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HYSTERIA IN CHILDREN

by

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The Requirements for the Degree of Doctor of Medicine

University of Nebraska College of Medicine

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HYSTERIA IN CHILDREN

For the last quarter century the medical world has been paying more and more attention to the preventive aspects of disease. The late nineteenth and early twentieth centuries saw the discovery of the causes of many of the diseases which had been killing people for centuries, and with these discoveries came not only the cure of many of them, but the conception of prophylaxis and public health. From this beginning, very soon, came the wave of interest in the child, and the realization that, to a great extent, the health of the adult population depended on the health of its children. It has come to be a generally accepted fact that it is to the public interest that the children grow up as nearly physically perfect as it is possible to make them, and that this will result in sufficient economic advantage to the state to justify the use of the taxpayers money to bring it about.

This attention to physical well being is a great step forward over the time when the doctor was expected to concern himself only with the actually physically ill, but we are now entering, or have entered, another phase. We are finding out that man is more than a mere system of anatomical parts, and that functional alterations can be brought about by other things than molecular or structural change. We have talked about the healthy mind in the healthy body, but have forgotten that unless the mind is healthy the physical health of the body makes very little difference to the general happiness of the individual. For hundreds of years it has been customary to section an individual into body and mind, the body belonging to material science, and the mind to religious and philosophical speculation. For centuries the insane were dismissed as being possessed of devils, and the beginnings of the humane treatment of these unfortunates is one of the most

480555

recent of our advances. In the meantime, in spite of our progress in the realm of physical disease, our institutions for the care of the mentally ill were becoming more crowded than ever, and the healthy body did not seem to be resulting in the healthy mind. For a number of years men whose lives are devoted to the study of mental conditions have been convinced that the ultimate causes lay far behind the immediate illness, and that the problem of mental disease lies less in its treatment than its prevention.

Strecker[164] says that if the same neglect of simple actually known facts that prevails in regard to mental hygiene existed in the field of physical hygiene, we should have long since degenerated into a nation of weaklings. The actually insane are, as a rule, well cared for physically, and the treatment of the sick mind is receiving much attention from specialists in that field. However, the medical profession in general has given little thought to the individual whose mental illness is not great enough to require institutional care, but who goes through life an unhappy, maladjusted, suffering soul because his outlook on life and habits of thinking are as deformed as a harelip would be to his face. We call these individuals neurotics, and the general run of doctors dismiss them as one of the annoyances that must be borne since nothing can be done about them. R.S. Miles[116] says that neuroses cause more suffering among the human race than any other ailment, and perfectly balanced emotionally stable adults are no longer the rule, and Strecker[164] claims that the world is sick because the majority of its inhabitants have not a working concept of healthy thinking. He believes that until individuals learn some measure of control of their minds, they cannot expect to exercise intelligent management of social and economic problems. Viewed in this light it would seem that a study of the reactions of the individual to the tests of life, which, after all, is the mind in action, is as much worth while as the reactions of

the body to the presence of pathogenic microorganisms. After all, the mentality is the ubiquitous and dominating element of human life, and the body is merely its instrument.

It has been found that to understand the mind of the adult, one must of necessity know his childhood, and the time to establish true mental health is in that period. Strecker[163] says that if one third of the amount of attention that is now given to the bodies of children were given to their minds, there would eventually be a decrease of mental illness and maladjustment, and an increase in efficiency, adjustment and happiness. The personality is moulded during childhood and early adolescence, and it is during this time that things first go wrong. If we have discovered anything at all about mental illnesses it is that they are the outward signs of intrapsychic difficulties, which conflicts, in turn, are dependent on traits of character that have their origins in the childhood of the individual. For too long the behaviour of children has been considered by physicians as well as laymen, to belong to the province of ethics, unless this behaviour is so grossly out of the ordinary as to stamp the child as objectively abnormal. Nerves and maladjustment constitute a kind of poor health to which physicians pay little attention until it reaches the stage of hospitalization, or conflict with authority outside the home. The significance of these conflicts to the future life of that child has not been appreciated by the general practitioner and pediatrician, to say nothing of parents and teachers. W.A. White[175] says, "This has been called the century of the child; we have discovered the child, but have not yet discovered how to treat him." Preventing nervous children from becoming psychotic adults is one of the greatest fields of preventive medicine.

The functional nervous diseases of childhood are many and varied, and all of them worthy of careful study by every physician coming in

contact with children. This study is of hysteria as it appears in children, undertaken with the idea not only of studying its manifestations during the childhood period, but also of its significance in the child with regard to the adult that is to be.

There are many definitions of hysteria, many of which are limited by some particular theory of the person making them. Hysteria has so many manifestations that it is impossible to include them all. I have accepted that of Hassin[77] as as simple a one as can be found. Hysteria is a bodily (or mental) disturbance without structural lesion, and dependent in a way unknown to the patient on mental causes. Jelliffe[95] says that hysteria has been described through the ages, but still remains the great enigma of the human personality. There are, however, a few definite conclusions on which one can start the study of this disease:[112] (1) organic alterations are absent, (2) the symptoms are dependent on psychic emotions, and (3) the psyche is diseased.

Hysteria was one of the earliest diseases to receive the attention of medical thinkers and writers though the recognition of its existence among children is a comparatively late development. For centuries it was believed to be a disease of adult women only. Jelliffe[95] tells us that descriptions of hysteria appear in the various sacred books of the East. As early as 1800 BC a description of it as a disorder of menstruation appears in the Vedas. All through the medical historical records we have the development of the idea of the unsatisfied uterine longing as being of genetic relationship. The very word is derived from the Greek word meaning uterus. Plato[161] wrote of it: "The matrix is an animal that longs to generate children. When it remains barren for a long time after puberty it feels it difficult to bear, it feels wroth, it goes about the whole body closing the issues for air, stopping the respiration, and occasioning various diseases, until desire and love bringing man and woman together, make a fruit and gather it as from a tree." This interpretation stood for centuries. Hippocrates[152] wrote

of globus hystericus, "The uterus is a living creature which feeds on masculine semen, and when this means of nourishment is too scanty, looks around for other sources, and so in hypochondriacs it wanders upward as high as the throat". No Freudian is stronger in the belief in the relation of sex and hysteria than were these early writers. The idea of uterine wandering persisted up to the time of Galen. He proved that this was impossible, and formulated the theory of menstrual retention, and from his time on the literature discussed uterine vapors that struck various parts of the body with the resultant symptoms.[95] The idea of uterine etiology did not disappear entirely until about the middle of the eighteenth century, though it was doubted by many for some time before that. During this very early period also, the more dramatic aspects of hysteria, such as convulsions, received considerable attention as evidence of demoniacal possession, and many were cured by exorcism and other preternatural methods. These people were regarded with curiosity and somewhat uneasy and uncritical admiration, and at the same time revered and esteemed, but believed to be a problem of the clergy rather than the medical profession, since this aspect of the disease was not considered part of hysteria, according to the conception of the time, as it attacked men and children as well as women, who were the only ones allowed to have hysteria in that day. However, by the early seventeenth century, its occurrence in men was clinically accepted, though the distinction between hysteria and hypochondriasis was not clear cut, the one being considered the female and the other the male manifestation of the same disease.

In 1617 Carolus Lepois[95] first observed that hysteria existed in children, and the next year he made the revolutionary statement that neither the uterus, the stomach, or any internal organ could be blamed for hysteria; that it is the head only which is its generator, and this not sympathetically but idiopathically.[51] This article again reiterates

that it can occur before puberty. From this time on its occurrence in children was fairly generally recognized, but Lepois' theories of causation were apparently either ignored or forgotten for more than a century.

Late in the eighteenth century Mesmer brought out his principle of animal magnetism.[90] Mesmer did not recognize the significance of his work or his cures, but he started a wave of interest which did not stop until the understanding, not only of hysteria, but all the psychoneuroses was on a much firmer basis. Even during Mesmer's lifetime his followers split into the fluidists, who claimed that neuroses were modifications of the "nervous fluid", and the animists who had some idea of interpreting both hysteria and hypnosis in terms of thought and imagination.

By the beginning of the nineteenth century the occurrence of hysteria in children, boys as well as girls, was well recognized, though it was believed to be rare. Georget,[51] in 1824, and Landouzy,[57] in 1846, reported cases in children. In 1855, Briquet[42] wrote of it as a nervous disease of the brain, and just as apt to occur in children as in adults. He claimed that one fifth of all cases of hysteria occurred in children under twelve years of age. In 1859, Scanzoni[57] wrote an article advancing the claim that it was due to masturbation.

The pioneer in the modern investigation of hysteria was Jean Martin Charcot, who was the first to make a systemic study of the neuroses, at the Salpêtrière, and formulated a clinical picture of the various types.[71] Charcot's first publications were were around 1870, and from then until about 1895 his school flourished, and while many of his ideas are no longer accepted, most of the great psychiatrists of that period began their studies with him. His conclusions about hysteria were that it was adisease which could be studied like any other, that is, was on a physiological basis, and was caused by a special form

of degeneration of the nervous system. He believed it to be a true psychosis. He taught that hysteria manifested itself in two ways. The first was the persistent symptoms or stigmata, of which he believed the patient to be unaware, and the most common of which were retraction of the field of vision, pharangeal anaesthesia, certain forms of cutaneous anaesthesia, and various painful areas or hysterogenic zones.[85] The other form was the temporary obvious symptoms as convulsions, paralyses, etc. He made wide use of hypnosis, and taught that the three phases of hypnosis (lethargy, catalepsy and somnambulism) were organic symptoms which might be taken as definite signs of hysteria.[93] He reproduced paralyses in his patients by means of hypnotism, thus proving that they could be the result of specific ideas in the patient's mind. This was an immense step forward, and was probably Charcot's most valuable contribution, although he believed that such paralyses could only be produced in an individual with a definite hysterical taint, his "grande hysterie".[79] While Charcot's ideas were soon attacked by his own pupils and others, they received very wide acceptance by the world in general, and for the next thirty years hysteria was a very fashionable disease, and occupied an extensive domain, being believed capable of producing all sorts of lesions including hemorrhage, ulceration, fever, gangrene, edema, gastric ulcer, hematemesis,[7] etc. However, as time advanced, one "hysterical" syndrome after another has been removed to a more stable classification based on organic lesions. The belief in the stigmata and the hereditary taint have clung the longest.

Even while the Salpêtrière school, fathered by Charcot, was flourishing there were many who disagreed with him, wholly or in part. Bernheim, of the Nancy school, gradually came to the opinion that artificial hypnosis was due to suggestion, and that the phenomena which Charcot had described as hysterical were capable of being produced by suggestion.[79] He declared that not merely hysterical people were hypnotizable, but

that practically everyone could be hypnotized. The vogue for hypnosis waned considerably from this time on. At about this time also, (1880-95) Moebius, in Germany was giving voice to the theory that all of the phenomena of hysteria, physical as well as psychical, have a common psychogenic origin, and that emotion forms the essential part of the hysterical reaction.[95] He taught that the hysterical symptom was an abnormal expression of emotion, different from the ordinary emotional reaction because of a primitive kind, and that the only difference in liability to these symptoms lay in the greater or less resistance of the personality.[170]

In 1880 S.H. Desseau[57] wrote and article on hysteria in boys in which he recognized the factor of emotinnal instability in its genesis, and pointed out that the symptoms could be cured, but not the hysterical disposition. He considered, as important causes, overstimulation of the growing brain from excessive study, fear, regret, ill treatment, or grief. He believed that there was a faulty supply of nutrition to the nerve centers, and warned against drugs, except a tonic to "supply material for generating nerve force". Barlow,[11] writing in 1881, of hysterical analgesia in children, challenges Charcot's statement that anaesthesia and alteration of the special senses were indications of hysteria. Hun,[94] in 1892, advocated mental rather than physical treatment for it, and Putnam,[129] writing in the same year, on hysteria in children, laid emphasis on the etiological significance of the home conditions, though he, with all the others of this period were firm believers in the hereditary factors. While the purely mental aspects of the disease were being more and more recognized, in the late nineteenth century, there were many who did not give up belief in its physical basis. A.A. Eshner,[56] in his article, "Hysteria in Early Life", written in 1897, stated his belief that the disease has a pathology of its own, depending essentially on metabolic and nutritional changes in the cellular elements in the central nervous system, and he believed

that it only needed improvement in staining methods to bring this out. Taylor,[167] Biller,[15] Burr,[24] and others of the period agreed with Eshner.

The pupils of Charcot who have had the most influence on the modern conceptions of hysteria are Janet, Freud, and Babinski. There are many others who have added to, or modified, the conclusions of these, but a detailed study of the work of all of them is outside the province of this paper.

