THE PATHOGENESIS OF THE NEUROSES IN CIVIL LIFE AS OBSERVED AMONG AN INDUSTRIAL POPULATION AND THE TREATMENT.

T H E S I S

SUBMITTED FOR THE

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THE PATHOGENESIS OF NEUROSES IN CIVIL LIFE.

INTRODUCTION.

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INTRODUCTION.

Functional Neurosis may be defined as an abnormal emotional state, which is not subordinate to actual lesion of tissue.

The writer at this stage proposes to work very briefly through the normal development, composition and activity of the mind to the pathological.

The tracing of human development back to sub-human ancestors has helped considerably in the understanding of certain innate qualities in the human mind and is explanatory of certain aspects of human behaviour.

The mind, so far as it can be conceived, and for purposes of description, has been divided into two compartments which inter-communicate, namely the conscious and subconscious. The term "conscious" refers to that part of the mind which is dealing with ideas at the moment. The "subconscious" is that part to which these ideas are relegated, accompanied by their attached emotions, after the conscious has finished with them. These ideas and emotions may be described as lying dormant in the subconscious and more or less ready to be called forth at will, the readiness, of course/

course, depending on the vividness with which they have been dealt in the conscious.

The mind is heir to certain innate qualities which we call instincts and to these instincts, which are primarily of a self-interested and egoistical nature, are attached emotional and energising qualities. The instincts are subconscious in character and constitute the motive power behind our desires, strivings and interests in life.

In the conception of the subconscious, it is necessary to remember that normal mental life is only partially expressed consciously, and that the individual is often unaware of the motives of his actions and cannot remember many of the past experiences which have played a part in shaping his character, ideals and motives.

The most important instinct is that of Self-Preservation.

Dr. W. McDougall has enumerated seven primary instincts with their attached emotions, namely:-

Instinct.	Emotion.
Self-Preservation	Fear.
Curiosity	Wonder.
Pugnacity	Anger.
Self-Assertion	Positive Self-Feeling.
Self-Abasement	Negative Self-Feeling.
Parental	Tender Emotion.
Revulsion	Disgust.

He also describes a few innate tendencies which he considers are not true instincts and which he calls "pseudo-instincts /

"pseudo-instincts". The most important of these is the "herd instinct" which makes men collect together into communities in spite of many disadvantages to the individual.

His definition of instinct may be given here verbatim:-

"Instinct is an innate psycho-physical disposition which determines its possessor to perceive and to pay attention to objects of a certain class; to experience an emotional excitement of a particular quality upon perceiving such an object; and to act in regard to it in a particular manner, or at least to experience an impulse to such action."

Hence it appears that instinct is made up of Perception, Emotion and Action. Thus if a dog sees a cat the accompanying emotion of anger engenders pugnacity which results in action.

The instincts are therefore of a dynamic nature. They have their habitat in the subconscious and are transformed into action without first having to be referred to the conscious. Thus a bird fears and flies from a cat without having derived conscious experience on some previous occasion.

The primary instinctive tendencies of childhood are directed entirely toward self-interest.

As life proceeds, the child develops and weaves around these instincts ideas, and certain appropriate modes of action in relation to them. These ideas are derived from social influence and the quality of that influence will necessarily determine the nature of the ideas. A good social influence and education will help to make him acceptable to others and make him desire to be well thought of.

This /

This is described as the Self-Regarding Sentiment and is the organisation of ideas grouped around the idea of oneself and consists of the instincts of self-assertion, submission and the herd, and of ideals of honesty, truth, self-control, sense of duty, courage, love, conduct, self-respect, self-esteem, family pride and patriotism.

The term Complex has been applied to this organisation of ideas and instincts around a certain object. The driving force of the Complex is derived from the instinct part of it. The duties of the self-regarding sentiment, sometimes called self-Complex, are to protect the individual against the dynamic tendency of the instincts for self-satisfaction, and to divert the energy derived from the instincts into channels which will be of service to the self-regarding sentiment, and to the community at large. This process is called Sublimation and is exemplified in cases where ungratified maternal instinct gains more or less satisfaction in bestowing kindness on dogs, etc., or in philanthropic duties. The chief sublimating agents in childhood are games and sports.

The instincts in the subconscious mind are still there, but their edge is blunted.

The sublimating ideas run parallel in association with the instinct, not forcing it out of existence, but "shouldering it off" on to other lines which give a modified /

ified satisfaction to the instinctive desire.

The constant pressure of the instincts in their desire for expression is shown in mob behaviour. The vast majority of the individuals of the mob would not have conducted themselves as they did had they been alone. In the mob, however, there is the example and sanction of numbers leading to pacification of the self-regarding sentiment. Hence the deterring force on the instinctive impulse is removed, and it is allowed free exit.

In the writer's view the same is seen in the tendency in many people to the hero-worship of criminals. Here they see in the criminal act the fulfilment of the desire of their own instincts and the resulting subconscious gratification which they feel is transferred to the criminal himself.

It appears, therefore, that the subconscious mind contains dynamic instinctive tendencies which are held constantly in control by the conscious mind, the controlling ideas of which are derived from ethical, aesthetic and social standards. The process of sublimation is automatic and is not associated with any feeling of compulsion.

Thus a person whose instincts are perfectly sublimated will act well and automatically under any circumstances even when to his own disadvantage.

This state of affairs is a durable one and will stand /

atand a considerable amount of strain.

The formation of character is dependent on the strength and organising powers of the self-regarding sentiment to recognise and sublimate the egoistic instinctive tendencies.

As the self-regarding sentiment is not compatible with the instinctive tendencies, anything that we do contrary to the ideas of the former produces in us the pin-pricks of conscience, which give rise to feelings of shame, self-reproach and remorse. This condition is called "mental conflict". The discomfort produced in the conscious mind by the mental conflict is removed by being repressed into the subconscious.

The manner in which the repressed material is treated in the subconscious depends on the strength and efficiency of the self-regarding sentiment. Should the self-regarding sentiment not be efficient enough to deal with the repressed material, then the repressed material continues merely to be repressed or, in other words, is constantly dammed back from its return to the conscious mind.

Apparently the longer this process is continued, the greater become the explosive forces or emotions attached to the repressed material, and the greater and more insistent must be the efforts of the conscious mind to keep it repressed.

This constitutes pathological repression and it is this condition which is the foundation work of most neuroses.

If the repression takes place normally, that is, given adequate strength and efficiency of the self-regarding sentiment, the repressed material is assimilated and its pent up forces are drained off by the process of sublimation, leaving it harmless to produce further discomfort and activity.

The term Neurosis is of wide significance and embraces conditions which vary from "nervousness" to insanity.

During the War a certain group of symptoms were observed in a large number of cases. These symptoms have been termed war neuroses, or anxiety neuroses.

Many men, untrained to war and probably the possibility never contemplated by them of taking a part in war, suddenly found themselves confronted with enormous changes from their normal life, and with the necessity of reforming their ideals, which had been slowly developing from birth, and had become part of their personality, and adapting themselves to the new conditions. To the man, who hadall the advantages that environment and education could add to the perfect balancing of his personality, the process of adaptation was a heavy task, but to the impressionable and sensitive man the task was enormous.

In /

In a minor degree we see in civil life the same thing. The well balanced man goes through life taking the disappointments, pin-pricks, knocks and changes, assimilating and modifying them, regarding them as experience gained, re-adapting himself, and apparently becoming a better man.

On the other hand there are those who proceed normally to a certain point in life, when something happens for which they are unprepared. They are unable, through some fault of training, education and environment, or from some inherited factor, to adapt themselves to the new situation, or to gain experience from it, or to build up new ideas around it which will make it tolerable tothemselves. The result is that such individuals begin to show signs of mental and physical deterioration. They become morose, irritable, sleepless, easily fatigued, lose their appetite, lose weight, and become deficient in concentration.

This state may become more or less stationary with these symptoms present in a modified degree, or it may proceed to actual insanity. It is possible for a perfectly balanced mind to develop these symptoms as a result of excessive and continuous strain or from some predisposing cause.

The predisposing factors are both physical and psychical.

In civil life the principal physical factor is the general debility following the infective toxic conditions /

ditions such as Influenza, Malaria, Dysentery, Paratyphoid and unknown febrile conditions.

Next in importance is exposure to extremes of climate and physical fatigue.

The psychical factors are chiefly prolonged anxiety, monotony and shock.

The author proposes in this thesis to give an account of his views on the subject, based on his experience of neuroses seen in general practice.

SECOND PART.

PHYSICAL CONSIDERATIONS.

S E C O N D P A R T.

PHYSICAL CONSIDERATIONS.

Prior to the consideration of the mental factors which enter into the production of the neuroses, an examination of the physical factors which have a bearing on those conditions may be discussed at this point.

It is conceded that body and mind are inter-dependent. There cannot be one without the other. It is apparent, therefore, that any factor which tends to stimulate the bodily condition will have a tonic effect mentally, and vice versa. Therefore such conditions as paratyphoid, malaria, influenza, dysentery and unknown febrile conditions, by disordering the action of the heart, lungs, bowel, and other viscera and by lowering the vitality of the body generally will cause feelings of weakness and inefficiency. Similarly, prolonged bodily and mental strain, especially when there is loss of sleep over a considerable period, will have the same effect, and the enervation produced by prolonged residence in a tropical climate may conceivably play a part in the causation of neurosis.

Although it can be readily understood how these physical factors can play a part in the causation of a neurosis, yet it is doubtful if they alone, in a person of /

of sound mental and physical constitution, can produce a neurosis.

In all probability an individual who is suffering from a neurosis and ascribes the commencement of his condition to one or other of those physical factors has, from a mental point of view, prior to his illness, been laying the foundation of his condition. The feelings of weakness and inefficiency due to the physical condition have been more in the nature of activators of the neurosis than true causal agents.

It is obvious, however, that the physical factor must not be ignored because where there is weakness of the body there must be some corresponding loss of mental tone.

It is, therefore, reasonable that a patient suffering from a neurosis should have his general health stimulated as far as possible, so that the resulting increased mental tone would enable him more efficiently to grapple with the mental factor when elucidated.

Endocrine System.

The consideration of the general physical factors which play a part in neuroses leads to an examination of the Endocrine System and its relationship to the psychical.

There is no doubt that the proper and even functioning of the ductless glands is necessary for the stabilisation of health. Their functions are governed by the autonomic /

omic nervous system.

The Pituitary gland is concerned with the growth of the body, deposition of fat, sexual activity, sugar metabolism, blood pressure, tone of involuntary muscle and with the secretion of urine. It has been shown that stimulation of the sympathetic nerves supplying the pituitary gland will cause polyuria.

The Suprarenal gland, as demonstrated by the administration of the active principle adrenin, according to Cannon, acts upon all tissues receiving sympathetic nerve supply as if they were receiving nervous impulses. It causes dilatation of the pupils, hairs to stand erect, vaso-motor constriction with rise of blood pressure, contraction of uterine muscle, relaxation of intestine, and, generally, a slowing of the heart-beat due to rise of blood pressure, and sugar to be liberated from the liver.

Further, Cannon has shown by experiments on animals that under strong emotions such as rage, fear, anxiety and in pain the secretion of adrenin is increased leading to relaxation of intestine, increased blood pressure and glycosuria.

The function of the Thyroid gland, as observed from Cretinism, Myxodema and Exophthalmic goitre, apparently controls general metabolism. The general growth of the body, the condition of the heart, respiration and generative /

ative organs are dependent on its proper functioning. The emotions attached to accidents, shock, and prolonged anxiety or mental strain are generally conceded to be responsible for hyper-thyroidism.

The influence of the testes on the general metabolism of the body may be observed from the effects of castration. In boys before puberty the results of castration are sterility, non-appearance of the beard and moustache, the voice remains childish, the body becomes fat and the mental attitude to the world is modified, although there is no loss of business capacity. The prostate and vesiculae are atrophic. Injections of testicular extract in some cases of advanced age have resulted in beneficial effects in increasing virility.

The ovaries have control over menstruation and apparently have some action on the vasomotor system.

When this influence has been withdrawn by artificial removal of the ovaries or when their function ceases at the menopause the patient often suffers from flushings, headaches or some form of neurosis. The breasts, uterus, and vagina atrophy and obesity may develop. The influence over the breast tissue may even extend to cancerous growths, double oöphorectomy resulting, in a number of cases, in retrogression of the growth.

It would seem that the ductless glands can be affected /

fected both physically and psychically, and it is apparent that, since they are of such vital importance, any factor which tends to diminish or increase the secretion of the glands must necessarily bring about changes which have a psychical reaction and should influence functional neuroses. Here again it is doubtful if the upsetting of their equilibrium could, of themselves, in a person of sound mental and physical constitution, produce a neurosis. It would be safer to regard the effects of their irregular activity more as predisposing causes of a neurosis than causative. The mental factors would develop subsequently as the result of the induced abnormal bodily sensations.

Chronic Sepsis.

Cotton lays stress on the importance of the relationship of chronic sepsis to the neuroses.

He finds that local foci of infection which give no local symptoms and of which the patient may be unaware, can cause serious systemic diseases, both by spread of organisms and by dissemination of toxins. He considers that the neurotic patient harbours multiple foci of infection which can often only be located with the greatest difficulty. The origin of infection he finds to be practically always the teeth, and secondary to this toxaemia are /

are disturbances of the Endocrine System.

He enumerates the types of dental sepsis:-

(1) Unerupted and impacted teeth, especially third molars.

(2) Periapical granulomata.

(3) Carious teeth with infections.

(4) Apparently healthy teeth with periodontitis.

(5) Devitalised teeth with gold crowns.

(6) Extensively filled teeth with evidence of infection at the root.

(7) Gingival granulomata in apparently vital teeth.

He finds that the tonsils are nearly as frequently involved as the teeth. The treatment must be extraction in the case of the teeth and enucleation in the case of the tonsils.

The nasal sinuses may also be the seat of chronic sepsis.

From the teeth and the tonsils secondary foci of infection can occur in the stomach, duodenum, small intestine, gall bladder, appendix and colon by swallowing the bacteria. Or infection may be carried to other parts of the body by the lymphatic system of the blood stream.

The genito-urinary tract is frequently infected, especially in women, the source being probably through the lymphatic system.

Haemolytic and non-haemolytic streptococci and colon bacilli are mostly responsible for chronic infection /

fection.

Treatment would be directed first to the original focus of infection. Cotton recommends excision of an infected cervix uteri. Autogenous vaccine and anti-streptococcal and anti-colon bacilli serum are essential to the proper treatment of these cases.

He goes so far as to state that while not minimising the importance of psycho-genetic factors in the causation of the neuroses, he is inclined to place them in the position of precipitating factors rather than exclusively causative factors. He considers the claims of the advocates of psycho-analysis to be often extravagant and without justification or foundation.

Considerations of the Emotional Cause of the Neuroses.

Emotional disturbance of some kind plays an essential part in the causation of the neuroses.

Individuals vary greatly both from the inherited qualities with which they begin life, and from the effects of environment, education and upbringing which have been instrumental in the formation of their personality.

Psychological Types.

Jung has pointed out that among the many individual differences in human psychology there exist typical distinctions /

inctions. He has isolated two types which he has termed the Extraversion and Introversion types. The Extraverted type is characterised by an outward movement of interest toward the object and the Introverted type by a movement of interest away from the object toward the subject and his own psychological processes. The Extraverted view-point sets the object at greater value than the subject and goes out towards the object, whereas the Introverted extracts feeling from the object, the feeling experience being the chief thing and not the object in its own individuality. Thus one sees everything from the view-point of the objective occurrence, the other from the angle of his conception.

Everyone possesses both extraversion and introversion, but when the extraverted attitude is exaggerated then the Extraverted type is produced and similarly the Introverted type.

Hence it is plain that these types can think and feel around the same object and be affected by it in different ways.

Thus one person on seeing a bolting horse may rush in and try to stop it, whereas another might be so overcome with fear that he runs away or remains inactive.

It would appear that over-development of one or other of those attitudes would lead to deterioriation of mental /

mental equilibrium which would be conducive to the development of a neurosis when a suitable opportunity presented itself.

One man may find himself in a certain situation which he takes as a matter of course. Another man is confronted with the same situation, but, from some defect in his personality, developmental or hereditary, begins to develop certain symptoms which unfit him for the ordinary duties of life and make life more or less intolerable for him.

Mental Conflict.

The neuroses have for their basis, from their psychical point of view, the mental conflict with the attending discomfort, which results from the clashing of the two incompatible mental qualities, i.e. the primary instinctive impulses and the acquired self-regarding sentiment.

Our primary instinctive impulses have to be, in some way, controlled in order to let us live according to accepted social standards or to make us acceptable to those who conform to those standards, and still be at peace with ourselves.

This can only be brought about by the process of sublimation by which process these impulses are not abolished but diverted into related channels which give a modified /

ified satisfaction which leads to pacification. Thus ungratified maternal instinct can gain modified satisfaction by philanthropic duties and by bestowing kindness on animals, etc.

Those who have not been so fortunate as to work out their own salvation from this point of view must, in order to conform to social standards, adopt another method, the method, as Freud has pointed out, of repression.

Here, there is merely the attempt on the part of the individual to forget or to beat back those impulses without finding or working out a method which will afford them a modified satisfaction, since a complete satisfaction is denied them on account of accepted social standards.

Thus we see that if the individual's instinctive impulses are not adequately controlled by the development of his self-regarding sentiment, either through lack of proper environmental or educational influence or from some hereditary factor, then he can only put those impulses out of sight of himself and of others by the process of repression or trying to forget.

As with the instinctive impulses, so with terrifying, painful and revolting experiences. If the emotions attached to those experiences are not faced, grappled with and resolved so as to make them endurable, then repression must be resorted to in the attempt to relieve the mental pain /

pain and discomfort.

An attempt to forget painful experiences seems at first sight a natural thing to do because we experience mental discomfort by dwelling on them. The difficulty is, however, that apparently the mind, once impressed by a powerful emotional factor, cannot forget, any more than it can forget the innate instinctive impulses. It may be possible to beat back the cause of the anxiety and discomfort, for the time being, into the mental background, but to hold it there requires constant conscious watchfulness and effort, because, on account of its dynamic nature, it is ever attempting to return to consciousness.

