one sometimes sees attacks to which the term hystero-epileptic might quite reasonably be applied. Take first the apparent combination of epilepsy and hysteria. I remember a woman among my out-patients at the National Hospital for the Paralysed and Epileptic who while sitting in front of me had an attack which (except for the absence of tongue-biting and of micturition) most closely resembled epilepsy, and when this ceased she passed into hysterical convulsions. It may be said, perhaps, that this was hysteria following a true epileptic attack, what Sir William Gowers called post-epileptic hysteria. But in the following instance that order was reversed, the hysterical attack coming first.

A woman (Mrs. A), who had been several times in hospital, and who is no doubt a first-class hysteric, is subject *inter alia* to fits. These have been always diagnosed as hysterical, yet several observers have noticed that they look very like epilepsy. On Nov. 15th last I saw a fit of the following nature. I had just been hypnotising her, and had been pressing her rather strongly with the suggestion that she was to get rid of her symptoms. I mention this because she is rather apt to have a fit when she is too much bothered by examination or remedial suggestions. She had returned to her normal state, and was being helped into her walking jacket by her husband, when she closed

her eyes, began to moan, and sank limply into his arms. He put her into a chair and then movements of the body began, I think of the nature of opisthotonos, which she often has. Thus far there was no suggestion of epilepsy; but then instead of coming round her eyes opened, rolled upwards and to the right, her face became congested, her right arm became rigid at first and then banged up and down on the side of the chair. This second stage of the attack was repeated about three times. Here, then, was a good representation of epilepsy, and indeed of unilateral epileptic convulsions, preceded by a distinct hysterical stage and, as I think, hysterical throughout.

On the strength of these and other cases I believe in the existence of hystero-epilepsy. I quite admit that I have never seen the complete and regular drama in four acts, which appears to have been the rule in the palmy days of "*la grande hystérie*" at the Salpêtrière—consisting of epilepsy, contortions or clownism, *attitudes passionnelles* or dramatic stage, and delirium, in regular sequence—but I suppose we have all seen selections from it; the common hysteroid fit represents in a mild way the clowning stage, and sometimes we witness the dramatic stage in which a past scene is re-enacted by the patient. Here is an instance.

A young sailor was sent into Queen-square Hospital with the following history. In the course of a gun drill an explosion had happened and a piece of flying metal had struck him on the head and rendered him unconscious. Ever since he had been subject to fits characterised (we were told) by unilateral convulsions. But in the hospital nothing happened until the day when he was about to leave. Then he had a fit, witnessed by the resident medical officer, in which he acted out the scene of the gun drill. He listened for the word of the commanding officer, made the proper reply, went through the manipulation of the gun, and, finally, presumably when the explosion happened, fell down on the floor.

Let us leave the subject of fits and consider some of the interparoxysmal symptoms, and in the first place those symptoms which are so common that Charcot considered them to be characteristic marks or "stigmata" of hysteria.

Anæsthesia.

The most important of them is anæsthesia, and the characters of hysterical anæsthesia are so important from the point of view of theory that I must dwell on them a short time, though doubtless they are familiar to you. Hysterical anæsthesia may be so marked and so well defined as inevitably to suggest a local lesion of the nervous system. What can be more natural than to suppose that a hemi-anæsthesia of the face, trunk, and limbs is due to an affection of the posterior part of the internal capsule on the opposite side? Yet in other cases where the anæsthesia is less widely spread it can be easily shown that it corresponds to no anatomical lesion. The anæsthesia which covers the area of a long glove or stocking might, it is true, be produced by a peripheral neuritis, but this explanation fails when the fingers or the feet are left out of this glove or stocking, as sometimes happens. Indeed, it is now generally admitted that hysterical anæsthesia corresponds, not to any real distribution of nerves, but to the patient's conception of her anatomy. And that the anæsthesia is conceptual (if I may use that term) can be shown in a really curious way. It can be demonstrated in some cases, where the anæsthesia appears to be absolute, that the patient really does feel after all. This fact—now known, I think, as Janet's sign—was first shown to me many years ago by Dr. R. H. Crowley, now a Member of our College, and at that time house physician to St. Bartholomew's Hospital. The demonstration was simple, you might say ludicrously simple. A girl, who had other puzzling nervous symptoms, exhibited certain areas of anæsthesia. When after closing her eyes you put a finger on one of these anæsthetic places several times, at the same time saying to her, "Say 'yes' when I touch you," she said nothing. But when you did the same thing and said to her "Say 'no' when I don't touch you," she regularly said "no" each time she was touched. Of course, shamming was suggested, but at best it must have been a very stupid sham; and I have seen this symptom in so many hysterical cases since that I feel sure it is genuine. Some

patients, as might be expected, will see at once the absurdity of being asked to say "'no' when I don't touch you," and will tell you so. And even with those who reply readily enough at first, if the absurdity is brought home to them, as it may be by incautious laughter on the part of the bystanders, you will never get them to answer thus again. Still you may be able to apply the test in other ways—say as follows.

A woman was completely anæsthetic on the right half of the body and had only partial use of the right hand. I put my finger on the left part of her chest, where sensation was natural, and told her to touch with her right (semi-paralysed) hand the place that I had touched. She did so with some effort. Then after reminding her that she could use her left hand quite well, I touched the right (anæsthetic) side of her chest and told her to touch the spot with the left (non-paralysed) hand. She did so, thereby showing, of course, that she had felt the touch. I tried this a second time and she did not touch the spot, but nevertheless lifted up her hand to do so, again showing that she had felt the touch. I tried once more and this time she did nothing.

When the anæsthesia involves the muscles and deeper parts, as well as the skin, a very striking condition is produced, which is generally associated, I believe, with the name of Lasègue, though it is recorded also by Duchenne. The patient, Mrs. A, whose fit I described just now, has exhibited this condition for many years. Her left arm, and indeed all her left side, is entirely anæsthetic both as to the skin and as to the deeper parts. When she watches it she can use it moderately well; when she shuts her eyes she cannot move it at all for she is unconscious of its existence. She does not know where it is, and if you tell her to grasp it with her right hand she fumbles about to find it; and if while she is doing this you put your left hand into her right she thinks she has got hold of her own left hand. One sometimes hears of patients who after amputation of a limb retain a "phantom" of it; but here is a patient with a sound limb, who nevertheless when she shuts her eyes has not got "the ghost of a

notion" of it. Nevertheless, this anæsthesia is not real, for she has been seen doing up her hair, with both her hands behind her head, where she could not watch them.

It is certainly very difficult to explain this contradictory character of hysterical anæsthesia. I do not think it has ever been described in anæsthesia dependent on organic disease. I do not know of any region of the brain, to deficient functioning of which it can be ascribed. All that one can say so far is that the patient is in a peculiar mental condition in which she feels, but does not feel that she feels. But then, again, before we explain it in a purely psychological way, there is another fact that must give us pause—namely, that in many such cases the anæsthetic parts do not bleed when they are pricked. This seems to bring us back to the brutal world of flesh and blood.

Retraction of Field of Vision.

About the second "stigma" of hysteria, concentric retraction of the field of vision, similar remarks may be made. It does not inconvenience those who are affected by it. Janet noticed patients, whose visual fields were much restricted, playing at ball in the court of the Salpêtrière without any inconvenient turning of the head to watch the ball. He also quotes the case of a boy who, having been frightened by a conflagration, had fits whenever he saw a flame. His visual field was reduced to 5°, and beyond this limit he seemed to see nothing, But when a lighted match was introduced into this blind part of the field a fit followed. Again, when a hysterical patient has quite lost the sight of one eye, it is possible by means of prisms and other apparatus known to ophthalmologists to show that the blind eye still sees.

Hysterogenic Zones.

The third "stigma" is the hysterogenic zone. This term expresses the fact that pressure upon certain parts of the body will produce, or it may be stop, a hysterical fit. I think that with regard to

these "zones" we in this country are in the same position as we are with regard to hystero-epileptic fits. We do not commonly see them in a complete form. Sometimes, however, we do, and often we see them in a modified or ill-developed form. Dr. Glynn mentioned in his Bradshaw lecture the case of a boy under Mr. Luther Holden, who fell down in convulsions whenever a place on his skull was touched. I remember an out-patient at Queen-square Hospital in whom, without the least expecting it, I produced a hysterical fit by "ovarian" pressure. I ought to say inguinal pressure, because the patient was a man. I also remember a young woman with a persistent hysterical cough. Sudden pressure under the left breast produced a wince, a gasp, and a cessation of the cough. I found this out quite unexpectedly whilst looking for tender points. Now as to such tender points, I suppose everyone knows that they are very common in hysterical patients, and that they may be found without any suggestion in patients examined for the first time. They are commonest where the hysterogenic zones are commonest—i.e., in the inguinal region (so-called ovarian region), the inframammary region, the spine and to each side of it. Sometimes they are more than tender, and the patient will say that the pressure causes an oppression at the chest, a lump in the throat, or makes her "feel queer." I therefore regard these tender points as the basis upon which is developed the full-fledged hysterogenic zone.

According to psychological theories the hysterogenic zone is a subsidiary agent. That which really produces the fit is the emergence of the particular memory or idea with which the fit is invariably connected. Touching the "zone" is only a sort of signal for the explosion of the mine. This seems a reasonable explanation in some cases —for instance, where a fit can be produced by touching the site of an old injury. It is not so readily applied to the commoner cases. These tender points have a fairly regular distribution over the body. The ideas, on the other hand, upon which the fits depend must be very various in different cases. Why should touching the same stop produce such different tunes?

So much, then, for the stigmata of Charcot. It is somewhat pathetic to think that in the very land that gave them birth they have fallen from their high repute. One eminent French physician maintains, as we shall see, that the real stigmata of hysteria are mental, not bodily; another, that these bodily stigmata are due to sheer suggestion. They may, no doubt, have been over-estimated by physicians and over-elaborated perhaps by certain patients. But they exist, in a rudimentary form perhaps, in patients who never heard of their importance, so they are not, in my opinion, mere passing fashions, like ladies' ruffs or crinolines. Even at that estimate they deserve some attention as "milestones" in the history of the disease.

Contracture of Muscles.

Hysterical contracture of muscles is a very common symptom and important for our purpose, because it may be regarded from either point of view, the physical or the mental. At first sight it appears a purely physical phenomenon, and quite comparable to the contracture which occurs in connexion with disease of the pyramidal tracts. As in a transverse myelitis, so in hysteria we may witness rigidity of the lower limbs, with extension of the feet and legs and internal rotation of the thighs, so that to tell whether the case is hysterical or not we may have to appeal to other factors than the contracture itself; and even then the condition of the plantar reflex may be the only point to decide the diagnosis absolutely. It is, of course, universally held that the presence of an extensor plantar reflex indicates organic disease. And to this I should agree with one proviso—viz., that the extensor reflex should be permanent. For we know that such a reflex may occur temporarily after an epileptic fit. And I have seen it under the following circumstances:—

A boy was admitted into St. Bartholomew's Hospital. When I saw him (which was once only, on the day before his death) he had vomiting, progressive coma, and extensor plantar reflexes on

both sides. I thought he had a cerebral tumour, but the post-mortem examination showed that he died from Addison's disease. Nothing abnormal was found either in the brain or the spinal cord, and a careful microscopical examination of the cord made by Dr. Farquhar Buzzard showed that it was perfectly normal.

But my point, from which I have digressed, was the close resemblance between hysterical contracture of the lower limbs and that resulting from disease of the pyramidal tracts—so close, indeed, that it has been suggested that a malnutrition of the pyramidal tracts is actually the cause of such hysterical contracture.

Nevertheless, if we consider the way in which some hysterical contractures originate, we shall be tempted to believe that in certain cases they are dependent upon mental influences. Such an origin has been suggested even for the ordinary cases of paraplegic rigidity which I have just mentioned. Most of us have seen cases where, for the relief of pain or other reasons, a splint has been put on the forearm, and after its removal the muscles have remained rigid. That this is not a mere local affection, caused by the mechanical restraint, is shown by the fact that the rigidity may spread beyond the muscles originally confined by the splint, perhaps to the whole limb. Immobility seems to have become a fixed idea. Perhaps the rarer cases of contracture of the muscles of the trunk may seem more convincing, because in them the possible influence of pyramidal tract disease can be eliminated. The examples which I will now give are from Professor Janet's book on "Neuroses and Fixed Ideas"; they illustrate his view that muscular contractures may depend upon a mental state.