Janet, according to G.W. Smeltz,[53] was the first to maintain that the symptoms of hysteria were purely mental in character. He formulated the theory of hysteria as a "malady of the synthesis of the personality". He taught that it was a form of mental depression, characterized by restriction of the field of personal consciousness, and a tendency to dissociation and emancipation of the systems of ideas and functions that constitute personality. According to Janet, there are two kinds of psychic operations: easy ones requiring of a few elements only, and difficult ones which require the systemization of an infinite number of elements, involving a new and intricate synthesis in each operation. When the "nervous tension", or "psychic force" is lowered by puberty, disease, fatigue or emotion, there is a general lowering of the level of psychological performance. In hysteria the lowering of the psychological tension is localized in one particular function, which disappears in consequence from consciousness, or is dissociated from the rest of the conscious personality. The dissociation is mainly of a function which has been weak or disturbed, especially if it has been in activity at the time of the great emotion. The function which is lost by this loosening of the personal synthesis might be simple, as the memory of the appreciation of pain, or might be complex, as when a whole system of ideas is dissociated. Janet does not explain why the personal synthesis is loosened,[63] and except that hysterical dissociation is said to occur at moments of great emotion, he offers nothing

as to what brings the dissociation to pass.[79]

Probably no one has aroused more controversy among those interested in conditions of the mind than has Freud, and only the briefest treatment of his theories can be given here. As early as 1880, Breuer, working under Freud, noted that hysterical patients became apparently well after a forgotten event of a personal and emotional nature was recalled under hypnosis.[77] From this he started on the hypothesis that the individual roots of the hysterical symptoms are in the ideational complexes with marked feeling tone, which come about as the result of physical or psychical trauma.[95] Freud started from this, and at first included the suppressed memories of any emotional content, and gradually came to his present thesis of the sexual etiology as the sine qua non of all neuroses.[46] He teaches that the unconscious mind contains many forces, chiefly, if not entirely, of a sexual nature, which are utterly repugnant to consciousness, but which, nevertheless, are continually endeavoring to force their way into consciousness.[63] In this attempt, they are continually opposed by the repressive force, which Freud has termed the censor, which, when it does not succeed in completely repressing the primitive trends, only allows them to become manifest in some disguised or symbolic form, that is, there is a "conversion" to a physical symptom. At first the sexual force was thought to be some specific trauma, but later regression, that is, the return, or desire to return, to an infantile type of love, or to sexual experiences which had existed only in the patient's childish fantasies, was sufficient.[79] These memories or desires are unpleasant to the superego, or ego ideal, of the individual, and he represses them by a more or less conscious effort. They are not forgotten, in the sense of being annihilated, but become unconscious. If repression is entirely successful, the unwanted memories never reappear in any form; if only partially successful the memories or desires appear again in

consciousness, but under a disguise, the disguise forming the hysterical symptom. The "psychic energy" derived from the repressed ideas is said to be "converted" into a physical symptom or sign.[79] The particular form of conversion symptom chosen by the mind is not an accident, but is determined by mental events which have caused that part of the body to be associated in some way with the unpleasant memory or desire. To the Freudian the symptom has a double function. It is an end to the repugnant tendency which, disguised as it is, hides its real nature from consciousness, while the disability it causes is a manifestation of the disapproval of the personality, directed to the whole unconscious process.[65] He explains the well known fact of the mental calm of the hysteric, that, following the development of the conversion symptom the psyche is at rest. Freud admits that there are some people who are constitutionally unable to convert their complexes, and for these he says there is continued repression, and an anxiety state results, which he includes as a manifestation of hysteria. His treatment is by psychoanalysis, including interpretation of dreams, believing if all of the offending material can be "ventilated" conflict will end, and the hysteria will be cured.

Whatever one's own opinion may be as to Freud's theories concerning the etiology of the neuroses, his work has been of great value in the study. His belief that the etiological factors would be found in the past life of the patient, forms the basis of the mental investigations carried out by all psychiatrists of today. Up to his time, except for belief in the evil effects of masturbation, the sexual conflicts of the neurotic were considered to belong in the medical curiosities of Hippocrates' day. Finally, his method of treatment is to teach the individual to analyze his own difficulties and face them. This is the basis of present day psychotherapy.

His critics feel that he has had a tendency to generalize from a very small number of specific instances, and that all the neuroses

cannot be translated in terms of his theory of the libido, however wide his interpretation of sexuality may be.[79] They feel that by his employment of opposites he can prove anything he wishes, in that any psychic fact or symptom may betoken one of two things, itself or its precise opposite.[44]

Babinski was a pupil of Charcot, but he departed far from his teacher's theory of the physiological cause of hysteria. In about 1892 he was writing of his theory that all of the manifestations of hysteria are due to suggestion alone.[7] His work received little general notice up to the time of the War, probably because the interest in hysteria had died down, especially on the part of the general medical men who rejected anything that could not be handled on a mechanistic plane. During the War Babinski and his associates had an immense amount of material on which to work, and he felt that he had entirely confirmed his belief that the symptoms were entirely produced by suggestion, and could be entirely removed by explanation and persuasion.[95] In fact, he claimed if the patients were not cured by counter suggestion they were not hysterics but malingerers. He said that predisposition, personal or hereditary antecedents, the nature of the individual and his emotional constitution were etiological factors, but of secondary importance to that of suggestibility. He considered that minor manifestations of hysteria were present in anyone placed under certain circumstances, and under active causes which diminish the psychical resistance. Babinski's critics feel that he confused the symptoms and the disease, and that his investigations did not go deep enough into the ultimate causes of the condition.[63] However, he emphasized the great suggestibility of the hysteric and brought out the true nature of the stigmata, and their relation to suggestion.[48]

The other main theory concerning hysteria, which many have taken for their own beliefs, or have modified in some way, is that of Pavloff, or rather Krasnogorski's[101] application of Pavloff's work on the conditioned

reflex, to hysteria. He believes that hysteria is on a physiological basis, which makes his ideas acceptible to many who reject the purely mental theories. He thinks that the reflexes of the cerebral cortex are temporary, acquired, adaptive, conditioned reactions, which function as long as the conditions under which they have been established, exist. The cerebral hemispheres have this positive function, and also develop great inhibitory activity, with resulting reciprocal induction, that is, the excitation of some cortical cells produces inhibition in others, and vice versa. The normal activity of the brain is based on a precise and flexible balance between these excitatory and inhibitory processes. The various stimulations always arising in the individual's environment become conditioned, and begin to evoke one or another activity, if they have occurred simultaneously with this activity several times. However, the functional neuroses reveal pathological changes in the reactivity, not only of the cerebral cortex as a whole, but also of its separate conditioned reflex systems. Krasnogorski and his associates believe that hysteria is a disorder of cortical and infracortical activities, based on the functional insufficiency of the cortical cells, which are characterized by hypoexcitability and quick exhaustion, as well as extreme sensitivity to new stimuli. In the hysteric the flexibility of balance between the excitatory and inhibitory processes is lacking; the dynamic equilibrium being shifted aside and not quickly restored as in the normal, but resulting in excitatory or inhibitory after effects of long duration. They also believe that a conflict between excitation and inhibition is of significance in provoking symptoms of hysteria. They think that in hysteria there may be segregation of parts of the cortex for long periods, with resulting inactivation and exclusion of large fields from the general analysis and synthesis of the brain.. The cause of such segregation is considered by Ross[77] to be an emotional reaction,

first aroused by a certain mental mental event, this reaction tending afterward to be aroused by any other mental event which has been associated with the first one. The secondary mental event may be totally without emotional significance in itself, but by virtue of its association, becomes capable of arousing the emotional reaction without the presence of the primary event in consciousness, or, in the absence of any conscious connection between the primary and secondary events, which may both, nevertheless, be fully conscious. E.E. Mayer[113] in his criticism of the conditioning school, feels that it does not answer why humans vary so greatly in respect to the conditioned reflex responses, or what is the true significance of the unsocial substitute reactions.

For most people no one of the above theories sufficiently explains the nature of hysteria, and most have formulated a rather elastic conception of the disease as a faulty reaction to personality difficulties, which may be conscious, but are more often unconscious. In other words, hysteria is more than a symptom, or collection of symptoms, but a psychogenic expression of an inadequate personality. According to Bleuler,[16] it is a manifestation of a strong personal need for expression and a more active character, combined with a circumscribed feeling of inferiority in real accomplishments. Smeltz[153] believes that the content of the unconscious is about the same in all individuals, whether normal or abnormal, but he subscribes to the Freudian view that in the abnormal, repression is incomplete. In the hysteric, the repressive forces displace the objectionable impulses away from the field of conscious awareness into peripheral somatic ennervations. Adolf Meyer[144] considers it an example of under reaction rather than over reaction to difficulty, characterized by a removal of the usual inhibitions controlling human actions, especially those against the free play of the emotions. Others (Hassin,[77]

Jelliffe[95]) think it to be an over reaction to slight psychic stimuli. Whichever of these is true, there is an inability to control emotional display, and profound emotions are aroused by stimuli that do not produce much response in the normal individual. For some reason the hysteric is not able to obtain satisfaction of his emotional strivings along normal paths, but his emotional instability is so great that the personality must have some type of outlet. This need for emotional satisfaction is greater than his ability to adapt and conciliate the separate factors in his personality, and some compromise must be made. The hysterical symptom is the result, and through it the personal needs and wishes are unconsciously and imperfectly gratified.[81] It is a flight into disease, as a reaction to an unbearable situation, or one wished to be otherwise. The fundamental inadequacy of the individual is an inability to face reality. By the development of the symptom, he is attempting to compel consideration, secure care and tenderness, evade responsibility, and obtain power over others, who have adjust themselves to the disease. The reaction is always a retreat or flank movement,but never a frontal attack. Bleuler[16] thinks that the choice of the hysterical symptom as an outlet for the conflict, is because of a weakness of the health conscience, which allows the patient to create for himself a makeshift on the path leading to disease. He believes, along with White,[176] Henderson and Gillespie,[79] Smeltz,[153] and others, that there must be , in addition to the conflict, which is present in all neuroses, a psychopathic predisposition to this particular form of reaction. In the normally functioning mind, there is also constantly going on a"battle of motives", and the normal individual may find the wish to be sick, in order to escape his conflicts, coming into the struggle for supremacy between the several elements, but for him this method of escape is closed, no matter how strong the wish may be.[176] The hysteric can be deceived by his own subconscious, the normal mind cannot. The nature of this predispos-

ition is under dipute, and will be discussed more fully in the consideration of etiological factors of hysteria. In the development of the somatic reaction to the mental conflict, suggestion operates powerfully, and, since the suggestion of disease is in harmony with one side of the conflict, the desire to escape, the suggestion is accepted. White[76] believes that the crises of hysteria are always associated with certain unconscious ideas that are connected with some previous experience, having alarge content of painful emotion, which has been forgotten or dissociated from consciousness. The conditions of dissociation may have origin in severe emotional shock, or be the reaction of a badly knit personality to the demands of reality. This agrees with Bleuler's[16] view that usually the pathogenic wishes are unconscious, while in the patient's consciousness, the opposite impulse is not only important, but dominant. As a result of this prominence of the bodily disturbance, there is little or no conscious mental perturbation. From the fact that the symptom is the solution of the problen, and that it is misrepresented in the patient's consciousness, arises the patient's "belle indifference", first described by Charcot.[77] The patient is unaware of the real meaning of his symptom, and if he thinks about it at all, he believes it to be simply an illness in the ordinary sense. Henderson and Gillespie,[77] in their textbook, do not believe that the onset of the symptom necessarily involves repression, but may be the result of intense mental conflict without repression. They feel that the connection between the symptom and the conflict may not be as much repressed as neglected, and that the actual problem may remain in the patien't mind, but is no longer acute, since the symptom has provided a solution of an indirect kind.

Gregory[70] says that hysteria is always the reaction of the infant. He feels that the specific symptoms are largely repetitions of action

patterns, established during early life, and to which the individual returns, as a reaction to reality. W.A. White[176] defines the term as a type of reaction in those who in mental organization still are children. Strecker[164] calls hysterics "adult children", and C.M. Campbell[30] says that in these individuals, the child continues to direct the activity of the apparently emancipated adult, and that any psychopathologist is bound to have a keen interest in the problems of adaptation in childhood. Wechsler[172] believes so firmly that the roots of the symptoms can be traced to early childhood, that he says he would regard with suspicion any diagnosis of hysteria in an adult or middleaged person who had previously been well adjusted.

The prevalence of actual hysteria among children under the age of puberty is a matter of some dispute. B.R.[130] Rachford, in his book, "Neurotic Disorders of Childhood", says it is rarely met with before the age of seven, but is common from ten to fifteen. He thinks the milder forms are commoner in children. Price[128] agrees with him as to the age limitations. He says it is commoner in girls than in boys, but is more severe in boys. Sachs[143] reports it as rare in children, but says that when it does occur, it is an important factor in the future life of the child. Gordon[66] feels that it would be diagnosed oftener in young children if early and mild manifestations were recognized.

In taking up a consideration of the etiology of hysteria in children, we must consider the mentality and constitution that he inherits, and the influences to which he is exposed. The influence of heredity as a causative agent is in considerable dispute, but there is a general sentiment at the present time against using the term with any sense of finality. Babinski[7] rejects the influence of heredity entirely. Sachs and Hausman[144] say that hereditary influences are important, but that environment is just as much so. Corson[37] thinks that heredity and constitutional endowment is one etiological factor, but

not necessarily the only one. McGeorge[109] studied a large number of cases, and found an unstable heredity in a large per cent of them. Rowe[141] feels that, while other elements than heredity are the more important, the biological background makes the development of the mechanism easier or harder. According to Allen,[4] inherited physical or mental disabilities make a child less able to face his environment, but he feels that in this there is an added factor that, because of these disabilities, the training of the child is not normal. Griffith[76] considers inheritance important, but feels that the bad effect of heredity may never appear under proper environmental conditions and training. Cameron[27] says that that which is inherited is mainly a variation in susceptibility in the degree of reaction to the influences of environment. Gregory[70] considers that the mental mechanisms, built as reactions to the early environment of the individual, are definitely built on an inherited basis. L.J. Doshay[58] in his article, "Evolution Disproves Heredity in The Mental Diseases", says that heredity in the psychic diseases has never been established, although it is everywhere accepted more or less as a fact. He says that if the neuropathic constitution is an inherited characteristic, and transmitted in the germ plasm, then, by the confirmed laws of selection and "survival of the fittest", the neuropathic families harboring such disabling inherited traits, should have been eliminated long ago in the struggle for existence against healthier elements. However, neurotics and psychotics carrying such defective traits, are ever on the increase, and the more complex and stressful the environment, which should all the more readily remove these undesirable weakling stocks, the greater is the increase in their numbers in ratio to the healthier types. He concludes that this defective trait of the neuropathic constitution is not inherited in any form, but is developed entirely by unhealthful environmental agencies. He claims that we are all susceptible to mental disease, because of our extremely complex brain mechanism, and that

most of us show mild manifestations of mental instability at some time or other during life, but have sufficient resistance to overcome the small nervaous traumata. He points out that in the present day, even the strongest advocates of heredity admit that mental diseases are not inherited in the form of the disease, but as a predisposing constitutional trait. He claims, and gives a number of authorities who support him, that the neuropathic constitution appears in untainted families as much as the tainted. Glueck[65] adds to this evidence by calling attention to the fact that a serious hereditary burden frequently lurks in the background of happy and successful people, and E.E. Mayer[112] says that if one runs the gamut of all the relatives, maternal and paternal, of any person, whether he be normal or abnormal, one cannot help meeting a near or distant member who has shown signs of some neurotic disturbance. Burr[24] says that there are three types of individuals. In the first the heredity is good, the nine months in the uterus and the birth is normal. This person will go through life normally unless some external environmental thing breaks him. The second type is made up of those who, because of hereditary defect or congenital injury, come into the world with weakness which leads inevitably to early breakdown, no matter how good the environment may be. The last is made up of those who cannot survive the stress and strain of life unless they have a good environment, and wise guidance to maturity. The debate of heredity alone, versus environment alone, is interesting but impractical, since it is environment alone that is amenable to correction or control.