Should the offending factor be successfully beaten back, it lies in wait ready, at the slightest prompting, usually from some associated occurrence, to return.

Hence the individual is in a constant state of apprehension lest the offending element returns to his consciousness and must in consequence exert mental energy to keep it repressed.

An individual who is repressing an experience will naturally avoid talking about it, and shun all society where it may be talked about in order to help him to forget.

Repressive power must be maintained, therefore, against forceful emotional elements which are constantly trying to obtain expression. The process may be described as /

as a "bottling up" of explosive forces and as such may be conceived as analogous to the manufacture of a cartridge whereby the powder gains in explosive force in proportion as it is packed more firmly.

Cruickshank sums up the views held by Freud, Jung and Adler as to the nature of the primary conflict.

Freud finds the primary conflict in the sexual sphere and considers the nature of the patient's reactions to all problems determined by his early sexual experiences and especially by his attitude towards and experiences with his father and mother. Jung finds the problem to be that of satisfactions, here and now, of the mental energising factors, this is, of course, a much wider view than that of Freud. Adler finds ambition, the desire to assert superiority and to gain one's own ends, the great emotions which, when once baulked, lead to neuroses.

Clinical Types.

Various forms of neuroses have been recognised and names given to them, i.e:-

(1) Psychasthenia.
(2) Anxiety Neurosis.
(3) Hysteria.
(4) Phobia.
(5) Obsessions.
(6) Migraine.
(7) Traumatic Neurosis.

Psychasthenia.

Psychasthenia may be defined as inability on the part of an individual to face and adapt himself to the changing problems of life. It may conceivably result from the general debility following febrile conditions, and from prolonged residence in tropical climates. Throughout life there is the necessity of facing and overcoming difficult or almost intolerable situations. These situations are, under normal circumstances, faced and overcome by assimilating and modifying them and adapting ourselves to them.

Thus progression in life takes place.

On the other hand, a compromise may take place in which there is only partial adaptation accompanied by a certain degree of repression. Or, in the worst circumstances, difficulties are magnified out of all proportion and retreat from the situation occurs accompanied by suffering and the formation of anxiety symptoms.

This is the situation of regression and extreme repression. The patient suffers, is annoyed with himself and loses his self-esteem.

It is a retreat inwards away from reality and indicates inability to adapt himself or to progress.

Thus the commencement, or the re-animation of a neurosis may occur when a relatively difficult task has to be faced.

It /

It is due to lack of independence of thought and action which may be ascribed to an error in development from the stage of complete dependence on the parents.

In the case of a man this is more likely to be associated with the mother. It is a common experience to see young men of twenty years of age, or over, brought for consultation by the mother and, on being questioned concerning their ailment, allow the mother to answer the questions and are, apparently, more or less dependent on her.

Abnormal mother dependence may be caused by the father's addiction to alcohol, as the child, on account of the father's condition, must necessarily come to her for everything. Should the father maltreat the mother, that is again a very strong incentive for the abnormal attraction of the boy to the mother.

As in all neuroses regression may occur in varying degree. Excessive indulgence in alcohol and taking of drugs are, in the writer's view, indicative of the regressive type. These indulgences are attempts on the part of the individual to bolster up his self-esteem in the case of failure to face a situation or to help him to face a situation for which he does not possess the necessary adaptive power.

Regression in its worst form may show a reversion to the infantile state.

Psychasthenia may be conceived from the mechanism described /

described above and it is essentially a condition of inadaptability whether in connection with the family, school, opposite sex, society, one's profession or religious inclinations.

The attitudes to the problems of life are those of indecision, procrastination, irresolution and evasion.

The condition may show itself in a mild form in childhood. The child, not liking his lessons or unable to adapt himself to his playmates, develops a pain somewhere so as to avoid going to school.

As life progresses the urgency for adaptability to new conditions becomes more insistent. Success in adaptability signifies the normal or proper attitude to life. Failure denotes the psychasthenic or mental weakling who, instead of facing his problem, resolving it and adjusting himself to it, retreats from it and in retreating may be accompanied by the feelings of remorse, shame, anger or humiliation which must be treated by repression if life is to be more or less comfortable.

Problems may be treated partly by adaptation and advancement and partly by retreat and repression. Should the latter eventually predominate, as in the case of having to meet a task of unusual difficulty or in face of a problem involving considerable emotional strain, the situation may be treated by complete retreat and repression.

The /

The symptoms of indecision, procrastination, irresolution and evasion vary in proportion to the degree of Psychasthenia.

If retreat and repression become more consistent and complete there follow other symptoms which transfer the psychasthenic into the so-called neurasthenic state.

The psychasthenic state may be regarded as ground favourable for the development of other neuroses.

Anxiety Neurosis.

Anxiety Neurosis, or, as it is sometimes called, Neurasthenia, may be defined as a series of symptoms resulting from a faulty outlook on the problems of life with consequent failure in adaptation.

It has been discussed how that the painful mental factor is kept from admission to the consciousness by the expenditure of mental energy. The mental energy, which should be used for normal purposes and for overcoming daily difficulties, is diverted and dissipated to maintain the repression.

The mind becomes preoccupied with internal distraction and has lost some of the power necessary for dealing with the ordinary affairs of life.

General Symptoms:- Fatigue on slight exertion is usually marked and is independent of the muscular development of the patient. Very often the fatigue is of a selective /

ective character, coming on early if the patient has to perform some duty which does not interest him. Everyone has, of course, had experience of this phenomenon, though not to the same degree as in the definitely neurasthenic patient. Loss of weight is common and may give rise to anxiety. It is generally due to loss of appetite. Organic disease, such as tuberculosis, diabetes or malignant growth must be carefully eliminated.

Gastro-intestinal:- The appetite is commonly depressed and may be very capricious, the patient being difficult to please.

Digestive disturbances such as fullness after food, feeling of distension, severe flatulence and acidity are common. Definite pain, excepting occasionally that of flatulent distension, is not common. Organic disease would be suspected if pain occurred with a definite time relation to the taking of food. Constipation and diarrhoea are commonly complained of, and some consider that mucous colitis is frequently merely a nervous manifestation. Great care, however, in this instance is required.

Urinary System:- Frequency of micturition and increased amount of urine are common, as Cannon has pointed out, especially after emotional outbursts. Sugar is not uncommonly found in the urine of nervous patients.

Genital System:- Nocturnal emissions may cause distress out/

out of proportion to their importance. They occur more commonly in nervous than in healthy people. Impotence in men may cause great distress, particularly if it be attributed to previous excess or masturbation. Dysmenorrhoea in women may be purely of nervous origin, and dyspareunia due to vaginismus, without local lesion, is a manifestation of repugnance either to the sexual act or to the partner.

Circulatory System:- Tachycardia and feelings of discomfort round the heart accompanied sometimes with pain and a feeling of constriction are common symptoms. When such symptoms are not accompanied by signs of organic disease of the heart and blood vessels, kidney or pulmonary disease and anaemia, they may be attributed to a nervous condition.

The "effort syndrome" is a test whereby a patient is asked to run up about twenty steps which will quicken his pulse rate. If the pulse rate returns to normal in about one and a half minutes, the absence of myocardial impairment may be assumed.

These circulatory disturbances very often occur when the patient is sitting quietly and doing nothing, as he thinks, whereas he is brooding over something or has received a stimulus which has brought about an emotional state.

Vaso-Motor System:- Blushing, pallor, sweating and coldness of the skin are common.

Respiratory System:- A serous nasal discharge occurs in some patients and, in consequence, they complain that they "catch colds" whenever exposed to a draught. The discharge remains serous in character and is thus distinguished from a genuine coryza by not becoming purulent. Shortness of breath on slight exertion is common. In many neurasthenic patients the respiratory rate is quickened and respiration shallower than normal.

Aural Symptoms:- Buzzings in the ears may occur periodically. Intolerance of noises is common and many patients complain of the noise of their heart beats. This last symptom may be a cause of insomnia.

Ocular Symptoms:- These may take the form of an intolerance to light, more or less marked, and very often associated with headache. Or, the patient may be able to read quite well for a time and then the words become blurred and run together with the result that he has to give up the attempt to read until they recover. The possibility of errors of refraction must be carefully considered in such instances. There is a tendency to widening of the palpebral fissure.

Nervous Symptoms:- These are insomnia, nightmares, somnambulism /

nambulism and headaches. Insomnia is due to two factors, i.e. mental preoccupation and fear of nightmares. The patient's mind is busy consciously and subconsciously maintaining the repression and is therefore unable to attain to the state of mental and sensory indifference to stimuli which precedes sleep. Secondly, he is afraid to fall asleep on account of the dread of nightmares which he is anticipating. Nightmares are due to leakage of repressed memories during sleep. It is only in certain types of nightmare that memory returns without control. Thus the soldier may dream of shells and fighting. In the civilian, however, memory is more commonly distorted, invested and symbolised, the dream being more often of some horror never actually experienced. Freud argues that everyone has wishes which he would not like to tell to others or even admit to himself. He considers the dream disfigurement due to the disagreeable nature of these wishes which "by the act of the censor" have been permitted to escape from repression only in symbolised form. Thus in the analysis of certain dreams he sees symbolical representations which have a definitely sexual significance. Thus staircases, ladders and flights of stairs or the climbing of these, are, he states, symbolical representations of the sexual act. In dreams of anxiety he argues that the fear we experience is only seemingly explained by the dream content. If the content of the dream /

dream is analysed, the dream fear is no more justified by the dream content than the fear in a phobia is justified by the idea on which the phobia depends. Anxiety is only superficially attached to the idea which accompanies it and comes from another source. He considers that neurotic fear has its origin in sexual life and that the content of anxiety dreams is of a sexual nature. Thus the woman who dreams of falling is in fear of being tempted sexually.

Somnambulism has the same mechanism as nightmares, but in the former the patient acts as well as visualises the memory.

"Headaches", or, more commonly, "peculiar feelings" in the head are often present. The patient complains of feelings of discomfort, of bursting feelings, of swelling of the scalp, of bands being tied round the head and feelings of weight or pressure on the head. These are generally related to periods of increased anxiety or may be fairly constantly present with exacerbations periodically. Pains of all kinds may be complained of in various parts of the body, such as in the rectum through fear of cancer. The sacrum and back are situations where pain is commonly complained of, and especially so in the case of women. Uterine trouble, such as fibroids, cancer, etc., must be carefully eliminated. Giddiness is common and is usually associated with a change of position, as in suddenly rising from /

from the sitting or lying posture.

Hallucination.

An hallucination may be defined as a sense perception experienced in the absence of any objective stimulus. Hallucination may concern any of the senses and are termed auditory, visual, tactile, gustatory, etc., according to the particular sense affected. The first two are the commonest. Visual hallucinations or illusions are distinguished from the others in so far that there may be an actual objective stimulus existing but which is erroneously perceived. Thus a delirious patient changes the pattern in a wall-paper into insects, or a bed-post seen at night may take the form of a man. There may be hallucinations of temperature or pain or feelings of movement in some part of the body. Provided the patient recognises that the hallucination is relative to his illness and merely objective, there can be no question of insanity.

In the neuroses hallucinations of a mild nature occasionally occur, such as noises, singing or bands playing, bells ringing, bad tastes in the mouth, bad smells, etc. These are more or less discounted by the patient. On the other hand, if they are not so treated, the possibility of incipient insanity must be considered.

Mental Symptoms:- Inability to concentrate, although at times /

times due to physical conditions, is, in neurosis, always complained of. The patient's mind is diverted and preoccupied by his anxiety or conflict, and consequently finds difficulty in bringing his mind to bear steadily on any subject.

Failure of memory, in varying degree, necessarily follows failure in concentration. The failure in memory generally applies more to the smaller, every-day details than to old events as the mental preoccupation blots out the memory of the smaller details of the day. These two symptoms, associated with insomnia, very frequently bring about the fear of insanity.

By the interaction of these symptoms a sense of inferiority may gradually take hold of the patient and he becomes shy and awkward in company. This sense of inferiority is very different from that which everyone possesses who makes any pretence to be sociable and which prevents the individual from adopting overbearing mannerisms. The neurasthenic, on listening to others conversing on subjects with which he is not familiar and being in an emotional and anxious state, conceives himself to be inferior to them. He develops feelings of shame and remorse at his inability or lack of energy in not having acquired the knowledge of his fellows. He constantly forgets that he may know something which they don't know and thus loses a prop on which to support his feeling of self-respect. A neurasthenic patient /

patient whose mind is well stored with general knowledge does not, of course, necessarily develop the inferiority sense in this respect, but he may do so in the moral sphere. Ideas of an unworthy or ignoble character, such as thoughts of an entirely selfish nature, hatred, greed or the "death wish" of a parent or friend who has annoyed or obstructed him in some manner, may have entered his mind which he considers unexplainable and which he thinks are peculiar only to himself. He lacks the knowledge that unworthy ideas enter the mind of everyone which, in the normal, are put aside and discounted and are not permitted to produce any emotional reaction.

In childhood, the normal child endows the parent and generally most grown-up people, if they are at all worthy, with exaggerated qualities of virtue and knowledge, and it is only as life progresses that he begins to realise slowly that they are "flesh and blood" like himself and that in all likelihood, they entertain the same ideas and have the same promptings as he has. Respect is not lost, but he has developed a more balanced and human view of his relationship to others. Thus life progresses normally. If, however, for any reason, a childish attitude of exaggerated respect for qualities in others is maintained, there will be a tendency for the development of a sense of inferiority, and such an individual will, when faced with a difficulty /

culty or anxiety, have a desire for support and a tendency to retreat from his difficulty. A modified sense of inferiority in relationship to the parent is considered to be of social importance as it fosters a respect for law and order in the community.

Neurasthenic patients complain of anxieties of all kinds. They tend to become anxious about everything and appear to have lost their sense of proportion. Everything may be difficult to them. Their emotional reactions, such as their feelings of shame, remorse, fear, and general worries may cause them to suffer from a general difficulty in attending to the affairs of life, to a complete paralysis of mental activity.

Mental conflicts commonly concern matters of sex. Many think that sex thoughts are signs of an immoral and depraved mind, and particularly so if these thoughts take the form of actual desire. They do not realise that it is normal and physiological to have such thoughts and desires and that virtue is the result of resisting such desires.

Masturbation is a common cause of mental conflicts, both from the physical and moral point of view. It may give rise to the depressing emotions of fear, anxiety, shame and remorse. The popular point of view is that the habit has deleterious effects physically in the form of causing early sterility, ill health and "nervous troubles." Morally, some may think that they have committed a sin or that they have /

have indulged themselves instead of begetting children. Although the habit can certainly have deleterious effects physically in the case of boys practising it to excess, yet, when it is remembered that it is of universal incidence, it cannot be said to be the cause of ill health or sterility any more than can be ordinary sexual intercourse.

In a similar manner nocturnal emissions may be the cause of conflict. The patient may ascribe them to sexual thoughts by day and may think that he has an "objectionable mind", or he may be worried over what he thinks is a "loss of strength."

The soldier in war may derive his conflict from the thought that he is a coward because he feels fear. He looks at his fellows and sees that they are apparently calm and without fear. In consequence he thinks that he is the only one who is afraid and therefore unworthy and to be despised. Unfortunately, he does not realise that his fellows are behaving well in spite of their fear and that courage consists in doing things in the presence of and in spite of fear.

Mental conflict may arise from a wide range of causes. Thus some may develop a mental conflict from falsifying their income tax returns, and others may find theirs in religion or politics or in their profession. As mind and body are closely inter-related, the symptoms due /

due to the repression react on the physical condition with the result that the latter is impaired. The impaired physical condition results in impaired mental vigour, so that greater mental effort is required to maintain the repression. The greater mental effort required to repress accentuates the symptoms due to the repression, and so a vicious cycle begins.

Similarly, the impaired bodily vigour following infectious fevers and continued physical fatigue accentuates the symptoms in the individual who is the subject of such repression.

The condition may remain more or less stationary with the symptoms and physical manifestations existing only in a modified degree. The patient feels the strain of life more than he did formerly and worries about this. From the symptoms due to the repression he develops minor bodily ailments.

On the other hand, the condition may develop so rapidly and be so insistent that collapse of the whole mental organisation may soon take place.

Conversion Neurosis or Hysteria.

Conversion neurosis is the name given to a neurosis which demonstrates itself by the production of pseudo-physical manifestations.

Before the mechanism of conversion neurosis is discussed /

discussed a few points regarding the suggestibility of individuals and the factors which increase that suggestibility may be given here.

In childhood, when the critical capacity is necessarily small, ease of suggestibility is marked. In disposition some people are much more suggestible than others. Thus Jung's introverted type can be recognised as being more suggestible than the extraverted type.

The well educated person with a large store of well organised knowledge which can be called upon readily, is not so suggestible as the uneducated person, as his mind is more critical.

A person will accept suggestions more readily from someone whom he respects than from an inferior or an equal.

Illness and fatigue, by reducing mental vigour, increase suggestibility.

In the abnormal anxiety conditions suggestibility, particularly suggestions in sympathy with the dominant mood, tends to be increased. The dissipation of mental energy in maintaining the repression makes the mind less resistant to suggestion on account of the lowered mental vigour. Similarly, the preoccupation caused by the repression diverts the attention and causes weakening of the power of discrimination.

In the dazed condition, similar to a light hypnosis, such as occurs after accidents, it is increased.

Suggestions /

Suggestions may come from within. Thus the manifestations of fear, such as diarrhoea, palpitation, breathlessness, etc. may suggest physical disability to the patient.

Suggestions may be derived from a previous illness, such as pains and headache. Deafness may be suggested by a temporary deafness due to catarrhal trouble or the "tingling" following a loud noise. Suggestion of illness may even come from the medical attendant directly in speech or indirectly in manner. By repeatedly asking the patient regarding pain or testing for anaesthesia, both may be accepted by the patient as existing. Pain derived from experience of a previous illness may have been very slight, but by auto-suggestion may become greatly exaggerated. Almost any symptom can be produced by suggestion provided the ground is suitable.

