THE COMMON NEUROSES

"To physicians who are students not alone of the manifestations of disease, but also of the workings of human nature, there are few chapters in the history of medicine more interesting than those which record the welcome by each generation of the supposed advances in the treatment of disease. Each generation announced its cure for diseases, provided its remedies to relieve symptoms, and invented methods of treatment that seemed to put off the inevitable tendency towards dissolution. Yet few of these inventions and discoveries maintain their early reputations, and succeeding generations invariably abandon most of this supposed medical progress in favour of ideas of their own, which later suffer a like fate. Plausible theories have not been lacking to support the successive remedies and methods of treatment, but the general acceptance of them was always founded far less upon theory than upon actual observation of their supposed efficacy. Certain remedies were given, and the patients began to improve. Patients who did not have the remedies continued to suffer, and sometimes the course of their disease led to a fatal termination. Even with the best remedies death sometimes took place, but that was easily accounted for on the ground that the disease had secured so firm a hold that it could not be dislodged even by a good remedy. The connection of cause and effect between the administration of the remedy and the improvement and eventual cure of the patient seemed to be demonstrated.

"What the old physicians did not, as a rule, appreciate, or at least failed to value at its true significance, was the effect upon the patient's mind of the taking of a remedy."

J. J. WALSH: "Psychotherapy."

THE COMMON NEUROSES

THEIR TREATMENT BY PSYCHOTHERAPY

AN INTRODUCTION TO
PSYCHOLOGICAL TREATMENT FOR
STUDENTS AND PRACTITIONERS

BY

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PREFACE TO THE FIRST EDITION

Although the output of psychotherapeutic literature is very large, and although the author is aware that what is contained in the following pages has in it little that is original, he yet believes that this book may fill a gap. Most of those now in circulation are pledged to some particular method, and there has been little recognition of the possibility that different methods of treatment may be used with advantage in different types of illness, and for different individual patients. After a fairly long experience in which he has tried most of the psychological methods now in use, and some others, not necessarily psychological, which have fallen too completely out of use, he has come to the conclusion that not in one, but in a judicious selection from many methods, will the key to the successful treatment of functional nervous disorders be found. He is therefore indebted to a large number of other workers, to so many that it is not possible to acknowledge them all here. The writer to whom he owes most is Dejerine. Dejerine was not lucky in the time of publishing his psychological books. Already the most enthusiastic of the English psychotherapists were under the spell of Freud. They paid little attention to the French writer, and when they have mentioned him it is clear that they had not been interested enough to understand him fully. Freud's methods were so immeasurably an advance on the hypnotism which most of them had previously been practising almost exclusively, and his conceptions so much more brilliant and fascinating than Dejerine's, who lived in a plain workaday world, that this need not surprise anyone.

Now, however, that Freud's views are less potent therapeutically than it was at one time hoped they would be, the time has perhaps come when the more sober and less dazzling idea may receive some of the attention which it failed to attract ten years ago.

Much, then, of what follows in these pages will have been inspired by Dejerine, but there are other writers to whom acknowledgment

should be made: to James J. Walsh of New York, whose large book, "Psychotherapy," is too little known; to A. F. Hurst, for repeated demonstration on the methods of removing hysterical symptoms and for ceaselessly preaching the too often forgotten doctrine of the need for psychotherapy in all kinds of illness; to the late W. H. R. Rivers, for making the doctrine of repression intelligible; and to many others.

If criticism may be made of these workers, it is that their scope of enquiry has not been wide enough to make their books as useful to the practitioner as is desirable; the same defect cannot be urged against a writer already named to whom every one is indebted. No one could say that Freud was narrow. There is no field of human enquiry into which he has not been prepared to introduce his scheme; and therefore there is no section of the psycho-neuroses to which it has not been applied. It is probably true that the claim that the psychoanalytical theory has some bearing on every kind of these disorders is justified; it has thrown much light on the mechanism of their production, and has explained many things that were mysterious; yet it is more than doubtful whether psychoanalysis is always the best method of therapy. There are cases where it is the best, but there is a large majority where it is unnecessary and perhaps harmful, and where better results can be obtained by something much simpler. There can be little doubt of its danger, and it is possible that on the whole, as practised at present, it works more harm than good to the community.

Nevertheless it must be acknowledged that the present interest in psychotherapy is due largely to Freud. He has been the great stimulator and investigator, and without him we should have been nothing. Much of the criticism against him has come from those who have failed to grasp his meaning, and much has been merely Pecksniffian. Most of it has assumed that the Freudian doctrine rested on sex, an assumption which has been curiously fostered and perversely gloried in by his followers. But sex is not the foundation of Freud's theory; it is nothing more than a finding, one which, although of great importance, is by no means the only one, though it has been emphasized to such a degree by the school of Freud that there seems little else in the picture. If it were true that the importance of sex was his chief discovery, then it has been no discovery at

all. There is not a novel or a play written which does not depend to a considerable extent on this great fact of life, and at all times all men have realized its enormous import. But every artist in life has been aware also of the other motives for human conduct and happiness, and here, while due allowance will be made for sex, the other interests of life will be shown to play an important part as well.

There are many other authors to whom the writer is indebted who cannot be mentioned; and besides them there is a large number of wise physicians with whom he has had many conversations. They are too many to name individually, but there are three whom he would like specially to mention here. Two of these are not with us now; to the late Dr. Williamson of Ventnor, who introduced him to nervous patients, and taught him how to speak to them, he owes an unforgettable debt; he owes the same to the late Sir Victor Horsley, who gave him many opportunities of treating them over a long series of years, and who never wearied in impressing the importance of these illnesses on him, at a time when most people were merely bored with them. The third, Dr. Henry Head, showed him a new light in a very dark hour, and by his encouragement and advice became the real author of any psychological knowledge which the writer of this book may possess.

It is his belief that the great bulk of functional nervous disorders can be treated successfully by the general practitioner. It is to him and not to specialists that the book is addressed. If he is not to do the work it cannot be done at all, for these conditions are among the commonest that he meets on his daily rounds; and here the writer can speak with the confidence of knowledge, for though he has been studying these patients specially during the past twenty years, he was also a practitioner in general middle-class practice during seventeen of them, and he can vouch in what good stead his psychological knowledge stood him in every class of patient. And if the general practitioner is to undertake this work, the treatment must be simple and reasonably short. None but a few could undertake to see an individual patient daily for months or years in the fashion which the analysts have decreed. It is hoped that the principles laid down in the following pages may give some rules which will enable the busy doctor to restore these patients to their

place in the struggle of life in a state of comfort and with the ability to make a good fight.

To those whose interest in patients suffering from these disorders has dated only from the Freudian epoch, and whose education has been on Freudian lines, much of what is written in these pages would seem too simple to be worthy of study; it would appear to them to be as unworthy of their notice as any other kind of faith cure: but the author ventures to think that this system, which is really Dejerine's system, is different from other faith cures, and that it rests on a sure foundation.

The order of the chapters calls for some explanation. After some essential preliminaries have been cleared away, the approach to the various problems has been made in the order in which doctors commonly find these problems presented to them in actual practice. The author has had in his mind an imaginary patient, and has considered what he would do with him as each question arises. This method has led to a certain amount of repetition for which no apology is made. There are certain things which may be repeated with advantage, when it is intended that they shall be really believed.

No claim is made that this is a complete treatise on the functional nervous disorders. It is no more than a record of personal experience. No condition is dealt with which the author has not seen and treated. This has its disadvantages, for in many respects his experience has been limited; for example, his opportunities of studying nervous children have been those only which a general practice afforded; those of studying these conditions among the working classes have been the same, with, in addition, the brief and too specialized period of the War and the first two years of the Peace among the nervous pensioners. On the other hand, it may be claimed that there is no statement in these pages which has not been founded on a fact which has been personally observed. Every history quoted has been taken by the author himself without the aid of any assistant or other clinical worker. It is therefore hoped that there may be something to atone for his lack of width in experience.

PREFACE TO THE SECOND EDITION

It was stated in the preface to the first edition that in the author's opinion the majority of patients suffering from neurosis could be treated by general practitioners. In the seventeen years which have passed since this was written, he has seen no reason to change his mind. The majority of patients are not difficult to treat. But perhaps it should have been said then, and must therefore be said now, that there is a residue which the general practitioner will be well advised not to touch. Most of the patients suffering from neurosis are suffering from conditions which it is not difficult to get rid of; at the other end there are some incurables, and there are also some curable but difficult to cure. This would be no reason why the practitioner should not try his hand at them, but for the fact that it is sometimes easy to make them very much worse, so much worse that great discredit to the doctor and to psychotherapy may ensue, disregarding for the moment what happens to the patient.

In the present edition the attempt has been made, more especially in Chapter XIII, to indicate those cases which the general practitioner would do well to leave alone It is hoped, however, that he will not be deterred by these cases, which are not difficult to recognize, from practising psychotherapy on those which are suitable. There is indeed a crying need for him to contribute his share. More and more it is becoming evident that the minor examples of neurosis are to be found everywhere, that an enormous amount of preventable sickness is due to them, and that if these patients are not treated by the general practitioner they will be treated by nobody.

It is probable also that these easily treatable patients suffer more from what goes on in their homes and in their daily life than do those with severer neuroses, which are apt to be connected with deep infantile repressions. The specialist is the proper person to take charge of the latter, but the general practitioner knows far more than anyone else about the conditions of the homes, the

jealousies, privations and so on which are probably the most important factors in the origins of the more curable neuroses. Therefore on this ground also he is the proper person to treat them.

Much of the book has been re-written. The views expressed in the first edition remain substantially the same, but many more examples illustrating principles have been added, and it is hoped that some obscurities have been cleared away.

The chapter on the Application of the Freudian Method has been omitted for several reasons. In the first place the author desires to emphasize that there is a great deal of psychotherapy called for, for which the Freudian approach is quite unnecessary, that any idea which suggests that Freudian analysis is essential for all patients suffering from neurosis is of the same order of ideas as that steam hammers should be used to crack nuts. Secondly, if this work of treating patients suffering from neurosis can be done in great part by the general practitioner, psychoanalysis cannot be the universal method. Psychoanalysis is essentially a specialist's method. Thirdly, no one not a Freudian can give an adequate description of psychoanalysis. No one not in the movement has really acquired the state of mind for viewing these doctrines as the Freudians view them, and it is therefore better that descriptions of the doctrines and methods should be left to Freudians. Mere acceptance of a dynamic unconscious, of repression, of distortion does not constitute a belief in Freudian doctrine. That does include a definite inventory of the content of the unconscious, or at least of certain fundamentals, which are stated to be present always. These fundamentals do vary from time to time, as might be expected in any growing body of knowledge; but it has been impossible for the author to keep pace with these expanding doctrines, and it would therefore be unfair for him to write of them.

At the same time the author acknowledges that although the doctrine of a dynamic unconscious, a doctrine which he himself accepts and exploits, was known before Freud, it is due to Freud that it has been made a practicable thing. Throughout the book the reader will find that many of the mechanisms, by which the mind seems to work, are discoveries of Freud's, and indeed no one

can practise psychotherapy at all without being to a large extent in Freud's debt.

Though, then, the therapy described in this book will help many patients, it will not help all. Some will require a deeper investigation into the unconscious parts of the mind. Even this does not imply that the Freudian doctrines need be accepted in their entirety. I have described certain patients who have been treated by these deeper methods in " An Introduction to Analytical Psychotherapy." The practitioner is, however, recommended to familiarize himself with the methods of this book first, and then if he is sufficiently interested to proceed to the other one.

It is obvious in this book that a certain amount of material previously unconscious does tend to appear in consciousness by the mere process of history taking, and that therefore there is a sort of analysis employed here also; it is, however, of a simple and straightforward nature which calls for little interpretation, and that of a common-sense kind only. It is not an analysis which is likely to lead the doctor or patient into difficulties. The Freudians would certainly agree that it is not Freudian analysis.

Some doubt was felt about retaining the chapter on the Treatment of the Manic Depressive Psychosis. A reviewer said of that chapter that the treatment recommended was but a pale shadow of that employed in mental hospitals. That is possibly true; but there is a considerable number of these patients who are not and never will be in mental hospitals, who are going about and who must be helped by the general practitioners or not at all. Their friends do not wish them to go into mental hospitals, and though the reasons for this may seem ridiculous to psychiatrists, they will remain to be taken care of, until the public have become more convinced than they are at present that the hospital is the best place. It seemed, therefore, that although a doctor in practice cannot organize the treatment of these patients as it is done in a mental hospital, he should have some idea about what his problem is; and as many of these patients do resemble in their symptomatology the patients suffering from anxiety states, it is as well that emphasis should be laid on the differences not only in diagnosis but also in treatment for the two conditions. It has therefore been decided to retain the chapter.

CONTENTS

THE COMMON NEUROSES

CHAPTER I

INTRODUCTORY

A functional nervous disorder or neurosis is a nervous disorder where no physical lesion has been found. The term has been used in two senses: (1) where it is believed that a physical lesion exists, though it has never yet been discovered; (2) where it has not only never been found, but where it is believed that it does not exist. It has been said that it is inconceivable that a neurosis can be present without some alteration in the physical state of the central nervous system, and that therefore it is nonsense to talk of a disease without a lesion, that all that we can possibly mean is that our methods are not delicate enough to detect the changes in question. We cannot, however, conceive of any personal experience at all occurring without physical change. There is physical change in the retina when we see any object. There are even fairly well proved theories as to what this change is. But no one would call it a pathological lesion. Similarly there must be simultaneous change in the visual centres corresponding to those in the retina, and indeed all nervous activity must imply change. But again no one would call these lesions. All that is meant therefore when it is claimed that the neuroses, which are to be dealt with in the following pages, occur without lesion of any kind, is that the changes which occur are of the same nature as those which take place under circumstances which are never thought of as pathological, that they are the ordinary metabolic bodily changes which go on with all kinds of mental activity. The objection therefore is of no value. The first class of neuroses is one that tends to disappear before the advances of physical neuropathology; thus chorea and Parkinson's disease would a few years ago have been classed among the functional

nervous disorders, but now appear among the physical diseases of the brain.

The morbid conditions in the second class are also entitled Psycho-neuroses, because it is believed that their causes are psychological, mental, that they are due to an alteration of mental functioning. In certain works the words Neurosis and Psycho-neurosis are used in a very confusing way; here no distinction is made between them.

The definition of a functional nervous disorder given above might be taken to include the psychoses; and in some quarters there has been a disposition to obliterate or at least to minimize the distinction between the two conditions. It has been said that the difference is legal, not medical, that it is one of degree only. In the present volume no such view is entertained. However great the difficulty may be in making the distinction in actual practice in certain cases, there is no real similarity between the two states; the difficulty is one of diagnosis, a difficulty that occurs in all kinds of illness. The theoretical distinction between them is clear. The psychotic lives, in so far as he is a psychotic, in a world of fantasy; the neurotic lives in the real world; its difficulties are greater by far for him than they are for normal people, but they are the same difficulties which all of us have. The difficulties of the psychotic arise from the fact that he is living in quite another world, in one which is not subject to the ordinary physical laws. Any psychotherapy which he is capable of receiving would require to be of a different order from that offered to a neurotic; of an order that would need to vary with the peculiarity of his own special fantastic universe, of an order which cannot be treated of here.

For example, a man believes that his neighbour is using some electrical apparatus which results in giving him severe pain in the head. His belief in this is of the same order and fixity as mine is that I am now sitting on a chair. If anyone tried to prove to me that I was not sitting on a chair I should not listen; his arguments would merely weary me; and if he persisted in them, and invited me to engage in some intellectual exercise which would in the end convince me that I am not sitting on a chair, I might in time grow angry, but I should remain unconvinced.

In exactly the same way, with the same force and intensity,

the man who lives in fantasy believes in the reality of the hostile electrical apparatus. He will not listen to the arguments of anyone who tries to convince him of the unreality of his belief. and soon any argument about it will make him angry. There is no avenue of approach here for any kind of psychotherapy such as will be treated of in these pages.

For this clear distinction between sanity and insanity the author is indebted to some remarks made by Dr. Henry Devine, during a debate on psychotherapy.

Patients, then, with a psycho-neurosis are ill, and yet there is no lesion in any of their organs. The problem presented is to understand how this can take place. The solutions proposed have been various, and before the attempt is made to give one here, it will be worth while to consider in what ways this has been done by other people.

The laity have long recognized that a patient might say that he was ill when he was not ill; and their explanations have usually been unfavourable to the patient. They have assumed for the most part that the affair was due to some perverseness on his part, that he was "putting it on," that he was imagining his pains and aches. Such explanations, though seemingly simple, are really very difficult. The friends have usually urged the patient to pull himself together and exert his will: and very often they have induced him to believe that he is suffering from some lack of will-power. Without going into any lengthy disquisition on the nature of the will, it is interesting to consider for a moment the lives of these critics of the neuropath. When are they exerting will-power? To hear them one would imagine that they are daily struggling against an overwhelming tendency to be inefficient, and that if they relaxed this struggle for a moment they would soon be in the condition in which the unfortunate patient is. In reality nothing of the kind is happening. Healthy people are not making any stupendous effort to carry out their work. Work, if it is of any interest, is carried out with more ease than is idling. If work is being done in a condition which requires constant flogging before it is accomplished, it will be found to be of very little value and will soon better not be done at all. Every one of us who has a full day has a longing to have an idle one, but the desire is purely illusory;

no sooner is it granted than we turn to some form of activity so long as we are in good health. What we have wanted to escape from is a boring routine, never, as in the case of the neuropath, do we seek a cessation from activity.

There is, however, such a thing as will-power. Having been wakened in the morning I am loath to leave my bed. I make an effort of will and get up. In the evening I come home from my routine of work, and see a pile of letters which ought to be answered. There is also a novel in which I am interested, and there is a concert on the wireless which I should like to hear. I must make at least one effort of will to sit down to the letters. If in the first example, however, I find myself very soon back in bed, and have to get up again ; or if in the second I find myself every now and again turning on the wireless and then by an effort of will turning it off again and making another attempt with the letters, I may as well give up. In the first example I am obviously ill in some way ; in the second my mind will not be on the letters, and I shall make a bad job of them, and may as well listen to the wireless and have done with it, though it is likely enough that I shall not enjoy the wireless either for reasons which will be plain later on. It is all very like the engine starter of a motor-car, which may be used for a few seconds, but for a few seconds only, to start the engine. It is bad practice to keep on using it, for that will only run the battery down. If I have to use it unduly, there is something wrong which I ought to investigate. Note that I can move the car for some yards by means of the engine starter alone, but the ultimate results of doing so will be very serious. Equally, nothing but damage will result from any prolonged attempt to work by the exercise of will-power.

An imaginary pain is a contradiction in terms. If I say I have a pain, I either have it or I am a liar. There is no possibility of my having a pain which is not present. The idea of perverseness is equally difficult to maintain : at all times there have been those who could cure neurotics ; if the disorder were merely due to perverseness it is difficult to see why it should disappear in the presence and because of the advice of certain individuals who have a reputation for being able to cure patients suffering in this way. The really perverse person with a reputation to maintain would resist all the more. The situation was described with rare wit by

Sir James Paget: "The patient says that she cannot, the nurse says that she will not; the truth is that she cannot will."

There have been other popular explanations, which need not be considered here. Some of these, such as the theory of Christian Science, have had a germ of truth in them, which will be treated of later. It will be more profitable at this stage to trace some of the more important medical views which have been advanced.

The first modern physicians to make a serious attempt to treat these patients were Charcot and Weir Mitchell; and though of these two Charcot got nearer to the truth, Weir Mitchell's views were the more fruitful in immediate results. Charcot did recognize the mental origin of these illnesses, but his methods tended rather to accentuate than to cure the evils from which his patients suffered. Weir Mitchell, who believed that the morbid states were mainly physical in origin, cured his patients; but he did more; after his work it was impossible for anyone who had studied his results to hold the "perverse" theory. It is interesting to note that he succeeded in establishing the reality of these disorders in a manner which did not admit of doubt, although the observations on which he rested his views were in part fallacious. He pointed out that the patients who suffered from nervous illnesses were not well physically, though no one organ of the body presented any sign of disease. He showed that they were often extremely thin, that their hearts were liable to sudden increase of rate on very little provocation; he said that they were almost always anæmic. Such people, he declared, cannot be called well; it is only that we have not observed them carefully enough. They are physically ill in the same sense in which people are ill who have pneumonia.

It will, however, be shown later that extreme loss of flesh, though it is a physical state, may be due in the last resort to a mental cause; that increase of pulse-rate is one of the commonest results of emotion; it is even probable that many of those whom he called anæmic were only pale, another common sequel of emotion, and that if their blood had been examined their hæmoglobin content would have been found to be well within the normal limit. Yet because he cured his patients he did good work in promoting the study of these disorders. He cured them by the hundred, and thus showed that there was some law about them, that they were not

merely the subjects of caprice. It does not, however, follow that he recognized what the law was which he was obeying; it is indeed fairly certain that though he was working according to a law he did not know it.

His theory was that these patients were suffering from exhaustion of the nervous system, of a kind comparable to that of a run-down battery. Their voltage was low, and therefore they were easily fatigued; they had no energy to send to their stomachs, and so could not digest their food; their hearts became irritable from the same reason. The lack of nutrition which resulted from the failure to digest their food increased the exhaustion, and a vicious circle was set up, which was capable of continuing indefinitely. This exhaustion theory of the neuroses has flourished for a long time; it is not by any means extinct, and it is the basis of much of the medical treatment of these disorders at the present time. It contains a great deal of truth; there is no doubt that fatigue does interfere with digestion and nutrition, and that such interference does lead to further fatigue. But the great vogue of Weir Mitchell's treatment has passed away; and if it had contained as much of the truth as its author thought it did, this would not have happened. That some other factor besides that of exhaustion is present becomes evident to anyone after a very short experience with these patients.

That of the writer of this book may be given. At an early stage of his medical career he was brought into contact with patients suffering from functional nervous disorders, and for several years the only treatment he employed was that of Weir Mitchell. As is well known, this consisted in a logical application of the theory that they were exhausted in their nervous systems. They were confined rigidly to bed; they were fed in a manner calculated to increase their body-weight rapidly, because it was believed that from this excess of nutrition their nerve cells would pick up energy more readily; they were massaged, because people who lie in bed and do nothing become flabby; they were isolated from their friends and from their business, so that they might thereby obtain more complete mental rest than they otherwise would. As these measures were carried out a good deal of criticism was received as to their soundness. It was said that they were grossly overfed, and that their digestions were strained and even damaged by this. The

charge may be admitted. In one hundred consecutive cases of the writer's—consecutive cases, not selected ones—the average gain in weight was 22 lb. in six weeks. It is quite possible that such overfeeding did damage some patients' digestions, although the writer did not actually have such a disaster brought home to him. It was said that complete isolation is good for nobody; that is possibly true. It was said that on the whole massage is not good for these patients, that it increases their irritability. All these criticisms may be true and just, but they are not to the point.

This was the exact method by which Weir Mitchell cured his hundreds; and it is the method with which the author had for a few years a very great measure of success. Many of these patients whom he treated twenty years ago by the strict Weir Mitchell plan are well now; and yet he has to a considerable extent abandoned the method, and has wholly abandoned the theory. When he began he was enthusiastic, and his results were good, especially his immediate results. As time went on he began to hear of relapses in old patients, and he found it difficult to be quite so enthusiastic with the new; and as he became less so, he found that even his immediate results were less satisfactory, until presently they became very bad indeed. A large number of the patients at the end of their treatment were experiencing very much the same degree of illness as they had been before it was begun. The contrast between the results of the earlier and later years was a striking, puzzling, and disconcerting phenomenon. It was so great that the writer began to consider seriously whether he ought not to give up treating these patients altogether.

Criticism directed against the treatment, therefore, fails to hit the mark if it is regarded as a physical thing. That which produced remarkable immediate results in the year 1900 should have been producing the same in the year 1905 if the phenomenon in question had been a material one, and it was doing nothing of the kind. The treatment, so far as it was physical, went on in exactly the same way. The gains in weight were as satisfactory, or, as some critics have said, as grossly unsatisfactory as before; they were the same as in the successful epoch. The rest was carried out as carefully; everything was done in the same way. The sole difference lay in the mind of the doctor. He did not speak in quite

the same way to the patients; there was a psychological change in him, and, so far as he can judge, there was no other change. He no longer believed that exhaustion was the sole factor at work in these cases; not, at any rate, that this exhaustion could be abolished of necessity by rest, however complete. There were still some cases where it could be so terminated, but they were not by any means the majority. This phenomenon of early cures in the history of a treatment with gradually diminishing results is common to many kinds of therapy.

This experience with the rest cure is not one in which the author finds himself alone. Many others have had the same series of events in their practice. Weir Mitchell did not apparently encounter the difficulty himself, but every man finds it hard to be critical of his own work. His theory came to him in time of war. It was to war-worn soldiers that he first unfolded his view that they were more susceptible of fatigue than other men. The significance of this will be appreciated later.

This summary, however, of Weir Mitchell's teaching requires some modification. Although he laid stress on the physical, he did also in fact use psychotherapy, perhaps unwittingly. He did a great deal of moralizing, constantly pointing out to his patients that they were leading aimless, selfish lives which were not conducive to health. To ensure that his teaching would not be immediately discounted by the criticisms of friends he insisted on isolation, and in a sense the patient was isolated even from the nurse who was forbidden to discuss symptoms with the patient. Quite deliberately he made illness a dull thing; when used to dominate the family it had been rather interesting. Because he was a man of magnetic personality with great power of influencing people, a thing he was never fully aware of himself, he never arrived at the view that perhaps the physical part of the treatment was the least important. In his writings the main stress was laid on the physical side, so much so that in the materialistic-minded age, in which he lived, the mental aspect was overlooked. Therefore when his teachings came to be applied by others, the same results were not obtained.

The next view of importance may be called the reflex view. It is one which is cropping up constantly in various disguises, and it

will probably continue to crop up from time to time. The point of origin of the reflex varies in accordance with whatever may be the special medical interest of the day. Seventy years ago, when the early investigators began to make gynæcology a science, minor gynæcological conditions became a favourite starting-point for nervous states. Women who were tired and who had backache were cured of all their symptoms when they received treatment for some supposed affection of the uterus. They wore pessaries, they were curetted, they were treated for erosions of the cervix. These measures did good during an epoch; they then gradually disappeared from practice. By no means all of these patients were recognized as suffering from a nervous disorder; many if not most were thought to be suffering from the local condition which was being treated. In those who were recognized as suffering from nervous exhaustion it was supposed that the constant irritation from the local lesion, the continual incoming of sensory impulses, caused a reflex discharge of nerve energy; the total quantity of nerve energy available for bodily use was therefore diminished, and so the patient became exhausted. Alternatively the general symptoms were looked on not as exhaustion symptoms, but merely as the remote symptoms which a lesion of the uterus might bring about through the agency of the continued irritation from the lesion. This under certain circumstances is a possibility. Head has shown, in his remarkable work on "Certain Mental Changes that accompany Visceral Disease," that a local lesion is capable of producing mental symptoms. But he showed also that the conditions for this were not common, and he demonstrated in a very rigid manner how the diagnosis should be made. There is no suggestion in his work that because a local disease has been found it is therefore the causal agent of general nervous symptoms. It is only in certain circumstances that it becomes so. As time went on it became clear that there were many women with displaced uterus who did not complain of anything, and therefore that such lesions *per se* were not causes of nervous states. It should be noted that it was only minor gynæcological states which were regarded as efficient causes of these general nervous conditions; no one suggested that gross lesions such as cancer of the cervix were the points of origin of the illnesses in question.

At another time the eye became the offending part of the body; and in ophthalmology as in gynæcology it was always minor affections which were held responsible for the general symptoms. Astigmatic errors of refraction of about 0·25 D were the sort of lesions which were supposed to cause symptoms of magnitude. The best results were obtained by men who were careful to use a cycloplegic, and who employed an astigmometer, a fact which seemed to lend colour to the validity of the truth of the theory. It required a really careful man to get the good result. Yet the view has almost disappeared; for as with the other physical methods, relapses become more frequent as the epoch wanes in which the treatment flourishes.

At another time the nose is the peccant member, and once more it is the small lesions which are so potent for evil—spurs and deflections, not malignant growths. Again this epoch passes.

There have been others, such as when dropped kidney or general visceroptosis have been regarded as the causes of widespread symptoms. These periods have had their time of growth and of decay like the others.

The next important view is the toxic theory. The patient is—for this view is alive and current for the moment—supposed to be suffering from the effects either of bacterial poisons or of some toxin which he elaborates within his own system, the so-called auto-intoxication. It is never massive infection which is the cause; if the poison is bacterial the dose is so small that it often cannot be detected, and the condition has been labelled subinfection. If the cause be auto-intoxication the toxin is not a well-known poison like acetone; it is some obscure substance that cannot be named, but which is usually thought to be absorbed from the bowel.

No doubt it is true that a mild infection may cause symptoms, but patients who are ill because of this are not suffering from psycho-neurosis and are therefore not amenable to psychotherapy, but they may be curable by physical measures. Their symptoms may indeed resemble those of psycho-neurosis, but that does not make the two conditions one and the same thing. It is of course the business of the diagnostician to distinguish between apparently similar things. There are many logical fallacies in the arguments which are commonly put forward such as that, because certain

patients have illnesses like those of neurosis, and become well after surgical treatment, all neurosis is really toxic. The absurdity of the argument can easily be shown if turned round. It would be ridiculous to say because certain people suspected of infective processes sometimes become well after psychotherapy, that therefore all infections are nervous in origin.

All these organic theories and practices have certain elements in common. They have a season during which they flourish; at this time they work many cures. The men who achieve these cures are very enthusiastic and zealous. After a time the number of cures begins to fall off, and the methods begin to give place to others. Even during the period of success, there are always men of eminence in the speciality concerned who remain unconvinced, who, although they are the kind of men who would be as careful as the successful therapists, nevertheless do not get cures. They are men of a critical rather than of an enthusiastic type.

It is further important to note that in all these examples at which we have looked, the lesion which has caused the nervous state has been of a minor kind. It is erosions of the cervix and not malignant disease that is reported. Now the symptoms of the functional nervous disorders are not, as it were, minor editions of the general symptoms of grave disease in that region. In the early stage of cancer they ought to be the same as those supposed to be caused by erosion of cervix, but they are not. Indeed, it is one of the continuing regrets of the surgeons that the early stages of the graver disease are symptomless.

In the ocular cases examples of astigmatism which really interfered with vision were not held responsible for nervous states; it was, as has already been stated, where the degree of error was about 0·25 D that symptoms might be caused. The explanation given was ingenious. It was said that a patient with effective astigmatism was so defective in visual acuity that he accepted this with equanimity, and made no effort to overcome it, for indeed no effort of which he was capable would have made any difference to his sight. With the patient with slight astigmatism, however, the desire to see clearly, to have everything in sharp focus, made him constantly try to overcome his corneal astigmatism: he could accomplish this by a partial contraction of his ciliary muscle so as

to make a compensatory astigmatism of the lens. The continued nerve strain of this produced symptoms. There is, however, no proof that people who have always seen things slightly out of focus have any desire to see them sharp and clear. Indeed, a number of persons who have a visual acuity of half the normal are wholly unaware that there is anything wrong till they have been tested. The idea, therefore, of the struggle to see clearly was a pure assumption. Again, the vast majority of people have astigmatic eyes: indeed, an astigmatic error of 0·25 may be considered normal, and a perfectly emmetropic eye as an abnormality, if we are to consider the normal organ to be what the overwhelming majority possess. That which everybody possesses with health cannot be a cause of disease in some.

If we accept these organic views we are driven to believe that symptoms of great magnitude may be caused by trivial departures from the normal, and that these symptoms are of a totally different kind from those produced by more serious lesions in the same organ. We are compelled to hold that remedies are valid only during an epoch, and that they can be applied only by certain individuals whose successes do not depend so much on their knowledge as on certain psychological gifts, of which enthusiasm and the capability of believing are perhaps two of the chief.

These thoughts bring us naturally to see that these cures depend for the most part on the presence or absence of belief. When belief is present in abundance then the theory works; when it begins to fail the theory begins to fail too. This introduces us naturally to psychological views of the functional nervous disorders; and it may be said here that it will be necessary to observe the same caution in examining these views as was shown in examining the organic.

We have seen that cure was not of itself a criterion of much value in determining the validity of a theory. We must always allow for the effect of faith and hope. For some reason the profession do not like to think that their remedies may depend on these two factors; why, it is not easy to see. Almost every human relationship depends on them. Work without faith will not produce trade, not at least in any volume. In dealing with one's lawyer or one's stockbroker one relies on both faith and hope; and as a

matter of fact doctors dislike exceedingly the suspicion that their patients do not trust them. And yet the medical objection to the thought that cures are faith cures is profound. Practitioners of psychotherapy are not exempt from this failing. They wish to believe that their psychology is as objective a science as anatomy, but why they should think that faith and hope on the part of their patients are not objective things, which they can study, is not at first sight obvious. It is certainly important that we should not have faith in unworthy things. It is therefore essential that we should take care to see what it is in which we are going to try to make our patients believe. This book will advocate faith and hope, and make them the sheet anchor of treatment, but what it will attempt to teach will be not faith in a treatment or in a doctor, but the method by which these patients can reacquire faith in themselves. The problem before us is to discover why these patients have lost faith in themselves, and what steps should or can be taken to restore it.

CHAPTER II

SOME PSYCHOLOGICAL VIEWS OF THE ETIOLOGY OF THE NEUROSES

In the previous chapter discussion was made of various physical theories, which set out to account for the origin of neuroses, and proof was offered that every hypothesis of this kind was difficult to maintain. It was also pointed out that reports of cure could not of themselves be accepted as evidence of the truth of a theory. Cure must indeed be present as one of the essential evidences of truth; but one cannot imagine anyone putting forward any view without being able to report some cures, all the more as they are, as we have seen, comparatively easy to obtain. A theory, to be accepted as true, must be able to account for the onset of illness, as well as for its cure. This the organicists have rarely attempted to do. They have never been able to show why one person should suffer greatly because of a slight astigmatism of which another is wholly unconscious, why retroflexion should cause pain in one woman while it causes nothing in another, why one individual should eagerly accept every unfavourable opinion from any doctor, while another, more robust in mind, but often much less so in body, flouts all precautions, though he knows the wisdom of carrying them out. We shall find as we proceed that such things are easily accounted for by most of the modern psychogenic hypotheses.

Secondly, a theory to be true must accord with other ascertained facts. It is not in accordance with any such that nasal spurs should be regarded as the causes of fear, insomnia, and fatigue.

A cause, to be acceptable, should be found in all cases of the disease under investigation. This is a difficult canon to satisfy; all that can be reasonably expected is that it should be found in a very large number, and that this number should tend to increase with the skill of the observer.

With these conditions in mind we may now proceed to review some of the psychogenic views on the nature of these illnesses.

The simplest view of all is the one which has been already alluded to in Chapter I as the perverse view. According to this there is nothing wrong with the patient, and all he need do is to pull himself together, and go about his business. It is a view which has its successes, and, in the hands of one very skilled person at least, it had great success. Dubois of Berne carried out this method with such efficiency as perhaps was never attained by any other person; but it is not given to many to be able to do what he did. He told his patients that there was nothing wrong with them, and that what was needed was a loftier set of ideals, which he thereupon proceeded to give them, expounding the philosophy of Seneca and Plato, so that no one would have thought that it was, as he says himself, a medical consultation at all. To some extent we all employ this method, and our success with it depends on many factors; on our education, our character, our eloquence, and our ability to make an impression. That the method enters into all psychotherapy is probable, but it is one which is discussed better in a work of general culture than in one which is professedly medical. It is not specifically medical; it has invariably been already exploited by the patient's friends before he comes to the doctor, and it has therefore already failed before the medical man gets the opportunity to use it. While therefore high ideals are not to be neglected, the therapist should be ready to supply something else in addition.

Before we proceed to describe other forms of psychotherapy in common use, it will be advisable to turn our attention to some simple facts of psychology. It is not proposed to insert a chapter dealing specially with the psychology necessary for the understanding of these patients. What will be done now is to describe as much as will enable us to make a beginning. As the book proceeds other psychological problems will be dealt with and explained as they arise. There are two phenomena on which all psychological theories of the neuroses rest, the emotional reaction and the conditioned reflex.

The Emotional Reaction

It is common knowledge that many medical students faint at their first operation. The student sees something which is repugnant to

him, his heart stops beating, no blood is sent to his brain, and he falls to the ground unconscious. If we did not know better, this sounds a formidable train of events. The action of two of the most important organs of the body has been interfered with, and for the moment reduced to a state of complete paralysis. But we know that the matter is of no moment, and the sufferer is commonly left to his own devices to get well, and crawl away when he has recovered consciousness. But he has undoubtedly had symptoms which are identical with those of organic disease. Again, if we see something disgusting in our food, the desire to retch is almost uncontrollable, and we may even vomit. This occurs although we may not yet have tasted any of the food in question, so that there is no suggestion of anything noxious having entered the body. As in the previous example, we have had symptoms of illness in the absence of organic disease, but in the presence of an experience associated with a strong emotional tone. Common everyday examples of reaction of this kind are to be found in connection with nearly every organ of the body. Fear is well known to be followed by tremor of the limbs, which may be so great that the legs may give way, and the individual fall to the ground; profuse sweating may take place. More commonly in children than in adults urine and fæces may be voided in the presence of fear. It is a commonplace that anxiety may cause drying up of the saliva, so that the tongue cleaves to the roof of the mouth, that it may make the appetite disappear, and that indigestion may follow if food be forced down. It has been shown in these cases that the gastric juice and motility are altered so that the cause of the indigestion is not far to seek.

In the middle of last century, Beaumont, a Canadian doctor, had a patient, Alexis St. Martin, who had a gastric fistula after an injury. Beaumont was in the habit of inspecting the interior of his patient's stomach. If the patient was happy the ingestion of food was followed by certain phenomena. The stomach blushed rosy red all over, gastric juice poured down its walls like sweat down a hot skin and the organ went into churning movement to mix the food with the gastric secretions. If, however, Alexis was depressed or emotionally upset these things did not happen. The stomach remained pale, no juice was secreted and there were no movements.

The importance of this particular example cannot be exaggerated.

As the chief factor in indigestion it turns up again and again in practice. It is the foundation of all the crank dietetics, which are the bane of every doctor's existence. The patient believes that he cannot eat this, that and the other. When he tries to do it, he does so in a state of psychological depression. In consequence the food will not encounter normal gastric conditions, and indigestion ensues. The patient is therefore always right, and is able to quote triumphantly that what is one man's food is another man's poison. This subject will be returned to later. Every woman is aware that in times of anxiety headache is not unusual; and we all know that when we are anxious, we do not sleep so well as when we have tranquillity, that our sleep in the former condition is apt to be broken and disturbed by disagreeable dreams, and that in the morning after such a night we awaken unrefreshed. We have all experienced, in times of prolonged anxiety, that we cannot concentrate our minds, and that we are prone to all sorts of gloomy forebodings, not only about what has made us anxious at the time, but about many other things as well.

All these events are matters of everyday knowledge, and it may be pointed out now that the symptoms which have been enumerated above as those specially connected with emotional states are curiously like the symptoms of one kind of the functional nervous disorders. Indeed, the only difference between them is that the latter do not tend to disappear easily, while the former do.

These symptoms have been called the Emotional Reaction, and it is obvious that they may be divided into two classes: one where the response is of a positive character, the other where it is negative. The vomiting in the presence of revolting food is positive. It serves to call the attention of the subject to the fact that he may be damaged, and the anti-peristalsis is a sure guarantee that this will not take place. It is, therefore, like many other symptoms to which the body is subject, defensive in nature. Another positive reaction is palpitation of the heart in the presence of fear; the organ is beating with more force and at greater speed. This, too, is defensive, though the advantage is perhaps not obvious now. If, however, we think back a little in the history of mankind, we shall soon perceive that without fear the human race could hardly have survived. Man, poorly armed, was set in the midst of strong and savage animals;

unless he had had the power to run fast and far when occasion called for it, the human race would not have persisted very long. To accomplish this it was necessary that the blood supply of the muscles should be increased, to allow for the repair necessitated by the more rapid using up of their energy, and for the removal of the products of combustion. The heart must be made to beat faster and more strongly. Hence the palpitation. For exactly the same reason, palpitation is one of the symptoms of anger. Anger normally should be followed by fighting, which will again lead to the necessity of increased supply to the muscles. Cannon has shown that in these states there is an increase of adrenalin secretion, a powerful muscle stimulus, a substance which compels stronger and more rapid contractions, and also a mobilizer of blood sugar, a substance which provides chemical energy for the increased work, so that exhaustion of the muscle may be delayed. He has shown that these events occur in all the emotional states where violent and prolonged action may be necessary, such as in rage, hunger, fear and pain.

Increase of adrenalin secretion and sympathetic stimulation are two aspects of the same state, and it may be noted here that sympathetic stimulation while it increases the force of the circulation is inhibitory of stomach activity.

As examples of the negative response to emotional states there may be cited the fainting of the medical student at the sight of blood, and the giving way of the legs in the presence of fear. Can these also be said to be advantageous to the subject ? In the first instance which has been given, it is not very difficult to perceive the advantage. There is no other way in which the student can escape from a sight which is repugnant to him in the highest degree. He cannot possibly leave the room ; he would never hear the end of it if he did. Fainting not only removes him from the obnoxious sight, but it leaves him with his self-respect intact. It does not leave him the complete respect of his fellows, who will twit him with it afterwards ; but it does leave him absolutely with the feeling that he himself had done all that could have been expected of him, with the feeling that he had stayed to the last gasp, and that had he been thinking of himself only he would have left while there was yet time. We shall see how much this preservation of self-respect enters into the symptoms of the neuroses.

It may be noted also that the negative reaction may be a defence reaction when the subject is being pursued. When attacked we have several methods of defence open. We may fight. We may run away, or we may collapse and lie quite still. If we lie quite still the animal which is hunting us will not see us so easily as if we are moving. To accomplish this our paralysis had better be as complete as possible. It is probable that this last is the most primitive defence reaction, as it is certainly the simplest. Then at a more advanced stage comes running away. Finally, as soon as man has a weapon or skill enough to construct a trap, standing and overcoming the hunter is a better reaction still, better because it is usually safer to turn and attack our difficulties than pretend they are not there or run away from them.

The Conditioned Reflex

An important modification of the emotional reaction is called the Conditioned Reflex. For the pioneer study of this we are indebted to Pavlov.

If hungry puppies who have not yet tasted meat are shown meat nothing happens, but if they have once tasted it the mere sight of it will cause saliva to drop from the jaws when they are hungry. This is not an innate emotional reaction, as tears are in grief; it is a reaction which has been created by a condition, the condition that they had tasted it before. This is, however, not usually called the conditioned reflex. The taste of the meat causes a flow of saliva the first time it is perceived. There is nothing, therefore, very interesting in the fact that the sight of it should later have the same effect. The reflex can, however, be modified in a remarkable way, so that it will happen that a stimulus by itself utterly indifferent will be followed by the reflex. If a bell is rung whenever the food is shown, and if this is made an invariable rule, after a number of seances the ringing of the bell alone will be followed by the flow of the saliva. This is the conditioned reflex, so called because it is conditioned by some other previous event. The emotional reaction is unconditioned, it occurs without previous training. It is not necessary to suppose that the dogs had any mental image of the food at those times when it was not shown, and the bell alone was rung. This cannot be proved directly in the case of dogs, but the conditioned

reflex is common in human beings, and the proof is to be found in them. It was common for soldiers after they had returned from the front to jump and exhibit other symptoms of alarm if they heard some explosive noise such as the bursting of a motor-tyre. The more intelligent were aware that before they had had time to think they had experienced the same feelings as they had previously when a bomb had exploded near them. But there were others who could not think of any reason why they should have felt alarm. They would say that it was " just their nerves " and be content to leave the matter there. If, however, they were asked to think whether the noise reminded them of anything, they would give the same reason as the others had done, and they would acknowledge that the fear they felt was exactly the same as that which a bomb would have brought about in them at the war.

The conditioned reflex therefore introduces us to the conception of unconscious mental processes. This conception has been the subject of some confusion ; and it is necessary that it should be understood.

Unconscious Mental Processes

Confusion has arisen as to what is meant by Unconscious Mental Processes for at least two reasons ; first, because there is no very clear notion as to what constitutes a mental process : for most people the idea is that a mental process is the same thing as consciousness ; secondly, because the word " unconscious " or " subconscious " is used to denote different kinds of function. Though it is hard to draw the line, we have to distinguish between a mental process and a reflex. No attempt will be made to do this by definition. We may say that a mental process implies choice, or at least the appearance of choice, and that a reflex does not. Thus the movement of the pupil under the influence of light has no choice about it, and it is not thought of as anything but as a reflex. On the other hand, it seems as if I can move out of this chair, but that it is equally open to me not to do so. I think I have choice, and if I move, the action will not be looked on as a reflex, but as the result of a mental process. We extend the same idea to understand the actions of other people. Our belief that other people have mental processes rests on the appearance that they are exercising choice of some kind. We have

very little doubt that a number of their actions are purely reflex, but we are equally certain that a large number are dependent on choice, and that therefore they betoken the presence of mental processes.

Let us further extend this idea to certain acts of our own where apparently choice was exercised, but where there was no consciousness. If I am walking along a crowded street with a friend, I may be so engrossed in conversation with him that I am wholly unconscious of the passers-by. Yet I do not collide with them. It is certain that something in me must be seeing them and avoiding them, for if I am blindfolded I shall assuredly knock against them. Now this avoidance implies choice, the faculty which we have taken as the criterion of the presence of a mental process. In short, it argues the existence of a mind in me of which I am not always conscious. This kind of subconscious mental process is one with which my consciousness can get into touch easily. I can at any time watch it doing its work.

The second source of confusion about the subconscious arises, as stated, from the fact that there are several kinds of subconscious. There are things on the margin of consciousness, which keep swinging out and in. The people on the street are in that category. There are all the things which I know, but which are not in consciousness for the moment nor on the margin, such as the multiplication table which was not in it a moment ago but which is there now.

More important for our subject, however, there are events which have been forgotten, but which still influence action, although the subject cannot by any voluntary means recall them. This is a kind of unconscious which it is hard to believe in, but which assuredly exists. Fortunately it has been subjected to experimental evidence. It is possible to hypnotize a subject, to order him that in exactly one week he will write the operator a letter and that in the interval he will not remember anything about the matter. The subject awakens, and remembers nothing of what has taken place at the seance. In exactly a week he writes the letter as ordered. If asked why he does so, he will furnish some reason other than the true one, of which his ordinary consciousness is ignorant. Now the writing of that letter implies choice ; that choice was not exercised by his usual consciousness, a fact which once again predicates subconscious mentality. It may be said that the writer had no choice ; he had to

write the letter; but this is only a verbal or philosophical difficulty. He had that degree of choice, which we all have, to obey an impulse or not. It is necessary to keep clear of philosophical considerations when we are studying practical matters. If we say that this individual had no choice, it will not be long before we shall be obliged to face the problem of whether anyone has choice in any circumstances at all or not. There is a powerful school of opinion which holds that we have none, but as no one of its adherents extends these views into the practical affairs of his own life, we need not trouble about them here. It is probably true that if, in the experiment which has been just described, the subject were ordered to do something utterly repugnant, such as commit a real murder, the experiment would fail.

Examples of this kind of subconscious process are also common without the intervention of a second person. Many people have the power to arrange to waken an hour earlier than usual. They impress on themselves before they go to sleep that they must do so. They do not think about it again either before they go to sleep or in their dreams; but they awaken at the appointed time. The awakening must be due to some mental process, and at the time of its operating the desire to awaken was certainly not in consciousness.

Other interesting examples are easily found. A young man was playing cricket, and was afraid that he would make no runs. A friend, wishing to encourage him, bet him a shilling that he would make at least eight. He accepted the bet. Now this young man had to count every shilling he spent. He at once regretted his bet, and said to his friend that if he made seven he would hit his wicket; he said this in the spirit of the joke which is made in earnest. He then dismissed the matter from his mind. When he went in to bat, he counted his runs, a thing he always did, and after a time reckoned that he had made seven; he then hit his wicket. Then suddenly he remembered his threat to do this, which he had forgotten. He was quite sure that he had never thought of it while he was batting, and was certain that the execution of it was a pure accident. But as he was walking to the pavilion he felt very miserable, for he thought that he would never be able to convince his friend of this. When he got to the pavilion he found that he had counted wrong, and that he had made nine, so that he had no need to apologize or do anything

disagreeable except pay his shilling. The view put forward here is that when consciousness had registered seven—that this number was wrong is immaterial, the point is what consciousness thought it was —this acted as a stimulus to the old resolve, which was now wholly unconscious, and it was realized.

This view is open to criticism. The man might be a liar. If this hypothesis is to be adopted we need not trouble further about psychology. All psychology depends on being able to trust the reporter. This young man was well known to the observer, who had every confidence in his truthfulness.

It might have been a coincidence. That is the usual explanation of the sceptic. Coincidence is commonly a lame reason given to explain phenomena which we do not understand. Hitting the wicket is a rare method by which batsmen are dismissed ; it must be remembered that the man had thought of it already. These two factors make coincidence an unlikely explanation if mathematical chance be considered. The most feasible explanation is the one offered, and it is the more likely because this kind of thing is really very common.