McGeorge[109], in his study of environment and hysteria, claims that environment is the only cause that can be found in seventy five per cent of the cases, and most of the authors agree with Morse[117] who says that heredity probably has much less to do with the peculiarities of these children than the association with and example of their parents.

It is a general observation of individuals studying this disease that there will nearly always be another nervous person in the family, but it is believed that his influence is more by suggestion and example, than that the child inherits his peculiarities. Wile[180] observes that the child forms only one part of the problem of childhood, and most of the other part is his parents, or parent substitutes. White[175] says that the child in the family is very much like the glass of milk in the ice chest, absorbing the flavor of all the personalities about him. Griffith[72] thinks that constant association with nervous uncontrolled parents is the most common etiological factor of hysteria, and DeMerritt[50] feels that because the parents have a fundamental lack of will power, they are unable to enforce real discipline with the child. Morse[118] claims that if the infants and children of neurotic parents are fortunate enough to be brought up and cared for by sane and calm people, they seldom show evidences of nervous instability, but if the offspring of stable and common sense people fall into the hands of neurotics, they quickly become unstable and excitable. Every child is very suggestible, and most children will fall under the influence of any suggestion which is persistently made to him by the grown up persons around him.[28] Morton[119] points out that character is caught, not taught, and says that in his experience, the child's reaction type will nearly always resemble that of his parents. No matter what precepts the parent thinks he is instilling into his child, if the child is continually associated with one who dominates the situation by abnormal conduct, he will reject the direct suggestion and embrace the indirect.[18] Children do not discriminate what, or who, to imitate. Strecker[163] says that imitation is the psychic mechanism we use to supplement our weaknesses, and that in it we are rather close to the psychic process of identification. He thinks that this attempt at identification is the emotional driving force back of the imitation of children, and that this is the beginning of ideal-

ization, and a force which will be very influential in determining its future behaviour in adverse circumstances. If we believe in heredity as an important etiological factor in the development of neuroses, we can easily see that the child's hereditary taint is going to be fostered, and grow in such an environment. If we believe in environment alone, we can understand that the child, whose main influence is a maladjusted individual, has a handicap at the start that will be hard to overcome.

The infant is born into a world that is new and strange, and, according to Smeltz,[63] he brings with him certain emotionally toned components which represent strivings, cravings, and impulses, intrinsically bound up with the basic or primitive instincts, such as are characteristic of all living things, and are manifested in the human organism, as in animals, in those functions which have to do with race and self preservation. In the human infant, as in the animal, these are given relatively free range, and tend to dominate conduct in such a manner as to give the most direct and unreserved gratification to the individual's instinctive cravings. In the process of growth and psychological development, there is encountered increasing conflict on the part of the child, as it begins to feel the pressure of social prohibitions, and with it the necessity for modifying or conditioning its conduct in reference to its former self, in such a way as to meet the demands of the more adult social environment. The forces entering into this process go to make up the ego, or social, or ideal self. However, this ego always remains more or less in conflict with the wishes, cravings, and desires characteristic of the more primitive, instinctive, or infantile self. The organism that succeeds in maintaining itself in a state of dynamic equilibrium in the midst of these shifting emotional trends, is one whose condition is synonymous with emotional health and stability. The way in which the transition is

made is thus seen to be of paramount importance to the child's future life, and it is the parent who has the greatest influence on the course that the child will take, there being several attitudes on their part that are particularly conducive to bad mental habits, especially of the hysterical type, on the part of the child.

The first, and one that is found in a very large proportion of the cases, is too scrupulous care of children, especially by those who do not hide their fears and apprehensions from the child. Maternal over protection saps the independence of the child, and gives him poor preparation for psychic maturity. Young[119] calls attention to the fact that before school age the child must go through a transition from almost complete dependence, to a beginning of that period of essential independence and self assertion. Anything which protects him from experiences which would otherwise form part of his normal training is bad. In some children this may be physical disability or disease, but in too many it is simply that the parents kept them from those experiences. This element is so important that Allen[1] makes the definite statement that over emphasis of the parent-child attitude, with persistence of infantile relationships, and lack of experience as an individual facing new situations, in the home and outside the home circle, appears to form the background of all but very few cases of neuroses in childhood. Sweet[116] points out that the evolvement of the self sufficient, balanced, sagacious adult, from a dependent, inexperienced cautious infant, is a process of growth, and that to prolong any phase of infancy beyond its normal time is dangerous, robbing the over protected child of the opportunity of arriving at some of life's stations on schedule. This parental attitude is usually a manifestation of the parent's own difficulties and maladjustments. The parent who has had much unhappiness tries to spare the child all unhappy experiences, and to guard it against even necessary pain.[83] As a result, the child has no chance to learn the

mechanism of combatting the immediate desire, or to develop patterns to guard itself against disappointment. In many cases, the child is regarded merely as an instrument for parental pleasure, satisfaction, or expiation.[178] He may be merely a toy, an outlet for parental emotions, a comfort and solace, a satisfying but spoiled object of manifold solicitude, or he may be a victim of parental fears, disappointments, and vicissitudes. This is particularly apt to be true if there is an abnormal relationship between the parents, or if one parent is absent, either temporarily or permanently. McGeorge[109] believes that in this respect the loss of the father has a great influence in the development of hysteria, in both boys and girls. He says that in the case of the daughter, who is often close to the mother emotionally anyway, she becomes too closely identified with the mother. He believes with the Freudians that there is, especially during adolescence, a definite trend to the father, which is normal for a girl at that age, and represents a necessary development of her sex life. If she is deprived of the father she gropes blindly for a new love object, and is apt to return to the mother, but this time with an intensification of emotional relationship that is not normal. In the case of the boy, the mother always represents safety and security from the world and adulthood, while the father represents the ultimate achievement of manhood. He will tend to turn to his mother when he wants to escape from difficulty, and will want his father in more venturesome moments. As he gets older his attitude toward the adventure of life, and hence his interest in and identification with his father normally increases at the expense of his demand for refuge in the mother. If he is deprived of his father, the protecting influence of his mother is apt to be too great, and hamper his adaptation to the adult world.

Whatever the reason for this over protective attitude, it is apt to have one or more bad effects on the child. The parent, and it is

usually the mother, wishes to keep the child as dependent on her as possible, and does everything she can to make the dependent role more attractive to the child than the independent one, with the result that he wants to go through life reacting in the childhood pattern.[103] As has been pointed out before in this paper, this is an important etiological factor in the genesis of hysteria. Rowe[141] points out that the emotional experiences of a child's early life are nearly always pleasant, and that there is always danger of his wanting to get back to this. If there has been excessive mothering, the child will be apt to go on demanding excessive love and care throughout his life. If he is unable to get it from an adult world, we have either a disillusioned individual who retires from the world of adult emotional relationship, or one who learns by bitter experience that his infantile reactions will not work. During the first few years of life the child is weaned, is taught sphinctor control, and must learn, to a greater or lesser extent to subordinate his own wishes and desires to those of others. Gregory[70] notes that weaning is especially hard on a child whose every wish has been anticipated, and that he is apt to show excessive conservatism about his food all his life. Wile[172] says that the mental health of the child is manifest in the development of adequate and acceptable habits with reference to food, to the excretions, to sleep, and to the genital areas. Culpin[48] emphasizes that the overanxious parent tends to stress the emotional aspects of those prohibitions which form so great a part of the education of the child. The teaching of sphinctor control, enforcing the demands of modesty, childhood sex manifestations, etc. are given such importance in the eyes of the mother, that the child's attention is unduly forced on them. This, according to Allen,[4] is usually the result of maternal experience in association with a strong sense of responsibitity, and points out that, more often than not, it is afirst or only child who suffers under this treatment. In

his investigation of a series of cases, he found that 89.5% of all cases of hysteria were only, or youngest children, or children isolated by years from others. He says that excessive attention to the child, without knowledge of when to take notice, and when not, leads to exaggerated dependence of the child on the mother, and increased anxiety on the part of the mother.

Another result of over solicitude on the part of the parents, an especially important form from the point of view of hysteria, is the family attitude toward illness. If the child has some true physical disability, the mother has a ready made excuse for keeping him tied to her side. If he has not, every detail of his life is apt to be interpreted from the health point of view. Every condition and symptom of his own , or of anyone else, is discussed in front of him, and their importance stressed. If he suffers from any illness, he is petted and coddled, and any independent, more adult reaction to life that may have been forced upon him, is no longer necessary, and he can be the complete baby again as long as he is ill.[163] This escape into illness, then, becomes a very tempting pathway, at any time he sees an independent existence, or unpleasant experience, being forced on him. The factor of auto suggestion is important in these children, and Price,[128] Abt,[2] and others, tells us that hysterical children often have the symptoms of a previous organic affection, and Hecht[75] and Thomas[161] point out that hysteria may complicate organic disease. Thomas[161] also says that in young children, the symptoms are probably nearly always imitative or autoimitative, and if the child sees some other member of the family win his desires by illness, of if he himself has won that way in the past, he is very apt to turn to it again in time of stress. It is a well known fact that children affected with major or minor ailments, will, in different environments and surrounded by different persons, present great variations in the clinical picture.[97]

Another parental attitude which may engender hysterical symptoms in a child, but which occurs much less commonly than the above, is that of over strictness. The effect is really much the same, for it prevents the child developing the self assertion and sense of responsibility normal for his age. Training in implicit obedience, such as occurs in soldiers, is said to heighten suggestibility to such an extent, that hysterical symptoms are easily produced.[79] McGeorge[109] thinks that dependence and lack of initiative in a child is just as important as its opposite, for excessive self assertiveness on the part of the parent mey produce the negative reaction of self abasement in the child. Gregory[70] says that some mothers show their overconscientiousness by too much cruelty in training during the second, third, and fourth years, and that this is fully as bad as the other extreme. If, in addition, such a child finds that illness exempts him from his hardships, he may find it easy to turn toward hysteria. Morton[119] points out that proper authority does not mean dominating a child's life, but guiding it.

A third parental attitude, which is even less common than the other two, is that of neglect, but when it does exist, the harm is as great, if not greater, to the susceptible child. The child of the indifferent mother starts out in life with a handicap of uncertainty and fear.[119] Every parent is a citadel for his child, and it is just as harmful to let it crash too quickly, as to keep it up too long. Very often the neglected child has the added difficuty of being always in competition with a more favored member, to whom he is compared to make him feel his limitations.[178] If his physical and mental ability are, in addition, actually of a type that cannot meet the normal stress and strain of life, he is less able to cope with the fears engendered by parental neglect.[130] Young[139] believes with Morton[119] that fear is the underlying etiological factor in all neuroses. He says that fear is fund-

amental and inherent in the human organism, being necessary for self preservation, and as a result, the individual from birth is confronted with feelings of insecurity, varying in character and intensity with the economic and intellectual level of the home. For these feelings of insecurity, he must find compensation in some sort of protective mechanism, and to nearly every child the symbol of protection is in the parent. If the parent fails as this protection, the child's adjustment suffers a serious setback.

A situation frequently found in the case of hysterical children, is that the child has been allowed to completely dominate the family scene. The love of power is one of the most universal and fundamental of human characteristics. In the case of the infant, too often everything is done to make baby satisfied. The child senses this unconsciously, and wants to hang on to whatever bit of power he has obtained. Young[189] believes that this is the result of a fundamental feeling of insecurity, that exists in everyone, because of the threats to biological stability that start at the moment of extrusion from the protective environment of the maternal uterus. This desire for domination is a desire for an adequate response to neutralize the feeling of insecurity. Sweet,[166] along with Young[189] believes that attention from his fellow creatures is a primal necessity for all normal human beings. Both say that attention must be had, even at great cost, and if favorable attention is not available, then unfavorable is better than none, pointing out that many children prefer physical punishment to lack of any. Emotional habit patterns which are formed subsequent to birth, are basically conditioned, and one of the most potent means for this conditioning is the satisfaction of biological needs, the most fundamental urges being the strongest of conditioning factors. Young[189] and Morton[119] both believe that fear, expressed through a feeling of insecurity, in the "play for attention" is one of the most potent factors in early

habit formation, with the resultant influence on the adult life patterns. This need for the attention of his environment is necessary for normality, but when the child finds himself the most important thing in the environment, he is reluctant to give up any of the limelight. The child learns his power very young, and is prepared to keep on ruling his environment to the extent to which he is allowed. The child who has been taught that he is the center of the universe has a delightful time until his universe changes. Unfortunately as time goes on, either he finds himself, for some reason, no longer the center of the family, or on entering the larger world, finds that he is not as important there as he was in his own small circle. This is a fearful shock to his ego, and his precious security is threatened. Young[189] firmly believes that from these early beginnings may be built up a long train of subsequent defensive reactions, which become more and more involved as life progresses. He claims that, given one weak spot in adjustment, with its consequent threat to security, and there is built up a long train of defensive reactions, always attempting to bolster up the ever crumbling structure, whose foundations are built on sand. This child must find some means to restore himself to the center of the stage, and if illness has proved a refuge to him in the past, he is apt to seek it again. This is particularly true of one already possessed of what Morton[119] calls the "inferiority-fear" complex. He feels inadequate to face a larger world, and can find no way to restore to himself the necessary sense of importance, except to get attention by sickness. The hysterical reaction is a poor expedient, but it is the best he can find.