1. (Vol. I., p. 304, Obs. 8.) A girl who was living in a state of much depression since the death of her only relative became the subject of a criminal assault. Her assailant, however, only succeeded in placing his hand on the right side of her abdomen. She subsequently became subject to hysterical attacks and other symptoms. On admission to the Salpêtrière the right side of the abdomen

was intensely tender to touch and the abdominal muscles were rigid, particularly on the right side.

2. (Vol. II., pp. 423–428, Obs. 126.) A man had, amongst other symptoms, hysterical hemiplegia with hemianæsthesia. While this was half cured he went back to work and tried carrying parcels on his shoulders. This gave rise first to pain at the back of the neck, then to contracture of the muscles there, so that his head was constantly drawn backward, and he could not bend forward. Curiously enough, when this contracture developed the hemiplegia got well. One day he again attempted to carry a parcel, and was very much upset because he let it fall. But the result was that the contracture suddenly disappeared.

This sudden and apparently unaccountable recovery from hysterical symptoms is remarkable, though not uncommon. It is a fact that should be remembered by those who have theories as to the results of treatment.

3. (Vol. I., p. 294, Obs. 1.) Contractures of the abdominal muscles, lumbar muscles, and thigh muscles of the left side, followed by contracture of some of the neck muscles, fixing the patient in a peculiarly awkward position, resulted from the following circumstances. A girl stumbled over the body of a drunken man and ran away in a great fright. A month later hysterical fits developed, in which she had the hallucination of a man pursuing her, and tried to escape, at the same time turning her head to watch him. After each fit she assumed the following attitude—spine arched to left, body bent forward, abdomen folded on left side, head turned to left. This position gradually became permanent, owing to continuous contracture of the muscles concerned.

4. (Vol. II., pp. 428, foll., Obs. 129.) The position of another patient was as follows : Slight flexion of the trunk to the left, owing to contracture of the left abdominal muscles—viz., rectus and obliques ; slight flexion of the left thigh with adduction and inversion of the limb, which was fixed in this position by rigidity of the thigh muscles, though she could move the foot and knee. This rigidity had been preceded by clonic spasms of the muscles concerned. The actual outbreak of the hysteria was recent, and was due apparently to the loss of a sister and other troubles, but the peculiar form of it—that is, the position determined by the muscular contractures—was ascertained to correspond with the position which the patient had been in the habit of assuming years previously, under emotional circumstances of

a certain kind. Later on the muscles on the left side of the abdomen, which had been rigid, became paralysed, and she fell over to the right side, almost reversing the previous position.

This last case reminds me of a girl who was under my care in St. Bartholomew's Hospital some two years ago, who could not walk without persistently bending her trunk to the left. The left lower limb was also affected, but almost in the reverse fashion to the French case which I have just quoted, for the thigh was rotated outwards and the foot dragged behind her, at the same time pointed outwards. In this way she limped along, all hunched over to the left side. It appears that she had had pains in her back, and on getting medical advice about them had been told that she had curvature of the spine. After this the peculiar attitude gradually developed. I think the idea of spinal disease must have taken great hold of her, for even in hypnosis (and she was a particularly good subject) I had much difficulty in getting her to admit that she had no such disease. The inclination of the trunk was a passable representation of lateral curvature, but I could not account for the peculiar position of the left lower limb. She eventually recovered, got married, and the last time I saw her was going out to her husband's farm in Canada.

Peculiar Features about Hysterical Contractures.

Now although it would seem that some hysterical contractures may be dependent upon a persistent or recurrent mental state or "idea," yet I doubt whether they can all be explained in this way. At any rate, contracture seems to be a symptom which would well repay careful investigation.

There are two peculiar features about hysterical contractures which I might mention here, without discussing them at length.

First, that such contractures, or, at any rate, some of them, persist during sleep. It is not always easy

to observe this for oneself. There was a woman in Queen-square Hospital last year whose hand was fixed in the "obstetric position." Dr. Adie, house physician, kindly observed her at my request during her sleep, and found the position the same. Mrs. A, the patient whose fits and anæsthesia I have already described, came to me last year with her right middle finger firmly flexed into the palm. Her husband assured me that the contracture remained during her sleep. So it did during hypnotic sleep, though in this condition the finger could be easily coaxed to open. The persistence of a hysterical contracture during natural sleep is not, perhaps, what we should expect, yet it has long been known. F. C. Skey, the well-known surgeon of St. Bartholomew's Hospital, notices the fact in his lectures delivered in 1866. After commenting on the fact that chloroform anæsthesia will remove hysterical contractions of the fingers or elbow he says: "To bring this morbid state of the muscle within the influence of the mind as its cause is almost of necessity to infer the local evil to be wilful; but if it were so, the state of unconsciousness during sleep would remove it, which it does not, for the contraction is constant by night and by day."

The second point is that, when such contractures are forcibly overcome, the patient seems to suffer intense pain. The reason is not obvious. Is it due to some purely local condition of the muscles? Or is it the expression of some more general law? For some authors have noticed that pain in the head occurs when functions which hysterical patients have lost, such as memory, sensibility, or motility, are being restored in the course of treatment. Now, since permanent hysterical symptoms, such as paralysis, anæsthesia, contractures, and the like, are often ushered in by pain, it may be that in the reverse stage, from symptom to cure, pain is a stage through which the patient must pass.

Of course, in these remarks about pain and the persistence of contractures during sleep I exclude cases in which adhesions have formed about the joints—a complication which, according to Weir Mitchell, readily occurs in hysterical cases.

Vaso-motor and Nutritional Symptoms.

All the symptoms that I have mentioned as yet are common and well-known symptoms. I have dwelt on them chiefly to show that they may reasonably be interpreted from the psychological point of view. This, indeed, is the kind of interpretation which most modern theories on hysteria employ. But it will have occurred to you, no doubt, that there is another class of symptoms which are by no means easy to interpret in this way; I mean the rarer class known as vaso-motor and nutritional symptoms. Examples of this class are—fever, muscular atrophy, certain skin affections, œdema, congestions, not to mention obscure affections of secretion and excretion, as of sweat, milk, and urine. The existence of many of these has been denied, and others have been relegated to the limbo of malingering—perhaps correctly, but I doubt whether we can get rid of all of them in this way.

Affections of the Skin.

Skin affections have been described, mostly vesicular or bullous in appearance, ending in superficial ulceration; and the eagle eye of the dermatologist will pick you out lesions worthy to be dignified with the name "dermatitis neurotrophica"; but generally there hangs over these a cloud of grave suspicion that there has been some self-inflicted injury. This difficulty arose in the case of a woman who was for a long time under my care in St. Bartholomew's and Queen-square Hospitals. A very marked hysteria was in her case combined with disseminated sclerosis (the latter verified post mortem). The right loin, right side of abdomen, and right lower limb, all of which parts were anæsthetic in a hysterical sense, were covered with oval scars, the sequelæ of superficial ulceration, which were edged round with dark pigment, so as to form quite a striking picture.[2] This pigmentation I believe to have been due to arsenic,

[2] See Brain, October, 1907.

which had been freely administered before I saw her. She developed very few lesions while in my wards, so that I cannot speak with certainty as to the method of their production.

This question of self-infliction of injuries in relation to hysteria is an extremely interesting one, but can hardly be discussed in the time at my disposal.

Muscular Wasting.

Muscular wasting may be seen in hysteria, affecting (it may be) a single limb or segment of a limb, but not picking out individual muscles nor exhibiting electrical reaction of degeneration. It resembles, therefore, the muscular atrophy sometimes seen in hemiplegia rather than that of progressive muscular atrophy.

Ecchymoses.

Ecchymoses into the skin may occur, though they are uncommon. A lady, who had had a hysterical fit the night before I saw her, showed me two dark patches on her leg, and said she often "came out in bruises" after the attacks, though she was not violent in them so as to injure herself; and that once she had had a spontaneous black eye. Perhaps I may mention that I once described several cases of paroxysmal ecchymosis or œdema of the eyelids coming on without obvious cause, and that one of these cases was a hysterical girl. Another lady, whom I took to be an example of severe hysteria, told me that she had had an attack of extreme pain in the left arm, and that with this the limb had swollen and turned black, but this I did not see for myself.

Gilles de la Tourette[3] observed the following case. A girl, aged 19, had some mental upset one evening, upon which followed a storm of weeping, bad dreams all through the night, and towards morning pain on the inner side of the right leg. Next day at this spot there were an oval patch

[3] Nouvelle Iconographie de la Salpêtrière, vol. iii

of ecchymosis (5 cm. × 3 cm.) and right hemi-anæsthesia most marked in the painful leg. She was confident that the mark had not been there before and that it was not the result of a blow.

I need hardly remind you that the stigmata of mediæval saints which sometimes appeared during trance or ecstasy have been interpreted, rightly or wrongly, as hysterical hæmorrhages; and the same interpretation might be given to the story of the woman who averred that certain black bruises on her thighs were caused by Satan lashing her with his iron tail, because she resisted his temptations, or to that of Alizon Device, one of the Lancashire witches, who said that a blue mark under her left breast was caused by the devil in the form of a black dog sucking there.

Œdema.

Hysterical œdema was described by Sydenham. He says:[4]—

> Just as this disease attacks all the internal parts, so also does it sometimes take possession of the external ones—namely, the muscular flesh of the jaws, shoulders, hands, legs, and ankles; sometimes causing pain, sometimes swelling. Of such swellings, that of the ankles is most remarkable, differing in two ways from that of dropsy. Dropsical swellings are, in the first place, greatest towards the evening; in the second, they retain the mark of the finger just like wet paste. In hysteria there is no such impression, and the puffiness is greatest in the morning. Generally also it is one ankle that swells. In respect, however, to size and shape, hysterical and dropsical swellings are so much alike that the patient can rarely be undeceived as to their nature.

Sydenham does not mention any change of colour in the skin, but Charcot and his school[5] described a "blue œdema" in which the surface shows a dusky congestion or cyanosis, and it would seem, according to the statements of other authors, that exceptionally the skin may even be red and hot,

[4] Epistolary Dissertation to Dr. Cole, Section 29.

[5] Gilles de la Tourette, Nouvelle Iconographie de la Salpêtrière, vol. ii., p. 265.

and that incisions have actually been made into such swellings.

Hysterical œdema generally occurs in association with some other lesion, such as a contracture, a paralysis, or a painful joint. Generally it persists for some time, but sometimes it appears and disappears rapidly. The diagnosis of such paroxysmal hysterical œdema from the œdema described by Quincke (so-called angioneurotic œdema) has been discussed by Dr. F. H. Edgeworth in the *Quarterly Journal of Medicine* (Vol. II.).

The Hysterical Breast.

The hysterical breast, which in its fully developed form must be a very striking symptom, appears to be a combination of pain, œdema, and congestion, localised in this particular organ. The first reference to it was made, I believe, in 1667 by that distinguished Fellow of our College, Thomas Willis.[6] He describes the pain, tenderness, and swelling of the breast, and the associated hysterical convulsions. Later, an equally distinguished surgeon, Sir Benjamin Brodie, says in his remarks upon local hysterical affections:—

> Young women are subject to an affection of the breast corresponding to the hysterical affections of the joints, and indicated by very similar symptoms. These cases have been noticed by Sir Astley Cooper in his observations on disease of the breast. The patient complains of pain in the breast, and shrinks on pressure being made with the fingers or even on the skin being slightly pinched. Not infrequently the examination of the part produces twitches and motions of the body; yet if it can be dexterously managed while the examination is being made that the patient's attention should be otherwise engaged, not only these motions do not occur, but she may seem scarcely sensible of pain. The morbid sensibility is not confined to the breast, but extends to the axilla and down the arm. No distinct tumour is perceptible in the breast, but when the disease has been of long continuance the whole organ becomes slightly enlarged, probably in consequence of an increased determination of blood to the small vessels; yet there is no redness of the

[6] De Morbis Convulsivis, Ch. vi., Obs. 1.

skin, and indeed the skin is even paler than natural, with a somewhat glossy appearance of its surface.