Those who are curious on the subject will find examples easily enough. Many have been described by Freud in the "Psychopathology of Every-Day Life."

Prolongation of the Reaction

We have seen that the symptoms of the emotional reaction differ from those of the neuroses chiefly in their frequency and duration. Many girls will blush if they are embarrassed, but in neurotic blushing the patients may blush every time they come into company. Anyone may have an attack of palpitation on excitement, but in healthy people this dies down very quickly ; in neurosis it seems to come on when the patient is undisturbed ; it may waken him out of sleep, and it may last for hours. Why should certain people have these normal reactions prolonged until they become an illness ? The answer to this is not simple. In many instances when we have given it, the case is finished and the patient cured. The question is, therefore, one of the utmost importance.

1. The reaction may be prolonged because for some reason it is dreaded either because it is so uncomfortable in itself or because of

the consequences it is supposed to bring about. Timid people with palpitation may easily believe that the symptom means that their hearts are not strong. In this belief they may unfortunately have been strengthened by their doctor, who may have warned them to take care. If the patient has been induced to believe that this was necessary he will get palpitation often. Every time he sets out to do something which entails cardiac strain he will be to some degree afraid to do it; and we have already seen that fear causes palpitation. The more he does the more palpitation will he get, and the more palpitation he gets, the greater will his fear become. There need be no end to this vicious circle unless his views are changed.

On the other hand, the doctor may say that there is nothing wrong, and leave the matter there without further explanation. This may be equally disastrous. A patient with symptoms who is told baldly that there is nothing wrong is apt to think that the doctor does not understand his case, and, as most people do not seem to understand, he can pass easily into a state of despair, which of course will cause an increase of symptoms.

In the section on treatment the method of steering between these two difficulties will be indicated.

2. The reactions may be prolonged because of associations which produce a conditional reflex. This has been already discussed on page 20. The associations may themselves be seemingly indifferent. For example, a man had headache every time he ate meat. This had been put down to some idiosyncrasy, but nothing had been discovered to account for it. After an enquiry which lasted for some weeks it came out that in his adolescence he had been troubled by sexual desires, and that he had considered them to be very wicked. He read somewhere that meat stimulated desire, and he resolved to cut meat out of his diet. But he was fond of it. Every time he ate it he got a headache. Here we have an example of a protective emotional reaction. It protected him from sin. He did not himself perceive this, but thought his headaches came on for some unaccountable reason, and indeed he consulted several doctors to get them cured. The headaches therefore were no longer in consciousness associated with any sense of sin. Later he married and the sense of sin in consciousness had gone. But the headaches continued. They may be said to have continued as a conditioned

reflex, or because of unconscious mental process, i.e. the protection against unconscious sin. When these ideas became conscious, the patient was able immediately to eat meat with impunity, a fact which gives some support to this view, seeing that no treatment over many years had had any effect while the ideas remained in the unconscious part of the mind.

3. The symptoms may continue because the patient derives an advantage from their presence. We must not think of this as malingering. The patient with neurosis is unaware that he keeps ill because of the advantage. The malingerer is fully aware that he will gain some advantage. The grosser examples of neurosis kept up in this way are to be found in patients receiving compensation for injury. Some of these are no doubt malingerers, but the majority are not. Less gross examples will be found as we proceed. One may be given here. A lady of forty suffered from attacks of extreme exhaustion which always disappeared during a rest cure, and always reappeared as soon as she went home. At home there was an impossible mother, who was probably certifiable. When her history had been taken the patient saw that it was this factor which brought on the attacks, and when she saw it her sense of duty enabled her to go home and keep well. She has done so now for fourteen years, though for only four of them was her mother alive. The question of the diagnosis from malingering will be discussed in Chapter XI.

What are the principal depressing emotional conditions which initiate the series of emotional reactions which for one of the above reasons become prolonged into continuing or constantly repeated illness ? Fear, anxiety, boredom, feelings of inferiority, jealousy are all common causes. We shall discuss these at length throughout the book, and they need not be elaborated further here.

Dreams

The study of dreams has thrown much light on the subject of subconscious thinking. And though in certain quarters the claims to interpret all dreams have been exaggerated, their same study is worth while. It is not proposed to enter fully into the matter in this book ; but from a simple dream a further example of subconscious thinking may be shown. A boy dreamt that he was walking past

a hedge and saw a bird's nest with eggs in it. He recognized the hedge; he was in the habit of passing it, and was sure that he had never seen the eggs. When he awoke he went to the spot, and there were the eggs as in the dream. He told me the dream as an example of one which had come true. If we care to hold such a view, there is nothing more to be said. We may here also believe that the boy was untruthful; knowing him, I cannot. There remains the unconscious mind. When he had passed the hedge by day he had been so absorbed by other things that he had not noticed the nest, exactly as the passengers in the street are not observed. The unconscious part of his mind had, and told him about it at an early opportunity.

For the present this subject may be left. The psychology necessary for understanding the view to be put forward here on the nature of the neuroses has been outlined sufficiently; much will be filled in as we proceed. We have seen that emotion causes symptoms which resemble those of the neuroses. The chief if not the only difference is in their duration. The modification of the emotional reaction, the conditioned reflex, implies the possibility of unconscious processes, which are as capable of producing effects as are conscious processes.

With this as a basis we shall proceed to study the symptoms of the neuroses, observe the manner in which a case develops, see how it responds to treatment, and in what circumstances relapses occur. It is hoped when this has been finished that it will be demonstrated that the emotional reaction and the conditioned reflex are sufficient to account for all the physical phenomena of the neuroses.

Endocrine Imbalance

Before we can proceed, however, there is another view of the neuroses to be considered—the endocrine view. It comes naturally here because it involves both physical and psychological factors; it is one which perhaps is of importance rather for the future than for the present or the past. Reference has already been made to Cannon's work, in which he has shown that adrenalin secretion is augmented in emotional states. But it is also probable that excess of adrenalin in its turn causes emotionalism. The endocrine view of the neuroses would be that our emotional states depend on some departure from the normal balance which exists between the various

ductless glands, and that the neuroses are in consequence symptoms of that departure. This may be so. All the phenomena of mind depend in some degree on the endocrine mixture which is presented to the nerve cells ; in thyroid imbalance we have an example of this. The hebetude of myxœdema, the lack of interest amounting sometimes to dementia, depend wholly on the absence of thyroid secretion. The restless apprehension of Graves Disease is dependent on excess of the same secretion. But at the present day this is the only condition of the kind in which we have anything approaching to exact knowledge. Other glandular secretions may be found in the future which will in other mental states produce as profound a change in patients as does the administration of thyroid now in the myxœdematous. But for elinical use in nervous cases there are no such secretions known now, though recently some have been discovered valid in certain physical diseases ; the successes which are quoted at present must be considered as having been achieved by the same means as those employed by the gynæcologists of old, the means of faith in a method. That there is much theoretical support for their use is true, but, in the words of the quotation at the front of this book, " plausible theories have not been lacking to support the successive remedies, but the general acceptance of them was founded on their supposed efficacy."

CHAPTER III

CLASSIFICATION OF THE PSYCHO-NEUROSES

At present the classification of the neuroses is unsatisfactory, because although there are certain types of reaction to be described presently, the picture in a given case is apt to be blurred by the individuality of the patient, which can provide all sorts of cross-currents of its own.

From what has been written it will have been inferred that the author's view is that neurosis is a manifestation of a faulty response to the difficulties which life offers and further that in the main the faults lie in three directions (1) by over-reaction, the positive response, (2) by under-reaction, the negative response. (3) There is a third method of possible reaction, the obsessive compulsive which for the moment may be regarded as the appeal to magic. There is no infallible method of putting patients into one of these categories and excluding them from the others. Many patients present symptoms which might put them into all three; but that is a difficulty with all classification. Categories should be firm and definite at the centre, but are bound to be vague at the periphery. They are of value if they help to clarify our minds and also if they help in treatment.

(1) Over-reaction

In the previous edition of this book patients in this class were called *neurasthenic*; the state was called neurasthenia. This word has, however, been given so many meanings that it had better be dropped. As originally used by Beard it meant what it said, viz. that there was weakness or exhaustion somewhere in the neuron, probably in the nerve cell. Later, as used by Dubois and Dejerine, it ceased to have that meaning, and connoted that the patient was ill largely because he had misunderstood his emotional reactions. Still later, Freud restored the word to its original meaning. He

believed the condition to be rare, but held that there was a state of real physical exhaustion to which he gave the name of True Neurasthenia. This was thought to be due to excessive masturbation, and to be physical. Later still it was considered that patients who suffered from it needed psychological treatment.

Meantime other names had been given to the old neurasthenia of Dejerine, viz. Anxiety Neurosis, Anxiety Hysteria, Anxiety State. These were supposed to represent different conditions, but the distinction was never very clear. The name which has been retained by the majority of writers is Anxiety Hysteria to differentiate it from so-called Conversion Hysteria, which is just Hysteria as we have known it.

Here we shall call the condition in which the patient meets his difficulty by the positive response the Anxiety Reaction (formerly called Neurasthenia). The name is not good, but everyone now seems to bring the substantival adjective Anxiety into the title of this category. To do so is in truth tautological, because everyone agrees that manifest or latent anxiety is present in every example of neurosis.

These patients then display the positive emotional reaction and correspond to the advanced primitive man who tried to fight his enemy or who ran away actively and who in doing so secreted a good deal of adrenalin.

As a special variety of the anxiety reaction is the *phobia*. A phobia may be found in any patient, but it may occur without any other symptom present. It is then an example of anxiety which has not been distorted into a bodily symptom but has remained simply as an anxiety. Though undistorted as a sensation it has invariably become detached from its proper object which has become unconscious, so that as a rule it seems a meaningless fear until its proper object has again been brought into consciousness.

(2) Under-reaction

What used to be called hysteria is often called now Conversion Hysteria because the manifest anxiety has been converted into the hysterical symptom; it was considered that because of this, consciousness had got rid of what was troubling it most, viz. anxiety. This is often but by no means universally true, as will be explained

later. These patients who respond to difficulty by under-reaction may be said to correspond to that primitive man who eluded his enemies by lying quite still. As a rule, nowadays this is carried out only partially. In this book this reaction will be called simply Hysteria.

Although many patients will display manifestations of both reactions, it is worth while preserving the two categories. In the anxiety patients nothing is found which is not found sometimes in everybody. Anybody may have a headache from anxiety, or diarrhœa from fear, or palpitation from stage fright. It is only when these things become so frequent as to interfere with the easy conduct of life that we begin to call the syndrome an illness. But in hysterical paralysis or convulsions we strike something that never occurs in normal people. All normal people, from time to time, have anxiety reactions, but hysterical reactions always point to something radically different.

(3) Obsessive Compulsives

The third category is that of the Obsessive Compulsives. These patients seem to be perpetually trying to put their thoughts right. They are haunted by ideas of something being wrong which they can put right by thinking, or if that fails by ritualistic practices. Both these methods seem akin to primitive magic. These patients never get away from their troubles. They are harassed by them so long as they are awake. This is the most serious form of neurosis.

It must be emphasized that many patients will show all forms of reaction, anxiety symptoms, hysterical symptoms and obsessional symptoms at the same time, while on the other hand phobias, hysterical symptoms and obsessions may occur in isolation, or one of these may dominate the picture.

Something must be said here about the word " neurotic " which will be used from time to time. Unfortunately in ordinary speech this word has acquired a contemptuous connotation which the noun " neurosis " has not. The word is used here without such connotation, simply as the necessary adjective to the noun.

CHAPTER IV

SYMPTOMS OF THE ANXIETY REACTION

We may now, then, define the anxiety reaction as a series of symptoms, which arise from faulty adaptation to the strains and stresses of life. It is caused by overaction in the attempt to meet these difficulties. The symptoms are those of the *positive* emotional reaction. They may occur in any region of the body. They may be regarded as representing an ineffectual struggle against a difficult environment. They are general and local. There are also certain mental symptoms.

General Symptoms

Fatigue on slight exertion is very often present. It bears little relation to the condition of the muscular tone, or to the amount of exercise taken. A man, whose muscles are as hard as iron, may complain of fatigue on walking a hundred yards. It is often quite unaffected by long rests in bed. Not always but sometimes it is curiously selective. Thus a patient of the writer's was utterly fatigued by washing her niece's hair, but she could bicycle twenty miles without much trouble. Slight mental exertion may also bring it on, so that the patient cannot read, or even talk for any length of time, without becoming exhausted. Again the selective nature of the fatigue will often be obvious; it is seldom that these patients cannot sustain a long conversation with a doctor who is willing to listen to them describing their symptoms, though talking with other people on general subjects may exhaust them in a few minutes. In general it will be found that fatigue comes on early, when the exertion is of a kind in which the patient does not feel interest. This need not make us think that it is being exaggerated. We are all aware that the same kind of fatigue overtakes every one of us, though not to the same degree. We are easily tired with a bore, and most of us while we are young will become more quickly

tired with weeding the garden than with a game of tennis. Every patient does not show selective fatigue. In many it is simply that they are much more easily tired than they should be. What this fatigue really means will be discussed later.

Loss of weight is very common. It is usually due to loss of appetite. It may be very great in amount, and give rise to considerable anxiety as to the question of organic disease.

Local Symptoms

It may be repeated here that the local symptoms are all those which may occur in any one of us as an emotional reaction. It is notorious that each of us reacts to emotion specifically to ourselves, rather than to the kind of emotion. Thus one person who is worried may go off his sleep, another will lose his appetite, another will feel very tired, and so forth. None of us shows all the possible reactions which we might. We shall not then expect our patients to show all the possible symptoms. As time goes on these local symptoms spread, and others besides those which were present originally will appear, but at first there will be but a few. It often puzzles patients that, if their dyspepsia does not depend on some disease of the stomach, it should exist as an isolated symptom, or that their headache should remain confined strictly to some distinct region of the head. They feel strongly that such a phenomenon must point to some local lesion. If they can be shown that this applies to every one in health, as well as in disease, the matter becomes simplified.

Affections of the Alimentary System. Loss of appetite, sometimes amounting to complete anorexia, is common. The appetite is apt to be exceedingly capricious, and the patient to be difficult to please. The mere sight of food, to which a few moments before he had been looking forward, will often abolish the appetite altogether. He complains that the mouth becomes dry, and that he can neither chew nor swallow it.

Indigestion is common. The chief complaints are fullness after food, a feeling of distension with eructation of wind, which may be beyond all reason and persist for hours, repeating of food, and acidity. The dyspepsia is often selective in a way that is incompatible with reality. Thus the patient may be able to eat beef but not mutton, fish but not chicken, and so on. Vomiting may

occur, but if very pronounced the patient more often belongs to the hysterical type. Definite pain is not common, and if there is a persistent complaint of pain after food, especially if it has a time relation to the taking of it, organic trouble should be suspected. The physical signs of dilatation of the stomach may be present, and are due to the condition of atony of that organ which is connected with the overaction of the sympathetic system. This dyspepsia depends on a physical alteration of the stomach functions. It has been shown that there is an alteration of the gastric secretions, delayed motility, and loss of muscular tone. These effects are also found as the result of emotion.

Constipation, diarrhœa, mucous colitis and spastic colon are common symptoms and will be spoken of fully in Chapter VIII.

Urinary System. Pain associated with loose kidney, polyuria, frequency of passing water, and prostatic pains are all common and are dealt with in Chapter VIII.

Genital System. Impotence in men may occur and is usually accompanied by great mental distress.

Ejaculatio præcox and nocturnal emissions are also common. Usually these symptoms cause much further anxiety, setting up vicious circles.

In women dysmenorrhœa, amenorrhœa, frigidity, dyspareunia, commonly accompanied by vaginismus, are all common.

Circulatory System. Tachycardia, cardiac discomfort, amounting sometimes to pain, palpitation, sense of constriction in the chest with fear of impending death, are common symptoms. The subjective sense of the heart's action may be greatly exaggerated; unimportant irregularities such as extra-systoles are felt, accompanied by a feeling of alarm.

In all these circulatory disturbances, while exercise may bring on the symptoms, they are even more liable to occur when the patient is at rest, very often when he is sitting quietly in a chair, doing nothing as he will express it, but when he is, as a matter of fact, brooding over something, or has received in some way a stimulus which provokes an emotional reaction. The meaning of this will become obvious later.

Vasomotor System. Blushing, pallor, sweating, coldness of

skin are common. The sweatings may be exceedingly profuse, and are usually thought by the patient to be very weakening. Seeing that sweat is merely a dilute urine, it is difficult to see why sweating is by itself a weakening thing. Many people take frequent Turkish baths without any feeling of exhaustion; on the other hand, they feel greatly refreshed. The idea that sweating is exhausting came probably from its frequency in fevers, especially in the fever of phthisis. The consumptive patient does feel exhausted after his sweat, but this is also after a bout of high temperature, when he has been drenched with toxins. Coldness of the skin is usually accompanied by an absurd fear of catching chills; patients subject to this symptom wrap themselves up in mufflers, and see that all the windows are hermetically sealed.

Respiratory System. There is a kind of person, who is well known to every doctor, who catches cold every time he alleges that he is in a draught. But if that kind of cold be enquired into carefully, it will often be found to differ considerably from the ordinary coryza. The latter begins with a serous discharge which becomes purulent later; in these nervous rhinorrhœas there is nothing but serous flow. The condition is a prolongation of the wetness of the nose which every one feels after discovering that he has left the house without a handkerchief. These patients have often sovereign remedies for colds which are very successful in their own cases. Every doctor has a number of them in his practice, and is aware how they seem to spend their whole lives running away from colds, how they wrap up their mouths when they go out and make themselves ridiculous by wearing shawls when they go from one room to another. They are peculiarly annoying to every one they come across.

Shortness of breath on slight exertion is common; it is stated that the respiratory rate is quickened, and that respiration is shallower than normal in most nervous patients.

Nervous System

The symptoms are somatic and mental.

I. Somatic

Peculiar feelings in the head are common. They are often described at first as headache; but closer questioning usually reveals that they seldom amount to pain, the definite complaint

of which should put the doctor on his guard. They are rather feelings of discomfort, of swelling of the scalp, of a band being tied round the head, bursting feelings, stuffy feelings, as if the head were packed with cotton wool, weight on the vertex, pressure especially on the frontal and occipital regions. Pain may certainly be complained of and may be very severe, even agonizing; it is common enough about the nape of the neck, but it may be present over any part of the head. These symptoms are often present constantly, and have exacerbations which may last for days. It will be found that these are associated with periods of increased emotional disturbance.

Tremor in company, especially when the attempt to lift a glass or a soup spoon to the mouth is made, can have two grave effects; one is that the patients often find that it is abolished by alcohol, a most dangerous discovery, seeing that the dose must be steadily increased; the other is that people afflicted in this way are apt to withdraw themselves altogether from social contacts.

Ocular Symptoms. Associated with the headache so called there is often intolerance of light, which may be so slight as to be relieved by the mildest tint in a pair of glasses, or so great that the patient will spend the day in a darkened room, and at the outset of the medical visit the eyes may be tightly shut. But if the doctor can wait half an hour he will usually find that the eyes are open before he leaves. It is not suggested that this means that the photophobia has been fraudulent; what is meant is that the emotional reaction to fear may be overcome by that to curiosity.

Muscæ volitantes are frequently complained of. They are present in the eyes of everybody, and the amount of annoyance which they cause is in proportion to the amount of attention which is bestowed on them.

Functional Asthenopia. In this condition the patient can see to read quite well for a certain time, varying from a few minutes to half an hour. Then the letters become blurred and run together, and he is obliged to give up the attempt to read. There may be pain in the eyes if it is persisted in. Although this symptom may be associated with an error of refraction, it is not due to any such error. This subject will be dealt with more fully in the chapter on treatment.

Aural Symptoms. Buzzings in the ears may come on in periods which may last for days or weeks. Accompanying them there is a degree of deafness, which is not, however, great in amount. Patients are also troubled with the noise of their pulses in the head; this may be an important factor in causing insomnia. Intolerance of noise is extremely common; associated with this there is often a real hyperacousis.

Giddiness is common. It often comes on on changing posture, as in getting up from lying down. It is usually a subjective sensation of being unsteady, not an apparent rotation of external objects.

Pains of all sorts are common in many parts of the body. The headaches have already been mentioned; others which are frequent are a feeling of a claw in the abdomen, severe neuralgic pain in the rectum and in the breast, both of which are often associated with the fear of cancer, persistent peculiar feelings in the epigastrium, the pain of loose kidney, and various pains in the muscles called "rheumatic."

It is probable that many of the cases of rheumatism treated successfully at various watering-places are really nervous. Where there is no joint stiffness, nor the presence of nodules of fibrositis to be felt, the diagnosis of any physical condition should be received with scepticism. During the War a very large number of soldiers with stiff muscles were treated by hydrotherapy unsuccessfully, and were later quickly cured at neurological hospitals.

A pain of considerable importance is that in the sacrum and back. It is especially common in women, but it occurs in men also. When it is associated with retroflexion or retroversion of the uterus, treatment of that organ by replacement and the use of a pessary will often afford relief. But it is probable that the pain in nearly every case is a symptom of a general nervous state, and that the success which undoubtedly frequently attends local treatment is due to the same cause as is that which may attend the operation of fixing the kidney, that it is, in short, brought about by a psychological, a mental process.

Insomnia is one of the most important nervous symptoms, and one of the commonest. It is of several types: there may be difficulty in getting off to sleep, broken sleep, or waking finally at three or four in the morning. It is seldom that there is no sleep,

and it is probable that the patient gets more than he believes he does; but it is of no use to rely on some one else's report that the patient is sleeping much better than he thinks he is. The patient is not having enough sleep unless he reports himself satisfied. This is true of all nervous symptoms. They cannot be regarded as better till the patient says that they are. They have no existence except in the patient's mind, though again it must be emphasized that that is a totally different thing from saying that they are imaginary. The sole criterion of cure is that the patient should say that he is well. Along with the broken sleep there are distressing dreams, and the patient often awakes more tired than when he went to bed.

II. Mental Symptoms

Inability to concentrate is always complained of. It would be difficult for anyone suffering from a large number of disagreeable sensations from any cause to concentrate. None of us concentrate well when we have toothache. When we are anxious, and the anxiety is constantly obtruding itself on our attention, we cannot concentrate on our work. There is therefore no need to be surprised at this symptom, nor to consider that it is a sign of mental deterioration, and yet that is what the patients commonly do. From failure of concentration there naturally follows failure of memory; and though this is not the only cause of memory failure in these patients, it is a most important one as regards their daily forgetfulnesses, which is the form that the complaint usually takes. Memory for old events is well preserved, but they forget little things they have to do, and mislay things to an abnormal degree.

From these two symptoms and from the insomnia springs one of the most important symptoms of all, viz. fear of insanity. This is a fear which haunts almost every nervous patient. It is one that very little discussion serves to dissipate in the majority of cases, but it is also one that the patient will not as a rule disclose spontaneously. He will give little hints that allow of the subject being dealt with, if the doctor cares to follow them up. As Head has put it, he plays a low card of a suit. It is often held that a neurotic is a person who is always complaining loudly, and not one who is playing low cards. He is playing low about some things, but by no means about all, and the exceptions are very important. It might even be said that he complains most loudly about the

unimportant things, and tends to conceal those about which he might reasonably be most anxious.

For example, a young man had symptoms connected with his eyes. He could not focus, nor read without pain; light hurt them. In his history there were none save head symptoms. He was examined all over. His head and eyes were healthy. When his abdomen was about to be palpated, he asked that no pressure should be put on it, as he had just had an attack of "congestion of the liver." He was tender and rigid in the lower right quadrant, and on cross-questioning it looked as if he were convalescing from an attack of acute appendicitis. There was a history of a previous attack a year or so before. Fortunately he had another attack while under care. At operation an acute inflamed appendix with adhesions was found.

Shyness and **awkwardness** in company are common. They are associated with a sense of inferiority which has usually been present since early childhood. People may feel inferior in four ways, intellectually, morally, socially or physically. The sense of inferiority is one we ought to have in some degree if we are to be the sort of people with whom others can live and work. It makes us conscientious, it keeps us to our work, for we feel we shall fail if we do not take trouble and care over it; it makes us pleasant companions, for we are not overbearing in speech or manner. But with neurotic patients it may be so overwhelming that it prevents them doing anything at all. They conceive themselves to be the poorest specimens of humanity, the most worthless, ignorant, most incapable people in existence. They are not necessarily anything of the sort. They are apt to make a composite photograph of a number of other people, and then compare themselves with that as if it represented one person. Thus they meet one who knows literature, another who knows French, a third who knows astronomy. They credit all three with the knowledge of all these things, and compare the result with themselves. They forget that there is possibly something which they themselves know and which the other three do not.

In the moral sphere they suffer in the same way. They meet people who express only noble sentiments and who perform a large number of kindly acts: rightly they admire these expressions of

an elevated nature. They look into their own minds, and they perceive there that there are a good many thoughts which are ugly and of which they are ashamed; they look at their deeds and see that many of them are selfish. They think that thoughts and deeds of this kind are peculiar to themselves, and that the people whom they admire so much are free from them. It is a revelation to them, which at first they cannot believe, that everybody has unworthy thoughts, which it may be a sign of wisdom to keep private, that everybody sometimes does mean and ugly things. This sense of moral inferiority was very clearly marked in the neurotic soldiers. Under the stress of bombardment they experienced fear. They may not have shown it, but none the less they despised themselves for feeling it. It did not occur to them that their fellows, who were not showing it either, might be feeling it also. They were sure that the others were not feeling it.

It may be pointed out that this crediting other people with perpetual virtue is a common attribute of childhood. The normal child, who is brought up by parents with any spark of worth, considers that they are omniscient, and the pattern of everything that is right. To some degree he extends this to most adults. He learns that there are some adults who are bad, but he considers that they are very abnormal and unusual people. Some time or other he discovers that his parents are not the all-good, all-powerful people he thought, and when he has reached this state he has *ad hoc* grown up. Some never grow up in this respect, but retain the childish view. They have a fixation of the childish attitude, and are often described as having a parental fixation. In times of stress, as in the War, they experience some return to the childish attitude in respect to their regard for other people, as has been explained. This return to a mental attitude which properly belongs to a different and younger period of life is called *Regression*. It is a common thing in many guises in nervous people, but is found also in those who manage their lives satisfactorily. No one quite gets rid of the feeling he had towards his parents, and probably the survival of it is of social importance; it is one of the factors which tend to foster the respect for law and order in the community.

In the sexual sphere this feeling of moral inferiority becomes very

potent for evil. Many young people of both sexes imagine that they are peculiar in having sexual desires and in practising masturbation. They believe that if people only knew what they were really like no one would speak to them.

The sense of social inferiority can also be a very distressing affair. People who have made money and who cannot cope with the customs of the class into which they have moved can become miserable and ill about it. It is oftener the wife of the money-maker rather than the maker himself who is thus afflicted. Often, too, the children of a poor relative are made to feel their inferior position by the well-to-do, and this may often happen when the intention of the rich relative was good.

Physical inferiority, especially plainness in a girl, may lead to shyness and illness. The case of Byron who was soured in boyhood because of his lameness will occur to every one. It is specially in the sphere of the genitals that physical inferiority is most acute. Men who think that the penis or the testicles are too small frequently exhibit very marked inferiority. Young men whose hair on the face is not as luxuriant as that on their fellows suffer in the same way.

Often enough the feeling of inferiority is productive of nervous illness, but it may be compensated or even over-compensated. Possibly Napoleon was over-compensating for being undersized, when he felt it incumbent on him to conquer Europe.

It must not be supposed that every neurotic patient suffers from the sense of inferiority; but, as we shall see later, its presence or absence is a most important point in prognosis. It is always worth while to form an idea as soon as possible as to whether it is present or not in any individual case.

Phobias of some kind are common in the anxiety reaction, but the phobia may also occur as an isolated symptom and remain so for years. The patient may be quite well in every other way except when the phobia is present. Further description of this symptom will come more appropriately when we come to consider treatment.

Attacks of fear may be so acute as to deserve the title of *panic*. Sometimes the patient will name a cause for the panic, which will probably be quite inadequate to explain anything, such as that he knew that there must be a cat in the room. But often he will say

that he does not know the cause; the panic just came on. With time and careful enquiry, by the methods to be detailed later, long-forgotten causes in childhood which were adequate then, and are important now only because they have remained unconscious, may be found.

Anxieties of all kinds may occur not only as causes but as symptoms of the illness. These must be considered at great length in the chapters on treatment and need not be further considered now.

A woman of thirty-five lived with her mother with whom she got on very badly. She decided to leave home and earn her living. She made several attempts to do so, but at each attempt she fell ill, and among other symptoms panic was always present. She herself had thought that she had had a series of physical illnesses, but as time went on she accepted the view that it was a series of emotional reactions. She devoted a good deal of thought to the subject, and woke one night with a feeling that panic was coming on. She managed, however, to try to think what it was all about, and at this point a childhood recollection came into her mind. She had been punished by her mother and sent to bed. A servant carried out this last part of the punishment, and told her that she had known a child who was naughty, and who had been whipped and sent to bed. A few hours later her father called to her to come downstairs, and on getting no reply he went up to her bedroom and found not only that she was dead, but that the Devil was in the act of carrying her soul away. The patient believed this story and was terrified. The story was then totally forgotten. After it had been remembered and thus discounted panics lessened. It certainly seems possible that this story, though buried in the unconscious, became activated though not conscious when the patient tried to disobey her mother.

Hallucinations of sight, of sound, and of the other special senses are sometimes looked on as pathognomonic of insanity. But they occur in perfectly normal persons, and therefore also in neurotic patients. The test is that already laid down. What does the patient think of them? If he recognizes that they are a symptom of his illness, then he is not, so far as they are concerned, suffering from insanity. If he maintains that they have an origin outside himself, then his views are those of fantasy become reality, and so far

he is insane. They are symptoms about which patients are shy of talking, and it is possible that they are commoner than is usually supposed.

These are the common symptoms of the anxiety state; the list is not complete, for the symptoms of this condition comprise all the sensations which the human body is capable of feeling, and all the ideas the sane mind can entertain. When we consider it carefully, it will be seen that they are the symptoms which are often associated in healthy people with the presence of anxiety. When we are worried and anxious we feel unduly and absurdly tired, have uncomfortable heads, cannot concentrate, cannot sleep, eat badly, and our digestions are apt to be upset. A history of anxiety will be found to be closely related to the onset of symptoms; and relief from that anxiety will remove, or at least modify in a favourable way, the symptoms from which these patients suffer.

To make this clear let us consider the genesis of an actual case. A lady of about forty-five complained of fatigue so great that she could hardly walk across the bedroom floor; her concentration was fair, although she said that her head felt as if it was empty; she was depressed because she was such a useless person, she was liable to "bilious" attacks, and had to be careful of her diet. She did not have very many complaints, which makes it easier to study their sources of origin. These symptoms had been present off and on for twenty-two years. She had had six formal rest cures during that period, several of which had been highly successful in making her feel well at the time, one or two had done little good. Before the first she had had an attack of influenza, had been exhausted and nervous after it, and remained so until some one had put her through a rest cure. That was the history as she gave it; she believed that she was a person who had become ill because she had been overwhelmed by the toxin of influenza. As such, the case had been accepted for years. It is well, however, to be suspicious of post-influenzal "neurasthenia". Examples of it often yield very interesting stories. On closer enquiry it seemed improbable that this lady had had influenza at all, although there was a history of something like that illness before each nervous attack. At the time of the first epidemic, she had had one of those influenzas

which occur without temperature. There was much of the illness in the house, and she went to bed like the rest. On further enquiry it transpired that she had had a piece of news which had upset her very much, her father had committed suicide. Neither this nor the influenza, if it had really occurred, were enough to have caused the prolonged illnesses which followed, and other factors were therefore sought. At the time of the " influenza " she was considering the question of whether she should become engaged to be married ; and here scruple naturally came in to add to the other worries. Ought she, with such a family history, to marry ? It must also be added that the doctor during her convalescence had said that influenza might be followed by symptoms such as she was exhibiting, and that such cases were troublesome, a further cause of worry. In the end she decided to marry if she got well ; she was promised that this would happen if she had a rest cure ; she had it, became well, and married, on the doctor's advice.

Now at this time she was fully persuaded in her mind that her nervous condition had been an exhaustion due to influenza, and that that exhaustion had been cured by the very rational treatment of resting and building her up. The scruple had by this means been ingeniously relegated to some limbo in the back of her mind, but there it was only biding its time. Fear of influenza was, however, firmly implanted in her mind. Consequently when the next epidemic came along she promptly became ill again, and remained so till she had been given the treatment in which she had faith. The common remedies had had no effect before, and therefore they had none in the second event. They had none because she had no faith in them. It was necessary to give a formal rest cure each time before the symptoms would disappear. This series of events recurred again and again. The amount of success which attended these treatments varied greatly. The last one of all had been a failure, or nearly so. The first five had been carried out with great pomp and circumstance in nursing homes, but the last, for financial reasons, had been carried out in the wards of a hospital, and the specialized attention given in the others was lacking ; the rest, the food, the massage, she admitted, were as good as ever, but there was something wanting. The house physician was not as sympathetic as her private doctors had been, that is to say, there was a

malevolent psychological element present, which had been absent on previous occasions, so that this time the charm would not work.

There was, however, a further reason why this last treatment should not have succeeded, viz. that at the end of it her brother committed suicide. This, of course, brought back the old scruples. She had children; ought she to have brought possible psychotics into the world? It may be said that when these matters had been brought to light and had been discussed she quickly lost her fatigue, and within a week or two was walking fifteen or twenty miles a day.

We have here a case which exemplifies in a very clear fashion some of the reasons why in these patients the emotional reaction becomes prolonged. One of the most important is that it is wrongly interpreted. She had an emotional reaction which was mistaken for a physical disease; this was in itself a depressing thing, and it increased her worry, which again was followed by further symptoms, and in this way a vicious circle was set up, which was kept going by every doctor whom she came across. Now, this is a thing which ought not to happen, but which is happening every day. There is an unfortunate belief in the minds of many doctors that they are bound to give a patient a diagnosis, when they have really no grounds for doing so. They are also prone to advise on important matters when they have not sufficient information. The doctor who advised marriage did not really know why the patient hesitated to marry, neither for that matter did she. Both thought it was because of fear that she would not be strong enough, but with a little exploration of her thoughts the real reason, fear of transmitting an unfortunate heredity, would have emerged. Even then it was not the doctor's business to advise. He could have pointed out that the risk was there but not in great amount, that everybody must take some risks if they are to do anything at all, and then have left it to the patient to decide. The doctor in these cases should not be an adviser as he must be in physical disease, but merely the person with whom the patient can talk things over freely. The rôle of director of conscience is one which he will find he is constantly being invited to take up, but it is one he should be slow to adopt.

Doctors are apt to think that if they do not give a name to a disease, and that if they do not advise, the patients will lose con-

fidence. In the absence of any very clear signs they are apt to give a fancy name. In the above case there were no grounds for believing that the patient had been seized by the epidemic. The lapse of the usual time in which the others in the house got better did not suffice to make her feel well, and therefore it became established that she was subject to influenza of a peculiar nature or that she was in some way specially liable to its ill-effects. Not only was she subject to the disease in a peculiar way, viz. without temperature, but it had a very prolonged course, and gave rise to unusually great depression. When anyone begins to believe that sort of thing about herself, consequences may easily arise which may be prolonged. Influenza therefore became with her a word of evil power in itself, as a thing to be specially dreaded, and it acquired in this way an autonomous capability of causing symptoms; but it also became a word of power for a second reason, viz. because it became the stimulus for a conditioned reflex. The idea "influenza" was associated with the question: "Should I have married?" This had never been answered, only put into the back of the mind. Those who are presented with a crucial problem of this magnitude have no choice about what must be done with it; they must, if they are to have peace, thrash it out, and come to some reasoned conclusion. They often try to meet it by putting it out of their minds; but, in Morton Prince's phrase, they are by this means only putting it into their minds, where it lies until it is stimulated, when, although it may remain unconscious, it becomes active and exerts an influence of some kind.

We may learn from this simple case some other lessons of the course of a neurotic illness. It is full of periods of betterness. These occur when something of a hopeful nature has happened. The first treatment (Weir Mitchell) was carried out by an enthusiast at a time when it was possible for a doctor to be enthusiastic about it, and the effect was great. Not only did she become well, but this doctor's enthusiasm was such that her scruples were put into the shade by the strong light of his certainty of cure. Unfortunately his very success was the cause of further trouble. When she was next attacked there was no possibility of cure except by a very expensive method, and this, of course, becomes in itself another cause of depression, and therefore of more symptoms. In the later

years of these attacks she had come to look on herself as a useless creature, who was far more trouble to every one than she was worth. One of the misfortunes which attends success by a special physical method is that the patient must believe that it is the only method by which cure can be attained; and this belief will be all the more fixed according to the number of other kinds of treatment which were tried before the successful one was hit upon. In the nature of things this is likely to be more elaborate, and therefore more costly, than any other. In case of relapse the patient will approach all the other cheaper methods without hope or faith; and they will therefore do nothing. It will be necessary therefore that the method which succeeded should be repeated, and even that no detail should be omitted. Sometimes it may be essential that it should be carried out by the same man. How different is the picture if the patient has become well by understanding that her troubles were due only to a prolonged emotional reaction! In the face of threatening relapse she need only recollect why her symptoms are present, and immediately she will begin to discount them. They will then no longer breed further depression nor consequently further symptoms, and there will be a reasonable hope that she may cure herself.

We see also that an anxiety neurosis is not a continuous state, but that it consists in a series of illnesses, which are separated from one another. This phenomenon will be found in all attacks of the kind, even in those which at first sight seem absolutely continuous. It is a phenomenon which makes a criterion of cure very difficult. There is nothing but time to show whether a patient has really come out of this liability to fall ill on little provocation or not.

This history has been dealt with at some length, because it teaches many lessons very clearly. It is fairly typical of a kind of case which is common in general practice, and it is of a sort which is amenable in the highest degree to a comparatively simple therapy. All that was needed for this patient was that her history should be taken carefully, and that she should be induced to discuss her troubles. She was most anxious to do so. The thing was not buried in any inaccessible region of her mind. Unfortunately no one had seemed to think that these troubles were of medical importance, and therefore she had never confided them to anyone. It did not take more

than two or three sittings to get the whole story. Time is often the factor which deters a doctor from embarking on such an enquiry. But doctors had spent many hundreds of hours over her case, so that that factor need not have prevented them all from tackling the history. If it had been obtained, the errors of the interpretation of her symptoms could hardly have been made.

In this example the period of time during which the patient has remained well makes it fairly certain that the explanation of the case which has been given is correct. She has remained well for fifteen years. Twenty-two years of invalidism followed by fifteen years of complete health certainly suggest that the treatment which separates these periods was on correct lines.

CHAPTER V

DIFFERENTIAL DIAGNOSIS OF THE ANXIETY REACTION

Diagnosis must be made from other functional disorders, from organic diseases and from the psychoses.

We shall deal first with the diagnosis from the other functional disorders. There is no hard-and-fast line between these. Hart has pointed out that an individual may react to anxiety on different occasions in different ways. One day he may react with anxiety symptoms, on another hysterically; i.e. on one day he meets his difficulties by over-reaction, on another by under-reaction. While this is true, it is true also that any one person does tend to react more in one way than in another, and the mode of his habit of doing so is important. For an educated person the hysterical method is more unusual than the other, and it is on the whole of worse prognosis in him than it is in the uneducated. It means that he has given up the fight, and even his hysterical manifestation may be hard to cure. He will be more likely to have relapses. In the case of uneducated patients this does not hold good. It is a commoner mode with them. It does not offend against their conceptions of the physiologically possible, and does not signify the same degree of moral deterioration. They are as a class much less accustomed to be their own responsible leaders. Every educated person feels that he is responsible to himself for himself, that he must go on making efforts, and that if he gives up doing so, he gives up all; the uneducated feel much more that some one else is responsible for them, and that they may give up the struggle in life for a time without loss of self-respect, until some more competent leadership arises. They do not reason these things out: this is an unconscious or hardly conscious class feeling.

In hysteria the physical signs tend to be in the limbs rather than in the viscera; the hysterical patient is not so disturbed mentally

by his condition, which he regards with placidity, sometimes even with satisfaction, in contrast to the other's anxiety about it; in hysteria there is a loss of function such as a loss of sensation, of memory, or a paralysis, whereas the anxiety patient's symptoms are those of over-reaction.

From obsessional or compulsion neurosis the diagnosis of the anxiety state is simple, if the obsessional condition be not concealed by an anxiety state, as it so often is. The patient may appear to be suffering from a simple anxiety reaction, and this may be successfully cleared off, when it may be found that it merely was an added factor to a severe obsessional state.

That there is not a fundamental difference between the anxiety and the hysterical types was well shown in many of the war cases. When a man was treated successfully for his paralysis, it was common for him to acquire headache, insomnia, etc., which had not been present before, and which were obvious anxiety reactions brought on by the prospect of facing the war again.

Diagnosis from Organic Disease

For the general practitioner the diagnosis from organic disease is that which he will be called on to make most often. From a study of one thousand consecutive patients returned under the National Insurance Schemes as suffering from physical disease Halliday found that about one-third had in fact no such disease, but were the subjects of neurosis. The patients were not selected. They were examined by a team of specialists and then by a clinician of standing. If Halliday's findings are correct, and there is every reason to suppose they are, neuroses are more commonly mistaken for something physical than most doctors seem to think.

The diagnosis of neurosis should not be made merely because after a thorough physical examination nothing physically wrong has been discovered. Neurosis is an illness which does not depend merely on negative findings. It has positive symptoms of its own, and *no diagnosis of neurosis should be made unless these symptoms are present.* The doctor who relies on negative physical findings alone will experience difficulty from several directions.

(1) Physical disease may be present long before it can be detected.

(2) Trivial irrelevant physical abnormalities can nearly always

be found by modern methods if these are pushed far enough, but these may not be the cause of illness. (3) Physical disease which is effectively making a person ill may drift on into a neurotic state.

Phthisis, pernicious anæmia, peptic ulcer, sinus infections, even cancer of the stomach or large bowel are among the commonest diseases causing the first difficulty. Ten years ago we had many patients who had fallen ill with symptoms which seemed neurotic, such as sudden insomnia, but which turned out to be indicative of encephalitis. If, however, a state of ill-health has lasted for some months, and there are still no signs of physical disease after careful examination by modern methods, it is extremely unlikely that organic disease is present. It is on the whole uncommon for the neurotic to come to the doctor at all until his symptoms have been in existence for some months. In practice, therefore, the difficulty will not often arise if due care be taken.

The second difficulty is greatly enhanced by our increased diagnostic powers. Even in the old days, before all the modern methods of investigation had been invented, it was easy enough to find " causes " of illness as we have already seen, erosions of the cervix, astigmatism, auto-intoxication. X-rays and biological examinations of various kinds have enormously increased our power of finding something wrong, but there has not been a corresponding ability to assess the value of what is discovered. New instruments, if they are easy to use, have a pernicious influence. The sphygmomanometer is an example. The significance of medium rises in blood pressure is not yet certain, but patients are being told frequently that their symptoms are due to this. The invention of the stethoscope was also followed by a great increase in the apparent number of cases of heart disease, which after a hundred years we know was largely illusory. Certain dyspnœic patients with dropsy were found to have cardiac murmurs, therefore, with singular lack of logic, it was inferred that every patient with a murmur would soon have dropsy and dyspnœa. The clinical pathologist is also an instrument too easy to use, and his findings are apt to carry too much weight. It is significant that the invention of the ophthalmoscope was not followed by an apparent outbreak of organic disease of the brain ; and the conclusion must be drawn that it was

too difficult an instrument to be used except by those who were already well informed in their subject.

Thirdly, suppose a man has a cardiac lesion, and is ill because of it. He is put to bed. If he is the breadwinner this may make him anxious, and thus symptoms may be brought about in addition to those due to the organic condition. Getting about again is, however, also an anxious matter, lest he should do too much and break down again. Therefore getting up may also cause symptoms.

Symptoms establishing Diagnosis

If then the physical findings do not help us completely, although if the illness has been present a long time they are more reliable, on what are we to base our diagnosis? There are four points of great importance: (1) The peculiar and often contradictory nature of the symptoms. (2) The presence of nervous symptoms. (3) The attitude of the patient towards his symptoms. (4) The whole life history.

(1) It will often be found that the patients have been frequently ill off and on, and that the history of these illnesses does not run a true course. They have influenza without temperatures or ptomaine poisoning when no one else has it. All sorts of odd things give them symptoms. They get diarrhœa if they drink tap water, but are well with soda water. They get violent headaches if they take a mild aperient, or when the temperature is warm because they had sunstroke some years ago. They are badly affected by weather, draughts or certain foods. If histories are carefully taken these things will be easily brought out.

(2) It will be found too that they have almost always some mental symptoms of anxiety, panics or phobias or apprehensions.

(3) Their attitude towards their illness is typical. Generally the patient with serious organic disease is not very interested in it. He seldom talks about it, and often is disinterested to the point of filling his doctor with despair. He tries to evade his regulations when they are too restrictive; he can take interest in the other affairs of life. The neurotic is in every way the opposite of this. He talks of little else—at least he manages to bring it into most conversations. He is for ever seeking a fresh diagnosis, provided it is not too serious, and one might say provided he can ignore a

disease he has really got. In the case described on page 38 we have an illustration where organic diseases are relatively uninteresting to the patient compared with neurotic symptoms. We learn here also that a neurotic patient is in some odd way incurious about symptoms which may be serious. The truth is he dreads them, and therefore ignores them if he can. He objects like the rest of us to serious disease, though as we shall see, minor disease may in fact be welcome to him.

(4) The history of previous illnesses will show examples of these anomalies throughout the patient's life, and that illnesses arose in times of stress.

The absurd question is sometimes raised whether it is worse to miss an organic condition or a neurotic one, and of course the answer must be that both faults are bad, but on the whole it is not realized what tragedies may ensue from diagnosing an organic disease when the main trouble is neurotic. We hear terrible stories of cases of organic disease which have been missed because a doctor has said there is nothing wrong; but those of us who work among the neuroses can tell of equally terrible stories of patients with these illnesses where an organic label has been attached. A young man had a painful rash in the groin which extended to the penis, which he feared might be syphilitic. There seems little doubt that it would have been impossible for him to have acquired that disorder. This is said advisedly. He was a continent homosexual. He brooded about it for two months, and then told a syphilologist that he had had a sore penis and a rash. Apparently no cross-examination of his history was made. A blood examination was positive, but it is probable that this was a laboratory error, because all subsequent examinations were negative. Treatment for syphilis was instituted and continued for several years, during which the patient was in a state of misery. It seemed probable that the rash was herpetic, and as during the next six years blood examinations were always negative it is probable that the patient never had suffered from syphilis. Until doubt was cast on the diagnosis this patient had been in the grip of a severe conflict for all these years. He thought he ought to tell his employer; he dreaded doing so. Even if he had syphilis he certainly had also a severe neurosis, which cleared up quickly enough when that aspect of his case was treated.

Diagnosis from the Psychoses

From the psychoses the diagnosis may often be extremely difficult. Here, again, a nervous condition may be concealing some graver state. A lady complained of insomnia due to hyper-sensitivity to noise. Her doctor had written specially that she was " in no way mental." She was under observation for some weeks before it transpired that she was worried because she believed that people cut her, and talked about her in a libellous way. She had committed some peccadillo thirty years before, or thought she had, it matters little which, so small was the affair, and she had the delusion so strongly that she was being slandered that she had even consulted a solicitor about it. Such a case can be diagnosed only by spending enough time with the patient to gain complete confidence.

Schizophrenia in its early stages closely resembles a functional nervous disorder. In time there will be some manifestation that the patient does not distinguish between reality and fantasy, or there will be some departure from orderly conduct. Thus a young woman complained of exhaustion and of little else. She gave a perfectly coherent story of an attack of chickenpox some months before, since when she had been exhausted. She was listless and apathetic, and took little interest in the talks about her illness. Apathy is not common as either an anxiety or an hysterical symptom, but it is not enough by itself to make a diagnostic point. After about three weeks, during which time she remained " exhausted," she told me a curious story of a panther walking round the balcony of a Swiss hotel in which she had been staying. She saw its eyes in the dark. This story was received without criticism. A few days later she said she was pregnant, although she was actually menstruating at the time. She also said that her lover visited her in the hospital by night. This was quite impossible. Later she showed further signs of mental disintegration, but for the first three weeks the diagnosis was impossible.

The depressive stage of *manic depressive insanity* may closely resemble neurasthenia. The diagnosis is of extreme importance from several considerations.

It is important because the two illnesses are being constantly confused. The mild depressive is usually labelled " neurasthenic " ;

the more advanced patient is called *border-line*. This is an extremely unfortunate word. There is no special tendency for the neurotic patient to become a depressive, any more than there is for a healthy person ; indeed, it is possible that he has less tendency to do so.