Symptoms.

Motor System:- Almost every variety and degree of paralysis and paresis may be found. They do not, however, correspond exactly to those due to organic disease. Thus in cases of paresis defective inhibition of the antagonists of a given movement is a common phenomenon in hysteria.

Hemiplegia, Diplegia, Monoplegia, Paraplegia, etc., may be simulated.

In /

In hysterical paralysis of the leg the hysteric drags his foot along the ground, whereas the genuine swings his leg from the pelvis. If the hysteric is asked to extend the limb, passively flexed at the knee, the hamstring muscles are found to contract first and thus prevent the extension of the limb.

In the upper limb in the genuine paralytic there is flaccidity first, then rigidity and flexion.

Arm jerks, knee jerks and ankle jerks are exaggerated on the affected side in the genuine. Ankle clonus and extensor plantar reflex are present. Abdominal reflex on the affected side is absent.

Hysterical contracture may occur. The contraction attitudes do not usually correspond to organic types. The contracture usually, though not always, disappears in sleep.

Hysterical tremor may simulate any form of organic tremor.

Irregular movements, such as chorea, tetany or occupation neuroses may be simulated.

Sensory System:- Anaesthesia, paraesthesia, and hyperaesthesia may be present. These may be brought about by methods of examination by suggestion. Anaesthesia when established may be complete or partial and may involve both deep and cutaneous forms. It corresponds to the patient's idea of what such anaesthesia entails and thus does not correspond to the distribution of the peripheral nerves /

nerves.

Digestive System:- Chronic vomiting and anorexia to the point of refusing all food are common.

Nervous System:- Hysterical attacks may range from a mere faint to elaborate and prolonged convulsions with passionate attitudes. The movements are purposeful. Struggling takes place with those who are attending. There is no tongue-biting or involuntary micturition. Thus they can be distinguished from ordinary epilepsy. Certain situations are frequently chosen for the exhibition of these attacks. Thus a female patient of the writer used to have them at parties where men were present. A certain degree of automatism may follow hysterical attacks, as in epilepsy. This can only be distinguished after all the facts of the case have been fully investigated and observed.

The patient does not usually remember anything that has occurred during the attack.

Special Senses:- Complete blindness may occur, unilateral or bilateral, and all degrees of amblyopia. There may be defects in colour vision or coloured vision may be met with. Concentric diminution of the field of vision may occur. There may occur hysterical ptosis, blepharospasm, ophthalmoplegia and convergence spasm. Aphonia, stammering and other defects of articulation may be present. There may be /

be complete mutism and deafness. Facial spasm is common and difficulty in swallowing, due to spasm in the mechanism of swallowing, may occur.

Aetiology:- Freud considers that sexual experiences in childhood, before the age of seven, consisting of stimulation of the genitals, coitus-like activities, etc. constitute the traumata from which hysterical reactions proceed. Impressions received in early childhood are necessarily strong since they have been received before the critical faculty has been developed.

These experiences come under three groups:-

(a) Children who have been assaulted by grown-up strangers, the preponderating result of which is terror.

(b) The more numerous cases in which a maid, nurse, governess, teacher or some near relation initiated the child into sexual intercourse and probably maintained a regular relation with him for years.

(c) Sexual relations between two children of different sex, mostly between brother and sister, and often continued past the age of puberty. The witnessing of sexual relations may be equally important.

He does not claim that all who have had sexual experiences in childhood develop a neurosis, but that it depends on the emotional reaction that takes place in later life on recollection of the experience. It may be possible to /

to understand Freud's theory more broadly as embracing love, affection, shame, fear and anything in any way connected with sexual activities.

Freud states "that the outbreak of hysteria may almost invariably be traced to a psychic conflict arising through an unbearable idea having called up the defences of the ego and demanding repression."

The dynamic repressed emotional element remains active subconsciously, awaiting an opportunity to express itself. This opportunity may be given by the occurrence of any circumstance which may have an association with the repressed memory.

In those who may be predisposed to hysteria and possess the capacity for conversion, it can express itself indirectly and still be more or less palatable. This expression constitutes the conversion symptom. Thus, as Freud points out, the symptom may be regarded as a mechanism of defence, since part of the emotion attached to the unbearable idea is transferred to the symptom and by doing so weakens the force of the painful emotion. In other words, the patient subconsciously erects his symptom between himself and his conflict. Similarly, it may be regarded, from the patient's point of view, as a solution, more or less, of the conflict since the subconscious painful emotion is weakened by being partly transferred to the symptom. Although the patient has partly succeeded in /

in solving the incompatibility within himself, he has now burdened himself with a memory symbol, as Freud describes, which remains in consciousness like a kind of parasite either in the form of a persistent motor innervation or a constantly recurring hallucinatory sensation.

Again, as the emotional desire to satisfy the instinctive tendencies is always present, the development of the symptom activated by some factor such as disappointment in love, desire to escape danger or some irksome duty, is a Wish-Fulfilment. Thus the soldier about to attack may develop a paralysis suggested by a feeling of weakness in the legs caused by fear.

The patient does not recognise the cause of the symptom and consequently believes that it is genuine.

The determination of the particular symptom depends on various factors. A patient may copy a disease which he has seen in someone else, particularly someone whom, in childhood, he wished to resemble. He may copy a disease in someone who has gone through a similar experience. On the other hand, symptoms already present which have been produced by emotional shock are simply made more permanent and stable. Thus mutism, deafness and blindness stabilised in this way are a guard against speaking of, hearing and seeing that which revives the painful emotional memory. The patient who is suffering from a conversion symptom has, by the production of the symptom, diverted his /

his attention from the cause, which is the mental conflict. In consequence the cause is lost sight of and the symptoms of insomnia, headaches, nightmares, etc., due to that cause, tend to disappear. There is now some physical disability which distracts the patient from the real trouble and he is satisfied as he is relieved from facing that trouble. Should the symptom be removed, by suggestion or persuasion, the refuge is lost and the symptoms of the conflict will be apt to return. The patient will either remain in a state of anxiety or will produce some other conversion symptom unless he faces his conflict and resolves it.

The essential difference between the hysterical and anxiety types of neuroses is that, in the hysteric, the symptoms are expressed outwardly, while in the anxiety type they are expressed inwardly. Hysterical people are generally of low intelligence, with no self-control, selfish, acting on impulse, always seeking pleasure, and treating anything of an unpleasant nature, which may happen to them, by immediate repression. They usually have had their own way as children, and, as such, have taken refuge, by repression, in illness when thwarted in anything they desired.

Phobia.

A phobia isa fear for which there is apparently no adequate reason.

The patient knows that his fear is absurd and is often ashamed of it. The fear is very great and the patient may be quite unable to carry out the dreaded action, or he may do so only at the cost of the greatest suffering.

Freud classifies phobias into two groups:-

(1) Common phobias, in which there is exaggerated fear of all those things which everyone fears to some extent such as darkness, solitude, death, dangers in general, illness, traffic, bad weather, noise, snakes, fire, etc.

(2) Specific phobias, in which there is fear of special circumstances that inspire no fear in the normal person, e.g. Agoraphobia, claustrophobia, etc.

Phobias are always found associated with an anxiety state. The repressed emotion, as Cannon and Kempf have pointed out, affects the autonomic nervous system with consequent derangement in function of the viscera and endocrine glands, thus exciting a further emotional reaction with the production of anxiety by repercussion. This anxiety cannot be attached to the repressed material and is consequently attached to some other idea. The nature of the phobia tends to be determined by the conditions

which /

which were associated with the repressed material. Thus if a child has been shut up in a cupboard with which some emotional disturbance has been associated and which has been treated with repression, then that child may develop Claustrophobia. Freud finds that Claustrophobia etc. are recollections of a state of panic and that what the patient actually fears is a repetition of such an attack under those special conditions in which he believes he cannot escape it. He finds that in many cases the anxiety has a sexual origin but does not attach itself to ideas from sexual life. In these cases he finds that the cause is a "sexual tension" produced by abstinence or protracted sexual excitement.

He points out the frequency of the coexistence of phobia and obsession. Thus a phobia can develop at the beginning of an anxiety neurosis and the thought content of the phobia, accompanying the state of fear, can be replaced by another idea which becomes a protection and lessens the fear.

In illustration he quotes a case of Obsessive brooding and Speculation. "A woman suffered from attacks of this obsession that ceased only when she was ill and then gave place to hypochondriacal fears. The theme of her worry was always a part or function of her body, e.g. respiration. Why must I breathe? What if I try not /

not to breathe?

"At the beginning she suffered from the fear of becoming insane, a hypochondriacal phobia common enough among women who are not satisfied by their husbands, as she was not. To assure herself she was not going mad she had begun to catechise herself and busy herself with serious problems. This quieted her at first but, with time, the habit of speculation replaced the phobia. For more than fifteen years, periods of fear and of obsessive speculation had alternated in her."

A phobia would appear to be a dread of fear associated with certain circumstances, which circumstances are carefully avoided by the patient.

Obsessions.

An obsession may be defined as an idea which dominates the mind and which is accompanied by emotional reaction apparently out of proportion to the idea and often showing absurd relationship to it. Thus a patient may carefully step over the lines of a pavement and exhibit the greatest anxiety while doing so.

Obsessional neurosis appears to favour the male sex more than the female sex.

Freud finds that "obsessions are always reproaches re-emerging in a transmuted form under repression, reproaches /

proaches which invariably relate to a sexual deed performed with pleasure in childhood."

First, there are experiences, in early childhood, of sexual seduction which form the objects of subsequent repression. Then there come later the deeds of sexual aggression against the opposite sex which constitute the acts to which self-reproach, shame, mistrust, etc. become attached.

These causes of the conflict can reasonably be extended to other factors, such as disappointment in love or desire to escape a danger or irksome duty.

Repression takes place and separation of the painful emotional reaction from the unbearable idea is brought about as a defence against the latter. This emotional reaction, however, persists subconsciously and being free from the unbearable idea must, on account of its dynamic nature, attach itself to other ideas which are not in themselves unbearable but which, through this false connection, become obsessions.

It is characteristic of obsessional neurosis that, should the repressed memories be reawakened accidentally, spontaneously or in consequence of some current association, they never appear in consciousness unchanged. The obsessive idea with its attached emotion appears in consciousness in place of the repressed memory and so constitutes compromise-formations /

formations and a defence.

Thus, in one of Freud's cases, a girl reproached herself for things which she knew were absurd viz:- for having stolen money, for having counterfeited coin, for having dabbled in magic, etc., according to what she had been reading during the day.

The replaced idea was that she was reproaching herself with the onanism she had been practising secretly without being able to renounce it.

The self-reproach can transmute itself into any other unpleasant emotion. Thus self-reproach for having performed a sexual deed in childhood can transmute itself into shame for fear that another person should hear of it; or into hypochondriacal anxiety in case some bodily injury will be the result of the act which caused the self-reproach; or into dread of the community for fear of punishment; or into dread of temptation for fear of personal lack of moral strength to resist.

In another case Freud shows how the original unbearable idea is not replaced by another idea but has been replaced by acts or impulses which have served as measures of relief or as protective proceedings and which are now associated with an emotional state which does not fit them. Thus a woman becomes obliged to count the boards in the floor, the steps in the staircase, etc., acts which she performed /

performed in a state of distress. She had begun the counting in order to turn her mind from obsessive ideas of temptation. She had succeeded in doing so, but the impulse to count had replaced the original obsession.

Migraine.

The condition is characterised by severe headache, usually unilateral, and often associated with disorders of vision. The headache usually spreads from the eyebrow and forehead over the top and back of the head.

Heredity is an important factor in the disease and it has been found that, in certain families, migraine often alternates with epilepsy, insanity and hysteria. It may often be traced back to childhood when the attacks were known as bilious headaches.

Symptoms:- The attacks may give warning to the patient. Some may feel an excessive sense of well-being or experience an excessive appetite before the onset.

Some may experience a visual scotoma or homonymous hemianopia, the vision recovering in about twenty minutes, and the headache commencing in the opposite side to the blind field. Some have a blurring of central vision, the scotoma opening out in horseshoe shape towards the periphery of the field of vision with prismatic colours in its margins.

Occasionally a psychical aura in the form of a certain scene /

scene occurs before each attack. There may be spasmodic action of the pupil in the affected side which dilates and contracts. Vertigo occurs in some. In others there may be numbness of the tongue and face or head or a tingling sensation, or psychically there may be excitement, confusion or depression.

Unilateral or general headache follows in about half-an-hour after the prodromal symptoms. It usually begins in a small area and spreads. It is described as being of a penetrating, sharp, boring character. The pain may gradually extend to the neck and pass into the arm.

Nausea and vomiting may follow.

The face may be pale and the pulse slow.

The affection is prostrating and during the paroxysm the patient may be scarcely able to raise his head from the pillow. The slightest noise or light aggravates the condition. The attack may extend from one to three days and is recurrent. In those with an hereditary tendency the recurrence may persist throughout life.

In women the attacks often cease after the climateric and in men after the age of fifty.

Different views are given as to the causation.

(a) That it is toxaemic due to disorders of intestinal digestion from disturbed uric acid output or from some self-manufactured poison.

(b) That it is a vaso-motor affection with

transient /

transient spasm of the arteries.

(c) That it is of reflex origin arising from a refractive error in the eyes or from troubles in the nose or sexual organs.

(d) That it may be caused by powerful emotion, or mental or bodily fatigue.

Cruickshank sees a psychical cause for migraine. He states definitely that "in each and every migrainous patient and in most violent neuralgics there is repression of rage and humiliation felt in the face of some problem - practical, ethical or intellectual - that appears insoluble. "Like most neurotics, the migrainous and neuralgic always seek excuses if life denies them the longed for triumphs; postpone decisions when action is called for, and 'arrange' that what is attained should appear in an intense light." The migrainous patient asserts his superiority and in face of or in anticipation of failure to gain his end or impose his superiority, develops migraine. Blame for the failure is transferred by the patient from himself, who is the true cause, to the headache and thus he attempts to "save face."

Thus a patient who has to perform an uncongenial task, and probably feeling he could do another much better, develops a migrainous headache as an excuse.

Failure in solving such tasks and problems continues with the recurrence of migraine, so long as personal responsibility /

responsibility for the failure in action or the personal inadequacy or failure in thought are unexpressed or unrecognised.

The migrainous patient takes refuge behind his migraine and, at the same time, regards it as being the cause of his inabilities.

Cruickshank considers that most neuralgias, trigeminal neuralgia or sciatica, are the expressions of a desire to shirk a duty or avoid a danger.

Traumatic Neurosis.

Buzzard and Greenfield point out that concussion may result either from direct or indirect violence.

The former is due most to blows from clubs, stones, etc., and the latter to jars transmitted from the spine, as in landing on the heels with the knees straight or in landing in a sitting position from a height, or from blows on the chin, the shock being transmitted to the middle cranial fossa through the ramus of the lower jaw.

Similarly, the force produced by an explosion may be transmitted to the brain and spinal cord by the cerebrospinal fluid. The concussion varies in degree from a momentary loss of consciousness to prolonged unconsciousness, retrograde amnesia, and mental confusion.

True concussion may be associated with fracture

of the skull and some subarachnoid haemorrhage, but, on the other hand, no macroscopic changes may be observed. They describe the condition of Internal Hydrocephalus which may result from concussion in the adult. Damage to cranial nerves sometimes results from concussion.

Concussion is important relative to the age of the person and the condition of the arteries. Thus injuries which, in youth, may lead to no ill effects, would, in later life, lead to gross loss of function.

Concussion to the spinal cord results most frequently from blows on the back, especially over the thoracic region, causing abnormal straightening of the spine, or falls on the head causing a sudden backward flexion of the neck, or, as in the case of soldiers, a bullet striking or piercing laterally the spinous processes.

Here, again, there may be all stages from concussion, pure and simple, to gross lesion.

Symptoms:- Those observed in the earliest stages of shock are:- Muscular relaxation, impairment or abolition of the deep reflexes, presence of extensor plantar response, retention of urine or overflow incontinence, irregularity of the pupils, impairment of light reflex, and sometimes haemorrhages of the retina. The cerebro-spinal fluid may contain blood cells.

These symptoms may disappear in a few days, but, as they pass off, symptoms of a psycho-neurotic nature may supervene /

supervene.

It is highly probable that after concussion pure and simple, unaccompanied by any emotional reaction, anxiety symptoms would not supervene. The likelihood is that, at the time of the injury, there was actually in progress, without the patient being aware of it, the development of anxiety. The development of this anxiety may have been going on for some time, or a very short interval may have occurred between the accident and the loss of consciousness in which fear may have been active. On regaining consciousness, the patient may have treated this painful emotional disturbance by repression.

Injury may act as a precipitating agent of a neurosis already begun. Amnesia, a loss of memory of a certain consecutive train of events, may be complete or partial. It may embrace a period before or after the accident.

Diagnosis.

The differential diagnosis of psycho-neurosis has to be made from the early stages of various diseases, the principal being exophthalmic goitre, heart disease, disseminated sclerosis, general paralysis, locomotor ataxia, manic depressive insanity, paranoia and dementia praecox.

Exophthalmic Goitre.

The symptoms generally develop slowly and a period of lassitude and easily induced fatigue may precede the development /

development of definite symptoms. Progressive loss of weight, with increased appetite, may occur early.

Some increase in the size of the thyroid gland is nearly always present as the condition develops. The enlargement is usually visible, but may only be detectable on palpation. In a few cases the goitre reaches a considerable size. Pulsation of the gland is often visible and is transmitted from the carotid arteries. A true expansile pulsation may occur.

Ocular Symptoms:- Exophthalmos is present in about 80 per cent of the cases and is of variable degree, varying from a very slight protrusion of the eyeball to extreme proptosis.

Von Graefe's sign, which is due to delayed descent of the upper eyelid so that when the patient looks down the sclerotic remains visible for a period between the upper margin of the cornea and the eyelid. This is an important sign and should be looked for as it may give an indication of the presence of the disease before exophthalmos has developed to any great extent. Weakness of convergence is sometimes present.