Pain and tenderness were therefore the leading feature in the cases seen by Brodie; and further, from what he says concerning the twitchings and movements produced by handling the breast, we may suspect that it was not only tender, but might have formed a hysterogenic zone. But certain other physical phenomena, missing in his description, are much in evidence in the description of Gilles de la Tourette [7] and other French authors. The nipple becomes erect, the breast swells, it may be to twice its natural size or more; the skin, which in some cases retains its normal colour, in others becomes bluish-red or bright red, and this congestion has been said actually to go on to gangrene of the skin. Féré has witnessed such swelling and redness develop in a very short space of time, apparently for no other reason than that the patient's attendant had said something that offended her. These phenomena are for the most part paroxysmal, but the pain and swelling may persist in the intervals of the attacks.

Causation of Physical Symptoms.

If I have spent your time, Sir, in speaking about these particular forms of hysteria, it is because they seem to have a particular theoretical interest. They do not fit very easily into the psychical interpretation of hysteria. We can readily understand that hysterical convulsions may be produced by the overwhelming power of some terrible memory; that pain and loss of sensation (which, after all, are but modifications of consciousness) may be produced by affections of the mind; that paralysis, or prolonged contractions, of voluntary muscles might be due to some perversion of volition. Moreover, all these things may be artificially produced by skilful hypnotism. But it is difficult to see how such outward and visible signs as œdema, congestion, or

[7] Nouvelle Iconographie de la Salpêtrière, vol. viii., p. 107.

ecchymosis can be produced by purely mental agencies.

This much, however, may be said: First, that we hardly know as yet how much emotion may do towards modifying our bodily states. And emotion is certainly an important factor in hysteria. Secondly, that these same physical symptoms which I have been discussing sometimes appear and disappear in a way which seems to suggest that they depend upon the patient's state of mind. I will conclude this lecture with two cases which point this way; they shall be very briefly put.

1.[8] A girl, under the care of Professor Janet, had œdema of the wrist and dorsum of the hand. She had also anæsthesia of that side affecting both the skin and the deeper parts, so that (like the case I previously mentioned) she could only move the parts while she was looking at them. The œdema could be dispersed in the following way. While her attention was diverted to some other subject a whispered command was given to her to move her fingers. This she did unconsciously. She was then told to look at her hand, and she said in surprise, "Why, my fingers are moving. I suppose the swelling will go next." And so it did within an hour. The removal of the one symptom through some curious mental connexion effected the removal of the other.

2.[9] A case is given by Dr. Charon and Dr. Courbet relating to the mode of production of a hysterical breast. In an institution for children at Amiens was a girl, aged 13½, who was subject to hysterical convulsions and attacks of sleep. She had menstruated twice; her breasts were highly developed for her age. It so happened that the sister of the ward had an abscess of the right breast which had to be opened. Secondary hæmorrhage occurred after the operation, and caused great alarm in the establishment. The girl was particularly upset, for her own mother had died a year and a half previously from cancer of the breast, which had twice been operated upon. She lay awake for a long time in the night and in the morning felt a sharp pain in the right breast, and found it to be red and swollen. She said nothing, hoping it would pass off, but the following day, when she was having a douche, the affection was discovered. The right breast was swollen, immobile, of a

[8] Névroses et Idées Fixes, vol. ii., p. 511.

[9] Nouvelle Iconographie de la Salpêtrière, 1913, March–April.

uniform bluish-red colour, hot to touch, tender, but not otherwise very painful. She asked the doctor whether it was serious; he reassured her and the breast soon got well.

The authors of this paper are confident that any sort of trickery could be excluded, and they consider that it was a case of "vaso-motor affection," due to "auto-suggestion."

LECTURE II.

Delivered on March 24th.

MR. PRESIDENT, FELLOWS, AND GENTLEMEN,—In my first lecture I considered some of the most striking symptoms of hysteria with the view of showing the difficulty in choosing absolutely between the two alternative methods of explaining them—namely, the physiological and the psychological. I must now turn to the various theories that have been propounded about this disease, limiting myself for brevity's sake to a few, and to recent theories only.

Briquet, the pioneer in modern studies of hysteria, says that it is a disorder of that part of the nervous system which subserves the emotions. Dejerine says: "What emotion can produce as temporary effects, hysteria can produce as lasting effects." Sir Bryan Donkin lays stress on exaggerated impressionability or tumultuous emotion as a principal factor in the disease. Oppenheim holds that hysteria is a disorder of the mind, principally affecting the emotional sphere, and consisting in a want of proportion between the intensity of the stimulus and the strength of the reaction.

Russell Reynolds, Charcot, and Moebius all emphasised the importance of "ideas" in producing hysterical symptoms. Bernheim and Babinski find the keynote in "suggestion." Sollier maintains that there is a torpor of the brain, local or general. Dr. S. J. Sharkey looks on hysteria as a peculiar condition of the brain in which the current or nerve force is distributed in an irregular and fluctuating way, so that some centres are apt to be flooded, others left high and dry, the result being in the one case overaction, in the other paralysis.

Dr. Parkes Weber, regarding hysteria from the point of view of phylogenesis, suggests that it is a sort of secondary sexual character.

Most of these opinions, valuable as they are, have not been elaborated into precise theories, so as to explain in detail the wonderful variety of symptoms which meets us in this disease. Let us go on then to authors who aim at more detailed explanation of the facts.

Physiological Views.

Dr. Charlton Bastian[1] studies hysteria from the point of view of anatomy and physiology. He thinks, however, that the term "hysterical" should not be applied to all nervous affections for which we cannot find an organic cause; there are some which we may justly term functional, but not hysterical. The class of cases which he would thus detach from hysteria is a limited but very important one—viz., paralyses, motor and sensory. One reason given for thus detaching them is that such paralyses may often be found in patients who exhibit no other symptoms—no fits, that is, nor mental peculiarities, such as proneness to exaggeration or caprice, which Bastian apparently considers to be most characteristic of hysteria. Further, whereas hysteria is generally considered to be a perversion of the highest cerebral functions, these paralyses can, in his view, be shown to depend on local affections of the nervous system, and that not only of the cerebral cortex, but also of the lower centres and of the afferent nerve fibres. I alluded in my first lecture to certain similarities between hysterical and organic paraplegia; these and other similarities between hysterical and organic paralysis are studied by Bastian in detail and in a most interesting series of cases. I must be very brief in considering these.

A young woman was unable to move her right arm. There was (at the time of observation) very little sensory loss, except that there was loss of muscular sense in that arm. There was no rigidity. She stated that she could imagine or picture to herself movements of the left (non-paralysed) arm, but could not imagine movements of the right. This type of monoplegia corresponds to the effects of a local lesion in the arm centre of the left

[1] Hysterical or Functional Paralysis London, H. K. Lewis, 1903.

Rolandic area—an area which, in Dr. Bastian's view, is not so much motor in function as kinæsthetic. Movements were no longer possible, because the memories of movements were annulled.

We may take other kinds of case. The hemianæsthesia so common in hysterical cases would be explained as a failure of function in the posterior part of the opposite internal capsule, and a paraplegia, unaccompanied by loss of sensation, but accompanied by rigidity, as a failure of function in the pyramidal tracts of the cord.

Consideration of So-called Functional Paralysis.

Any views enunciated by a physician of Dr. Bastian's experience, and enforced by the cogency of argument whereof he is a master, must deserve the greatest respect. Yet I cannot altogether bring myself to agree with him in separating these forms of so-called functional paralysis from hysteria. His arguments for so doing are mainly two. First, that the affection is a local one. But is this satisfactorily proved? Take the fairly common case of a hysterical hemiplegia, which is generally incomplete and non-spastic, but combined with a hemianæsthesia which is often very marked. On the localising hypothesis there must be two lesions, one in the Rolandic centre and another in the sensory part of the internal capsule. Does not the necessity for supposing two lesions indicate a weak spot in the localising hypothesis? Again, take the spastic cases, and particularly spastic paraplegia. We cannot thoroughly discuss these without reference to Babinski's sign (the extensor plantar reflex). The presence or absence of this is not mentioned by Bastian, for the very good reason that the sign was not known at the time when he wrote. Still, knowing, as we now do, that Babinski's sign is always absent in functional disease, we may assume that it would not have been found in Bastian's cases. Here, then, would be a contradiction; rigidity is present, and from its presence we are asked to infer an abnormal condition of the pyramidal tracts, but Babinski's sign, a far more delicate index of the con-

dition of the pyramidal tracts, is absent. Take, again, the symptom of anæsthesia. If this symptom (as I endeavoured to show in my first lecture) is in a sense unreal—i.e., that many of these patients feel, though they do not know that they feel—surely this militates against the notion of a local lesion, even of a "functional" nature, in the afferent tracts. For how can nerve fibres be so damaged as to bar the transmission of conscious sensations and at the same time let the subconscious sensations through? Lastly, it appears that such paralyses, whether motor or sensory, have been made and unmade by hypnotic suggestion. It is difficult to suppose that such an action takes place in the conducting fibres or anywhere else than in the highest centres.

Dr. Bastian's other reason for refusing to call these forms of paralysis hysterical is that many such patients have no hysterical fits and exhibit no hysterical temperament. But others of them certainly do have fits, and what is more to the point, occasionally a paralysis of this kind appears as the direct sequel of a hysterical fit. About a patient's temperament it is often difficult to be sure without an intimate personal knowledge. Besides there are some patients whom with Charcot we must recognise as "*hystériques placides*." Lastly, in the history of these hysterical paralytics we often find the same sequence of events as in typical hysteria—namely, a neuropathic family history, disappointments, grief, anxiety, fright, ill-health, traumatisms, and (shall I say it?) surgical operations. So that I would still continue to class them as hysterical.

Pathogenesis of Functional Paralysis.

As to the pathogenesis of this functional paralysis, apart from the localisation of it, Dr. Bastian speaks with reserve. He considers (without entirely adopting it) the hypothesis of a vaso-motor spasm causing local defect of function. That hypothesis is naturally suggested by the sudden appearance and disappearance of the symptoms which we often witness. Against it stand the cases where the paralysis lasts for months or years. Another

hypothesis is that of a local malnutrition of the affected nerve areas, primary and not dependent upon any change in the blood-supply, just sufficient to interfere with proper function, but not sufficient to produce structural disorganisation. But we do not know, I think, of any such kind of malnutrition; and moreover the sudden and unaccountable changes which sometimes occur in such cases are very difficult to explain on the basis of a malnutrition, whether from vaso-motor or other cause.

I give as an illustration of this curious changeability the following case of hysterical aphemia or mutism. It will be remembed that Dr. Bastian has pointed out that this particular symptom of mutism, as we see it in hysteria, is just what would be produced by a local lesion of the fibres leading downwards from Broca's convolution to the bulbar nuclei. My case is quoted by Dr. Kinnier Wilson in his article on Hysteria in *Brain* (Vol. XXXIII., p. 312).

A young woman, intelligent, quiet, apparently unexcitable, and anxious to get well, was admitted under my care at Queen-square for an incomplete hysterical hemiplegia. After some weeks she began to stammer. To stop this faradisation was applied. The result was unexpected, for she suddenly became unable to utter a word, as dumb as the son of Crœsus in Herodotus, or as the priest Zacharias in the Gospel of St. Luke. The sister of the ward invented a treatment of her own—namely, to manipulate the patient's tongue. One day, while this was being done, she recovered her speech. But such a speech! A loud, harsh, syllabic monotone, produced with a mouthing and an effort, which was most unpleasant both to hear and to see—"δεινὸς μὲν ὁρᾶν, δεινὸς δὲ κλύειν." It was so disagreeable, in fact, that for the sake of the other patients her hours of speech had to be curtailed; and finally, as it seemed necessary to do something, she was given an anæsthetic, together with the firm assurance that when she came round she would speak quite well. But again the unexpected happened, for when she came round she was completely dumb again, and in spite of all persuasion, whether in hypnosis or otherwise, dumb she remained up to the date of her discharge and for some weeks after. Then the final turn of the wheel came in the following curious way. She happened to find unexpectedly in a drawer a lost picture of her deceased father, concerning which she and the aunt with whom she lived had had frequent discussions as to whether the face looked to the right or to the left. On finding it she

said suddenly, "Look, auntie, I was right," and soon afterwards she recovered her speech entirely.