Block[17] believes that the highest power in man is his self control, and Core[38] considers the most important single factor in the etiology of hysteria is a lack of training in this quality. The result of the interaction of the individuality of the child and his surroundings is the

formation of self control. McGeorge[109] points out that it is only in later years that voluntary control is exercised over the instincts, and that the training of the child to prepare him for such control is up to the parents. If the child is allowed to grow up, giving way freely to every emotion, his preparation for self control is poor, especially if the child finds that by such action, he not gets all the attention he wants, but also has all his desires satisfied. Every child, normal or abnormal, is constantly experimenting with his whole environment by the use of various modes of behaviour, innate or acquired, to find situations in which the behaviour is successful, or in some way satisfying. The self control of any individual is normal for the environment responsible for its production, but in the event of the environment being false, then the resulting self control is defective, as judged by the subsequent surroundings. It is self control that determines one's behaviour to current events and, in the event of its being badly defective, under conditions of pain or discomfort, then, instead of being resolved consciously and thereby increasing experience, the hysterical reaction is liable to come into play in order to relieve the ego from distress.[58] Thomas,[163] in his study of hysteria in children, also considers lack of self control a potent factor, and adds that parental example often acts as suggestion in this. He also points out the evil of excessive parental sympathy and anxiety over any little thing that may go wrong with the child, which encourages the child to make a great emotional display over very trivial things. Morse[110] thinks that the hysterical child is simply the superspoiled child, who has been allowed to attain his desires by making any sort of scene until he got what he wanted. Both Jelliffe[95] and Rachford[130] think that a good deal of this is due to the unwise desire to stimulate the young child, and the attention that he gets from emotional display. On the other hand, Spaulding[157] says that parents often disregard tantrums and excess emotion in early infancy, but later think they must not curb the child's

personality, and often encourage him to express himself without restraint, in any way he chooses. Richards,[136] in writing of common parental attitudes, points out the danger to the child, of bringing him up to be too much of an individualist in his relationship to the rest of society, by teach- him him that the world owes him freedom to live his own life as he chooses. She points out that these children are not only given an ex- agerrated sense of thei own importance, but, instead of being free, are made slaves of their own emotions. According to Spaulding,[157] ex- cess display of emotion may have one or more of three sources. It may be because the situation is one in which the child is prevented from domin- ating, or which threatens to thwart his desires. The situation may threaten to break down some compensatory mechanism that has been cul- tivated in the past to avoid facing difficult situations. The third is the uncovering of the initial inadequacy, or imagined inferiority, on account of which the secondary compensation has been formed. The individual who has been used, all his life, to go on a grand emotional debauch, whenever his personality seems about to be thwarted, wishes to project all his conflicts into something concrete, and the hyster- ical reaction comes very easily to him.

As a result of heredity, or fundamental lacks in environment, or both, there develops an individual of a character which Abt[2] and others consider so typical of hysteria that they describe it under the mental symptoms of the disease. Others (Sachs,[145] Brill,[21] Jelliffe[95]) list it as a mild form of the disease, which may or may not go on to the severe. Still others (Biller,[115] E.E. Mayer,[112] Bleuler,[16] Burr[25]) believe it to be a character in which hysteria develops easily, but which may or may not do so, depending largely on the stress of the enviromment. What- ever one may think about how the hysterical personality should be clas- sified, most authors agree with Wechsler[172] that hysterical symptoms do not sprout forth in persons who have not previously shown some of the

general characteristics of the hysterical personality. He says that not only can the roots of the symptoms be traced to early childhood difficulties, but also the behaviour and personality conflicts. McCarthy[108] says that the hysteric is an individual who from birth reacts badly to the stress and strain of life, and Streaker[165] reports that in studying the amnesic states, he found consistently a history of early personality trends, suggestive of the hysterical reaction. Jelliffe[95] says that, when one finds a malady due to thousands of causes, one will find that each plays a minimal role to the hysterical personality, and that the foundation is a psychically abnormal character. Richards[137] considers it a type of personality indicating a nervous system organization which must be carefully steered through the traffic jams of life. Brill[21] claims that, in certain constitutions, a neurosis is simply a question of environment, and Sachs[143] says that the entire conception of hysteria presupposes an abnormal mental state. Kasanin and Kaufman,[97] in their study of the functional psychoses of childhood, begin with the statement that there is prevalent in modern psychiatry, the theory that the prepsychotic personality determines to a great extent the type of reaction in the psychotic individual. They feel that, since the personalities of children are relatively less complicated, one may hope to arrive at the understanding of the underlying factors with greater ease than with adults. There do seem to be different types of character in which the hysterical psychism finds special opportunity to develop into more elaborate forms.[170] White[174] defines mental illness as a type of reaction of the individual to his problems of adjustment, which is conditioned by two factors: the nature of those problems, and the character equipment with which they are met, and he believes that breaks in adjustment do not ordinarily occur without the cooperation of some lack of balance in the personality makeup.

One of the characteristics most commonly met in hysterical child-

ren, is extreme emotional instability. The mood is in a constant state of fluctuation. The emotions are easily kindled, strongly felt, and restrained with difficulty, or not at all. The explosion will be out of all proportion to the affect shock, both in intensity and duration.[95] Even in the normal child, we have a deficient development of control, as measured by adult standards, but in the hysterical child there is very poor power of judgement as to the weight of the cause which excites the emotion. The cause is exagerrated in his mind, partly by a process of imagination, partly by want of experience, and partly by habit.[73] These children are always carried away by the excitement of the moment. Richards[137] believes that the self motivated stimulation of uncontrolled emotions, is just as serious a factor in touching off biological instabilities as foreign proteins, in other words, that these children are actually allergic, and must be desensitized to the stimulations of the environment. Henderson and Gillespie[77] call attention, in this connection, to the contrast between actual shallowness of the feelings, and the intensity of the expression of them.

Another very characteristic hysterical trait, is the constant and persistent desire to be the center of attention, and the child will adopt any method of behaviour that he has found will bring about this end, and this is usually at the botton of the emotional outbursts which, as pointed out by Bleuler,[16] are usually of a theatrical character. However, if it suits his purpose, he may find it more profitable to appear indifferent or reserved, though this is a less common reaction in children. Mayer[113] says that the hysterical personality, instead of accomadation itself to given situations and possibilities of life, is under the necessity, for himself and others, to appear more than he is, and to live more than he is able. He points out that hysterical reactions occur largely in immaturely developed persons. When a dilemma appears, personality reactions require a decision, and some at-

tempt at a reasoned inquiry. If hysteria follows, it is because reason has no solution, and archaic impulses are released. As has been said before, the hysteric constantly suffers from a constant sense of his own inadequacy of personality, but is possessed of a constant drive to compensate, or at least to fool the world. Bleuler[16] even characterizes the temperament as a mild manic type, with vivid wishes and the need to assert the personality. Every thought, feeling and action of the hysteric is centered on himself, and he is selfish and vain to an excessive degree. However, he is influenced by the opinion of the world on these traits, and is very apt to disguise his selfishness under the guise of supersensitiveness.[15] While some hysterics are capable of much effort and sacrifice for those they love, the manifestations of love must be very theatrical, and the loved individual must be exceptiocally faithful, and loud in gratitude to the hysteric, and the affections of the hysteric may change from love to hate at any moment.[16] A more common reaction, because it is easier, and exempts the hysteric from accomplishment, for which his personality is inadequate, is to attract attention by inviting pity.[95] This is the more typical manifestation because it tends to the more infantile level, on which the hysterics attention is apt to be fixed, and exempts the sufferer from necessity of adjusting to the adult level of reality.[172] Bleuler[16] states emphatically that the hysteric wants to be sick, not just to appear so. As a result the slightest sensation is caught hold of and magnified, his intense will to believe, along with his characteristic lack of mental inhibition, acting as very efficient autosuggestion.[95] He also has the feeling that others do not appreciate him or his sufferings, and that he must accentuate them to make them understood. His egoism is very easily injured, by real or fancied neglect, but the pains of others excite very little interest, and may arouse jealousy.

Other manifestations of the desire of the hysteric for the lime-

light, is the fact that he is nearly always untruthful. This lying may be with a purpose, to get out of an unpleasant situation, but more characteristically shows as a tendency to deception without reason. He is compelled to make anything he tells more startling than the story of his companion. Hysterical children do not, as a rule, get along well with their contemporaries, who are little inclined to act as his worshiping public. Also, his inability to shine in group activities makes him pretend indifference and disparagement.[124] His great desire is to excell in those activities in which the group is inferior, but he usually lacks the ability to do this, so he bolsters up his own sense of weakness by egotistical lying.

The hysterical child is characterized by an excess of suggestibility. Jelliffe[95] points out that few people can think for themselves, but must be led by the few, and adopt their phrases, formulae, and ideas. However, the hysterical presents this characteristic to an exaggerated degree, especially along certain lines of suggested action, and they have a lack of inhibitory power against suggestion. The personality of the hysteric is defective, his emotions are easily aroused, and he wants more attention than the normal person. Any suggestion which offers him an outlet along these lines, is eagerly grasped by the psyche.

Jelliffe[95] says that negativism is very characteristic of the hysterical child. This is a type of negative suggestibility, and is part of the wish to attract attention. Sachs[193] says that, more or less consciously, the hysterical child develops an antagonistic, if not a negativistic attitude. He says, "Ican't", when he means, "I won't". By developing this attitude he gets a type of emotional satisfaction, by proving that in this, his personality is stronger than the other person's. It also may prove him better, because different, from the ordinary individual, and many peculiar habits, and likes and dislikes, develop on this basis. Cameron[27] says that negativism is the response of the dom-

inating, egotistical child to consientous, but timid and uncertain handling. It may also serve to the child as an act of revenge against an over dominant parent.

The hysterical is definitely deficient in will power. He has not sufficient driving power to think things through, or sufficient self control to face reality.[77] His attention and concentration are poor, and he is incapable of any sustained effort to gain his ends. Sachs[143] believes it is not so much a direct lack of power to exert the will, as a tendency to exert it in a perverse fashion, and this seems to be true, as very often the defective solution at which the hysteric arrives, is really more trouble, and actually less satisfactory to the ego, than the normal one would be.

Abt[2] concludes that the hysterical child is not exactly a mental defective, but is not in a state of mental equilibrium. Coutts[41] points out that only a small proportion of the excessively emotional children become subjects of definite neuroses in later life, but that their personalities always present a weaker defense against them. Mayer[112] warns us that the mere presence of emotional conditions in a child, does not constitute hysteria, but is a danger signal, which should be noted by those interested in him. Wechsler[172] describes the type of person most apt to develop hysteria, but adds that not every hysteric shows all of the above mental traits, nor does the occurrence of one or more of them in an individual, make of him a maladjusted neurotic. Burr,[25] in pointing out the difficulties in any personality study, says that there are so many x's in the equation, several of which will remain unknown no matter how much science may advance. Malamud and Lindemann,[11] in their study of psychiatric reaction types, conclude that mental diseases, no matter how specific certain single factors may seem to be, are actually caused by a cmbination of a great number of factors, none of which can be regarded as the sole cause.

Given the hysterical personality, which seems to be partly innate, and partly developed as a result of environmental factors, there is usually a precipitating situational cause for the development of symptoms. White[176] says that the hysterical tendency may remain indefinitely latent, until something happens to produce the characteristic response. The hysterical child is one whose innate reaction patterns are always defective, and the precipitating situation is one which threatens the satisfying situational conditions that he has managed to build up for himself. In some, it is not one, but a series of minor situations, which can, as a rule, be handled successfully by the normal child. Occasionally the exciting factor is so severe that even a child without a neurotic background would have difficulty in dealing with it. Thomas[168] emphasizes the effect of trauma in this connection, and it is true, as Babinski[7] points out, that the pain, and more or less persistent inhibition of movement, resulting from trauma, can act as a starting point for autosuggestion, and the hysteria will survive the exciting cause. This is particularly apt to be true if the trauma has caused a large amount of excitement in the family and sympathy for the sufferer. Closely connected to this is organic disease as an immediate cause. Even if the hysteric is actually sick or injured, his inherent feeling of inadequacy makes the psyche seek exaggeration or continuation of the physical symptoms. The organic factor may be minimal, but can easily act as a starting point in a susceptible individual. However the suggestion offered by the trauma or organic disease, merely provides the outlet, but do not supply the motive, which is in the individual's own conflict of mind.[38]

Allen[4] gives first, in his list of the exciting factors of hysteria, the birth of the next child. As has been pointed out before, most hysterical children are only children, youngest children, or children who have been set off in some way from others, and have been the center of their little world. The birth of another child often involves a period

of readjustment in the normal child, but the hysterical is absolutely unable to reconcile himself to share the stage with another. The hysterical symptom may be the result.