Circulatory System:- Increased frequency of the pulse is a constant symptom and may be the first to appear. The heart is irritable, so that slight emotion or exercise may cause an acceleration. Throbbing of the carotid arteries and abdominal aorta is frequently complained of.

The /

The area and force of the cardiac impulse are increased. The first sound is accentuated.

Nervous System:- Patients suffering from exophthalmic goitre are in a state of continual agitation and nervousness, and restlessness may be very marked. They tend to worry about trifles. A fine regular tremor of the extended hands is present more or less in all cases. In a few the tremor may be coarse and jerky.

In the differentiation of anxiety symptoms from the early stage of this condition special notice may be taken of the progressive loss of weight in spite of increased appetite. Should ocular symptoms be present, then diagnosis is easier.

The symptoms of the circulatory and nervous systems may closely resemble anxiety symptoms.

Heart:- Palpitation and precardial pain must be carefully diagnosed as independent of physical causes. The condition of the arteries, as to thickening; the valves, as to whether there is any incompetence or stenosis; the myocardium, as to dilatation, hypertrophy, fibrous myocarditis, and fatty degeneration; the kidneys, as to chronic nephritic conditions; and blood pressure must be thoroughly investigated.

Disseminated Sclerosis.

The onset is slow and the disease is chronic. Feebleness of the legs with irregular pains and stiffness are /

are among the early symptoms. The knee jerk is exaggerated and ankle clonus and an extensor plantar response can usually be elicited. There is absence of abdominal reflex. Intention tremor is usually present and there is scanning speech, the words being pronounced slowly and separately. Optic atrophy may occur early but is usually partial. There may be nystagmus. Vertigo is common.

The gait is conducted on a wider base than usual and difficulty is experienced in attempting to toe-and-heel a straight line.

Vertigo is a fairly common symptom in the neuroses, but should any of the above mentioned symptoms be present little difficulty may be found in differentiating early disseminated sclerosis from a neurosis. Anxiety, of course, may be present engendered by the feeling of physical inefficiency, or from any other cause.

General Paralysis.

In the early stage there are generally irritability and inattention to business, sometimes amounting to apathy. Sometimes a "change of character" develops which is evidenced by the patient performing acts which astonish his friends.

Instead of apathy there may be an extraordinary degree of physical and mental restlessness, the patient continually planning and scheming.

A common feature is the development of an unbounded egoism /

egoism. He boasts of personal attainments, property, etc.

Following these indications there may be offences against decency and the law. At this period there may be no motor symptoms but, on the other hand, irregularity of the pupils, Argyll-Robertson pupils, optic atrophy and changes in the deep reflexes may precede the mental symptoms for years. (Osler).

In the early stage of General Paralysis, the irritability and inattention to business may be suggestive of a neurosis, but if a "change of character" were noticeable, then the patient would be regarded more as developing the former. In contrast to the feeling of inferiority characteristic of the neurotic, the patient suffering from General Paralysis may develop unbounded egoism and boast of personal attainments, etc. The presence of any physical signs would, of course, contradict the possibility of a pure neurosis.

Locomotor Ataxia.

Pains usually of a sharp, stabbing nature occur which dart from place to place. Occasionally they are associated with a hot, burning feeling. A sense of constriction about the body, paraesthesia (numbness of the feet, tingling, etc.) may also be among the first symptoms. Argyll-Robertson pupils and paralysis of the external muscles of the eye may be early. Optic atrophy, which /

which occurs in about 10 per cent of cases, is often early and may be the first symptom.

A difficulty in emptying the bladder is often an early symptom.

Loss of deep reflexes is an early symptom and may occur years before the development of ataxia.

Anxiety neurosis may be associated with the early stages of Locomotor Ataxia due to the feeling of increasing physical inefficiency. Should the above mentioned symptoms be present, the incidence of Locomotor Ataxia will be demonstrated and the anxiety symptoms, if of recent date, may be attributable to the condition.

The pains in a neurosis, as contrasted with those of Locomotor Ataxia, are more localised, persistent and "aching" in character.

Manic Depressive Insanity.

Kraepelin considers that "the whole domain of so-called periodic and circular insanity, simple mania, the greater part of the morbid states termed melancholia and also a not inconsiderable number of cases of amentia only represent manifestations of a single morbid process."

Manic States.

Kraepelin points out that hallucinations frequently occur and that the train of ideas shows important and well marked disorders. In states of excitement patients are /

are not able to follow systematically a definite train of thought, but continually jump from a series of ideas to another which is entirely different. Incoherence of thinking leads to confusion and patients may complain that "one thought chases the other and just vanish like that." In depressed patients the same not infrequently occurs.

Delusions are frequent and in their simplest form are connected with the feeling of mental inefficiency and show a hypochondriacal tendency. The patient may think he suffers from cancer, syphilis, is becoming demented, etc., or he may have ideas of sin, persecution or greatness.

The mood is mostly exalted in mania. Patients may be "over merry", "more than satisfied" or visionary.

Sexual excitability is increased, which leads to conspicuous behaviour, extravagance in dress or sometimes jealousy and matrimonial discord. They may become arrogant and "high flown" or, when contradicted, they may show extreme rage with outbursts of violent abuse.

The manic state is characterised by a "pressure of activity". This varies in degree from a restlessness of behaviour to an agitated desire for hurried enterprise according to the severity of the mania. "Pressure of speech" is often very marked and is a manifestation of the general "pressure of activity." Isserlin has shown that the number of syllables spoken in a minute by a manic patient amounted to 180 to 200, while the normal produced not /

not more than 122 to 150.

The feeling of fatigue is completely absent in the patient, in spite of the most intense motor excitement which may persist for weeks or many months with slight interruption.

Depressive States.

The slightest depressive states are characterised by the appearance of a simple psychic inhibition without hallucination and without marked delusions.

Thinking, in general, is difficult to the patient. He is unable to collect his thoughts, his head feels heavy and stupid and everything is confused. He must consider a long time on the simplest matters, calculates wrongly, does not find words and makes contradictory statements. Impressions of the external world appear strange and awake no response in them. Their own body feels as if it did not belong to them and their voice sounds leaden to them.

The mood is sometimes one of profound dejection and hopelessness or of indefinite anxiety and restlessness. The patient loses all sense of humour and apparently nothing can interest him or give him pleasure. He is dissatisfied with himself and gives way to gloomy thoughts. He only sees difficulties and disappointments and life presents no attraction to him. Thus the thought of suicide may occur to him. Fears of all kinds may arise in these states /

states.

Total absence of energy is conspicuous. He has no spirit or will-power. He cannot rouse himself, cannot come to a decision, and does everything the wrong way. Everything seems a mountain to him and the smallest bit of work costs him an effort out of all proportion. Finally the patient gives up every activity and sits brooding all day long. His sorrowful expression shows no emotion and his speech is monotonous, slow, laboured and monosyllabic.

Ideas of persecution frequently occur. The writer had a patient who thought that children were following him about and laughing at him. Shortly after the appearance of this symptom he committed suicide by drowning.

Incoherence of thinking leading to confusion and ideas of persecution or greatness are not features of the functional neuroses, but the manic depressive may resemble the former in his hypochondriacal tendency in so far that he may think he is suffering from cancer or syphilis, etc. In this case, of course, a pure delusion would be indicated in the absence of some cause for the idea, such as pain in the former or exposure to infection in the latter. In the depressive state, in its slightest form, the presence of restlessness, indefinite anxiety and hopelessness may serve to cause some difficulty in the differential diagnosis. The presence, however, of conspicuous behaviour, intense /

intense activity, or "pressure of speech", as in the manic state, or the presence of intense dejection with the characteristic speech of the depressive state, would serve to clear away any doubt on the diagnosis.

Paranoia.

The morbid picture of Paranoia is comparatively poor in detail as the more striking disorders only extend over limited domains of the psychic life and leave others wholly untouched, or nearly so. Observation and perception, in general, proceed without hindrance although the impressions are often morbidly interpreted. The patients remain permanently sensible, clear and reasonable. Genuine hallucinations do not occur. (Kraepelin). Patients may have frequent or isolated visionary experiences which occur mostly at night. They may see stars, shining figures or various apparitions.

There is no disorder in memory outside the delusion. Pseudo-memories are frequent and are usually closely associated with the morbid circle of ideas. These may be only a wrong interpretation of experiences subsequent to their occurrence, or they may be wholly invented utterances or events in the form of memory pictures. The common source of pseudo-memories and of delusional interpretation is from the tendency to morbid imaginings.

The mental disorder characteristic of Paranoia shows /

shows itself in two ways.

Firstly, the whole system of thought is of a morbidly personal nature. Thus, what happens in his neighbourhood is not indifferent or casual but has a profound relation to himself. Secondly, he lacks the ability to place in proper proportion to actual fact and experience the products of his imaginative powers.

Delusions are mainly concerned with ideas of injury and exaltation. The delusions mature slowly. At first they are confined to suspicions, arrogance, overweaning conceit or secret hopes, but these in time grow with fresh experiences built up on a prejudiced outlook on the experience of life until they become more and more fixed. The delusions are systematised or mentally worked up and uniformly connected, without gross internal contradictions. Obscure points are put aside as far as possible and smoothed over by laborious thought so that the delusion structure gradually arises.

The delusion built up in this systematised manner with a certain amount of correctness becomes stable and characteristic.

The mood corresponds to the delusions existing. Thus patients may be shy, suspicious, dejected, irritated, self-conscious and confident.

Patients may remain without any definite disorder and may continue to earn their living permanently without

becoming unduly conspicuous.

Some withdraw themselves, bury themselves in books and compose comprehensive documents. Some are restless, change their situations frequently or show a disinclination for regular and continuous employment. Some, in spite of ability, never accomplish anything correctly and are always unsuccessful. Others spend more money than they can afford or busy themselves with difficult problems for which they have insufficient understanding and knowledge.

Very often they only come under notice when they have made themselves conspicuous by some action relative to their delusion.

Generally they possess self-control sufficient to avoid conflict with law and authority. Not being sufficiently tormented by their ideas, they are not usually driven to any reckless violence. They may confine themselves to more or less harmless action, such as abusive language, threats, complaints to the police, attempts to force entrance to highly-placed officials or persons, advertisements in the newspapers, or exploiting people on the ground of delusional claims. Suicide is not common.

In differentiating functional neurosis from Paranoia in its early stage, difficulty may be experienced at first in the apparently rational basis of the delusion of the latter. According to the carefully constructed delusion, the patient suffering from Paranoia may appear shy, suspicious /

suspicious, dejected, irritated and self-conscious. Only a careful examination of the delusion would lead to a proper understanding of its character. Differentiation would be facilitated if the patient made himself conspicuous by some action relative to his delusion.

Dementia Praecox.

This disease occurs most frequently in early adult life in families already tainted with insanity, epilepsy, or other neuroses, but occasionally it occurs in some with no insane heredity. The characteristic feature of the disease is affective indifference and apathy. As the disease advances the patient appears to live more and more in a world of his own. He loses interest in ordinary affairs. He lacks initiative and persistence in the ordinary business of life and sinks easily into dependent positions. He may laugh, cry or have violent attacks of anger with adequate cause.

The onset may be very slow. The slowness of onset may be particularly remarked in the patients who have always led a solitary, suspicious and unsociable life and are disposed to brood over small injuries or imagined slights. Such patients begin to suspect those around them of plotting against them or they may hear voices telling them of persecution against them.

There is a tendency in patients, at first, to argue, contradict and act in opposition to advice.

Delusions /

Delusions of a fleeting character may be present. Hallucinations may also be present, the patient laughing, talking, or becoming angry in answer to voices.

His manner of shaking hands is characteristic. Instead of grasping, the hand is held out limply and takes only a passive part.

Physically, patients are often of the thin, weedy type, narrow-chested and poorly developed, with simian hands and feet, deformed ears and other signs of degeneration.

From the above early symptoms differential diagnosis from the functional neurosis will be based on the history of hereditary tendency and the presence of delusions or hallucinations. In functional neurosis the patient may be suspicious and unsociable, but he does not tend to show apathy of any marked degree. The physical configuration of the patient may also afford a clue to the condition.

Prognosis.

The prognosis in psycho-neurosis is complicated by various factors.

The physical health of the patient is important in relation to prognosis. Should any active physical factors, such as exophthalmic goitre, gastric pain, abnormal heart conditions /

conditions or any debilitating disease be present, they will have an enervating effect on the patient's already weakened mental vigour which will lessen his power to grapple with his neurosis and to correct his faulty outlook.

Similarly, continued residence in enervating tropical climates or the continued pressure of hard work, mental or physical, will act by further increasing the feeling of inefficiency and constitute a retarding influence in the correction of the condition.

Environmental factors are important. If the patient's worries are related to his home, financial or professional conditions they will tend to be irremovable or recurrent and a permanent cure hardly to be expected should the conditions be persisted in. For example, if the patient receives the experience which he is repressing under any of those conditions and he still continues under those conditions, the tendency will be for him to maintain the repression. He will not be able to view the experience with the perspective which he would tend to do if unassociated with the conditions under which it happened. Again, should the patient succeed in becoming dissociated from the environment, and feel comparatively well as the result of doing so, a subsequent return to the environment will tend to reawake his trouble unless he has, in the meantime, resolved it.

Education /

Education and upbringing are of great importance. The more intelligent the patient is and the more correctly he has been brought up in accordance with the accepted standards of conduct, the more likely will he be able to face his conflict and resolve it permanently. If the patient has been spoiled as a child and who is therefore of a tyrannical, self-seeking nature and whose natural instincts have not been toned down by the steady exercise of control, the possibility of a cure is more remote. In this case he will have to remodel his whole outlook which, if he is grown-up and his habits and mode of thinking are more or less fixed, will not be an easy task. On the question of heredity Freud, while admitting its importance in the neuroses, finds that it is by no means necessary to their production. If an individual belongs to a so-called neurotic family he does not necessarily develop a neurosis, but when a neurosis does develop it is as much dependant on a specific cause as upon heredity. The influence of hereditary predisposition acts more as a precipitator and stabiliser of the neurosis once it has been activated by some specific cause. Many cases make good recovery, but there are others who are entirely intractable to any form of treatment. The outstanding difficulty is, of course, to get the patient to reawaken, deliberately, his trouble and face it. In cases of long standing /

standing the tendency is for patients to prefer the symptoms due to their repression, and to which they are accustomed, rather than to bring to light that repression with its attending mental discomfort. The more intimate and the more painful the repressed experiences are, the more difficult it necessarily is for the patient to bring them to light. In these circumstances there may be doubt during the treatment as to whether everything has been revealed which has a relation to the causation of the neurosis. If the root cause has not been entirely revealed, but sufficient to cause an improvement, there will be a tendency to relapse. Thus in an hysterical patient, if a symptom has been removed by persuasion or suggestion, another may ultimately be formed in its place by the patient as a protection against his conflict or the symptoms of anxiety may return.

The psychasthenic can only be judged by his increasing ability, or otherwise, to face his problems and to resolve them.

In neurasthenia, the disappearance of symptoms such as nightmares, insomnia, etc. is a favourable indication and particularly so if there is a marked, concurrent improvement in the general physical condition of the patient.

Phobias and Obsessions may disappear under treatment but only the lapse of time will prove the permanence or /

or otherwise of the cure. Generally, the non-appearance of the symptoms after a lapse of six to twelve months is a favourable indication.

The prognosis is usually good for those patients who are keenly desirous of being cured and are willing to speak openly, once they understand the reason for it, on their most intimate experiences.

The tendency to relapse is probably most marked in those with hereditary predisposition.

T H I R D P A R T

PHYSICAL TREATMENT.

T H I R D P A R T.

PHYSICAL TREATMENT.

The physical treatment of the neuroses refers to the use of those remedial agents which do not necessarily make a direct impression or have any remedial effects on the mental aspect of the conditions.

The essential preliminary to the treatment of the neuroses is to examine thoroughly the physical condition of the patient so as to make entirely certain that there is no condition present which could, by lowering the bodily vitality, produce a corresponding effect mentally. Careful examination at the same time establishes the patient's confidence in his physician.

Very frequently it may be found that the neurosis disappears of its own accord with a return to satisfactory physical health after a morbid physical condition such as dental sepsis, chronic appendicitis, gall stones, chronic endometritis or early tuberculosis has been discovered and rectified, provided the patient were previously mentally stable. In such cases the writer has found the emotional factor to be related to the feeling of inefficiency in the presence of the necessity or desire to carry on business /

business, or household work, or to support the family.

The following cases show recovery from an early neurosis on removal of a septic focus, without psychotherapy.

Case 1. T.W. a man, age 40 years, with a large family, complained of a general feeling of weakness, loss of appetite, sleeplessness, irritability, nightmares, sweats, and an increasing inability to concentrate on his work. He was an engineer. His wife explained that for the previous two months at home he had become increasingly irritable, could not tolerate the noise of the children, had declared that he was tired of life and often wandered about the house in an aimless, preoccupied manner. In particular he had worried about financial matters and how his family were going to live if he were unable to work. She became afraid for his sanity and would not allow him to remain alone in the house. Previously, he had been a stolid, good-natured man and at all times pleasant to live with. Examination showed advanced caries of the teeth and pyorrhoea. Extraction of the teeth was advised and carried out. He was given 3 M. Tinct: Iodide Mites t.d.s. for a few weeks, and has now returned to work, apparently quite recovered. No psychical treatment was undertaken.

Case 2. J.G., a lawyer age 39 years, complained of a general feeling of inefficiency, loss of confidence, loss of weight, disturbances of digestion (gastric pain and flatulence), increasing irritability, worry over trifles. These symptoms had been gradually increasing for the previous six months.

Physical examination showed some pyorrhoea and a mild degree of tenderness over the appendix region which did not give him trouble excepting an occasional "soreness". Extraction of the teeth and appendicectomy were advised and carried out, with the result that his commencing neurosis disappeared and his normal health was regained. There was no attempt at psychical treatment.