Now I can hardly think that a local variation of blood supply, still less a local malnutrition of nerve fibres, was responsible for all these curious fluctuations in her speech.

Vaso-motor Hypothesis of Hysterical Symptoms.

The hypothesis of a vaso-motor spasm or vaso-motor paresis as a basis for hysterical symptoms, which Dr. Bastian only suggests, is adopted without reserve by Dr. T. D. Savill. This author considers:[2] 1. That "hysteria consists of an instability or undue irritability of all the nervous and reflex centres throughout the body, and particularly those of the vaso-motor and sympathetic systems." 2. That "hysterical paralysis or tremor and many other hysterical phenomena hitherto unexplained are produced by vascular changes in the nervous system and elsewhere." The only mental process that he admits is that emotion, as a determining factor, may set in action the irritable vaso-motor machinery. "Given inherently unstable nerve centres and cells throughout the nervous system, emotion starts vaso-motor changes and thus disturbs the blood supply and the nutrition of other unstable centres sufficiently to produce in them an abeyance or an irritation of their functions."

Savill lays great stress on certain vascular phenomena which may be witnessed in the skin, such as general or partial blanching and patches of transient congestion, which he affirms are very frequent in hysteria, and, indeed, characteristic of it. He argues that similar processes may take place in the central nervous system, and that local flushing or ischæmia of nerve centres thus caused may bring about hysterical paralyses or other symptoms. For myself I do not agree that the skin symptoms mentioned by Savill are in any way characteristic of hysteria; and I think that there is no independent evidence of the supposed vaso-motor affections of

[2] The Lancet, 1907, vol. i., p. 1693.

the nervous system, and that even if they existed they would furnish a very poor explanation of the phenomena of hysteria. Nevertheless, we shall do well to remember that the mental state which we call emotion has a close connexion with our bodily states, and especially with the state of our vaso-motor apparatus; and further, that in the opinion of several authors (as I mentioned at the beginning of this lecture) emotion is an essential factor in the production of hysteria.

Psychological Views.

You will have seen that both of these English authors approach the problem of hysteria from the physical or physiological side. We will now consider the opinions of two distinguished French authorities (I must limit myself to two) who take the other point of view. In dealing with the French literature I must acknowledge my obligations to my friend, Dr. Kinnier Wilson, both for his excellent article in *Brain* which I have just mentioned, and for other help.

THE VIEWS OF PROFESSOR BABINSKI.

Just as Dr. Bastian would curtail hysteria as viewed from the physical side, so would Professor Babinski curtail it as viewed from the psychical aspect.

Hysteria, according to Babinski,[3] is essentially a matter of suggestion. The symptoms arise in conformity with ideas that have been implanted in the patient's mind, and they can be removed by "persuasion," by which he appears to mean a counter-suggestion of a reasonable kind, calculated to restore the patient to a normal condition. The patient is not a malingerer, for she does not produce the symptoms consciously and of set purpose; nevertheless she does, unconsciously, produce them, and they are never of a kind which she could not produce voluntarily. There is simula-

[3] See principally Ma Conception de l'Hystérie et de l'Hypnotisme (Pithiatisme). Chartres. Imprimerie Durand. 1906.

tion, but it is unconscious and involuntary simulation. How, then, does the patient come by the ideas to which the symptoms conform? And how does it come to pass that in so many patients we find, again and again, the same symptoms (i.e., the same ideas) recurring with such regularity that they have been called "stigmata"—that is, characteristic marks of a disease? Babinski's answer is that these stigmata are suggested by the physician as he examines the patient.

Suggestion as a Factor in Anæsthesia.

Say that a patient is being examined for hemianæsthesia; the touch first on one side of the body, and then on the other, accompanied by the question, "Do you feel that?" in each case is enough to make the patient suppose that she ought not to feel alike on the two sides of the body—and consequently she does not. And it is, as a fact, noteworthy that often before she was examined she did not know that she was hemianæsthetic. In his own practice, Babinski tells us, when the examination is so conducted that no such inference can be drawn from it by the patient, hysterical anæsthesia does not exist.

Now, I have no difficulty in believing that anæsthesia can be produced in this way; indeed, I remember a striking instance of it. There was a girl in Queen-square Hospital whose illness I had diagnosed as hysterical. My then clinical assistant was deeply interested in the study of the distribution of the sensory nerve roots. He told me one day, and demonstrated to me, that this patient was anæsthetic in the area of one of the cervical roots. This, I felt, was a blow to my diagnosis. Next week the anæsthesia had spread to the area of the adjacent nerve root. The following week, however, it had spread all over her body. So we settled down comfortably to the original diagnosis. The patient had somehow appropriated the anatomical knowledge of her examiner.

But that all, or even most, hysterical anæsthesia is produced by such suggestion I cannot admit. Other physicians are as careful as Babinski in

their methods of examination, and yet they find anæsthesia in patients who have never been examined before. You will remember, Sir, the method described by Dr. Glynn in his Bradshaw lecture, in which no question is put to the patient at all. Sometimes, too, we find anæsthesia distributed in ways which we do not ourselves expect —for instance, in irregularly scattered patches. Lastly, it sometimes happens that the patient knows that she is anæsthetic before she comes to the physician. The following illustration of this is from Dr. Kinnier Wilson's paper; it is a case that I well remember, under the care of Dr. James Taylor at Queen-square Hospital. A woman, who had had exceptionally good health previously, developed hysterical symptoms after a fall. She discovered for herself before she came to the hospital and before she was examined by any doctor a numbness and loss of sensation on the right side. There was nothing in the manner of her fall to suggest to her an injury on this side, for she struck her back and her head and supposed that these were the parts injured.

I conclude, therefore, that suggestion by the physician is by no means the only way in which anæsthesia and the other stigmata are produced: I doubt, indeed, whether it is a usual way.

Other Symptoms and their Relation to Suggestion.

Then there are all sorts of other symptoms, which are evidently not suggested by the physician or friends, because they come as a complete surprise to them. These, we are told, may be the result of "auto-suggestion." Now, auto-suggestion is a word as convenient as "auto-intoxication," and about as unsatisfactory. The last part of it implies something coming from the outside; the first part "auto" implies that the preponderant factor is the working of the patient's own mind. Now this would take us back to the remembrance and to the mental elaboration of any previous experiences and any previous ideas—in short, to an explanation which may indeed be correct, but which comprehends far more than the "suggestion" with which we started.

There are further objections to making suggestibility the sole canon of hysteria. We all know people who are gullible enough who are not at all hysterical; and, on the other hand, many hysterica patients are not particularly open to persuasion, at any rate when you try to remove their symptoms that way, whether in hypnosis or out of it. And for the majority of them, granting the supposed susceptibility to suggestion, what causes this? It can hardly be a primary attribute of their minds; there must surely be something beyond it.

And what of such symptoms as œdema, congestion, hæmorrhage, and so-called trophic symptoms, which are so difficult to explain on any psychological theory? These at any rate are not such as the patient could produce by will, apart of course from self-mutilation. Some of them Babinski would class as secondary symptoms. Muscular atrophy, for instance, he considers to be secondary to disuse of the limb. With others he deals very summarily—namely, by denying their existence. They do not suit the theory and therefore they must go. This seems rather too drastic: Professor Babinski is, we know, a giant among neurologists, but he ought not to play the part of Procrustes.

THE VIEWS OF PROFESSOR JANET.

I must now turn to the views of Professor Pierre Janet. For the sake of brevity I am obliged to put them before you in a somewhat dogmatic form; but his method as I daresay you know, is not dogmatic or deductive, for his generalisations are built up on the results of close study of hysterical patients. Certain questions are involved here, of a psychological rather than a medical nature, such as the nature of our personal consciousness and of what is often called now subconsciousness. On this subject Janet advances the following statements.

Consciousness and Subconsciousness.

From our earliest years our ideas—that is to say, mental phenomena or (more shortly) mental states

of all kinds, whether they be sensations, volitions memories, or emotions—have been grouping themselves together into a system in which they become bound together by innumerable ties of association. How or when this system originated we do not know, but the process of addition to it is always going on. Each time that a new mental state is brought into relation with this system we are aware of the fact, and this assimilation or synthesis of the new with the old constitutes a personal perception or act of consciousness.

But much goes on in our minds of which we are not conscious. An impression may be made on our bodily organs and the corresponding mental state arise, a memory may recur or an emotion stir within us, yet we may not realise the fact, because it has not reached the dominant system of our personal consciousness. Many instances will occur to you ; thus of some things, such as the sensations from our internal viscera, we are hardly ever conscious, at least in health ; other things may not reach our consciousness, because at the time it is busy with something else. In questioning a candidate for examination you might not hear the clock strike ; in listening attentively to a lecture you might not notice how close the room was. Such trivial instances show at least that our consciousness has a limited range ; it cannot take in an unlimited number of things at once, especially if one of them is particularly engrossing. Now the assumption may be made that this limitation of the range or "field" of consciousness differs in different individuals, that we have not all the same power of simultaneously taking into it a large number of mental states, and further, that in hysterical patients this power of synthesis is pre-eminently defective.

The importance of this last dictum will appear as we go on ; meanwhile we may ask what happens to the mental states which never rise into the personal consciousness, but remain (as the phrase goes) subconscious. These too may combine into systems, separate from though analogous to the system of personality. The chance for such a combination to begin comes when our personal consciousness is at a low ebb, as may happen during the exhaustion

of illness or anxiety, or during morbid reveries, or from the paralysing effect of a sudden emotion, such as terror, which has given us, so to speak, a knock-out blow; or perhaps because we are so constituted that our personal consciousness has naturally a feeble and noncomprehensive grasp—that is to say, because we are predisposed to hysteria. A vivid impression made upon us at such times becomes associated with other impressions of the moment and with appropriate memories of the past, and thus is originated an independent system of ideas withdrawn from our personal consciousness, a secondary consciousness. Under favourable circumstances this secondary system may grow until it interferes with the primary system or even threatens to usurp its place. The hysterical mind offers a favourable soil for such a growth, for the personal system cannot assimilate readily, and thus leaves the more material for parasitic systems to feed upon. The central government is weak and there results a turbulent home rule all round.

Varied Meanings given to Subconsciousness.

Perhaps I have gone too far in stating these things in the terms of a definite theory. I hasten to add that Professor Janet himself puts forward his views on subconscious phenomena less as a cut-and-dried explanation of facts than as a convenient way of summarising facts. In this he is certainly more moderate than others whose speculations on this subject have been inclined to run riot. For subconsciousness is fast becoming quite a popular word—most unfortunately, I think, for there is still much doubt what it ought to mean,[4] whether it means merely what Carpenter described as "unconscious cerebration," or whether the "subliminal consciousness" of Myers, a mental substratum possessed (as he thinks) not only by every man, but by all men in common, and indeed a part of the infinite mind, or whether the "unconscious"

[4] See Subconscious Phenomena, by Münsterberg and others, Rebman, Limited.

of Freud, that large dark chamber of our mind, the door of which is partly open at night to dreams, but mostly closed by day, until the psycho-analyst comes to call spirits from its vasty deep.

Again, the subconscious system of ideas, or secondary state of consciousness, has been elaborated into the conception of a dual, alternating personality like Dr. Jekyll and Mr. Hyde, or other more historical cases; or even multiple personalities, more than one of which may coexist in the same patient at the same time, as in the famous case of Miss Beauchamp described by Dr. Morton Prince [5]—I beg her pardon, I ought to say the Misses Beauchamp, for there were some four or five of her in the same body. Two of them had a simultaneous existence—namely, the original shy, prudish, neurotic Miss Beauchamp, and a certain rollicking girl called Sally, who knew all Miss Beauchamp's thoughts and doings, and chiefly employed herself in getting her into scrapes. Truly a remarkable psychological family, several people in one, including this oddly assorted pair of Siamese twins! To speculate on their personality makes one's head go round.

Mental "Stigmata."

But to return to hysteria. The fundamental defect, according to Janet, consists, it is true, in a feebleness of mental synthesis; yet this is a condition which has to be inferred and cannot be directly observed. But there are certain very common mental traits open to observation to which he gives the name of mental stigmata, adopting the term used by Charcot for certain common bodily symptoms. These I need only just mention, because I think you will not doubt their existence. Neither will I stop to show their connexions with the fundamental feebleness of synthesis; I will leave that to you. Now we may mention among such mental "stigmata":—

1. Suggestibility—not merely that an idea can be

[5] The Dissociation of a Personality.

easily implanted in a patient's mind, but that it tends to develop there and engross the whole mind.