It must be admitted that certain psychiatrists believe that the difference is one only of degree. They point out that over a long history certain patients will be found exhibiting what may be called frankly neurotic symptoms, while at another they will be in what is clearly an equally frank psychotic depression. They point to examples where it is very difficult to say to which category any patient should be assigned. Both statements may be accepted as true. The writer believes that the first condition is not common. Out of 1,043 patients, with a diagnosis of neurosis, whose cases were followed up for from three to ten years, about fifty became insane, i.e. less than 5 per cent.[1]

It is inevitable in all medical work that the diagnosis of some cases must be difficult. Typical measles is easily diagnosed clinically, but there must always be a number of examples where there is doubt. Similarly, typical pernicious anæmia is also easy to recognize, yet there are some examples where all the findings point to that disease, but as they are refractory to treatment, they must belong to some other category. It seems retrograde to group conditions into one category where there are usually marked differences, and where the proper treatment should be very different. We ought rather to seek out differential points, for it has always been by doing this that clinical medicine has advanced. Here we shall stress those differences, acknowledging that there will be some examples where the diagnosis will remain uncertain.

There are many reasons why a diagnosis between the anxiety state and a psychosis is important. The prognosis in the two conditions is different, and that in a somewhat complicated way. The depressive is almost sure to become well ultimately, provided he is taken care of properly, i.e. if he is not allowed to commit suicide ; on the other hand, many will in future years be liable to relapse. The neurotic must be made well ; he does not tend to drift into good health as the depressive will, but if properly cured he should not relapse. The majority of neurotic patients, if they

[1] "An Enquiry into Prognosis in the Neuroses." T. A. Ross. 1936.

are to be made well enough to take their places in society, will achieve the desired result in a few weeks or months ; the depressive attack is quite indefinite in duration ; it may take weeks, months, or years.

The proper therapy of the diseases is entirely different. The anxiety patient should be investigated as regards his history in a thorough and searching manner, and then should be encouraged to do more than he thinks he can, as will be explained in subsequent pages. Proceedings of this kind are harmful to the psychotic. Close investigation of his past with much probing and cross-examination, anything approaching psychoanalysis, in this stage certainly, will make him much worse ; and a part of the discredit which has fallen on psychoanalysis is due to the persistent attempts by some analysts with insufficient experience on these very patients. Equally, making the depressive do more than he feels he can do is harmful. He is a person whose available physical energy is at a low ebb, and it is very easy to make him over-fatigued.

The reason of greatest importance, however, for making an accurate diagnosis is because of the danger of suicide. The chances of the neurotic so doing are small. Out of 1,186 neurotic patients only seven were known to have committed suicide. There may have been more, but it is improbable that there were many more. This figure is possibly even too high, as some of these patients were only doubtfully classified as neurotic.[1] The psychotically depressed patients have a much greater liability to suicide than this. Those who deal specially with these patients indeed consider that nearly all of them are potential suicides, and they do not weary in impressing on the profession the gravity of this, a gravity which is increased very much in view of the fact that nearly all these patients would recover temporarily at least if they were protected from suicide.

It is not only, however, from the point of view of protecting the psychotic from suicide that this question is important. It is equally important that the neurotic should not be protected. He is often already terrified that he will destroy himself and if the doctor hints either by word or deed—as by having him watched—that he shares this fear, distinct harm will have been done.

The diagnosis itself depends on several factors. The history

[1] See "An Enquiry into Prognosis in the Neuroses."

may give helpful data. In the case of the depressive, the attack may have come out of the blue; the most searching enquiry may fail to reveal any reason, either of a physical or of a psychological nature, capable of accounting for it: but this is not so always. There may be a history of strain of greater or lesser magnitude, The presence of this is therefore of little help, but its absence, provided that we are sure of it, is in the direction of diagnosing a psychosis.

The history of previous attacks is of more assistance. The story of the psychotic may be that of periods of ill-health which lasted for months. In the intervals the patient was quite well, when he never thought of his health, and never saw a doctor. The patient suffering from a neurosis is seldom absolutely well between the attacks—not, at any rate, for years. Between his attacks he did think of his health and took care of it. The psychotic, when well, behaved as if he were invulnerable, and thought that he was quiet right in doing so.

The history is still more strongly in favour of a psychosis if the attacks of depression are preceded by periods of well-authenticated voluntary overwork: the words *well authenticated* are important. Many neurotics will give overwork as the cause of their breakdown, but in the majority of them the story will not stand investigation. The friends of the depressive, however, will furnish detailed stories of voluntary gross overwork, which these patients carry out in the intervals of their attacks of depression. The psychotic patients themselves will probably deny that they have overworked, unlike the neurotic who will always agree to its being the cause of his illness.

While he was at work the psychotic often behaved as if he was unaware of fatigue. There is often too in his case something extravagant in the schemes undertaken—not necessarily anything definitely insane—but they are unnecessarily laborious, and really uncalled for. Real overwork except in sweated people is not a common thing. People, of course, vary in their output, but few sane people exceed their strength, and the history that they have done so should arouse suspicion. The sane are saved by their sense of proportion and by the feeling of fatigue, a thing which is often not experienced by patients in a manic or hypomanic state.

There are certain features of the depression itself which are different in the two disorders. An outstanding one is that in the psychosis the depression is independent of the environment, whereas in the neurosis environment makes a great difference. If the neurotic is taken from uncongenial surroundings, and put where he is happy and hopeful, his symptoms will become much less prominent, and they may even disappear, so long as the surroundings remain wholly to his liking. Thus, merely taking him away from home, if he is not getting on well there, will do him a great deal of good, even though this may be only temporary. In the wider sense of the word environment, he is always cheered by the visit of the doctor in whom he has confidence, unless previous visits have included some very unpleasant business. Any organized treatment in which he has faith will for the time being make him better. None of these things makes any difference in the state of the psychotic. Take him from home, give him the doctor he has most faith in, initiate any treatment, his gloom and his other symptoms remain with little change.

In nothing is this indifference to environment more clearly shown than in the failure which these patients experience when the attempt is made to give them æsthetic pleasure. If the sun is shining the neurotic will appreciate the beauty of the country as well as anyone else, in fact he will probably explain that he does so more than most people; the depressive will say that he can appreciate the beauty intellectually, but that he cannot feel it, that it makes no appeal.

It is not only, however, in the absence of pleasure in external things which normally give pleasure that this indifference is displayed. Emotional displeasure is equally absent. Remarks which to the healthy or neurotic person would cause the utmost resentment are met by depressives quietly and with resignation. The death of a friend is heard without a tear. The patient will say that he knows he should be sorry, but that no such feeling is present. There is therefore the curious paradox that though we are in the presence of a person who is in great misery, we cannot make him sad.

A simple test, which brings out both the absence of pleasure and of displeasure, may be made. The patient is shown in succession a number of pieces of silk of different colours. When these are

shown one after another to anyone not suffering from a state of mental depression he will say as each is put before him whether he likes it or not if asked to do so. When they are shown to a depressive he will make no choice. He will neither like nor dislike any which are shown to him. They will all be indifferent.

The way in which the patients give their histories is often very characteristic. The neurotic will be full of his physical and mental disabilities; the psychotic may tell of them, but he will also, even at the first interview, give considerable prominence to his belief that the whole thing is largely his own fault. He has been lazy, or idle, or imprudent, or vicious. The neurotic may feel all these things, but he will not say them straight off. It will be many days before he will voluntarily reveal them, though he may do so earlier if he is probed. The psychotic is on the whole anxious to say them; he wishes to let every one know how unworthy he is. The suspicion that he is a psychotic is specially profound if these confessions of unworthiness contain an unsolicited story of sexual wrongdoings which the patient himself presents as the whole cause of his illness. This particular kind of story is one which the neurotic never tells except with urging. He tends to blame other people or circumstances, not himself.

Retardation, both of mind and body, is common in the psychotic. If asked a question the response is not made till an appreciable time has elapsed and the words come slowly. It seems as if something were dragging on the cerebral processes. The bodily movements are slow and the posture is stooping as if the patient were very weary. The viscera seem also to have slowed down. Atonic dyspepsia and constipation are usual.

If the two illnesses are watched for a few days their course will be recognized to be quite different. The anxiety neurotic has varying moods, which change quickly. One day he is decidedly better, the next plunged in despair. Little annoyances make him worse. Hope always makes him better. The symptoms of the psychotic are steadier. He may remain for weeks in the same state of gloom; suddenly for no reason he may say he is well, that the cloud is lifted, and that he feels to-day as well as he ever did in his life. Such a period is apt to be of brief duration, a few hours or a day or two, and then the fog of depression settles as densely as

ever. When he does begin to get well, he does so in a more unwavering way than the neurotic.

The psychotic has poor insight compared with the neurotic. Feeling himself unable to do his work, exhausted, unable to concentrate, he yet does not look at the matter as one of illness, but as proper punishment for his faults, quite the reverse of the neurotic's attitude. The sins about which he has so much remorse are almost always peccadilloes, the sort of thing which every one has done, but this gives no comfort.

Patients with more profound depression may be quite inaccessible, but they provide no problem of diagnosis from a neurosis.

It is important to note that these differences are to be found in all degrees of the illnesses. A mild psychotic well enough to be at work will show characteristics of his illness as well as one more seriously ill though in less degree. A neurotic may be so ill that he may be bedridden, but he will still show the characteristics of his illness. This is another reason why it is difficult to think of the depressed neurosis being merely a milder example of the depressed psychosis.

The somatic symptoms in the two illnesses may be similar; they are commonly those of headache, dyspepsia, constipation, insomnia, and weariness. But the psychotic does not complain nearly so much of these things, as he does of the mental depression, which overshadows the others. The neurotic, on the other hand, is greatly interested in his physical symptoms, which he is always ready to discuss with gusto.

The question now arises as to why one should classify patients of this type with few mental symptoms among the psychoses, and how does this fit in with the previous definition of a psychosis as fantasy become reality? These patients are not insane; they are not living in fantasy; why classify them with a disease which is the commonest type of insanity? There are other diseases which remain clinical entities, where the patients are sometimes sane and sometimes insane, and we do not change the diagnosis because the patient has stepped from the category of sanity into that of insanity. Epilepsy and exophthalmic goitre will at once come into the mind in this connection; the delirium of the fevers is another example. The manic depressive disease in its textbook description is associated

with the life of fantasy, but it is a disease with physical signs and symptoms also; each of these may be greater or less according to the case, so that at the mild end of the scale we get down at last to those where there is but one mental symptom, viz. depression. But—and this is a point of importance—wrong therapy, i.e. the therapy of prolonged psychological probing, or the therapy of making a patient of this kind exert himself unduly either mentally or physically, may turn the case with few symptoms into one with many. Moreover, in a large majority of those who answer to the description given, if the history be taken with care—and this can be done without probing, by simply letting the patient talk—some acts or thoughts will almost always be found which are inconsistent with a life lived in reality, e.g. that God is specially punishing him, that he has committed the unpardonable sin.

In **hypochondria** there is a fixed idea of ill-health, which is irremovable. The patient is usually an elderly man who states that some part of his body is affected, his kidneys or his liver or his throat or any well-defined part. He constantly seeks medical aid and undergoes any treatment recommended; he is a thoroughly good patient. Any new treatment suits him, but never does any good; nevertheless he comes back to his doctor to whom he is usually faithful. Suddenly the illness shifts to another organ, and the first seems to disappear from consciousness. One organ will usually last him as an object for the projection of his disease ideas for years, so that he is usually dead of old age before he has gone round the body. He is incurable, but should be taken care of and humoured by doctors, or he may fall into the hands of quacks and be fleeced. In all other respects these patients are usually shrewd, intelligent people.

There is also a more serious type. An oldish, middle-aged man suddenly announces that he has cancer of the stomach. By thorough examination he is shown that this is not true, and he keeps well for a week or two and then suddenly decides he has some other grave disease, which he also gets rid of after thorough examination, only to get a third disease very soon. Such a person is on the eve of a severe delusional psychosis. It will usually be found that for a few weeks before the onset of the hypochondriacal

ideas the patient had been unduly anxious and been sleeping badly.

In the frankly insane, hypochondriacal ideas are common and may dominate the picture.

There is a kind of patient, usually a woman of early middle life, whose sole interest lies in her abdomen. She has usually had many operations, each of which has been followed by temporary improvements. The temptation to regard such patients as examples of neurosis is very strong, but it is probable that they are incurable though capable of temporary benefit. They have been well described by Robert Hutchison in " Lectures on Dyspepsia " ; an example will be found on page 112 of this book.

General paralysis may commence with a depressed state and give difficulty until some physical sign or some disorder of conduct reveals the true nature of the illness. It is not, however, common for the patient to do anything very outrageous before the case is diagnosable if care is taken. There will usually be some signs, such as pupillary irregularity or fixation, tremor of tongue or face, difficulty of speech or the like, which should give rise to suspicion.

CHAPTER VI

GENERAL CONSIDERATIONS ON THE TREATMENT OF THE ANXIETY REACTION

We have seen that, speaking broadly, patients who suffer from the conditions described as the anxiety state, have lost confidence ; the problem for their treatment which is now before us is to discover how confidence can be restored.

There are three ways in which people can meet any difficulty. One is to tackle it ; this is the best. A second is to refuse to try, which may or may not be a good method. If one is offered a post for which one is wholly unfit it would be wise to refuse ; but obviously this method is liable to abuse. The third method is to fall ill, seemingly at least, so that one is excused from trying. This is the neurotic solution, and is the worst. When confidence has been achieved or restored, the last solution will no longer be adopted.

We have mentioned a number of therapeutical methods, many of which had at one time been highly successful, some of which are in certain cases successful now ; and when we sought for a factor common to them all we saw that faith in something, which might be either in a person or a procedure, was always present. There are some who consider that the faith which works these cures is always in the person, one who is specially gifted. If this were true, psychotherapy could be practised by only a few doctors. A study of cases which have been temporarily cured does not seem to justify this statement. The lady whose case is described on pages 42 *et seq.* had had a special treatment repeated several times by different physicians, and provided that it was administered with care she derived some benefit every time. On two consecutive occasions, indeed, it had been administered by the same person, the first time with the greatest success, the second with considerably less.

Transference

The belief in the person has, however, dominated the thought of one particular school so much that a special word has been invented which has crept into general literature and which had better be discussed; there is a measure of truth in it, and it represents what often constitutes a danger to both doctor and patient. The word is Transference. The feelings of either hate or affection which the patient has felt for some one else are supposed to be transferred to the doctor. If the former happens, that doctor will do no good; this seems sound enough as a fact. If the transference is that of love, he will work any kind of wonder on that patient. Without it he can do nothing. This highly dubious proposition has been accepted without cavil by a large number, indeed by the majority, of those practising psychotherapy. If the word love meant only trust and affection the thing would not excite comment; but what is meant is love in the sexual sense. There is no doubt that a patient does often fall in love with the doctor, and when it does occur it is a great nuisance for both; but when it is present without the possibility of doubt, it has seemed to the author to prevent the miracles of faith from taking place, and that for a very good reason. Such a patient will if cured no longer see the beloved object, and this may be quite enough to prevent recovery from taking place. As soon as she begins to feel well, she will also begin to consider that she will have to leave the doctor very soon; this will at once arouse anxiety, and relapse will follow. It is therefore likely that we shall do well to suspect a method which openly aims at obtaining what is called the positive transference. Every doctor knows these patients, who keep hanging around his house for years, who profess that he alone does them good, but who never show a single proof that their statement is true.

The idea of transference is a discovery of the psychoanalytic school. To do its adherents justice, it should be stated that they do not look on it as the final condition to be aimed at. It is a temporary phase, but one through which all must pass. Its management is acknowledged by the school to be one of great difficulty and delicacy. It is an art to be achieved with pains. The author considers that the real art necessary is to obtain confi-

dence and trust, which shall go no farther than these words mean in ordinary speech. This matter will be dealt with again in subsequent chapters.

It is not, then, faith in either a doctor or in a method which is the aim in therapy. The aim is that the patient should recover the faith which was once in himself, or if he apparently never had it, that he should endeavour to acquire it. The function of the doctor is to help him to find it, and he has no other function of any kind to perform. To do this he must get himself acquainted with as much information about the patient as is possible. He must learn his history, not only his medical history but as much of the whole story of his life, in the broadest sense, as he can. He should become familiar with his philosophy of life, his religion, his habits, his tastes, and indeed everything about him. How is this to be done? By showing interest; and this implies listening to the patient far more than talking to him. All these patients wish to tell everything about themselves to anyone who will show the smallest degree of interest in them. The treatment of a neuropath will then be found to be almost the same thing as his examination; so long as the patient is being treated he is also being examined; so long as he is being examined he is being treated.

Examination of a Patient suffering from Neurosis

We must therefore commence by describing in detail how a neuropath is to have his examination conducted from the very beginning. To many this will seem too elementary, but this is really one of the most important parts of the book.

There must be a difference between the examination of a patient whose condition is already fully developed before the doctor who is going to treat him comes into contact with him and that of one who, while under care for some other complaint, is beginning to show signs of the development of a neurosis, which was not present at the outset of the illness. The case of the latter will be considered first.

When a patient in a doctor's practice complains of illness for which the doctor cannot find an adequate physical cause, he should make a special appointment with him, at a time when he can give him a clear hour, and go over the genesis of the attack in the way

which will be described presently. Too often the patient is told that there is nothing wrong, and is dismissed. This is done from the best of motives; the doctor usually believes that the information will comfort the patient, whereas in a number of instances it does the exact opposite. The patient is feeling ill; he has perhaps headache or depression. He knows that these must come from something, and to be told that there is nothing wrong may only lead him to the conclusion that the doctor does not understand the case.

There is another reason why telling a patient that there is nothing wrong and leaving the matter there may do harm. In Chapter II it was stated that the patient might be deriving some benefit from the illness, a fact which might be in consciousness or not. Whether it is or not the result will be the same. We have just seen that the benefit might be that the illness secures the attendance of the doctor, which may be a love reason, or may simply be that a nervous person is happier when a doctor is in charge. Whatever the benefit, such a patient is likely to be depressed when told there is nothing wrong, for if there is no illness the benefit will cease very soon, and an increase of symptoms may well follow such an assurance. There are also, as we shall often see, other advantages to be derived from illness. Before we say anything so dogmatic we must have possessed ourselves of much more information than is commonly obtained in one interview. The patient is often told that he is run down, that he needs a rest, that he has been overworking, that he has dyspepsia and needs a special diet. It is not denied that advice of this kind often results in relief. If the original cause of the attack is a trivial one, if it is already over, and the patient is only now suffering from the fear that there is something the matter with him, he will get well, if only he has faith in the doctor. But a false diagnosis of this nature even in a mild case has its dangers. The patient has been told not to work so hard, and if he is a timorous man, he may develop fear of work, and it may become a matter of great difficulty to get him ever to work hard again. Overwork is an extraordinarily popular cause of a nervous condition; naturally so, for nothing else could reflect so much credit on the patient. To be one of that noble band who have sacrificed themselves on the altar of duty, of devotion to family and so forth, is a very great source of pleasure; and to

be told so by a wise physician will increase respect for him very much. Such doctors are thought of very highly. As was stated in the previous chapter, it is, however, very doubtful whether overwork, in adults at least, is a matter of much consequence in the causation of this illness.

With regard to children this does not hold good. They can be driven to overwork in a way which adults would not tolerate ; but even in their case anxiety will be found, fear that the parents may be displeased being one of the most important.

In adults the author has never come across an alleged case of overwork in a nervous patient, where there had not been at the same time some overwhelming anxiety which had been altogether overlooked, usually not talked about by the patient because, as a rule, he had not been very proud of its existence. The consequences of too little work are of infinitely graver import than any amount of overwork : the number of neurotics of about fifty-five to sixty, who were quite well till they retired, and who thereupon developed a neurosis, is very great. We have fortunately in us a principle of laziness which saves us from really working too long.

It is not, of course, every patient, who is told that he is overworking, who meets with the disaster of being unable to return to work. Most will slack off for a little and then return to their work and no harm be done ; but the danger is there.

Unfortunately graver things are often put into the mind of a patient who has nothing wrong physically ; his blood-pressure is taken, and he is told that his symptoms are due to its being raised. The doctor may not say anything alarming, but these are the patients who look up the subject in a book, and then keep the matter found therein to themselves and brood over the impending stroke. Or a fancy diagnosis is given, of congestion in the brain or of anæmia of that organ, for which nothing much can be done.

It is very easy for the doctor in busy practice to fall into these errors ; the patient does not seem very bad, he himself is much pressed ; he feels that he must say something, and he has often seen people who thought that they were ill but who got better if only something definite was said to them. There can be no doubt, however, that practice of this kind makes a large proportion of the cases of neurosis which are seen. Over and over again the writer

has met with patients who believed that they were physically ill; a short discussion, which convinced them that their bodies were healthy, and which also showed them that they had been needlessly anxious about them, has been followed by recovery which has lasted for years. He feels indeed that the majority of the examples of nervous disorders met with are magnified into something greater than they need have been by a hasty diagnosis which had never been intended seriously. Doctors may feel that they have not time to treat these patients in any other way than that in which they do, a way which after all is followed by a number of good results; as a matter of fact, the amount of irritating time which they do spend on them is great. If all the time were counted up it would be found that they spend many hours which might have been saved by one or two serious interviews at the beginning.

Examination of the Developed Neurotic

Where the doctor encounters the patient for the first time in fully-developed neurosis, the procedure is easier. Such a patient, if treated at all, must be taken seriously; the first interview is one of the most important of all, and if a patient arrives with the kind of symptoms which suggest the presence of a neurotic state, and the doctor is pressed for time, he should defer the taking of the case till he has at least a full hour to spare. For the first few interviews, no period less than this is of much value. The patient has a good deal to say, and he must be allowed to say it spontaneously: one hour will not as a rule allow him to complete it; he has no doubt often extracted half-hour interviews from others before, but in a whole hour he will feel that he has been given a chance of starting. He should be asked to say what is wrong, and full notes should be taken of all that he complains of: if he is given rein, the complaints will probably be numerous; but even if he is allowed full liberty, as he most certainly should be, he will not be able to state everything of which he does complain. Therefore, when he is done, the doctor should enquire about the health of all those systems of the body which the patient has omitted to mention. Unless the former has taken full notes at the time he will certainly not do this completely, and this is the first point where it will be discovered

that absence of notes is a grave omission, and a handicap in the handling of the illness which may never be overcome.

Procedure of this kind may be thought to encourage a patient to think that he is very bad, and it might be held that symptoms, of which he had never thought, would be suggested; if one or two systems were specially selected, and enquiry made of them alone, this might indeed be true; they might become fixed in the patient's mind: but if every region and function of the body are asked about, no such untoward result ever follows. The procedure is necessary for two reasons: first, for the doctor's own information—he must be absolutely sure what it is with which he is dealing, and this not only in the sense of making a physical diagnosis, but also to know with what manner of man he is in contact; secondly, he must let the patient know that he is not afraid of his story, or of any number of symptoms which he may describe, that he is interested in him and in them; it is only when he has shown this that he will have any authority to speak definitely to the patient about them, for it will be only then that the latter will know that he knows.

After the whole of the symptoms have been obtained, the history should be taken.

Do not, however, make this order too rigid. Let the patient give the story in his own way. If left to himself he will commonly give some symptoms, then some history and then go back to symptoms. To the listener this is at first confusing, but if the doctor says he would rather have it in an orderly way he will only get a neat medical history which will be of little use. One idea, as is well known, suggests another; if the patient has said that he has a headache this may remind him of a very bad one in childhood which he will then naturally proceed to relate, and this may be a key story. If he is told that the history will come later he may never tell this story because it may not occur to him again, and because any rebuff may make the patient think that the doctor evidently was not interested in that kind of thing, therefore it becomes inhibited.

If he has difficulty in starting it will be convenient to begin with the story of the present attack. A date for this may be assigned, and the patient may even say that before that he was in good health. Such a date will almost always be found subsequently to be wrong; as time goes on it will be discovered that there were symptoms from

time to time of a similar or at least of a neuropathic nature before that; and if the patient is in an advanced state of the illness at the time of being seen first, it will be found almost certainly that he has had previous attacks, that he recovered from the others only after some very special treatment, which, however, has failed to give relief this time. Sometimes, but this is rare, it has not even been tried. Such a patient may be one where the illness had acquired value, and where the patient is not ready to face the consequences of becoming well. A lady had torticollis for which she had consulted several doctors in vain. She came under the care of a Christian Scientist, and after a time there was complete cessation of the spasmodic movements. They returned in three days, and she sent immediately not for the Christian Science healer, but for a doctor whom she had had previously, and who in fact had not been able to help her. Asked why she did not send again for the person who had at least succeeded better than anyone else she could give no rational answer. It came out, however, that so long as she was ill she was receiving a money allowance from some one, and her circumstances were such that she really could not afford to be well. This is a very crude example. Others will be found which do not depend on money but on more subtle advantages.

The patient should be asked to say what he considers were the causal factors in bringing on the attack which he is describing, and also those of the previous attacks. Spontaneously he will often tell of some great anxieties, even though he does not appreciate their full significance; many of them will, of course, have come out in the history; more often he will refer to overwork, which every one seems to have accepted without criticism, or he will refer to some infectious disease, of which influenza is easily the prime favourite. No comment of a critical nature should be passed on these views at this stage. Until the patient has been examined, the doctor is in no position to say anything. If the patient has not mentioned anxieties and is asked now whether he had any at the time of the onset, he may say that there were some. He may tell of things at this early stage which he has never told to anyone before, because he will by now have perceived that he is in the presence of some one who is in earnest about his case, and because the talking over all his symptoms, with close investigation of their

time of onset, has stimulated his memory, and has brought many things into consciousness which had not been there for a long time. For the first time, too, he may have had the idea presented to him that such matters were of real importance.

On the other hand, he may say that he had no special troubles at that time. If he says this, nothing further need be said at the moment; in a day or two he will certainly refer to the matter, and say that since the previous conversation he has remembered something which did trouble him very much at the time of the onset of the symptoms. It may be said that we all have worries and anxieties, and that therefore we may be attaching ætiological significance to things that are normal, that we are making exactly the same error that the ophthalmologists make in attributing grave general symptoms to normal astigmatism. It is, however, not anxiety as such which brings about illness, but the way in which it is regarded and how it is met that is important.

Take, for example, a youth who is worried because he is masturbating. If this is universal, why should it cause particular worry to anyone? But the lad is not really worrying about masturbation. He has been told that this is a major sin, he has also been told that he will go to hell if he commits major sins, and he believes in hell and does not desire to go there. He has read, in some of the literature which is shoved under doors, that the practice leads to paralysis, or to physical ruin of many kinds. He thinks that he is the only person of his acquaintance who is practising this disgusting vice. It is then fair to say that he is not anxious about masturbation but about other things, and one must therefore enquire why the patient is anxious about the matters which have been elicited. A question of this sort may seem to him to be quite absurd. He takes it for granted that every one is so agreed that a habit like masturbation leads to the absolute ruin of body and soul, that he may almost think that he is being laughed at if he is asked why he is worrying about it. So much is this so that when I ask patients why they are worrying about a certain thing, I add that I can see several reasons why they may be, but that I wish to know which of these is affecting them. Our astigmatic is not worrying about astigmatism even consciously, but what will happen to his eyes if he "strains" them.

We must beware, however, when we do get the confession of an anxiety at this stage. What we get may not be of very much importance. In many cases it is not. The real anxiety is apt to be buried a little more deeply, and not to come out till much more work has been done at the case. What we get at this stage are more likely to be secondary anxieties, which, however, are often of great importance; they usually have to be treated some time, for they will have acquired autonomous power, and be capable of producing symptoms by themselves. The truth is that it is never one anxiety which is of importance; it is many. There is no such thing as *a* cause of a nervous illness; there are a number of conditions which favour its growth and development.

We should try also to see why patients get better after an attack. Sometimes it will be because some painful situation was resolved, such as the escape by marriage from an uncongenial home, or because a new treatment was given in which the patient believed. Sometimes the story will be a surprising one. A lady who had gone from treatment to treatment without benefit was advised to go to a certain hospital where there were "border-line" cases. She was shown into a waiting-room and was left there for about twenty minutes. Getting wearied of this she went into the corridor and saw a patient clearly "over the border" struggling with some attendants. She fled from the building, and could not quite understand why she was very well in a week or so. She saw, however, when it was pointed out, that illness which led perhaps to this result was worse than facing disagreeable situations, and, quite unwittingly of course, had decided that it was safer to be well.

When the history of an attack has been worked out in this way, the attention of the patient should be directed to previous attacks. It is almost certain that these will now be told of readily. Some will have been told already.

Their causes, if possible, should be ascertained also; if it is many years since they occurred, this may be a matter of some difficulty, but if the patient does not remember any reason for his illnesses at the first interview, he may later; there are moreover methods, which will be described shortly, whereby his memory can be stimulated. The mere asking, however, at this interview sets his thinking machinery in motion, which will go on after the consultation is

over, especially if he is left alone and given time to meditate. It is a good plan to insist that this shall not be merely passive meditation. It is advisable that the patient should write out what the interview was about. Writing stimulates memory, and the memories which have already come up will not be forgotten by the next interview if they are written down. In subsequent interviews after the doctor has given some explanations this practice is still more necessary. The patient will by then have received some quite new ideas, and he will probably not get them quite right. Writing will show easily where he has become confused.

As regards note-taking, it will probably be only at first that this will be possible, but it is at first that it is necessary to get the firm outline of the case. Later the patient may hesitate in his talk and say he does not wish this written down, and the doctor must lay down his pen. It is no use to say that he is careful to keep his notes locked up. If the patient does not wish the matter to be recorded and the doctor persists in doing so, the only result will be that the patient will cease to talk, not from malice, but the stream of memories which formerly was being stimulated to flow will be checked quite apart from the patient's volition.

When these histories have been duly noted, we should go over the whole life of the patient. We should know about his childhood, its illnesses, when he went to school, how he fared there both as regards work and play, how he got on with his fellows; and we should continue that for the other periods of his life. It will be said that this is a proposal for an interminable enquiry; but it does not take such a prodigious time as might be thought. Even a detailed and long-winded person will get through most of it in three or four sittings, and many will do it in two. Occasionally it will take longer; the patient only can decide. I have had one patient who without repeating herself took over forty interviews of an hour each solely to recount her history. It was in the end well worth the time. This great length is, however, uncommon. Usually the patient stops, and what is obtained may not be a complete biography; but during the rest of the treatment many gaps will be filled up.

It is absolutely essential that no third person should be present at the interview or series of interviews, where the complaints and

histories are being recorded. If another person is present the patient will not tell even all his physical symptoms, and he will certainly not confess to a single one of his anxieties. His friends have in the past probably laughed at him for being such a worrying person, so that he will be silent about them in their presence. They have also probably laughed at most of his physical complaints, and therefore he will shorten the list if they are in the room, and then he will feel afterwards that there are things about his history or symptoms of which the doctor is ignorant. Not very long ago it was not considered quite seemly for a girl or young lady to see a doctor alone, but the day for that is probably past. There are perhaps still some doctors who have fears for their own reputations, but the anxiety patient is not usually a vicious or revengeful person, and certainly these fears are groundless. Whether this be so or not is not very material, for the interests of the patient demand absolutely that the interview should be a private one. This of course does not apply to the physical examination by the doctor of patients of the opposite sex, which can be carried out thoroughly and comfortably only in the presence of a nurse. But except at times of physical examination, i.e. at all the subsequent interviews, the doctor and patient should be alone.

The Physical Examination

After the history has been completed, the next step is the physical examination. This must be thorough. The patient should be in bed, for he must be examined from top to toe. It is not fully realized what a powerful therapeutic instrument lies in the hands of every doctor in the shape of the art of physical examination. These patients have been examined often; most of them know how each system of the body should be dealt with; many of them have been examined by first-class clinicians. It is possible that the opinions of some leader of the profession are about to be challenged during the course of the treatment. The doctor will have little chance of obtaining a hearing unless his examination is quite the most complete that the patient has ever gone through. In addition to the importance of what the patient may think, the doctor has no right to differ from anyone else unless he has been as thorough as he was.

The above paragraph represents what was found necessary by the author a dozen years ago and will still do so for many practitioners. In actual fact the writer now seldom examines a patient physically. Most of those he sees have been sent to him by clinicians of high standing, all of whom are free from the error of making fancy diagnoses, and he feels that it would be rather absurd of him to examine patients who have been given a clean bill of health physically by physicians of that calibre. He is careful, however, to point out exactly why he does not examine, to say quite frankly what is true, that Dr. Blank is a more skilled examiner than he is. No patient will think the worse of the person who is going to treat him for that. All these patients know that medicine is highly specialized, that one man may be more skilled at examination, and another at some particular kind of treatment. If, however, that patient has not been examined by some reliable person the above holds good.

In all cases where the physical examination leaves him in any doubt the doctor should withhold his opinion, either until some sign of which he is doubtful becomes clear, till some necessary laboratory report has been obtained, or until he can get another and special opinion on the matter. There is never the slightest lack of confidence on the part of a patient towards a doctor if the latter says that he does not know, and that he must wait or else obtain some further advice. These patients are very weary of omniscience on the part of doctors, and for most of them one who is in doubt is a refreshing experience. If, however, there are enough data to warrant a diagnosis, it should be given unhesitatingly. But the doctor must be sure enough to be able to give it once for all. There must be no re-examinations once the opinion has been given. There is no room for doubt after that; there is very little confidence for a doctor who changes his mind.

What should the Patient be told?

The question now is: What is the patient to be told? The answer is easy to say, but often very difficult to carry into practice. He is to be told the truth. The difficulty is the very old one of knowing what is the truth. We may begin by saying that of all mistaken policies that of telling a patient that he has not got a

serious lesion, if he has one, is the greatest. If a patient has heart disease, and he is told that he has a healthy heart, the deception will not have a very long life, and the confidence in that particular doctor will vanish entirely. But if a patient has a cardiac murmur, is he to be told about that? The murmur perhaps does not have any organic origin, but even if it has it may be of no clinical or pathological importance. If such a one is told bluntly that he has heart disease, grave harm may be done; but he should be told that he has the murmur, and as far as possible its value should be explained. Its value should be stated truthfully; if the doctor thinks it a serious factor which is causing symptoms, he should say so. If, taking into consideration the patient's age, occupation, history of the possible cause, etc., he thinks it of no importance, he must explain carefully exactly why he considers that it has no significance. This evaluation of physical signs is a thing that every doctor must practise at all times, and there is no doubt that it is being done every day. It is suggested, however, that it might be done somewhat more elaborately as a rule. The patient must not feel that he is being laughed at for being fussy because he wants to understand the importance of his lesion in a very complete way.

The writer feels that much mental misery would be saved if the nature of all diseases were told to any patient who wishes to know about them. Patients with cancer are almost universally deceived. It is not long before they know that this is taking place. And when they do realize it they suffer much more than they would have if they had been told the truth. Stories are current of those who, when they heard that their disease was malignant, have turned their face to the wall, and died. In the first place, it is difficult to see why that event should be held up as undesirable. Secondly, there are ways of telling. It is not advocated that a patient should be told baldly that he or she has cancer, and that the matter be left there. The probable expectation, the course of the symptoms, the possibility of relief, must all be entered into. If the matter is approached in this way, there will be a short period of shock and depression, followed nearly always by a readjustment, and the patient will be much happier. This is true of the most nervous people.

Not only have we to evaluate the importance of signs in them-

selves, but also to do so in regard to the production of the nervous symptoms under consideration. We have to make up our minds whether we believe that loss of concentration, fear of the dark, and a host of other symptoms can really be brought about by a tiny degree of astigmatism, or by gout, or by any other of the numerous diseases which may have been diagnosed, and which may, as a matter of fact, be in existence. They may be responsible for some symptoms from which the patient is suffering, but not for all of them. These others may be truly nervous. We shall then have to try to make quite clear to the patient which symptoms belong to the physical disease and which to the functional condition. This will sometimes not be easy. Accurate diagnoses do constitute a great difficulty, but we shall also have to face often the difficulty of purely fancy diagnoses handed on from other doctors, which we must combat whenever we meet them. Diagnoses like "weak heart," "weak lungs," "congestion" or "anæmia of the brain," and all the others which no one would dare to give as a diagnosis to a class of medical students, come under his head.

These fancy opinions are given for various reasons. Sometimes the doctor believes that the patient has nothing wrong; but he does not dare to tell him that this is his belief. He feels that all that will happen is that the patient will go to some one else who will supply a diagnosis, probably help the patient, and incidentally get credit. Sometimes the motive is even less courageous than that. If the diagnosis of "lungs weak, but not diseased" is given, the doctor will be in the right whatever the event. If the patient becomes well, he was never told that there was need for anything but care; if the patient later on shows signs of tubercle, he had been clearly warned of this possibility. What then is the harm? Such a patient who feels that he has only escaped tubercle by taking a great deal of care, by always going to bed early, by never overtiring himself, and so forth, is a person who will be apt to go on taking care always, one who will live in a degree of unnecessary fear for the rest of his life; a man who feels that he has to take any sort of care of his health is a man who is to some extent ill. Sometimes this class of diagnosis is given from mistaken kindness; the doctor fears something grave, but does not wish to share his fears with the patient, and so gives an opinion, which means, as he

thinks, very little, but which is meant to be enough to make the patient careful. The kindness is, however, apt to be a mistaken one, and the patient may not have his fears relieved but rather strengthened by the fact of its indefiniteness.

If then the doctor is convinced that there is no physical disease, or at any rate none which has any bearing on the production of the symptoms, he should say quite plainly that these are not due to any organ of the body being affected in any way; and thereupon the patient should be promised that with proper treatment he will become well. He will probably respond by agreeing to do anything which might help to bring this to pass, and if the examination has been carried out in the method suggested, there will be little difficulty in getting him to make a good start.

Many doctors are shy of promising a cure, feeling that such a thing savours of quackery. We need not be afraid of employing the measures of the quack if they are not bad ones. The quack's whole stock-in-trade is a promise of cure. That does not in itself make the method bad. It is only inadequate. The quack has not made the physical or mental examination necessary before he promises. He does so to all comers. He is not prepared either to go on with the subsequent mental treatment which the following pages will describe. He takes one good thing and uses it often with success, but illegitimately when used for all patients. It is, however, a good thing to do, failing to do it may be a cause of failure to cure. These patients are hanging on our words; do not let them think that we are for ever diffident. Not to promise a cure when it is right to do so is quite as bad as promising it when it is not justified.

Treatment of the Fully-Developed Neurotic

It will be most convenient to describe first the treatment of the advanced case, and to suggest later what things may be dropped in one which is less severe.

Fatigue. The most prominent thing clinically about many patients is that they are tired in mind and body; and we have to ask ourselves first what we are going to do with this exhaustion. Before we do that we must try to understand what it means. The idea of exhaustion is not a simple one; the sensation does not

correspond merely to any fact of the withdrawal of a certain quantity of energy, which has not been replaced, so that voltage, as it were, has been lowered. It is not as if the body started with, say, a voltage of 100, and that after a certain amount of exertion, which might be capable of measurement, that voltage had fallen to 80, so that now the potential was too low for effective work to be done. Dejerine pointed to the ordinary experience of a regiment on the march on a hot day. A particular objective has to be reached by a certain hour. The men are continually falling out. The regiment is halted, rested, and fed. The march is resumed, and almost at once the men begin to fall out again. Again they are rested, and again they fall out as soon as the march recommences. The wise commander will then make the band play stirring music, and the men will usually no longer fall out but will march well.

We cannot conceive that the band could act as a restorer of energy; if treatment of this sort can make men, who were apparently exhausted, do more work, the exhaustion in question must have been wholly psychological. The men had been bored, they had been thinking of their homes, often, no doubt, with anxiety; they had suffered from a feeling of exhaustion which was of the nature of an emotional reaction to these thoughts. The band distracted their thoughts; it made them forget their anxieties and remember enheartening things. The emotional reaction was abolished, and they became able to march. On a very large scale a similar phenomenon was displayed in the Great War. The Retreat from Mons was physically a very fatiguing thing. The army marched and fought without sleep, and with little food, for about a week. At the end of that time it was exhausted, and for a day or two all that it could do was to lie down and rest. Then it got up, and performed the feat of arms of the Battle of the Marne. So on the whole it recovered from this grave over-exertion very quickly.

It is of interest to note that this necessity for rest did not become imperative until the army had been covered by a fresh army which had done no fighting up till then. That is, so long as the danger of annihilation was present it was possible to keep the army going; as soon as this danger was obviated the feeling of fatigue was, as it were, allowed to dominate. This is a very clear example of how

the sensation of fatigue, the conviction that one cannot go on another step, depends always to some extent on mental factors. Though most of these men recovered quickly, many did not. Some, indeed, remained in a state of apparent exhaustion for many years.

It was the lot of the writer to come into contact with many of them, both during the period of the War and after its close. He had the opportunity of taking their histories, and it often emerged that though their fatigue had commenced at the very beginning of the Retreat, yet they had been able to keep up with it, which, if their exhaustion had represented a lowered voltage, they would hardly have been able to do; they should have been captured. It is clear that such a fatigue depended on other factors besides those of a using-up of energy, and there can be little doubt that it was in part at least a reaction to those overwhelming emotions which beset all soldiers, and which some of them were unable to withstand. There is no need to use or think of any opprobrious epithets in this connection. In any community there must be a very large number of people who cannot stand these emotions; and courage is at the best a specific and not a general thing. There are many men, who can stand shell fire, who cannot resist a woman's frown, or go near a case of diphtheria. These men, who became fatigued early and remained so for so long a time, were unable to face the ordeal of returning to the War, though many of them desired and, in the writer's experience, even offered to do so. Their symptoms therefore continued as long as the possibility of having to return remained. When they were certain that they would not have to do so, many of them did recover until the pensions policy of the Government made it more profitable to be ill than to be well, when some of them deteriorated.

But though much of this fatigue is only an emotional reaction, prolongation of reaction may lead in its turn to a measure of physical fatigue. The reaction leads to increased metabolism, so that more tissue is used up. It leads to imperfect digestion and assimilation of food because it alters gastric secretion, and therefore it may cause emaciation and lead to physical weakness, so that a real exhaustion ensues. We must therefore reckon that because of neurosis we may have persons truly exhausted in the physical sense, though it must also be clearly recognized that this is a secondary

thing and not a cause of the nervous symptoms primarily; yet in itself it may be the further cause of nervous symptoms, for it is not denied that people are more prone to emotionalism when they are physically fatigued.

It is necessary to be precise here. If it be granted that fatigue makes people more emotional and that emotionalism is the important factor in the causation of the neuroses, then it may be said that fatigue has after all been admitted to be the primary cause. Emotion has been sandwiched in as an intermediate factor, but the important point practically is the fatigue; for, as a rule, fatigue is a thing that is more easily manageable than is emotion. We can send a man to bed much more easily than we can stop him worrying. It has, however, been pointed out that in ordinary life normal people are hardly liable to an over-fatigue which is genuine; the various checks that prevent them becoming really overworked have been indicated. The Retreat from Mons is not the sort of affair to which the mass of people have the slightest chance of being subjected; some at least of those who were apparently exhausted by this stupendous effort became so before it had really been made, and the majority recovered very quickly. What is specially doubted here is that there is any condition of lowered potential of nerve energy, which lasts for months or years and which may be regarded as the cause of symptoms over a prolonged period.

Physical fatigue is a thing that is recovered from quickly; a few days, a few weeks at the outside will overcome it. When we meet with people without organic disease who say that some over-exertion has fatigued them for months or years, we may be sure that we are dealing with a phenomenon which can be abolished by psychotherapy, one which will assuredly not be removed by further rest; every doctor who has seriously attempted to treat all his patients who suffer from chronic fatigue by prolonged rest must have had many disappointments. It is not doubted that he will have many successes, for no one can administer any physical remedy without psychotherapy; it is easier to administer psychological treatment which has no taint of the physical, though again it must be admitted that it is not possible to eliminate that completely either.

The author's experience, by which he arrived at the conclusions he has, may be of some interest. The observations he was able to

make were conducted in six epochs, which were fairly clearly marked off from one another. There was a first where he administered prolonged rest while he himself was in a state of great enthusiasm. In it the results, the immediate results at least, were very good. Next came an epoch where the rest was employed as strictly, but without much enthusiasm, with indeed a growing scepticism, and in this period the results were not so good. In the third epoch, the treatment was still strict, but it was given without hope at all, and the results were bad. This period, like the two previous ones, lasted for two or three years, at the end of which the watcher of these unfortunates thought it would be well that he should give up having anything more to do with those who suffered from a neurosis.

Then, however, he was lucky enough to be directed to the writings of Dejerine, which for him threw a new light on the whole question. He is slow at changing his mind, and did not abandon the idea of prolonged rest, but while the patients were in bed, he added on the teachings of Dejerine, and at once the whole situation was changed. The immediate results became fully as good as they had been in the first epochs, and as the years went on he knew that these patients had learned something which kept them well after they had left the shelter in which they had become so. They had learned not to be invalids, whereas the teachings of the first epoch had necessarily made them believe that for the future they must never exceed an arbitrary standard of exertion. This fourth epoch lasted from about 1911 to 1917. During its later years rest was never wholly abandoned, but was gradually lessened, until, from having had a duration extending to months, it never exceeded two or three weeks. From 1917 to 1921 there came an epoch when it was not possible to procure rest at all. The author was then working in the military and pensions hospitals which were devoted to neuropathic soldiers and pensioners. Of the latter he does not wish to speak at present, because the whole therapy was so vitiated by the pensions system, as will be explained later, that it was impossible to gauge the value of any form of treatment. In the military hospitals, however, it was manifest that very much could be done for fatigued persons, even if rest was not a part of the treatment. The results were, considering the absence of many

facilities, fairly good, a thing that was experienced in all the other hospitals of the kind. The writer, however, did often regret that it was impracticable to keep a number of the men in bed. There was no doubt in his mind that certain men, who had lost much flesh and who had difficulty with digestion, would have improved as regards their fatigue had it been possible to give them a period of rest in bed. His experience during this time confirmed what he had already arrived at, that psychotherapy is the factor of importance, but it also led him to see that he had been right in not abandoning rest as unnecessary in a large number of cases. The present epoch, which is civilian, is serving to confirm this view; but it is also becoming evident that the rest period may often with advantage be still further curtailed.

These observations have been carried on for more than thirty-five years and the conclusion which has been come to is without doubt that exhaustion has only a minor effect in the production of these fatigue symptoms, but that altered mentality has an effect which is overwhelming. Altered mentality may not be, probably is not, the whole story, but the something else is for the future.

Those who hold the contrary view, viz. that prolonged rest and great care in the resumption of exercise is necessary, have often a very difficult problem before them. It is common to meet patients who have been exhausted apparently for years, and who have been informed that chronic exhaustion must be respected. They have been told that when they begin to exert themselves, they must proceed with the utmost caution. It will frequently be found that such people get to a certain low standard of achievement, and remain there obstinately. They become able to walk five or six miles a day, but any attempt to get beyond this mark results in a degree of exhaustion which utterly unfits them to do anything for several days. The increase may have been ludicrously small, say a quarter of a mile in excess of what had previously been accomplished with ease. Such a result can hardly have proceeded from a physical cause. We cannot suppose that the energy at our disposal is so finely available that the addition of one extra twentieth to what we habitually do easily should make us prostrate for many days. That is against all our other knowledge of the manner in which the body works. But on the theory of the emotional reaction,

the phenomenon is easily explicable. The patient had been educated to be afraid of overdoing exercise; the reaction to the emotion of fear that he would do too much, and suffer from relapse, produced the sensation of fatigue, possibly even a real inability to go on because of an inhibition of the energy which was there, in a manner comparable to the inhibition which we saw overtook the student's heart muscle when we studied the emotional reaction in Chapter II. A patient will often say that he had no such fear on occasions where this had happened; but from the conditioned reflex we know that such conscious fear was not necessary.

If patients complain of exhaustion as a prominent symptom they will probably be found in bed at their own homes. If they come to hospital they will in the ordinary course of affairs go to bed that evening, and no one need suggest the next morning that they should get up. It will, indeed, be probably part of the routine of the hospital that the patients shall be in bed when the doctor sees them in case he wishes to examine them. Therefore there is never any need to order them to bed. Neither should they be ordered to get up. They will be quite willing to try if they are so ordered, and then the initiative will soon have passed to them. They will faithfully attempt to carry out any instructions, and will soon be able to tell the doctor that they have done so, but that they are very much the worse for it. If, however, they are given no orders but only the explanation of the symptom as outlined above, with a demonstration of how exactly it fits the case as provided by their own histories, they may then ask why they are in bed; and it is an advantage if it can be pointed out that they are there because they did not wish to get up, that it is their own affair; nobody ordered it. If they then ask if they are to get up they must be told to use their own judgment, that they have had an explanation of fatigue and exhaustion, which they either believe or do not believe. If they believe it they will probably want to get up. If they do not believe it, they must not get up with any idea that that will please the doctor, for it certainly will not do so. He has no desire that anyone should get up till he has been converted to the new view. They may try to put the doctor into a corner by asking how they can believe till they try. The answer to that is that hitherto all their experience has led them into fallacy, and there-

fore trying does not seem the procedure; and they may be told that others have believed without trying. Either the propositions laid down are obviously true or they are not. It is no use for them to try if they do not perceive that they are true.

They may already have asked whether they are to get up at the end of the first interview, i.e. before they have received any instruction on the nature of exhaustion, and then they should be told that as the doctor has not yet completed his examination of the case he does not feel entitled to give instructions.

Occasionally a very thin patient whose digestive powers are considerably weakened should be kept in bed, as he can be more easily fattened there. It should then be clearly stated that that is why he is being kept there, and then it is better not to give the views on exhaustion till the doctor wants the patient to get up. It is no use heating the iron and letting it cool down again. If the patient does not spontaneously get up soon after receiving this explanation, the doctor may take it that he has failed to make the point.