Case 3. F.R., an engineer, 49 years of age, complained of flatulence and a feeling of fullness after meals, loss of appetite, slowly increasing loss of weight, irritability, "nervousness", worry over trifles, feeling of inefficiency and loss of interest in his work and in matters in general. He had a large family to support. Complete physical examination revealed no abnormal condition. He was treated with the usual sedative and digestive medicines for the stomach, but they did not improve his condition. His neurotic condition became gradually worse and ultimately he found it difficult to go to work on account of his irritability and feeling of inefficiency. He worried considerably /

considerably about the support of his family. Some Psychical treatment was attempted, but nothing definite came to light. The writer had known him, for about seven years, as a level-headed man. Ultimately an urgent message came from him that he had suddenly developed violent abdominal pain. Gall stones were diagnosed and he was sent to the Infirmary where a large gall stone was found associated with some infection of the gall bladder. He had never previously shown any symptoms of gall stone. He is now back at work and quite normal mentally and physically. No further psychical treatment was attempted.

Case 4. G.L., a woman, age 43 years, who had considerable home duties to perform, complained of an increasing feeling of weakness, loss of weight, irritability, disinclination to work and a desire to run away from her duties, worry over trifles and general feeling of inefficiency. She often sat down and wept.

Physical examination showed the presence of chronic endometritis and cervicitis, menorrhagia and anaemia were present. She was advised to have curettage performed, which was carried out. Since then she has become progressively better and is now performing her ordinary household duties with pleasure. No psychical treatment was necessary.

The following case illustrates recovery after an early tuberculosis has been cured by treatment, without psychotherapy.

Case 5. A. McC., a typist, age 18 years, keen on her work and anxious to please her employer, complained of loss of weight, feeling of inefficiency, loss of confidence, lack of concentration, worry, irritability, sleeplessness and nightmares. Careful examination revealed nothing physical except a slight degree of anaemia and constipation. She was treated with Iron and Arsenic and aperients, but during the following two weeks her neurotic condition became progressively worse and she had to give up work. She began to develop a slight cough and examination revealed some moist râles at the apex of the right lung. Her sputum was examined and tubercle bacilli found. She was ultimately sent to a Sanatorium from which she returned cured after nine months' treatment. Since her return she has been at work for about a year in perfect physical health and without any neurotic symptoms. No psychical treatment was given.

There is the necessity to recognise also in some patients the neurotic symptoms following the febrile infective conditions or prolonged physical fatigue.

Here again in those patients the feeling of inefficiency, following the toxaemia of the febrile conditions /

ditions, in the face of the necessity or desire to perform their duties is, in the writer's view, the underlying factor which causes the neurosis. Very frequently no psychical treatment is required, the patient regaining, of his own accord, a normal mental outlook on his return to normal physical health, provided he was mentally stable previously.

Case 6. J.S., age 35 years, musician, suffered from Influenza complicated by acute otitis media. He was ill for about five weeks with the ear trouble during which he suffered considerably from neuralgia round the ear and side of the head. He became depressed, worried about his work, irritable, sleepless, and suffered considerably from his feeling of inefficiency. Pot. Brom. grs. 10 t.d.s. and a holiday of about ten days made him quite fit to resume his work. All nervous symptoms passed off without psychotherapy.

Dyspepsia.

In the writer's experience the gastric symptoms in those suffering from the neuroses very often take the form of acidity and flatulence, with pain resulting from flatulent distension. In these cases he finds a mixture of Bismuth Carb grs 10; Sod. Bicarb. grs 10; Mag. Carb. Pond grs. 10; Aq menth pip ad ℥j beneficial when given three /

three times daily about half an hour after meals. Meat, vegetables and fatty foods are eliminated from the diet for a few days and are then gradually restored.

In extreme cases when the patient has gradually eliminated most of the ordinary solid foods from his diet, having considered them to be the cause of his indigestion and having substituted for them, in great part, the proprietary or liquid foods, it is advisable, very gradually, to increase the amount of solid food. The gastric mucous membrane, from long disuse, may not be in a condition capable of digesting much solid food. The patient, of course, must have the cause of his gastric symptoms explained to him. The slow increase of the solid part of his diet will not only appeal to his reason but will be of value from a persuasive point of view.

Constipation.

It is most important, if constipation be present, that it should be corrected to prevent auto-intoxication. The writer prefers to use medicinal Paraffin if possible. Unfortunately with many patients it is not entirely certain in its action. It may be found, however, that if movement of the bowel is first obtained with Castor Oil, Mag. Sulph. or Ext. Cascara Sagrad liq, regular movement may be maintained by persevering with Medicinal Paraffin.

Headache.

When headaches are severe and of frequent occurrence Aspirin grs. 10 may be given. It is better if the patient can lie down for an hour in a quiet room after having taken the Aspirin.

A powder consisting of Aspirin grs v; Phenacetin grs iv; Caffein Cit. grs. iii, very frequently acts like a charm. As with Aspirin alone, the patient should lie down for a time.

Irritability.

When this is evident, the writer usually gives Pot. Brom. grs. x; tinct. Nux. Vom. M v Aq ad ℥ss, t.d.s. Strychnine should only be used in small doses where irritability and restlessness are pronounced.

Sleeplessness.

This is one of the most important symptoms and its correction is essential. Hypnotics, of course, have no actual remedial effect on the causation of the neuroses. Their action is merely to bring about that relaxation or rest of the tissues which is so essential to the renewal of mental and physical effort. Such rest is therefore necessary to the patient if he would have renewed mental vigour to battle with his morbid outlook by himself or to help his physician in assisting him to do so. Sleeplessness, unless checked, is apt to become a habit.

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The hypnotics commonly used are Bromide, Chloral Hydrate, Butyl Chloral Hydrate, Chloralamide, Bromidia, Chloretone, Paraldehyde, Veronal, Medinal, Luminal, Sulphonal, Trional, Dial and Hyosein.

Of these the writer uses in particular Bromide, Medinal, Paraldehyde and Chloral Hydrate. Bromides are useful in the earliest stages of sleeplessness, but in the later stages they do not have much effect. Grains 30 of Pot. Brom. at night can often produce sleep in mild cases. If sleeplessness is severe, it may be necessary to combine it with grs. 10 Chloral Hydrate. Medinal gives a refreshing sleep with no disagreeable after-effects. The usual dose is five to ten grains. It can be continued for a long time.

Paraldehyde is valuable for its rapidity of action, but unfortunately its pungent taste and disagreeable odour prevent some patients from taking it. It is certain in its action and produces a particularly refreshing sleep. With some patients it loses its effect, but with others it may be employed for a considerable time beneficially. The dose varies from two to four drachms. It is a cardiac and respiratory stimulant. In some cases where it is impossible to administer it by the mouth it can be given per rectum mixed with some gruel.

Chloral Hydrate is contraindicated in advanced arterial degeneration and in very feeble persons on account of /

of its depressing effect. In early cases of insomnia a dose of ten or fifteen grains of Chloral may be given at bedtime and continued for a long time if necessary. It is sometimes given at night when another hypnotic, such as Medinal, has been given earlier and only resulted in a few hours' sleep. In this case a dose of ten or fifteen grains is given.

Although the employment of hypnotics is often essential, the patient must, as soon as possible, learn to sleep without their aid. The best way is to give full doses for about three nights and then gradually to decrease the dose without the patient's knowledge. In some cases the writer has found that, after a few days if, say a dose of Paraldehyde has been put on a table at the patient's bedside at night with instructions that it can be taken only if necessary, the patient will go to sleep merely by the confidence engendered by the proximity of the hypnotic.

Other factors play important parts with relation to sleep, namely:- Food, Fatigue, Exercise, Alcohol, Tobacco, Baths, Fixed hours for bed-time, Bedroom and clothing, and Pain.

Food.

It is necessary to eat well to sleep well. By eating well the blood is required for purposes of digestion and consequently there is a corresponding fall in the blood supply /

supply to the brain. Some sleep best when a meal has been taken an hour before going to bed, others when it has been taken immediately before going to bed. If suffering from insomnia it is advisable to take some light food when awake, such as milk, cocoa and biscuits. It may be necessary to cut down the nitrogenous food taken during the day.

Fatigue.

Mental or physical fatigue will produce insomnia. In this case it will be necessary to shorten the hours of employment or to regulate them with periods of relaxation. Sleep is induced with relaxation. To go to bed immediately after working late at night on some concentrated matter is to go with brain and muscles in a state of tension which is the opposite to that required. Therefore all forms of occupation, whether work or games, which require concentration should cease at least an hour before bed-time.

Exercise.

For insomnia exercise of a mild nature should be indulged in, but care must be taken not to advise exercise to a person already exhausted. In the writer's view, games requiring skill, such as golf and tennis, if the patient does not possess much proficiency in them, should be avoided as the playing of them will probably increase the/

the irritability of the patient if he compares himself with other players.

Fresh air is, of course, necessary for the maintenance of health. If the patient should be exhausted, he would derive benefit by sitting out in the fresh air unoccupied for, say, half an hour at a time.

Alcohol.

The effect of alcohol varies with different persons. In some it promotes sleep, in others wakefulness. Here the individual effect would have to be ascertained and the patient advised accordingly.

Tobacco.

Smoking, when carried to excess, undoubtedly produces insomnia. Curtailment should be advised. To advise complete abstinence may only serve to increase the irritability of the patient.

Baths.

Hot baths at bed-time have, in some, a beneficial effect in promoting sleep but, in others, they have the opposite effect.

Fixed hours for bed-time.

As sleep is a habit, the patient should be directed to go to bed at a regular hour every night. Once the habit of going to sleep at a regular hour is acquired, the custom should /

should be kept up. Probably the best hour to advise for going to bed is 11 p.m.

Bedroom and Clothing.

Excess of warmth or cold will interfere with sleep. If the patient suffers from cold feet, the bed should be warmed with a hot bottle which should be removed before going to sleep. The bedroom should be well ventilated and the temperature kept regulated so as to be neither too cold or warm. There should be no noises such as clocks ticking or windows rattling.

Pain.

Pain from any source is, of course, contrary to the inducement of sleep. This can only be rectified by treating the source of the pain.

In the treatment of the neuroses it is of great importance to improve the general health of the patient as far as possible. For this purpose various means are employed.

Massage.

This is recommended by some for patients confined to bed. It should not be given immediately before or after a meal. When given late in the evening it is considered to benefit insomnia. Massage should be general, the whole body, limbs and trunk being treated systematically.

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The masseur should be intelligent and of a cheerful and tactful disposition. He must avoid talking of the troubles of other patients whom he is treating and discussing the patient's symptoms with him. Massage is contraindicated where there is exhaustion. Its use would merely increase the fatigue.

Electricity.

This can be used sometimes with advantage in the neuroses. The faradic current is used for producing contraction of the muscles and so bringing about the same effect as massage. The faradic current may also be useful as a means of persuasion or re-education in cases of functional paralysis. The contraction of the muscles proves to the patient that they still retain their ability to contract.

Fresh air.

This is always necessary. If the patient is suffering from exhaustion he will be unable to combine mild exercise with the taking of fresh air. In this case he will be obliged to sit or lie while taking the air.

Exercise.

Where exhaustion or fatigue are not evident, exercise of a mild nature, such as short walks, may be indulged in. When exhaustion is evident, relaxation is the object to be aimed at. While in a state of exhaustion, either /

either from prolonged mental concentration or physical effort, the muscles are in a state of tension. In order to eliminate this tension the patient should be instructed how to bring about relaxation. A beginning may be made with the muscles of the legs, and so on, until he is able, in time, to develop the habit of relaxing his whole body at will. Relaxation is necessary for the renewed effort of brain or muscle. If there is no relaxation, exhaustion must supervene.

In the neuroses, tonics, such as Easton's Syrup, 3ℓ t.d.s. are beneficial when exhaustion and fatigue are prominent symptoms. Arsenic, Ovaltine and Sanatogen are given under the same circumstances.

A change of air and environment are often beneficial.

Should the patient's means permit, a holiday to some place which has not been previously visited, is important. A patient living in the country should go to a seaside place and vice-versa. Dwellers in a relaxing climate should go to a bracing place. The novelty of the surroundings is an aid to the distraction of the patient's mind from his immediate troubles, pending the time when increased physical well-being produces increased mental vigour and so enables the patient to view his anxieties with greater perspective and more impersonally. For similar reasons, a holiday without the family is important.

Most /

Most cases have to be judged on their merits with regard both to rest in bed and isolation. If a patient is suffering from overstrain mentally, socially, professionally or physically, or where there is pronounced loss of weight and weakness, then rest in bed for one or two weeks is indicated. Similarly, more or less isolation would be advisable in those patients suffering from overstrain socially or professionally whose anxieties are related to the meeting of or dealing with many people.

Both rest in bed and isolation have to be considered carefully. Both forms of treatment may give the opportunity to the patient to brood even more over his anxieties and worries and so tend to aggravate his condition instead of improving it. To advise rest in bed in the case of many psychasthenic patients or indolent types of neurotics would be merely pandering to their desires and would, therefore, be harmful. On the contrary, in such cases, every encouragement should be given towards the development of energy and the facing of troubles. Two cases may be described in this connection illustrating the harm which can be done by prolonged rest in bed.

Case 7. A.H.T., a married man, a potter to trade, age 58 years. The writer first attended this man about seven years ago for a mild catarrhal infection of the nasal and bronchial mucous membranes. Temperature 100°. He was advised /

advised to stay in bed. In four days' time his temperature was normal and most of the catarrhal symptoms had subsided with the usual diaphoretic treatment. Easton's Syrup ℥ t.d.s. was then given and he was advised to try out of bed on the following day. Altogether he succeeded in remaining in bed for about five weeks by reason of various indefinite symptoms which could not have much foundation on fact. The longer he stayed in bed, the greater became his anxiety regarding his health. He became sleepless. Ultimately he had to be practically forced out of bed and great difficulty was experienced in getting him to return to work. He returned to work after about four months. His anxiety began to disappear slowly. The writer has always had similar difficulty with him for slight illnesses during the last seven years. He stayed away from work on the slightest excuse. Efforts to help him psychically have met with practically no success. At the age of fifteen years he was seduced by a woman of thirty years of age and, although married, continues to masturbate at 58 years of age and apparently does not have the necessary force of will to stop the practice. He lost his work about a year ago and, since his enforced idleness, anxiety has become more and more pronounced. Persistent argument has failed to give him any help. Apparently he finds greater contentment with his anxiety than in trying to correct it.

Case 8. J.S., a boiler-maker, age 60 years, was first attended by the writer eight years ago for nasal and bronchial catarrh. He was practically free of all catarrhal symptoms in about four days' time and was advised to get out of bed. He then began to complain of vague rheumatic pains, loss of appetite and a feeling of general weakness. Altogether he succeeded in remaining in bed about six weeks and during that time developed some anxiety symptoms. He became irritable and sleepless, and worried about his health. He lost about 14 lbs. in weight. Nothing definite could be found physically during this period. He had treatment with Salicylates and Bromides. Easton's Syrup was also given but stopped when irritability became evident. The writer, on many occasions, advised him to get out of bed, but, unfortunately, he was sympathised with and encouraged to remain in bed by his family. His anxiety condition began to improve when he began to get up. This man, for the last thirty years, has been unable to leave his house, except accompanied by one of his family, for fear that "something might happen to him." Even when going to work, he had to be accompanied by someone whom he knew well. He is free from anxiety so long as he remains in the house, which he now practically never leaves, since retiring from work. He has come, from long custom, to regard this state as his happiest one and nothing will induce him to talk about himself with a view to rectifying matters.

Psycho-therapeutic Methods.

Psycho-Analysis.

Psycho-analysis deals with the deep motives behind neurotic symptoms.

The mind is regarded as being dual in character, namely, conscious and subconscious.

Consciousness embraces only a small part of psychic life, while the subconscious part contains memory and those qualities which shape personality. If there were only consciousness, with nothing dynamic behind it, then decisions or desires would be simple and uninfluenced by deeper factors.

The subconscious mind, however, contains powerful forces of unrecognised hates, loves, fears, etc., some of which are in conflict with standards of civilisation, ethics, etc.

It is from these subconscious or unrecognised factors that neurotics in particular, and other people as well, suffer from the inexplicable inhibitions and compulsions in every-day life. The subconscious mind can be the source of inspiration as well as the source of suffering. By psycho-analysis is meant the study of the subconscious mind, or, in other words, the attempt to discover the unrecognised motives, trends, desires or conflict of the patient with a view to bringing these hidden factors to recognition /

recognition and so permit him to deal with them consciously.

The object of Freud's method is to examine the whole of the subconscious mind if possible so that every source of emotional suffering may be discovered and dealt with by the patient.

The nature of the subconscious is explained to the patient and the object of getting him to learn its content. The patient is thus encouraged to reveal his story.

It may be mentioned again that Freud holds that the conflict associated with infantile sexual experiences constitutes the bases of the neuroses and that there can be no cure until it and the experiences are brought to light. In this form of treatment the supposition is that in the neurotic all desires, trends, etc. are wrong and the whole field of his subconscious mind must be cleared up before there is a cure.

It is obviously a very long treatment and one suited only for those who may be highly specialised in it.

There is a danger in it in so far that it may bring to light factors in the patient's mind concerning which he had no anxiety. The danger may be particularly great if the personality be regarded purely from the sexual point of view. The knowledge of these factors to a hypersensitive patient may merely add to his anxieties.

The commoner, less complicated and safer method

is /

is for the physician to confine his examination to the immediate anxiety from which the patient suffers and, if necessary, to trace that back to some remote cause. Treatment by psycho-analysis presupposes intelligence on the part of the patient and, may it be added, on the part of the physician. Psycho-analysis is impossible for all feeble-minded persons, all proceeding to dementia and all in maniacal states.

It is inadvisable ~~of~~ for hysterical young people, dementia praecox and manic depressives.

It should not be used for those whose anxieties can be relieved by simpler means.

Analysis of Dreams.

Jung regards the dream as a primitive way of thinking and, as such, it is considered to link up with mythology, folk-lore and primitive thinking in general. From this conception comes the idea of the symbolical meaning of the contents of the dream.

The dream may be regarded as the expression of the subconscious mind consequent on the elimination of the control of the conscious mind by sleep.

When painful memories and thoughts have been repressed, either consciously or kept out of sight by the interests of the day, they tend, on account of their dynamic quality, to leak out in the form of dreams when the /

the patient is asleep.