2. Distractibility. This is merely the obverse of suggestibility; while the patient is occupied with one idea she forgets all others.

3. Feebleness of will, so called "aboulia." Whatever "the will" means, it implies at the lowest estimate a weighing and comparison of many motives, which is just the sort of thing which the hysterical patient cannot do. Sir James Paget, I think, put it thus: It is not that the patient will not, but that she cannot will.

4. Changeability and waywardness, as of symptoms, so of disposition and desires—a trait that has been most unjustly transferred to the whole female sex. "Varium et mutabile semper Femina" was the excuse the gods gave to Aeneas—when he deserted Dido! though it would have been more honest to say with the drunken sailor in the *Tempest*—

> Then to sea, boys, and let her go hang.

Amnesia.

But there is one mental peculiarity on which we must dwell longer—namely,

5. Defective memory—amnesia. In accordance with Janet's fundamental hypothesis, we should expect that a person who cannot gather up into his consciousness many things at once would have a bad memory. Nevertheless, loss of memory in the ordinary sense of the term—namely, a general forgetfulness of all events extending over a given time in the past—is not, I think, very familiar to us as a symptom of hysteria. Possibly that may be because, like anæsthesia, the symptom requires to be looked for. Thus a girl under my care in St. Bartholomew's Hospital gave us a fair history of her illness, but on questioning her more closely concerning the onset it was found that she had totally forgotten all the events of a fortnight or so

at that period of her life. She filled up this gap apparently with what she had been told. Her mother, to whom we referred, knew all about the girl's peculiar loss of memory, but had not thought it worth mentioning. So in this case the symptom was found out almost by accident. Similarly the sister in charge of my then female ward at St. Bartholomew's Hospital told me not long ago that when hysterical patients who had been in the ward came back to visit her after their discharge, being apparently well, many of them did not remember anything about their illness nor what had happened to them in the ward, or at most had hazy memories about it, "like a dream." But Janet gives much more striking instances of this kind of amnesia, where a piece of the patient's life is clean cut out of remembrance.

But in addition to this localised amnesia there is a loss of memory which may be called "systematised." The patient forgets everything connected with a particular person, or a particular event, or even a particular conception. It is a class of memories that disappears, not a series of events in time. This is less strange than it seems at first sight, for our normal memory is a faculty which is given to specialising. One man remembers people by their faces, another by their voices. I knew a gentleman who had a wonderful memory for histories, poetry, languages, derivations of words, and so forth, but if he took a hand at whist he could hardly remember a card that had been played. Now what the hysterical patient is most apt to forget are the things connected with the causation of her symptoms. Thus Mrs. A (already mentioned in my first lecture), when she came to me for a contracture of her fingers, gave me an account from which one would have supposed that the contracture came on spontaneously, until her husband said, "Why, you have forgotten to tell the doctor about the dog that bit your hand." And this brings us to a sort of amnesia which we should all admit to exist—namely, that after a severe hysterical fit the patient, when she has come completely round, forgets all the circum-

stances, physical and mental, of the fit itself. But in all these cases of hysterical amnesia there is a fact which must be emphasised—namely, that the memories are not annihilated, they are simply in abeyance, and under appropriate circumstances can revive. Thus, if the patient's fits be of the dramatic or somnambulistic type, the drama, or at least its *leit-motif*, recurs in each attack. Or perhaps under hypnotism or by means of automatic handwriting the patient may be made to reveal the lost memories. So we may put it in this way—the memories have disappeared from the system of personal consciousness, and the patient cannot call them up at will, but they remain in the subconsciousness, attached probably to some independent system of ideas, in connexion with which they can automatically reappear.

Fixed Ideas.

After saying that hysterical patients are apt to be forgetful, changeable, and irresolute, it seems almost a contradiction to say that they are dominated by fixed ideas. So far from being a contradiction, however, it is almost a corollary of what has been already said. In speaking of a fixed idea we generally, I think, refer to the obsession of a psychasthenic patient. This is something actually present to his consciousness. He knows too well the feeling that he may have committed some crime, the fear that he may be suffering from some disease, the impulse to injure himself or others. As a set off, indeed, to the unwelcome presence of this idea, he generally retains some control over it, so that it rarely becomes completely realised, either in thought so as to become a delusion, or in action so as to become a crime. But the fixed idea of the hysterical patient is altogether subconscious. It is part of, indeed the nucleus of, a secondary system of consciousness. Thus, being out of relation to the system of personal consciousness, ignored, uncontrolled, and uncorrected by the patient and by the realities of her daily life, it is all the more likely to become fixed and to develop abnormally, both in precision of detail and in over-

powering effect. You and I, perhaps, with our humdrum lives and phlegmatic temperaments, hardly recognise the picturesque and realistic power of a vivid idea. Yet you remember how the widowed Lady Constance describes the loss of her only son—

> Grief fills the room up of my absent child,
> Lies in his bed, walks up and down with me,
> Puts on his pretty looks, repeats his words,
> Remembers me of all his gracious parts,
> Stuffs out his vacant garments with his form—
> Then have I reason to be fond of grief.

So long as the fixed idea remains buried in the subconsciousness it may give rise to no overt trouble; but should circumstances arise to weaken the grasp of the personal consciousness, so that it vacates its proper dominion, then the subconscious idea may assume command. The result is a hysterical fit—that is, a somnambulism, or second state of consciousness, in which the patient passes out of relation to her real conditions, into an imaginary set of conditions dictated by the fixed idea or reminiscence of the past. As we do not often see in this country perfect specimens of hysterical somnambulism, I will quote one from Janet's writings.[6]

A girl had been alone in lodgings with her mother; she had nursed her day and night and worked in the intervals for her daily bread. When the mother died the daughter tried to restore the respirations, but the only results of her efforts were that the body fell from the bed and she had the utmost difficulty in replacing it. The girl's fits began some time after the funeral. In the fit she went through the scene of her mother's death, partly in word, partly in action, with all the terrible details; and when that was over began preparations for her own suicide by throwing herself under a train. She stretched herself on the floor of the ward and lay there half frightened, half impatient, waiting for the train to come. At last it came; her eyes dilated with terror, she gave a loud shriek, and then lay motionless as if dead. This fit might be repeated more than once, but when it was well over she picked up the work she had been doing and went on with it, totally unconcerned

[6] Les Névroses, Paris, Flammarion, 1910.

with what she had been through, because, indeed, she was now totally ignorant of it.

In such a fit the sudden and complete development of the idea and the equally sudden and complete disappearance of it are in striking contrast with the persistent, conscious, but incompletely realised obsession of a psychasthenic patient.

Action of Subconscious Ideas.

But the subconscious fixed idea, without superseding the personal consciousness and without taking temporary control of the mind, may have other more permanent effects upon the patient. I have mentioned the theory that hysterical paralysis is due to an idea. This originally meant that the patient did not move because she thought she could not, or because some thought restrained her from moving. It was urged as an objection that patients denied the existence of any such thought. This difficulty disappears now, since we have learned that there are many thoughts in our minds of which we know nothing. In some cases the existence of such an unrecognised thought can be shown by the history, as when the paralysis can be traced back to some suggestive event, such as an injury, or a fright, or the sight of some stricken person, Or again, the symptom may follow directly upon a hysterical fit, so that we may suppose that some part of the idea, which was elaborated in the fit, survives when the fit has subsided. In the drama of suicide, just mentioned, if the imaginary train had gone over the patient's legs, it is quite likely that she might have remained paraplegic. In many cases, however, we can obtain no clue to the patient's fixed idea, unless we can make some direct appeal to the subconsciousness, by hypnotism or some similar means. But if you grant that a subconscious idea may act in the way described, then it is obvious that a large variety of hysterical symptoms may be explained in this way, not only paralyses, but also pains, spasmodic movements, and some peculiar contractures like those quoted in my first lecture.

There are other ways in which Janet's theories are adapted to the explanation of hysterical symptoms. Anæsthesia, for instance, can be referred at once to his fundamental conception of hysteria—namely, the inability to realise many ideas at the same time. Owing to this inability sensations, which may be at the same time unimportant for the patient to realise, are allowed to drop out of her personal consciousness, and fail again to find a place in it. We can understand the peculiarities of hysterical anæsthesia when we consider it from this point of view; how it is that the patient is unaware of her anæsthesia, how it is that she can still feel, though she does not recognise that she feels, and finally the distribution of the anæsthesia, which does not correspond to anatomy, but to the anatomical ideas of the man in the street about a hand or a wrist, an arm, or other parts. Though of course if a functional anæsthesia befell some member of my audience whose anatomical conceptions are correct, and who think in terms of Dr. Head's diagrams, its distribution might possibly be different.

Hemianæsthesia, limited by the middle line, has always seemed to me a little curious regarded in this light. I suppose Janet's explanation is that we think of ourselves as made up of two halves, right and left. I wonder if we really do. An observation by Dr. Foster Kennedy, quoted by Dr. Kinnier Wilson,[7] seems to point that way. Dr. Kennedy, while going his rounds as house physician at Queen-square Hospital, found a woman who had hysterical hemianæsthesia of the left side, with her right arm so placed that her right (sound) hand was well to the left side of her body. It occurred to him to test the sensation of the right hand while it was in this position, and he found it was anæsthetic, which it had not been before.

The Psychological Representation of a Function.

Anæsthesia has been advanced as an explanation of diverse other hysterical symptoms—for instance,

[7] Brain, vol. xxxiii., pp. 334, 345.

it has been said that retention of urine is due to anæsthesia of the bladder, and anorexia nervosa to anæsthesia of the stomach. But of many things of this kind Janet takes a much more general view which is based on his idea of that which we roughly call a function. This idea I must try to put before you, in concluding this lecture.

I suppose that by "function" we generally mean a combination of bodily events, so that they work harmoniously together towards some given physiological end. In some of these combinations the organisation is complete and fixed almost from our birth, like that of the circulation, over which we have little, if any, personal control. Over others, like that of micturition, a certain amount of control is still exercised. In others, like that of walking, we can watch the gradual change from conscious effort to something like automatism. It is worth noting, however, that even when practice has made a function perfect, it is still liable to be upset by unusual mental conditions. A person who can walk without thinking along a country road, or even saunter through the traffic of a big thoroughfare, might be unable to walk in a State procession down the nave of Westminster Abbey, because, as we say, he is "nervous."

The combinations necessary for the performance of a function are made in the central nervous system, and in the case of the lower, most completely organised, functions we know the groups of cells and fibres, the so-called centres, which chiefly preside over the function. We know something of the anatomy of even such a high function as that of speech, and we imagine that similarly for the very highest functions there must be some anatomical arrangements in course of formation, though we must own we do not know. Now Janet holds that for the due performance of a function an organisation, comparable to this bodily organisation, must have been made in the mind. Just as simple sensations and memories are built up to form the idea of an object or of a movement, so a far more complicated system of ideas and memories is built up to form the psychological representation of a function.

Perhaps you will think this rather too transcen-

dental, and will find in it only the desire to escape, as many desire to escape, from the thraldom of our vile body, as in the Ideas of Plato, and the bodies celestial of the Apostle Paul. But no denial is made of physical organisation within the brain; it is merely asserted that in the present state of our knowledge it is more profitable to study the psychological aspect.

Exercise of Function in the Hysterical.

Let us assume that combinations or systems of ideas exist in our minds, which represent functions. These in the normal mind must be in touch with and under the control of that large system of ideas which we have called our personal consciousness. But in the hysterical mind this is evidently just the proviso that may fail, because the unifying personal element is feeble. The bodily conditions necessary for the exercise of a function may be perfect, the psychological organisation, also necessary for it, may exist, but this latter may have dropped away from the personal consciousness. Two possibilities may then arise: either the patient may be utterly unable to exercise the function voluntarily and consciously, or else the function may exercise itself automatically and without control. I will take but one illustration—namely, the function of speech.