In an institution it is often found advisable to keep the patient in bed for a few days from a purely psychological point of view. It is helpful that the first lessons about treatment should be given without the possibility of their being weakened or confused by the comments of other patients.

If the patient is enthusiastic and decides that he will get up, he may need to be restrained for a day or two, not longer. As he has probably been in bed for weeks, he may if he stays up for hours the first day get certain sensations which may frighten him, and it is important that he should not be frightened at first. The first day therefore he should not be out of bed for more than an hour or two. He should, however, be got on quickly. After three or four days he may certainly be up all day.

The next point is: Where is the treatment to be carried out, in the patient's home or in a hospital or nursing home? There are objections to both. A hospital has the advantage that the patient is removed from the surroundings in which he has become stale during his illness, and that is no small gain. Against it must be set the fact that some day he must return to these surroundings, and that their associations may be difficult to face again. If the

cause of the illness has been unhappiness in the home, it will be necessary that this should be readjusted before his return there, and this is a thing which the physician will have to keep in mind while he has the patient under his care. It may be that it is the patient who needs the readjusting, but it may also be the home. It is incredible what difficult tasks some people undertake when there is no need for them to do so. Out of a mistaken idea of kindness, women take their mothers-in-law and sisters-in-law to live with them, and then quarrel with them and about them for years, before it occurs to them that the *ménage* is impossible. There are many variants on this theme, and they repay study. Of course, in such cases, home treatment is extremely difficult; and the doctor who tries it will certainly experience trouble.

A further benefit from hospital treatment is that when the patient begins to get about, which will be before he is by any means well, he can do so without all those who had witnessed his illness seeing how he is doing, and shaking their heads over his initial difficulties, or telling him, if he is succeeding, that they had always known there was not much wrong. He will in hospital also meet those who have been through the same difficulties, and who have overcome them; but—and it is a big but—he will meet also those who have tried and have been discouraged, and, still worse, those who have not tried very hard, and who are discontented. On the whole the easiest route is that of the institution, but if this is impossible there is no patient, however ill, who cannot be treated at home.

Preliminary Treatment

We have now examined our patient and found him free from disease, or at least from such disease as could cause his symptoms, and he has been told that he can be cured by appropriate treatment. We must proceed to give him an inkling of what this treatment is to be. We have not yet told him what his illness is, we have only given the negative information that his organs are not in a state of disease. Now it is of no use to leave anyone with a negative diagnosis. The condition need not of necessity be given a name; at this stage it is more important that the patient should become aware by what processes he has fallen into ill-health than that a name should be given to the trouble. Let us suppose that

he is convinced that he has no disease in the usual acceptance of the term; and it may be said that unless he does believe that this is true the whole of this elaborate examination has been useless, and a point has been lost. He may then be asked what his own view of the matter is, and the commonest reply is to the effect that his nerves are run down. This is the sort of phrase on which he has been leaning, and the opportunity may be taken to indicate that it means literally nothing. It will be found almost certainly that he attaches no definite meaning to the word *nerves*, nor how they could be run down. One may help him to clarify his ideas by showing him that the nervous system has often been regarded in some ways as being like an electric battery, whose energy might indeed run down, and require re-charging; it is well to do this—it is easier to destroy a false system of belief if it is clear than if it is vague. He may then be told that the idea, which many intelligent people hold, that the nervous system is a power battery is a pure hypothesis, and that it is just as likely that it is not, that it is possible that it is more of the nature of a telephone exchange into which messages come and from which they go. When these have gone to a muscle it is no longer prevented from contracting, and it then exerts its function, and contracts. His weakness, in such a view, would then consist in his muscles not having received the necessary permission to act. In this view the real power battery exists outside the nervous system, in the muscles, the liver, and in all those parts which display active metabolism. The nervous system is like the detonator of a shell, a thing which merely releases energy. It does require energy to release energy, but it does not require very much. The failure in the nervous system is not in that it lacks power, but that some of the operators in the telephone exchange have refused to connect two subscribers. Even if the nervous system be a power battery, it does not follow that his too early fatigue is due to failure of power. The energy of the battery might be being diverted to something else, and so the muscles might not receive their stimulus because it had gone elsewhere. Clinically it will be found that either of these explanations will fit the symptoms better than any view of lack of nerve energy. It will be found from the history, and the patient may be shown examples from his own by now,

that his fatigue depended on some block or on some diversion of the nerve energy. He became fatigued too soon at some time because he was afraid to do a thing, which is nearly the same as to say that he did not wholly desire to do it; or he was intensely preoccupied with some worry, which caused a diversion of the energy.

He may therefore be informed that his fatigue is partly a real physical phenomenon, as will be explained presently to him, but more a phenomenon of the mind, and it is as well that this word *mind* should be used straight away; but as soon as it has been used it must be explained. If it is left without explanation harm may be done. He will think one of two things or both. He will consider that the doctor believes him to be insane or on the point of becoming so, or he will believe that he thinks that his symptoms are put on or exaggerated. The first idea must be dealt with by telling him that the word mental means that the symptoms depend on systems of ideas and not on bodily disease, that this has nothing to do with insanity, which is, of course, a specialized meaning of the word. It is sometimes recommended that the word *psychological* be used instead of *mental*. It has the advantage that it does not convey the idea of lunacy, but it has the disadvantage that to the average person it conveys very little meaning at all, and that it has usually to be explained by saying that it just means mental.

It is indeed important throughout to use simple and not scientific words. A patient is always intrigued with a long word which he does not understand. It confers a sort of diagnostic dignity on his case, and though part of the patient wants to be rid of his illness another part is proud of it. It is seldom that he will ask the meaning of a word he does not understand; he will just accept it as the name of the morbid condition from which he always knew that he was suffering. Thus I heard a woman tell her husband, who had always held that there was nothing the matter with her, that the doctor had discovered what her disease was, viz. Vicious Circle.

The second difficulty will need some more careful explanation. The patient must at once be told that the reality of his symptoms is not doubted in any way, that in everyday life it is easy to recognize many symptoms which do not depend on bodily disease, but on

ideas, that no one doubts their reality, and at once examples must be given to him. Several have been mentioned in Chapter II, under the discussion of the emotional reaction. No one doubts the reality of the fainting of the medical student; no one thinks he has put it on or exaggerated it; no one believes that he would have fainted if he could possibly have avoided doing so; for he will get no sympathy or help, indeed he will be laughed at to a certain extent, good-naturedly, but still laughed at, for the occurrence. And he himself knew before he went to the operation that here there was no sympathy for the fallen. His consciousness therefore would tell him that he had nothing to gain and everything to lose if he fainted; at the moment we need not concern ourselves about any subconscious advantage which he might have derived—we shall come to that later; the patient with whom we are supposed to be dealing has not yet received any explanation of the subconscious, for which he is not yet ready, and therefore we must confine ourselves strictly to consciousness. By fainting, the student's pride received a blow which he would very willingly have avoided if he possibly could—that is the point which will help the patient to understand at the present stage of teaching. Similarly with all the various forms of the emotional reaction which were studied, none of them are things which the subject consciously wanted to do. The man who saw a beetle in his porridge, of which he had as yet eaten none, derived no conscious advantage by vomiting at that moment. He would not desire to impress on his fellow-eaters that he was ill; he had no need to get their sympathy. Indeed, his natural impulse would be to hide the source of his symptoms and his own reactions from himself and every one else as quickly as possible.

It is well to give a good many examples to be able to show to the patient that the phenomenon of the emotional reaction is not a thing that turns up occasionally here and there, but that it is extremely common, a thing that in its less striking manifestations is of daily occurrence. No one doubts the validity or the genuine nature of tears; no one seeing another weeping begins by thinking that the case is one of dacryocystitis; the first idea of the beholder is always that the person weeping is suffering from grief. It might be dacryocystitis, and the diagnosis can be established for certain

only after taking the history and making a physical examination; but grief is the commoner and more likely cause. And yet, though patients are aware of all these things, they have considerable difficulty in grasping the idea that their own faintings, dyspepsias, or fatigues can be due to emotion and not to grave organic disease of the heart or of the stomach, or to exhaustion of the nerve cells.

Certain psychologists have said that it is the tears which cause the grief, that on the receipt of bad news there is a reflex discharge of tears and a choking sensation, and that the sensations caused by these two constitute grief. That this is nonsense can be shown at once. Smoke if the house is on fire brings about tears and the choking sensation. This time, however, terror and not grief is the accompanying emotion.

We may then say to the patient that his exhaustion and, indeed, all his illness depends on the same set of reactions as those which we have just described; and that each set of symptoms has been brought about by some depressing ideas. He may say that he has had no such ideas, but if his history has been taken in the manner recommended it should be easy to indicate that his periods of getting ill have coincided with times of stress, and that his periods of getting better have occurred when something more agreeable was happening to him, not the least of which may have been the finding of a doctor in whom he could have trust. He will probably have no difficulty in following this argument and in accepting it.

If the patient is in bed he may say that if the whole illness is due to erroneous ideas, he does not see why he is being kept in bed. If he has become very emaciated he may be told that it will be easier to fatten him if he stays there. If he is in good physical health he must be told that he must use his own judgment about getting up, but that there is no hurry. As he has stayed in bed probably for months, it will not matter much if he stays a day or two longer till he has really absorbed the new views. At any rate, as has been said already, he is not to get up to please the doctor, because the doctor is not anxious that he should try, but that he should consider and understand the new ideas. If he is in an institution it is desirable that he should understand the doctor's explanations thoroughly before he mixes with other patients, so that he does not have the chance of being confused by theirs.

Moreover, to go straight from the doctor to other occupations does not help to fix the new views in the mind. They are apt in any case to fade very quickly. More often than not if the patient goes off to something else straight from the consulting-room, he will have forgotten most of what the doctor said by the next day, and what he has remembered will frequently have been distorted. These are all good reasons for not hurrying to get him up.

It is a very striking thing how quickly a new view is forgotten even by an intelligent person, and this is much more certain to happen if he is well occupied. Such an one will say that he perfectly understands all that has been said to him, and will show that he does so. Next day, if he is asked to explain how he became neurotic, he will say that he does not know, that he has been puzzling over that for months, and that he would be glad of enlightenment on the subject. If, moreover, he is asked how bodily symptoms can be produced in the absence of bodily disease, he may still know nothing about it, though yesterday he seemed to grasp the ideas easily. A variation of this is that he will give some grotesque distortion of the explanations which have been put before him. He will say perhaps that he was informed that there is no such thing as fatigue, that he was told that his symptoms were imaginary, or again he may say that the instruction was that he was greatly run down and must take the utmost care.

It is on this account that it was suggested on page 72 that the patient should at first write a résumé of the interviews, not only to impress them on himself but also that the doctor may be able to see where the distortions have taken place.

This forgetfulness is a phenomenon which will be encountered again and again during the course of the treatment, and the doctor must be prepared to repeat his explanations often. There are few tasks more wearying than this, and the doctor will often feel that the patient does not wish to understand. In a sense this is true. The patient feels, rightly, that there is something sinister in the aspect of affairs which is being put before him. However little he may have the matter under his control, he feels that it is humiliating to be so emotional as to have fallen ill. If only it could be shown that his illness was due to overwork and that his nerve battery had in consequence run down, that would be creditable.

That theory would be easily remembered, and would never be misunderstood, but what has been taught comes into serious conflict with, and upsets, the *modus vivendi* which the patient had arrived at, and from which he had derived some advantage at some time, for a nervous illness is always an escape from something.

If the patient is in bed in an institution, should he be allowed visitors? Certainly not his fellow-patients, as he is in bed largely to keep away from them. Should he be allowed friends? If the confinement is only for a few days there is no need for visitors, and the fewer there are the more time will the patient have to do what should be his chief business at the moment, to think over his interviews with the doctor. Should he be in communication with his friends? No cut-and-dried answer can be given to this. A patient with an uncongenial wife or husband, or one with over-anxious relatives had better be cut off from them for a little. Patients, on the other hand, who are anxious about, say, a sick relative, had much better hear about him. Even bad news is less productive of anxiety than is uncertainty. Here the doctor must use his common sense. While he is in bed the patient may, of course, have books and sober newspapers. The yellow press is better forbidden at first, and so also are sensational books.

If the patient is in bed because he is emaciated with an atonic and perhaps dilated stomach, he may object that he cannot be expected to eat so much in bed as if he were up, that it will increase his indigestion to do so. This is a fallacy. All these secondarily fatigued people digest better in bed than out of it. The motor activity of their stomachs is poor, and this part of the stomach's work is obviously lessened by the horizontal position; it has not to send the food up so long a hill to get it into the duodenum.

The next difficulty lies in the fact that the patient may be a selective-food faddist. He must be shown how his dyspepsia arose, that it did so at some period of depression or anxiety, that at that time he did not associate the dyspepsia with the anxiety, but with some error of diet, and that in this way he became afraid of some particular foods; these foods would then become real causes of dyspepsia, for whenever he ate them he did so in a state of belief that they would cause discomfort; this is the equivalent of anxiety, which might be enough to give him an attack. He may be shown

that the presence of foods on his forbidden list has no real relation to any scientific fact, but that it depends solely on his views. In short, he must be shown that his dyspepsia continues because it is of the nature of an emotional reaction, which is repeated at every meal.

A word of caution is necessary here. Do not inform the patient that the dyspepsia or any other symptom commenced at a time of anxiety. If you do the most likely thing is that you will immediately be contradicted, and you will not then be able to impose your view. Ask simply when he began to notice it. He may say that he does not know, but soon he will probably say that it was in such a year. From the notes of the history you will already have the evidence that this was a year of anxiety; and here too is an instance of the advantages of accurate note-taking in these cases. Unless you had the note, the year would probably be denied. It is not suggested that the patient is telling lies; it is only that he is biased against your views, not against you, and we all think that truth lies in accordance with our bias.

Explanations of this kind will persuade most patients to take a reasonable amount of food; and they will tell with astonishment of the wonderful way in which they managed to digest it. A patient, aged forty-one, had been ill for three years with symptoms of which dyspepsia formed one of the most prominent features. He complained of continual gurgling noises in the abdomen, of passing wind for hours at a time, both by the mouth and the anus, and of fullness in the stomach. He had been on a diet of Benger's food for about two years. On going more deeply into his history, it transpired that his digestion had troubled him off and on since he was a boy of sixteen. He did not think that he had any special anxiety at that time; but it was not difficult to show that he had. He had been bred in the country and had lived there all his life; he was passionately absorbed in country pursuits, in the habits of wild life, and so forth. He was also essentially a home boy, very devoted to his mother. Personal relationships of this kind easily provoke emotional reactions. At sixteen he was sent to an office in the City of London; he hated the office, he hated the City, and he became dyspeptic for the first time. The dyspepsia was attributed to change of diet and

to change of air; it became so bad that he was sent home for a time, where he soon became well again. He returned to the City, and the dyspepsia again presented itself. At nineteen city life was definitely given up, and he was fortunate enough to get into an occupation which involved much travelling abroad. This interested him very much, and though he was not much troubled with dyspepsia, he had already formed the habit of studying his diet, and had become a careful person in that respect; so long as he was careful he did not suffer.

Three years before he came under care he had influenza, which had been followed by the return of severe indigestion, for which he had been rigorously dieted, with the result that he had become very thin, and could take only the special food indicated above. It was therefore easy to show him that at sixteen he had had a very considerable emotional strain, and had in the next few years formed erroneous habits of thought about food, which had tended to favour the recurrence of dyspepsia. Most of this talk took place at the first interview; some details were filled in later, but enough was said on this one occasion to make him believe that he might swallow the ordinary hospital dinner that evening with impunity. He did so, and reported the next morning that he had enjoyed it immensely, and had not suffered at all. There had been no need to approach the full diet gradually, and in most cases that is a practice to be deprecated. To this an exception must be made in those patients who approach the condition of severe anorexia nervosa, for in them the physical state of the stomach has deteriorated so gravely that only the simplest diet will remain down, and grave consequences may ensue if care be not taken. They are not common cases, they will be described elsewhere, and need not trouble us here. The great point is that if the history is taken properly, there should be no difficulty in getting the patient on to a normal diet straight away, i.e. as soon as, but not before, he understands. Above all, special foods are to be avoided. Their very success is a disaster, because it makes the patient feel that he was right when he thought that he had a weak stomach of which special care ought to be taken.

The case just detailed is an example of another fact which will crop up over and over again. It is that these patients come to

use their symptoms as a means of attaining ends, which they are not otherwise able to accomplish. The patient hated the City, and it was ultimately dyspepsia which enabled him to leave it. Some would even say that the dyspepsia was from the first an attempt on the part of the unconscious to achieve this end; that does not seem likely, and any endeavour to make the patient think it may be disastrous, at this stage at any rate. However this may be, it is certainly true that he did get what he wanted by its means. We may further note that in the end it is an unprofitable method. It may be easy to get something one wants by it, but it is not so easy to get rid of the symptom once its value has departed.

A patient who has been persuaded in this way to eat, and who remains interested in his progress, will soon put on weight and gain bodily strength. He should be kept in bed until he has attained a reasonable amount of body-weight, and he should then be allowed to get up and gradually do more day by day. If the nature of fatigue has been explained it will be found frequently that he will express the same astonishment at its disappearance as he did at that of the dyspepsia. It may be, however, that he will remain as tired as ever; the treatment of this will be dealt with later.

It is, of course, understood that if he has been in bed, the theory of fatigue which has been given above is expounded to him. If he is not kept in bed at all, either because his case is not sufficiently advanced to warrant such a measure, or because, as may well be the case, he has been resting for many months already, the exposition will be given before he attempts to exert himself. It may seem superfluous, to the point of impertinence, to say that this should be done properly. One often meets, however, with patients who, when the explanation has been started, interrupt by saying that they have been told all this already, and that it is no good. It then appears that they have been informed that there is no such thing as fatigue, or that if they will take sufficient exercise they will work through this fatigue, or that some equally unbelievable theory of that kind has been put before them. It will be granted that no view of the sort has been given in these pages, and unless all the details described above are attended to,

the view which is given is not the one advised here. After this has been done the patient may say that it may be true, but what is he to do ? how is he to carry it out ? To this the answer is that when he has understood it, if he then believes that it is applicable to himself, he will find that his too early fatigue has vanished.

CHAPTER VII

THERAPY OF LOCAL SYMPTOMS BY THEIR EVALUATION

Nearly all the somatic symptoms of which the patient complains can be dealt with in the way described in the last chapter. The principle on which the treatment depends is simple. The symptom has started originally as an emotional reaction; it has been perpetuated till it has become a habit because it was misunderstood. It was looked on as a manifestation of organic disease, and a remedy was sought for this. Sometimes that remedy was apparently found, but often it was not; the search, if it involved much disappointment, caused further emotional reaction, that is prolongation of the symptom. When, however, the patient was led to perceive all this it often disappeared. As has been stated elsewhere, this is not the whole explanation of the perpetuation of symptoms, but it is clinically one of the most important, and it is the explanation which the patient is at this stage most ready to grasp. The different clinical manifestations should therefore be dealt with after this fashion seriatim from the beginning of the treatment.

The patient will frequently make an objection of this kind. He will say that it may be true that his indigestion started from the anxieties of the year so and so, but that yesterday he had indigestion from eating fried fish, that he was perfectly happy when he was eating it, and that he never thought for one moment, and of this he is positive, that it would give him any discomfort. Here, we may have an example of the conditioned reflex: he had at one time attributed dyspepsia to fried fish, and therefore fried fish acted like the ringing of the bell by itself in the case of Pavlov's dogs. Stated another way, it is an example of the fact that belief has not necessarily anything to do with consciousness. Indeed, the stronger a belief, the less does it enter consciousness and the more certain is it as a guide to action. After my work is over I return every day to my own house; my thoughts are filled with the events of the

day, and the anticipations of what is to happen next. There is no conscious thought about the way home nor about my ability to get there; and yet I am walking in some complicated direction under the full belief that it will get me to the place to which I wish to go, though this desire is absent from consciousness too. The proof that I am walking in this belief lies in the astonishment by which I should be overtaken if at my journey's end I found myself anywhere but at my own door. When belief is so profound as this that it need never enter consciousness, we call it habit, and there is no greater mystery—but just as much—in my stomach responding to a habit, than there is in my legs doing so when they carry me home.

There is, however, another possibility. When fried fish caused indigestion yesterday, the patient may have had some trouble about some other thing altogether, and this may have been accompanied by the emotional reaction which brought about the dyspepsia. This may be discovered after a little investigation.

For example, a young man completely dominated by his mother had lost all his symptoms. One day he told me that they had all come back and that my theory must be wrong. He was asked when they came back and he said that this happened the day before, soon after breakfast. A relapse at this time of day is commonly connected with a letter, and he was asked whether he had not had a letter at that time from his mother. Rather shamefacedly he confessed he had, and that she had upbraided him in her usual fashion. He had totally forgotten about the letter. Indeed it seemed obvious that the recurrence of the symptoms had served the purpose of obliterating the letter from his mind. At any rate as soon as the matter was discussed the symptoms again disappeared. This case has been reported fully elsewhere.[1]

These objections from a patient should, of course, be welcomed. The fact that he makes them is a proof that he is thinking seriously over the view. They should be thoroughly investigated, and as a rule it will not be difficult for him to see that the theory does not break down. Every time he debates about it, and is convinced that the instance in question fits in, his belief in the view will be strengthened. It is necessary to say to him that he must bring forward

[1] See "An Introduction to Analytical Psychotherapy," T. A. Ross, Ed. Arnold. Page 128.

objections, and argue them out. Many of these patients, if they have been treated by physical methods only, have been accustomed to receive their doctor's opinions *ex cathedra*. This is quite useless here. The success of the treatment depends wholly on the patient believing what he has been told, and the belief necessary must be real belief, not the thought that he does believe. No one can arrive at real belief without argument.

We shall now take up the consideration of the commoner symptoms, and shall begin with one of the most important, viz. Insomnia.

Insomnia. There are few symptoms which can produce such havoc as this if it is not treated in the right way, and there are few which in many cases can be made to disappear so easily. The patient is first asked how long he sleeps. He says so many hours, and he is then asked how long a person ought to sleep. He will probably reply, seven or eight hours. He is then asked what will happen to anyone who gets less than that. He will likely say that he will become insane, or that some damage will happen to his brain of a very serious character, or at the least that he will feel very bad and unfit the next day. We need not be surprised that the patient has such strong views on the subject: they are being dinned into his head on all sides. The idea that sleep is that necessary period of rest which the fatigued brain needs or it will become seriously impaired, is held generally. Such an idea is not denied here; but it is possible that sleep is something else as well, that the whole of our sleep is not that necessary rest, and that therefore a good deal less than we would like may be quite safe. When we enquire who is it that sleeps most and who least, we shall find that it is the brain-workers who sleep least, i.e. the class that uses its brain most sleeps least, the class that ought to need most sleep if sleep were that necessary brain rest. Does this class fare worse than the manual-worker class? A working man of fifty is an old man, an intellectual of the same age is a young one.

Walsh tells a story which Max Müller recorded of a conversation between himself and Humboldt. Humboldt was then an old man of eighty and Max Müller was forty. "Ah, Max!" said the old man, "when I was your age I had time to do something. Now I must have four hours' sleep." When asked how much he had formerly, he replied that he used to throw himself on the sofa for an

hour or two. Now the lack of rest of this or any other intellectual worker must be as much insomnia as if it were that of a patient lying awake. It ought as clearly to send such people off their heads as it would patients, and the patient may have this pointed out to him. He will reply that these things may be true for healthy and particularly strong people, but not necessarily so for a patient in his condition. The reply is pertinent, but it can be answered. As soon as a patient realizes that his insomnia is not so serious as he had thought that it was, although he may still have bad nights, he will find that they are not followed by such bad days as when he was worried about the want of sleep. Secondly, it is true that patients may lose almost all their other symptoms before they lose their insomnia; this is a very sure proof that the insomnia was at any rate not the cause of these other symptoms, a belief the patient was almost certain to have held. In a very large number of instances, if the patient accepts such a view he will, after a night or two, begin to sleep.

From all these considerations we may suppose without much difficulty that sleep, in addition to its being a rest to the brain, has another meaning, viz. that it is the withdrawing from interest. Humboldt had many interests and therefore did not sleep much: that is true for all the intellectuals. It is the explanation of the old joke of people sleeping in a church and not in a theatre. Bergson puts it in a beautiful way when he tells of a mother sleeping beside her sick child, while a thunderstorm rages outside. The noise of the peals does not waken her, but if the child takes a deeper breath than usual she wakens at once; she is awake to the child all the time, but not awake at all to the weather. Now the insomniac patient is also tremendously interested in something, and this interest is the thing that keeps him awake. He is unduly interested in the question of whether he will sleep or not. It is probable that most patients get the amount of sleep necessary for the tired brain to be restored; what they miss is that part which the rest of us get from lack of interest. They fill up this time when they are lying awake with all the worrying thoughts to which they are prone, and of which they have legion; these add their quota of emotional reactions to those already started by the worry about sleep itself; it need cause no surprise that they feel ill the next day. But it is

not the want of sleep that makes them ill after a bad night, but the anxieties over which they had been brooding.

In some books on the subject a number of dodges to secure sleep are advocated, such as putting the feet in hot or in cold water, sponging the spine with hot water, rubbing the head, fixing the attention on something, such as imaginary sheep going through a gate. Such plans may succeed for a night or two, and then they fail. They succeed not so much because of any intrinsic merit of their own, but because they gave the patient hope. He was in despair about this terrible symptom, the plan gave him hope. Some days later he is sure to strike against an anxiety, and this may cause a return of the sleeplessness. Now, if he has had his feet in hot water that night, and yet not slept, he will be plunged into further despair, for another remedy has failed, even while it was being administered. It will never succeed again, and it is improbable that any other dodge from that doctor will succeed either; at least it will have much shorter success. Further, that doctor cannot now proceed to the plan of belittling the exaggerated importance of sleep, for if he did not think it so very important why did he suggest the ritual for producing it? It is of course true that for many people hot baths, hot douches, or gentle massage may induce a sleepy state, but in these patients the anxieties are so powerful that they will very soon override any such soothing measures. The despair caused by any return to insomnia is much too strong for them, and we must therefore combat that despair itself from the outset.

If the patient cannot accept the view, or if his insomnia shows signs of becoming one of absolute want of sleep, a thing rare in the neuroses, though common in the psychoses, the doctor may be driven to drugs. A popular drug in the hands of the laity is alcohol, which appears to them to be safer than hypnotics. Without venturing into the question of which is the more harmful, it may be laid down as a rule that no neurotic symptom should ever be treated by the administration of alcohol. The fact that the patient is often afraid of hypnotics, and is not afraid of alcohol, is a point in favour of the former. Patients find that many of their other symptoms also are greatly relieved by alcohol, and while they may not become drunkards, they may get into the habit of meeting too many of their difficulties by the administration of this drug; in actual fact, a

number of chronic alcoholics began to drink because alcohol relieved their nervous symptoms.

There are many other drugs which are helpful in the treatment of this insomnia, which are not dangerous, and which leave no craving; one can be just as unscientific in withholding hypnotics as in giving them when it is not necessary, and as a temporary measure it may be necessary to administer them. It should be always a matter of great regret that they are being given, and they must be regarded always as temporary. They are to be given till the anxiety which is keeping the patient awake has been discovered and dealt with. This will take place as the investigation proceeds. Drugs of the barbitone group are the most suitable for the insomnia of the neurotic. An effectual dose must be given at first; ten grains of sodium barbitone will in most cases be about the right amount. This may be gradually diminished, and it will be found that it is easy to do this. It was formerly my custom to do this in some way which concealed from the patient that the reduction was being carried out; and then to tell him, when the drug had been discontinued, that he had as a matter of fact been sleeping without it. I do not now do this except very rarely. When the patient has had a few good nights, I say to him that now that this has occurred, it will not harm him very much if he has one which is not so good, and that it might be well to reduce the dose. If he is responding to treatment he will be keen for the adventure; he will approach the night without those terrors which beset him when he first came under care, and he will probably sleep. There will be no great difficulty in repeating the experiment till the drug is dispensed with.

The question of the objections to hypnotic drugs is one of considerable interest. Formerly the hypnotics in use were in themselves undesirable substances. Those like chloral and opium did create a craving which was often difficult to break; when continued for years they led to considerable deterioration of character. Hypnotics of the barbitone group have not much tendency to produce such ill effects. It is easy to wean a patient from them if the insomnia has passed away, and therefore it is often held that they may as well be given till the insomnia comes to an end spontaneously. There are, however, a number of patients who do not respond to the simple measures which have been detailed, in whom the

insomnia is kept up by some anxiety which has not been discovered. If they are getting drugs and sleep they will not make any effort to understand why they do not sleep; and the real cure for their insomnia probably depends on their achieving this knowledge. It may be therefore necessary to let them lie awake before they will work at the subject; they have not done so because they will have to face something highly disagreeable before they win through, and they will not do this till necessity compels them. It is not proposed to go further into this yet, as certain explanations must come first. The subject will be returned to on page 156.

When drugs are being done without, either from the outset or later, it is essential that there never should be any promise given that sleep will come. If a promise of sleep is given and it does not come, ground will have been lost. The idea we are trying to inculcate is that for to-night it does not much matter whether sleep comes or not, that it will come some day, and that if it is deferred no great tragedy is going to happen. Some of those who have tried the method and found it wanting have promised the patient that if only he will not worry about sleep he will sleep, which is not the method at all, and which as it stands is simply an untrue statement. Indeed such information would be on the whole a method of keeping a patient awake; for it would make him very interested if he believed it, and this interest would keep him awake to see if it came off. Others have said somewhat crudely to the patient that it did not matter whether he slept or not, and have left the matter there. The patient does not think so, and of course a bald statement of that kind will only tend to keep him awake from the annoyance it will bring about. The subject must be approached in a very careful way; the explanation must be given very slowly, and if there is to be success, the patient must see for himself that he has held exaggerated views about the importance of sleep. If the method is carried out with care and patience, there is nothing more extraordinary or more gratifying in all psychotherapy, nothing which will more readily earn the gratitude of patients, than its results. Relapses of insomnia, as of all other symptoms, will occur; and in early stages of the treatment, if the patient is not seen the day after the first bad night of the relapse, it will be apt to continue. It will be found that some anxiety has disturbed the patient the first night,

and that the second was due to the fear that the insomnia was coming back. These relapses should present no great difficulty if the first attack was successfully managed.

Fear of Insanity. This symptom is one which besets nearly every patient, and he should be asked why he fears it. In most instances he will not be able to point to any disorder of conduct, nor to any insane idea; but he will say that no one could go on having these feelings in his head and remain sane; or that he feels from time to time that he is losing control, or that the insomnia will drive him off his head. The last reason has already been dealt with (pages 37 and 54).

It is rare for a patient suffering from an anxiety state to become insane. The writer has endeavoured to get statistical evidence on this point. Out of about a thousand patients diagnosed as suffering from anxiety states, observed over a period of from three to thirteen years, he has reason to believe that about fifty became insane. This figure, though not accurate, is probably approximately so. The patient should therefore be told that he cannot be given the promise that he will never become insane any more than he can be given the promise that he will never break his leg, but that this illness has nothing to do with insanity, that it is quite understandable that with these feelings in his head, he should have thought so, whereas the majority of those becoming insane do not have these uncomfortable feelings, and that they do not usually think that they are losing their reason. It would not be true to say that they never think it, for of course a number do.

Correlated with the fear of insanity is that of **suicide.** Many patients express the fear that they will kill themselves. It is exceedingly rare for a patient suffering from an anxiety state to do this. In the same group of patients (1,000) not more than eight patients, possibly fewer, sought relief by this means, so that it seems fairly true that the common saying that these patients are too fond of themselves to do this is true. The patient may therefore be told that he does not belong to the class that commits suicide. The doctor, however, must be sure that he is not dealing with a psychotic depressive.

There are certain other fears, such as the fear of closed rooms, of the streets, of being in a train, which are not amenable to this kind of explanation, and which will be dealt with later, under phobias.

Headache is a symptom which will tend to disappear as the patient gets better in himself, but at this stage it will be helped and may be abolished by dissipating the patient's fears about it. It is probable that he thinks that there is some disease within the skull. A large number believe that a doctor is only guessing when he says that there is none. He has not looked inside the skull, he has not seen the brain, he cannot really tell. It comes as a genuine surprise for them to learn that it is easier to be sure about the presence or absence of intracranial disease than about intra-abdominal disease. It is essential that the doctor should ascertain whether they hold such views by direct questioning, as they are far too polite to think of saying such a thing themselves. There is also a subtle distinction in their minds between disease and there being something wrong; they have some idea that when we say that there is no disease we do not mean that the organ is quite healthy. This is of course merely inaccurate thinking, but that is a thing which will have to be combated constantly. With this symptom there is often a large amount of fancy diagnosis to be overcome; anæmia of the brain seems to coexist with congestion of that organ. Most people, however, are aware that worry will cause headache, and most can see that anxiety about the headache itself can keep it in being. The history will show that the headaches did become bad when the anxieties were more pressing, and were relieved when they got less.

Ocular Symptoms. There are two eye troubles which can usually be relieved by understanding them. There are very few patients who do not complain of specks floating before their eyes; and the belief seems common that they mean that their livers are not acting properly. With a dose of calomel the spots will disappear, only to return soon and require further hepatic treatment. There is no reason to suppose that they have anything to do with the liver. Every one has them, and anyone can see them if only he takes the trouble to look for them. The patient should be told that they are really small particles which we all have in our eyes, that they are seen only because his attention has been directed to them, chiefly because he had nothing else to do. The phenomenon is like that which occurs when we are in a room with a ticking clock and do not hear it till some one says, "Bother that clock!" We

cannot then avoid hearing it for a little, till our attention has been diverted by something of greater interest. This explanation will abolish the symptom.

The second eye symptom is one of much greater importance, viz. asthenopia. In this condition, which is very common and productive of much misery, the patient cannot use the eyes for near work except for a short time. When he begins to read he sees the letters clearly and distinctly, but after he has read for a few minutes, they begin to run together, the print becomes blurred, and he has to stop. Accompanying this there may be also a certain amount of pain in the eyes. He will have seen oculists, and the history of that is characteristic. Glasses will have been prescribed to correct a low amount of astigmatism, say 0·25 in the axis of 90. These will have suited him splendidly for a few weeks, and then the trouble will have recurred, when he will have visited the oculist again. The axis of the cylinder will then have been changed to 92, and all will be well for a little. The writer has seen one patient who had had six different prescriptions, which differed from one another only in a slight change of axis, in one year from the same man. The patient may also have been told to use the eyes very little, in case they become strained. Now a difficulty of this sort cannot be due to an error of refraction. If the error is less than 0·50 it is certainly not of any importance from the point of view of reading. And notwithstanding all that has been said to the contrary, a few degrees of angle in a cylinder do not matter. It is true that the oculist who displays the greatest care in the prescribing of his lenses will get the best results; if he uses a cycloplegic and an astigmometer, he will impress the patient much more than if he dispenses with these aids, and he will in this way obtain more surely the beneficial effects of hope, which will last only until the next violent emotion is experienced, and then its good results will tend to disappear. The history of the symptom will show that it began in a time of strain, and often enough it can be demonstrated that the first attack came on at a time when the patient did not want to see.

The story was common among the soldiers during the War that when they were in hospital after some event such as being blown up, from which they had become convalescent, the nurse would bring them a paper to read, and that in a few minutes they could not

distinguish the letters any longer. If they could be persuaded to think over what it was, about which they had been reading, they would often report that they had lighted on war news. In the condition in which they then were, this was the last news they wanted to read about, and the eyes were thrown out of focus, a good example of a psychological defence, comparable to the dyspepsia described in the previous chapter. Consciously they conceived the idea that they had strained their eyes or that these had been damaged in the accident, and that they must be very careful of them, and not use them much. This would defend them from reading further disagreeable news, but as, like all defences of the kind, it is apt to act indiscriminately, it also prevented them from reading at all. This fear that reading will damage the eyes will be found in almost every instance to be the factor which keeps the symptom in being. It may take a good deal of combating because the patient will usually have received medical instruction from some one to take care; but as soon as he believes that no harm can come to his eyes, he will be able to read in comfort. This is a good example of the perpetuation of a symptom by reason of the misinterpretation of an emotional reaction.

How trifling the precipitating cause may be and how easy the cure is shown by the following example. A lady of fifty-seven had been able to read for no longer than ten minutes three times a day, for thirty years. If she exceeded that amount the vision became blurred, if she persisted the eyes became painful, and she might even get a headache which would last as long as three days. When, as a young woman, she had seen an oculist, he had remarked casually, as she was leaving the room: "Don't strain your eyes." This instruction, given apparently light-heartedly, she had been carrying out faithfully ever since. She was told something of the mechanism of accommodation, and also that she had taken his instructions too literally, and that she could not damage her eyes in the way she was fearing. A few days later she informed me that she had read the whole of the "Pilgrim's Progress" in a day, with comfort, a thing that could not have been accomplished in three sets of ten minutes.

Alimentary Symptoms. The treatment of gastric symptoms has been dealt with in the previous chapter. There remains to be considered the management of those connected with the bowel—

first constipation. It has been said that constipation is usually an affair of difficulty in passing the stool, that the trouble is in the rectum itself, and that all that is needed is to persuade the patient that he will have an action if he believes that he will. I have not had great success with the method, but others probably have, and it should be tried. There is a good deal of wrong thinking among patients about the use of aperients. Some hold that their employment is unwise, that it is not natural to use them, and that we ought not to do so. Lauder Brunton pointed out long ago that it is also unnatural to keep a cook, and that, if only we ate all our food raw, we should not need aperients. There are some sects who do this, and perhaps they manage without aid to get their bowels to act. But a number of people in ordinary life will require an aperient if they are to be comfortable. They are often in trouble from the following train of events. They have been given a daily aperient, say two grains of cascara, and they take this every night. One day they miss their stool, and fly into a panic; on the following night they take a double dose, which gives them diarrhœa, and upsets the rhythm of their bowel. The next day they miss again, and soon they become lost. Now what they should have done was simply to take their ordinary dose on the evening of the day on which they missed their stool. They increased their dose because of the belief that it is dangerous to go a day without a stool, dangerous from auto-intoxication and some of the other bugbears which a fanciful pathology has invented. It should be taught that no danger comes from two or three days' constipation. The patient will say that if he misses a day he gets a pain in the abdomen. That is a mental pain, and it will disappear as soon as he becomes convinced that no harm will ensue.

There are others who think that, unless their stools are liquid, they are constipated, and who overdose themselves every night. Their history usually shows that they have the fear of auto-intoxication, or that they have had piles, which they fear will be damaged if they miss a day. A short discussion on the nature of the normal consistence will put them on the right lines.

Mucous colitis used to be a common nervous manifestation, but has now fallen out of fashion. It is still seen occasionally when the patient may pass large sheets of mucus, even casts of the bowel. If it is explained that it is of no importance, and if the doctor takes no

interest in it by constant inspection of stools, it will probably disappear. Its place has been taken to some extent by spastic colon, but the colon is not for some reason as popular a seat of functional symptoms as it was.

Nervous diarrhœa on slight emotional disturbance is common. Many patients will have a loose stool just before medical interviews. It is well known that many men had it just before going over the top in the War. It may be exploited unconsciously. Thus a man who had been a manager in a department of a business was displaced to make room for a nephew, and he himself was given the position of commercial traveller, a position he disliked intensely. This was before motor-cars, and it was his business to catch many trains. He frequently missed his train because of diarrhœa, which came on just when he was due to catch one. In the end he proved that his health would not stand travelling and he got back to his old post—a dangerous method of getting one's own way.

In such circumstances the patient has usually displaced the cause on to some article of diet which he then says he cannot take. When patients say that a single apple or an orange gives them diarrhœa it is well to look out for some emotional cause, which of course may be in the past, the symptom being perpetrated by the mechanisms we have studied.

Flatulence may be of several kinds. The eructation of excessive quantities of wind is common. Patients may belch for hours on end, and the noise may be audible at considerable distances. They will doubtless be taking considerable quantities of carminative medicines for this, and will probably be on a rigid diet. They will usually accept the explanation that this wind cannot come from the decomposition of food, and that what they are doing is to suck in air, and belch it out again. Many dodges have been described to overcome the trouble, which will almost certainly disappear if the patient is told that he must stop the eructation, however uncomfortable it makes him to retain the wind. If he has been persuaded into the proper mood he may be incredulous, but he will certainly try ; and if he tries the symptoms will disappear. A commoner complaint is the feeling of fullness after meals which causes discomfort round the heart. This is only part of the atonic dyspepsia which has already been discussed, and it will disappear when the digestion improves.

Passing excessive quantities of wind per rectum, so that the patient loses the sense of modesty and passes it in the presence of other people, is a bad habit, which depends on some idea that it is dangerous to retain wind. When he realizes that nothing will happen to damage him if he does retain it till he is alone, the wind will cease to be passed in excess. It is probable that there never was excess, but only a failure of retention. A patient in a small ward annoyed the other patients by prolonged passing of wind soon after he had gone to bed at night. He was told that he must get out of bed and go to the lavatory and stay there till all the wind had been passed. The symptom disappeared almost immediately, no doubt because of the inconvenience of getting out of bed.

The treatment of the abdominal pains, especially the pains in the rectum, is a matter of diagnosis. The fear of cancer of the rectum is frequent, and the patient must have the assurance that the diagnosis is certain. This pain is quite a common form for the emotional reaction to take, and it may be easy to make out from the history that it did come on at periods of stress. Fear of appendicitis, especially in young women, frequently keeps up a pain in the right iliac fossa, and has in the past been a frequent cause of useless operation.

Cardiac Symptoms. There may be organic disease present, about which the patient is unnecessarily anxious. There is a large number of people with mitral incompetence, who have perfect compensation but who are being treated as if they were about to die. A little dyspnœa, a little cardiac discomfort is regarded as the signal for a further curtailment of their liberties. And although in high quarters there has been of late a serious attempt to put the stethoscope in its proper place, so that doctors shall not be influenced by hearing a murmur, there has been at the same time an attempt by the very same people who belittle it to replace it by the electric cardiograph as an arbiter of fate. Careful explanation on common-sense lines is what is wanted to cause emotional dyspnœas and pains to disappear.

It is more frequent, however, for those who complain of their hearts not to have any organic signs at all. They complain of pain, irregular action, feelings as if the heart were going to stop, and so forth. They will have seen many physicians who will have told

them that there is nothing wrong, and yet they will not have believed them. It will be found that they have heard of patients who, although they were supposed to be healthy, have died suddenly, and that the verdict at the inquest has been that they have done so from heart disease. Patients will seldom volunteer this; they must be asked if it is not so.

It is usually young people who complain of this, and they may be told that sudden death in this way is very rare indeed except in the aged. They have, however, probably heard of certain young men dropping dead on the football field. They must be shown that the chances of their doing so are infinitesimal. A fear of this kind may, however, depend on some deep-seated anxiety which may take a long time to find and get rid of.

A doctor who gives these patients an unfavourable opinion will be believed more readily than he who gives a favourable one. If pressed about this the patients will say that very few doctors will tell the real truth if it is unpleasant. This is not usually the real reason; it is common enough that the patient is deriving some advantage from his supposed weakness, or that he did so at one time.

The War left a number of cardiac patients whose histories are interesting. There were a number of men who developed irregularity, and who were in consequence kept at home on account of it. This irregularity was a thing whose importance often enough they did not altogether believe in themselves, but they were secretly glad of it; often they were not able to get rid of it after the close of hostilities. The symptom was, of course, kept up by the moral conflict caused by their having welcomed the escape from the War, a conflict which they had never settled; how to deal with this will be described later. These patients were also liable to fainting attacks, for which the treatment will be detailed later also, as neither of these difficulties is easily got rid of by the kind of explanation which is being considered now. For example, a patient wounded during the War was told he would probably be sent to England if he developed tachycardia and insomnia. The prescription for the first was the inhalation of pipe tobacco, for the second keeping awake by voluntary effort. He succeeded in developing both symptoms. He was told in many places that his heart was normal, but one doctor said it was seriously affected, and this was the only doctor worth listening to

while the War was on. After the War he had difficulty in getting rid of his trouble, which took the form of wakening up with violent palpitation as soon as he was falling asleep. He had, before he was well, to acknowledge a good many unpleasant things about himself, and that was probably why it became difficult to believe in the functional nature of his trouble after it had ceased to confer any benefit.

Urinary Symptoms. Polyuria will disappear as a rule when the general state improves, but there may be a fear of diabetes which is easy to remove by direct assurance. Frequency of passing water is often associated with the fear of prostatic disease. Such a patient has usually been examined per rectum only, and a slightly enlarged prostate has been found; he has looked up the literature and the symptom has developed.

Prostatic pain of dull aching character with acute episodes are common. They are usually associated with a considerable degree of mental depression and misery. The patient is commonly in a state of considerable conflict about sex. These cases are often regarded as surgical and treated by massage of the prostate.

The pain of loose kidney often gives a great amount of trouble. It is frequently associated with general visceroptosis, and is accompanied by aching in the loin and back. Often enough it can be found that the pain became more definite and more constant after some doctor had discovered the lesion, and had told the patient that it was the cause of her ill health. There then ensued a period when the patient wore a belt, usually with satisfactory results at first, but less so later; at the end of this an operation to fix the kidney was performed. This may have cured the pain or it may not, the result depending probably on purely psychological factors. If the patient can accept the position that the pain became really unbearable only after she knew about it, and that it therefore falls into the category of mental pains, of the same nature as the neurotic headache, improvement or disappearance of it may follow. These patients are usually very thin, and should be kept in bed till they have acquired a proper amount of weight. They are certainly more comfortable when they are fat; whether this is a physical or a mental phenomenon is difficult to say.

Many of the symptoms are possibly associated with general viscer-

optosis, and here again it is difficult to estimate how much of what is felt by the patient, the dyspepsia, the general misery and nervousness, are the result of the physical condition. These patients also are better when fat; they are often benefited by a proper belt, and they are certainly amenable to the psychotherapy of hope. It is not possible to say whether wearing one's stomach and intestines in the pelvis should *per se* give rise to discomfort or not. It does seem fairly certain that the discomforts complained of are more than the physical condition accounts for; because the mental attitude which the patient adopts has certainly a very marked influence on the amount of the discomfort. Operations for raising the general height of the viscera may succeed or they may not. The author has naturally not seen the successes, but he has seen some of the failures. How fallacious the reported successes may be is demonstrated by the following example.

A lady had suffered from general nervous symptoms for years, accompanied by obstinate constipation; general visceroptosis was present in an extreme degree. After prolonged medical treatment she underwent the operation of festooning the colon with, she said, pronounced benefit. The operation had been performed about two years before she came under care; the constipation was manageable, and she was better, but she still had some neurotic symptoms. Now the author had known this patient some years before, and though she said that she was better, it seemed to him that her life was as full of the same disabilities as formerly. She suffered from as many headaches, as much fatigue, and certainly an immense amount of difficulty with the bowels. With regard to the latter, she said that it had taken some months before the benefit of the operation showed itself, nearly a year. She had then written to the surgeon asking if she might expect to feel better soon; he had replied hopefully, and had also sent a prescription for an aperient pill, which she had taken regularly. Since, but not till then, her improvement had commenced. Now it would seem that this surgeon had really given her the power to endure her troubles with more fortitude, a thing not to be despised, but one also which can often be achieved without a serious operation. It can also be understood how a surgeon who received a report of this kind from a patient would be

prone to include such a result among his successes. None of us can easily be a critic of our own work ; our bias in its favour is so great that we usually fail to display any acumen when we are investigating its weak points ; therefore surgical reports on the results of operations for visceroptosis, though they may be perfectly honest, should be received with caution. Again the author wishes to emphasize that he himself is under the handicap of never seeing the striking successes.

These patients are certainly often very intractable. They resemble the hypochondriacs in some respects more than the neurotics. After any treatment in which they believe they are better for a time, but are prone to relapse quickly. They are willing to undergo innumerable operations, each of which is successful for the moment.

Genital Symptoms. Frigidity in women may lead to dyspareunia with or without vaginismus. This is usually an indication that the patient considers the sexual act disgusting or even wrong in some way, or that she is frightened of its consequences. Sometimes the exact reason is discovered easily. It may be found that there was a faulty sex education. There are mothers who tell their daughters that the act is a disgusting affair ; in less direct ways girls are often led to look on it with aversion. It may be found that the patient has married against her wish, or she may be in love with some one else, or at least not in love with her husband, or she may have for a variety of reasons ceased to love him.

In these circumstances the secretion of mucus and the relaxation of the musculature of the vagina may be inhibited. These two factors, which normally ensure that coitus may take place at least painlessly, are present when desire is unchecked. They occur normally as an emotional reaction, and if they are not present the act is almost certain to be painful for the woman. If she has been hurt once, a not uncommon event on the marriage night from haste or awkwardness on the part of the husband, she may thereafter approach the act in a state of fear, which as we have seen in other parts of the body may set up a vicious circle which can go on indefinitely. If the matter can be explained to her, and she can see that fear of being hurt is now the chief cause of the trouble the symptom may disappear.