The dream may take several forms.

After excessive strains and shocks the dream may take the form of reproducing the painful experience in all its details. It is accompanied by emotion greatly exceeding in force that experienced during the waking state because the control of consciousness is absent.

If fear be in the dream, the patient awakes sweating profusely, cold, with his heart beating violently and with the facial expression and tremor characteristic of fear.

If the emotion be grief, the sleeper awakes sobbing and with his eyes streaming with tears.

Frequently the dream is not a reproduction of the patient's anxieties or repressed experience, but takes a dramatic and symbolical form differing so widely from the experience that the patient fails to recognise any relationship.

Here, the repression may be regarded as so powerful that even the subconscious mind permits it to escape only in disguised form.

By analysis of the dream an attempt is made to find out the significance of the symbol, its relationship to the experience and so to reveal the nature of the conflict.

Relative to the interpretation of those symbols foreign authorities consider them to be of a fixed nature and /

and representative of definite characteristics of the dreamer; thus, dreaming of walking up a staircase shows a definite desire for the sexual act; anxiety dreams of snakes show that the dreamer is in fear of masturbation, etc. They find that they appertain practically always to the sexual sphere.

Free Association.

Freud holds that ideas do not come into the mind in a haphazard manner, but that every idea is determined by some preceeding thought or some fresh stimulus.

To permit of free association having free play it is advisable for the patient to keep his eyes shut, his limbs relaxed and to be lying down. This prevents, as far as possible, any stimulus coming to him which interferes with concentration on the question before him. He is then instructed to concentrate on some idea which is relative to his conflict and to say immediately the idea which first comes into his mind following the preceeding idea. He must not allow himself to judge as to whether it is important or otherwise, but to say it immediately and wait for the next idea which replaces the spoken one, and so on. By this means it is hoped to arrive at the cause of the emotional disturbance.

Treatment by Hypnosis.

The use of hypnosis has not been possible on account of the prejudice which exists against it and also on account of the position of the writer, who is engaged in general practice.

Treatment by Suggestion.

Waking Suggestion.

The efficacy or force of suggestion depends, in the first place, upon the authority of the doctor and the expectancy of the patient.

The principle, in this form of treatment, is to introduce into the mind of the patient suggestions of a tonic nature with a view to raising his whole moral and mental tone. In this connection suggestions are given of cheerfulness, hopefulness, vigour of body and mind, confidence, self-reliance, altruism and thought of others. Suggestions of altruism and thought of others have for their purpose the distraction of the patient's attention from his anxieties.

Specific suggestions may be given against definite morbid and depressing thoughts with the view to re-associating them with healthy emotions, or against symptoms, such as headache or pain of any kind. The suggestion should not contain the word which describes the patient's condition /

condition. Thus, in the case of fear of anything, the suggestion should be one of "greater boldness or confidence". In the case of headache or pain in the back, the suggestion should be "the head will be easy" or "the back will be easy." The use of the word fear, or headache or pain will only serve to leave the impression of such on the patient's mind and so negative any good from the suggestion.

Treatment by suggestion alone does not appeal to the patient's reason. He merely accepts the suggestion and, if one may so describe it, acts reflexly upon it.

The writer regards suggestion as an adjunct to treatment and of greatest value after the cause of the neurosis has been determined and has been explained to the patient.

Suggestion in some form is always intermingled with the treatment of neurosis and the greatest care must be exercised to make sure that the patient receives the right kind.

In most hysterical and nervous patients who are broken down in will, strengthening suggestions given by the physician will act, if they may be so described, as mental splints enabling the patients, in time, to face their troubles.

Auto-Suggestion.

Auto-suggestion consists in the patient himself summoning up healthy ideas one after the other with the view that, by dwelling on these for a time to allow them to take effect, a healthier state of mind may be gradually produced. The patient is instructed to induce, as far as he is able, a state of relaxation of body and mind similar to that previous to sleep taking place. He is instructed to think over the proposed healthy ideas beforehand so as to become familiar with them. By this means the tendency of the patient, during the period of relaxation to recur to those morbid thoughts with which he is already preoccupied and which could only end in their being accentuated, can be greatly averted.

This should be done occasionally during the day-time as well as when in bed at night or awaking in the morning.

The writer has found considerable benefit resulting from treatment by auto-suggestion in such cases as excessive smoking or drinking, general or indefinite fear, lack of energy, lack of confidence and pessimism regarding health.

It is explained to these patients, as simply as possible, that their trouble is due to their own manner of thinking, namely, that they are constantly suggesting to /

to themselves that they cannot free themselves of the very troubles which they would like to be rid of.

Thus, the excessive smoker or drinker who wishes to curtail either habitsis torn between the desire to do so and the suggestion coming from himself to satisfy his desires. In other words, he is tempted by himself. He repeatedly succumbs to the desires and ultimately considers himself unable to resist. The impulse to satisfy the desires has obtained the upper hand. He would, therefore, counteract the impulse by suggesting to himself: "There is no temptation." The more the tempting idea is inclined to obtrude itself, the quicker the formula should be repeated with the intention of "squeezing out" the obtruding idea so that in time it is not permitted to enter.

General or indefinite fears are to be counteracted by auto-suggestions of boldness. The patient would like to be fearless, but he is suggesting to himself that he is afraid. Therefore he should suggest to himself: "I am becoming bolder", repeating more rapidly as the idea of fear obtrudes itself.

Similarly, lack of energy, lack of confidence, pessimism regarding health are treated respectively by auto-suggestions, "I am working more vigorously daily", "I am becoming more sure of myself daily", "I feel better daily." The auto-suggestions should be made with conviction and, if so done, the patient, in time, will believe /

believe them.

The writer considers that the auto-suggestion should not contain the same word as the patient uses to describe his condition, for similar reasons to those given under Suggestion.

As with suggestion, auto-suggestion can be regarded as more efficacious as an adjunct to treatment after the underlying cause of the trouble has been discovered and explained to the patient.

Auto-suggestion can be employed for the correction of any form of morbid outlook, e.g. the desire to steal or to kill, for sexual irregularities, inadaptability to the conditions of one's work or profession or bad habits in general.

The patient must, of course, be keenly desirous of having his condition corrected.

Auto-suggestion can be recommended without the patient necessarily being in a state of relaxation.

Treatment by Persuasion.

Persuasion is the form of treatment by which an attempt is made to appeal to the patient's powers of reason.

This, again, is connected with suggestion, especially that derived from the personality and authority of the /

the doctor and the expectancy of the patient.

Treatment by persuasion consists in encouraging and admonishing the patient and in arguing with him, if necessary. It should be systematically and persistently done.

The effect of persuasion may be obtained by getting another opinion on the patient's condition which corroborates the first opinion. This is exemplified in the following case.

Case 9. M.H., a woman, age 34 years, with a family of eight children. She was very poor and lived in two rooms. She was thin, badly nourished and worried. She was attended by the writer for intercostal neuralgia. After treatment by Salicylates for a week she began to develop anxiety symptoms of sleeplessness, irritability, tremor of the hands, loss of appetite and palpitation. She became convinced she was suffering from pleurisy as she was not improving. No amount of argument could convince her otherwise. She was greatly worried over her inefficiency and consequent neglect of the family. She was sent to the Infirmary (Out-Patients) where the diagnosis was confirmed. The anxiety symptoms soon improved.

Two weeks later she returned, complaining of a cough which had developed. Examination of the lungs revealed nothing important. The following week she became firmly convinced that she had contracted tuberculosis.

Anxiety /

Anxiety symptoms had returned again in force. The writer sent her to the Tuberculosis Dispensary where no evidence of tuberculosis could be found. The anxiety symptoms again improved.

Again, about a month later, she consulted the writer concerning some dyspeptic condition. She was firmly convinced she had developed cancer. Her abdomen felt normal and her gastric symptoms had troubled her for only two weeks. The writer was unable to convince her that she was not suffering from cancer and consequently sent her to the Infirmary for examination. The diagnosis was confirmed with a similar result, as previously, to the anxiety symptoms.

She returned, under similar conditions, on three more occasions and had to be dealt with in the same way. Ultimately she left the district.

This, of course, was a hopeless case. Her only chance of recovery was to be separated from her home conditions which, on account of poverty, could not be done.

Attempts to teach her how to react healthily, as far as possible, to her circumstances failed. She was of an unintelligent type.

Various means may be employed as aids to persuasion.

The faradic current may be used to demonstrate to the patient, by the contraction of the muscles in a paralysed /

paralysed limb, that the limb still has power in it. Elucidation of this fact would have to be followed by re-education, namely, a beginning would have to be made with simple movements of, say, the fingers. From simple movements the patient is led on to more complicated and co-ordinated movements of the fingers and finally to movements of the wrist and arm, until complete control is obtained. Pricking the hand of a paralysed arm with a needle may induce a slight reflex movement which will be sufficient to demonstrate to the patient that movement is still possible, after which persistent encouragement and re-education will enable her to move it fairly well in a short time.

To remove a symptom by persuasion it is best to commence with some suitable point. Thus, in hysterical Aphonia a start can be made from the sound produced by coughing, which demonstrates to the patient that she has not actually lost her voice.

In hysterical deafness, advantage may be taken of the auditory-blink reflex. The patient is placed before a mirror and is directed to look at the reflexion of his eyes. On a loud noise being made behind him he will see himself blink. It is then pointed out to him that he must have heard something, the result of which was actually demonstrated to him. He is then urged to listen as attentively as he possibly can and he will gradually be made to hear sounds of diminishing intensity.

Once /

Once treatment by persuasion has been begun, it must be vigorously pursued until some relief of the symptom takes place. The sooner relief of the symptom takes place the better, otherwise the longer the treatment is continued without result, the more the patient becomes confirmed in his idea of the stability of his condition. Suggestion or persuasion may by themselves remove a symptom, but they will not cure the condition if the causative factor is left intact. The removal of a symptom only may be superseded by an anxiety condition, as is demonstrated in Case 19, which is dealt with later.

The value of persuasion is to be estimated more as an adjunct in treatment after the cause has been determined.

Some Considerations Preliminary to the Employment of Psycho-therapy.

If anxiety symptoms be present and there is no physical abnormality to account for them, or if they remain after any physical abnormality has been rectified, then psycho-therapy must be resorted to.

The first consideration in the psycho-therapy of the neuroses is the attitude of the patient towards the doctor.

The anxiety patient is necessarily one who has lost confidence. He has so many and complicated worries and /

and feelings of physical unfitness that his sense of proportion has left him. He has no sense of humour left. He takes himself very seriously. In all probability he has consulted a few doctors who have "pooh-poohed" his troubles and put him off with a bottle of medicine. They have probably told him that there is nothing the matter with him and that he is imagining his ailments. Yet, he feels ill and medicines have not improved his condition. These experiences have not served to increase his confidence, either in himself or doctors. He begins to feel that he is incurable.

It must be remembered that the neuropath is generally shy, retiring, secretive, suspicious and is in the habit of "bottling up" his worries. He is shy because he has a feeling of inferiority; retiring, because he wishes to be alone with his troubles; secretive, because he does not wish anyone to find out that he is anxious; suspicious, because he is constantly, consciously or subconsciously, looking out for anything which may revivify his mental discomfort. All these characteristics, of course, make him "bottle up" his worries more and more.

Therefore, before information can be extracted from such a patient, he must feel respect, liking, friendliness for and confidence in the doctor. This must necessarily be so as he will be required to speak of his most intimate life and experiences. The difficulty lies in /

in obtaining such an ideal state of affairs. Generally, if the patient is anxious to get well and the doctor shows a sympathetic attitude towards him, that he is greatly interested in him and is anxious to help him, he will respond after a consultation or two. It is also essential that the consultation be in private. The presence of a third person will invariably tend to curtail the candidness of the patient on his intimate affairs. It is characteristic of neuropaths that they do not wish anyone to know of their worries, which is readily understood when it is remembered that they are, all the time, busy trying to hide their worries from themselves.

While dealing with this subject there may be mentioned the question of transference. By this is meant the transference by the patient of his or her feelings of hatred or love from the objects of these emotions to the physician. In the case of transference of love occurring and becoming observable by the physician, it would be necessary for him to explain to the patient, as tactfully as possible, that she was becoming too much attached to him and too reliant on him; that that was, under the circumstances, very apt to occur but that so long as she recognised that fact clearly no harm would be done. At the same time it would have to be made clear to her that she must attempt to become well instead of toying with the new experience or sensation. She could be assisted in this by /

by auto-suggesting that her attitude towards her physician was one of respect, liking, admiration, etc. Should she succeed in getting back to this attitude, it can be understood how that the period of respite from the previous object of her affection would lead her to a more perspective view relative to that object.

On the other hand, should the love which, after all, in the adult is a sexual matter, for the physician be maintained, the awkwardness for him is too obvious to require elaboration and, so far as the patient is concerned, there is as much chance of her having gratification of that love with the new object as she had with the former. She therefore continues to have her conflict if resolution does not take place as described above.

In the case of hatred there could be no question of further treatment from the physician and resolution could hardly be hoped for. The tendency would be for the patient to transfer his hatred to all doctors which would end by deterring him from seeking further treatment. Under these circumstances he would tend to retain his conflict.

It may not always be possible to avoid transference, but, in the writer's view, it is an attitude on the part of the patient which should not be encouraged.

It is, of course, possible to warn the patient or her relatives of the possibility of transference taking place.

We /

We have seen that the anxiety symptoms are caused by the repressing of the emotions associated with a mental conflict of some kind. It therefore follows that if the patient would become well again he must cease repressing or trying to forget the painful emotional disturbance associated with his conflict. If the patient would cure himself without aid, he must have the courage to cease trying to forget that experience, thought, action, etc. which is the cause of his conflict and bring it back fully into his mind, with its attending painful emotions, think about it, face it and resolve it. If he should lack the courage to face his trouble or the necessary knowledge or intelligence to resolve it when once faced, he must be assisted in doing so.

It should be explained to the patient that his symptoms are due to conflict in his mind which he is trying to forget or run away from and that he will improve only when he recognises that conflict, faces it, becomes familiar with it and adapts himself to it. As simple and convincing language as possible should be used so that there may be no doubt as to his understanding. He is to understand that he is "bottling up" emotions of fear, shame, remorse, etc. instead of letting them escape and then altering his view of them so as to make them tolerable to him under all circumstances.

He is then encouraged to speak of his experiences and /

and memories and is allowed to proceed in his own way along the paths of association, provided he keeps to his own experiences and memories.

Careful attention must be paid by the doctor during the narrative because any slurring over of a particular part may indicate that that part is too painful for him to remember and he is still repressing it. Therefore he should insist on the patient thinking more particularly on that part and speaking out all he remembers before being allowed to proceed.

Encouragement is necessary, because the tendency of the patient is not to speak of the memories he is repressing.

The patient should not be discouraged from giving free play to any emotion, whether weeping or swearing, evoked by speaking of his memories. This, in some, is the outward manifestation of release of the repressed emotions.

The patient must be encouraged to believe that only by trying to remember and speaking of everything related to his memories, even at the expense of the most intense suffering, can he hope to become well.

This method should be tried first as it will be found sufficient in most cases met with in general practice to bring about favourable results.

If the patient states that his symptoms date from

a /

a definite experience, then little difficulty may be experienced in relieving his condition as it is likely that he will remember fairly accurately the details of that experience.

Difficulty is often experienced in old-standing cases in getting them to speak openly. This attitude has, in all probability, been accentuated by experiences in previous consultations when the doctors did not appreciate the emotional nature of the trouble and consequently discouraged the patient from speaking on anything which seemed to them irrelevant.

If the patient is very slow, or is very diffident in speaking about his experiences, it is legitimate to ask questions occasionally. However, great care must be taken in this since prompting information may act as suggestion which, in a person whose suggestibility is increased by his condition, may only lead to putting ideas into his mind which were not there previously, and so add to the confusion.

Certain possible attitudes of the patient must be remembered as he is giving his narrative.

He may regard his experience from an impersonal point of view, narrating it in an indifferent manner as if he were relating something which happened to someone else.

Or, he may rationalise on some fact giving reasons for /

for his conduct which are not true reasons. He is really attempting to make excuses for his conduct to his self-regarding sentiment. It is a subconscious process and can be quite genuine. He is not intentionally telling lies. Thus, a good swimmer may stand on the bank watching someone drown. Afterwards he worries about not having gone in to try and save the drowning person. He argues to himself, or others, that he did not go into the water after the drowning person because he did not know him, had never seen him before, and that probably he wanted to commit suicide in any case. He does not admit that he was afraid to go in. Again, a man worrying because he has understated his income for income tax purposes may rationalise that living is so expensive now that he does not see why he should pay money to be given over to America, that he disagrees with the high rate of taxation, etc. He does not admit that his true reason for defaulting is because he does not like to part with his money.

After all, very few of us are really happy. There are many varied and insistent anxieties in highly civilised life. Very few of us can jump into a rough sea or swift river to rescue a drowning man or make out our income for income tax purposes accompanied with the stimulating emotions of joy and hope. However, in the event of defaulting with our consciences in instances such as these, we need not develop a neurosis as long as we recognise /

recognise that we were cowards or cheats. The candid acknowledgement of our shortcomings gives the opportunity for their correction and, more importantly, prevents their repression in disguised forms.

Or, certain thoughts may be so unpalatable to the patient that, by his powerful effort to repel them, he comes to regard them as thoughts outside himself and is apt to attach them to some other person. Thus, a married woman with strict views on discipline and propriety, seeing a married woman friend with a man other than her husband, no matter how innocent the relationship, may ascribe motives to her of improper desires, little knowing that that is exactly what she would like to fulfil herself. She is really giving herself away.

The following six cases are illustrative of anxiety neurosis.

Case/0. M.T., a married woman, age 28 years, complained of feeling intensely nervous and irritable. She had pain radiating up the back and neck. Her head seemed to be held in a vice. She suffered from palpitation which was independent of exertion, nightmares, "buzzings" in the head and sweatings. She was worried over the most trifling affairs. She would weep for no particular reason. Loss of appetite and weight were marked. In appearance, her eyes had a startled expression and she seemed to be in a state of apprehension. She had become practically unable /

able to do her ordinary household duties through the aggregation of the above symptoms.