1. "Functional paralysis" of speech, in an incomplete form, is seen in hysterical aphonia, hysterical stammering, and possibly in other varieties of speech affection. In a complete form it is seen in hysterical mutism or dumbness. Yet in such cases the organisations necessary for speech, whether bodily or mental, must be intact, for the patient may find her voice under the surprise of an electric shock or perhaps will talk in her sleep, and in any case we know full well that some day she will speak quite well.

2. The other condition—viz., uncontrollable speech—is not, I must own, very familiar to me. But Janet has seen many examples of what he calls

hysterical logorrhœa, in which the patient pours forth, for hours together, floods of conversation, generally of a disconnected kind and forgotten as soon as uttered. The only illustration I could myself give was not a case of pure hysteria, for the lady who was the subject of it became insane. All her friends knew that an attack was coming on when once she began to talk; soon the talking became incessant, and delusions became intermingled with it. One delusion was that she was the recording angel, and the things that she recorded, in a loud voice, were extremely embarrassing to many of her friends.

Now, whether you grant the existence of psychological equivalents of functions, or whether you think the conception too vague and elastic, still you will admit that such an idea may help to give some definiteness to our notion of a "functional disease" which hitherto has been based simply on negative characteristics.

I hope, Sir, that I have not wearied you out with this discussion on theories, and I hope that in trying to put them into the compass of one lecture I may not have seriously obscured the authors' meaning.

In the next lecture I propose to consider Professor Freud's doctrines about hysteria, and since that will involve the discussion of certain disagreeable topics I must ask you your pardon in advance.

LECTURE III.

Delivered on March 26th.

MR. PRESIDENT, FELLOWS, AND GENTLEMEN,—The doctrines of Professor Sigmund Freud on the subject of hysteria and other neuroses have not been generally known in England till within the last few years, since they were at first published in a tentative and disconnected way, and only in German. But lately an American translation of his principal work has appeared, and his theories have been expounded in England by Dr. Bernard Hart, Professor W. Brown,[1] and Dr. David Forsyth, so that doubtless they are familiar to many of my audience. But in view of their original character, of the wide application that has been made of them, and of the keen controversies to which they have given rise, it is necessary that I should attempt some exposition of them.

THE VIEWS OF PROFESSOR FREUD.

They originated, historically, in observations made by Dr. Joseph Breuer, and by Freud himself, some 30 years ago. The first case reported by Breuer was briefly as follows:—

A young woman under the strain of nursing her father developed a severe hysteria with manifold symptoms. Among these symptoms was a sort of alternating mental condition. Thus at certain times of the day she was excited and had hallucinations; at others she was somnolent, and at others again normal. While in the somnolent phase, a sort of auto-hypnosis as it seemed, she uttered sounds and disjointed phrases which were discovered to relate to previous events of her illness, and it was found possible by suitable encouragement to get her to talk of these events, and to express her feelings concerning them. After such a talk she

[1] THE LANCET, April 19th (p. 1114) and 26th (p. 1182), 1913.

was always better. Artificial hypnosis was then substituted for the auto-hypnosis, and then further progress was made. She could narrate precisely the conditions which had given rise to particular symptoms, and after that, provided the emotion appropriate to the occasion manifested itself, the symptom in question disappeared. This was called the "talking cure" or "chimney-sweeping," or in more dignified language "katharsis."

Summary of Earlier Conclusions.

This method of treatment was applied by Breuer and by Freud to other cases, and from a study of them were derived their first conclusions about hysteria, which may be summarised as follows:—

1. That a hysterical symptom may originate from some disagreeable occurrence, the memory of which is still active, though it has passed from the patient's consciousness.

2. That the symptom can be cured if this memory can be revived in consciousness, and if the patient can be brought fully to relate the occurrence and to express the emotions to which it gave rise.

3. That the reason why the patient has forgotten the disagreeable occurrence which has so affected him—the mental trauma, as it may be called—may be of two kinds: Either (*a*) because when it arose he was in a condition of inattention to his surroundings, a sort of day-dream or state of incipient double consciousness. These states, which Breuer calls "hypnoid," he considers to be common in hysterical patients. In genuine traumatic hysteria the mere shock or fright may produce such a state *de novo*. Or (*b*) because the memory of the occurrence is so disagreeable to the patient that he has voluntarily banished it from his consciousness. The hysteria has then arisen by way of "repression" and is designed to protect the patient from objectionable memories. Such hysteria by repression is called by Freud a "defence-neurosis," and it is apparently the only kind of hysteria which he now recognises.

4. What is the relation of the hysterical symptom

to this repression of the memory or idea? The answer is that though the patient may successfully banish from his consciousness the disagreeable idea, yet he cannot thus rid himself of the emotion which attends upon it, the "affect" as it is technically termed; and this would remain as a source of distress were it not that hysterical patients have the faculty (so it is said) of directing this emotion into bodily channels and thereby converting the affect into a symptom, such as pain, spasm, paralysis, and the like. But when the original idea, the skeleton in the secret cupboard of the mind, has been dragged out into the light of consciousness, and the emotion stirred by it has been poured forth in words or tears or passionate display, then the symptom which represented the emotion is no longer needed, and disappears. This is cure by "katharsis." It is, as Aristotle said of tragedy, "a purge for the emotions."

Later Development of Theories.

No doubt these views are simple and attractive. One might doubt, perhaps, the universal efficacy of treatment by "katharsis," and one might ask for much more evidence and explanation concerning the supposed hysterical faculty of "converting" emotions into symptoms. Still we recognise the emotional element in hysteria, and we recognise also the relief given to pent-up feelings—by tears, or perhaps by oaths. But such simple statements are very far from representing the theories developed later by Freud. In these latter, it is true, hysteria remains as a type of a "defence-neurosis," based on the repression from consciousness of disagreeable ideas. But this power of repression is elaborated into a mental faculty which forms the keystone of a large system of psychology. Secondly, the simple plan of hypnotism, followed by "katharsis," is replaced by the method of psycho-analysis. Thirdly, the particular class of ideas and events at the bottom of hysteria, and indeed of all neuroses, is declared on the testimony of psycho-analysis to be solely the sexual class.

Now, it would appear that Freud arrived at his larger theories partly by studying dreams (his own and those of his patients) with the aid of psycho-analysis, partly by studying the symptoms of neurotic patients in the same way, and partly (as it seems to me) by sheer speculation.

The "Censor" and the Unconscious Mind.

The object of psycho-analysis is to bring to light ideas which have been lost to consciousness or which, it may be, have never been apprehended in consciousness. For, according to Freud, the greater part of our mental activity is unconscious. There is within our mind a great mechanism or system of the Unconscious, which receives impressions, stores them in memory, and groups them together by association. Moreover, in this same system, or chamber, of the Unconscious are domiciled the emotional elements of our being, appetites, impulses, and desires, which are constantly striving for an outlet in action and in conscious thought. But before they can arrive at their goal they must pass through another stage called by Freud the Fore-conscious or Pre-conscious. Into this stage they cannot pass till they have been brought into conformity with certain standards, rules, and regulations; but once having been brought into such conformity they can pass into the stage of the Fore-conscious, ready to be called up into conscious thought or action. This sounds so obscure that I will venture on an analogy. You are going to pay your respects to Royalty. You gather together without any formality in certain suites of spacious rooms. These I compare with the Unconscious. Going on with the stream you must pass a door, where certain lynx-eyed officials stand, who may require you to correct any error in your costume, under pain of being turned back. Once past that door you find yourself, not indeed in the Presence, but in an ante-chamber, which you may call the Fore-conscious, and ready at the beck of the authorities to be called into the Royal presence, which I venture respectfully to compare to the highest stage, that of conscious thought.

Now the standards, rules, and regulations, to which our thoughts must conform before leaving the Unconscious, have been elaborated by the many influences which have been brought to bear on each individual in the course of his life—education, religion, public and social opinion, previous experiences, previous mental conflicts, and the like. Such influences are summarised, I might say personified, by Freud under the title of the "Censor." The Censor determines what thoughts and strivings from the Unconscious shall be allowed to play their part upon the stage of consciousness, or again he can withdraw his licence, and relegate them back to the Unconscious. But there for good or evil they still exist, and it is asserted that by means of psycho-analysis we can find them out.

A great discovery, if only it be true.

The Process of "Free Association."

Now the assumption has to be made that our thoughts are not determined by chance or by our own volition, but that thought follows thought as surely as event follows event in the physical world; and further, that if any occurrence or thought in the past has given rise to a chain of thoughts which eventuates in a symptom or an idea in the present, this chain can be traced back from the present to the past. For contemplation of the present idea will cause an associated thought of the past to arise in the mind, and contemplation of that thought a further one, and so on from thought to thought till the whole chain can be unravelled. This is called the process of "free association." We must emphasise the word "free." It means freedom, not only from external interference, but also from interference from within. For if the unravelling of associations leads to thoughts which do not meet the demands of the Censor they will be repressed by him, so that either they will not rise to the surface at all or else they will arise in a modified, perhaps an unrecognisable, form.

Psycho-analysis.

The actual process of psycho-analysis is much as follows. The patient must give his willing and intelligent coöperation, and for this it will probably be necessary to furnish him with some explanation of the method to be followed. And first he must give a full and detailed account of his symptoms and the history of his illness so far as he can consciously remember it. It is to filling up gaps in this account or to the explanation of particular symptoms that the psycho-analysis is primarily applied. (I defer for the present the consideration of dreams.) For this he is placed in a restful position, on a couch or chair, usually with his eyes closed, and is told to concentrate his attention on the circumstance or symptom under consideration, and to say what thoughts come into his head or what pictures arise before his mind's eye in connexion therewith. His attitude is to be simply one of contemplation; he is not to try to think of appropriate things, nor yet in any way to criticise the thoughts that do occur to him, but simply to let them come, and to tell them to the physician, no matter how trivial, irrelevant, ridiculous, or disagreeable they may seem to be. From the thoughts or pictures thus obtained others will be obtained, and so on, I must not say *ad infinitum*, but until something essential or important has been reached. It is for the physician, I presume, to settle when to stop, and for him also to settle during the process what clues are to be followed up. In most cases, at any rate, a long process of disentanglement of ideas is to be expected; success in which process will depend partly on the facility with which the patient can produce mental pictures, and partly on the skill of the physician in selecting likely lines of research.

Now if, as I should imagine is often the case, the patient says that no thoughts will come, this, according to the psycho-analyst, is due to the action of the Censor. Thoughts are there, and probably important ones, but they are barred because they are disagreeable to him, or lead up to others that are disagreeable. The patient must be assured that thoughts are ready to come, and if by

urging or persuasion or any other means he can be brought into a more contemplative and less critical frame of mind, it is said that they will come.

To an outsider it must be owned the situation seems to be peculiar and even to have a touch of comedy. It reminds one irresistibly of the "thinking shop" in the *Clouds* of Aristophanes, where the old country bumpkin Strepsiades is lying on a couch—less clean and comfortable than the couch in a Harley-street consulting-room—and Socrates, who is in vain trying to extort some ideas from the old man's head, says :—

Σω. Οὗτος, τί ποιεῖς ; οὐχὶ φροντίζεις ; Στ. ἐγώ ;
νὴ τὸν Ποσειδῶ. Σω. καὶ τί δῆτ ἐφροντίσας ;
Στ. ὑπὸ τῶν κορέων εἴ μοὐ τι περιλειφθήσεται.

. . . . .

Σω. οὗτος, καθεύδεις ; Στ μὰ τὸν Ἀπόλλω 'γὼ μὲν οὔ.
Σω. ἔχεις τι ; Στ. μὰ Δί' οὐ δῆτ' ἔγωγ'. Σω. οὐδέν πάνυ ;

. . . . .

Σω. μὴ νυν περὶ σαυτὸν εἴλλε τὴν γνώμην ἀεί,
ἀλλ' ἀποχάλα τὴν φροντίδ' εἰς τὸν ἀέρα,
λινόδετον ὥσπερ μηλολόνθην τοῦ ποδός.

Socrat. Are you not thinking ?
Streps. Certainly I am.
Socrat. What was your thought then ?
Streps. I was wondering
How much these bugs would leave upon my bones.

(Socrates reproves him and proceeds) :

Socrat. Now, are you sleeping ?
Streps. No such luck, by Heaven.
Socrat. What have you got then ?
Streps. Nothing.
Socrat. Nothing at all ?
Streps. Nothing, but what I have in my right hand.