Another exciting factor, which is closely related in its effect to the first, is a rearrangement of the family relationship in some way.[4] This may be the removal, for some cause, from the family scene, of the individual, usually the mother, who has always been his refuge from the world, and on whom his psychic subterfuges have always worked. It may not be that that individual is removed, but the child's security in the relation may be threatened by the introduction of a step mother or step father. The hysterical child is very emotional, self centered and jealous, but, being incapable of loving anyone, except in relation to his own desires, must find some means of bringing the love object back to his side, at the same time avoiding the admission that his personality is not such as to hold love by itself.

Dodd[62] says that the success of adaptation of a child during its first four or five years of life, is measured by the reaction to the arrival of another child, and its entry into school life. This is often the hysterical child's first attempt to mix with others, and to take his place as an individual in the world. He is plunged into new surroundings and new disciplines, and has to find his own level with other children. For the unprepared child, this transition may be extremely difficult, expecially to the child of this peculiar nature. His tendency is alwys the hysterical one of wanting to go back to the infantile protected condition, so that his inadequacy may not be shown up in this new situation. As illness will get him out of school, it is to him an extremely rational escape from this particular situation. This is is especially true if there is a discrepancy between the child's intellectual ability, the school programs, and thehmme expectations.[134] These children are incapable of making up, by sustained effort for

their intellectual lacks, and they do not wish to admit that they either cannot or will not do the work, so all they have left is to be too sick to do it. Allen[4] says that the discipline of school, while often given by the parent as a cause, seldom is, as that feature of school life is usually accepted by the child as a matter of course.

The question of the influence of sex trauma, in the Freudian sense, as a precipitating factor in the development of hysteria, finds less agreement among the students of the subject than do the ones discussed above. Sachs and Hausmann,[144] in their textbook, give early sexual irritability as one of the causes of hysteria. Brill,[21] in his study of psychotic children, came to the conclusion that psycho-sexual adjustments are undoubtedly very important in childhood, and Strecker,[163] in his study of the psychology of normal children, emphasized that it is important not to block the child's curiosity, especially on sex, which, since it is one of the strongest potentials, arouses the greatest curiosity. However, he believes that part of the reason for this curiosity, is not as much the child's fundamental interest in things sexual, as an artificial one created by the adults about him. Stack[158] believes that sex is a subject about which no one is wholly rational, and which everyone approaches with a certain degree of tension. He says that to any discussion of it, we bring the embarrassments, guilts, and personal perplexities that we have acquired in the process of adjusting the most powerful and most individualistic of emotions to the exigencies of our social environment. If this lack of complete sexual adjustment is as universal as he claims,it seems hardly possible that it is the sole cause of neuroses, as is claimed by the Freudians. Somerville,[156] in a discussion of the psychology of hysteria, gives the opinion that it is probable that the greater part of the content of the subconscious (at least the part which mostly influence our conduct) consists of repressed wishes, wishes

that are unethical, or of which we are ashamed, or which are selfish, but not all necessarily sexual, as Freud believes. Thomas,[168] in his study of hysterical children, found masturbation, the commonest childish sexual manifestation, infrequent among them. Other authors would not agree with him. Morton,[119] who believes all neurosis is on an inferiority-fear basis, feels that sex is secondary to the complex, but that sexual malpractice may either spring from the feeling of inferiority and fear, as an attempt at compensation for it, or may be the cause of the complex, because of feeling of guilt and remorse. He thinks that this situation, where the sex aspect is superficial, but the fear is fundamental, is especially apt to be true in children. Mayer[113] believes that response to experience is more important in the neurotic conflict, than the sexual or libidinal drives, even in the very wide connotation of these drives, as is given by the modern psychoanalyst. However, he calls attention to the fact that various sexual maladjustments loom up frequently in the life histories of hysterics, and that many of the older cases show a marked preoccupation, in one form or another, with matters pertaining to sex. Campbell[80] says that we have been influenced by an altogether too simple, conventional conception of the life of the child. He thinks that the precocious development of sexual interests and activities, and disproportionate prominence of certain elements in these complicated functions, is in itself evidence of a neurotic instability, except in cases in which unfortunate external circumstances have forced the development of the instinct. The men who take the middle ground in the argument (Morton,[119] Mayer,[113] Kasanin,[98] and others) feel that, while there are other etiological factors than sexual maladjustment, this part of the individual's life must be carefully investigated, whether the case be in a child or an adult.

The above precipitating causes, with the possible exception of the one of sexual trauma, are very common situations in the lives of

all children. The special liability of hysterical children to break under the onslaughts of life, is shown by the fact that they cannot manage situations, which the normal child can deal with satisfactorily, with little or no psychic conflict.

The symptoms of hysteria are so manifold, that no one individual, child or adult, ever exhibits the majority of them.[144] In fact, hysteria in children is, more often than not, monosymptomatic.[77] Cameron[18] says that the hysterical symptoms of the child are the fruits of the doubts, forbodings and anxiety of the parents. Parents do not usually fear the onset of organic nervous disease in their children, nor, unless there has been trauma, contractures, paralyses, etc., but they fear and make much of the child's appetite, his sleep, and his excretory functions, and it is along these lines that most of the suggestion is offered to the child. The symptoms have certain general characteristics, in that there are practically none that could not be produced in the beginning, either by volition or by emotion, though they could be sustained in this way for only a short time.[77] Also they correspond strikingly with the usual concepts of disease entertained by the lay mind, and there is an unconscious determination of the locus of the symptoms by previous experience.

Wechsler[172] points out that the general symptoms of hysteria are so numerous that it is almost impossible to discuss them in detail, without making a text encyclopedic, and says it is not necessary, provided one understands the mechanism of their causation, and realizes that there is hardly a sign or a symptom which hysteria cannot simulate. In this study only those symptoms common to children will be studied, particularly in reference to the characteristic differences from those of adults.

While the stigmata are no longer considered necessary for the diagnosis of hysteria, their presence is evidence that one is dealing with an individual who is highly suggestible.[16] Hassin[77] observes, what

was noticed years ago, even by those who believed in the diagnotic importance of the stigmata, that they are much less common in children than in adults. However, as Sachs[143] points out, as the child grows old enough to appreciate their importance, they will appear, especially if he has been subjected to many examinations.

Disorders of sensation are not as common in children as in adults.[144] Any of the senses may be exaggerated or diminished. In childre, hyperaesthesias of various kinds are very much more common than anaesthesias.[130] The child mind is not given to complicated mental manoeuvers, and, to the child, any sort of illness or injury, brings discomfort and increased feeling, rather than its opposite. Although there is no intentional malingering, the pains are most apt to appear when they will be of most advantage to the child.[72] Hysterical headaches are common in children of school age, but, as Abt points out, seldom appear in younger children, unless some other member of the family is subject to severe headaches. Wechsler says that these patients go into considerable detail about the severity of their pains, but at the same time, show a certain detachment, if not indifference. Griffith claims that headache, widespread hyperaesthesias, and joint pains are the commonest disorders of sensation in children. Children also are apt to have abdominal pains, as "stomach ache" is a common worry of the parent.[172] Morse[118] describes children who could not bear the lightest touch on their bodies, but who wore their clothes without complaint, and could sit or lie down without discomfort. The presence of hysterogenic zones, which when stimulated will bring on hysterical attacks in those prone to such attacks, is only found in children who have been subjected to strong suggestion along such lines.[144] Bleuler[16] calls attention to the fact, if definite boundaries are not fixed through suggestion of the examination, the hysterical disturbance of sensibility changes in limitation and intensity, when tests are varied by distraction or various

combinations of suggestion. Anaesthesia of various kinds, though less common, do occur in children. They usually disappear during sleep, and at that time the child can be roused by stimuli they cannot feel when awake. In case of hemianaesthesia, the child may also be blind, and have loss of taste and smell on the same side, though such a complicated combination of symptoms would occur in a young child very rarely.[144] In regional anaesthesia, the lack of relation to anatomical nerve distribution is even more marked than in adults. It usually comes on suddenly, and may leave suddenly, or may recede inch by inch. While the disturbances of sensibility do not obey definite rules, it is characteristic that they do not cause any real inconvenience to the child, and he does not injure himself because of them.[9]

Of the disturbances of the special senses, the visual function is most apt to be upset in children, according to Sachs and Hausman,[144] though Abt[2] thinks they are rare. Bilateral loss of vision is even rarer in children than in adults, and is usually transitory when it does occur. Hassin[77] says it may follow shock, and that the child will be unable to perceive even the strongest light, but will seldom bump into obstacles. Blephorospasm and photophobia are fairly common. The contraction of the visual fields, as one of the stigmata of hysteria, is still believed in by many. Robinson[137] gives a number of cases which he picked up in routine eye examinations, but a number of his cases had not been considered abnormal before. He calls attention to the fact that eye complaints are now a common hysterical symptom in children, which he considers a result of the suggestion of advertisements, school tests, etc.

Abt[2] does not think that disturbances of hearing are common in children, but Griffith[72] says that hysterical deafness is very apt to follow a blow on the ear. Disturbances of smell and taste are very rare in children.[15] Speech disorders are fairly common, and Hassin[77]

thinks that a fright or sudden emotion, is often the precipitating cause. Many authors put stuttering down as an hysterical symptom of this type, but Wechsler[172] says that all stuttering is not hysterical. The hysterical type differs from the true, in that the patient is usually quite indifferent to his defect in the former, but intensely self conscious about it in the latter. Aphonia is one of the commonest speech disorders of childhood.[143] It usually comes on suddenly, and is absolutly complete, every phonated word and sound being lost. Its return is usually just as sudden and just as complete. Occasionally they are only able to whisper, and some can talk, but have peculiarities of accent, articulation, or intonation.[77] Some children will return suddenly to baby talk.

The motor symptoms of hysteria are so many that only the most general treatment of them will be given here. In children, the motor symptoms are apt to be massive, there being not the slightest possibility of moving a toe, if there is foot paralysis,[144] etc. In children, hemiplegia is not common, and is very easy to diagnose, as they do not know enough to make it complete.[143] Rachford[130] does not believe that paralysis is a common manifestation in childhood, especially in younger children. When it does occur it is apt to be regional and very limited.[144] It does not keep to anatomical lines, even as much as it does in adults, but affects muscle groups that belong together psychically.[16] As has been mentioned above, anaesthesia of the paralyzed part is less common than in adults, who consciously or unconsciously conclude that a totally paralyzed part must be totally without feeling. Contractures are rare among children, and the limb can usually be straightened out in sleep, or during anaesthesia.[7] The vasomotor disturbances, such as blueness and coldness from disuse, seldom appear in children.[77] The hysterical limp is characteristic. They do not circumduct, but drag the limb, as if dead.[7] With children's paralyses, an actual injury

often gives the first suggestion. Astasia abasia is a peculiar motor difficulty, which is commoner in children than in adults.[91] In this, the child can move his limbs in a lying or sitting position, with no sign of anything wrong, but is incapable of standing or walking normally.

The minor motor manifestations of spasms, tremors, and tics, are very common among children. Wechsler[172] states that there is hardly an abnormal involuntary movement which cannot be caused by psychogenic disorders. They generally have a definite pattern. Hysterical chorea is apt to be more coordinated, and less varied, than true chorea.[79] Abt[2] calls attention to the fact a child who has had true chorea may subsequently have the hysterical form, if subject to psychic irritation. Choreiform movements, tics, and other spasms are more common in children, and may occur in epidemics, sweeping through whole classrooms.[71] In these, usually only a few muscles are involved, and if the attention of the child is arrested, the movements will cease. They may consist of jerking of the head, shrugging of the shoulders, twisting the body, biting the upper or lower lip, facial grimaces, blinking, nodding of the head, etc.[55] Tremor is not particularly common in children, but may occur.[77] Globus hystericus, is probably an esophageal spasm, often coming on with any emotional excitement, and usually appears and disappears suddenly. Sinemark[132] emphasizes that in these cases, the adults usually suspect some horrible disease, which doesn't help the child any. Rachford[130] gives this as the commonest hysterical manifestation in children.