Physical examination showed no trace of organic disease. She had been healthy until six months ago when she began to develop pain in her back and neck.

It was then explained to her that her condition was due to something which was causing her great anxiety. She thought that this might be so and immediately began to weep.

After considerable persuasion she was induced to speak of her worries which she did, weeping profusely during the narrative.

The principal facts were that she was married two years ago to a man whom she did not love. There was no involvement, however, with any other man. After the death of her child, which was four weeks old, six months ago she began to feel nervous. Her husband accused her of being a weakling and unfit to rear a baby. She had felt this bitterly. Her husband's aunt, who was living in her house, was apparently an officious and domineering person and caused considerable trouble in her home by interfering and made matters still more strained between her and her husband. Her husband had been brought up by this aunt since childhood. Her husband always "sided" with the aunt when any differences arose between her and his aunt, and she had always "given in" with the view to preserving peace in the home /

home . She had been strictly brought up and knew very little about sex matters when she married.

She obviously felt much better after she had given this information and was told to come again in a few days and speak of her troubles, as she had no one in whom to confide. In about a week she returned feeling worse than ever. It was suggested to her that she had not told all her worries. After considerable hesitation and display of emotion, she told how her husband's aunt had informed her, shortly after the death of her child, that her husband was illegitimate and had asked her not to tell her family of this fact. She promised not to do so, but had worried intensely about withholding this information from her mother in whom she had always been in the habit of confiding. She herself did not worry about her husband being illegitimate.

The writer advised her to inform and confide in her mother on the matter. She did so after a few days, as her mother lived at a considerable distance from her. The effect was dramatic. She explained, at the next consultation, how the pains in her back and neck, the buzzing in her head, the feeling of constriction round her head disappeared as if by magic, giving place to a feeling of lightness and confidence. When she returned home, however, her symptoms had partly come back. She was now faced with the fact that she had told her secret after having /

having promised her husband's aunt not to do so. She was consequently advised to face the situation and inform the aunt of what she had done. She had the courage to do so. Shortly afterwards the aunt left her house and she has improved rapidly since. All that remained was for her to adapt herself to her irritable and unsympathetic husband, which she has succeeded in doing. She is now, a year afterwards, looking and feeling well, has no worries except those connected with her husband from which, of course, she cannot entirely escape.

In this case the conflict which was distracting the patient's mind and causing her symptoms was the feeling of shame that she was withholding important information which she thought her mother ought to know, her mother being the most important influence in her life and the person for whom she entertained the deepest regard.

Her conflict, in the second instance, was due to the feeling of shame at having broken her promise to the aunt and fear at having to face the situation of informing her that she had done so.

The foundation of the neurosis lay, no doubt, in the irritation produced by the groundless accusations of her husband with relation to the death of the child and in that due to the interference of the aunt in her home.

Case 11. M.J., married woman, age 39 years, complained of pain radiating from the lower end of the spine to her head. She suffered from sleeplessness, irritability, loss of confidence, palpitation, loss of weight and a general feeling of inefficiency. She had an anxious expression.

Physical examination did not reveal any definite abnormality. She had been well until about a year ago when the above symptoms gradually began to develop. She was an intelligent woman and had been well brought up. Considerable tact had to be used in the method of approach to her condition. She was given Pot. Brom. grs. 10. t.d.s. for three weeks. The restfulness created by the Bromide helped her slightly, but she saw that medicine was not doing her much good and, when it was suggested, agreed that worry might be causing some of her trouble. Eventually she was induced to speak of her troubles. Up till a year ago her husband had treated her fairly well, but since then he had developed a bullying manner, called her objectionable names which she did not merit, and occasionally maltreated her physically. Often she had wished to leave him. However, she was deterred from doing this as his position was such that, had there been any publicity, he would have lost it. There was also a family of four young children to consider. She knew no one locally in whom to confide or to whom she could unburden her worries. She had lost all affection for her husband since she suspected that there was an entanglement with another woman.

For /

For the sake of the family she was determined not to take any action in connection with this matter.

Having finished her narrative she was considerably surprised to find the pains in her back and head improved and a feeling of buoyancy to which she had been a stranger for some time.

She was encouraged to return frequently and speak of her worries. Irritability, sleeplessness and palpitation gradually improved. She began to gain weight. Consultations on this subject seldom take place now since, as she states, she is supported by the knowledge that she has someone in whom to confide if necessary. Life has become relatively bearable to her.

Her difficulty in adapting herself to the situation was, of course, due to her refined upbringing and not having had experience of a similar situation. Adaptation is gradually improving on the suggested lines of developing the critical judgment, examining each situation as it arises, determining its value, discounting it and so developing the habit of eliminating any painful emotional reaction to it. The position is a difficult one on account of the patient not being able to get away from the cause of her anxiety, but so long as anxiety symptoms can be warded off something has been attained.

The case is illustrative of how anxiety symptoms can be relieved by the release of the painful emotions attached /

attached to experiences merely by speaking about those experiences.

Case 12. D.T., a man, single, complained of palpitation, loss of appetite, pains in his head and back, flatulence, a feeling of weakness and inability to do his work as satisfactorily as he used to. Physical examination did not reveal any definite morbid condition. He looked anxious and was worried and had lost weight. Easton's Syrup 3ʃ t.d.s. was given for two weeks, but he did not improve. It was suggested to him that he was worrying about something and, after considerable reluctance, he admitted that he was subject to nocturnal emissions. He was worrying greatly about these emissions and was attributing his symptoms to them. He thought that he was steadily "losing strength", and that his general physical condition was deteriorating. He had never masturbated nor had he ever had relations with women but had thought of them in a sexual manner. His anxiety, however, did not arise from any moral idea but was apparently only related to the physical aspect.

After it was explained to him that the emissions could not harm him physically any more than a married man could be harmed by relationship with his wife and that his symptoms were really due, not to the emissions, which were quite natural, but to his anxiety about them, he began to improve rapidly and is now free from anxiety in this /

this matter. The emissions at the same time became less frequent.

In this case the mental conflict with its emotional disturbance is related to the physical.

Case 13. J.H., a man, age 23 years, had been feeling in indifferent health for about a year. He was subject to palpitation and depressed moods. His memory was not so good as it used to be. Loss of appetite and weight worried him. He was losing interest in his work. Physical examination did not reveal any abnormal condition. After considerable persuasion, he stated that he had masturbated when he was eighteen years old, after having been seduced by a woman, and had continued to do so for two years, after which he had stopped the practice. About a year ago he had been told by someone that insanity and various nervous diseases were apt to follow the practice of masturbation. This knowledge had worried him intensely and he had tried hard to forget it. He was greatly afraid of anyone knowing these facts about him. He was shy in company and often felt that he would gladly give ten years of his life to be so free of anxiety as others appeared to be.

He admitted feeling considerably relieved after revealing these facts.

It was explained to him that masturbation was practically similar to ordinary sexual intercourse and could /

could be no more harmful. Its universal incidence was pointed out and he realised how that probably half the people of the world should be insane or suffering from nervous diseases if his information were correct. He steadily improved in health after a few more consultations, in which he repeated his story until he could face it without feeling emotional and until he could stop the habit of trying to forget it whenever he began to think of it.

In this case the conflict was related to the fear of insanity and disease. The symptoms were caused by the attempt to repress the knowledge which was the cause of the conflict. Relief of the symptoms was attained on release of the painful emotions consequent on speaking of the source of the anxiety and by acquiring the knowledge necessary to give the patient his sense of proportion.

Case 14. H.T., a man, age 21 years, complained of palpitation, irritability, sleeplessness, loss of appetite and loss of weight, occasional headaches and an oppressed feeling. He was shy in company and could not enjoy himself as he saw other people enjoy themselves. He was worried over trifles. Physical examination was negative.

After considerable encouragement, he told how he had masturbated /

masturbated when about fourteen years of age and had continued periodically for about a year, when he had stopped the practice. About a year ago he had read in some book that "self abuse" was one of the worst sins that could be committed. He had not worried about having masturbated previous to reading this book. Since acquiring this knowledge he had worried excessively and admitted that he thought some of his trouble was due to this worry. He had no one to confide in and, in fact, had never thought of speaking about such an intimate matter to anyone. In company he felt inferior to everyone as he thought that he was one only of a very few who had ever committed such a sin. He felt considerable relief during the narration of his story.

It was then explained to him that people who wrote such books were usually of an ignorant type and had little real understanding of such matters; that it was difficult to see how such a practice could be sinful when ordinary sexual relationship was not; that the practice was of universal incidence so that he need not think he was by any means an exception; and that, in reality, he had shown considerable courage and determination in stopping the practice as he had done. He was instructed to think over these points until quite familiar with them. His anxiety soon disappeared and he now leads a normal, contented /

tented life.

The conflict in this case was in the moral sphere. The release of the painful emotions by speaking of the anxiety did good, but there was the necessity for the acquisition of additional knowledge to bring about a proper sense of proportion and finally to dissipate the anxiety.

Case 15. G.T., a boy, 18 years old, musician, complained of tremor of the hands, palpitation, lack of concentration, nervousness over trifles, headaches, and a feeling of "being afraid of almost everything." He was pianist to a picture theatre and managed to perform only with difficulty on account of his lack of concentration. The writer at first thought that his condition was probably due to tobacco poisoning and treated him with Tinct. Nux. Vom. M. 8 and Pot. Brom. grs. 10 t.d.s. with abstinence from cigarettes, but he did not improve during the next two weeks. Physical examination did not show anything abnormal. On being questioned concerning secret worries, he stated, after considerable hesitation, that he worried considerably about his father who, during the last year, frequently came home drunk and always, on these occasions, abused him and his mother to whom he was greatly attached. He did not mind abuse of himself so much, but when his mother was attacked he felt it bitterly. He lived in dread of /

of his father coming home at night in case he might be drunk. Even when the father was sober, for as long as he could remember, he was never considerate to them. In consequence of telling this story he felt better. It was explained to him that his symptoms were in all probability due to this anxiety and that he would have to try not to allow his experiences to affect him to such an extent, which, of course, was easier to explain than to do. To this end he was encouraged to speak of and discuss his troubles as much as he could and not to "bottle them up." He was very ashamed of the state of affairs in his home. His sex life showed nothing irregular except that he was extraordinarily innocent of all knowledge related to sex.

He had some success in adapting himself to home conditions and, in consequence, his symptoms somewhat abated.

In about three months' time he consulted the writer concerning balanitis which had troubled him for about a week. It appeared to be of simple origin, but the writer, unfortunately, asked him if he had had relations with a woman. He denied this and made no further remark at the time. About two weeks later he came back with the symptoms of the neurosis as bad as ever. The balanitis had cleared up in a few days with treatment. During the talk he suddenly and explosively asked why he had been suspected of /

of having relations with a woman as "such a thing" had never entered his mind and was entirely contrary to his principles. In fact, he had hardly ever thought of such matters. He stated that, during the previous two weeks, he had been very worried and had brooded over being asked this question and did not wish the writer to think he was of that type. It was explained to him that the question was merely a routine one and implied nothing more than the desire to have accurate information. This explanation apparently satisfied him, and for the next four months he was comparatively free of his symptoms. At the end of this period he again consulted the writer. On this occasion his anxiety centred round the agitation he felt when dancing with a girl. After these occasions he also noticed a moisture at the end of the penis which also worried him. It was explained to him that it was normal and natural for any man to feel pleasure in close proximity to a woman, but that his agitation was due to his violent effort to repress that feeling of pleasure, either owing to his ignorance of such matters or from some idea that such a feeling was morally wrong. After some amplification of this explanation he understood and declared, "Really, I must be a bit simple." Shortly afterwards his father left the home permanently and the patient has been in satisfactory health now for two years.

This case is illustrative of the type of patient who is /

is in the habit of treating his experiences by repression. This attitude is traceable to the conditions of home life where an irascible, unjust and overbearing parent, instead of attempting to explain and helping the child to understand his troubles, drives the child to repress or treat his troubles with his own immature judgment through fear of approaching him.

The conflict which was the cause of his symptoms began when he saw the object of his affections - viz. his mother - being maltreated unjustly. As there were no means of redress, he had to treat the painful emotions attached to these occurrences by repression. He found this the easiest course to follow since he had acquired the habit of doing so in previous years owing to the unsympathetic attitude of the parent.

He had been brought up strictly by his mother who, in her turn, had been forced abnormally towards her child owing to the character of her husband, the result being that the habit of repression was increased. When faced with a new situation, such as dancing, he became agitated when in close proximity to a woman. He did not realise that the agitation was due to his repressed sex instinct.

With regard to the writer's question concerning the balanitis and the development of anxiety symptoms from it, the explanation may be understood from the fact that he was often unjustly treated by his father. However, as he had /

had no respect for his father, any unjust accusation did not end in the development of anxiety. With the writer it was, apparently, a different matter, because what he conceived to be an unjust accusation ended in the formation of anxiety symptoms. Fortunately he was not afraid of the writer and could ask for the explanation of the so-called accusation. The case is illustrative of the increased suggestibility of the neurotic and of the danger and of the care that must be taken in suggesting material which is not relevant to his case.

Two cases illustrative of anxiety neurosis following injury may now be given.

Case 16. J.I., labourer, age 40 years, with a family of seven young children, was attended by the writer, seven years ago, for an injury to his back. Generally, he was of poor physique, probably due to under-nourishment. He was of an unintelligent type. At his work a wooden plank had fallen on his back while he was bending down, from a height of ten feet. He was carried home by his friends and was seen, an hour later, by the writer. He appeared to have received considerable shock. There was pallor of the face and rapid pulse, but no external evidence of bruising. A mitral murmur could be heard in the heart. He complained of pain in the back and legs. After two weeks in bed the pain in the back and legs had almost /

almost disappeared and he began to get about with comparative comfort. In about another seven weeks he had practically recovered when compensation trouble began. He was sent, in the first place, to the medical referee of the Insurance Company who, quite rightly, told him that he would be fit for work in two weeks. This he resented, the reasons for his resentment being that he thought the Insurance Company and the referee were "trying to do him out of his money"; that they thought he was malingering while he knew himself that he was willing to work; that his work was too heavy for him in his present condition. The pain in his back and legs and palpitation returned. He became sleepless, lost appetite and weight. His expression became anxious. He was interviewed at the Insurance Office on a certificate from the writer being received that he was worse and was not able to work. He was again sent to the referee who advised electrical treatment at the Infirmary. His anxiety symptoms, however, became steadily worse. He was interviewed frequently at the office of the Insurance Company where it was the custom of one of the clerks to feel his pulse and where it was repeatedly suggested to him that he was fit to do some work. This was a source of great irritation to him but, for fear of raising prejudice against him at the Office, he had tolerated it. Only after eight months did he inform the writer of these occurrences when the practice was immediately /

ly put an end to. Finally, one and a half years after the accident, he accepted a settlement from the Insurance Company. He had been advised by the writer to do so previously but he was alarmed at the consequences to his family if, after all the settlement money were spent, he were still unable to work. He could not be made to understand that the greater part of his trouble was due to anxiety concerning the question of compensation. The anxiety symptoms gradually abated after the money settlement. With the money received he began a small business of his own.

The conflict in this case centres round the question of compensation when faced with the necessity of providing for a large family combined with a feeling of unfitness, after the accident, to perform his work or an unadmitted desire not to return to that work for which he was not physically suited, with the prospect of an indefinite payment of compensation. Undoubtedly the Insurance Company did not help to curtail the neurosis. Under the circumstances, only a money settlement could be effective in clearing up the anxiety.

Case 17. J.C., plasterer, age 36 years, married, family of two, received his injury by the collapse of a scaffolding on which he was working. He fell on his back from a height of twelve feet. A small abrasion over the centre of the spine was the only external evidence of injury /

injury. He was considerably shaken and frightened by the accident but did not complain of much pain. In three weeks' time he was practically well again, except for a slight pain in his back. While at work he had earned £5 weekly from which he had managed to save a little. These savings, combined with the compensation money, had permitted him to live with comfort.

As in the previous case, when he was seen to be walking about in good health, the Insurance Company interviewed him and suggested that he was now fit to begin work. He resented this as an implication against his honesty, pointing out to them that it paid him better to be at work than receiving compensation. He became worried and anxious Irritability, sleeplessness and nightmares developed which made him feel still more unfit. The Insurance Company persisted in trying to get him to return to work and, after each interview, he had an aggravation of his symptoms. He began to lose weight. After showing considerable reluctance he admitted that he was really intensely afraid of working on a scaffolding since his accident and that, if he returned to work, his employer might send him to work on some high scaffolding, the thought of which he could not bear.

He was instructed that the only manner in which he could dissipate this fear and regain his confidence was to force himself to climb structures progressively high and so again /

again become accustomed to them. This instruction he carried out and finally accepted a settlement six months after the accident.

The conflict in this case was the repressed fear of scaffoldings. He could not bear the idea of returning to work on account of this fear. While he was receiving compensation he could live comfortably, assisted by some of his savings. However, when he saw the possibility of the compensation money being stopped, he also saw the necessity for him to return to work which, of course, he was afraid to do; hence the development of the anxiety symptoms.

He has now been free from anxiety symptoms for more than three years.

The following case illustrates amnesia following injury.

Case 18. E.P., girl, age 18 years, single, was treated by the writer for an "Influenza cold", Temp. 100°. She was well again in about four days with the usual diaphoretic treatment. She then began to develop symptoms of anxiety:- palpitation, sleeplessness, nightmares, irritability. Her expression indicated preoccupation. She was given Pot. Brom grs. 25 at night for a few days to promote sleep, but her symptoms became gradually worse and, at one time, she appeared as if she were becoming insane. She was unable to speak intelligibly at times.

She /

She would repeatedly and with sudden movements look behind her in an apprehensive manner. She could give no reason why she did this. She would look in an anxious manner beneath the bed-clothes, underneath the bed and in the adjoining room. She stated on one occasion as if she had lost something, but had no idea of the nature of the object lost. She had been brought up with care and apparently there was nothing irregular in her sex life.