(The real reply is too Aristophanic for translation, and too Freudian.)

(Finally Socrates explains to him the frame of mind desired :)

Socrat. You keep your thought too centred on yourself.
Let it soar freely in the boundless air,
Just like a beetle threaded on a string.

You might call that "free association."

Another difficulty may be that the productions of the patient seem to be utterly irrelevant and meaningless. This, too, is put down to the action of the Censor. Such futilities are supposed to represent thoughts which in their original state he will not allow to pass, and therefore they have been dressed up, as it were, in a fantastic guise and in this way have slipped past the Censor into Consciousness. To utilise them the physician must interpret them in a symbolic sense. This interpretation by symbols is a very important matter, but I will return to it later.

A Modification of the Procedure.

To be complete, I ought to mention here a modification of the process of psycho-analysis introduced by Professor Jung, of Zürich. A long list of a large variety of words is made out. These are read out one by one to the patient, and he is told to answer to each one, as quickly as he can, with the first word that comes into his head in connexion with each word that is read out. The time taken for each answer is noted on a stop-watch, and it is generally found that he is much longer in answering to some words than to others. This tardiness in reaction is assumed to be due to the fact that the word has called up by association some idea or memory that is disagreeable to the patient and which he therefore tries to repress. It indicates, we are told, "a repressed complex." "Complex" seems to me an unfortunate word, but it is used in this connexion to indicate an idea or system of ideas with which is bound up some powerful feeling. Now if the assumption made about the reactions to the test words be correct, we can find out by them the existence of such "complexes," and possibly, from the nature of the patient's replies, make some sort of guess as to the nature of the "complexes." So that, as Dr. Forsyth points out, this method may serve as a useful preliminary to a psycho-analysis, by enabling us to determine what tracks to follow out.

Difficulty of Psycho-analysis.

I believe that the above description fairly represents the process of psycho-analysis as described by Freud and his followers. If it be objected that in this description I have mixed up theory with practice, I reply that that is exactly what they do. Thus any hitch in the process is put down to the action of the Censor, whereas the very assumption of such a Censor is only justified by the results of the process itself. And the same for other assumptions made about it. But let us defer criticism for the present; enough has been said to show that the method of "free association" is not so easy as those terms might imply; indeed, what with the numbers and complexity of the possible trains of ideas, the barriers or "resistances" to their appearance interposed by the Censor, and the distortion of thoughts produced in their struggle for emergence, the psycho-analysis of a case may be a very difficult process. And also a very long one: Freud tells us that one of his cases was unfinished at the end of five years.

Upon data obtained by this method is built up the whole system of Freud—whether principally upon the psycho-analysis of dreams or upon that of cases of hysteria, it is hard to say, for he refers us from the one to the other in a way that is puzzling. But since he tells us that the interpretation of dreams is the "*via regia*" to a knowledge of the unconscious, I must not evade his views on that subject, and must tax your patience while I try to explain them.

Interpretation of Dreams.

We all know the dream as it presents itself to the dreamer—generally a sort of moving picture of persons, things, and situations, a picture which differs strangely from our waking thoughts, but in which nevertheless we can generally recognise fragments of our waking experiences grotesquely pieced together. This Freud calls the *manifest* dream: it is to be sharply distinguished from the thoughts which really prompt it, which he calls the

dream thoughts or *latent* dream. The manifest dream is a representation of the dream thoughts, but they are so altered and distorted that without interpretation they are unrecognisable. They are there, it is true, but they are jumbled, confused, and symbolised to such an extent that the manifest dream may be compared to a picture puzzle or a hieroglyphic, which needs deciphering to get at the dream thoughts.

How and why does this distortion take place? The "how" involves several processes; and I must mention some of them, since a knowledge of them is necessary for interpretation.

1. An object in the manifest dream may be compounded from several elements in the dream thoughts; this is called "condensation"; just as we may suppose a centaur to be compounded out of a horse and a man, or a mermaid out of a girl and a fish, or, to take words, just as we talk of the "Bakerloo" railway.

2. Allied to this is the process of "over-determination." A number of things in the dream thoughts may converge, or be piled up, as it were, so as to produce one thing in the manifest dream. Say you have been travelling abroad and the night of your return you dream of lions. Perhaps you started from the city of Lyons in France, read a book on the journey about big game shooting, and as you drove out of Charing Cross Station saw the name of Lyons over a tea shop. Thus the lions in your dream were over-determined.

3. "Inversion." The dream may invert the dream thoughts or take them in the wrong order, so that for interpretation it must be read backwards like Chinese. We might dream first of having a son and heir and afterwards of getting married; or a candidate for examination might dream he came out bottom of the class list because he really wished to come out top.

4. "Displacement of values." This means that the importance or the feelings which attach to a particular element in the dream thoughts are in

the dream transferred to something else, or suppressed or disguised. In dreams, perhaps in dreams only, we love our enemies. We might adopt a strange child, because we really felt anxious how to support our own. We might ask a crossing sweeper for a cheque, or give a penny to a millionaire. A young man, says Freud, dreamed that he had a hole in his overcoat and was terribly shocked at it. The rent had really been in something else. In technical language, the "affect" was transferred.

5. Dream thoughts may be expressed in the manifest dream by symbols, whereof the dreamer himself, whether asleep or awake, does not know the meaning.

6. We are further told, though this is less obvious that just as the dream picks up the happenings of our daily life and weaves them into a sort of drama, so in order to complete this drama it picks up the fancies and day-dreams in which we may have indulged in our waking hours, and incorporates them into the drama of the dream. This is called "secondary elaboration."

All these processes, and others which I pass over whereby the dream thoughts are transmuted into the manifest dream, are called the "dream work." But why should there be any such dream work? What need is there for all this elaborate misrepresentation? The answer given is this. Our dream thoughts are thoughts which in our waking state we do not recognise as desirable, and therefore the Censor rigorously represses them. But when we sleep, the alertness of the Censor, like that of our other faculties, is dulled, and then is the opportunity for such thoughts to crowd into consciousness. Nevertheless the Censor sleeps, as has been said, with one eye open; and therefore the dream thoughts must assume a disguise in order to evade him and get through into consciousness.

For simplicity's sake, I have omitted the consideration of certain types of dream, which are very common, such as dreams of falling, of flying, of being without clothes in the presence of others, and also of the important fact that the physical condi-

tion of the dreamer has an effect upon his dreams. About these things Freud has his special views, which will not commend themselves to everybody.

Causation of Dreams.

Why should we have dreams at all? According to the theory we are considering, dreams are caused by the striving of deeply buried impulses towards conscious gratification. This, apparently, is the final meaning of Freud's well-known formula, "the dream is a fulfilment of a wish." Now at first sight that seems a most untenable proposition. We often have dreams that we should be sorry to see fulfilled, and oftener still our dreams seem to have no relation to our wishes at all. But we must consider two points.

First. that the wish is contained in the dream thoughts, and must be sought there, not in the manifest dream where it has been efficiently disguised. Perhaps we may except some of the simple dreams of childhood, which may be understood without interpretation.

Secondly, what does Freud mean by a wish? In the earlier parts of his book he certainly speaks of very ordinary everyday wishes as being fulfilled in dreams, such as the wish to obtain an appointment, the wish to meet a particular person, the wish to go on sleeping, or even the following somewhat ludicrous position of affairs. A man dreamed a dream which he said the professor could not interpret as the fulfilment of a wish. Nor could he, until the interpretation occurred to him that the wish in the man's mind was that the professor might be shown to be in the wrong! But later Freud indicates that such banal wishes are not sufficient by themselves to produce a dream unless they can borrow energy from some of the primitive unconscious desires which are always struggling to emerge into consciousness. In his own words, "A conscious wish is a dream inciter only if it succeeds in arousing a similar unconscious wish which reinforces it." And further, though he does not distinctly assert it, yet it is more than once hinted

and implied by him that the chief unconscious inciter of dreams is the sexual desire. Thus a most important modification has been introduced into the original simple meaning of the word "wish." Why it should have been introduced is not clearly explained; I presume, however, partly because further and more prolonged psycho-analysis pointed that way, partly because this modification brought the theory of dreams into correspondence with his completed theory of hysteria and neuroses in general. To which theory, Sir, I must now turn again.

Theory of Hysteria.

Hysteria, he says, like the dream, is based on unconscious thoughts which have been repressed or modified by the agency of the Censor, and the symptoms of the disease, like the pictures of the manifest dream, have to be interpreted by psycho-analysis. But these unconscious thoughts have always a sexual basis. Indeed, in Freud's view this is the basis of all neuroses. He makes this sweeping assertion: "In a normal sexual life no neurosis is possible."

This is a great departure from the original theory of Breuer, according to which the psychical trauma, the memory of which gave rise to the hysteria, might be constituted by any disagreeable event; and it sounds strange, in view of Breuer's first case (quoted above), in which the sexual element was conspicuous by its absence. How, then, was this dictum arrived at? So far as I can make out by the persistent and extensive use of psycho-analysis, which showed that when a history was traced back far enough repressed sexual ideas always emerged. At one stage of his investigations, on the basis of 13 cases, Freud stated that the events which started these ideas were actual criminal assaults on the patient in early life. This statement, as you may easily imagine, had to be given up; the stories of the assaults were simply "phantasies" of the patient, which both he and the psycho-analyst erroneously took to be true. The factors originating the hysteria had then to be sought still further back in life. From this

necessity, it would seem, arose Freud's theory of sexuality in the infant. This theory is ingenious and interesting, but to my mind improbable and extremely disagreeable. Nevertheless, it holds such an important position in the views of Freud and his stricter disciples that I must ask your leave, Sir, to give the outline of it.

Infantile Sexuality.

The child, contrary to what is generally thought, has sexual feelings long before the age of puberty, indeed, from his earliest infancy. But this infantile sexuality differs from that of the adult in several particulars. It is unconscious, and not recognised by its possessor in any more definite sense than that of a vague impulse which seeks gratification. It has not the definite scope and definite external object that come in later years; and several regions of the body, not one only, can minister to its gratification. It may therefore be called "auto-erotic" and "polymorphous." It has in itself the germs of all adult sexual impulses, not only of those which are recognised as right and proper, but of those which are perverted and wrong. The right adult sexuality has to be evolved from it by severe processes of restriction and repression.

To follow this out in detail would not be desirable in a lecture, but I may give some brief indications of what is meant. When the auto-erotic impulse of the child first turns to an external object that impulse is bisexual; the homo-sexual element in it has to be suppressed, in order that the individual may become normally hetero-sexual. The first external object of the infant's desire—namely, his mother—must wane, lest in later life he be left under the domination of the so-called Œdipus-complex. The outlying regions of his body—skin, mouth, anus—or so-called "erotic zones," which originally helped to gratify his desire, must be suppressed in favour of the proper genital zone. I shall not elaborate these points; most of them are disagreeable, some like the following one are simply ludicrous. Thus we are told that a predominance of the "oral

zone" (mouth and lips) is indicated by a persistent habit of thumb-sucking. This is supposed to give the child some kind of sexual pleasure. One would naturally have thought the pleasure was connected with the remembrance of taking food. Such children, says Freud, become as adults "habitual kissers, and show a tendency for perverse kissing, or as men they have a marked desire for drinking and smoking." I hope, if only for my own sake, that this is not true. Yet such according to our modern Struwelpeter is the fate that

comes
To little boys who suck their thumbs.

And so on through a whole gamut of vicious propensities—sadism, masochism, exhibitionism, and the like—all of which are said to have their root in the undifferentiated sexuality of the infant. Though what positive evidence there is for these statements I really cannot discover.

The Mental Conflict in Hysteria.

Now the doctrine of hysteria is connected with this doctrine of infantile sexuality in this way. The infant, though sexually minded, is not worried by that fact. He is shielded by ignorance and lives happily in his garden of Eden. As he grows up the stream of his sexual impulses is narrowed and directed into proper channels by education and other influences. But with the arrival of puberty and under the stimulus of physical sexual development the strength of this stream is enormously increased. If the old channels are insufficiently obliterated they may be opened up again, and with such reopening comes the danger of sexual perversions. Add to this the change that has now taken place in his mental outlook; for consciousness is now directed upon the sexual sphere, which was previously hidden, and further, the revelation of it may take place in some sudden or disagreeable way. Then, to avoid the conflict between the stirrings of a natural impulse and the repugnance felt for the distasteful sexual idea, the individual resolves to banish this idea from consciousness.