It has often happened that patients with these symptoms are told that the vagina is too small, and they are advised to use glass dilators. If this succeeds it must be because they had faith in the remedy. It is not easy to say what is the calibre of a vagina, for like every other bodily tube, with muscular walls, its size must depend on the contraction or relaxation of the muscle. Normally it is closed and has no size. It dilates at childbirth and during sexual desire. To use a dilator in cold blood cannot produce the kind of relaxation we are aiming at. As examples of the genesis of these states we may take the following cases.

A young married woman complained of dyspareunia. A surgeon examined her and found that the uterus was displaced downwards; he proceeded forthwith to shorten the round ligaments. She was no better for this, and then her history demonstrated that she had become afraid of her husband, whom she suspected of having acquired venereal disease. It was natural that the operation should have failed to attain its object. Another woman, who did not wish to have more children, practised coitus interruptus. The introduction of the penis was easy, but after a short interval, well before the orgasm, she was seized with a severe pain, which caused her to jump away from her husband. She also had had various operative procedures, because no one had really taken her history; all that she had told the surgeons was that there was pain on intercourse. Now both these patients told exactly why the act had become impossible for them, the one because she was afraid and disgusted; the other because she was afraid of pregnancy. These reasons were elicited in both by means of ordinary history-taking, not in the first interview, but when they became quite sure that they would be listened to. They are good examples of something which we have seen is a common cause of a nervous symptom not disappearing even when vigorous treatment is carried out. *Both had good reasons for not wishing to lose the symptom.* At the same time they would have been glad to get rid of their pain. This is a common mental state, not only in the neuroses, but in other conditions. Most people would like to get rid of their gout but be able to drink their port.

We shall see later that though not all patients can be shown to have these contradictory desires so easily as can these two, with

care they can be found in a very large number of instances. A patient like the first is one very difficult to treat, for such a state of affairs usually means that there has been a disappearance of love. One like the second can be helped by substituting the use of a contraceptive for coitus interruptus.

Here we come against another difficulty in a considerable number of cases, viz. moral scruple; and the question arises, How far is a doctor justified in doing anything to break a scruple down? There are many who would say that he is never justified in such a course; but it seems to the writer that while a principle should hardly ever be interfered with, there can be no harm in discussing with a patient whether she is really conforming to her principles. Coitus interruptus is itself a contraceptive measure; the only thing about it is that it is a bad one. It is bad because it is uncertain, and probably because it induces a state of watchful anxiety at a time when the mind should be normally free from care of any kind. Both parties become obsessed with the idea that they may delay too long. If it be conceded that it may be practised without infringement of the moral law, then something whose only difference is that it will act more certainly and without watching cannot be very wicked.

The use of a contraceptive in such a case may not be followed by relief on the first occasion of its use, because the habit of watchfulness has become automatic, and the patient should be warned of this, and be told that after her automatic system has become reassured by practice, if such an expression may be allowed, all will be well.

In the majority of cases of this kind, care in the history-taking will reveal some good reason for the act having become an object of fear, distaste, or something of the kind, and in many cases a sensible talk will relieve matters very much.

Apart, however, from abnormal intercourse, other symptoms are treated by a great deal of unnecessary gynæcology. Backache is one of the commonest symptoms of neurosis; and it often calls for a pelvic examination. Small departures from the ideal in the position of the uterus are then found, and they are declared to be the cause of all the symptoms from which the patient is suffering. Again history-taking will show that these back pains were only a

part of a general condition. As the gynæcological treatment which has been given will have failed before the patient comes under observation, it will not be difficult to persuade her that her previous physical treatment need not be continued, though sometimes if she has had much pessary treatment she may want further experiments in this direction, or may be anxious for bolder operative procedures. If, however, other symptoms improve under treatment, these backaches will improve also.

Dysmenorrhœa is often merely due to the bad habit of lying in bed during the period, and will frequently improve if the patient will get up and pursue her usual activities. This treatment had better be attempted only after the patient is well in hand ; the endeavour to force a patient to get up and be about during this time, who is not fully persuaded by experience of the efficacy of psychotherapy, is not likely to be successful. It may be pointed out that this habit of lying in bed is largely one of class ; it is on the whole the middle-class girls, who have fewer interests than either the upper or working classes, who indulge it. The history will often show that the mother was unduly anxious at the outset of the function, that the patient was ordered to rest when she began to menstruate, or it may be that she received a chill on some occasion, with stoppage of the flow, and that the effect of this was painted in such lurid colours that every subsequent period was associated with fear. She had come to believe that in some way or another every time must be one of pain.

In **men** fear of **impotence** before marriage may be a very simple thing yielding easily to treatment, or it may be very complex and require much investigation.

The patient may have heard that other men had failed in this way and simply be afraid that he will do so also. For such it is often helpful if they are told that there is no need whatever to consummate the marriage on the first night, that if they do not they will probably be conferring a benefit on a girl who has had a very tiring day, who is probably herself very shy and timid, and who will appreciate being left alone. A thing that should not be said outright is that the patient should not marry till he is cured, for there is no means of telling whether he is impotent or not till he has married. It is worse than useless for such a person to experiment with prostitutes, for he will approach them in a state of

anxiety as to whether he will succeed or not, and anxiety is an inhibitor of erection. Neither should the doctor urge marriage. If the reassurances which are given make the patient confident, he can settle what he should do for himself. This is exactly the same advice as was given to the exhausted patient who wanted to be ordered either to get up or stay in bed. The views about exhaustion were put before him, and then he himself decided what he would do. In the history of these simple cases it will often be found that there had been much faulty education, and the commonest story is to find that the patient had masturbated, and had been told that masturbation leads to impotence. It may also be that the patient had been told that because he masturbated his children would probably be insane or deformed. There is no end to the untruthful statements which are made to boys on this subject by well-meaning but ignorant fanatics.

The causes of fear of impotence may, however, be more deeply seated. They may be dependent on childhood fixations which have become unconscious. The procedure then will have to be analytic and cannot be discussed here. These patients will probably be obviously severely ill with neurosis in many ways, and the case will probably be one for a specialist. If simple reassurance after thorough history-taking and several talks on causation does not put matters right, the case is a severe one; but there should be a fairly long attempt at simple treatment.

In married men who were formerly potent it may be that impotence has been added on to a neurosis or a psychotic depression. Such may be told that as they succeeded in the past, they will do so again when they are well. A more serious condition is when a man has ceased to be in love with his wife and has fallen in love with some one else. Whatever treatment he receives it is best that it should be given away from home, and he should not make further attempts until he is cured.

Clinically the fear of impotence may not be complained of directly. For example, a patient afraid to marry may come with the complaint that he has a disease which prevents him from marrying. He may be unconscious till talked to that the nosophobia depends on the fear of marriage. Or he may tell sadly that the only woman he ever wanted to marry is out of his reach. The variations are

endless, and it may be said that this symptom is common, that it is often concealed because of shyness, which itself may depend on the fear that the doctor will think it due to previous masturbation, or it may be quite dissociated in the patient's mind from the fact that he fears impotence.

A large number of patients who are treated by discussing their symptoms, by showing how they arose as emotional reactions, by proving how they were retained because these were misinterpreted, and by persuading them to see their real value, will become and keep well.[1] In its mechanism the method does not differ from that by which electricity, drugs, or any other method of a physical nature do good. They and it work equally by restoring confidence to the patient. But it has one overwhelming advantage over these methods, in that the confidence which is achieved is not in some agency outside the patient, but in himself. In the event of relapse he knows that he has within himself a method to make himself well again, and that there may be no need to come to any doctor for further treatment. The method will be followed by the disappearance of symptoms among those whose troubles are largely over, and who have remained ill mainly because they had conceived that they had a serious bodily disease which no one could understand. At all times, in all ages, they have been relieved of their symptoms as soon as they had received some treatment in which they could believe.

The method of treatment by the evaluation of symptoms should be tried very thoroughly in all cases before anything further is resorted to. It has many advantages besides that of abolishing manifest disabilities. It requires no apparatus beyond the ordinary diagnostic instruments which every doctor possesses. It requires no nurse or other skilled attendant. It can be practised either in the doctor's house or in that of the patient. It does require time on the part of the doctor, but it does not require any very specialized skill. It is well within the province of every practitioner of medicine. Indeed, a doctor in general practice has a great initial advantage over one who is engaged in the special study and treatment of these disorders. Such an one is apt to become suspect

[1] For some statistics connected with this the reader may consult "An Enquiry into Prognosis in the Neuroses," T. A. Ross, Cambridge University Press.

to the patients. They are inclined to think, and it must be confessed that there is a certain amount of justification for their thoughts, that a specialist runs his specialty to death. At first they are interested in the new doctrine, and give it a hearing, but if they develop new symptoms during the treatment, they are slow to believe that these too are functional, that these also are connected with anxiety, and they begin to long sometimes for a "proper doctor."

It is quite common for a patient, after all his original symptoms have been satisfactorily disposed of, to produce an entirely new one. When this occurs it is probably connected with the desire not to be well. He may then say quite openly, "Of course, you never admit that anything is physical." This occurrence will require to be dealt with by some form of analysis.

There are three essentials for successful practice of the method with which this chapter deals: the careful taking of the history, the complete examination of the patient, the telling of truth so far as the doctor is able to do so. The history which is necessary is not one which requires probing or any prying into secret places, which it may be painful for the patient to lay bare. All the history needful for this particular method is what the patient is more than anxious to tell if only he can get some one to listen. There is no taint of psycho-analysis about it. It will be said that it is just what every doctor is doing every day, and that the method is therefore hardly worth writing about. The author ventures to think that this is not so. It is seldom that the patient has had the opportunity given to tell his whole story to anyone; it is seldom that he has been examined from top to toe at one sitting; he often gets the impression that something is being held back from him. It may be added that in most practices he receives a bottle of medicine or its modern equivalent in the shape of a vaccine, a hormone, or a course of electricity; and no one is really clever enough to persuade a patient that there is nothing physically wrong, if he is at the same time prescribing physical remedies. We judge one another, sometimes consciously, sometimes subconsciously, by behaviour rather than by words, and the patient will believe that physical remedies do mean physical illnesses, no matter what the doctor may aver concerning their absence.

Once the diagnosis that neurosis is accountable for the symptoms has been made, there must be no hedging. This was put so well by Dubois that his words may be quoted.

" Here we have a patient reduced to utter helplessness for twelve years, after having resisted the therapeutic efforts of many distinguished, devoted and energetic physicians, who have recognized, although *with many regrettable hesitations*, the patient's neurasthenia. Why were these confrères not able to succeed during these twelve years of the disease, and why should the patient in the end have been cured in a few weeks ? Because they (the physicians) were not sufficiently imbued with the idea that nervousness is psychic in nature ; because they hesitated in the diagnosis, seeking a spinal affection when the psycho-neurosis was evident ; because possessed with the idea of the relationship with arthritism they attributed to the latter *some* of the symptoms ; because in speaking of rheumatism they thus gave a certain reality to the ills of the body, and admitted to the patient that their nature was in part at least physical. They were not able to transmit their convictions because they were not sufficiently clear in their own minds."

These words were written in the last quarter of the last century, and if we substitute vitamin deficiency or endocrine imbalance for arthritism and rheumatism they will explain why doctors do not succeed as often as they might with the method of treatment by evaluation of symptoms.

CHAPTER VIII

THE TREATMENT OF PATIENTS WHO IMPROVE AND RELAPSE

Nearly every patient after a few days of conversation on the lines indicated in the last chapters will experience a considerable amelioration of his symptoms. He will have better nights, will take his food with more relish and without indigestion, his outlook on life will brighten. He has received a new hope, even if he has not grasped the full significance of what he has been taught. An improvement of the kind in such circumstances is characteristic of the illness, and is not really an index that the treatment is being conducted on sound lines. It is mainly a proof that the patient has taken to the doctor. It is not wholly advantageous that it should continue. Dubois held, and probably correctly, that it was a disaster if it did. He said that it was a mere hypnotic affair, that the patient had probably not understood at all what was being taught, and that speedy relapse might be looked for when the patient returned home.

That such an issue is possible is well known to anyone who follows his cases up. Theoretically also this should be so. Patients who, even if they have understood, are persuaded as easily as this that all their former views are wrong, are mere weathercocks who will be blown the other way by the next wind of contrary doctrine. There should, therefore, be no dismay if, after a few days of being better, the patient is found to have regained all his symptoms, to have had a bad night, and to be in great despair. One of several things may have happened; all will be found to come under the category of anxiety.

He may have received anxious news, or some one may have been unkind to him, or he may have thought that some one had been, or he may have been dwelling on some unpleasant incident of the past, or some anxiety for the future. He may be perfectly

aware that one of these things had been the cause of his relapse, in which case they will require open discussion, and this discussion may be much more fruitful than the patient dreamt when he reported them. They may be quite simple; nothing has happened but that the patient has had an emotional reaction which he recognizes easily. It is possible that he may not have recognized himself that he has had one; he may have feared that he really has had a relapse, but in such an event a few minutes of conversation will bring him back to what upset him, and he will in this way receive a further lesson in the truth of the doctrine which he has been taught. He may have one or two relapses of this kind, and then they may cease. They may, however, reveal all sorts of trends which did not come out in the history, but which have been of importance in keeping up unhappiness.

A lady with such a relapse said that she had had a letter which had upset her; she was unwilling to say what it was about. With a little persuasion she said that it was from her husband, who had told her that he had had a pleasant evening the night before. When she was asked why that should upset her, she at first said that it had not, but a little reflection showed her that she grudged him pleasure while she was ill, secondly that she was unjustifiably jealous of other ladies to whom he had been talking. Moreover, she soon saw that because of her illness she had of late failed to be the companion to him that she had been in the past, and that she had been poor enough to think that he ought not to try to obtain even intellectual companionship with the opposite sex till she was well. Such a conclusion did not give her immediate relief, but it showed her that she was doing something which, unless she altered it, would be of necessity a cause of continual unhappiness when she did get home. It made her see that she must alter things in her own thoughts and conduct; it gave her a new outlook on life.

Another patient had repeated headaches, and she was invited to see whether she could not detect some disquieting thought at the beginning of each attack. She had accepted the view that anxiety was at the root of her trouble and that she had no organic disease; but the headaches had continued to be very severe. She said that before the onset of one attack she had been thinking

of an incident that had happened long ago. This had been recalled to her memory by the detailed history which she had gone through a few days before, "been stirred up by it," as she expressed it. She had been left some twenty years before, owing to the death of her mother, in charge of a small brother of six, when she herself was only seventeen years old. Shortly after this her father had married again. The stepmother had not been kind to the little boy, and the patient had not stood up for him as well as she might have done. She had often blamed herself for this, and had considered that she had been a moral coward. It was not difficult to show her that it would not have been a very easy thing to have interfered much, and that the boy might have had a worse time than ever had she done so. This discovery, and its discussion, had the effect of making her feel curiously better. She felt not only a relief from the actual headache, but as if she had learned something of great importance. In a few days she had another severe headache, and this time she had worked out the explanation for herself. In her house at home she had her husband's mother as a permanent boarder. This person had herself been in poor health, and owing to the fact that both were ill at the same time for a period exceeding twelve months, it gradually became evident that the arrangement was unsuitable, and it had been settled, before the patient had come under care, that it should come to an end. Though she was pleased at the prospect, it had not given any relief to her symptoms. She now knew why. A large part of her objection to the presence of the relative in the house had been due to the necessity for keeping her children as quiet as possible, so that they had never been able to have any friends to the house, or even to sing in anything above a very subdued key. The children were becoming afraid of enjoying themselves. Thus, to the patient, it became clear now that she had repeated the sin of her youth, the sin of not defending children from oppression who had been committed to her care. Again it was not difficult to show her how easily she had been led into this trap. The plan had been entered into to help and please her husband; it would have hurt him if she had complained that it would not work till it had been given a fair trial, and if she had given it up early she would have blamed herself just as much for that as for anything else.

There are several lessons to be learned from these two cases. In neither was there any incident called up from the unconscious. In each the facts were well known by the patient before our conversations. But these facts had never been correlated, never seen in the light in which they were afterwards. There is a difference between the two patients which it will be found helpful to recognize. The first patient was not aware that she had been jealous, and it was not easy for her to bring herself to see that she had been. All that she was aware of was that she was annoyed at her husband. She did not think that she was in any way to blame, and she had been throughout perfectly pleased with her own conduct. The second had believed that she was a coward, but she had not connected this with her symptoms.

These differences point to two distinct types of patient to which allusion has already been made. The first belongs to the group where there is a distinct feeling of superiority, the second to that where the predominant feeling is one of inferiority. Patients in the inferiority group are much easier to cure than are those in the superiority group. "Blessed are the humble-minded, for they shall be cured," said Dejerine. The feeling of inferiority, if it is not carried to excess, is one of the most valuable traits which anyone can possess. As was mentioned on page 38, it makes people conscientious, pleasant to work with, and agreeable as friends. Such patients can be shown that they are morally better than they thought they were, and the act of showing them that this is the truth about them is most helpful to them. Those, however, who are quite pleased with themselves are in a different category. The sense of superiority is one which they have developed as a defence against the disappointments of life. It is a working compromise which they have arrived at, and which makes life possible for them. The first breaking-down of it may well make them feel worse, for they become lowered in their self-respect, and have to pass through the valley of humiliation. This breaking-down, which is a necessity, must be done with the utmost caution. The patient must not be accused of the fault, though it is patent to the observer. He must be led up to it, and must accuse himself. In the instance which has been given, the patient was asked why she objected to her husband having pleasure which she could not share, and she was

unable to give any satisfactory reason; in the end she said that it was not a very nice thing for her to have felt in that way about the matter. If the patient is directly accused of the fault, the only thing that will happen will be that an intense resistance is set up, and she will never see the point, or only after a long time and at the cost of much ill-feeling towards the doctor. Once she has admitted her mistake, it is the doctor's duty not to let her feel too abject about it; she may be told that we all have imperfections of which we are unaware till they are pointed out.

In these two instances there was no difficulty in arriving at the events in the patients' lives which had occasioned the emotional reaction. The late W. H. R. Rivers suggested that the word "unwitting" should be used for such examples. The word "unconscious" does not meet the case. The patients are conscious of the facts, but they have never put them together. It may, however, happen that the patient may say that there was certainly no anxiety of any description preceding the attack, that he was feeling particularly well, when suddenly out of the blue there came a return of his symptoms; and he will usually maintain that this is proof that they are not mental in origin, but that there must be some disease of organs, or else why should they have come back? The most careful and honest searching may fail to bring to his mind any preceding anxiety. In serious cases this is indeed a commoner event than that the patient should be able easily to identify the cause of the relapse. We may take as an example the case of a man whose complaint was giddiness and confused feeling in his head, accompanied by the sensation that he was going to collapse on the street; not every time he was in the streets—there was no special phobia of them. He was convalescent, and was sauntering along looking at the shops, when suddenly he had one of his seizures. At the time he was quite happy, for he was thinking of getting back to work, and was feeling able to do so, as most of his symptoms had been absent for some weeks. When seen the next day they had all come back, and he felt that he was as bad as ever. He was of course pressed to say if he was sure that there had been no anxiety, and he was quite sure that there had been none. He was next asked to take the walk in his mind, and to try to see where he was when the attack came on. In a large number of instances,

if this is done slowly and minutely, each particular portion of the walk being visualized, the place where he began to feel ill can be identified. The patient will say that it will be impossible, and almost always he will show the utmost unwillingness to try. This is not wilful obstinacy, but, as we shall see presently, is part of the same mechanism which has caused him to fail to remember why the attack came on at all. He should be told that all patients say that it is impossible to identify the place, but that when they try most of them can do so. This is easier of accomplishment if the patient will relax his limbs and shut his eyes. When asked to do this he will probably keep them open, and it will be necessary to ask him several times to shut them.

The eyes are to be shut not because it is desired to hypnotize him, but only so that his attention is not distracted. If he keeps his eyes open he will probably say that he cannot visualize the scene he is attempting to, because he sees something on looking out of the window which is distracting him. At this stage we wish his mind to be employed in actively trying to recall the past as vividly as possible; its activity is to be in marked contrast to what it will be asked to do later.

After a period of resistance, he will begin to help, and will often arrive at the desired information. In the example which we are considering, the patient stated ultimately that he was looking into the window of a chemist's shop when he was taken ill. He was then asked to look with his mind's eye into the window, and to describe all that he could see there. After a period of saying that he could not remember, he said that he saw bars and cakes of soap, and that he saw nothing else. It will perhaps be doubted by those unfamiliar with such a proceeding whether a memory of this kind has any validity or not; but if the method is given a trial with some degree of assurance on the part of the observer, the results are constantly so remarkable that little doubt of its practical value will remain. It is probable that impressions are registered much more abundantly than we think; we do not know most of them because we have, as a rule, no occasion to want them, and therefore never recall them in ordinary life. For the method to succeed, the observer must overcome the resistance on the part of the patient; the latter will do his utmost to prevent its use. He will continue

to say that it is impossible, that no one could remember like this. He will need to be reminded several times that at least no harm can come from trying, and require cajoling in all sorts of ways to get him to go on.

Free Association

We have, then, our patient looking at bars of soap, and at nothing else. While he was doing so he became ill, and with difficulty dragged himself away from the spot, and went home feeling ill all the time. He was not in the least willing to admit that looking at bars of soap could make him ill; he looked at soap many times a day, and nothing ever happened from that. Moreover, at the consultation in question there was no emotional reaction from recalling the bars. Nevertheless he was so positive that it was this and nothing else which his mind was experiencing when he became ill, that it seemed well worth while to pursue the question of soap a little farther. He was therefore asked to keep the idea of bars of soap in his mind as clearly as possible, and to think of nothing else: in a short time that idea, he was told, would be succeeded by some other. He was then to say whatever that subsequent idea was, no matter how irrelevant it might seem to him. He was not to try to judge whether it was important or not, but simply to say it. This is the procedure of *Free Association*, which we owe to Freud. Freud holds that ideas do not come into the mind in a haphazard fashion, but that every idea is determined by a preceding thought, or by some fresh stimulus. To avoid the latter it is well that the patient should continue to keep his eyes shut and his limbs relaxed. The ideal position is that of reclining on a sofa, facing a corner of the room which has no pattern or picture on it, in which case the eyes may be open; the room should be reasonably quiet; the observer is behind the patient.

The first great difficulty is to get the patient to say what comes into his mind. Even if he is willing to help, he will almost invariably misunderstand so simple a direction; he will think that what is wanted is that he should go on searching for something, as he was doing just before, which has a bearing on the question in hand. That is not at all what is desired. The process wished for now is not an active one in the least; the patient is to lie passive with his

mind passive, and simply record what seems to wander into it, and then say aloud whatever that may be. He will usually say that nothing comes into his mind at all. He is then directed to go on thinking of the stimulus word or idea, whatever it may be, in this case cakes of soap in a chemist's window. If he continues to say that nothing comes, he may be told that probably things are coming, but that he thinks that they are irrelevant or trivial, and that he is not to exercise criticism on the matter but say whatever they are. At last he will say something, and on the occasion which is being related at present, the patient said that the word "cleanliness" had come into his mind, a very obvious association. The word cleanliness led him naturally enough to think of godliness, and that to a story which he was anxious not to remember, viz. to the recollection of an act of seduction. An obvious criticism of all this is, as has been already admitted, that the patient saw soap every time he washed his hands, many times a day, and that it is a little absurd to suggest that this particular display of soap should have stirred his secrets in so dramatic a way. On this occasion, at any rate, the criticism can be met. The chemist in question was Boots. The act of seduction had taken place in a boot-shop after hours, the patient being a boot-maker. The name of the shop was on the sill of the window, so that it caught the patient's eye at the same time as he was looking at the bars of soap. It will be said, perhaps: "Yes, but he put on his boots every day." These two things, boots and soap, are so common that if there was anything in the combination the patient should have been reacting in this way daily. Why, every time he put on his boots, he probably immediately washed his hands. The only theoretical reply to such arguments is that here there was a mass effect. It was a "Boots' Shop," which by clang association is the same as a "boot-shop"; there was an immense amount of soap, and it is a commonplace that a stimulus must have a certain intensity before a reflex occurs.

Empirically the objections are easier to answer. The method did result in the patient talking over a subject which was giving him a great deal of trouble. Again and again it will be found that it does bring up matters of importance, which have not been arrived at by ordinary history-taking, matters of which the doctor was previously in total ignorance, and which he could not there-

fore by any possibility have suggested to the patient. If the doctor on this occasion had said, when he had got so far as the bars of soap, "Now we shall find something sexual here," there would be occasion for severe criticism, but he suggested nothing; he only persisted in asking the patient to say what was coming into his mind, and he pursued the first word that turned up. It should be unnecessary to say that the doctor must never during this process suggest a single word, or point out a single connection between ideas. If he does, the whole validity of the associations disappears; and what is a valuable instrument of investigating the patient's mind becomes nothing but one for forcing the doctor's ideas on him. There is a time for comment, but it is when the patient has finished with his free association and has begun to talk about what it means. The doctor will then have much to say, as will be explained in a moment. It may also be permissible when the patient has associated along parallel lines and sees no connection between them to ask him how he reconciles this with that. What is not permissible is that the patient should have a word or idea suggested to him. It is extremely difficult to avoid doing so. Freud himself has done it, a thing which may easily be found in his writings.

It cannot be said that this process brought into the patient's consciousness something which he had totally forgotten; he had, as a matter of fact, thought with shame of the incident from time to time, but he had wished to forget it very much; when it recurred he had tried to put it out of his mind.

The question may now be asked why it should be a good thing to revive a highly disagreeable memory of this sort, which would probably be better forgotten. There are several answers to this very pertinent question. First, this patient had the idea that he had some serious heart disease, and the occasion was used by him to strengthen his ideas in this direction. He had felt giddy and faint, and these symptoms were a further proof for him that he was right in considering that his heart was weak, and that he must always lead a life of taking care. He had, of course, been instructed at the beginning of his treatment that emotional thought could bring about symptoms, and he had no doubt about this. This circumstance on the street, till he understood it, was not to him an emotional event; after he had understood it, it was. If it be

objected that the event could not be emotional till it was in consciousness, it may be replied that it was just on the threshold of consciousness when the symptom arose ; had the reaction not taken place, it would probably have come into consciousness. Consciousness, moreover, is not a thing with hard-and-fast boundaries. We are vividly aware of some things, less so of others at the same time ; some things are in the focus of attention, others not as clearly so, others on the periphery. At what degree of consciousness does an idea become capable of exciting an emotional reaction ? Certainly before it is in the centre of the focus of attention.

It is common to find that emotional reactions come as if to prevent ideas from coming into consciousness. Two striking examples have been given at some length in my " Introduction to Analytical Psychotherapy," pages 148 and 190. But, further, the study of the conditioned reflex has prepared us for the idea that reactions may take place to systems of ideas which are not in consciousness, to ideas, that is, which have been relegated to some part of the mind which is not identical with consciousness, and which has therefore been called the unconscious mind. The reaction is rather more elaborate than the simple conditioned reflex of dogs, as might be expected seeing that we are dealing with so much more complex a mental apparatus. We shall come across other examples where the most helpful conception is that there is such a thing as the unconscious mind. A thing cannot be dealt with by the ego till it has been made conscious ; in the unconscious it merely goes on being an irritant, probably because it has never been faced. The whole subject is treated more fully in my other book referred to above.

Every one should be able to look at any and every event in his life, even if he is ashamed of it. If we refuse to look at things of which we are ashamed, we may conceive of something happening like the following ; namely, that anything which is associated with the event in question has the tendency to call it into consciousness. A barrier is in some way interposed by our desire that it shall not come, and the event does not appear because it is kept out forcibly. Such a series of incidents must cause a conflict in the mind, and it need not surprise us if symptoms show themselves. There is a multitude of facts which show that such a barrier exists. They

have been provided by the researches of Freud and his followers, and for the further proof of its existence his works should be studied. This barrier has been called the censor, or censoring agent: it is not to be regarded as a voluntary excluding of the idea; it is rather that the highly unpleasant thought or memory does tend in many cases to be kept out of consciousness. Once the patient has learned to look at the disagreeable, its power to make him uncomfortable will be lessened. It is better if we have done shameful things to think of them as such, rather than to pretend that we have not done them at all. A skeleton in the cupboard is a gruesome and fearful thing, but if we look at it often enough it will become only a bag of old bones.

The idea which has been put forward here has been expressed in very noble language by a writer [1] whose interests were wholly unconnected with medical psychology, and whose zeal for uprightness of thought and conduct is unquestioned. As much doubt concerning the wisdom of reviving these disagreeable memories continues to exist, it may be worth while to quote the passage.

"Those who write have to see that each man's knowledge is, as near as they can make it, answerable to the facts of life; that he shall not suppose himself an angel or a monster; nor take this world for a hell; nor be suffered to imagine that all rights are concentrated in his own caste or country, or all veracities in his own parochial creed. Each man should learn what is within him, that he may strive to mend; he must be taught what is without him, that he may be kind to others. It can never be wrong to tell him the truth; for, in his disputable state, weaving as he does his theory of life, steering himself, cheering or reproving others, all facts are of the first importance to his conduct; and even if a fact shall discourage or corrupt him, it is still best that he should know it; for it is in this world as it is, and not in a world made easy by educational suppressions, that he must win his way to shame or glory."

After it has become conscious we shall frequently be able to help the patient to see his trouble in another light, so that it may no longer be a source of distress and therefore of symptoms. This was shown frequently in the war cases. For example, a man who

[1] Robert Louis Stevenson: "The Art of Writing."

thought that he had heart disease was progressing favourably, when one day he said that while he had been out walking on a common, he had suddenly had a heart attack. He said that he had been perfectly happy, not worrying about anything, and that therefore he could not accept the statement which he had been trying to believe for some weeks, that his heart was healthy, and that his attacks were due to emotion. Exactly as in the previous case, he was induced to take the walk mentally, till he came to the spot where the disability had shown itself. He was then asked to look at the scenery, and to describe what he had seen. He said that he saw a belt of bare trees. This led to the recollection of a wood in France where his company had been heavily shelled, and where he had been much afraid. He had conceived the idea that he was a coward. Apparently he did not know that the others were probably afraid too. He was told that cowardice did not consist in being afraid, that courage did not consist in the absence of fear. He soon saw that every one is afraid in such circumstances, that courage consists in continuing at duty though one is afraid, that cowardice consists in shirking duty, and that it might even exist without active manifestations of fear. Even in the case of the boot-maker it was possible to find some ray of comfort. He would not have believed, nor would it have been right to have tried to make him think that the event did not matter; to have done so might have undermined whatever sense he had of the difference between right and wrong, and have left him rudderless. But it was possible to show him that every one does wrong, that his particular wrong was by no means unheard of, and that its very memory might help him in future. Further, he was shown that never looking at it caused him, when its associations were sufficiently stimulated, to fly into a panic, whereas if he would but look at it sometimes, he would get used to it. The mere act of talking about events of this kind to some one who can be trusted has of old been known to be consolatory, else the practice of confession would not have persisted, nor would it have been so often revived, as it has been, where it has fallen out of use. There is a type of person who needs a confessor: such an one needs the assurance that he will not be utterly cast out if his wrongdoing should become known; he needs to hear what a person of more sturdy type knows

already, that deeds like his have been done before by those who were still able to go on facing the world.

It is not being argued that every one needs a confessor, or that the practice should become general. The majority of people in this country at any rate get on perfectly well without one. We know that the reformers of the sixteenth century were men of a peculiarly robust type, and we can understand how they could see nothing but wrong in the practice. We know also that the system is one liable to grave abuse if the one who hears the confession is untrustworthy. Nevertheless there remains a large number of people who cannot get on without it, who feel the need to have the assurance from some member of the herd whom they can trust, that they have not transgressed the herd law to such an extent as to render them liable to be driven forth. However little inclined the doctor may be to take up the rôle of hearer of confessions, he has no option in the matter. For all these reasons, then, it is justifiable to unearth a buried memory. At first the patient may be shocked at his discovery, and here the tact, skill, and kindness of the physician are important factors.

An investigation of this sort may reveal much more than some recent error, and may be indicative of a long-standing unhealthy habit of mind. In the course of a certain case, the patient had a relapse on trying one day to read the newspaper. What had caught his eye was the honours list. He had got no farther than merely to see that there was one in the copy before him. By the method of free association it came out that, some months before, he had seen that a rival of his had obtained a knighthood. This started a long series of memories, from whose study it appeared that he had never been able to stand other people being recognized as better than himself; this was a thing that he had never realized before, but which he saw had ruined his peace of mind for nearly the whole of his life.

A patient may have several relapses of this kind, and it may turn out that they all refer to the same incident, or, on the other hand, each may refer to several distinct incidents or complexes.[1] The

[1] A complex is a set or constellation of ideas which are associated with emotional tone of marked character. Such a constellation may be either in or out of consciousness, and, as we have seen, it may have an effect on the patient in either case.

first event is apt to be rather disappointing to the physician, who feels that the patient ought not to have been caught in the same snare twice. It will be found, however, that patients do forget the things which they have been taught. It has been mentioned already that they will forget the theory of the emotional reaction, after they had shown that they had understood it thoroughly. Much more often will the unpleasant discovery be made that they have again buried complexes, which had apparently been fully exposed, and seemingly been accepted with satisfaction or at least resignation. Men who have thought themselves cowards, and who had had complete proof which has pleased them that they never had been anything of the kind, will forget the whole of the information which they had acquired on this question, which they will then have to receive afresh as if it were new. There is no use in being impatient at this; it occurs in nearly every case, and it is a great trial to the patience of the doctor.

Why should a man forget the pleasing idea that he had not been a coward? One answer is that though the thought that he was one was unpleasant, it was yet part of the complex of ideas which had made him ill and which had therefore got him out of the War. To lose any part of this complex may therefore be dangerous, for if the whole complex were to disintegrate, its results, the symptoms, that got him away from the War, might disappear also, and he would be eligible to return. All this reasoning would be, of course, unconscious. No one supposes a patient reasons this out. It is a defence reaction like those described on page 25.

Many of the relapses, however, will refer to other complexes. It is never one event that makes a man a neuropath, but always several.

The question therefore arises how we are to know when we have finished our work. This can be answered only on empirical lines. When the patient has continued to be free from any symptoms of importance for some weeks, we may infer that there are not many grave complexes left for us to investigate and deal with. We may let him go on the understanding that he will report himself should anything further arise. If he has been well taught, he will have acquired the art of settling a number of his subsequent difficulties for himself; as soon as he has begun to do this, his immunity against serious relapse is greatly enhanced.

CHAPTER IX

TREATMENT OF RESIDUAL SYMPTOMS

Consideration has now been given to the case of the patient who became well after simple explanation that his symptoms were due to misinterpretation of the emotional reaction, and to that of the patient who recovered but had relapses; we must now turn our attention to those conditions in which he does not lose any or all of his symptoms by explanation. It is seldom that he does not lose a considerable proportion of them. If he loses none, the fault probably does not lie with the method, but with its application. It has been rushed; explanations have been given before the doctor was in a position to be sure. He may have been right, but he may not have had sufficient proof; in this way he may have annoyed the patient, who will thenceforth tend to disbelieve all that he has to say. It must be remembered that we are asking these patients to change their whole scheme of thinking, a thing which, as we all know in our own lives, is difficult of accomplishment, a thing which can hardly be done at all unless there is complete confidence, and also a certain amount of liking on both sides. It is not easy to accept explanations from a person whom we dislike, and abruptness and early contradiction on the part of the doctor may easily create a very active feeling of hostility which will prevent any good from taking place. Unfortunately if such a disaster occurs the patient will not only not become better; it is certain that he will be made worse. There is no such thing as an indifferent result in psychotherapy. This is as might be expected. Each new treatment is looked forward to with hope, and if that hope be not realized at all, there will be a correspondingly great depression; further, every failure in treatment makes it harder for any subsequent attempt to succeed, for each tends to decrease the patient's faith in doctors or in treatment of any kind.

Care and absence of hurry will obviate most of these dangers, and

the physician will find that as he gets more used to the method, the various pitfalls will become easier to avoid.

The next problem may now be considered, viz. where many of the symptoms have disappeared, but some have remained; the patient is 75 per cent. better, and stays there.

We shall begin by studying certain examples where the patient is deriving some benefit from being ill of which he may or may not be conscious. Usually he is not. This, though not the only cause of prolongation of illness, is a common one, and to the doctor it may be very obvious indeed. The patient has lost the most disagreeable of his troubles, and what remain only prevent him from returning to the responsibilities of life; it will not do, however, as a rule to say this to him. The crudest examples are to be found in those who will obtain a monetary advantage from being ill. Instances of this are commonly met either under the Workmen's Compensation Act, or after a railway accident, where the patient will get a smaller sum if he gets well quickly than if his illness is prolonged. It is difficult to resist the idea that such people are malingering. As a rule, it is probable that they are not. By malingering we mean that the patient is saying that symptoms are present when they are not, or that he is fabricating and displaying physical signs like paralysis, which he himself well knows to be false.

Now let us suppose that our compensation patient has lost his headache, his dyspepsia, his insomnia, and has begun to get about, but that he still feels tired. This might quite well be expected at first, but the idea may strike him that if he returns to work, he will not be able to keep at it, seeing that he becomes tired so soon. This is a genuinely depressing thought, and one which may well be increased by a continuation of the fatigue feeling itself. In its turn, therefore, it will increase and prolong the fatigue. Though we may try with the utmost patience it will be extremely difficult to persuade him to see the train of events till his compensation has been settled, and then it will be quite easy. The post-War "neurasthenic pensioners" furnished another obvious example of this kind of thing. By the use of the methods already described it was easy to get rid of most of their symptoms, but it was nearly impossible to get them to feel quite well. A pensioner while he was ill was drawing a disability allowance, which, if he had a family,

would keep that family in the necessities of life. If he got well his personal allowance would drop considerably, and the family allowance would disappear. The man therefore who was getting well became, *ipso facto*, the prey of the most distressing thoughts. The streets were full of unemployed : what chance had he, with his long record of illness, to get a job by which he could earn his living ? He must have known that he had none. To become well meant literally that he and his family would starve ; to get well, therefore, was the greatest tragedy that could happen to him. He therefore did not recover, and it is difficult to conceive how such a combination of adverse circumstances could be overcome. The writer worked for some time among these patients, and does not remember any one of them who recovered completely under his care. A healer of note, who enjoyed a vogue in London for his ability to cure obstinate cases, visited one of the pensions hospitals to give a demonstration. One after another the men were seized with epileptiform fits, so that the healer was obliged to leave. One can well imagine the scene. His reputation was exceedingly high ; it was thought for a time that he could cure every one. These patients must have thought so too, for his fame was in all the papers. Each man must have seen himself cured by a method which was not to be denied ; each man must have seen his family starving as the result of this magician's visit. The terror throughout the hospital must have been extreme, and an epidemic of symptoms was the result.

With these crude examples before us there will be no doubt of the potency of the desire to retain symptoms, because of the fear of what health may bring forth. A good many civilians who are not caught in any compensation net can be persuaded to see the matter clearly. Some will find it out for themselves. A Colonial barrister had lost headache, dyspepsia, and some other symptoms, but had retained one of prominence, viz. that of fatigue when he stood for more than five or ten minutes. This symptom had been present for many years ; it had first appeared while he was pleading in a very long case, when he had had to address the Court for about a fortnight. In other ways he was not a strong man ; he had suffered from pulmonary tuberculosis. This was known to the judge, who allowed him on this

occasion to have a seat in Court and to speak seated. He had never given up the practice. All attempts to drop it had resulted in such a degree of fatigue that the privilege had been allowed to continue.

It was suggested to him that the advantage of retaining the symptom was so great that it would not be likely to disappear, that few barristers were allowed to be as good as the judge, and address the Court from the same favourable position as he enjoyed. Laughingly he accepted the view put before him. In a day or two, however, he came to say that he had been thinking the matter over, and that there was more in it than seemed to be present at first. He said that he had discovered that he was making money out of the symptom. Clients would come to him and ask him to take up their case, and he was in the habit of replying that he could not do so, because Court work fatigued him so much. As his advice and help were widely sought, what frequently happened was that he was then offered double fees. Still he would refuse. The client then usually said that if he would give his advice to Mr. So-and-So, naming another barrister, he would be glad to pay the patient his full fee. This arrangement would occupy a very small fraction of the time which would have been taken up if he had had to go into Court himself, and so the symptom had become the basis of a lucrative habit. The patient was surprised at this finding, and was not at all pleased at it; but in a few days he reported that his fatigue had almost disappeared.

The patient may not wish to get well enough to return home. This is unfortunately a common thing. Sometimes it will be stoutly denied, but often enough he will tell about it easily if the question is dealt with at an opportune moment. A lady, who had suffered chiefly from symptoms of fatigue for about four years, and had had many treatments which had resulted in her being nearly cured each time, but never quite, said that the proof that the cure had not been complete on any of these occasions lay in the fact that she always relapsed in the train as she was going home. She had formed the theory that her condition was incurable, that the good effect of treatment lasted only while she was under the personal influence of the physician, and that therefore it was of little use for her to try to get well any more. She believed that

she had never become well enough to stand the effort of the railway journey home without the immediate recurrence of her chronic exhaustion. The question was put to her: What was wrong with her home? She was surprised at it, but acknowledged that her mother and she lived an impossible life together. She thought the matter over, and decided that she must readjust things so that she would be able to face the difficulty. When she had done so, and had come to the conclusion that two people ought to be able to manage to live together, her symptoms disappeared, that is, she went home and remained well. She had seen that there was no inevitable fate whereby she must fall ill as soon as she came away from the protection which an institution or a doctor afforded, because she had learned exactly what it was that made her ill. The removal, from the mysterious, of the cause will of itself do much to make symptoms capable of being easily overcome, or at least more bearable. When patients are trying to fight some unknown force they have no plan to guide them; as soon as they see what it is they are fighting against, some accommodation can, in many instances, be arrived at. It is known that this patient has remained well for fifteen years, four of them with her mother, who then died.

Rationalization

The fear of going home usually has reference to some individual of whom the patient ought to be fond, but is not. This painful fact has usually been put out of the mind; it has not been looked at at all so far as this is possible, and therefore it has not been regarded as an explanation of the difficulty. The patient will say that the idea never occurred to her. The mind will have some explanation, and if the right one is not to be looked at, some plausible one is invented, and given as the reason. This is called *rationalization*, i.e. a reason which has been made. It is one of the commonest phenomena to be met with, and we have already met with it from time to time. When the right explanation has been arrived at, it may not always be easy to get the patient reconciled to making a new effort to make a fresh adjustment; in some cases indeed it may be impossible; in the case just quoted it was done after careful thinking on the part of the patient, who tried to see how she could alter her own errors in the partnership, and for four

years at any rate she succeeded in making things successful. But too often the patients cannot see the faults on their own side and see only those of the other member. This depends to a large extent on the presence or absence of the superiority or inferiority feeling (see page 124). It may be true, of course, that the fault may be on the other side, and in that case it may become necessary to determine whether the home environment should be changed. Sometimes this may be the only thing to do, with any prospect of success. The grown-up daughter of the active mother, who gives her nothing of any importance to do except to arrange the flowers and to clean the parrot's cage, would obviously be better out of the house, earning her own living. Mother-in-law combinations, indeed most " in-law " arrangements, are often better broken up. These things are often clear to the patients themselves, but they may need the backing of the doctor to get them accomplished. There are other partnerships which cannot be dissolved ; and if possible the patient must then be encouraged to get some employment outside the house. It should be something about which she can get really enthusiastic, and this is therefore an individual thing about which no rule can be laid down. If such an interest can be obtained, the patient, now that she knows that her symptoms are due to the home environment, and not to some baffling disease, will probably be able to manage her life better.

Too much comfort in an institution may make the patient unwilling to depart from it, especially if the home is in a poor or shabby locality. This must simply be faced.

It was often observed at the Cassel Hospital that during the last week before the patient returned home there was a return of symptoms, and there was little doubt that there was an increased liability to minor accidents such as spraining one's ankle. The inference that these occurred purposely though unconsciously was strong. If the patient had seemed previously to be well, it was pointed out that these symptoms were produced, unconsciously of course, for the purpose of delaying discharge. Many patients, if they had sufficiently absorbed the teaching, saw this and their difficulties disappeared. Some did not but were nevertheless discharged, sometimes with quite good results, but sometimes not. Others were able to play on our kinder feelings with such skill that

they were kept on. As a rule this was an error. Many of these after months of residence were no better.

A more serious thing, which may prevent the disappearance of symptoms, is that the patient leans too much on the doctor. This leaning may be only the natural leaning of the weak on the strong, or it may be due to a pleasure in being in his society which may amount to being in love with him. The last danger is a real one. This has been mentioned already in Chapter VI, but there is a little more to say about its management here.

Management of Transference

We saw that the psychoanalysts have enlarged on this rather tiresome and sometimes awkward complication of medical practice, and have given it the name of transference; the meaning of this is that the affection, worship and trust, or conversely the hate, contempt and distrust, which the patient felt previously for some one else is transferred to the physician. There are several interesting points in this connection; the physician does not become loved or hated, honoured or feared and distrusted, for those qualities only which he has displayed in himself. He takes on the virtues of the person from whom the transference has been made, and enjoys or suffers on account of the virtues or shortcomings of this other person. The person whom he commonly represents is ultimately the father of the patient. A curious example may be seen every day by one who is the head of an institution where such patients are congregated. Here we have an assemblage of adults, each of whom is in a personal relation with the physician. It has been agreed tacitly between each patient individually and the doctor that they will tell him everything that may be of interest in their lives, that they will withhold nothing. If the physician is also the head of the place, he will soon find that there is a large series of exceptions about which he will obtain no information. One patient may be grossly annoyed by another, but he will never report it. If the physician knows of it and asks why, the answer will be that it would not be fair, and the absurd phrase will almost always be used that it is not fair to tell tales out of school. Even if it be pointed out that this is not a school, but a place where the person who is being annoyed is paying money to get a result, which is

being jeopardized by the conduct of the other person, the answer is still the same. The physician will not be unjustified if he then considers that he has become the subject of a father transference, and he will find that in other respects he enjoys all the prestige which the father of that person enjoyed, but also that he is credited with his defects, and suffers accordingly. The opportunity should be taken of showing the patient what has happened, and from this beginning much can be done to help him. It can be demonstrated that he has in other ways never left off leaning on his parents, and that when things have gone wrong in the world he has not tackled them by himself, but has looked for and leant on his father, if not in the actual flesh, then in the person of a substitute.

One of the difficulties is that our feelings are not simple, not those of love *or* hate, admiration *or* contempt, but always a mixture. To our parents we felt affection because in the beginning they cherished us, gave us much comfort. But also we felt dislike and fear of them because they thwarted and punished us. As we grew older we learned that it was sinful to regard our parents as other than unusually good and great people, and therefore one's dislike of them tended to be repressed and to cause mental conflict if it was stimulated to come into consciousness, even if it never arrived there. Later still for some people the attempt to admire their parents becomes more difficult by the bad behaviour of the parents; then if the early dislikes have been seriously repressed, new serious conflicts may arise; often discussion will relieve much of this.

These transferences may be curiously specific and produce what are almost illusory appearances. I was once asked by a patient whether I possessed a black coat and vest to be worn with striped trousers. As I never wore such a suit in the hospital I told her that she had never seen me in it. She then said that though she had not seen me in it lately, she could have been sure that at an earlier period I had worn it always. She identified the time which had been one in which she was afraid of every one. She then identified the suit as being one worn by a schoolmaster of whom she had been afraid. She had evidently transferred to me some of his qualities, and his clothes along with these.

When the transference has taken the form of adult sex love the matter is more difficult. From time to time patients will be found

who, after a good deal of difficulty, will say in so many words what it is that they feel, and the doctor will not be able to ignore the fact. If the patient has no difficulty at all in saying it, she is probably insane; the usual thing in a sane patient is that the confession is made only after a struggle. She desires to say it, but cannot get it out. Sometimes it is only hinted at, but so strongly that it cannot be ignored. The doctor should not change his manner nor be offended, and he must not let the patient think by word or deed that anything dreadful has happened. He should point out that she has become too much attached to him, is too reliant on him, that it is a thing which is apt to happen, and that if it is only frankly recognized it will do no harm, but that she must try to keep in mind the goal of health for which she is striving. It will often be found that she felt much the same towards her own father, and then the management of the complication is that of the so-called father complex. There are those who would insist on her seeing that her affection for her father had been sexual in the sense of the word in which everybody commonly uses it; but it is also possible that the affection which the patient felt for any other man, after her father, had in it that hero worship which she had previously felt for him, and that there is nothing sexual present in the usual connotation of that word at all.

Standards of Health

Apart from the special question of prolonging absence from home, these patients have often a quite impossible standard of health. They have created an ideal person who has always a perfectly comfortable body, which never aches and never gets tired. They will be willing to return to work when their own body conforms to this ideal; they really do not seem to know that every one has discomfort nearly every day; sometimes they never knew that fact, sometimes they have merely forgotten it. Trotter's statement that severe pain occurs to almost every one every day will certainly be strange news to them; they will hardly believe at first that severe pain can exist as a phenomenon at all in a person who is in perfect health. It is probably true that the profession on the whole has not recognized this either. Trotter's paper on "The Physiology of Pain" (*Medical Science*, Vol. IV, page 44), is worthy of study.