Actual convulsions are commoner in older than in younger children, and Griffith[71] says they are never as common in children as in adults. On the other hand, Hassin[77] thinks they are quite common in children. Sachs[143] says that hystero-epilepsy is the rarest, but gravest, manifestation in children. Rachford[130] points out that many neurotic children have convulsions in early childhood, and these may be kept up, though

usually in a mild form, as an hysterical symptom. Hassin[77] points out the difficulty in separating hysterical convulsions from true epilepsy in children. However, hysterical attacks present much more variability than epilepsy. Hysterical convulsions may have prodromal symptoms, and aura, many of which are the result of suggestion. They are often preceded by an emotional disturbance. The convulsive seizure is atypical in some way, and lasts much longer than true epilepsy. The fits usually occur only in the presence of others, or when some adult is near, there is never any more than a minor injury, and the attack is often brought on by refusing the child some desire.[71] The child often has memory of the episode after it is over.[7] Some think that the movements have symbolic significance, and represent as a reliving of an emotional episode.[71] Others believe them to be a defense against weakness, helplessness, or disagreeable recollection.[77]

The visceral hysterical symptoms are by far the most common in childhood, since, as has been pointed out before, diseases of the viscera are most feared by his parents for him, and of these, disturbances of appetite, and digestive functions, occasion the greatest alarm.[77] Sweet[166] says that too much has been said and written by physicians, nurses, teachers, and everyone interested in child welfare, about malnutrition and its evils. He gives three reaseon why a child will not eat. (1) He is not hungry. Appetite cannot be turned on and off, like a faucet. (2) He is sick. The loss of appetite is an early sign of illness, especially in children, and it is unwise to force it. If food is pushed in at this time, there may easily develop a distaste that lasts for months or years. (3) By not eating, he gets something he wants more than food, the undivided solicitous attention of every adult about him. This last form often has started as one of the other two. Dodd[52] says that at present the knowledge of the use of food is more widely disseminated than ever before, and there is an interest in the welfare

of children such as the world has not previously known, but the problem is weighing down the mothers with a load of anxiety, and interferes seriouly with family life. Feeding problems loom large to the parent of the normal child, but in these the child usually gets both the food and the victory, and no one is hurt except the mother and her discipline. However, in the hysterical child who is emotional, sensational, and negativistic anyway, the situation is much worse. It is also very hard to distinguish between simple poor family habits about the child's eating, and true anorexia nervosa. Dodd[52] says that the main fault is that most parents regard it as a problem of getting food into the child (Jahr[90] calls them "calorie stokers") and the child views his meals as anything but pleasant intervals in the day. He further points out that when the attempt is made to get food into a child against his will, the victory belongs with, and remains with, the child. No child reasons beyond simple and apparent logic, and so to him no evident reason exists why victory should not be his on other fields of conflict, and a spirit of negativism is engendered. The hysterical child finds this an excellent way to assert himself, and with his extreme suggestibility, may carry it to the point of malnutrition, and the condition may actually become serious. He is very apt to add vomiting to his lack of appetite, and many have dysphagia, gastralgia, etc as part of the same problem.[71]

Wechsler[172] believes that hysterical constipation is the commonest manifestation of the disease, and in children the same abnormal attention is paid to defecation as is paid to appetite. Hassin[77] says this form of constipation may be a spasmodic irritation, due to excessive fixing of the attention on the function, but Veeder[171] thinks that it may begin as rebellion against an over solicitous mother. Sachs[143] gives the opposite condition, diarrhea on emotional excitement, as an hysterical symptom. Disturbance of the urinary excretory function is less common

but does exist. This is usually an inability to urinate, but there may be incontinence.[77] Frequent urination is commoner than actual enuresis, but the latter does occur.[55] Dodd[52] thinks that enuresis often begins as an accident, but may continue in a susceptible child as an hysterical symptom, if the mother makes much fuss about it. He says it is more apt to happen when the child is under conditions of greater strain than usual in its environment, and is therefor, demanding more emphatically than usual, the refuge represented by its mother.

The only respiratory symptom that is common in children is spasmodic cough.[55] However, dyspnea and rapid respiration occur in some very suggestible children.[72] Some children can bring on asthmatic attacks to get their own way. Sighing or gasping respiration may occur.[127]

Rachford[130] says that the more profound mental disturbances are not common in children. Hysterical twighlight states are very rare.[16] Amnesias have been recorded in children, but are believed to be a sign of very serious mental degeneration, when they do occur.[144] The same may be said of fugues.[77] Children's conflicts are seldom complicated enough for them to wish to drop out part of their life; and a child's psyche is more apt to seek escape by protection, that is, return to the mother, than to run away mentally. The child's life and experience is not usually such that an escape from his environment is apt to suggest itself. He wants to adapt it.

Griffith[71] and Hassin[77] believe somnambulism to be a fairly common hysterical manifestation in children, and consider it to be closely related to fugues. Griffith[71] thinks that the motivation is usually easy to find in children. These men do not believe that the patients are really asleep, pointing out that their perceptions are often acute, though they pay no attention to their surroundings. During somnambulism, the patient commonly lives through a vivid experience, little, or not at all, related to his surroundings. Griffith[71] notes the regularity

in the development of each attack, the same features repeating themselves each time, or, more rarely, each attack beginning where the other left off, as far as mental content is concerned.

Abt[2] thinks that sleep disturbances of all kinds are manifestations of hysteria in children. These children often find it difficult to fall asleep. This may be the result of fear, or be associated with other hysterical manifestations. Pavor nocturnus is given by him as an hysterical symptom, and is considered so by Epstein[55] and Griffith[72]. Culpin[48] says that night terrors may be a temporary disturbance, without significance for the future welfare of the child, may be a symptom of hysteria, or may be a sign of a nervous tendency which in itself calls for careful handling in order to avoid psychoneurotic reactions of later life.

Sachs and Hausman[144] say that hysteria is diagnosed less frequently than in former years, and emphasize that the diagnosis should be positive, and not just a process of exclusion. Bartley[13] says that, while true hysteria is rare in children, it is to the general practitioner that these cases usually come at first, and that the more severe forms, in either childhood or later life, could often be avoided, if the seriousness of the milder forms were recognized by those dealing with children. However, the diagnosis should not be made lightly, or without the exclusion of organic disease by every diagnostic method at one's command. Campbell[31] points out that there are two dangers in dealing with these children. One is the danger of inadequate physical examination, and the other, which may cause as much harm, is the over emphasis on minor physical conditions, elicited by highly specialized procedures. Meagher[119] says that nothing resembles malingering as much as hysteria, and that nothing resembles hysteria more than malingering. However, he warns against the habit of many doctors of putting down

all hysteria as malingering. It is true that the dividing line between hysteria and simulation is hard to draw.[74] In hysteria the disability continues long after any advantage can be gained, in that the patient lacks purposive discrimination. Also, since the patient conceals the gain from himself, as well as others, the value of the symptom may be difficult for the observor to guess. Morse[119] says it is very hard to distinguish between the superspoited normal child, and the hysterical child. In the case of the differentiation between hysterical and organic paralysis, and also the disturbances of sensibility, there are exact rules, and the diagnosis is usually fairly easy.[7] The diagnosis of psychogenic pain has to be based on an exclusion of adequate physical cause, on an estimation of the individual's suggestibility, consideration of his attitude toward his surroundings, and the detection of a determining factor to account for the localization of the pain.[20] Since the processes of thought are simpler in the child than in the adult, the direct relation of the suggestion to the symptoms of the disease is much clearer than is usually the case with adults.[162] The diagnosis of the hysterical personality is important, but its presence does not necessarily exclude organic disease.[78] The child's environment should be studied to try and find the situation in it that brought the original reaction type. Kenner[96] emphasizes that verbatim reports of the complaint will often give many clues as to the background. He urges the interviewing of all the adults in the child's environment, and also to get the child's story. When this is determined, the investigator should go on to discover the occurence of new factors, at about the time of the appearance of the symptoms, which would tend to force the patient to give up the original reaction type, and the degree of suddeness with which the patient is faced with this.[111] One cannot make a diagnosis or pursue therapy until the purpose of the symptom is found, and the question as to what the symptoms represent, as to the personal striving and the imperfect way

of attaining individual ends, is answered.[87] Hysteria is an adaptation which is inferior and unhygienic, but intelligible, and often open to modification.[50] It is up to the physician to find out why the patient wants to be so dependent.

Authors differ considerably on the subject of treatment of these children. Many of the earlier writers agreed with Bleuler[16] and Wyllie[182] that the symptoms are usually curable but the disease seldom is. Hassin[77] says it is essentially a chronic disease, its prognosis depending on individual features, and etiological and psychic factors. However he adds that, generally speaking, children are more apt to recover, since they are more suggestible, and become victims from milder causes, which are more easily removed. The younger the child the easier the cure.[78] Sachs and Hausman[144] do not believe it to be a permanent condition, especially in children. They think that many individuals will develop it under special provocation, and under special somatic or social conditions, but once these conditions are improved, or relieved, the condition may disappear. Wechsler[172] says that while all cannot be cured, all can be helped, if treated honestly and intelligently. Jelliffe[95] considers the prognosis favorable in childhood. Mayer[112] feels that the medical profession has been too ready to dismiss these cases as hopeless victims of an hereditary taint. He says that what enthusiastic charlatanism has done, the physician can do. Bleuler[16] says that the curability depends on the severity and extent of the psychopathic predisposition, but thinks that if hysteria is only a partial symptom of a twisted character, which cannot get along either with people or with fortune, little can be expected. On the other hand, Brill[21] says that by recognizing exaggerated emotional states in early life, one can produce some immunity for later life, and Hyde[88] believes that because a child has neuropathic ancestry, is no reason that he be given up as lost, with the idea that no matter what is done, the effect will be

vitiated by the burden of his inheritance. Hohman[93] thinks that, in life, one can make much of poor material and spoil good, and Sachs and Hausman[144] believe that proper training and educational measures can, to a great degree, neutralize the evil effects, both of heredity and bad environment. Stern[159] answers those who complain that all patients cannot be cured, by pointing out that not every surgeon gets perfect results with every patient he operates, but that does not stop him operating; and those who only treat the symptoms, by noting that the well informed medical men is no longer satisfied to meet surgical conditions with symptomatic treatment only. Doshay,[53] in his plea for more general treatment of the condition, points out that, as the result of the widespread tuberculosis campaign, society successfully brought this formerly dreaded human scourge under control, so that tuberculosis today neither carries the former fear of transmission to the offspring, nor the previous stigma and hopeless outlook for the treatment of the afflicted. This result was accomplished, not through any brilliant discovery for the treatment of tuberculosis, nor a preventive serum, but through a determined effort to eradicate the disease, fortified with only the simple knowledge that healthy environment is the strongest weapon against it. He feel that the same can bedone for any of the neuroses, and by the same methods.

Richards[137] believes that the neuropathically handicapped child is always a grave liability, with regard to his ability to meet adult responsibilities thrust upon him, but she also contends that if we take the assets and liabilities of the growing organism into consideration, much can be done for these children. She thinks that the object in treatment is to try and find out what kind of environmental and developmental assistance offers the given contitutional endowment its best chance of development. Gordon[66] thinks that in dealing with these children, preparations for the future, for the adolescent and adult

periods of life, should aim differently from the preparatory measures applied to the normal. Strecker[163] feels that the object of all mental hygiene is to modify behaviour so that the objective of psychic maturity will be obtained with a minimum of friction. However, he does not believe that, because one cannot obtain a perfect result in a given case, we should abandon treatment in that case.

Campbell[31] states that what is essential for the management of the hysterical patient is not so much a profound and detailed knowledge of psychological mechanisms, as the full realization of the simple fact that the hysterical symptom indicates a second rate, and evasive, way of meeting the demands of life. In other words, hysteria is a problem of the conduct of life, and the aim of treatment is to enable the patient to deal with life in a more adequate way. He warns the physician to keep clearly separated the problem of the genesis of the symptom from the problem of the exploitation of the symptom by the patient, and advises him not to forget one for the other. There are no laws of treatment except that of therapeutic individualization.[95] The object of treatment is to change the inner and outer circumstances so as to make the neurosis futile.[16] Unless we teach a new attitude of life, the condition will return.[79] Jelliffe[95] give reeducation as the ideal psychotherapeutic goal. Our attempt should be to reconstruct the individual on a firm basis of a reasonable and healthy philosophy, that permits him to understand his weakness, his strength, his limitations and his powers. Barker[10] reminds us that normality is a pure abstraction anyway, says that we should strive toward children with patterns that, on reaction with environments that are not too inimical to them, will make adequate adjustments, and will develop personalities of harmoniously balances functions.

As with every other disease, prophylaxis is the ideal, and Jelliffe[95] tells us that recognition of the susceptibles, by the rank and file of

physicians dealing with children, is the first requisite. Eng[54] says that mental hygiene has no single mode of approach guaranteeing success, nor is there any panacea theory that can be applied universally to the training of children. The suggestions given below, as to the training of neurotically disposed children, are really no different from those which should be given to any normal child, but as Richards points out, many doctors, as well as parents, are apt to feel that a child with a neuropathic constitution may be excused from habit training. There are floating about in our midst many recipes for parental guidance in child development, and parents, especially those who are themselves emotionally immature, are often carried away by the catch phrases of common psychological parlance.[136] One of these, which offers parents an excellent excuse is the danger of repression in childhood. The result of this is that parents, who have taken the doctrine literally, thrust complete freedom of choice on mechanisms of judgement and control in their most immature stages of development. This is a heavy strain even on a normal child, but one with a tendency to hysteria is very apt to break under it.

Barker[9] advocates that all children, especially those predisposed to "nervousness" should undergo psychic hardening, and it is along this line that prophylactic measures may go. It may seem that this is not the province of the physician, but parents are now educated to consult the doctor for other things than physical disease alone, and the physician is often able, if he is interested enough to do it, to aid, by advice and counsel, in the training of children along the lines of mental health.

In earliest life the child is almost wholly responsive to sensation.[163] The human infant has a keen desire to explore his environment, and Strecker believes it imortant that, during babyhood, the child have free and unrestricted chance to come into contact with his environment. Wilcox[177]

emphasizes the need of properly balanced scientific neglect. He feels that too many rules for the life of the very young child is injurious, and urges that the infant's right to do the unexpected occasionally should be admitted, and urges the adults around him to give such variations no attention. Griffith[71] advises the avoidance of over excitement of young children, especially those of nervous ancestry. He also believes that a definite effort should be made to keep these children from seeing the manifestations of nervousness, and warns against too constant association with nervous relatives. He also calls attention to the bad effect of too careful rearing of a child, with adults only. Jelliffe[95] also thinks that excitement is bad, but warns against the hot-bed type of culture. He says we should regulate the mode of life of the child, but not make a fetich of it. He believes that the child should not be handled too tenderly, nor yet be left absolutely to its own recources.

Strecker[143] states that the most dynamic psychological factor is imitation. Children do not discriminate as to what to imitate, except that they are prone to choose those qualities, in the adults of the environment, that seem to the child to get, for that adult, what he wants. The environment of children is in the hands of adults, and an attempt may be made that this environment be filled with qualities that may be counted on to build a sound personality. This is often extremely difficult, and can only be attained to a partial degree, since, as has been emphasized before, these children usually have neurotic parentage. The neurotic parent is seldom willing to see her share of the responsibility for the difficulties of the child, and in addition is often unwilling to face her own difficulties honestly, and understand her own life.[90] However, DeMerritt[50] believes that there is value in explaining to the parents how their defects react on their children. The neurotic is not a happy individual, and, in many cases, a simple course of psychother-

apy for the parent may give her sufficient insight to at least help in preventing the same unhappiness for her child.