Ultimately, by questioning the parents with a view to learning if they could remember anything in her past life which could have any bearing on her illness, the mother remembered that, when she was eleven years old, she had an injury to her head. She had been sent to a shop about a hundred yards from her home on an errand. When near the shop a wooden board had fallen from the roof of a house and had struck her a glancing blow on the head. The blow could not have been severe as there was only a slight abrasion on the scalp. She had been carried home "unconscious" by a man who was a friend. She recovered consciousness in about ten minutes and was up and running about the same evening. The writer, assuming that she had experienced terror when the board fell and had treated the experience by repression, questioned her on the subject, but she did not remember anything. She was again questioned next day and encouraged to try to remember and ultimately she gave the name of the man who had carried her home.

After /

After further encouragement she remembered being carried into the house, which clearly proved that she was not entirely unconscious. Step by step, she remembered leaving the house. Fortunately, snow was on the ground at the time, which greatly assisted her in the recollection. She remembered meeting two people whom she knew while going to the shop. Then came the remembrance of the falling board and the fear. She was encouraged to remember all details, from the time of leaving the house until she was carried back and placed in the bed. Every day, for a week, she was made to repeat the details of her recollections until she became familiar with them.

She rapidly recovered and is still well two years after her anxiety attack.

In this case the terror was so great and the repression so powerful that there was a complete blank in her mind concerning the experience from the time she left the house until she was carried back. By re-associating and linking up the events during the amnesic period, her consciousness was again brought into continuity and she lost that feeling of having lost something.

Three cases illustrative of Conversion Neurosis may now be given.

Case 19. J.D., age 26 years, woman, single and an only child, was treated by the writer for an "Influenzal cold". She /

She complained of headache and pain in the back, especially the lumbar region. Temp. was 102°. The temperature was normal in two days and the headache and lumbar pains had practically disappeared. Her fiancé arrived on a visit to her, of four days' duration, at the beginning of her illness, and had then to return to work. On the day after he left she developed a severe headache, particularly on the left side with spasmodic contraction and dilatation of the left pupil and a certain degree of photophobia. The pains in her back returned with greater intensity. These symptoms became progressivly worse, in spite of treatment, until her back became so painful and rigid that it was practically impossible to move her. The writer considers himself guilty of accentuating some of these symptoms by enquiring concerning them and by examination. He refrained from examination, however, as far as possible, as he felt that it was a case of hysteria. Her fiancé was sent for and it was noticeable how she improved during his stay of two days. After he left the symptoms became worse than ever. Her parents were elderly and, on account of the difficulty of moving her in bed, obtained the services of a male friend to help them. Again it was noticeable how she complained much less when this friend was raising her than when her parents did so.

It was explained to her that her excitement at her fiancé's presence and disappointment at his leaving so soon /

soon was the cause of her trouble and that she would have to face the situation and adapt herself to it if she wished to become well again. She did improve, however, as a consequence of this explanation which was made as simple as possible.

In case there might be a possibility of meningitis a consultant was called in who thought that it would be safer to regard her condition as possibly Tubercular Meningitis. Generally, she looked remarkably well through it all. Her appetite remained satisfactory. She was admitted to the Newcastle Royal Infirmary, where she remained two months under treatment by the consultant who determined that she was not suffering from Meningitis. While in hospital her engagement was broken off by her fiancé, after which, as the writer learned, she began to improve. She consulted the writer two months after her discharge from hospital. On this occasion she looked very ill. She had an anxious expression and had lost appetite and weight. She was very dark under the eyes and came into the Consulting-room supported by her mother. She had, however, overdone the blackening process beneath her eyes and, before she could detail her troubles, the writer soaked a piece of cotton-wool with methylated spirit and removed part of the pigment The effect was striking. She suddenly appeared to recover her vigour and stated in definite terms that she would never consult the writer again. The writer considered it necessary /

necessary to expose her trick on account of the needless anxiety she was causing her parents.

Curiously enough, two years after this incident, she again consulted the writer. In the meantime she had been well until two months ago when she had married a widower with two of a family. Since then she had been suffering from severe headaches periodically. On questioning her on her domestic life, it appeared that quarrels had been taking place between her and her husband. She readily admitted that the headaches developed after these quarrels or some worry. She had apparently gained greater control since her previous experience and understood the explanation that her headaches were due to the emotional disturbance consequent on the quarrels or worries and that so long as she recognised that fact the headaches would gradually tend to diminish and ultimately cease to develop. From information obtained from her mother, the writer learned recently that she was suffering less from headaches.

In this case the patient was an only child and spoiled. The conflict was due to the painful emotional disturbance consequent on her fiance leaving her. She was unable to face this trouble and, in order to protect herself or distract her mind from it, she developed physical pain, this pain being suggested to her by her influenzal condition. When the male friend helped to move her /

her in bed she obtained a modified gratification to her disappointed sex instinct which resulted in a modification of the pain and consequently greater ease in being moved in bed. After discharge from hospital, where she had been treated with a strong faradic current as a means of persuading her to lose her conversion symptoms on account of the irksomeness of the treatment, she began to develop anxiety symptoms when she could no longer take refuge behind the conversion symptoms. No doubt the dissipating of the conversion symptoms was aided greatly by the breaking off of her engagement to be married. She now knew that further regret was useless and that her fiancé would not return to see her. The blackening underneath the eyes was, of course, a deliberate trick to obtain sympathy.

Again, the case illustrates the increased suggestibility of these patients and how accentuation of symptoms can be brought about by repeated examination.

Case 20. M.H., married woman, age 40 years, suddenly complained of pain in the head and a feeling as if a tight band were bound round the head. She fell, but was caught by her husband before she reached the floor. When seen by the writer about half-an-hour after the occurrence she was lying in bed, moving the left arm, but the right arm lay apparently paralysed. She would not speak and appeared to be in a semi-conscious condition. Towards evening she became /

became restless and talked in a rambling, indistinct manner. She was given Paraldehyde ℥ ½. Next morning, after a good night's sleep, she could answer questions fairly coherently. The right arm still remained motionless but showed distinct movement when pricked with a needle. She now realised that she could move the arm and, by the evening, was moving almost normally. She progressed satisfactorily for two days and then developed violent pain in the back of the neck and upper dorsal region, for which no cause could be found. This pain continued for three days in spite of analgesic treatment. She was then given Paraldehyde ℥ ii in an attempt to make her sleep, but on this occasion it caused severe vomiting. With the incidence of the vomiting the pain in her neck and upper dorsal region entirely disappeared. She was going about the house in two weeks from the commencement of her illness.

During the previous three months her general physical condition had been deteriorating on account of lack of food owing to her husband being out of work. She had also become very anxious over the situation. Combined with these facts there had been quarrels among the family and her two daughters had been "harsh and unsympathetic" with her on several occasions. She had felt very upset on these occasions and often wished she could escape from it all. She had been healthy, except for minor ailments /

ailments, and had been free from anxiety until recently. Her two sisters who came to attend her during her illness were plainly hypochondriacal.

It was explained to her as simply as possible that her debilitated physical condition had increased her anxiety; that her anxiety constituted the cause of her illness; and that if she wished to avoid its recurrence she must learn how to face her anxiety instead of running away from it and finding refuge behind illness.

This case shows the ability of the patient to convert her conflict into physical symptoms. When she saw that her arm was not paralysed, she had to find something else which was suggested to her by a stiff neck, the result of lying in the same position for a considerable time at the commencement of the illness and of which she complained to the writer. The attack of vomiting made her forget the pain in her neck.

Case 21. M.M., girl, age 18 years, single, was seen by the writer during a "fit." She had never had a fit before, but was described by her mother as being "a nervous, irritable and highly strung girl." She had left the kitchen, where she had been working, and had gone into another room where three young men were playing with her brother at cards. She had been watching the game for two minutes when she suddenly fell and began convulsive movements /

ments in all her limbs. When the writer arrived she was lying on the floor with the four young men trying to hold her. She had one arm round the neck of one of the men while her legs were moving convulsively in all directions. Her clothing was considerably disarranged by her kicking. Her tongue was not bitten. The "fit" soon ceased when the men were sent out of the room and her mother and the writer were left alone with her.

In this case the conversion symptom is due to unsatisfied repressed sexual desire, the passionate attitude being the subconscious indication of the wish and invitation for satisfaction.

Explanation of the "fit" was given to the patient on these lines. She has not had a repetition of the condition now for three years and has become less irritable and nervous.

The following two cases are illustrative of Migraine.

Case 14 affords the first example in which there was severe pain, particularly on the left side of the head, with spasmodic contraction and dilatation of the left pupil and a certain degree of photophobia. In this case there was undoubtedly a painful emotional disturbance.

It may be that there was an element of repressed rage and humiliation at her fiancé leaving her so soon, as she was spoiled as a child. Her mother informed the writer /

writer that she used to "show a good deal of temper" when she did not get what she wanted and often complained of severe headaches. If this were so, it would bear out Cruickshank's theory of the causation of Migraine.

The writer, however, is inclined to view the Migraine in this case as due entirely to disappointment in love, as he knew her to be genuinely in love with her fiancé, the unbearable idea arising out of the prospect of not being able to see him again for a considerable time.

The headaches in the last part of the history of this case could not be classified as migrainous.

Case 22. J.G., a married woman, age 34 years, family of three children, complained that for many years she had been subject to severe pain in the left side of her face and head sometimes radiating down to the shoulder. She suffered on these occasions from some blurring of vision. The pain lasted usually about two days when vomiting occurred, after which the pain ceased. She was unable to carry out her household duties with satisfaction during the two days of pain. She remembered her father used to suffer from severe headaches periodically. She knew when the headaches were developing by a tingling sensation in the side of her head.

She admitted that the pain used to be much more severe when she was younger than it had been recently.

On /

On being questioned as to whether she had noticed any special circumstances under which the pain seemed to develop, she said that she noticed it most frequently when menstruation was coming on. During menstruation she usually felt weak and unfit to perform her household duties and attend to her young family satisfactorily. Very often she worried considerably beforehand in anticipation of this occurrence.

She noticed the pain sometimes developed when she desired something which, at the time, she could not afford to buy.

Again, she noticed its incidence sometimes when any of her children were ill.

In this case the Migraine can result from three types of conflict related to different subjects. Firstly, the conflict related to the feeling of inefficiency in face of the necessity of performing her duties. Secondly, the conflict related to the baffled desire to obtain something. Thirdly, the conflict related to the unbearable idea of seeing the object of her affection suffer.

She admitted that recently she had begun to think that her headaches were of a "nervous" nature and that she had often thought how foolish it was to worry over the matters which caused her worry. This recent attitude would account for the improvement in her symptoms, as she was beginning to recognise the cause of those symptoms.

She was instructed to recognise always that these worries were the cause of her headaches and that, if she did so, she would tend to improve. The writer has not since seen this patient.

The following two cases are illustrative of Phobia.

Case 28. J.L., age 39 years, complained that he used to be very afraid of the dark which, at one time, caused him considerable anxiety. Fear of the dark had troubled him since as early as he could remember. This fear had abated considerably within recent years, which he attributed to his development of a greater sense of proportion. He admitted that he still suffered from a feeling of apprehension in the dark or when opening a dark cupboard, especially when feeling debilitated after Influenza or any other cause. He could not say what he was afraid of in these circumstances. His sex life as a child had been normal.

On being encouraged to think of his early life relative to any circumstance which could have caused fear of the dark, he eventually remembered, as a child between four and five years, being terrorised by stories told him by a domestic servant and which usually related to murders and burglaries performed in the dark.

Since remembering this factor in his early life he has gradually lost the feeling of apprehension.

The /

The fear in this case is due to the repressed memories of revolting deeds performed during dark.

Case 24. A.M., a married woman, age 26 years, complained of intense fear of traffic. In fact she was unable to leave her house on account of this fear. Whenever she attempted to go out she suffered from severe palpitation, apprehension and trembling of the arms and legs. Both her parents were "nervous" and irritable. She had enjoyed good health until she had married, although she had always been of a "highly strung, nervous disposition." She had always been easily frightened. The fear of traffic had commenced after the birth of her child and had become gradually worse. She had become greatly afraid of the prospect of the birth of the child from a physical point of view when she was about six months pregnant. This fear had continued until the birth took place.

Enquiry into her early sex life showed nothing irregular and her married life was apparently normal. Questioned as to whether she remembered any event which took place about the time when she was six months pregnant, she recollected, with some difficulty and emotional display - blanching of the face - when standing one day waiting for a tram-car she saw a child narrowly escape being run over by a motor car. This incident frightened her intensely. She admitted that she had forcibly tried to forget /

forget the incident. Shortly after the incident she became apprehensive concerning her confinement and, after her confinement, she developed the fear of traffic.

The case illustrates the repressed emotion of fear from the particular experience being transferred to her prospective confinement. After her confinement was over the repressed fear, not being applicable to the confinement and being unable to attach itself to the original cause, had to find some other element to which it could attach itself, viz. traffic, this having been suggested by the causal experience.

She improved very satisfactorily.

The following case is illustrative of Obsession.

Case 25. M.H., a man in a small business, 40 years of age, while consulting the writer concerning a dyspeptic condition, complained that periodically when he returned home in the evening he had the habit of walking about his sitting-room "toeing and heeling certain parts of the design on the carpet." He was very preoccupied with the process and usually felt very worried when engaged in it. He noticed that he did not sleep well the same night after these occasions.

He was instructed to observe if these occasions coincided with an unusual business worry. In three weeks' time he returned and admitted having noticed the coincidence /

incidence. This discovery soon led to a cure of the obsession.

He was repressing the anxiety connected with his business but the anxiety being still forcibly and obtrusively present in his mind distracted him into performing the toeing and heeling of the pattern on the carpet, with the consequent attachment of the anxiety to that process.

The two following cases illustrate the anxiety dream and a death-wish dream.

Case 26. J.H., a man, age 30 years, was recovering from Influenza. He was debilitated, worried and irritable. For five consecutive nights he had a nightmare which caused him the greatest terror, the details of which he could remember with the greatest accuracy on account of its vividness. He awoke from the nightmare sweating profusely. It consisted in two men fighting in the middle of a field. They would fight for a considerable time and then blood would begin to flow from the nose, mouth and ears of one of the men in such quantities that large pools were formed in the grass. He was not alarmed at the actual fighting but the terror began when he saw the blood issuing from one of the men in such large quantities.

He was able to remember, when about eight years of age, witnessing a particularly vicious fight between a Spaniard and a coal-miner which took place in a field near his /

near his native village. On the other hand, he could not give any reason why he should be so terror-stricken at the appearance of the blood.

By means of free association, using blood as the commencing point, he eventually recalled, with revulsion, when about four or five years old, witnessing a bullock being slaughtered. He also remembered running away and vomiting at the sight of the rush of blood when the butcher cut the throat of the bullock.

He had, as a child, treated this experience by repression and even after the lapse of more than twenty years the attached painful emotion showed itself in the form of an anxiety dream.

This particular nightmare never returned.

Case 27.

While discussing with a friend the subject of dreams, he described one which he had experienced, as a boy ten years of age, with extraordinary vividness and which he remembered with the same vividness now, forty years afterwards.

He dreamt "that he was leading his father by the hand towards a gallows where he was to be hanged, and he was doing so with a feeling of pleasure."

He had no anxiety concerning this dream and could not now remember any incident which might have led to this typical death-wish expressed in a dream.

SUMMARY.

The cases described are representative of those met with in the course of general practice among an industrial population.

From observation of the cases there is emphasised, in the first place, the necessity for the greatest care being taken in determining the physical condition of the patient. The first six cases demonstrate how anxiety symptoms can develop in an individual who has been previously free from such, as the result of definite physical disease. Other cases again show the development of anxiety symptoms without any abnormal physical condition being present to act as a precipitating agent.

Anxiety, in some form, constitutes the emotional basis of the neuroses.

This anxiety is treated in various ways by different individuals. All have the common error of trying to repress or trying to forget or not wanting to see this anxiety.

Some, on account of the effort of trying to forget, develop anxiety symptoms, while others, according to individual idiosyncrasy, convert the anxiety into some pseudo-physical abnormality or transfer it to some other condition which takes the form of a phobia, obsession, etc.

Everyone has anxieties, but those of us who are fortunate /

fortunate or successful in avoiding a neurosis have developed the habit of facing our troubles and resolving them, instead of trying to forget or run away from them.

Many suffering from neurosis become well once they have released their repressed emotions by speaking of them, realising their nature and resolving them.

Unfortunately, there are others who, from poverty or circumstances, do not show much improvement, as they cannot free themselves for a time from the ever-pressing anxiety such as that related to household duties, professional duties etc., which affects them and are so prevented from obtaining a perspective view of their troubles.

Again, old standing cases are often hopeless, such as Cases 7 and 8. They have developed the attitude that the acceptance of their symptoms is preferable to facing and resolving their anxiety. They have no desire to be cured.

Throughout the cases there is a noticeable lack of the purely sexual basis for the neuroses which is so prominent in the cases described by foreign authorities. In this connection the writer thinks this can be understood when it is realised that there is no people which has been so busily engaged in sublimating itself as the British, in the form of sports and philanthropy. The most poverty-stricken children can be observed everywhere to be as enthusiastic in kicking their ball of newspaper as the large number of adults which enthusiastically follows football /

football, cricket, boxing, shooting, fishing, etc.

Again, the writer sees the possibility that the people among whom he practises, being industrial and having often to work hard for small wages, are of a type which does not readily develop neuroses. They are sublimated by their struggle against the hard facts of existence. They have had to face and resolve their anxieties by force of necessity and, in consequence, their character is less complicated than those who enjoy much greater leisure.

Finally, the sublimation of the instinctive desires as a means to the development of peace of mind cannot be described as a new conception. Buddha taught - in its purest interpretation - that peace could only come to the soul when it no longer desired or sought material things. In other words, when it became "as nothing." Then, and only then, could it expect to escape the punishment of re-incarnation and be absorbed and become one with the tremendous and apparently indifferent forces which surround us and of which we are only dimly aware.

It may be safely remarked that very few of us need ever expect to attain to such perfection.

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