By talking over freely the patient's dreads and fears of the ordinary world, he will, in favourable cases, gradually be led to see that from one aspect the reason why he does not get better is that he does not wish to. He does, of course, wish to get rid of his discomforts, but he does not wish to face responsibility. He would like to experience all the pleasures of being ill without its drawbacks, and if he can but see this, he will soon be well. If he can see that he has either misinterpreted some emotional reaction, or made too much of some trivial ailment, he will cease to do either. He may say, even if he does see these things, that he does not know what to do so that he may benefit by the knowledge, and that he does not understand what attitude of mind he is to adopt in order that he may feel well. There is no need for him to do anything. If he has really grasped the situation, the illness will fade away gradually.

There are, however, many patients whose residual symptoms are not dependent on a desire to retain the advantages of illness which can be met by simple discussion. There are some constitutionally too feeble to stand up to the difficulties of the world. They may see that they are gaining an advantage by being ill, but they cannot face the world. If this kind of patient is forced to make the attempt he will collapse very quickly. It is difficult to distinguish between these patients and those whom we have just been considering, but the kind we are now talking about will soon display their inability. It is well, however, not to put anyone too readily into this rather hopeless class. It exists, but the doctor must be on guard that he does not give up trying to get patients back to normality too readily. It is a habit which a doctor may fall into and then he soon begins to feel that most nervous patients are incurable.

Phobias

There are other, patients who are perfectly willing to face the world as is shown by their constant efforts to keep at their work and perform their social duties, but whose lives are rendered miserable by the continual presence of symptoms which may not be amenable in the least to any sort of explanation on the level of consciousness. The most important of these are the patients with a phobia.

The Phobia deserves special consideration not only on this

account but also because it may occur mono-symptomatically, i.e. the patient may be quite well unless he is put into a position which stimulates the phobia. A patient with a phobia of railway trains may be perfectly well if he keeps out of trains. This is not universally true, for phobias may occur also in cases with a rich symptomatology.

A phobia is a specific fear which the patient himself knows is ridiculous but which he cannot overcome. It differs from the psychotic fear, such as that poison is being put into the food, where the patient is certain that the idea is true. It differs from the ordinary neurotic fear, such as that of impending insanity, in that such a patient believes in his fear, and has as we have seen some grounds for doing so.

Phobias may be divided into two classes, those of environment and those of disease.

Phobias of environment are related to heights, closed rooms, open spaces, church, thunder, theatres and so on. Fancy Greek names have been given to them, acrophobia, claustrophobia, agoraphobia, and many others. They are of no value, for they tell us nothing of why the patient has the fear, and the important thing about a phobia is to find out why it arose. The real fear is never about the circumstance to which it has become attached in consciousness. Phobias of environment may be abolished for the time being by the presence of a trusted friend, but this is not always true.

The phobia of disease, of which syphilis is the commonest, is frequently relieved for the time being by special physical examination, but if it has been a true phobia—an irrational fear—it will return. Any patient may have substantial though erroneous grounds for a fear of disease which is removable by explanation. That is not a phobia, where the fear is always groundless so far as the patient is aware.

If the phobia is a solitary symptom the doctor will of course hear of it, but where it is only one symptom among many the patient may not tell of it for fear of being laughed at.

Thus a woman of fifty complained greatly of exhaustion, general anxiety, outbreaks of temper which had made social contacts almost impossible. She said nothing about any phobias. After

about a fortnight she said she had had a bad night because of owls in the garden. She was asked if it was the screech that had disturbed her. She looked surprised and said: "No, the beating of the wings." She said that was terrible, but could give no reason. The idea was followed back, and it appeared that she had always been terrified by the beating of birds' wings. With encouragement she remembered that when she was about ten years old a brother had in play shut her up in a barn, that suddenly a hen had fluttered about her head, and that she had fainted. That did not, however, seem to be the beginning. She felt that she had been frightened before that, and indeed the reaction seemed excessive unless she were already afraid of birds' wings. Then came a vague recollection of being chased as a very little girl by a goose with outstretched wings. It was not clear, but she felt it had happened. This seemed to explain the phobia which did in fact disappear, so much so that she was able to take up poultry work as her occupation while convalescent in the hospital: there is indeed a photograph extant of her standing with hens on her shoulders, in her arms and round her feet. Luckily for psychological investigation we were able to get this story confirmed by an old nurse. An interesting addition is that a few days later she told me that she had always been afraid of going to Heaven; she had often wondered why, but now knew it was because of the angels' wings. This is an interesting example of how a repression spreads to many collaterals which then form a complex.

It will be clear why bringing this repressed material into consciousness abolished the fear. It was essentially a childhood fear. By repression it was shut off from consciousness and therefore never could have adult judgment passed on it. As soon as it was admitted to adult consciousness it was seen to have no value.

We see also that the specificity of the phobia is a phenomenon easy to understand. This is brought out again clearly in the following example. A young naval lieutenant had a phobia of the dark, but only when he was ashore, never at sea; he had had it ever since he could remember. He was asked to think of his childhood, and especially of the evenings when the house was dark. Such recollective thinking should be practised in the relaxed condition recommended for free association. This patient remembered,

after careful thinking conducted in this manner, that he had to go up two flights of stairs when he went to bed, that the middle landing was the place of terror, that he used to approach it slowly, and that when he had got to within two steps from the top of the first flight, he rushed it, ran to the foot of the next, and tore up the remainder of the stairs, not pausing till he had reached the shelter of his own room and had shut the door. Then he remembered one night clearly when his fear had been particularly bad, when he could hardly be induced to go to bed. It came into his mind that what he had been specially afraid of was a curtain which hung outside the drawing-room door. He was afraid that he would see a face looking round its edge. He then recalled that he had seen such a face the night before, and that he had rushed shrieking upstairs to his own room. He further knew that this had been the first occasion of the nightly panic. His mother had come up, and had upbraided him for being a coward. He then remembered that the moon had been shining, and that it had made shadows, and he believed now that that had caused his eyes to play him a trick. He knew that it was not any fear of the supernatural, but of real burglars, which had troubled him, and he came to the conclusion that this accounted for the curious circumstances that he was troubled with the phobia only when he was on land or when the ship was in port. At sea there are no burglars. When these things had been worked out he lost the symptom entirely, and it did not return.

We may conceive that before the symptom had been explored, darkness acted as a stimulus for the burglar complex. The child did not wish to remember this, both because of its own inherent unpleasantness, and also from the implication of cowardice which it carried. The facts were therefore kept in the unconscious; they were repressed; the emotion of fear was attached to nothing, and appeared as a senseless thing. If the child was ashamed to remember the cowardly act, much more would the young sailor desire not to do so; and therefore he had never remembered it, and the fear had remained unattached. When the reason was brought to light, it was not difficult for him to see that there never had been any cowardice in the matter at all, that no one could have expected a child to have behaved otherwise than in the way he did. Darkness ceased to have any more power as a complex stimulator, for he

knew that burglars are uncommon people to meet, and not very formidable when met, compared with many other enemies whom he had encountered without much difficulty. It was not easy to get him to make the exploration necessary for the recollection of the story; there was much resistance, evidenced by his frequent declaration that it was impossible to remember things which happened so long ago, by his saying that no ideas came into his mind, by his saying that the process was making him feel confused and giving him a headache. Such signs of resistance are usual during the course of an investigation of the kind, and require patience and firmness to be overcome. When the emotional cause has been obtained, and talked over, the relief is very great. The confusion and headache which are encountered in such an investigation often constitute a very real difficulty; they may make the doctor afraid to continue, but if he is sure that the patient is of the neurotic and not of the psychotic type, no harm will follow. The latter kind of patient can be made definitely worse by being made to follow up an investigation of this sort; this happens seldom to the neurotic.

A regimental sergeant-major, who had been taken prisoner by the Germans fairly early in the War, became intensely depressed when he got home after the Armistice. He said that the reason why he was so, was that every morning as he shaved he felt tempted to cut his throat, and that he had the fear that he would do so. He could not give any explanation why he felt this. He considered that it was unreasonable that this should have come on after he had got home, where he wanted to be and where nothing disturbed him, when it had not been present in Germany where his environment had been very miserable. He dreamed of being in a barber's shop with his throat cut; he was obsessed by a recollection of his boyhood, when he had seen a body on which this injury had been inflicted. He was also greatly upset by a story he had seen in the papers of two brothers who lived in America, who had quarrelled. One had slashed the other across the eyeballs with a razor and blinded him; the blinded man had forgiven his assailant. He was then asked whether he had a brother, and he said he had, that this brother had also been taken prisoner, but that he had disappeared and that nothing had ever been heard of him. He did not know of this till he had come home. He was asked to tell all about this brother.

This proved to be a long story, but its elucidation threw an entirely new light on his own case, and was followed by the disappearance of his symptoms. When he himself was taken prisoner, the Germans were brutal towards the convoy, and though he was the senior prisoner present, and as such somewhat responsible, he had made no comment or protest. One prisoner was killed by the Germans, but again he did nothing, fearing his own fate. No one blamed him for not protesting; to have done so would only have brought useless punishment on himself. In Germany the thing did not weigh on his mind as a neglected duty.

He came of a family of regular soldiers; his father had been a regimental sergeant-major; he was one himself; and the brother, before the War, held the same post in his father's old regiment. He had no admiration for his brother. He was immoral and drank, and was always in trouble. One day the brother wrote to him saying he must have money by return; the regimental accounts were about to be made up; he was short, and could not find anyone from whom to borrow. If the matter were exposed he would be punished. The patient was very angry; he thought with horror of the disgrace to his father's memory, and he wished that his brother was dead, and quite definitely that he would cut his throat. He forgot he had so wished, and when he recollected it while telling the story he trembled and sweated. He was very gloomy and depressed for a day or so, and it almost seemed as if he had been made worse; but this soon passed. Now when he knew that his brother had been taken prisoner and had disappeared, he felt sure that his brother's fellow-prisoners had also been ill treated, and that he had protested, and been murdered for doing so. Here, then, was the man whom he had thought good for nothing and worthy only to have his throat cut, the hero, the much better brother of the two. The only meet punishment for the patient would be that he should do to himself what he had wished for the brother. It will be seen that his dream of his own throat being cut was only a pictorial representation of this thought, that his agitation over the story of the American brother was because it bore on his own case. It will also be seen that the real cause of this agitation, viz. that he had wished his brother's throat cut, had been relegated

to the unconscious, where, however, it was still alive and active. His case needed only free discussion for the symptoms to be dissipated. He soon saw that his fear depended on a series of assumptions, for none of which was there an atom of evidence. He had no proof that his brother had done any of these things in Germany, nor that he had been murdered. Further, he was told that most people have the death wish for some relative, and that it is a totally different thing from a wrong act.

A symptom may be of such recent and dramatic origin that it will often seem surprising that the patient did not work it out for himself. A man who was seen in 1922 had the fear of being alone in a railway carriage. By the method described he arrived at the fact that it had been present only since 1917. By dwelling on the subject for a little he remembered the occasion on which he had first noticed it. He was travelling home from the city in one of those compartments which are semi-divided from the others, where the partition does not go up to the roof. The division in which he was seated was empty of other passengers, but there were plenty of people in the other divisions. He was reading a book, and was immersed in it. He suddenly heard a terrific bang, was greatly startled, turned round and found that he was quite alone in the carriage. He was seated on the side away from the platform, and rushed to the other side to get out, but found that the train was just leaving a station, and that it had gathered a fair amount of speed. He was afraid to get out, and he remained in the carriage panic-stricken till the next station, where he alighted. He had never travelled in a train by himself since. Now it is interesting that the man had never tried to think out why he had been so alarmed; he had not even tried to think what the loud noise could have been. Without assistance from the doctor when invited to do so, he had no difficulty in constructing a reasonable view of what had happened. At the station in question it was obvious that the rest of the passengers had got out, and that, after the manner of outgoing passengers, they had left the door open. He had not noticed that anything of the kind had occurred, because he was immersed in his book. The train had then started with the door open, and this had been banged-to by some porter when it had already got nearly out of the station. Now why the panic?

A few days before a bomb had fallen into the building in which he worked, while he was in it. He had not been hurt, but he had been frightened, and this second "bomb," for he knew now that the sound had resembled that, had been too much for him. Why was this never formulated? Because he was ashamed of it; he was ashamed to think that he had been moved to such an extent by something so much less than the men at the Front were enduring without panic every moment, and he was unable to meet this self-accusation of cowardice. That the whole incident should have been forgotten may be regarded as another instance of the defence against the emergence of the coward complex into consciousness. There were many civilians who struggled against this self-reproach. To them it could be pointed out that they were untrained and unprepared for such emergencies, and that it was absurd to make much of the events which were disturbing their peace so long after they were over. There was no feeling of *esprit de corps* in an office in the city such as was fostered at the Front, no feeling that men must do or die inculcated as part of the daily routine. How a man behaved at home was no real criterion of how he would have behaved at the Front; and as he had no duty to shirk, there was no question of cowardice involved, as has been explained in previous chapters. Considerations of this sort were put before this man, and in a day or two he was able to take a journey by train alone without discomfort.

In all these examples the buried complexes were fairly easily got at, and the fact that this may be so is important, because it is probable that doctors do not as a rule make enough effort to get these stories; too often patients have said that they had been laughed at for mentioning their fears. There are, however, patients for whose cases a very long time may be required. These patients are more often those in whom the phobia occurs as a single symptom.

A young woman had fear of walking in the streets or driving her car more than a few miles from home unless accompanied by a friend whom she knew very well. If she persisted panic ensued; usually she turned round and came home as quickly as possible. She had nearly given up unaccompanied railway journeys, which were always worse if the route were unfamiliar. Otherwise she was an active, busy, cheerful person who enjoyed life if she were

not threatened with having to go somewhere alone. This is of course a very crippling state of affairs. Shortly before these symptoms came on she had been engaged to be married and the engagement had ended unsatisfactorily. This was the only emotional event in the history. She did not think it had upset her much, and indeed it seemed too small a thing to have been followed by such a formidable symptom. The symptom lasted about ten years. She was seen off and on for five of these, getting a little better and a little worse, but never free to go where she liked. She was not afraid of assault of any kind which might take place on the road. The ending of the engagement had followed the young man's departure abroad, and seemed quite unconnected with any fear of sex or marriage. After months of investigation, certain childhood memories began to emerge, and as in the case of the patient with the phobia of birds, these were quite vague—memories of fantasies of being eaten in childhood, that if you travelled without protection you might go on and on for ever, that if you do not know the people you are with they might not be real people and so not protective. These memories had of course become overlaid when childhood was past, but became activated, but not consciously, when there was a check to adult development, under the stress of the love affair.

It does not seem difficult to believe that the patient when abandoned by her fiancé in whom she had put trust should have regressed to the position of desiring that protection from her mother, a responsible adult, which the child gets. This seems a common explanation of many neuroses. It, however, entails the liability of the reactivation of certain less desirable childhood qualities such as the belief in highly disagreeable fantasies. When these had become conscious they were judged by the adult mind and their power evaporated, so that for two years now this patient has been free.

Exceptionally a patient may overcome a phobia by refusing to be beaten. A man of forty suffered for sixteen years from a phobia of streets and enclosed crowded buildings, so that he had become a prisoner in his brother's house, not daring to go out except on very few occasions. He was very religious, but unable to attend church, which he wanted to do very much. He was totally unable

to give any reason for this. In his history there was a story of fainting at a missionary sermon in church where some medical details had been given. This gave one clue; he had thought that fainting was a sign of heart disease, and that therefore he might fall down dead in the street. He was reassured on that point, and then made up his mind that he must face the thing and go out. There was no pleasant fading of the phobia, however, so it is improbable that the fear of heart disease was the whole story. He was, however, determined to win and after three months of desperate struggle he succeeded; went to church and went about his business as he wanted. I think that his flaming religious enthusiasm assisted him a great deal and also it is probably easier to get on with a difficult task if some one is present who backs one up. It was not possible to go deeply into his case as he had a strong objection to what he called psychoanalysis, and once he had given such history as was conscious he refused to give more.

Phobia of Disease. This is usually a cover for some other disagreeable idea as in the case of a young man with a phobia of syphilis. Over and over again he had received proof that he had no sign of the disease. The investigations showed that he was afraid of his mother who had forbidden him to marry, though he wanted to do so very much. It seemed clear that the fear of syphilis had been acquired after he had seen some alarming notices about it. He had unconsciously welcomed it because it had provided a reason for not marrying which was less humiliating than the real one, that he was afraid of his mother. As he imagined it, the syphilis had been acquired innocently and so there was no shame attached. After this had been talked out he was able to face his mother and marry. I have described in considerable detail how this was done in this instance elsewhere.[1]

Another example may be cited. An ex-officer had a phobia of tabes which he knew was a syphilitic disease. He knew also just when he had acquired the disease, during the War. After some history-taking, a memory came to his mind which had been forgotten for five years. He had been guilty of a gross act of cowardice of a cold-blooded, deliberate kind which had not been discovered. As soon as he was off duty he went to a prostitute, and immediately became

[1] See "An Introduction to Analytical Psychotherapy."

obsessed with the fear of syphilis, which soon became the fear of tabes. He thought of nothing else. The fear seemed to hold such complete possession of the field of consciousness that there was no room for the memory of cowardice. The fear of syphilis was thus, to a certain extent, protective to his peace of mind, though at great cost. Most regular officers would, however, prefer to think that they had syphilis, even though it were their own fault, than think that they had perpetrated a deliberate act of cowardice. When the memory was revived, the patient became profoundly depressed, and it must be said that if a patient discovers something so disturbing as this he may become suicidal. This, however, is a risk which can be guarded against provided that the doctor is aware that it may happen. After a few weeks, the patient was able to see that there was no use in being too remorseful about it, that if he had been a bad soldier he was all the more called on to be a good citizen. He lost the fear of tabes entirely, which was of course of no further use to him, and made a good recovery. It must, however, be repeated that an investigation of this kind may be dangerous. So complete a forgetting of a striking incident in one's adult life could happen only if the thoughts connected with it were too intolerable to be borne. The doctor must be careful not to rush the patient. As, however, the results are often strikingly beneficial, and the illness crippling and not very prone to spontaneous recovery, the risk should be run. The more, however, that the doctor departs from history-taking and explanation of the misunderstandings, mainly medical, which have arisen through the years, the more deep analysis in short which he undertakes, the more must he be prepared for grave happenings. Unless the phobia yields easily, as in the earlier cases described, the beginner had better leave the case alone.

Phobias of Killing and Suicide. There is one class of phobia which must be specially mentioned, viz. the fear of damaging, even murdering some one, or of committing suicide. Both may be concealed and appear as fears of knives, of high places, or some other thing. The suicidal patients referred to are not those who threaten to commit suicide if they do not get their own way. The patients now referred to dread it. This condition may be easy to treat or difficult. A flying officer had fear at high altitudes, but no fear of flying twenty feet above the

ground, the latter being of course in reality much more dangerous. It came out that some of his relatives had become insane, and he dreaded that he might also. He believed that insane people all tended to commit suicide, but that one had about thirty seconds in which one could still exercise control. If you are only a few feet off the ground this would give time to land; but if you are 6,000 feet up you would become insane and commit suicide before you had time to get down. A discussion of his chances of becoming insane and of the relationships between insanity and suicide quickly put an end to the fear.

On the other hand, fear of suicide may betoken a conflict between a wish to commit suicide and the opposite. Discussion may be able to put the general situation in a better light, but if the patient shows much depression as the result of these discussions great circumspection is called for. A man had a fear of oncoming trains and shrunk back on the platform if one came into the station. He was married, but had also certain homo-sexual feelings which distressed him greatly. There was great conflict which he did in fact solve by suicide.

The fear of killing some one points usually to a desire, which may be conscious or not, of really killing that person in conflict with a fear that the deed may be carried out, and in conflict also with the idea that such a wish is very sinful, and frequently with the thought that the wish might actually bring about the death, or at least help to do so. As has been pointed out death wishes are common, and it is often a help to these people, who think all kinds of wishes nearly as wrong as wrong deeds, to consider that as they usually hold that good intentions never carried out are of no value, so bad ones never carried out cannot be very important. As regards a wish being really operative, it can be pointed out that this is a relic of primitive magic of which most people have a little, but which also should not worry us.

When the symptom is fear, say of knives, and if questioning indicates that the fear represents a desire on the patient's part to kill his wife, which fear previously had not been conscious, we are probably in the vicinity of something serious. A man, who had a fear of knives, said later it was fear of murdering his wife of whom he was very fond. On further investigation, it turned out that he

had fallen wholly out of love with her, but had fallen in love with some one else. The conflict on this account was severe. Circumstances compelled him to arrange to return home, and almost immediately he committed suicide.

This, then, is a kind of phobia which should be approached charily by the beginner. In fact any phobia which does not yield easily to superficial investigation should be relegated to the specialist.

There is another point noteworthy in these cases. As soon as the unconscious material was made conscious in the favourable cases it ceased to have credibility. This is one of the diagnostic points between a psychosis and a neurosis. Had the patient who recovered the infantile dread that people on a strange journey were not real people not seen at once that this was nonsense, had she, in short, believed it consciously as she did unconsciously, then she would have been insane. Certain childish beliefs, if retained in consciousness or revived into it, would in the adult be called delusion, but in the child normal.

Phobias about Sleep and Insomnia. In the section on insomnia it was promised that something would be said later about those cases where simple explanation or the skilled use of drugs did not procure sufficiency of sleep. It will often be found in these circumstances that the continuation of the symptom depends on phobias about going to sleep which the patient does not understand, but which are connected with the fear of some of the consequences of sleep itself, i.e. the patient is afraid to go to sleep. One of these is the fear of bad dreams. This was specially common in the war cases, where night after night a man would close his eyes at the risk of at once being engaged in scenes even more horrible than any he had gone through at the Front itself. Some of these men deliberately kept awake. These battle dreams were not difficult to get rid of as a rule. The man was refusing to think of the War by day, and it came to him at night when he could not keep it away. The question to investigate was: Why was he trying not to think of it by day? It was always difficult to get him to approach the subject; he would say that it did not interest him, he was now out of it, and why should he go back, any more than he need, to all that horror? If, however, he was bribed by the promise that if he would only talk about it a speedy cessation of war dreams would

ensue, he would usually do so. It would then be found nearly invariably that he had the idea that he had been a coward, and, when this was satisfactorily disposed of, the battle dreams would cease also, sleep would return, and the patient be better in every respect. Further, he would find that he could now think without discomfort of the War by day, and thus be able to take an interest in what every one else was interested in; in this way he would escape from that mental isolation which afflicts those who dared not think of a subject which was the only subject of general interest to every one else at that time.

In civil life the fear of bad dreams is not so common, but it may be a factor in insomnia. The treatment will then be to discover what the bad dream is about. Meantime we have to consider the case of the patient who is afraid of sleep itself. Now it is very rarely that a patient will say that he is afraid of the gift of sleep. If he says it right out it is probable that he is insane. Some psychotics are afraid that they will be damaged, or be taken away in the night, or be raped, or suffer in some other way if they fall asleep, and they will say it quite openly. It is not with these that we have to deal. The neurotics, on the other hand, who will not say willingly that they have this fear, possibly do not know that they have it themselves. A man was in the habit of waking at four in the morning, for which he could give no reason. In the course of taking his history, the reason came out. He had had gonorrhœa, and had been treated by large libations of barley water. He had been told to drink freely of this, and, being a conscientious man, he had taken more than a couple of gallons a day. He had felt rather distended, and the treatment had made his heart uncomfortable. He then imagined that the disease had attacked his heart, and he considered that it was probable that he would die. The time of death is usually at four in the morning; this was a thing which he had always believed, and he had wakened up at four to prevent his death. He had not remembered that death occurred at this hour till he began to give his history; it came out gradually while his memory was being stirred. He was a little sceptical about his power to awake himself in this fashion for this purpose. When he was reminded that a man may wake himself early merely to catch a train, he said he knew all about that, and saw that there was no difficulty in his

doing so for the more important object of keeping alive. Why, however, was the fear of death so great? This came out later by the method described for investigating subconscious thoughts (see page 127). He had often had fear of death. Then the memory came to him of a sermon heard in childhood where the fear of hell had been preached, and its certainty promised to those who were cut off while actually in sin. The gonorrhœa supplied that ingredient, and there was the necessity of early waking now completely explained. After this he slept longer every night.

A further point of interest in this case was that the man stated, after everything had come out, that he had no fear that he might oversleep himself and so miss what he was wakening for. He was a traveller, and accustomed to wake at odd times, and so knew that he would awake in time and that there was no need for him to resort to an alarm clock. His scepticism was itself conditioned by repression. To suit his theory of illness he had repressed *ad hoc* something that he knew all about, something he used every day, viz. that he could arrange to awake whenever he wanted to do so. It is a good example of the specificity of our repressions.

It is more common for patients who are afraid of sleep to have difficulty in getting off. These are the patients who do not discover anything about their trouble till hypnotics have been given up. One of them had had drugs for many months before she came under care; she had a great many other symptoms, and therefore her drugs were not interfered with. Even so they had done her little good. With ordinary doses she did not get more than two or three hours of sleep. Nevertheless she improved in her general condition, an example of the fact that want of sleep is not the cause of the disease, but only one of its symptoms, though it may bring others in its train. When she was decidedly better in her general condition it was suggested that as her drugs did her so little good, she might as well give them up. To this she agreed, and on that night she said that she did not sleep at all, and she further stated that a new symptom had arisen, viz. fear of the dark. She noticed it as soon as the light had been put out and she had attempted to settle down to sleep. On investigation, however, it appeared that it was not new, but something which had been revived; there can be little doubt that the hypnotic had played the part of damper to it, as

of course any sedative can to any symptom, and so prevent its appearance in consciousness. It happened that she was not seen the day after the first sleepless night, and she had another night of sleeplessness and fear of darkness. She was by this time very willing to try to find out what fear of darkness meant. She was asked to think of the idea, i.e. darkness, and report what came into her mind. After a pause she said, "Not death, anyway." This is a common way of giving a hateful association. We had not been talking of death; no hint of the idea had been suggested, and if it were not death of which she was thinking, there was no occasion for her to have mentioned it; in fact it is obvious that she could not have done so. However, it was true that death was not the very first word that had entered her mind; immediately before that there had come into her mind the picture of a very dark and cold chapel; then had come the idea "not death." This chapel she knew was a cemetery chapel to which she had been taken as a child of eight to her grandmother's funeral; she had been dragged very unwillingly to it. The reason for this unwillingness was that a day or two before this she had been taken to see the dead woman, and been made to touch the cold cheek with her own; this had given her a great shock. Sleep and death were also associated with each other, as indeed they are with most of us; sleep is the brother of death; we therefore must not attach too much importance to that. If the fact that sleep and death being associated should make us all fear sleep, there would be more insomnia than there is. We have not all, however, got the fear of death. With most of us it is usually an unimportant question; and so we have now to account for her fear of death, which was symbolized by fear of darkness and fear of sleep. Most of us do not fear death because we do not think it is the least likely to come our way. She, however, had been told by a doctor that certain of her headaches were due to a congestion of the brain. She knew that apoplexy had something to do with blood on the brain. Her mother had died of apoplexy, which made her feel that she was the more liable. People were moreover always assuring her that in many ways she was extraordinarily like her mother. She was therefore always expecting to die. The darkness had to do with the darkness of the chapel, which also was associated with her own death.

Here surely was a constellation of ideas, associated around fear of the dark, which were enough to keep a nervous person awake. On the night after these things were discovered she slept four hours, or double what she had obtained a week before from the use of hypnotic drugs, and thereafter the symptom steadily disappeared.

The fear of death is the commonest of all the fears that act in this specific way. Theoretically any fear may do it. Some patients seem to have acquired what may be called a habit of not sleeping, and this may be due to another fear, viz. that of failing in night duty. A woman had nursed a relative for years, and become accustomed to waking easily. The patient died, and though the duty had come to an end the habit of waking persisted. It will frequently be found that such a patient is indulging in some self-reproach in connection with her attendance on the dead beloved. She was not ungrudging enough, or once in the course of years she took a week's holiday. Such an one may be really doing penance, and with a little sensible talk will see that she has done enough.

This patient's insomnia, then, did not in fact depend on fears about sleep itself, but on certain events and their evaluation which had for long been buried in the unconscious. The treatment, which was of assistance, implied an analysis of this unconscious, but an analysis which does probably differ somewhat from that of Freud. It is narrower in its scope, for it deals mainly with the symptom presented at the moment. Freud, as I understand, is not specially interested in particular difficulties, but seeks to investigate the whole personality. The getting rid of an individual symptom has little value for him, because of the belief that until the whole personality has been analysed other symptoms will take their place. Hence the analysis is more widely diffused, and, as some of us think, tends to become interminable. The analysis recommended here also differs from that of Freud in that it does not depend on a theory of infantile development, which it is alleged will be found with great regularity when the wider analysis has been practised. However, to search beneath consciousness in order to find the latent as opposed to the manifest or at least easily discovered cause of symptoms, is an idea for which we are entirely indebted to Freud; it is from his work that we have learned the value of doing so.

Many examples will be found where something more than ex-

planation of the manifest symptoms and correction of the patient's interpretation of these are necessary, but where prolonged deep analysis on the Freudian model is uncalled for. Many of these can be undertaken by the general practitioner if he does not mind spending some time on them. The great thing is to allow the patient to talk without criticism, without giving him the feeling that he is boring the doctor, making sure that he will not feel he is being laughed at. I have described this kind of analysis more fully in " An Introduction to Analytical Psychotherapy."

It was stated above that the soldiers were unwilling to talk about the War because it had ceased to interest them, and it was shown that in reality they were too afraid of the subject to think about it. In civilian practice also the doctor will find the patient saying that he finds the topic being discussed at the moment " uninteresting." It may be accepted as certain that the topic in question is both important and distasteful. The doctor should never be deflected from his path by a patient depreciating a subject under discussion by the use of this word.

CHAPTER X

TREATMENT OF THE ANXIETY STATE (*concluded*)

We may now recapitulate what has been advised in the treatment of the anxiety state, and see whether we have satisfied those canons which were suggested as the criteria of the validity of a theory.

We have seen that the symptoms of the illness were identical with those which in health are called the emotional reaction, except only that they were prolonged, whereas those of the reaction are temporary. It was pointed out that the stimulus for the reaction, and therefore for the symptom, might be apparently one which was in itself not ordinarily a cause of emotion, but that it would then be found that it had become associated with some incident which was essentially connected with emotion; that such a usually innocuous stimulus caused the reaction conditionally.

Many examples were given which showed that the prolongation of the emotional reaction into a continuous illness might be due to a variety of causes. One of these, and perhaps the commonest, was the misinterpretation of the emotional reaction, so that it was regarded as being itself an indication that there was some organic disease present. This in its turn became a depressing thought, and so was followed by a further reaction, or symptom, which again increased the belief in physical disease, and in this way a vicious circle was set up, which is often not very difficult to break. Because this was true many different kinds of treatment which have no reference to the pathology of the disease are successful.

A second reason for the prolongation of the reaction was that the patient had some abiding preoccupation or anxiety, which habitually intruded itself, and produced an emotional reaction each time that it did so. These might be so frequent that the patient got little rest between the attacks. This in its turn was so depressing a matter that an effect similar to that of misinterpretation of the reaction was obtained. It was further shown that commonly the

patient was fully conscious of these anxieties, but might not have believed that they had any connection with his symptoms, or again that he might have known that they were what was making him ill, but that he did not know how to deal with them. In the last event it became the doctor's business to persuade him to look on his troubles from a different angle, to get a fresh light thrown on them, so that he could think of them more happily. In the case of misinterpretation his duty was to interpret correctly.

It was seen also that the patient might be wholly unconscious of the real reason for his illness, not only as a cause of it, but also as a fact in itself. Thus the sailor who had fear of the dark, which was really fear of burglars, had no knowledge that he was afraid of them (page 146); this was, so far as can be judged, wholly in the unconscious mind. In such cases it was shown that it was necessary to make an analysis to arrive at the cause of the symptom.

We saw also that there is an advantage in making a distinction between unawareness and unconsciousness. In by far the greater number of cases it will be found that the patient knows that he has certain anxieties; he knows also, but as a seperate and unconnected fact, that he is ill with certain symptoms. It is often said in such circumstances that he is unconscious of the cause of his illness. This is obviously a confused way of speaking. He may not be conscious that the anxieties are causal for his illness, but the facts themselves are in his conscious mind whenever he chooses that they should be so. It is better, therefore, that some word other than unconscious should be employed in this connection, as the word has now acquired a special meaning, viz. that the idea or constellation of ideas cannot be brought at will into consciousness. The word "unwitting," which was suggested by the late Dr. Rivers, has been used to mean that though the idea could be brought into consciousness, the patient does not connect it with his illness, and therefore it may be said that he was unwitting of its cause. This is in contrast to the case of the burglars, where the idea was truly unconscious.

This is not a mere academic juggling with words. The constant use of the word unconscious has emphasized the Freudian idea that there can be no neurosis unless there is repression, i.e. relegation of some emotional idea into the unconscious. Those whose intro-

duction to psychotherapy has taken place during the Freudian epoch are apt to spend many fruitless and irritating hours digging complexes out of the unconscious, which have often no bearing on the case, when their time might have been more profitably employed in readjusting obvious anxieties, which their patient and they themselves knew all about, but which neither of them were aware were of importance, indeed which they held to be of no moment because they had not been repressed.

It was also shown that though the important anxieties had often associations with obsolete childhood fears, they were also closely related to present conditions. Take the case of the patient who remembered that she had not protected her younger brother as she might have done (page 123). This was an affair of many years before, but in itself it was of no importance; it had become so only because it was something which she was doing still. Take the sailor with the unconscious fear of burglars in childhood, and it will be seen how minutely it fits into the idea of present anxiety. There was no such unconscious fear at sea where there are no burglars, it was present in port; and, as is well known, all docks are liable to be infested with thieves and other undesirable persons. This view, that anxieties to be effective must have some relation to the present, will be found to be in sharp contrast to that of the Freudian School, where, in certain circumstances, it is taught that the past as such is capable of causing symptoms now. A deeper analysis showed that this sailor was at that time not keen on remaining in the navy as he wished to marry but was too junior in the service. The illness therefore was connected with that anxiety also, very much a current one.

The existence of the childhood factors might discourage many practitioners from undertaking any psychotherapy at all, for frequently investigations into them may be time-consuming. It is therefore necessary to repeat that for the majority of cases met in general practice the discussion of current anxieties and the proper understanding of the emotional reaction, none of which is difficult to get at, will be sufficient. The residue of difficult cases which in the end probably arrive at the specialist's consulting-room, will provide more unconscious factors.

We saw also that a common reason why the patient did not get

well, even if all these matters were accepted by him, was that he did not altogether wish to do so, that the illness brought compensations, such as an escape from a home that was intolerable, or that it provided an excuse for evading some responsibility in life which he could not face. It did so in a manner which yet left him with his self-respect, so long as he fully believed in his illness. We can see again how these reasons are not as a rule unconscious, but that they never were connected in the patient's mind with the prolongation of symptoms, that here again is an instance of unwittingness. We can see also how phenomena of this sort might lead to the doctrine of " perverseness " (see Chapter II), but how different the reality is.

It is much the fashion in psychotherapeutic literature to say that " conflict " is the cause of neurosis, the conflict being between desire and duty. This is true enough, but every conflict implies anxiety, while every anxiety does not necessarily imply conflict, and it is on this account that the former word has been chosen here. The mother who has lost a child is worn by care, sorrow, grief, and has almost certainly anxiety about her other children, but she has not necessarily conflict about them. She may have a nervous illness from the anxiety alone. We cannot, however, have conflict in our minds without anxiety as to the outcome. Any depressing emotion, if it is intense enough, and is not met in the right way, may, in the author's opinion, cause a neurosis, and the word anxiety has been used throughout to denote any emotion of a depressing nature, because anxiety is apt to introduce itself whenever there is any other depression. If we lose a dear one, we automatically become anxious about the others; if we have done wrong, in addition to repenting, we may become anxious about the consequences to ourselves and others; if we lose one eye we become anxious about the other, and so on. There is no need, therefore, to introduce conflict specifically, though it will often be found. Anxiety is often denied the power of being a cause of a neurosis by itself, because, in addition to its being found, the patient will be discovered to be the subject of conflict also. But this is not a valid reason. We all have conflicts just as we all have anxieties, and each must be judged on its merits as to whether it is the cause of the neurosis in question or not. But it may be said that it is not

anxiety *per se* which causes a neurosis. It is anxiety either in overwhelming amount, and this may cause the illness without repression having occurred; or it is anxiety badly met, and when there has often been a measure of repression into the unconscious this occurs.

It is hoped that some success has been achieved in setting forth a theory of the neuroses which shall satisfy the conditions laid down in Chapter II. The view which has been put forward here depends on considerations besides those of therapeutic success, though the belief is entertained that that also is not wholly lacking. The attempt has been made to provide a consistent view, with universal application to all cases, which should account for the onset of these illnesses; the view is not in contradiction with other known facts, but is in harmony with them. The theory and the treatment are also logically connected. Finally the cause, i.e. anxiety in some form or another, is constantly present. The promise of an attempt to demonstrate that the ætiology, the course, and the treatment are based on the emotional reaction has also been kept.

There is, however, another aspect of ætiology which has not yet been dealt with, but which is of importance. We have so far dealt only with the ætiology of environment, and we have done so, not because it is quite certain that it is the most important, but because it is the only one with which we can deal. But many must have asked themselves the question why it is that some persons should react in these excessively disabling ways, while others exposed to the same vicissitudes of fortune withstand them with ease. The answer may be found in the early environment. Children brought up in a drunken or brutal household will in later life be more prone to fear than those whose early life was spent in wholesome surroundings. The method of history-taking recommended here should reveal this if it is present, provided the history is pushed back sufficiently. But even when this is done it will be found often enough that there was nothing exceptionally bad in the surroundings or training of the patient at any time. Even the psychoanalytic method may fail to reveal that the strains and stresses through which the patient was obliged to pass differed materially from those to which we are all liable. On the other hand, it is notorious that many, whose upbringing was bad in many

ways, and who later were subjected to great anxieties, have not fallen into neuropathic states.

We have also the curious fact that in one and the same family we may find examples of perfectly normal people, who were brought up in exactly the same way as other members who became nervously ill. In "An Introduction to Analytical Psychotherapy" (page 128), for instance, will be found an account of a neurotic twin whose brother was an unusually successful person. These two had exactly the same environment, of which the most prominent factor was a domineering mother. One was crushed by her, the other stimulated. These facts might be used as an argument against the anxiety theory of the neuroses, but the positive evidence in its favour which has been detailed in these pages is too strong for it to be dismissed lightly; there is no need for this to be done, for it is not difficult to find an explanation of the facts without discarding it. The problem is one which is to be found in all kinds of diseases. Every one is exposed to the infection of the tubercle bacillus, but only a small proportion of the population are affected with tuberculosis clinically. No one on that account doubts that the presence of the bacillus is a necessary condition for the manifestation of the disease. At one time it was hoped that by sterilizing milk, securing disinfection of the sputum of the infected, and so forth, this cause of the illness might be abolished. That is a hope which is now not so strong as it was. We no longer expect that we can eliminate this organism from the world, and attention has now been directed towards helping its victim to meet its onslaughts.

In exactly the same way all are exposed to anxiety, all react in some way to it, but few are overwhelmed by it to such an extent that they become neurotic. The parallel is completed by the fact that we cannot eliminate anxiety from the life of men, but we can do much to enable them to resist it.

In the case of the bacillary disease we believe that all sorts of depressing conditions, malnutrition, overcrowding, lack of holidays, etc., aid the bacillus in its onslaught, and in the neurotic we have tried to show how similar depressing conditions are to be met. But when all this has been attended to, there remains an unknown factor which has great determining power; for every one who lives in a slum, who is underfed, and made to work continuously, does not

acquire tuberculosis; nor do all escape whose lives have been spent under the most hygienic conditions. This unknown factor we call constitution or diathesis, and we believe it to be inborn, hereditary. It is something that we cannot touch, but notwithstanding that it is there, we do not despair of being able to make the patient a useful citizen. He will not be as well as if he had never shown the clinical signs of the disease, but he may be well enough. So, too, with the neuropath. He will be more easily upset than if his mental make-up had been like those of the majority, but he may be made well enough. Although he has been sometimes written about as the salt of the earth, it is not likely that he can be made into a first-class person. Some few there have been; but though they may come of the same family, the genius and the person who has had a serious attack of neurosis are seldom the same individual.

Duration of Treatment

The question arises how long treatment must last. The exact answer cannot be given, but there are factors which can easily lengthen it. If a note of pessimism has crept in during the treatment of the patients, or if they are told that it will take a long time, it is quite certain that it will take a long time. If a year is mentioned it will take at least a year, if six months—at least six months. As a rule, these patients are in no hurry. This must obviously be true if what has been written already is true. If the patient does not wish to face the responsibilities and difficulties of health, he will not hurry to be well, if the doctor does not expect him to. If he does wish to be well, he will be cast down and be made more anxious by this grave view. If he is given a period which he thinks too short he may be upset either because he may think that too little importance is being attached to his grave illness, or because there are reasons for wishing the illness to be prolonged. In another book, "An Enquiry into Prognosis in the Neuroses," I have given tables showing the duration of the illness, of treatment and of results, and have been able to show that in very many examples of long-standing neurosis, courses of treatment lasting from six weeks to three months have been followed by absence of symptoms for periods of more than ten

years. If the patient asks at an early stage how long the treatment will last, I say that it is much too soon to say but that I have had many patients as ill as he is who became well in periods of six weeks to three months. I often add that much depends on whether he co-operates or not. I do not tell him that he can co-operate if he likes, because it is possible that he cannot; he may also be told that the use of intelligence is a factor. He will be none the worse to be put on his mettle. If later it seems that he is prolonging illness to escape responsibility, this must be pointed out.

While a patient is having treatment, as soon as possible he should be given something to do. If he can be treated while going on with his regular work that is the best thing possible; but if, as so often happens, he has already given up work, he should not be idle once he understands that exhaustion is not the cause of his trouble. In an institution, work and games can be organized, but in private practice also the doctor must try to persuade every patient not to be given over to idleness. If the work is for the benefit of some one else, so much the better.

In general, apart from the period of treatment we must induce patients to see that work is, on the whole, the only possible medium in which people can live comfortably. The fear of overwork has been dinned into their ears so continuously, a gospel which they have readily absorbed and made part of their being, that it is by no means always an easy task to drive it out. If the patient's work is interesting in itself the idea of going back to it with pleasure is of course more welcome: such people, moreover, do not break down so readily as those who dislike their work. For the former, their life is really one long holiday, and they are much to be envied. It is true that even interesting work palls from time to time, but short vacations restore the appetite for it, and if these fortunate workers have broken down it is not hard to persuade them to return without fear. For the mass of mankind, unfortunately, work is dull. So many people are engaged in what is only a very small bit of a job that they cannot have any possible interest in the final result: their little portion has so much sameness in it that they get extremely bored with its everlasting repetition and monotony: and, as we have seen, when people get bored they feel tired, and may easily believe that they are exhausted. They will have

received this explanation in the course of their treatment, and they must keep in mind that, however tiring work is, idleness is still more so, so that there is no possibility of having a holiday unless one has worked for it: for a holiday is only the end of work, as pleasure is only the end of unpleasure. For these people, if they have any leisure time after their work, a hobby of some sort is important.

It is also in many instances necessary to introduce pleasure into people's lives. There are many people brought up in severely religious households, who have never been able to break comfortably away from the idea that pleasure in itself is undesirable. There are the members of such households who are not themselves enthusiastic about religion, but who have not freed themselves from the general gloom about life which severe religion is apt to produce; they usually have not been able to free themselves from the fear of parental displeasure, even though they may have left the parental household. A well-balanced life will have pleasure as part of its programme, just as much as work.

Nothing has been said in these chapters on treatment on the use of dreams. The beginner will do well to practise psychotherapy as far as possible without attempting to analyse dreams; their study is apt to lead to difficulties which he had better avoid; and it is clear that there is much to be done without their aid. If patients volunteer dreams, which the majority do not, they must of course be listened to. The subject has been treated in "An Introduction to Analytical Psychotherapy."

CHAPTER XI

THE HYSTERICAL REACTION: SYMPTOMS AND DIAGNOSIS

The hysterical reaction may be defined as one where the patient answers the difficulties of his environment by a negative response. The reaction is of such a nature that it is clearly impossible for him to continue to perform his duties at all for the time being. The majority of those who respond by the anxiety reaction can go on a little farther if they make an effort. If a man has only dyspepsia, insomnia, and is easily fatigued, he can at a push continue at his duty; he will only be inefficient; but if he has complete paraplegia, there are few occupations which he can follow at all. The reaction is therefore more completely disabling, and as might be expected the desire not to return to duty is more obvious than it is where the morbid condition is that of an anxiety state.

The symptoms are, as in the case of the anxiety reaction, very various, although there are often fewer present in a given case. Indeed, there may be present one symptom only, such as paraplegia. The symptoms are mental or somatic. In practice it will usually be found that hysteria is not met with in a pure state. There will be a number of symptoms of the anxiety type present also. Nevertheless it is convenient to describe the reaction by itself, not only for the sake of simplicity of description, but also because it may dominate the picture, and because its problems demand special handling. In every case there is loss of function.

In hysteria also, as has been mentioned already, we come on something which is new, in a way which we do not in the anxiety reaction. Every one of us has anxiety symptoms from time to time, attacks of palpitation, of inattention because we are preoccupied, insomnia, exhaustion in the face of something we don't want to do—as, for example, to talk to a bore. But unless we are of the hysterical type we never have functional paralysis or mutism

or convulsive fits. These do definitely mark out a person as being out of the common. They are not phenomena to which all are liable sometimes.

Mental Symptoms of Hysteria

These are amnesias, fugues, somnambulism, double personality, trances, deliria, "hysterical," i.e. emotional attacks, hallucinations.

Amnesia. This signifies loss of memory, not losing the power of recollection of incidents here and there, but losing that of definite blocks of time; a definite epoch is wiped out. Such losses of memory are common after times of the utmost stress, such as occurred during the War. A patient was blown up, and later, though he was officially informed of the date of his injury, and therefore knew it, he could remember nothing of a period of time which varied greatly, and which might extend both before and after the event. It might be that he could not remember the day of the injury: the time blotted out might be of any duration from this back to childhood. It might extend so far back that he knew nothing about himself at all, and so had lost his identity; and this might occur though he was behaving otherwise normally, eating, sleeping, and aware of all that was happening around him. It was often found that he knew what had happened till he went to France, but remembered nothing at all of what had taken place there, nor anything which had occurred for some weeks after his return home.

Now an amnesia for some time before and after concussion is an organic phenomenon, which is constantly present, but one extending for many weeks, months, or years before and after it, in a person not seriously damaged, may be confidently recognized as a functional pushing out from consciousness of everything connected with the terrible experience. It is as if the personal consciousness wished to be absolutely sure that it should not be remembered. The only safe way to bring this about is to make all experience forgotten which occurs at the same time.

Such states may also be found in civil life, and are associated with an experience involving terror, extreme shame, or other cause

of violent emotion. We are all aware of it to some extent when we have been very angry.

This kind of loss of memory is a cruder thing than that due to repression. The latter drops out certain incidents, and the patient is unaware that this has happened. In amnesia, everything for some period is forgotten, and the patient is aware that there is a gap.

Fugues. In certain circumstances, for which there is afterwards amnesia, the patient may wander, and when he comes to himself he may find that he is a considerable distance from the place from which he set out. Later he may repeat this wandering at times when seemingly there has been no apparent cause of disturbance, and again may know nothing about it on coming to himself. This constitutes a fugue. In such a state the patient cannot be unconscious of his surroundings, for he will buy food, may take a railway ticket, and indeed comport himself in such a way that he does not draw the attention of anyone to there being anything peculiar about his condition. Yet when he comes to himself he will be greatly astonished to find where he is. The fugue state may last for a few hours only or for several days ; rarely it lasts much longer.

An artillery sergeant-major, who was alone in an observation-post, was observed to leave it suddenly, and to run helter-skelter to the rear. He ran past his own guns, which apparently he did not see, and he did not stop till he had run several miles behind them. He then stopped, came to himself, and could not account for his presence in the place he had arrived at. Now the fact that he had run away from the enemy looked as if he had some appreciation of what he was doing : all those, however, who saw him run past the guns believed that he did not know who were serving them, nor even what they were. No one had any doubt that he was not responsible at the moment, and he was sent to England as a sick man : there was no idea of a court-martial. While in hospital there he wandered on several occasions, and remained absent for two or three days at a time. When he returned he could give no account of his doings while he had been away, but he was not in the enfeebled condition of a man who had been starved. It was possible by the hypnoidal method to find that, on each occasion, the onset of the

fugue had been stimulated by something which was associated with the original terror.

The writer has seen one patient go into a fugue. It is not common for anyone to have such an opportunity. In most instances one only gets the story afterwards. The patient, a woman with the history of many amnesic attacks, was seated on a chair and the discussion was approaching what might become an unpleasant subject. The patient suddenly got up and left the room. The writer took no action, for he thought that the patient had had an urgent natural call, and that she would return in a moment. As she did not do so, he went in search of her, but there was no sign of her in the hospital. She returned three hours later and said that she knew she was having an interview, and then everything went blank. She found herself a few miles away and had no idea how she had got to the place. She walked home, fully conscious.