Young[199] states that there is only one worth while thing that perents can give their children, and that is the ability to stand alone, at the earliest possible age. The transition from complete dependence to essential independence must not be sudden enough to result in too great a sense of insecurity in the child, but should be the goal toward which the parent is working all the time. In discussing the fundamental causes of hysteria, we emphasized the evils of excessive protection of the child, and the avoidance of this situation is important in prophyslaxis. Everyone sooner or later, has to bear pain and discomfort, and the sooner he learns to bear the petty annoyances of life, the less they will upset him. Jelliffe[95] says that every child should know what hunger and cold are, and disregard both. Barker[9] believes that, in the little ills of life, the individual suffers from the idea rather than the sensation, and he advises strongly against too much arranging of life for children, or too much concession to their likes and dislikes. Hartwell[16] emphasizes the importance of teaching the child to face his discouragements. Strecker[164] says that we should avoid trying to blot painful experiences from the mind to too great an extent. He says that, before a painful experience is put out of everyday mental circulation, it ought to be carefully and thoughtfully digested by the mind, so that something may be written on the profit side of the ledger of experience, and utilized for the future. He believes that repression and purposeful forgetting just leaves the bad part of the painful experience. The child should understand danger without fearing it too much.

Another important factor in building up strong psychic resistance, is the ability to make one's own decisions and stand by the results. Young[199] says that when a child has made his decision, unless the result

would be utterly disatrous, the parent ought not to intervene in any way to prevent the result of the decision from reacting on the child. Barker[9] warns against allowing too much vacillation, and also against allowing the child to blame others for his own mistakes.

One of the main ways that a child builds psychic independence is by rubbing shoulders with his contemporaries, and this is one thing that the overprotected child usually lacks. Jelliffe[95] warns against trying to build a so called perfect environment, which is usually anything but perfect for the child. Other children will give these children a contact with reality that no adult can give. Stack[158] says that there can never be complete understanding and comradeship between generations. In having the child play with healthy vigorous children, one brings the forces of imitation into play.[162] With other children he will learn that he must observe the wishes of others, and the need of accomadationg some of his own desires to the interest of the group. He will learn to bear little aches and pains without expecting an excess of sympathy. By group games he may be taught that he cannot always win, and he should not get in the habit of offering excuses for failure. However, Strecker[163] feels that a certain amount of spirit of competition is a good thing, pointing out that in later life the child will meet situations that are best prepared for by the desire to win. He advises teaching fair play and honesty, but giving the satisfaction of victory. Reichle[133] points out that the child vitally interested in some activity, has not time or energy to be neurotic. Dodd[52] emphasizes that the child should be taught to stand on his own feet in his relation to others, and that he should not be allowed to look upon his mother as an unhealthy retreat from the consequences of his own actions. However, Griffith[71] warns against allowing nervous children to be teased, if they cannot keep up with their stronger fellows, and feels that they should not be forced to play with older children, who can excell in all

things.

A decided attempt should be made, in training the child, to avoid undue attention to his visceral symptoms. Barker[9] says that childhood is the time to prevent meticulous anxiety concerning the effect of various foods. The parents should avoid food faddism, and discussing what is digestible and what indigestible in front of the child. Woodbury emphasizes that appetite is from pleasant recollection of food, and that its presence or absence is determined by sensory or emotional associations, delightful or painful, in relation to food. Jahr[90] reminds us that the secretion of the digestive juices is regulated by certain glands, which are, in turn, affected by the psychological and emotional states of the individual. Undue fussing about eating is not conducive to emotional calm, besides giving the child the feeling that whether or not he eats is of great importance to himself, and everyone in his environment. Wechsler[170] points out that no class of patients takes more readily to ceremonious diets, or makes a ritual of meals as the neurotic. Sweet[166] says that the parent's duty is to provide suitable food, and, having placed the child in contact with his food, his part is played. Food is of and from the parent, but feeding should be wholly within the province of the child. He points out that the natural sequence, hunger, appetite, and effort that results in satisfaction, has, as its basis, a part of that fundamental, invaluable instinct, self preservation. There is no greater joy in life than to have an urgent, earnest desire satisfied as the result of one's own efforts. Self satisfaction, in one form or another, is the true result of all endeavor, and we should allow children the privilege of hunger, and the joy of appeasing it.

One common factor in engendering in a child an abnormal interest in all of his bodily functions, is the discussion of them in front of him, both by his parents and the doctor.[37] The child comes to think it

a matter of great import that he did not eat quite as much as usual, or his bowels did not move, or that he wet the bed. Attention has been called before to the danger of this in giving the child an undue sense of his own importance, and there is also danger of arousing his fear. He is likely to let his imagination run rife, whenever any little thing is wrong, be seriously alarmed at every little ache or pain, and this may end in a full blown hysteria.

As a part of teaching the child to stand on his own feet, is training in self control. The child with a tendency to hysteria, is one who for some reason has not been trained to control his emotions. To this end he should be taught to control himself, in little things as well as big. Barker says[9] we must build up, in the child's mind, the fact that he must control himself in order to have his wishes gratified, and emphasizes that one of the first means is by making him see that he will never have any desire gratified just to avoid a scene, which is often the beginning of emotional instability in young children. Another means is by showing him that excessive temper makes him make a fool of himself, something anyone, especially the neurotic, dreads. On the other hand, it is also well to see that when he controls his irritability, he actually finds it a more profitable way of attaining his ends. Barker[9] warns against simply restricting the child's emotional explosions, but at the same time allowing them to become transformed into persistant moods of sulkiness and resentment. The cause for the explosion should be searched for, and the child taught that this energy could better be used along other lines.[25] Guthrie[25] views with pleasure the fact that while the emotional temperament may be modified, it cannot be eliminated by training and environment, since the creative faculty in art, science and literature depends on imagination and emotional susceptibility. However, he emphasizes the importance of recognizing the neurotic in early life, and guiding and

modifying his excessive emotionalism, by cultivating reason and common sense.

The above is an attempt at preventing, in the neurotic child, the evils of ever protection. However, there is just as much harm in too Spartan treatment. The child predisposed to hysteria, is a child who is really not as able to stand the buffeting of the world as the normal child.[15] In prophylaxis we must try to correct the effect of bad heredity and environment, and not make the child more unhappy, and less able to face the world than he was before.[32] As Osler[127] says, reeducation is the goal, but is not always feasible, since some of the patients would have to be rebuilt from the blastoderm. This does not mean that the hardening process described above should not take place, but that the material on which one is working must be carefully studied, that one does not bring on hysteria, while trying to prevent it.[122] White[175] emphasizes, that at all times, the child should know, without qualification, that he is loved. These children require a good deal of affection, especially while trying to wean them away from the atmosphere of over protection.[124] Hartwell[76] says that every child needs a responder, or at least one person who is intensely interested in him. The neurotic child is in special need of discipline, but at the same time he must keep the feeling of the sympathy and understanding of the adults around him.[52] This balance is difficult to attain in dealing with this type of child, because he is constantly seeking for signs of neglect. If the attitude of the parent is changed to too great a lack of shelter and guidance, the child may be driven to hysteria to get it back.[95] In the hardening process, the sympathetic adult should act as something of an interpreter for the child.[76] While teaching him to face his fears, they should be explained to him. Effort should be made to keep the child's feeling of confusion at a minimum. At first the child needs help in solving his problems, at the same time, constant training

and encouragement to solve his own, and ignoring his faulty reactions as far as possible.[124] Dodd[52] emphasizes that every child must achieve a standard by which to judge his own actions, that is, develop a conscience. He says that if the parent imposes an undue sense of limitation, the type of conscience developed will repress the natural urges to such an extent that the tension set up will inevitably give rise to rebellion. Such a child never develops a free sense of right and wrong. He also emphasizes that if the parent imposes, by authority or fear of punishment, standards for which the child can see no reason, a situation is set up in which the child demands routine, will avoid any unusual situation, and will be unable to form his own judgements. As far as possible the child should understand the reason for the limitations, and they should only be the necessary ones, letting him develop along his own lines in other ways. The influence of over strictness has been discussed before in this paper.

One of the main means by which one may achieve a balance between affection, firmness and indifference is by guiding the play for attention into proper channels.[157] This play for attention is a dynamic force which may lead to destruction, or to that most necessary of human goals, the feeling of accomplishment. The bad results of the play for attention have been discussed in the consideration of the etiological factors of hysteria. As has been said in that connection, the ambition to excell and attract the attention of our peers is natural to all of us, and the individual will accept any method which seems likely to bring to him the prominence and attention he normally desires.[177] In trying to preve nt the development of hysteria in these children, we should see to it that they get the attention they crave by proper means, and not as the result of behaviour that is unprofitable to the individual, and to the society of which he is a part. Sweet[166] notes that much that is finest and most altruistic in man's endeavors rests at

bottom on his conscious and unconscious wish for attention. If, while carrying on the course of training in governing his emotions and facing reality, one plays on his desire for attention and achievement, the habit patterns can be formed on a positive constructive basis.

If one does not get the patient until the hysterical symptoms have developed, the task is much more difficult, for it means that, not only is there the hysterical personality, developed by bad heredity plus bad environment, but also that there has been a situational stimulus, which has been too much for the child's psychic resistance. Once this method of escape has been used by the child, there is always a tendency to use it again. When such a child is presented, one must start with a careful personality study, and an analysis of the mental and physical states preceding the outbreak.[16] The operator must discover the nature of the child before attempting to recondition it.[182] Until the physician recognizes the conditions that foster the symptoms he can do little.[30]

The first requisite for successful treatment is the establishment of rapport between physician and patient, and, since the patient is a child, between physician and the parent.[165] The difficulties that one encounters with the parents of these patients has been emphasized before in this study. Griffith[72] thinks that treatment is seldom successful because the adults will not follow the doctor's directions. However, with tact, it may be possible to get the cooperation of someone. Although, as Sachs[143] brings out, it is no use undertaking treatment unless the child is under proper environment and direction, the child is apt to be taken to another doctor, and probably one who will make him worse, if the first physician who understands the mental nature of his trouble, does not proceed slowly and carefully in the handling of the parents. Strecker[163] emphasizes the importance of desensitization of the family toward the illness, and its reeducation into new habits of response

to the patient. Babinski[7] says that psychotherapy can cure hysteria, unless it is counterbalanced by opposing influences, and that the counterpsychotherapeutic action is often exercised, voluntarily, or involuntarily, by the entourage of the patient.

One of the quickest ways to get the confidence of both parent and child, is to take the patient seriously.[172] Bramwell[20] warns against telling that the troubles are of the mind, until a full history has been obtained, and the doctor is positive of his diagnosis. In fact, it is often better to wait until the symptom has been removed, before going into detailed explanation. These patients, and usually their parents, are not of a type to take kindly to any suggestion of mental disease. Of course, if they are accused of simulation, not only is the doctor actually mistaken in his understanding of the hysterical mechanism, but he probably won't get a chance at further treatment, and he has don done actual harm by intensifying the unconscious will of the child not to be cured.[144] In fact, Bleuler[16] thinks that the greatest obstacle to cure is when the patient, consciously or unconsciously, does not want to be cured. Wolfsohn[156] says that to get the confidence of the patient, the physician himself must have confidence in the correctness of his diagnosis, and in his ability to produce a cure.

The question of the importance of treating the symptom directly is somewhat disputed. Abt[1] says to pay no attention to the patient himself, and to show no concern for his symptoms. Jelliffe[95] advocates a purposeful neglect of the chief appearance of the disease, and Hecht[78] believes in his"method of disregard". The bad effect of discussing a child's ailments in front of him has been touched on before, but the symptom is the most important thing in the minds of both the patient and his parents, and its cure will go a long way toward establishing, in their minds, the confidence necessary for more fundamental analysis and treatment of the neurosis.[64] The cure of the symptom should be done

by psychotherapeutic means if possible, and suggestion is the method advocated by most. Hypnotism used to be used for this, but has been generally abandoned, especially with children.[2] Wechsler[172] says that hypnotism is in itself and artificial neurosis, an induced hysteria, and in using it, one is merely substituting one neurosis for another.

Gorson[39] believes that in dealing with a child, very frequently relatively simple measures may achieve results that would be much harder to attain in the adult, in whom the habits are more firmly entrenched. In some cases the symptom is an hysterical habit which has outlived its usefullness, and the patient is really,subconsciously, anxious to be rid of it, and so falls in quickly with suggestion. However, if it still increases his self respect in some way, he will resist suggestion.[79] The same is apt to be true if he has been taken from doctor to doctor, and has a fixed idea of the incurability of his condition.

How much use should be made of mechanical reinforcement of suggestion, is under some dispute. Bleuler[16] definitely states that localized treatment should not be resorted to, as it strengthens the idea that the disease is localized there. Crothers[43] says that the day had long gone by when the intelligent psychiatrist tried to manage the hysterical patient by sudden and even brutal shocks. However, the "method of surprise" in which a patient is assured he can use a paralyzed part, at the same time removing all support suddenly, or is given a sudden very painful stimulus, as first advocated by Brun,[168] is recommended by Hecht.[78] Williams[181] thinks that direct medical treatment of the apparent physical disorder, which results from an idea, is very injurious. Griffith[71] feels that any mechanical treatment should be directed to some other part of the body than that affected, and this by suggestion, to direct attention away from it. However Wolfsohn[186] advocates suggestion, reinforced by some mechanical agent, which will

assist in relieving at least some of the disturbed functions, and give the doctor a good start on more purely psychic treatment. Hecht[79] says that hydrotherapy and electrotherapy often work, especially if they are painful, and carried out along with the definite and positive assurance that they will cure, and can be stopped as soon as they do. Strauch[162] emphasizes the necessity of being emphatic and positive in suggestions of cure, but says this should not be directly to the child, but to his mother and attendants. Jelliffe[95] also feels that these indirect suggestions have more impelling force than direct commands. He emphasizes the importance of correctly estimating the patient's vanity, desire for praise, egotism and ideals. Cameron[29] says that children pay little attention to what is said to them, but are much influenced by what is said about them. This is especially true of the hysterical child whose negativism may be aroused by direct suggestion, but whose desire for praise and attention can be used in the indirect. Henderson and Gillespie[77] believe that the cure of the physical symptom must be done at one sitting, since if it is incomplete, it may go on in an incomplete form. However, Strauch[162] believes that the attempted cure by one stroke is dangerous, as it will arouse critical doubt if it fails. One advantage of reinforcing the suggestion by some rather unpleasant mechanical means is that it makes the continuation of the symptom unprofitable for the patient.[86] Gillespie[64] says that in treating, one should try to make the symptom change, and let the patient see the change in an objective way, thus giving the therapeutist a very pqowerful aid in convincing the patient.