The Censor bans the play. But he cannot stifle the desires and feelings which prompt it. They must have an outlet, and in the case of hysteria this outlet is provided by the "conversion" of them into bodily symptoms.

The Process of "Conversion."

Now in this so-called process of conversion there is much that is not clear to me. It is not obvious why the faculty of conversion should be only possessed by hysterical patients, nor what is its precise mechanism, nor why hysterical symptoms should satisfy desire, nor why, if the desire is always the same—namely, sexual—the symptoms that satisfy it should be so manifold. To meet this last difficulty we may perhaps introduce a further statement of Freud. He says that hysterical people have the habit of indulging in "phantasies" —that is, day-dreams, reveries, or castles-in-the-air. The content of these day-dreams is generally (so he says) erotic, in women always so. To the desire that prompts them these phantasies stand in the same relation as does the manifest dream to the dream thoughts, and like the manifest dream they have to be interpreted by psycho-analysis. It is these manifold phantasies which are converted into the manifold symptoms of hysteria. Thus, the parent of the symptoms is the phantasy, and the parent of the phantasy is the original sexual motive; or if you wish to connect the symptoms more directly with the motive you may use the language of the stable, and say that they are bred out of Fancy by Desire. The whole thing sounds very hypothetical, and we are told, indeed, by Freud that the relation between the symptoms and the phantasies is a complicated one and only to be understood by psycho-analysis.

Summary of Theory.

I will endeavour now to make a short summary of this complicated theory of hysteria.

The infant has sexual feelings, inchoate, indeed,

and unconscious, but so extensive and generalised that the germs of all adult sexuality, normal and abnormal, exist therein. Gradually to restrict this infant sexuality, by damming up undesirable tendencies, or by directing them towards other than sexual objects, such as the arts, poetry, and the manifold objects and ambitions of life, is the work of education and of the higher human faculties. But when in the course of physical development sexual ideas and aims press themselves to the front a struggle ensues between these opposing forces. "The flesh lusteth against the spirit and the spirit against the flesh." Certain individuals terminate this struggle by forcibly banishing the offending sexual idea from consciousness. But it continues to exist in the "unconscious"; and, moreover, the "affect," the emotion or feeling connected with it, cannot be thus banished. This "affect" is then dealt with by "conversion," which means that an outlet is provided for it into bodily channels, and thus arise the bodily symptoms of hysteria. So hysteria is called a "defence-neurosis" because it shields the patient from distasteful ideas and the feelings aroused by them.

There are other defence-neuroses, according to Freud; for instance, that which is known as the "compulsion-neurosis," which embraces apparently such conditions as imperative ideas and the majority of "phobias." In these, as in hysteria, there has been repression of an unpleasant idea, but the "affect," instead of being converted into a bodily symptom, remains and attaches itself to some innocent and otherwise unimportant idea, and from that vantage ground still torments the patient's consciousness. Paranoia is said to be also a defence-neurosis, but with a different mechanism.

All these diseases have a mental origin; they are "psycho-neuroses." There are others, simple neuroses, the mechanism of which is principally physiological. Among these Freud places neurasthenia, using the term, I presume, in a limited sense, which he asserts (on what evidence I know not) to be due to self-abuse, and the so-called "anxiety neurosis," which he ascribes to insufficient sexual gratification and particularly to coitus interruptus. To these neuroses, which stand out-

side his theory of hysteria, he does not apply psycho-analysis; and this is odd, because he applies it to almost everything else with a persistency which sometimes lands him in the ridiculous.

What Evidence is There?

The author of this theory which I have been endeavouring to expound, Professor Sigmund Freud, has devoted many years to the elaboration of it; he has urged it with admirable ingenuity, and with a wealth of illustration which cannot be reproduced in a sketch like the present; he has extended it over a wide psychological area, ranging from the masterpieces of literature to the happenings of everyday life; and as regards the therapeutics of the psycho-neuroses he seems to be regarded by some physicians as a sort of Moses who points the way to the promised land. Small wonder, then, that he has an enthusiastic following; small wonder, too, if you regard the content of his doctrines, that there are rebellious physicians among us, who say with Korah and his company, "We will not come up."

Now let us admit freely that the theory incorporates some factors which are *veræ causæ*, and not imaginary. Repression of primitive instincts and desires, and of many other motives, must go on in any civilised or moral person. The strength of the sexual motive and the need for government and occasional repression of it cannot be denied. The doctrine of "conversion of the affect," though very hypothetical and vague, yet recognises the large part played by emotion in hysteria, and tries to account for the bodily manifestations of that disease. But these are generalities; to prove an elaborate theory like the present, more precise evidence must be called. What evidence is there?

The answer made is, the evidence derived from psycho-analysis; and those who presume to doubt the validity of this evidence are told pretty plainly that it is beyond the criticism of those who are not themselves experts in the method. They are reminded that histological questions can hardly be discussed except by microscopists, nor chemical

problems except by those who have worked in a laboratory. But the parallel is not exact, for it is the method itself of psycho-analysis that is called in question—a method that involves many uncertainties and many assumptions. Outside criticism must therefore obtain a hearing, unless psycho-analysis is to become a purely esoteric cult.

Critical Remarks.

The method, and indeed the whole of Freud's theory, presupposes a determination in mental phenomena as strict as that in the physical universe, so that one thought follows another thought as surely as event follows event. Those of us who are the most steeped in physical science will be the most ready to assent to this. But I doubt whether the average man will endorse it as a universal truth; he will refuse to accept such a dreary fatalism. And indeed the semi-personified Censor of Freud seems a little inconsistent with it, he reminds one too much of those old-fashioned entities, Conscience or Free Will. But let this pass.

Then psycho-analysis professes to take present thoughts, symptoms, or dreams, and to follow them up through a series of past thoughts to those which have been long forgotten, or which, perhaps, never entered into consciousness at all. Is this possible? Only, I imagine, within narrow limits. Any one of us may have occasionally caught himself thinking of something, and, wondering how it came into his head, may have rapidly run back over his thoughts and found what started them in the present direction. But this is a process undertaken at once, concerning recent thoughts, which have been in consciousness, which have patent connexions with each other, and which are revived by conscious effort. Matters may be very different in psycho-analysis. The process may have to be carried back over many years, perhaps to the thoughts and desires of infancy. The successive pictures that arise in the patient's mind may have no apparent connexion with each other—at least, he is not encouraged to look for any. The thoughts which

we desire to unearth may have never been present to consciousness at all.

May we not justly doubt whether the things which come into the patient's head during examination really represent the thoughts he had long ago? All sorts of things may have happened in the meantime to obscure the original thoughts and to start different associations. His circumstances now are different to what they were then. And at least there is one new circumstance of the greatest importance, that is the presence and influence of the operator.

For in any but the simplest cases the operator will have to search among the patient's thoughts for clues to the riddle of them, and must form guesses and working hypotheses about the answer to this riddle. He can hardly avoid guiding the patient, consciously or unconsciously, in the direction of these guesses, especially if the patient be a quick-witted neurotic ready to divine the direction in which he is being led. In such a case the free association is no longer free.

There is a still greater danger to freedom when the patient's thoughts have to be interpreted by the operator. This must be done when they appear trivial or absurd or without bearing upon the subject in hand. Now to trace out the effects of the processes which have been described as "dream work"—condensation, inversion, transposition of "affects," and the like—evidently leaves much to the predilections of the operator, even if we assume Freud's canons about dreams to be correct. But how much more is left to him, when interpretation by symbols is employed? You may gather this from Freud's own words:[2] "In the symbolic interpretation of dreams the key to the symbols is arbitrarily chosen by the operator." How arbitrary this choice may be we learn from his chapter on the Material of Dreams. He says: "When one has become familiar with the abundant use of symbolism for the representation of sexual material in dreams, one naturally raises the question whether there are not many of these symbols which appear once and for all with a firmly established significance like the

[2] Interpretation of Dreams, Brill's Translation, pp. 245, 257, 316.

signs in stenography, and one is tempted to compile a new dream book according to the cipher method." (Such a lexicon of dream language has actually been prepared.) Then follow illustrations in which a whole variety of common objects are thus interpreted, regardless of the fact that they might just as well be interpreted some other way. Why should you think that a staircase means coitus or that a lady's hat means something grossly sexual? or why, if you think so, should you tell her so? Yet this has actually been done. And when Freud says: "There is no series of associations which cannot be adapted to the representation of sexual facts," one may reply—"of course, if you are determined to adapt them that way." In another of his writings[3] he says, "He who can interpret the language of hysteria can understand that the neurosis only deals with the repressed sexuality." One strongly suspects that the meaning of that language was invented by the interpreter himself.

I know that it has been said, in relation to this aspect of the question, that by sexuality Freud means something very large—that is to say, all kinds of emotions which can be connected with or find their root in the sexual sphere. Such a meaning may indeed be necessary to give to his theories that wide scope and extension which he desires. But the bedrock of his theories and of psycho-analysis as practised by him is sex in its barest and least attractive form. Let anyone read the "Interpretation of Dreams" and the "Three Contributions to the Sexual Theory" and judge for himself.

Again, it is said that the sexual factor is unessential and can be omitted from the new psychology. Professor Jung[4] appears to be discarding it as fast as he can. For sexual desire he substitutes desire in general, "*élan vital*," innate energy. When in the battle of life the energy of the individual meets insurmountable obstacles it turns back, or "regresses," towards the phantasies

[3] Papers on Hysteria and other Psychoneuroses, No. ix. The Rôle of Sexuality in the Etiology of the Neuroses (p. 192 of Brill's translation).

[4] Discussion on Psycho-analysis at International Medical Congress of London,

of childhood, and develops from them neurotic symptoms. The initial difficulty is the present obstacle, and not in the infantile past. This may or may not be true, but it is not Freud. Indeed, one wonders how two such distinguished exponents of the psycho-analytic method can have reached by it such different results. Besides, what thin and unsubstantial suppositions have we here been brought to. To adduce them in support of a theory is merely, as Aristotle would say, ἀπάγειν εἰς τὸ ἄλογον.

Therapeutic Value of Psycho-analysis.

There remains the question of the therapeutic value of psycho-analysis. It began as a therapeutic method—the katharsis or confessional treatment of Breuer—but of this we hear little now. Instead, there remains the psycho-analysis by which we hope to discover the paths and the places where the patient first left the road of health, so that by reëducation and appropriate suggestions we can set him in it once again. And if psycho-analysis be necessary for this object, and if it be reliable (about which I have expressed my doubts), I presume it must be used. But I cannot think that it is suitable for general use. The old ideal in therapeutics was expressed in the words "Tuto, cito, et jucundo." We will agree that "jucundo" is the least important point. No doubt Naaman the Syrian did not like the look of the waters of Jordan. Still one must allow that there are many things in one's physical and mental economy which one would rather not expose to view. Were I being treated for dyspepsia I would rather not see the semi-digested contents of my stomach. It would not give me an appetite for the next meal. And similarly for many things that may be lurking in obscure corners of our minds. Freud chose for his dream book a most appropriate motto, "Flectere si nequeo Superos, Acheronta movebo." And he might have added, on his own showing, that the heart of man is "deceitful above all things and desperately wicked."

The other two points, the "tuto" and "cito," are in this case, I hold, essentially connected. Given a rapid and reliable method of bringing the patient

to grips with his condition, and of directing his thoughts into healthy channels, we shall all welcome it. But if we are to go on for weeks, months, perhaps years, with a kind of mental vivisection, teaching the patient the while to revive and study all sorts of forgotten facts and fancies, and perhaps to invent new ones—then I fear the process will simply favour the growth of morbid habits of mind, and in the case of a psycho-neurotic will defeat the very object of treatment, which is to drag the patient out of the stuffy chambers of his own mind into the open air of everyday life.

But putting therapeutics aside, the main outstanding question is whether psycho-analysis can be trusted as a means of investigation. Does it really supply a means of penetrating the arcana of our minds? Is there any corroborative evidence of its value? Freud's whole system of psychology is based upon it—an imposing structure, it is true; but if psycho-analysis fails, an edifice without foundations.

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