Double Personality. The mental content of the fugue or amnesia is something which the patient desires to forget, and this is accomplished in all probability by the abolition of the ordinary personal consciousness during the time of the fugue. The personal consciousness will have nothing to do with this particular epoch, which then becomes split off, and which evidently acquires a consciousness of its own: otherwise the patient would not be able to comport himself as he does. He would not be able to go about the streets without injury, obtain food, or behave so that people would not detect him. This process is called Dissociation: the unpleasant experience, along with everything else which was happening, has become "dissociated." In this way we have a double personality set up, with two separate consciousnesses, which do not hold any sort of communication with each other. Except for such short episodes as a fugue, the condition is rare. Cases have been recorded where the alternations lasted for years: the writer has not met with one. Those interested in the subject should consult the works of Morton Prince.

Hallucination. Where the attempt to push the disagreeable complex out of consciousness has been only partially successful, some portion of it may remain; and this may be the origin of an hallucination. A soldier was troubled by the frequent symptom

of his name being called out loudly. Every time he heard it he felt that it must be that some one was calling him, and he would run back to the corner of the corridor to see if anybody was playing him a trick. In a moment he would be aware that there was no one, and that the occurrence was only a symptom of his illness. The name was always called by the same voice, but he was unable to identify it. He remembered none of his experiences in France after the first month or two during which he had been there. His record showed that he had been at the Front for about two years, and that he had lost his memory in some way about which no details were given.

He was put into a state of light hypnosis and was asked whose voice it was that he heard. He replied, " It is the voice of Sergeant Guy ; and he is calling to me to come out of the tunnel and help to fix the lashings of the bridge." When he had said this he woke up. The hypnosis was light and he remembered what he had said under it. He then said that there had been a canal between the German and British lines. The canal had raised banks. A tunnel had been driven through the British bank and a bridge thrown over. The first German trench was then taken. He himself had been blown up and thrown into the canal, out of which he had been fished half drowned. He lay in the tunnel, and then he heard the voice of Sergeant Guy calling on him by name to come out and help to fix the lashings of the bridge. He did not go. Again the voice called, and Sergeant Guy even came into the tunnel and ordered him to come out, and again he refused. That night Sergeant Guy was killed. He had been to him as a god, and he had felt for some weeks after that that he had been an unpardonable traitor in deserting the man whom he had worshipped, all the more because he was about to die. When this memory had been recovered the whole of the amnesia referring to France disappeared. This was the incident which he could not bear, which had made him sweep out the whole as far as he could. The small portion, which remained sticking up like the topmast of a submerged ship, we can picture acquiring an intenser vividness because it had no correlated parts, a vividness so great that it seemed to possess reality.

It will be noted that an hallucination is not in itself a symptom of insanity. Though each time it occurred he was startled for a

moment by its appearance of reality, he knew at once that it was part of his illness.

Somnambulism. This differs from the fugue in some respects. It comes on with no greater stimulus than that of going to sleep. If the patient is accompanied while he is walking, he may talk, and though at first he may pay no heed to the remarks of the person who is with him, he will after a few nights do so, and the attendant may join in the play which is going forward. The patient will then be found to be in some familiar surroundings, not of course the real ones, but elsewhere: the attendant will have become some other person, who is appropriate to the imagined environment. A consecutive story will then be unfolded, and if the watcher is skilful, and plays the part well, asks only intelligent questions, and makes little comment, the patient will talk easily, and recount the whole of something which has interested him very much. If the attendant is brusque, and, so to speak, gives himself away, and shows that he has nothing to do with the scene, it will probably change, or the patient will waken up. When he has done so he may remember the occurrence as a very vivid and consecutive dream, or he may remember nothing about it at all. If, then, he is informed of what he has said, it may be found that the content revealed is something of which he is perfectly aware, but that he is annoyed that he has said it; it is something which had moved him greatly, and which he had intended to keep to himself. It is curious how the patient, while able to create most of his environment, will help it on by such material means as are in his power. Thus, a certain naval officer, who in such nightly perambulations imagined that the hospital was his ship, always dressed in full uniform before he left his room. He had no difficulty in transforming the corridors of the building into the alley-ways of the ship, but he apparently did not desire to think that his pyjamas were his uniform. Thus, a lady for ordinary domestic walks would put on her dressing-gown only, but if the seance were to include a dinner-party or a theatre, she would dress elaborately for so important a function. When the transformation must be made by the mind it is done, but if it can be accomplished by material means the mind will not take the trouble—another instance of that economy of mental effort which has been seen elsewhere.

In what way can we place such symptoms into the category of a negative reaction? In both the fugue and the somnambulism there has been a failure to deal satisfactorily with a disagreeable experience during the ordinary waking life. The somnambulist, like the subject of fugue, has refused to consider the full import of his waking experience, has shoved it out of his life *en bloc*, and the symptom is only the sign of this. There is some matter which is troubling him but which he has not settled with himself in a satisfactory way. He has shirked some problem by trying to put it out of his mind, and all that he has succeeded in doing has been to put it into some other part of his mind, in which its activity becomes re-established as soon as his main personal consciousness loses control, either when sleep comes on as in somnambulism, or when the shock of a disagreeable association occurs as at the outset of the fugue.

Neither in the somnambulism nor the fugue is the patient unconscious, nor asleep in any proper sense of the word. He is in many ways exceptionally wide awake. He will see things which an observer normally awake will often overlook, and conduct himself with great circumspection. Thus, one somnambulist picked up a needle from under the fringe of a carpet which the nurse who was with her could not see: the patient stopped in her walk, looked down, and said that this would not do at all. The nurse looked also and saw nothing: the patient bent down to make the motion of picking up a needle: the nurse thought she was hallucinating it; but when she stood up the needle was in her hand. It was of a peculiar type with a gilt eye: the patient had no such needle in her possession, though she was a great needlewoman. It was therefore highly improbable that she had taken it with her on her walk. The same patient walked on a dark night some miles to post a letter, "woke up," and did not know where she was till she had gone a considerable distance, but then recognized a village which formed part of her favourite daily expedition. She woke in a wood, and recognized after a period of confusion as to where she was that she had correctly taken a usual short cut. Anyone who tries to walk through a familiar wood by night will recognize the difficulty of identifying the landmarks. Yet she must have done so while she was "asleep."

Hysterical Fits. Attacks of temper with tears in floods can also be regarded as mental symptoms of this condition, due to loss of the higher mental control. Associated with these there may occur the sensation of a ball in the throat, the well-known globus hystericus: these attacks may pass into the hysterical convulsion, also due to loss of the same control. The hysterical fit may sometimes be difficult to distinguish from the epileptic: indeed, it has been asserted of late that they are indistinguishable. But however true this may be, it may also be said with confidence that the nearer the fit approaches the regular epileptic, the greater will be the difficulty of its cure. It will be found more often that the hysterical fit suggests some purposive action, that the arms and legs do not follow the course of the epileptic fit, but are being used wildly in what looks like self-defence or attack, or that they are going through some action which recalls some other purpose. It is not true that the patient never hurts himself in the true hysterical fit, but it is true that he does not hurt himself seriously. It is probably true that before the War he seldom hurt himself at all, and that in the earlier war cases he did not do so. When it became known that this was a diagnostic point he hurt himself a little. It was very difficult to stop nurses and attendants from preventing him from injuring himself, and their solicitude encouraged him a good deal to try things which he did not try when he knew that he would not be succoured at the last moment. The presence of the deep reflexes after the fit is over is on the side of the attack being hysterical, but if the fits are very prolonged, and sometimes they last for hours, there may be absence of the knee-jerks after hysterical fits. After prolonged convulsions, which from the subsequent history and final disappearance of the fits were probably hysterical, the author has in more than one instance obtained the Babinski toe reflex. Similarly there may be absence of the conjunctival reflex, for there may be hysterical anæsthesia of the cornea, but the pupils usually react to light during the attack.

Delirium: Trance. After attacks of a violent nature, either with emotional displays of temper or with convulsions, there may be states of delirium, trance, or even stupor. The patient may talk continuously in a seemingly incoherent way, but the talk will have reference to something which has had a disturbing

influence on her in the past, and it may be possible to get considerable information which may be useful in the discovery of complexes. On the other hand, it often has reference merely to things which have already come out in the history and of which the patient is aware in her ordinary state, though she will not know that she has said them during the attack when she returns to her usual condition. In the trance state the patient will be with her eyes wide open, immobile, often in some dramatic position. If she is spoken to she will not answer: not a flicker will disturb her eyelids even with shouting. Such conditions may last for days: but this is not common. Leaving her severely alone, or doing something suddenly which is disagreeable, such as throwing a cold, wet sponge on her face, will usually terminate the phenomenon. In the war cases, however, such conditions of apparent coma were seen, where neither the appearance of neglect nor the disagreeable surprise had any effect in terminating the condition. That the coma was only apparent was shown by the fact that when a glass of milk was brought to the patient's lips he swallowed it easily; when the bottle was placed between his thighs he passed water. For weeks, however, the author failed to make any other contact with such patients, who woke spontaneously, not remembering anything of what had been happening.

The mental state of patients between such attacks is peculiar, and they may often show a resemblance to the condition of early dementia precox. A girl of nineteen, the subject of emotional attacks, always locked her bedroom door for fear that a man might come in at night; this would happen even at home. One cannot, of course, be sure that this was not a necessary precaution, but it is an unusual one to take. She dreaded to go to sleep, for the man might come through the window; she believed that she might be assaulted in her sleep and not waken, and therefore not know whether she were deflowered or not. A young and partly ignorant girl might hold such a view, and it might not be possible to reassure her that such an event could not take place without her being awakened; for hysterical patients are apt to distrust the reassurances which doctors give, looking on them, not wholly unjustly, as professional reassurers who will say and do anything to give a patient comfort. She believed that perhaps she had had connection

on a certain occasion by day; she could not remember exactly; she had been doing something with a man, but she did not think he had proceeded to any extremity, but she was unable to say for certain. This, too, might fit in with a sane mind which did not desire to remember accurately. There is nothing here which is inconsistent with reality, but it is all very near being so. Only time and careful observation can decide the issue in cases of this sort. But just as we shall see, in the diagnosis of physical states, an organic illness may seem to be hysterical for a long time, so here we shall be wise to keep in mind that the apparently severe hysteric may be in truth a psychotic. The standard will be the question of whether the patient lives in reality or in fantasy.

Somatic Symptoms of Hysteria

The somatic symptoms of the hysterical reaction are those of loss of function in some part of the body. They are sensory and motor.

Sensory Symptoms. Anæsthesia of the skin is common: it differs from the anæsthesia of organic disease in that it does not correspond to an anatomical, but to a mental distribution. Thus, if the hand is anæsthetic, the loss will correspond accurately with what we all know to be a hand; it will end sharply at the wrist, back and front. Now there is no anatomical distribution of peripheral nerves or of spinal segments which corresponds to this. Similarly if it be the body, the idea of this often fails to include the back, and there will be anæsthesia of the front and not of the back; there may be anæsthesia of the foot ending exactly at the ankle, or of the leg at the knee, and so on. There may be anæsthesia of the whole body and limbs, and it may be so profound that severe stimulation, like that of the faradic wire brush, may fail to produce the slightest sensation.

It is a point of dispute whether this anæsthesia has any autonomous existence of its own, or whether it is an artefact produced by the physician, through the means of suggestion. This view has been advanced most strongly by Babinski. It is unnecessary to go over the arguments here; it is quite certain that the physician can increase the symptom by taking an interest in it, and making frequent tests. At the same time it is improbable that he creates

it *de novo*. This point will be dealt with later in the section on the examination of these patients.

Anæsthesia of the special senses occurs, so that there may be blindness, deafness, anosmia, and loss of taste. The blindness may be absolute so that the patient has to grope his way about the room. It is diagnosed by the absence of any lesion which could cause blindness. It may be that the loss of vision extends only to the patient complaining that things are not clear, that colours seem washed out and without intensity. There may be an apparent refractive error, so that he has seemingly become short-sighted. The most characteristic loss in this function, however, is narrowing of the visual fields. Whether this is real or an artefact is again disputed; it is certain that the longer the examination is pursued the narrower do the fields become, so that the ultimate diagram may show a field of helicoid pattern. Much, therefore, of this phenomenon is an artefact, produced by interest in a symptom. Hysterical deafness may be absolute, so that the patient is undisturbed and does not flinch if a tray is hit by a poker just behind him. Such deafness is found organically in labyrinthine disease only. The diagnosis is difficult; the most satisfactory test being the presence or absence of the labyrinth reaction. The patient leans his head on a walking-stick which is held upright with its lower end on the ground, and its upper grasped in both hands. In this position he then runs round the stick a dozen times. At the end of this he will be giddy if the labyrinth is normal, and if he attempts immediately to walk off in a straight line he will be unable to do so. If he is able to walk straight the deafness is due to organic disease of the inner ear. Again, in the functional case there will be a temporary nystagmus after such a test; in labyrinthine deafness this will be absent. It is of course understood that his outer and middle ears have been found to be healthy by the ordinary methods. The diagnosis of anosmia and loss of taste is difficult, and fortunately not important.

On the other hand, there may be a hypersensitiveness to all modes of afferent impulses. There may be hyperalgesic patches on the skin, tenderness of the spine, increased sensibility to the disagreeable effects of light, hyperacousis, and so on. Hysterical headache may

be of extremely severe type. It is sometimes described as like a nail being driven into the skull.

Motor Symptoms. The motor symptoms comprise paralysis or abnormal movements of any voluntary action of the body, and this may be accomplished either by flaccid paralysis, by spastic paralysis, by contracture, or by clonic or choreiform movements. The paralysis may be a monoplegia, a paraplegia, or a hemiplegia.

These paralyses are not as a rule very difficult to distinguish from those due to organic disease. The diagnostic points rest on a knowledge of neurology and are fully dealt with in books on that subject.

Vasomotor symptoms are frequently present. The limbs are often blue and cold, and sometimes have a boggy feel about them. This has sometimes been attributed to the fact that they are kept absolutely without movement; but it is likely, from a consideration of the parallel phenomena of reflex paralysis, that there is a true nerve vasomotor change as well. The nails may show atrophy. As has been demonstrated by Hurst, this depends on mental influence, as is proved by the fact that the growth of the nail resumes its normal appearance from the date on which recovery of the paralysis is effected, by mental means only it may be.

The muscles themselves may show these atrophic changes, and there may be great wasting in the size of the paralysed limbs, a wasting greater than seems accountable for by mere disuse. In the War this was so striking a phenomenon that the French neurologists became convinced that paralyses of this kind were not truly hysterical, by which they meant that they were not dependent on ideas. The wasting was common in wounded limbs, and the theory was put forward that both it and the paralysis were due to reflex action. Just as in disease of the hip-joint there is wasting of the adjacent muscles, which is probably due to a nerve influence passing from the focus of disease to the cord, and reflexly back to the muscles, so here from the wound to the cord and back. The whole syndrome was therefore termed Reflex Paralysis. It was recommended that the patients who suffered from this condition should be treated quite differently from those who showed a frank hysterical palsy, who were in some way to be forced into health. The patients with wasting were to be treated as physically ill, in much the same

way as if they had been suffering from peripheral neuritis. The doctrine of reflex paralysis, as something midway between an organic and a functional disease, was held widely in France, but it obtained only a very insecure foothold in this country; for it was found that the paralysis was amenable to methods of persuasion in exactly the same way as any other kind of hysterical loss of power, that the atrophy made no difference whatever to the abolition of the palsy, and that when that had been overcome it was not very long before the wasting disappeared also.

Those who believed that reflex paralysis differed from hysterical paralysis were people of a turn of mind which makes it difficult for them to be sympathetic with hysterical patients. They were those who believed that hysteria should be treated unkindly, probably because they had no clear distinction between it and malingering. They thought that the hysteric should be made to pull himself together, to make an effort. The distinction between hysteria and malingering is theoretically easy, though in an actual example it may be difficult to make. In the former the patient really believes that he cannot move his limb, in the latter he knows quite well that he can do so. It is certainly safer to suppose that any given case is hysterical, till it has been proved by some incontrovertible observation that the patient is shamming. A false accusation of shamming does great harm to a hysteric.

Now there is no object in treating hysteria harshly. Mild methods of persuasion are quite as efficacious in removing symptoms as any others. This is not to say that there should be lack of firmness, but the presence of that need not imply unkindness. But whatever method of treating a hysterical paralysis is employed, it must be carried out thoroughly if it is to be successful. If a doctor intends to frighten a patient into losing a symptom, he must be prepared to frighten him altogether. Those who treated hysteria by severe methods did not carry out their ideas with the same thoroughness in the case of the patients who had wasting, as they did in those who had none, and therefore they failed to abolish the symptoms. They therefore were sure that they must be in a different category: the suspicion that they might be had made them carry out their treatment half-heartedly, and the failure confirmed this idea. In England, where harsh methods were never popular, mild methods

were on the whole used in all cases, and equally vigorously in those with wasting as in those without; there was therefore no special failure with them, and no need of the separate category. The whole story of this so-called disease is interesting as forming another example of the danger of theorizing from the results of treatment, but it has a unique interest in that, unlike so many theories of the kind, it arose not from successful but from unsuccessful therapy.

These nutritional changes have a further interest. They afford a proof which should satisfy the most materialistic that hysteria is a reality, that it is not a mere perverseness. No one by taking thought could make his limb shrink or come again to its normal girth.

The diagnosis of contracture may be more difficult to be sure about. The difficulty of excluding adhesions due to injury may be considerable, but here again the contracture is not usually that which would be caused by any organic lesion. Common contractures are that of the hand held in the accoucheur's position, of the hand and arm held straight out, of the fist tightly clenched, of the body bent forward so that the thorax is nearly at right-angles to the abdomen, of the pelvis being tilted to one side so that there is shortening of one limb, of the foot turned inwards in the position of talipes varus.

Clonic and choreiform movements may be of the most varied kinds. Movements of the head may resemble those of torticollis, but lack the characteristic vigour of that disorder. Head noddings and rotations of the head on the body may show themselves: these may be carried out at a speed which is very astonishing. In a patient under observation the rotation of the head occurred at about 250 revolutions in the minute, and yet the patient complained of no discomfort or giddiness. Clonic movements of the hand or the wrist, or a rotation of the radius on the ulna, may also be observed. Some of these appear to be purposive, but this is not always present. The chorea may closely resemble organic chorea.

Loss of function may also occur in the viscera. There may be a tendency to faint on small provocation; there may be loss of voice because of paralysis of the adductors of the vocal cords; there may be mutism in which the patient is not able to utter a

word. In both these last conditions the diagnosis is easy, for in the aphonic cases the patient is able to cough with a clear sound, and where there is mutism he is able to write without difficulty, and does so with excessive fluency; that is to say, again the difficulty shows itself not in accordance with any anatomical distribution, but solely with an uninstructed mental conception of voice and speech.

Difficulty in swallowing is not uncommon. The difficulty is said to be greater for fluids than solids. The diagnosis must be made from dysphagia due to organic stricture or cardiospasm. Hysterical dysphagia is due to pharyngeal spasm and not to œsophageal failure. The X-rays are therefore very helpful in determining the condition. But the history, as elsewhere, will give the most important information. The patient in the nervous case will sometimes give a history that she—for it is usually a woman—was eating a meal quietly and easily, when suddenly the food seemed to stick in her throat. This may have recurred at the next meal, or she may have had a period of freedom with a relapse later. It will be found further that at the first difficult meal she had received some bad news, or had been greatly upset in other ways; and that the recurrence of the difficulty arose from inability to believe that she could swallow or from some association connected with the original trouble recurring at a meal. Our life is greatly bound up with meals; they are full of associations of all kinds, and it is not surprising that a large number of neuropathic symptoms should be associated in one way or another with eating.

Hysterical vomiting. This is not uncommon. It occurs in many instances after nearly every meal. The food is frequently brought back as soon as it is taken. Patients will be encountered who vomit what looks as much as they have eaten, who do this for months, and who yet do not lose weight; they may be quite plump. It is possible that they take private meals which they retain, and vomit those only which are eaten in public. Sometimes there is a history of a physical cause for the origin of the vomiting. A soldier who had been treated for dysentery by the method of ipecacuanha administered orally began to vomit soon after the drug had been taken. He continued to do so after every meal for many months. Sometimes the history is that of an initial emotional reaction

produced by bad news with subsequent mental fixation of the vomiting.

Anorexia Nervosa. There is one form of hysteria which, in its graver manifestations, is fortunately not common, but which is of importance in that it directly threatens life : it is that in which there is complete loss of the sense of appetite. This is the condition known as Anorexia Nervosa. The patient is almost always a young woman and unmarried. She eats nothing to speak of, and to the observers at home it may seem to be literally nothing at all, so far as they can judge. She wastes till she has become a bag of bones ; the skin becomes dry, crinkled, and loses its elasticity, and she presents every appearance of one in the last extremity of malignant disease or of tuberculosis. The monthly periods are absent ; and this is a symptom which arises early in the condition. Yet for a long time she will preserve her energy, will walk considerable distances, much farther than anyone seeing her would have said was possible, and she will say that she is not ill. There is no doubt that from the beginning she will get food surreptitiously ; and if she is carefully and unobtrusively watched she will be found to be stealing it from the larder of her own home, soon after she has said in the dining-room that she could eat nothing, or after swallowing a crumb or two has declared that she has had enough. In the later stages she does become weak, so weak that she is unable to get about and has to be confined to bed ; but this does not happen for a long time after she has become emaciated. It is not of the uncomplicated condition that she may die, but many of these patients contract tuberculosis which carries them off quickly. The illness is an example of a loss of the sense of appetite. The patient has no desire for food.

This condition is often overlooked or mistaken for some wasting disease, especially tuberculosis.

All these symptoms of hysteria demonstrate loss of function in some way or another, and, in all, this may be regarded as a dissociation. If the hand is paralysed the patient seems to have lost the idea of his hand : it no longer exists for him : and its absence does not seem to inconvenience him greatly ; indeed, its loss usually gives him a certain amount of satisfaction. One with an uncomplicated

hysterical manifestation is not put out in the least by his disability; he is calm and placid about it, in a very different state from the patient with an anxiety reaction. If the disability is removed by treatment, and nothing further is done, i.e. if by simple suggestion the paralysis disappears, and the patient is then left severely alone, he will be very pleased, and for a day or two will sing the praises of the treatment; then a change may come over him, and he will be found to be depressed, often sleepless, and with headache. In short, he may be found to have passed over into the anxiety state. Later on he may develop a recurrence of his loss of function, or some quite new one may appear. He may have had paralysis of an arm, and later have aphonia. If an event of this kind occurs he will regain his tranquillity and lose his anxiety symptoms. Are we then to conclude that the hysterical symptom was protective against the anxiety condition? The answer is in many cases, Yes. While the patient was the possessor of a hysterical paralysis, no one could call on him to perform his duties. We must suppose that before the symptoms ensued these duties were being performed under great stress, and that the patient desired to get away from them. Paralysis enabled him to do so and yet retain his self-respect, so long as he believed that it was real. To show him that it was a paralysis in the mind only, and to leave the matter there, is to hurt his self-respect very deeply, and to invite him to return to work with even less morale than before. Hysterics are often spoken of as people who will deceive others; they possibly have not a sense of fair play above the average, for there are many who are not hysterics who are not above deceiving others when their interests are at stake; but there is one person whom the hysteric is anxious to deceive above all others, and that person is himself, and the paralysis enables him to do this in a most complete way.

It was pointed out that the form which the loss of function took depended on an idea and not on anatomy; the nature of the idea will therefore frequently influence the kind of symptom which occurs, and do so in a way that is not difficult to follow. In its simpler forms the idea of an injury will be the thing which is fixed and prolonged. A man receives an injury which divides the nerves supplying the muscles of his arm, and the arm becomes paralysed. The nerves are united, and in time their physiological state becomes

normal; the muscles respond normally to electricity, but the limb remains paralysed as before. A man falls on his back and receives a spinal concussion, which causes a physical paraplegia for a few days, but though no signs of cord damage ensue, he is left with a flaccid paralysis of both legs. It is quite easy to see what has happened in instances such as these; he has simply never realized the day on which he has become well. There will probably be some reason whereby he has not wished to realize it, but the fact for the moment is that he has not done so. Other reasons as simple may reveal themselves if the history is taken carefully.

A man had flaccid paralysis of both arms from the shoulders. He had been in an observation-post at Salonika; his duty each night ended before dawn while it was yet dark, when he had to return to his own lines: his path lay so that the quickest way home was to climb over a parapet, which had a ditch in front of it. One morning, while he was climbing the parapet, his arms gave way and he fell into the ditch, and thereafter he was unable to move them and they remained paralysed for many months. By the process of stimulating recollection described previously, he remembered that on that particular morning he had thought that it was lighter than usual when he was climbing the parapet. That was his first thought, the next thing that happened was the fall, the next the paralysis, which in some way he attributed to the fall. It would be a curious kind of fall of about four to six feet which caused a paralysis of both arms, and yet brought about no other injury. But it is clear that if he were only lucky enough to fall into the ditch he would escape the attention of the sniper who would be seeing him more easily on that lighter morning. Now it is important to observe that this real reason for the fall never got into his mind; at least he never remembered its doing so; he got no farther himself than the fact that it was lighter, but he agreed to the rest when it was suggested. Had he thought of the sniper he would have been justified in dropping into the ditch, and getting home by some more roundabout way, but there the matter would have ended; it is fairly certain that there would have been no paralysis. For that to occur it was essential that the fall should seem to have been caused by the arms giving way, that there should have been the appearance of an accident. The further point which

completed the diagnosis was that he was very tired of Salonika, and wanted to get home. This the whole incident was able to accomplish for him without loss of self-respect.

In the case of more subtle-minded persons the story will not be as crude as this, which was so patent that the surprise is that the patient ever took himself in. The following case shows that the form of the paralysis may satisfy more than the urgent need of getting into safety. The loss of power was of the whole right arm ; it had existed about eighteen months. The patient had been in Kut, and had taken part in a small sortie which was made for the purpose of delivering a message to the base. The party was attacked, and the patient was wounded in the foot, for which he was in hospital for a few weeks. He then returned to duty. Shortly after this he received an injury to the right shoulder, at the root of the neck, caused by falling off a wall on to a gun, which was followed by the complete paralysis of the limb. The patient did not lay stress on any part of this history ; it came out in the usual routine of taking the full story. A few days later he lingered at the end of his interview, and had obviously something else to say. This was to the effect that he was troubled by a recurrent dream, which he had not told to anyone. The dream was that he was on a horse, and that he was cutting a man down. Having got so far, he said that it was a fact that he had done so. When he received the wound in the foot during the sortie he was on a horse, and turning round saw that the wound had been given by a big Turk ; the patient had his sword drawn and he raised it to cut the man down. The latter held up his hands and called out in English : " For God's sake don't ! " He went on with his blow, which caught the other at the root of the neck. Before his enemy fell the patient saw that the arm fell first. The picture of this was very clear, first the arm fell and then the man. On thinking the matter over, he had the feeling that he had done something wrong to kill a man who had called out for mercy in English : he brooded over it and suffered from remorse. His own later injury to the shoulder resulted in a paralysis of the exact kind which he had wrongfully, as he saw it, inflicted on another. In this instance the form of the paralysis was determined chiefly by the sense of the rightness of the just retribution which the angry gods inflict on those who sin. This

attitude is not an uncommon one among hysterics, who are full of the idea that as a man sows so will he reap, and that the harvest will be identically of the same grain. It is of interest as some confirmation of the view that the next day the paralysis in this case had wholly disappeared, though no promise had been given that this would follow. The patient was, of course, shown that he had committed no sin, that no other course was open to him save to kill the man; he could not, seeing that he was charged with a message vital to the whole army, burden himself with a prisoner. It was clear that by this discussion the patient had got something off his mind which had been troubling it, and that with this the paralysis had disappeared.

Mere imitation will often determine the form of the disability. A patient with torticollis thrown among hysterics will create a large crop of them. So with all kinds of symptoms. Allied to this is the effect of direct suggestion, which may easily be accomplished unwittingly by the physician. In his early days the author had a very striking example of this. He was examining a man, and was unwise enough to say that one leg did not seem as strong as the other. There was no comment made by the patient, who did not seem particularly interested. Next morning, however, when he got out of bed he fell on the floor, and was wholly unable to move that leg. This paralysis was not difficult to get rid of; for the patient was ready to put faith in a doctor who not only recognized the diseases he had, but also those he was about to have.

In civilian life a compensation neurosis will frequently take the form of paralysis. A matron in a school fell on a parquet floor; she got up and walked away, but in a few hours she had developed foot drop. This was looked on as organic due to some injury of the cord, later as due to infection from septic teeth. On account of this latter diagnosis twenty-seven teeth were extracted. Incidentally this was fairly good proof that she was not malingering, as the extractions were spread over some weeks, during which she suffered a great deal of pain. When, however, she understood that what was keeping her ill was the temptation of a money payment, she renounced the money and became quite well in a week.

As will now have been gathered, the diagnosis of hysterical somatic manifestations rests on the history and on a knowledge of

the physical signs which accompany disease in the nervous system. As a rule there is not much difficulty; the signs of organic disease are never complete.

There are two diseases which are, in the author's experience, specially prone to catch the doctor who is not seeing many organic cases; they are disseminated sclerosis and paralysis agitans. *Disseminated sclerosis* presents difficulties because one of its earliest manifestations may be what looks like hysterical paralysis. There may be no physical signs of organic disease at all. No blame could attach to anyone who diagnosed hysteria in such a patient; she will recover from this manifestation, but later may develop some other symptom which, with his previous experience of the case, the doctor will be apt to diagnose as a further hysterical symptom unless he again makes as careful an examination as he did the first time, but by now there may be some unequivocal sign such as an upturned toe with the plantar reflex, or absence of the abdominal reflexes. This trap should make us remember that hysterical symptoms do not prevent a patient from developing organic disease, a truth whose application extends beyond the diagnosis of this special condition.

In *paralysis agitans* difficulty is found in those examples which occur *sine agitatione*. The patient is losing power, and is clumsy in his movements; the loss is often in one hand, or is hemiplegic in distribution. There is often a history of strain and even of shock which makes the diagnosis of hysteria very tempting. The history, however, does not show any rapid development of the condition, which is the usual thing in hysteria. There is a slow loss of the finer movements, which makes buttoning the clothes an increasingly difficult affair; there is slowly progressing clumsiness. When the patient is examined there is loss of expression of the face, which usually becomes rigid and immobile at an early date. The arm affected is stiff rather than spastic; the movements are performed accurately but slowly. There is no sign of involvement of the pyramidal tract; the reflexes are normal. Later the increasing rigidity makes the picture more easy to recognize.

Diagnosis from Malingering

From *malingering* the diagnosis may be difficult. Theoretically the difference between an hysterical paralysis and one which is

being deliberately imitated is whether the patient is conscious that he is shamming or not. That the distinction is a true one is revealed by certain cases where no amount of deliberate acting could bring about the symptoms. Few people, for example, could voluntarily assume the acute internal flexion of an hysterical talipes varus, and none keep it up for as many hours of the day as he is watched.

Certain examples of head rotation could not be imitated. A soldier sat up in bed and violently rotated his head at about 250 rotations a minute. Nothing like that could be done voluntarily. With flaccid paralysis, however, the diagnosis may be impossible. As a matter of practice a patient with apparently hysterical symptoms should never be accused of malingering. Even if he is, the reason why he is malingering needs enquiry just as much as why he has an hysterical palsy; and if the accusation is made, there is not the slightest chance of that patient, whether an hysteric or a malingerer, going any farther with that doctor.

A so-called malingerer is a person in a tight corner. He may even be suffering from grave organic disease, and be compelled to malinger because no one pays any attention to his complaints, or puts him off by saying that there is nothing wrong. A man had complained of abdominal pain and had been very carefully examined by modern methods; nothing had been found. His doctors were sure his case was functional. One day his own doctor, visiting him in his own home, passed his bedroom window before he came to the front door. He noticed as he passed that the patient was sitting up in a chair reading the newspaper. A moment later he was in the room. He found the patient in bed writhing with pain and was informed by the latter that he had been like this for half an hour. The doctor knew, of course, that the patient had not seen him at the window but had heard him at the front door. A very clear case of malingering. But in fact this patient had cancer of the pancreas and was dead in a few weeks. He malingered because no one would believe that he was ill and in pain. He did his best to make them understand.

CHAPTER XII

THE HYSTERICAL REACTION (*continued*)
EXAMINATION AND TREATMENT

Examination of a Hysterical Patient

This must be conducted with the same thoroughness as was recommended for the anxiety patient. The whole history of the patient must be ascertained in the same precise way. It will be found very often that a much more accurate date for the onset of the manifestation can be given at the first interview than is possible in anxiety patients. The symptoms are prone to come on more dramatically, and are likely to be associated with a much more pronounced and obvious emotional cause. When the date and cause have been obtained the history is by no means taken; we have yet to determine why the patient collapsed under the strain, for it is certain that every one exposed to similar strain would not have done so, and this can only be achieved by the long method of case-taking, recommended in Chapter VI.

There is one exception to the rule that an elaborate examination must be made; little should be done in the way of examining conditions of anæsthesia. If much attention is paid to this symptom it will only extend in area, and if the physician himself seems to think that it is of importance, the patient will assuredly not think otherwise. Neither should the symptom be ignored. The area of anæsthesia should be mapped out once; no correction or revision of it should be attempted, and some remark should be made such as that that sort of thing is common. The anæsthesia should never be alluded to again. It is essential here, even more than in anxiety states, that the examination should be made once for all; when it has been completed, and the opinion has been given, there must be no further doubt in the doctor's mind. He must never want to reassure himself on any point. The easy removal of the hysterical

manifestation depends entirely on the patient knowing that the doctor is absolutely certain in his own mind about its nature.

Treatment of Hysteria

It is necessary to distinguish between the treatment of the hysterical symptom and that of the underlying tendency. In the anxiety patient we saw that any measure which restored the confidence of the patient would be followed by improvement, and sometimes even by complete recovery which might be lasting. The attempt was made to show that it does matter, for many reasons, what the thing is in which the patient is to be taught to have confidence, if we are concerned not so much with the comfort of the moment, as with the ultimate outlook. All this obtains even more strikingly among hysterics than it does with those who are showing the anxiety reaction. It is sometimes said that one distinction between the anxiety patient and the hysteric is that the former is not suggestible, while the latter is. This is not true ; the anxiety patient is a highly suggestible person when compared to the normal man, but there are limits to his suggestibility ; there are none to those of the hysteric. He is the person who can be easily hypnotized, and for whom the external world can be changed into anything the operator pleases. He has already done something of this for himself, so that his healthy leg can become a paralysed one, not one merely which he does not use, but one, as we have seen, which may become blue with cold, and sometimes even atrophied. So much has the hysteric been able to change reality by the exercise of his mind that he impressed the French neurologists with the idea that here was a real physical state, which did not depend on mental operations at all, till the more sceptical English discovered that by changing his mind the atrophic phenomena changed too, and the reflex paralysis became nothing but an historical landmark.

It is obvious that if such a person comes into contact with some one more determined than himself, whose powers of suggestion are much stronger than his own, the most surprising phenomena in the way of the disappearance of these symptoms may follow ; and the immediate results of symptomatic therapy may be so good that the doctor is tempted to leave well alone, and not go farther, once

he has seen the manifest disabilities vanish. Any form of suggestive treatment vigorously applied will, in the majority of patients, remove these in a manner which savours of the miraculous.

It will be remembered also that in the previous chapter it was stated that if a hysteric was relieved of his manifest disability and nothing further was done, he might very soon pass into an anxiety state ; and when we consider these two points, viz. that the removal of the disability is often easy and that removing it may be merely to exchange a symptom which does not greatly trouble a patient into one which troubles him very much, we might, if these two propositions are true, be tempted to say that the removal of the manifest disability by some form of treatment directed to that end specially was not a thing worth doing. Yet that is the procedure which is advocated here *in certain cases*. In these it is quite worth while to begin by attacking the manifest symptom and getting it out of the way. Just as in the case of the anxiety patient we saw that sometimes the original anxiety which initiated the symptoms might have passed away long before the patient came under care, and that what he was suffering from at the moment was only misinterpretation of symptoms, which disappeared when a correct interpretation was supplied, so in the hysteric there may be an absolutely parallel condition. The environment which he was unable to face any longer when he acquired his symptom may have disappeared long ago : he may be suffering now from nothing but the belief that he cannot perform some function because of the presence of some illness which nobody understands.

It has been stated already that broadly speaking the hysterical reaction is commoner among the uneducated than among the educated. If the reaction is found in a patient belonging to the latter class, it signifies a more serious injury to the personality than it does in the former ; and the brusque removal of a hysterical symptom may cause serious shock. It is at least likely that the resulting anxiety state will be severe. In the uneducated, this does not hold so certainly, and the following methods may safely be adopted for them.

Treatment of Somatic Symptoms

When the history has been taken and the patient been examined in the usual way, he will be in a very suggestible state, and will be

ready to believe whatever the doctor says. If he is not it is usually the doctor's fault. He must first be informed that there is nothing the matter with his physical condition which could possibly cause a symptom of the kind from which he is suffering. The same precautions must be taken as were recommended in the treatment of the other neurosis to make him understand that there is no suggestion that he is shamming or exaggerating. A number of examples of the emotional reaction should be given. The meaning of the word mental must be explained. He must remain absolutely assured that his condition is regarded as genuine. If his story has shown the manner in which the loss of function occurred, and if he can be induced to see that it arose through the fixation of a reaction because of fear or other powerful emotion—and, provided that the history has been taken properly, there should be no difficulty about this—he may then be told that the loss of function persists only because he believes in its reality, and that as he can no longer believe in that, after all that he has said and heard, it will now disappear if he makes that effort which in health would be necessary to perform the function in question. He will probably say that he has tried often to do so, and that nothing ever happens. It will then be necessary to make him see clearly that trying *per se* is not the point; the point is the state of belief in which he tried. If he tried in the state of thinking that he had an obscure disease which was not a disease, the mental state of many hysterics about their symptoms, this effort would result only in failure. But if he can get hold of the idea that belief in a paralysis results in absence of power so long as that belief continues, and if he has now, because of the methods of examination and explanation employed, changed that belief, then he will be able to move the limb. This idea of "trying," "making an effort" in contrast with "believing," was much to the fore in connection with the teachings of the late M. Coué. While the author cannot subscribe to a considerable amount of what Coué taught, viz. that we should say that we are better whether we are so or not, and that it does not greatly matter whether we attend to what we are saying so long as we say it, he yet does believe that his doctrine of the impotence of will when opposed to belief is correct. If we are learning to ride a bicycle, we soon arrive at a stage when we can wobble for about fifty yards. If in this con-

dition we see an obstruction we shall almost certainly hit it. When we come to analyse such a phenomenon the following series of mental events must have taken place: first, an idea amounting to a belief that we shall hit the obstruction; secondly, an effort of will to prevent us doing so. The belief carries the day, which is a very curious thing, seeing that the obstruction is probably a much smaller object than the open road, and one therefore which should be difficult to hit. When we can ride properly we lose the belief that we shall deviate from the path on which we wish to go, and there is therefore no need to call in any idea of will at all.

Hysterical Paralysis. Some examples of this kind should be given and then the patient should again be invited to move his paralysed limb. Thus, in the example of paralysis of an arm from the shoulders which was described previously on page 188, the patient was shown that the paralysis was the fixation of a loss of function which arose as a defence, because it was the quickest way of escaping from a dangerous position. He saw this easily. He was then told that it had persisted because he had believed ever since that he was unable to use the arm, though there was no injury to the nerve or any other structure; and as some time had been spent on his examination, he was in the mood to believe what was stated. He was then directed to move his arm outwards, and after a few seconds it began to move in the desired direction. He was instructed not to make any gigantic effort, but simply to try in the usual way to think of the arm going outwards rather than to force it. This precaution is very necessary, because a forced effort is likely to cause innervation of the antagonists as well as of the muscles which it is desired to contract, and the limb will be glued to the side more firmly than ever. Once the limb has begun to move at all, progress will be rapid; the seance should continue till a very great improvement has been effected. This point is of the utmost importance. If the interview is finished before this has taken place, the patient will conclude that the method has failed, and it will then be a long time before it will succeed, if it ever does so. Therefore no one should begin the actual treatment of a hysterical paralysis by this means till he has at least an hour and a half to spare; it will not often take as long as this to make a decided impression, but the matter must not be left in the air, any

more than an operation would be left with the wound not sewn up, and a promise made that that would be attended to the day after to-morrow.

It is advisable also that when the actual treatment is being carried out the patient should not be touched. He will be glad if he can prove to himself that it was some manipulation which cured him. If he is touched he will say that something was done which made him well; his readiness to say this is the stock-in-trade of the osteopaths, who do, of course, help these patients very much. The mental effect which is desired is, however, one of a very different nature; what is wanted is to leave the patient with the idea that he himself has cured himself, and that no sort of outside interference had anything to do with it. He will then have learned that without doubt symptoms of a grave and prolonged character can exist solely because of a mental attitude. This will be found later to be of benefit. How great the danger is that he will think that something was done by some one other than himself to make him well was shown very often in the war cases. A man with hysterical aphonia, whose larynx was examined, began to speak the moment that the examining mirror was withdrawn from his mouth; another with paralysis of the arm began to move it freely immediately after the deep reflex of the forearm had been elicited by the hammer. The aphonic patient did actually relapse while under observation, and demanded that the "treatment" should be repeated. In addition to general objections to magic, this is one of the great reasons against the patient losing a hysterical manifestation by any means other than mental. If he relapses, and there are often many reasons why he should, he will require the same treatment again before he can again recover. This will commonly imply that he will need the same man to give it; for there may be something in the apparatus of the second man which is not quite right, or his manipulative skill may not be quite so good, or in some way he may not understand this difficult case in the same clear way in which the original doctor did. One who has relapsed has shown, *ipso facto*, that he has an aversion to getting better, and it will be easy for him to urge with all honesty many considerations of this kind, if the excuse for doing so has been furnished by a method. For such reasons the use of electricity, massage, and all kinds of mani-

pulations in the treatment of these manifest disabilities stands condemned, and they will not be described here. If the doctor fails by this method of explanation and persuasion, it means that he has not made the patient understand, or that he himself has not understood the patient, and this latter fault will usually indicate that he has not listened enough to the history, or that he has not elicited enough of it, or examined the patient with sufficient care and thoroughness. Finally, it may mean that he has not given enough time to the business; he himself may have lost heart after half an hour of trying, when another five minutes might have secured victory. If he has failed, the other methods by electricity, etc., are not open to him, though they may be to some one else; if he has failed with that particular patient by this method he will fail in any he tries, and he will be wise to say that the patient had better seek other advice. The latter will be perfectly willing that the doctor should go on with any other method, and will cheerfully follow it: he will probably be very pleasant to the doctor, and encourage him in his researches, and assure him that he never came across any doctor who tried so hard to cure him. Beware of praise from a hysteric. The doctor, on his side, will not be able to point out to the patient that he is failing to try, he will only find that nothing does any good, for that patient knows, unconsciously it may be, that that doctor cannot possibly master him, and that therefore there is no risk of his becoming well.

The patient who has been relieved of his manifest disability by simple explanation is in a very different position. He knows for certain that his disability existed only because he believed that he could not perform the function in question. His tendency to relapse is small; if he does so, he knows also that it is only an emotional reaction to be compared to a flood of tears, and therefore likely to last as long as that phenomenon. Further, as he sees that a prominent part of his case has been altered so dramatically by a mental process, he may be willing to pursue any further mental exploration which may yet be necessary; indeed, he will not be in a position to refuse to do so, and at the same time keep his self-respect. This last point must never be forgotten; the hysteric desires earnestly to preserve it; his illness has enabled him to retire from a difficult position and yet do so. The person of all

others whom he wishes to deceive is himself: he will not, for example, be found without paralysis in private if he has it in public, for then he could not be deceiving himself, and his self-respect would be gone. He would not be a hysteric in such an event, but a malingerer, a thing he really is not. All ideas of finding a hysteric out by spying are therefore foredoomed to failure, for there is nothing to find out.

As an example of the short duration of relapse in a patient who has been treated in this way, there may be cited that of a man who had been blown up, and had landed on his back. The history suggested a spinal concussion; but he had not recovered from the symptoms, although many months had elapsed. He suffered from a functional flaccid paralysis, and was unable to move his legs in bed at all. By the method just described he recovered their use and was soon walking well. Then there came an air raid; on such occasions the patients in the hospital were allowed to go into a subway if they wished, and this man thought that he would do so; but he found that he was unable to move his legs. Luckily he remembered what he had been taught, viz. that shock might be followed by an emotional reaction, and he thought that it would be right to allow five minutes for it to pass off. He therefore took out his watch, and at the end of the time he had permitted himself, got up easily and walked to the subway. Now if this man had been treated successfully by electricity, he would not have got better till he had had a further application of the battery.

It need hardly be said that treatment by this form of persuasion must be carried out by the doctor himself; and it must be carried out by the same doctor who took the history and conducted the physical examination. There can be no delegation of treatment of this kind to any assistant or masseur, however skilled and painstaking. The doctor himself will accomplish within an hour what will undoubtedly take such assistants weeks or months. They will, if they are reliable people, be able to inspire self-confidence in the patient to a considerable degree, but never with that intensity which the doctor, who has just examined the case, does with ease. For the patient knows that they do not know as much as the doctor, and they will not be able to combat all the curious medical lore which he has picked up in a career of invalidism. The doctor himself, too, must

see to it that he strikes when the iron is hot. He may take his time over the history and examination, a few days it may be; but as soon as he has given his explanation of the nature of the case, he must finish the matter either at that sitting or the next; and if at this second one, that must be not later than the day after the explanation.

It is obvious also that the doctor in question must be one new to the case. He who has had it in charge for years cannot suddenly say that he will now proceed to cure it. In the whole of this there is nothing mysterious or savouring of thaumaturgy. That is a thing to be specially avoided. The patient is fully awake, and during the conversations which precede the removal of the symptom he is to be invited to use his critical faculties to the utmost. There is to be no excitement or shouting of commands. Everything is to be open, logical, cold. The patient is to be, to use an old-fashioned term, convicted of his error, but there is to be no emotional conviction. The procedure is quite the opposite of the "Take up thy bed" idea. Anyone who has had one hysterical paralysis is liable in later life to have another; and it is essential that such a person should remember that it was in an atmosphere of logic that he was cured. Whether emotion is really present or not is another matter. Probably it is, and very likely it is an important factor, but in this phase of treatment, at any rate, it is not to be cultivated openly.

If the doctor will maintain the attitude of certainty for a comparatively short period, and repeat his reasons once or twice to a recalcitrant patient, the removal of a hysterical paralysis is often a perfectly easy thing. It used to be said that the war patients were easier than civilians. So far the writer has not found this to be true.

In the educated, more time must be spent in finding out just why the paralysis or other symptom occurred. The patient may be told that it is functional and the explanation of this given; but it should not be necessary, when all the reasons for the illness have been discovered, to have any seance at which the patient is made to move. Thus a woman with double talipes equinus who was very unhappy in many ways had acquired this contracture suddenly one day when she thought she was about to be discovered in a

compromising situation. She stiffened at the fear, and was never able to relax. The whole thing was talked out and explained. A few days after this had been done she walked smiling into the consulting-room without any contracture. She said that she had wakened up cured that morning. In certain cases of fugues and amnesias, especially, as will be discussed later, sudden cures must be avoided.

Aphonia and Mutism. All the other somatic manifestations of hysteria are amenable to this method; some forms are easier to influence than others. Thus, it is harder to abolish aphonia than mutism. Patients suffering from the latter disorder can be shown that they can move their lips and tongue; they will agree that they can do this and will move them at once; they can then learn that whispering is accomplished by a rather forcible movement of them; if they force the lips apart suddenly they find to their surprise that they have whispered the letter "p." With a slight change of position they have whispered the letter "b," then they whisper the word "pab." They know they can force their tongue down suddenly from the roof of the mouth. They have whispered "t." With a flatter tongue they make "d." Within five minutes they are whispering all kinds of sentences; once a single whisper has been emitted the rest is easy. It should be at once pointed out that they thought they could not even whisper, and they were evidently wrong there. If they are told boldly that they can put voice into it, they will. They have been so carried away by their own success that they cannot resist. Any mute can in this way be taught to speak within fifteen minutes. The seance must never close till he can phonate clearly. If the doctor is satisfied with a whisperer he will have one on his hands for weeks or months. But the aphonic is difficult. The reason for this is probably that mutism is a much greater inconvenience than is aphonia, and therefore the patient is more willing to part with the symptom.

Contractures are said to be more difficult than paralyses, but this is probably not so. The great point in contracture is to direct the patient's attention to the desired position, to which he has been unable to move the affected parts. If his fist is tightly closed, make him think of it as wide open; tell him not to try to open it,

but simply to imagine it open; it will soon become so. Striving to open it will only shut it up the tighter, because of the increased innervation of the antagonists.

It would be merely tedious and it is quite unnecessary to go seriatim through all the forms of contracture and paralysis which are amenable to this method. The principle in all is identical, and it is merely a question of the application of common sense to each difficulty. The principle briefly comprises complete knowledge of the history, a plain statement to the patient of why the disability continues, an inculcation of belief that he can overcome it now, followed by an attempt to overcome it without any forcing or the calling in of a hypothetical will.