The desirability of treating the patient by complete isolation is not agreed upon by all. Strauch[162] feels that if the hysteria is imitative, the child should be removed from the inducing person. Jelliffe[95] believes that the isolation technique is often advisable, since new scenes pique the curiosity, and invite interest. It is true that often the child's life can be regulated better if he is taken out of

his bad environment, and in some cases this is his only hope. It also makes easier the cure of the symptom by purely mental means, especially as in the new environment, this symptom, in which the child often takes considerable pride, provokes no sensation whatever.[35] Abt[1] feels tha anorexia nervosa, and other visceral symptoms, are best treated by isolation, and he says that many of them will make complete recovery by this means. Separation also removes the very important element of the visible nervous snxiety on the part of the mother. Wechsler[172] says that while the removal of the patient from the house may have temporary effect, it does not solve the difficulties left behind, and to which the child must return. Wolfsohn[186] emphasizes the importance of the hysterical psyche, and how much it has been modified by the removal from home, when the question arises of returning the hysterical subject to the same environment that originally caused the symptoms. Hecht[75] emphasizes that when the cure has been by isolation, the child should not be returned to the old environment too soon. If the child has been taken away because the environment seemed to have been so bad that any sort of adjustment seemed impossible, a considerable psychic resistance will have to be built up before the child can be returned to it. However if the parents see the child's improvement on being removed from home, they may be willing to adjust the environment to permit of his return.

Whether or not the physician makes the hysterical symptom his first point of attack, the treatment of the neurosis itself is his actual goal, and the first step in this process is to find out why the symptom occurred. Rowe[140] has found that if the symptom is cleared by suggestion, and then no further psychotherapy is used, the patient is at first pleased, but soon shows mental unrest, and another symptom is pretty sure to take its place. It is in this effort at mental analysis that the respect and confidence of the patient is so very

important to the physician.[165] Carlill[33] believes that even with children, the motives for the symptoms can often be recalled by mental exploration. Williams[182] says that most children will introspect honestly, if they know they will not be laughed at or blamed. However, he believes that, at times, the patient is not aware of the motivations. The use of Freudian psychoanalysis in hysteria in children is not generally advocated, and even those who believe in it, feel that it must be modified for children. Lehrman[105] believes that it can be used, but says that analysis of children is difficult. He feels that the chief obstacles are that the child tends to make use of the parent's protection to escape unpleasant analytic situations, or that he may accentuate the positive transference phenomena, and treat the physician as the beloved parent, whom it distrusts with its secrets. Wechsler[172] emphasizes that in order to practice psychoanalysis, one must be properly qualified and well trained. He believes that children may bring out their conflicts under it if they have enough confidence, but that since the success of the analysis depends on the patient's desiring a cure, which children very often do not, it often fails with them. Cassity[36] deplores the lack of attention to psychoanalytic technique in many clinics for children, and he feels that this is because of a misconstruction of the limits of psychoanalysis. He says that while it is actually impossible for an immature individual to grasp the significance of his conflicts, good results may be obtained by the child understanding the nature of his repression. He feels that with good transfer, mental catharsis takes place, and the patient is able to release energy that has been pent up, and fixed on some love or hate object. Brill[21] thinks that psycho-sexual adjustments are of great importance in childhood, and that psychoanalytic investigation is the best means of bringing this out. Clarke and Rourke[37] believe firmly in in psychoanalysis, but feel that in children it can be simpler and

less formal than with adults, since in children we are closer to the source of the conflict, and the material is, as a rule, less screened. They say that the difficulty is that the child does not, as a rule, seek or desire analysis, and that in them there is lack of insight, and absence of transference. Strecker[165] emphasizes the value of aeration or ventilation, whether or not Freudian catharsis is used. Many general practioners avoid any attempts at mental analysis and psychotherapy because they think it requires a very elaborate technique. Understanding and an earnest desire to help the child will go farther than any ritual of analysis.

When the conflict behind the whole hysterical syndrome has been discovered, desensitization and reeducation are in order. Bleuler[16] says that relapses are common unless the energy is led into channels that are proper and commensurate with the patient's endeavors, but he believes if this is done, they can often accomplish as much or more than the healthy. The child's fears should be relieved, and often are, by simple explanatory means. However, Strecker[165] feels that not every individual is capable of reacting constructively to the kind of knowledge which may be brought to light by deep probing, and sometimes it is unwise to remove all the props which the patient has utilized, even if such props are artificial ones. He believes that, before taking anything away, it is wise to consider what material will be at hand to supply the need which will arise. For this reason sufficient reeducation must have taken place before the child can be expected to really face his conflicts. In the process of reeducation, the principles discussed in detail under prophylaxis should be applied, except that, in a child who has already had a frank hysteria, one must proceed more slowly, and not let the child's props be removed too suddenly.[72] Griffith[72] says that our object is to make the child forget his symptoms, and build a personality that will make them unnecessary.

If the underlying cause of his development of the disease is understood, much may be done to avoid again giving him the sense of insecurity which sought reassurance in the symptoms. In this disease, while we aim at perfection, we should be satisfied to fall short of it, if we feel that we have made every possible effort to teach an infantile mind how to grow into an adult one. In all attempts at treatment one should remember that the production of the symptom is the result of a process of suggestion, which is a power which steadily diminishes with the development of the capacity for bringing reason and judgment to bear on the facts and happenings of everyday life. The development of this capacity is the fundamental task of true education.[65]

CASE REPORTS

Case 1-Hecht (78)

A.J. aged four, American male, of well to do family. Family of "neurotics". Fell and hurt arm. Family much excited. Child whined and cried at every touch. Slight contusion of arm. Arm rigidly flexed and adducted to body and every attempt to extend was attended by screams of pain. Swelling subsided but child complained that the fingers were stiff, and efforts to force extension were followed by snapping back and rigidity. Refused to use arm or hand. Two days later arm was dangling limp at side, no pain but complete paralysis of hand and wrist. Child being fed and dressed by family, but observed by the doctor playing in the street with no disability. In another week arm again stiff, and contracted at elbow, but relaxed when child slept. No cooperation on part of the family. One month later cured at one sitting by application of electric shock.

Case 2-Hecht (78)

A.L. aged four, Jewish female. Family in modest circumstances. Father in poor health. Mother nervous. Whole line of near relatives neuropaths. About three months before entrace showed tendency to be very quarrelsome and irritable. Four weeks before patient got overheated and had first attack. Hands and arms stretched full length above head, then thrown wildly about in air, body alternately stiffened and relaxed, legs kicked in every direction until trunk and limbs finally got very rigid, and chest convexly raised from the floor. When attack was over child had crying spell, but was allright the next day. Next spell followed reprimand from mother, and took its beginning in mother's lap, the child sliding to the floor, while screaming, jerking, frothing, breathing heavily, and making sucking noisy

movements with the mouth. Lasted about ten minutes. Two subsequent attacks induced by parental opposition, and under stress of great emotionalism. Three days before entrance the child had attack, and since then could not walk. Physical examination negative. Could move legs in bed, but would not unless examiner tried to prevent her doing so. Could not stand. Recommended to walk but will no success. Isolated to aunt's house. Practically starved for two days, then food placed out of reach. Completely cured by this method.

Case 3-Bronstein (22)

F.S. aged twelve, female. Entered hospital with pain in right lower quadrant of five weeks duration. Five weeks previously was seized suddenly with moderately severe and generalized abdominal pains, remittent in character, associated with nausea but no vomiting. Temperature 99-99.4 rectally. After five days the pain was localized in right lower quadrant and associated with definite tenderness, but no rigidity. Since onset of the above attack, child has been bed ridden. Abdominal movements aggravate the pain. In spite of rest and medical treatment the condition not alleviated. Physical examination negative except for tenderness over right lower quadrant and para-umbilical region. Rectal examination revealed tenderness in right lower quadrant. Impression was that of chronic appendicitis. Upon admission and during two days of observation temperature was normal, urine negative, and white blood count 8,700. Operation revealed normal appendix, confirmed by pathological report. Psychiatrist consulted because of the operative findings. Events preceding operation had to do with exaggerated conflict over child's loyalty to mother, who openly disbelieves, and the church, the child having recently become a Catholic. She was greatly attached to the mother, to the extent of an over fixation. She was overly mature, introspective, and had an exaggerated idea of her self importance. She liked to call attention

to herself. The mother recently had an operation, and the child admittedly took on her mother's ailments.

Case 4-Strauch (162)

O.A. aged five, male. Three months before entrance became ill with pains in various joints, the left knee being swollen and red for awhile. Two months later pains in right knee, ankles and shoulder joints. Had been three months bedridden when admitted to Cook County Hospital. On entrance manifested extreme pain on the slightest touch or attempt at passive movements of both hips and knee joints. which were contracted and held in moderate flexion. Swelling was not present anywhere. During sleep contractures disappeared, and boy would lie in any position of the affected limbs. Also free passive mobility, if child's attention was sufficiently diverted. After few days pain disappeared, and used legs in bed but was unable to stand or walk. The astasia and abasia proved refractory, perhaps as result of too much attention shown to him in frequent clinical demonstrations. After about four weeks he, rather unexpectedly, was found standing up in bed, and climbing over the railing, but was still unable to stand or walk on the floor. Then, his legs were submerged in cold baths twice a day, and within three days control was restored.

Case 5-Corson (39)

Nine year old girl brought to clinic because of baby talk, strange gait, poor adjustment in school, petulance, stealing, etc. Normal intelligence. Normal physically. As a result of study it was felt that girl was attempting to compete with a younger sister and asthmatic brother, by simulating behaviour of younger child. Treatment was removal of necessity for this competition and complete clearing up of symptoms and undesirable behaviour followed.

Gase 6-Griffith (72)

Girl, eighteen months old developed complete anorexia and feeding accomplished only by force, with great excitemtnt of all concerned. Would hold food in her mouth for hours rather than swallow it. Cured completely by placing plate of food before her, and if not eaten removing it in half an hour, with no comment.

Case 7-Stern (159)

R.S., male, ten years old. Only child of elderly father and neurotic mother. From early life, self willed, obstinate, violent temper outbursts if crosses. Mother always gave in to him. Nocturnal enuresis six to eight years, and rectal incontinence up to time of treatment. Child bathed and dressed by mother and slept in parent's room. For past two months has been restless at night, has developed clumsy gait, indistinct speech and choreiform movements. Parents directed to put child in separate room and make him do things for himself. No cooperation and no improvement in six weeks. Put in hospital for four weeks, and symptoms disappeared completely, but two weeks after discharge as bad as before. Hospitalization again desired by parents, but refused, and after a number of weeks, during which condition remained stationary, parents persuaded to change attitude, and follow directions, and complete cure followed.

Conclusions

1-Hysteria is a neurosis in which there are bodily symptoms, and absence of organic changes, and a diseased psyche.

2-The neurosis is a psychogenic expression of an inadequate personality, characterized by emotional instability, an inability to face reality, and a tendency to escape conflict by returning to an infantile state.

3-Heredity is an important etiological factor, but environment is more so.

4-The principle environmental factors in the genesis of hysteria in children are: (a) association with and example of neurotic adults, (b) over protection of the child, (c) too great attention to minor ills, (d) over strictness, (e) neglect, (f) permitting the child to occupy the center of the family stage, and (g) lack of training in self control.

5-As a result of heredity and environmental factors, and hysterical personality is developed, characterized by extreme emotional instability, excessive egotism, desire for self display, selfishness, tendency to deception, and deficiency in will power.

6-The hysterical personality does not necessarily develop the disease, but is more apt to do so than the normal.

7-The common precipitating causes of the disease in children are: (a) trauma, (b) organic disease, (c) birth of the next child, (d) rearrangement of family relationships, (e) entry into school life, and (f) sex trauma.

8-Disorders of sensation are not as common in children as in adults, hyperaesthesias and psychogenic pain being the most usual.

9-The visual function is the most common special sense to be disturbed.

10-Paralyses are rare in children.

11-Astasia abasia is commoner in children than in adults.

12-Spasms, and tics are common manifestations of hysteria in children.

13-Convulsions are not as common in children as in adults.

14-Visceral hysterical symptoms are the most common form of the disease in children. The most common are anorexia nervosa, and disturbances of defecation and urination.

15-The profound mental disturbances, as amnesias and fugues are very rare in children.

16-Somnambulism and night terrors are common manifestations in children.

17-The diagnosis should be made with care, and the reason for the symptoms sought.

18-The object of treatment is to enable the patient to deal with life in a more adequate way.

19-Prophyslactic treatment of susceptibles is important and includes teaching the child independence and self control, by a balance of affection, firmness, and indifference.

20-The symptoms should be removed by some form of suggestion, but removal or modification of the underlying etiological factors, and prolonged reeducation is the most difficult, but most important part of the treatment.

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