Hysterical Convulsions. There are some somatic manifestations which cannot yield to treatment of this kind; we may instance the hysterical convulsion. If the diagnosis is certain, and in the majority of cases there need not be much doubt, the actual attack should be entirely ignored. The patient should be allowed to fall if he seems to be doing so; he will not hurt himself seriously if he is left genuinely alone; if this instruction is carried out half-heartedly, he may hurt himself, for if he is reckoning on being saved he may allow himself more liberties than if he knows that no one will come near him. If he is in a room he should be left alone, and no assistance be given or interest shown. If he is in a ward he should lose some privilege, for which a medical reason can usually be given. In the army, the author used to say that no man who had fits could be considered safe in the streets for six weeks after one. Such men were therefore confined to hospital. Fits, which in that hospital had been very fashionable, disappeared.

Hysterical vomiting should be treated by being ignored. No alteration of the diet is to be made. The nurse must be firm, and insist that the food be eaten, and if the patient is sick after a meal, an equal amount must be given at once, and this may be repeated. This may not be ignoring the vomiting, but it is ignoring the cry of the stomach for gentler treatment. No harshness of language need be used, the patient need only be assured that this plan is certain to succeed; he will soon know whether the nurse is strong enough to carry the matter to a successful conclusion.

Anorexia Nervosa. There is one somatic syndrome which

requires more specialized treatment, the condition of anorexia nervosa. It is probably hopeless to treat this state except with isolation. The patient must be in bed; she must see no one except the nurse and the doctor; she must have no communication with her friends. She will complain to them if she can, and they will not know what to do. The feeding must be begun very gradually, for the stomach is in a condition in which very little food can be tolerated; it may be necessary to peptonize what is given at first, for there may be complete suppression of the gastric secretion. The quantity administered the first day should not exceed two ounces of milk every two hours. This is probably more than the patient has been taking for some time; if it is less it does not matter, for the patient must receive practical assurance that she is not going to be rushed, otherwise she will be frightened, and the result of the treatment may be prejudiced at the outset. The next day the amount may be doubled, and on the third day she may be given six ounces every two hours. If eight feeds are given in the twenty-four hours, she will by now be getting an appreciable diet, not yet one on which weight will be gained, but at this stage that is not the point of importance. This amount is almost certainly greater than she has been taking for weeks, and the stomach may strike; the whole amount may lie there for a day or two and then be vomited up. We have to be sure that we have passed this danger before we push matters. If, however, there are no unfavourable indications of this kind, the food may be increased about the fifth or sixth day by the addition of thin bread and butter with every second feed, and then every feed. The milk may be increased by two ounces every feed each day till the patient is taking four pints a day. An egg may be added, then milk pudding, then fruit, then fish, chicken, meat, till a normal diet is being taken. The details of this should be regulated by the weekly weighing, and a steady gain of four or five pounds a week should be looked for, not during the first week, but certainly in all the subsequent ones. The patient should be kept in bed till she becomes well nourished; for this to be achieved it may be necessary that the gain should be three or four stones, and there must be no yielding till a satisfactory result has been obtained. At first it is essential that the patient be fed by the nurse, for she will only play with the

food if left to take it herself. Later she should be encouraged to feed herself, but she should not be left alone with food till she has gained, say, half of the desired amount, for in the early stages she will throw it into the fire or out of the window. Later she should be trusted and be left with her food, and if the weekly weighing does not show as satisfactory an increase as usual, the nurse should again feed her. She will understand what the inference is, and probably she can soon be trusted again. The reason which is given may be that she is not yet strong enough to feed herself. It is not so much that these patients are fraudulent that makes them throw their food away, but that they are being treated under protest. They will aver that though they are thin, they are well: and their acts often give considerable colour to this, for, as already stated, they may walk long distances and do a number of energetic things. They say that they prefer being thin and do not seem to mind that they have become hideous. They point out that if they are left alone they give no trouble, they never complain, and that it is ridiculous to regard them as invalids. The treatment is therefore looked on as a sort of contest of wills. If they are watched by some one who acts in the capacity of a policeman they will obey the law, but if the law does not know its own business they will break it if they can, for they have no respect for it, and are quite candidly against it. They do not resort to hysterical devices, like vomiting; and if they do vomit, the doctor may be fairly sure that he is going too fast. At the same time, if watched and dealt with firmly and kindly, they are absolutely tractable and obedient. It is an odd and unusual mental state. Needless to say that part of the illness requires investigation. The problem is: Why did the patient wish not to take her food? This is to be solved by the methods described for arriving at the solution of any other neuropathic question. It may be that she lost appetite because of some sorrow, and that this was prolonged by the same mechanism as is any other hysterical reaction. It may be that she wished to be thin and overdid it.

In many cases a dominant mother seems to be causal, a mother who endeavours to regulate all her children's doings, one who has probably nagged the patient in the initial stages about taking more food till it became a point of honour to take less. If the

mother is herself of stoutish build, the daughter will all the more wish to be thin, to be the opposite of her mother in every respect. Every case, however, needs its own investigation.

The removal of bodily symptoms does not constitute the whole treatment of hysteria. All patients from whom such symptoms have disappeared will show a period when they are genuinely pleased. This may last a few days or longer, but it is apt to be succeeded by the development of symptoms of another kind, sleeplessness, depression, headache, and, in short, the symptoms of the anxiety state. The hysterical symptom may be regarded from one aspect as a relief from anxiety; it has removed the patient from the consequences of a difficult environment; the removal of the manifestation may bring the difficult environment back, and therefore the anxiety symptoms. This caused Freud to dub these cases "conversion hysteria," because the symptoms were a conversion from the symptoms of anxiety.

In the war patients this was easy to see. The disability gratified the desire of the soldier to leave the hateful surroundings in which fate had placed him, and at the same time it left him with his self-respect. He was able to feel that he had stayed there till staying had become physically impossible. The removal of the disability altered the whole of this in a terrible fashion. He now could not say any longer that it was impossible for him to return; all the terrors which he had escaped began to loom up again; worse still, it was clear to most men who were relieved of their obvious symptom by a method which depended on a mental attitude, that if they had not had a very strong wish to leave the War, they would never have had the disability. Self-respect was therefore apt to disappear, and a high degree of self-abasement to take its place. As was said at the beginning of the chapter, it might be argued that a method of treatment which produced so appalling a result was a bad one; that electricity would be better, because it can cure without robbing the patient of his peace of mind. No human being can go on as a good citizen who has learned to despise himself. The attitude can, however, be treated. It can never be the business of a doctor to teach anything except what he himself believes to be true; and if his teaching brings himself and the patient

up against something unpleasant, he must not shirk the truth, but must see whether the truth is as unfaceable as at first it seemed to be.

It is nearly certain that during the War no patients who had had a marked hysterical disability went back to the Front. This statement may be controverted; those who had charge of neurological stations at the Front did report that they sent their hysterics back with success. These patients had, however, been ill so short a time that their illness was little more than an emotional reaction. Secondly, there is no good evidence as to what happened to them after they had gone back, but all those who worked in home hospitals had plenty of patients who had been sent back to the line after a short illness, for which they had been treated in a Front hospital. Their cure had seldom lasted more than a few minutes after rejoining their unit. From the home hospitals no one went back to the Front. This fact could not, in the circumstances, be made known officially, but the men got to know it, and therefore the fear of returning ceased to operate very formidably. The difficulty left was therefore only the restoration of self-respect. This was sometimes easy and sometimes difficult. If the man had served a long time he could be shown that there is a breaking-point in every one, and that he must not despise himself because he had stayed in the terrible position till he had reached that point. If he had stayed a short time he could be shown that bodily courage is not the only civic virtue, that indeed a nation which consisted only of the physically courageous would be in the main a nation of savages. The nation which was ruled over by Cetewayo was a nation from which the physically timid were eliminated, and it is not really a desirable thing to have all the nations of the earth like that. The physically timid are the imaginative people, the inventive people, and it is a good thing to have some of these left alive, even if the main national purpose at the time should be the waging of war. Further, it was pointed out to these men that, if they had failed as soldiers, that was all the more reason for them to make good as citizens, and that there were many ways in which they could help the nation if they became well, but none if they remained ill. Such considerations in these simple cases were the points from which the restoration of self-respect started.

Among civilian patients the same sequence is common; there is a period of pleasure followed by anxiety or distress of some kind. The reason for this is often not so obvious as it was in the war patients; it will not usually be clear without some analysis. In every instance where an anxiety reaction comes on after the disappearance of a hysterical manifestation it will be found that the patient has now to face an unpleasant situation which she had been shirking, her share in the household duties, an unhappy home which the illness had allowed her to escape from often, and from which now she sees no hope of escape. Talking the matter over will often reveal the cause, and either it must be dealt with by getting the patient to reconcile herself to the difficult situation, or arrangements must be made so that she leaves it permanently. The former is what should be aimed at, but it may be one which could not possibly succeed. The daughter with the stepmother she hates, the childless woman with the drunken husband, and a host of similar unfortunates, may find the thought of returning unbearable, and in such cases it will probably be better that the patient should not be encouraged to return. We must remember that we are dealing with poor psychological material, poorer as a rule than that which is encountered when dealing with anxiety patients, and it will not stand unlimited strain. If the patient is dependent on a husband with whom she refuses to live further, it is desirable that she should be, or should become, capable of earning her own living; if this is impossible she should not be encouraged to have an allowance which will give the same material comfort which she had when she was living with him. The hysteric will often hold that she is entitled to be supported financially as fully as of old by the person with whom she refuses to live. Such an arrangement is not healthy, and should be discouraged. In circumstances such as she would think equitable she will have nothing to do but nurse her grievance that she is a woman who has no home, and in time that means that she will have nothing to do but develop symptoms. In some instances she may be financially independent, and then it is advisable for her to engage herself in some useful work, and she must be persuaded to see this, for it is probable that she will not do so for herself. All these things are obvious and hardly worthy of being stated, if it were not true that there are a very large number

of people who think that an objectless life can possibly be a healthy one.

Treatment of Mental Symptoms

We may now proceed to study the treatment of the mental symptoms of hysteria. The simplest cases are those where the loss of control manifests itself in frequent emotional storms, so that life with such a patient has become impossible for every one who tries it. Such losses of control have at first allowed the patient to have her own way. They are a regression to the childish method of obtaining the gratification of desire, by making things unpleasant for every one till these wishes are granted, and like all regressions they soon fail in accomplishing what they did at first. During these attacks there may be threats of suicide, which may give rise to considerable anxiety. There may even be half-hearted attempts to do it; a slight cut is made on the throat, the gas is turned on for a time when it is known that some one will soon be coming into the room to turn it off, an insufficient dose of some drug is taken, and the patient is found asleep with the empty bottle by her side. It is extremely important to be able to decide if such an attempt is genuine or not, and it is by no means always easy; it will be said that no hysteric commits suicide, but it is not always easy to determine whether a given hysteric is showing nothing but hysterical symptoms. A young lady had made two attempts: one of these was with an insufficient dose of chlorodyne, another was an attempt to jump out of a railway carriage. The other occupant of the carriage was a small and weak lady who was travelling with her; and though the patient, who was much bigger and stronger physically, succeeded in getting the door open, this companion had no difficulty in preventing her egress from the train. She had complained of headaches which appeared to be functional in nature; they were so severe that her head could not be touched, yet she was able to have it washed, whenever she wanted to have it done, and the nurse who washed it was able to rub it very hard. These headaches were so bad that for some weeks she had become hysterically mute, a mutism which was easily abolished by persuasion in the way described above. Here, then, seemed a typical example of a hysterical patient, who had made what looked like an attempt at suicide as a demonstration to call attention to

her grievances. In these circumstances she was not watched. One night she went through a window head-first, and fell two and a half stories, suffered severe concussion, was covered with bruises from head to foot, and might most certainly have died.

It is difficult to decide whether this was a demonstration or not. Sometimes I have thought it was, but she said afterwards that it was an accident. She was near the window, indeed leaning out, to demonstrate. The night sister was coming to her, and in the excitement of the moment she fell out. This seemed to be a true story. The patient was a person of highly jealous disposition; hysterical symptoms had failed to give her the peace which she sought; mutism, for example, had been cured; she had ceased to get satisfaction from her symptoms, for no one was any longer showing enough interest in them. It is necessary that a catastrophe like this should be risked. To watch an hysteric is exactly what she wishes; she desires those around her to make a fuss over her to pay her a lot of attention, to be anxious when she says that she will kill herself; all these things are the reasons for the demonstration, and she is gratified if she has succeeded in having made the doctor take a grave view. A patient who is able to make him take it is one who will not be cured by that doctor, for she will know that she is stronger than he is. At the same time there is, after all, no theoretical reason why an hysteric should not commit suicide. The hysteric is in truth a supremely unhappy person, even though it can also be said that she is placid and content about her symptoms; she is placid only because of her symptoms; that is to say, she holds happiness on a most unstable basis, on that of retaining a symptom of which anyone a little stronger than herself can rob her with ease. The moral of all this is clear; it is not that we need be afraid of hysterics committing suicide, for they will not do it very often; it is that we must not leave our hysterics with their manifest hysterical symptoms relieved, and do nothing further, for then we will only have made them in a wider sense rather more ill than if we had done nothing, unless we are sure that the cause for unhappiness is over and that we are dealing with a disability which exists now, only because the patient has not learned that she is not ill. If we keep in mind that the hysteric is potentially most unhappy and lonely, we will not fall into the error of saying

crudely, because a paralysis has disappeared and she is unhappy, that it is clear that she did not want to get well. Of course, she did not want to get well on our terms ; she wanted to get well of something else which she probably does not understand herself.

It is so rare for an hysteric to commit suicide that we must never watch one for fear of it. We should frankly take up the position that it is far better that one should occasionally do so than that the remainder should be watched, for watching is disastrous in these cases. The point is of great importance, for the threat is common, and the half-hearted attempt is common, and we must have a clear view about it, and not get panicky ourselves on the matter. Even if it be held that the subject of hysteria never commits suicide voluntarily, it is possible that any demonstration may be carried too far unintentionally. One might overbalance oneself on a window-sill, or strangle oneself with the cord of a blind, when the only intention had been to make one's friends anxious. It is possible that hysterical suicides are sometimes of this nature ; but again such things must be risked.

The above case, however, demonstrates what has been already said, that hysteria in the educated is more serious than in the uneducated. The patient was an educated person. In them we shall be wise to take steps to understand the situation which led up to the hysterical manifestation before we attempt to abolish the symptom. As has been said already, it is not nearly so necessary to do this in the uneducated.

The position, therefore, is that what has to be done is that the unhappiness should be treated of which these storms are the indication. We are presumably well acquainted with the history of the patient, and we have to some extent gained her confidence. We have now to show her in the manner already indicated that her tempers are an ineffectual attempt to make her position in life tolerable, and, as they have failed to do so, she and we had better seek another way out of the difficulty, that the only path which offers the slightest hope of success is the altruistic one, and that the present study is to try to find out what that path is for her. The announcement of this programme may raise a storm immediately, whose fury will be directed against the doctor ; calmness and patience will usually overcome this, and if it is very bad the patient

may be suitably left alone till she has cooled down, and had time to review the situation. If the storm is violent this may take a day or two, but more often it will have abated in a few hours. This is another interesting example of regression to a childish reaction. We all know the fury of the normal child, and how we have felt in its presence that that child would never speak to us again, and how, next time we meet it, it is as friendly as ever. This is what happens with the hysteric; words have passed which, if they had been between normal adults, would have terminated friendship for ever, and yet at the next meeting there is no trace of awkwardness on the part of the patient, though the doctor may feel embarrassed at the beginning of the interview. In time most hysterics will improve greatly under treatment of this kind, and their friends will wonder what has happened to them.

Treatment of Somnambulism. This consists in discovering what the attack represents. It will be about something which the patient does not wish to think when awake, but not necessarily something of which he is wholly unaware. It may be found fairly easily by piecing together parts of the story already given by the patient. In the case of the sailor described above on page 176, fear of darkness was the primary cause. Each night the quartermaster came for him about three in the morning to make a round. He accompanied him till he had signed the book, and then he left him, and the patient had to find his way through the dark ship to his own quarters alone. He hated having to go alone in the dark, and he hated still more the idea that he hated it, and he tried not to think about it. But he was not unaware of it. In some ways this resembles the battle dreams of the soldiers. They would say that they were not thinking about the War, and they would have dreams of a peculiarly vivid kind where the events followed each other in a logical manner, not in the confused fashion of the adult civilian dream. They were really not unconscious of the fact that they were dreading return to the Front, but they were trying to put it out of their minds; it would seem that if we are trying very hard to put an idea out of our minds, it is apt to come back with exceptional vividness when we are asleep and can no longer exercise choice in the matter, as if the idea had dynamic energy and would have its period of consciousness some time whether we will or no.

It is difficult to get the patient to allow the forbidden topic to come up, but if he is put into the relaxed position, and told that no doubt some disagreeable thought is going to come, but that it will be easier now that some one is present who will take care of him, he will often allow the idea to appear. When it has emerged there will probably be an emotional reaction, which may be severe, but this will soon pass if reassuring words are spoken.

Once the idea has been obtained the next essential is to persuade the patient to see his trouble in a different light according to the principles which have been already laid down. Here the ingenuity of the doctor must come in. No rules can be given; it is certain that a patient of this kind will have taken the worst possible view of the whole matter. In the war cases he usually thought that he was the only man in the whole army who was afraid; he often thought that most men wanted to go back to the Front; he considered that he was the most contemptible person in the world. It was not difficult to get matters of this kind viewed in a different manner, and to get the patient reconciled to his thoughts. Even if the thoughts are such that the patient cannot reconcile himself to them, it is probably better that he should recognize them and not pretend that they are not there. He will get used to them. Familiarity breeds contempt, and we will in time reconcile ourselves to any thought which, if avoided, is a continual potential scare. In the case of the naval officer, the cause of the fear of darkness was dealt with as has been described on page 146.

In certain instances it will be found that merely placing the patient in the relaxed position, which has been already described, is not a procedure which is sufficient for the desired information to be obtained, and that it may be necessary to proceed to hypnotism so called. There is no well-defined mental state corresponding to that word. The condition into which it has been constantly advocated here that the patient should be put for the practice of free association is one where there is a degree of hypnotism. He has been to some extent dissociated from his surroundings. Insomuch as he was protected from present stimuli which arise from the incoming impulses through the optic, auditory, and deep nerves (from joints and possibly muscles) he was dissociated from the present-day world. The completer that dissociation, the more is

he in the hypnotic state. The first thing when we wish to hypnotize is to place the patient in the relaxed recumbent position recommended for free association. Somnambulistic patients are easily hypnotized, and all that may be necessary may be to tell the patient quietly to go to sleep and to repeat this injunction two or three times. In a few seconds or minutes he may be in the state desired, and if asked what he was doing last night may proceed to unfold a tale.

If he should prove refractory, other methods may be employed. A simple one is to hold some shining object such as an ophthalmoscopic lens in front of and a little above his eyes at a distance of from four to six inches, and tell him to keep the eyes fixed on the object and to think of nothing else. After a minute or so he is told that his eyes are getting tired, and that when they have become too much so for comfort he may let them close and go to sleep. When he has done so the assurance that he is sleepy is given and he is told to go deeper into sleep, and these remarks are continued for a minute or two in a monotonous voice till the effect is obtained. When hypnotized the patient is asked what happened last night. The tale is listened to, and when it is completed he is told that he will remember what he has just said when he wakens; he is then commanded to waken, and all the time he is doing so—and the process is not instantaneous—he is told that he is remembering what he has just said. Discussion of it is begun before he is really quite awake, and continued. Unless this is done the patient may have forgotten the whole matter when he wakens, and one object of the proceeding be lost, that of reassociating events which he has been dissociating. Instead of asking the patient what he did last night, he may be asked while hypnotized where he is and what he is doing, when he may begin to relate some past experience which he has been through. There is a difference in the relation which he will give in either of these procedures from a relation of the ordinary dream. It is always a consecutive story which he tells; it deals with one subject; it is not distorted, but is a plain straightforward tale.

It is often advised that hypnotism should be practised only in the presence of a third party, that the possibility of a false accusation is considerable, and that therefore the doctor is running a great

risk if he does it. The writer has not attended to this rule, but as he does not use the method to any great extent, he is not sure whether the amount of risk is great or not. For the present purpose, if the third party is necessary, there seem to be weighty objections to using the method at all. The object of the procedure is to get something into consciousness which the patient has dissociated, and which is therefore probably in some way repugnant to him, which he will certainly resent becoming public. He will probably in the presence of a third party be more refractory to the process of being hypnotized, and less information will be obtained from him when he is in the hypnotic state. There are few doctors who will arrive at the power to make hypnotized people their slaves to this extent. Most will have to content themselves with a degree of hypnotism in which dissociated material is more readily yielded up by a willing patient than when the patient is awake. The practice of the writer therefore is to hypnotize without the presence of a third person, but to be sparing in the use of the method at all. He never uses it for the common somatic manifestations which are better treated in other ways.

It must be admitted also that there is a danger, in hypnotism, of the patient becoming too dependent on the doctor.

There are, however, some instances of somnambulism where the symptom is apt to continue even after its origins have been traced. It will frequently be found that the patient is for some of the reasons described in Chapter IX dreading becoming well, and that the symptom is being retained on that account. If this can be proved it must be discussed; and after that no special interest should be displayed in the continuation of the walking. The patient should not be watched or specially taken care of during his wanderings.

Treatment of Fugues and Amnesias. These are also conditions which may call for the use of hypnotism. These states were very common during the War, and yielded readily to mild degrees of hypnotic investigation. A soldier was unaware of anything which had happened after he had landed in France; he had a mental picture of riding a horse, which was in some way connected with the War, but it was vague and never led to any further recollections. Under hypnotism he remembered clearly that he was riding with a message to his own battery, and he knew what the

message was, viz. that it was to be a "sacrificed" battery in the retreat of March, 1918, i.e. it was not to retire in any circumstances, but remain where it was till it was destroyed. He then became aware in the dream state that he was riding not towards the battery but away from it, and further very soon that he was trying to run away. Then he recalled that he had met some other messengers from his own battery and that he had to go back with them. The whole terrible situation was lived through, and before he was allowed to waken it was suggested that he would remember all this, and also that he would not be much ashamed of it as the temptation had been very great. He did awaken with a restored memory, and it was not difficult to persuade him that the offence he had tried to commit was not a thing to be violently ashamed of for ever.

There are some who believe that benefit is derived from the working off of the emotion which such recollection produces. So far as the writer understands the idea, this emotion is supposed to be bottled up, and it is good to work it off. This is called Abreaction. It is a thing which the writer has always endeavoured to avoid, and it can be largely avoided if the patient is assured, while still hypnotized, that his offence is surely understandable and therefore forgivable. It is difficult to picture to oneself what unconscious emotion is, even to believe that such a state can exist. It is certainly easier to picture it being re-created when the emotional event is recalled; and if this is all that happens, it should be avoided without imperilling the treatment.

Though hypnotism was very useful in the war cases there is some danger in using the method in civilian patients, especially if they belong to the educated classes. It has been mentioned already that gross hysterical manifestations are in them significant that there has been a greater damage to the personality than in uneducated people. This is specially true for subjects of fugues and amnesias. Where these symptoms have occurred in such patients, there has commonly been something desperate in the history which it was essential for the patient's peace of mind that he should forget. Sometimes he has been swindling; almost always some disgrace is hanging over him. For him to learn suddenly what this is may be productive of serious shock, which on more than one occasion has been followed by an attempt at suicide.

The hypnotized person is frequently at the mercy of the hypnotizer, and if he is, cannot refuse to yield up his secret. If the slower methods of consciousness are being used, and the ideas which are coming up are intolerable, the stream of ideas will stop, and no patient should be forced to go on if he is unwilling to do so. In any event there is less shock from learning the thing slowly rather than suddenly. During the years since the first edition of this book, the writer has used hypnotism less and less. He feels that when it is successful the patient becomes too dependent on him and that in other ways it is not a very satisfactory instrument. Some reasons for this have been given elsewhere and need not be repeated here.[1]

Traumatic Neurosis. The expression is a contradiction in terms: trauma cannot cause neurosis, and is never followed by it unless the subject hopes to gain some advantage by it such as escape from the fighting line in war-time or to receive an unearned increment in cash in peace. In peace the money factor is by far the commonest.

Trauma may, of course, be associated with fright, but fright of the kind associated with an accident is not the kind of fright which causes neurosis.

It is of interest to note that we do not speak of traumatic psychoses, although psychosis may only manifest itself after an accident. The reason may be that the difficulty of a psychotic patient starting an action at law is great. The medical profession is perhaps more to blame than the lawyers for the scandalous state of things which exists.

It has been stated that no patient with traumatic neurosis ever gets well until the monetary question has been settled, and for practical purposes I think this is true. But it is not altogether true, for I have with some expenditure of time and energy got a few of these patients to see that their illness was kept up by anxiety about their health, spite against their employer, and often for the purpose of teaching some doctor that he was wrong. It is never easy to get a patient to see all these things about himself, and I should agree that it will always be cheaper for an insurance company to pay up than to pay adequate fees for doctors to cure these

[1] See "An Introduction to Analytical Psychotherapy," page 164.

patients, especially as we could not guarantee to cure them all. These patients are hardly ever malingerers. They all seem genuinely surprised rather than hostile when the view is put before them that a money motive is keeping them ill.

The symptoms may be of any kind, but paralysis and weakness of muscles and headache are the commonest. The case of a patient who became well after renouncing compensation is described on page 190.

CHAPTER XIII

THE COMPULSION OR OBSESSIONAL NEUROSIS

This is the most difficult neurosis to cure. An obsession is a persistent irrational thought which the patient knows is irrational, but which nevertheless he cannot expel from his mind. The thought frequently leads on to an act, a compulsive act, because no matter how ridiculous the patient knows it to be he cannot escape performing it. Obsessions and compulsions are found in mild degree in many people, and may not interfere with the ordinary duties or pleasures of life. They are often present in severe degree in patients with anxiety states, but the patients who will be described here are rather different from these. In these the symptom dominates the life of the patient. In all other respects he is commonly quite well, but his life may become a torture because he cannot escape from the tyranny of his thoughts.

A patient was obsessed in this way by the number thirteen. If he heard the word he felt a shock which was followed by a period of misery; he stayed in bed on the thirteenth day of the month and on the twenty-seventh, because the word "twenty-seventh" has thirteen letters in it. Everybody seemed to be saying thirteen at him in some way or another; thus they would say, "Oh, good morning," and with, as it seemed to him, a most perverse ingenuity, they would later in the day say only, "Good afternoon." He worked near Oxford Circus, and lost time by not going through it because the words "Peter Robinson" were displayed prominently. On going upstairs he would hop over the thirteenth step. Wherever he went, whatever he did, he was compelled to count the letters in the short phrases people used, to count the words in their sentences, to count his steps, the number of streets he passed, and so on. He gave so much time to the avoidance of the number that he had become totally unfit to do anything else, and his condition was truly one of great misery.

It will be remembered that a phobia differs from a fear like the fear of insanity, for which the patient can give excellent reasons, such as that his head feels so queer that he must be going mad. With regard to the phobia, the patient is unaware of any good reason for its presence. He dreads the street, not because of fear of an accident, but for some reason he does not know of. He will agree that the fear is ridiculous. So in the obsessional or compulsion neurosis, the patient is himself aware that the whole thing is illogical, or, if he has entrenched himself in some seemingly reasonable position, the shortest of arguments will turn him out of it, but will not relieve his fear.

A lady was dominated by the thought of dirt or contamination from something. If she dropped anything on the street, she would not pick it up, for it would have come in contact with dirt, from which it would never be absolutely clean; if, as often happened, some one picked it up and gave it to her, she would lose it again as soon as possible. When she got home after such an occurrence, she would burn her gloves, would wish to destroy her dress because her gloves would probably have touched it; she would bathe and change as if she had been in close contact with some horrible and potent infection. She would like to have used disinfectants freely —but how to get rid of them? They are all poisonous; a drop might get on to some fabric or the table; it is washed off; it is then mostly on the cloth with which the table has been washed; that can be burnt, but now there is some on the hands; they are washed, but a trace remains, and that is partly wiped on to the towel, and so it is never got rid of. The fear was that she might poison some one else; some one not knowing, and not as careful, might come in, touch that table or that towel, and be poisoned, and the death would lie at her door.

A life of this sort is very expensive. This lady burnt more articles of clothing than she could afford, and yet she never got abreast of her difficulty; there was always something contaminated which ought to be destroyed.

Patients with fear of dirt have frequently the compulsion to wash. They may spend one or two hours in the bath, not lying idly but vigorously washing the whole time. One woman used to take half an hour to brush her teeth, at the end of which her gums were sore

and bleeding. The obsession may be about anything. One woman had to get everything straight. She began with her clothes which had to be put on quite straight; in consequence she could and often did take two hours to dress in the morning. She then spent some more hours straightening the furniture, the pictures and everything, and soon the day was spent before her real household duties could be begun.

The treatment of these patients may be very difficult. We may begin by studying what happened to the man who was obsessed by the number thirteen. He was forty-nine years old. His obsession had been present about eighteen months when he came under observation. Just before it arose, he had been enlisted, late in the War, and had been living in barracks. He was a man of very high ideals and refined tastes. He hated coarseness of any kind. He would have liked to read the poems of Milton, and to play the music of Bach and Handel to his fellow-soldiers; they would listen to neither, and he himself was compelled to hear their ribald stories and somewhat unrefined songs. The obsession appeared, and he was soon removed to hospital and discharged from the army; but he could not return to his civilian work on account of his illness.

He said that soon after he had married he had had a similar attack, which had lasted two or three years. He had had another when he was about fourteen years old. There had been none previously to that.

At that time of his life he had lived in the country with his grandmother, who kept a single servant. This girl had believed a great deal in the bad luck which attends the number thirteen, not to any very absurd degree as he ultimately did, but sufficiently to impress him. So far he related this history easily; it seemed to him that it was enough to account for everything; at a susceptible age, he had been thrown much into the company of some one who had impressed this superstition on him. He had been greatly upset in the barrack-room, and the old discomfort had been revived. He had nothing more to say, and no further memories to give about the matter. He was, however, pressed to think a little more about it, and to explain, if possible, why this person had been able to influence him in so abnormal a degree. He then said that it was perhaps because he loved her, and she him. He became troubled and

confused, and on being further pressed, related how they had had sexual relations for about two years. After this he had gone to a boarding school, where he had come under strong religious influences, and where he had repressed the whole of the incidents related above. He had, he said, never consciously remembered them till they had flashed on his mind at this interview.

His marriage had been unfortunate. He had had connection with his wife before marriage, and had married her from a sense of duty rather than from love. He stated that he found later that she had not been a virgin when he met her, and this tended to augment his feeling that he had done a rather fine thing in marrying her. With this feeling of having done well, there came the distressing obsession about the number thirteen.

Again, in the barrack-room the coarseness of his fellows made him feel how much better he was than they; and again this was accompanied by the obsession.

We are now in a position to understand the genesis of the symptom. The patient was a man with highly developed superiority feeling. In Chapter VIII it was stated that patients of this type are difficult to cure. Their whole ability to continue in the battle of life has been founded on the conception that they are better than other people, and if this conception is destroyed, they are apt to become lost. At school this man had learned to admire very lofty ideals and to imagine, because he did so, that he possessed them in a high degree. He really did, but inasmuch as this was true, it shocked and pained him to think that there might also exist in the same mind, and that his own, ideas and practices of a very different kind. He fell from his high ideals before his marriage, but quickly restored himself by doing the right thing. Then, unfortunately, he began to despise his wife. Here his superiority feeling played him false.

His own early experience should have prevented him from thinking ill of her; if she was not a virgin, neither was he. He was not in the least a man who considered that there was one law for men and another for women; men, in his estimation, ought to be pure. That was his thesis. He could maintain his attitude of superiority only so long as he did not remember his own past history. It was, however, almost impossible that nothing of this past should come

into consciousness, and therefore a fragment eluded the censor, the number thirteen, and brought about an emotional reaction through the operation of the conditioned reflex.

The same train of events happened in the army, and continued after discharge.

It was hoped that, when the patient saw this mechanism displayed before him, he would get well. It was hoped that he would become humble, be content to see that he was, after all, made like other men, a compound of spiritual and animal instincts, that if he would but abandon his attitude of self-satisfaction and cease to despise anybody, his obsession would pass away. Unfortunately this did not take place. When this history was obtained, and its implications apprehended, the man was immediately shattered. He became confused, intensely depressed, wandered by himself, and soon arrived at a state where the danger of suicide seemed imminent. It became necessary to send him to an asylum, where he was lost sight of. He was met by some one in the street some months later and was back at work, but still obsessed by the number.

This man could not have been analysed further because he became unco-operative. He was probably too old to analyse at all. After a certain age it is difficult or impossible to make a fundamental change with comfort. After one has lived for nearly fifty years with the feeling that one is rather better than most people the shock of finding that this is not true must be very great. And though that criticism may be directed to this case it is quoted at some length because it provides some other lessons about investigating deeply into the causes of this particular neurosis. It is singularly easy to find what look like adequate reasons for the genesis of the condition, but only too often no benefit, or only a meagre one, results. As in this instance harm may be inflicted. On the whole the general practitioner will be well advised not to try an analytic procedure in these patients. Such had better be left to the specialist. It is probable that if this man had been treated only by encouragement, he would have become well temporarily at least. He had done so on a previous occasion, before he went into the army.

It is true that some patients do get great benefit after investigation. The woman who had to put everything straight was clearly trying to compensate for her life not being straight. Acts of dis-

obedience and deception in childhood, which she had never become reconciled to, came out in her history. Various sexual irregularities of later life were discovered also. After these had been discussed and evaluated she was able to see that she could not straighten her life by straightening articles of dress or furniture, and she improved very much.

It must not be thought, however, that re-education has no place in the treatment of all cases of this disorder. The patient with fear of dirt was helped very largely in this direction. An analysis was tried in her case, which did not proceed very far, but far enough to bring out that her real fear was of venereal disease. She was also enabled to see that though her ostensible fear was that by infection she might damage other people, her true dread was for herself. She could therefore be, and was, taught that venereal disease is acquired in one way only, and she was instructed in the principles of courage, of which she had been exceptionally ignorant. She gradually became aware of the small importance of events which happen to oneself, and the result was decidedly gratifying. She ceased to burn clothes, gloves, towels, and so forth; she learned to be able to pick things up which she had dropped. She became far more indifferent. She learned to look facts in the face. A result of this kind is not brilliant, but a brilliant result is not often to be looked for in these cases. Great patience over a long time is needed in the re-education of people afflicted in this way. Again and again they will fall back; at the beginning they may accomplish the forbidden act two or three times, and then fail entirely, and be very unwilling to try again.

The compulsion neuroses are certainly the most difficult of all the neuroses, but, by a combination of psychological investigation and re-education conducted in the manner shown above, a considerable amount may be done to help these patients. They need support for a long period, as failure in the early attempts is almost certain, and the patient will need encouragement to try again and again. It is unsafe to push analysis deeply, and although these patients seem at first sight to present material favourable for analytic methods, these must be conducted with great care.

CHAPTER XIV

NOTE ON THE TREATMENT OF MILDER DEPRESSIVE PSYCHOSIS

Although this illness is not a functional nervous disorder as understood in this book, it is a condition which those who deal with these disorders cannot escape treating. A large number of manic depressives never come under the care of those in charge of mental hospitals, for they are not certifiable because they do not show any of those disorders of conduct which would make that procedure necessary or justifiable. On the other hand, a large number are called " neurasthenics " and are sent for treatment to all doctors who undertake the care of nervous patients. The symptoms characteristic of the type which will come under treatment have been already described in the chapter on the diagnosis of anxiety states. They resemble in many ways those of the latter disorder, but with ordinary care they may be distinguished, as was shown there.

The treatment is that of expectancy, which is not the same thing as doing nothing. While these patients are impervious to the kind of psychotherapy described in this book, they are capable of receiving support and assistance in a way which may be unrecognized at the time but which is, all the same, highly appreciated by them.

Nothing, so far as is known, will shorten the attack, but much can be done to make it safe and comfortable for the patient. A statement of this nature can be made of many physical illnesses, and with regard to them the doctor does not hesitate to think that his continued presence is both necessary and salutary. Nothing, for example, can be done to shorten an attack of typhoid fever; much can be done to make it safer and more comfortable. No doctor leaves it in the care of nurses, however skilled and trustworthy, but he himself goes every day at least once and often twice for a period of many weeks. Such visits are for the most part

psychotherapeutical. Over a period of weeks no change will be made in the physical treatment; the visits are not really police inspections to see that the nurses are doing their duty, for the doctor has very little chance of detecting them if they are not. They are not made for the purpose of recognizing the accidents of hæmorrhage or perforation, for if these occur he will be sent for specially if the nurses are of any value at all; they are made almost entirely for the purpose of giving moral support in a long fight. From our study of the nature of the emotional reaction, we can understand fully the importance of this. We have seen that when hope is predominant all the glands of the body perform their functions in a satisfactory manner, that when the opposite condition is prominent the reverse happens. The daily dose of hope which a good and careful doctor inspires is therefore no mean factor among those influences which will turn the scale in favour of recovery. And it is not only to the patient directly that hope will be given. After the medical visit the whole household, including the immediate attendants of the sick man, will have received the same stimulus, which constitutes a store from which he will receive a further supply till the next visit. It is true, of course, that minor changes will often be made in the physical treatment: sleep will be provided for; measures to control temperature will be taken—but these are not the reasons for the frequent visits, though without them the main object of the visit would fail. "Always do something," said a wise physician to the author, one to whom he is eternally indebted, "Always do something at each visit in a chronic case, even if it be only to rearrange the pillows."

To return to our case of depression. It is to be recognized that the patient is in for a long illness of uncertain duration, one which we can do nothing to shorten, but one where we must be prepared to give support over a long period of time. It is, moreover, an illness where we must not always expect to gather the fruits of our labour. We may sow and another man reap and obtain much credit which in no way belongs to him. If compensation is necessary to the doctor, he will get it often from some other man's cases. After many months of unwearied attention to a patient suffering from this disease, it often happens that the friends of the patient think a change desirable; they have been told by so many people

that this, that, or the other person is the man for such cases, and perhaps soon after the change the long-looked-for cure takes place. But there is an interchange of luck in this respect, and the writer has often received credit for the recovery when all that had happened had been that he was the man in attendance at the end. Such undeserved praise or dispraise comes from the friends; the patient always knows better, and there is no class of patient from whom more sincere gratitude is obtained than from a depressive.

The first essential, then, is that the patient should be under care, and that he should be visited frequently, it may be daily or only every other day. His history should of course be taken in the same way as was advised for that of the neurotic patient, and the physical condition should be thoroughly investigated. The patient may be asked whether he has had any anxieties; if he says he has not, this statement should be accepted without question. It is essential that nothing in the nature of psychological probing should be done to a patient who is in this group. He will without doubt be a person who is, for the time at any rate, filled with the sense of inferiority, and probing into his past may tend greatly to increase this, and turn a mild case into one of gravity. Such a procedure may certainly turn a non-suicidal patient into one where the danger is present. Incidentally this is one reason for delay in the cross-questioning of any patient who appears to be in low spirits. It often takes several days to make the diagnosis between the depression of anxiety states and that of the manic depressive psychosis, and if the doctor is in a hurry about finding "complexes" he will often do harm. Often there is no depressing cause; sometimes there has been great strain preceding the onset of the illness, a thing which is common enough in many diseases which are not psychological—for example, in diabetes, paralysis agitans, and other conditions. Frequently these strains will have precipitated the attack, but the attempt to readjust the patient's ideas about them brings about no improvement. It is common enough to obtain a history of impending financial trouble precedent to the onset; and although this situation may presently clear, the patient continues in the attack as before.

Finally, the answer to the question whether there had been any anxieties may bring out a story of anxiety which is obviously a

pure rationalization. Thus a patient will tell of some sexual irregularity which he committed twenty years before, which he has never thought about since till he fell ill, but which he cannot now banish from his mind. He is convinced that this must be the cause of his illness; it proves that he is a worthless creature and that he is now being punished for it. It is certainly not the least likely that an event which has caused no symptoms of any kind for many years can be the cause of illness now. Such a statement may seem to contradict others which have been made in this book, as, for example, that mentioned in Chapter VIII, where benefit accrued from discovering and discussing a failure of duty which had occurred twenty-five years before, which had been more or less forgotten during the interval, and which had certainly not been a conscious cause of anxiety during that time. There is, however, no contradiction. The patient to whom reference is made in Chapter VIII was not benefited by the discovery of that incident as such. All ill-effects of it had passed off. Its importance lay in that it enabled her to discover a tendency to which she was still prone, viz. not to be sure whether she was in the habit of taking proper care of children committed to her charge. The old incident was therefore of importance only because it had a present-day bearing, and it had no other importance. All the complexes, whose emergence into consciousness produces amelioration of symptoms, have a present-day bearing. This rule is invariable. Now the events of which the manic depressive tells have, as a rule, no present-day bearing. They are things which have occurred to his mind as explanations of his illness, because he is in a condition of self-abasement and is seeking for proof of his unworthiness. Thus, a man who has led a blameless life for years will tell how twenty years ago he committed an act of unfaithfulness which he has never repeated; if that were going to have been a cause of illness it should have been one long ago. Its emergence into consciousness is of the nature of a symptom, not of a cause: it is exactly on a par with the common symptom of the well-to-do depressive that he is really on the brink of bankruptcy, and that if he were only financially sound he would be well. He may, as one rich man told the author, have only two hundred thousand pounds between him and the workhouse.

It may almost be said that if a sexual anxiety is given quickly

by the patient, i.e. as soon as he is asked if he has any anxiety, the case is psychotic and not neurotic. "Unsolicited garrulity about sexual affairs is always a sign of insanity," was one of the wise dicta of the late George Hermann. We might go farther and say that a sexual confession which is elicited with ease in the first interview, or before the patient really has had time to know and trust the doctor, is such a sign, and is of no causal importance.

All these stories must, of course, be listened to carefully, and the patient must be assured that they are not the cause of his illness, that they are only matters which have come into his mind because he is ill. The patient should, if possible, be given a less severe view of them than the one he holds; and though he will certainly not seem to accept this, he will probably derive some comfort. He should be told also that his illness is one which is perfectly understood, that it is one which belongs to a well-recognized group, and that the satisfactory thing about it is that every one who has it does become absolutely well. He will probably say that he wishes he could believe this statement, but he cannot, and he may then be told that that incapability of belief is one of the well-recognized symptoms of the illness, and that it also is a thing which will disappear. This is the kind of psychotherapy which is helpful to patients of this kind; and it must be repeated again and again. Every time the patient is seen he will wish to recite the tale of his sufferings, and though the doctor may know quite well what he is going to say, for there is little variation in the statement of any individual patient, he must sit quietly and listen: and every time he must not weary of repeating his message of hope, for undoubtedly it does give great comfort, a comfort which may last for a day or two. It does not abolish any symptoms, but it seems to make them more tolerable; it seems to make the patient capable of hanging on. It is at the same time possible to be fussy with these patients. Too many visits, e.g. visits twice a day, may do more harm than good. These patients have frequently the clearest insight into their condition; they feel that they may become insane; they often dread that they may be sent to an asylum; and if the doctor shows a sudden increase of solicitude about them they are apt to fear the worst. To steer between the difficulties of too little support and too much is an art to be learned only with practice. A daily visit

which is not hurried will be quite safe in any case where special watching is not needed till this art has been acquired.

The physical treatment of these patients must receive attention. The most important thing is that they should be rested. If they are not restless and are comfortable in bed, they may be kept there for considerable periods with great advantage. Often, however, they are not comfortable, in which case they will probably rest less in bed than out of it. But exertion of the nature of long walks, heavy garden work and the like, should be forbidden. Light occupation should be encouraged, if the patient does not feel that his head gets confused with it, in which case it should be stopped. He should not be left long alone. In many cases a special nurse is not necessary, but he should be looked in on often, and sat with for considerable periods of the day.

To obtain sleep is an essential point in the treatment, and these patients are very resistant to any psychotherapeutic measures. They themselves are not anxious about the evil results of insomnia, and therefore measures of reassurance such as were described in the chapter on anxiety states are of no avail. Hot baths may by inducing drowsiness be helpful, but almost all patients will need the help of hypnotic drugs. Very often the milder ones such as veronal and medinal may be sufficient. They may be given in doses up to 12 or 15 grains. If the latter dose does not succeed, these drugs are not suitable. It is sometimes said that a dose of 15 grains of veronal is not safe ; the writer has given it very often, although never to patients with unsound organs, and he has not yet seen untoward symptoms. Commonly, however, a dose of 7 grains will suffice. The doses should be kept as small as possible, as the medicine may be needed for a long time. It is common for these patients to get off to sleep at bedtime, and waken very early, say at two or three. When this is so, the sleeping-draught should not be given at bedtime, but should be left by the bedside to be taken when the patient wakens. The action of these drugs is short, and if, in a case of this kind, they are given at, say, nine or ten o'clock, the patient sleeps no longer than if he had had none. It is just during these hours from three o'clock onwards that a depressive patient ought not to lie awake. They are the most miserable hours of the twenty-four. The rest of the world is asleep ; there is nothing to

distract his thoughts, which present themselves then in their most distressing aspect. It is in these early hours that the risk of suicide is greatest. It may be worth mentioning that whenever a hypnotic dose is left by the bedside to be taken if the patient wakens, it should be a dose which is in solution in a medicine glass. These patients have been known to save up tabloids and cachets which have been left beside them, and to accumulate large stores of them, which have been intended to be used as a means of escape if the situation becomes absolutely intolerable. They will not as a rule take the trouble to possess bottles to store fluid doses.

These mild hypnotics may fail, and it may be necessary to use others. Paraldehyde is a safe and efficient drug. It should be given in a dose of about 3 drachms. If the veronal group has not been successful, it is not of much use to try a smaller dose than that. It is best given shaken up with plain water; there is nothing which will really disguise its taste, and these patients are not very discriminative in the matter of taste. It may be possible to reduce the dose later. Sulphonal in a dose of 20 grains which is to be given at 3 p.m. is also suitable; it will produce better sleep on the second night than it will on the first.

Chloral in a dose of 25 to 30 grains with 30 grains of bromide may also be used.

All of these drugs are habitually given in much larger doses than these in mental hospitals, but the use of larger doses is not recommended here, not from any fear of them, but because the ease with which sleep can be induced is a measure of the gravity of the case. If much larger doses than these are necessary to procure sleep it is probably a severe one, and one which demands treatment in a place where the patient can receive better protection than he can in a nursing home or in his own house.

The nutrition of these patients should be attended to. As a rule they have lost weight during the illness, and they should be put on a liberal diet and be encouraged to gain weight. There is usually no great difficulty about this.

The question of dealing with local sepsis is at present much to the fore in connection with the treatment of this and other psychoses, and those who believe in it can point to instances of very striking success. Patients have been ill for years, and have then been cured

in a few weeks by treatment of this kind. If the history of the disease is studied, this is exactly what might be expected to happen. Every one who sees these patients is struck by the extraordinary way in which a person who has been sunk in despair for months and years becomes bright, happy, and contented in a few weeks, when nothing special has been done at all. Those who are interested and experienced in a treatment rather than in a disease are, as a rule, not good judges in the matter of the value of that treatment. There are all sorts of treatments which these patients say "cured" their previous attack. In one attack they will have been cured by an operation, when it was declared that they were suffering from auto-intoxication which the operation had relieved; in another they were cured by the Salisbury diet, in another by some form of suggestion, and so on. One of the curious things which has sometimes struck the writer is that though they repeat that this or that man cured them by such-and-such means before, they have not hastened back to him, and they do not jump at the proposal that they should return to him. They will say that possibly the condition then was ripe for his treatment, but that it may not be so now. It seems that in their hearts they doubt whether he did effect the cure which they proclaim.

Now it is quite possible that courses of treatment do good, though not necessarily in the fashion which their authors believe. They often do good by the instillation of hope; and if the treatment is only announced as being very lengthy at the outset the patient may be tided over the waiting period, and be able to go on because he feels that something is being done; for the serious thing with all these patients is that they should finally lose hope altogether. Secondly, in nearly every chronic disease that we know of, there is apt to be a secondary anxiety state, grafted on to the original illness, which is due to the depressing emotions caused by the illness. In the insanities proper this is not present, that is, in those states where fantasy has replaced reality. But here we have no fantasy except that the world seems unnecessarily depressing. It is probable, then, that some of the symptoms which are present in any given instance are due to the ordinary emotional reaction caused by despair, and that anyone who is enthusiastic enough will improve such a patient to a considerable extent. That this is so is obvious.

Without special treatment one doctor will make the time to be gone through easier for these patients than another, this depending wholly on the faith in that doctor. We can go farther: we have already seen that a hysterical paralysis may follow an organic one, chiefly because the patient never realized that he had become well. The same thing probably happens here. The patient's symptoms may conceivably continue after his illness has really gone, because he has never been encouraged to think that he was well; it might even be said, because the excuse for becoming and feeling well has never been given to him. A new and, if possible, strange treatment may provide this excuse, and therefore the doctor should not throw too much cold water on proposals that such should be tried.

While it is very important not to think of a depressive patient as suffering from an anxiety state, the converse is also equally true. The danger, as we have seen, of the first error is that we may transform a mild case into a grave one; the danger of the second is that we may prolong an anxiety attack almost indefinitely by telling the patient that he should go on taking care, when this is the last thing of which he should be thinking.

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