HYSTERIA IN THE MALE,

with special reference to treatment by hypnotic suggestion.

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Hysteria in the male differs from the same condition in the female, chiefly in the comparative rarity of its occurrence - perhaps also in the fact that it is more usually mono-symptomatic in type, as exemplified in my second case.

The cases referred to in this paper, being only two in number seem rather scant material to submit for consideration, but in private practice, and especially country-practice, it is only at long intervals such cases are met with, and I have therefore decided to bring these forward without waiting longer for an opportunity of amplification.

The psychological element enters so largely into the consideration of hysteria, drawing thus upon our knowledge of human nature as well as of what is more particularly considered our science, and leading us into a minute study of our patients' temperaments and habits, that the subject becomes intensely interesting. I propose dealing with each case separately at first, then making some general observations based on the symptoms described, and lastly making some detailed reference to the subject of psychotherapeutics.

The first case I wish to mention is that of a young man whom I have known intimately since his childhood and who was scarcely 17 years of age when hysteria developed about five years ago. He was always a shy retiring boy, rather moody and obdurate, his temper not easily understood even by his mother who for the most part/

part had a great influence over him. With his father he was sulky and reserved, and this seemed to me to be accounted for by the father's over-strictness and lack of effort to understand the boy's nature. He was steady and painstaking at school and carried most of the prizes of his classes, but this seemed to be the result of natural ability, and without any mental straining.

At the age of 15 he was taken from school and apprenticed to a joiner 2 miles from his home. The work was very heavy and he generally came home tired - inclined to lounge about the house in the evening rather than to romp about with other youths.

It was less than two years after he entered on his apprenticeship that the first symptom of his illness became pronounced - namely - an unusual difficulty in getting him aroused in the mornings. Naturally the border-line between the normal and the pathological was difficult to determine, considering the nature of the lad's work, and thus it was only a year later, when the condition had become slowly aggravated that his mother consulted me about him. For a few weeks previous to this he had been worse than ever, although he had long been in the habit of going to bed very early and eating nothing after 6 p.m. just to see if it would enable him to get up more readily. To show his genuine anxiety to be up in good time it may be mentioned that once or twice when his mother said she would just let him lie till he awoke the next morning, to give him a complete rest, he lay awake the whole night lest he should miss his work altogether.

When I was consulted in 1901, the condition had become so

aggravated/

aggravated that it had sometimes been quite impossible to rouse him at his usual time - 5-30 a.m. - and, left alone, he had once or twice slept for 17 or 18 hours before awaking of his own accord. His mother had tried dragging him out of bed and setting his feet on the cold linoleum in an uncarpeted part of his bedroom, and sometimes this had been sufficient to awake him. Several times after this I had an opportunity of seeing him in his stupor and of trying to arouse him. I would draw him out of bed, pinch him, shake him, put cold water on his face and head,but succeeded only in producing various reflex movements while he remained as much asleep as ever. When I got him on his legs, they were sometimes limp and powerless and bent passively under him, but at other times supported his weight quite well. In the latter cases I would pinch his flanks but obtained only a rotatory movement of the body on the pelvis: stroking of the spine would produce a gradual bending backwards of the trunk: and slapping of the face was followed by side-to-side movements of the head. When his legs were in their normal condition as regards power, he was easily led across the floor, but when they were in the limp state the toes or heels dragged heavily as he was pulled forwards or backwards. All the movements thus produced by stimulation, were accompanied by a low inarticulate moaning sound.

On one occasion I applied hot cloths to the side of his head - each side in turn - and obtained rhythmic movements of the limbs of the opposite side, but on applying the stimulus to both sides simultaneously, the movements of both limbs became so rapid and/

and powerful that they soon ceased as if from sheer exhaustion of the patient who was sweating profusely. As a rule, after 20 or 30 minutes of such stimulation, he slowly straightened himself up, rubbed his eyes and opened them, looking surprised to see me there, and with no knowledge whatever of what had been going on, not even of the last stimulus applied just before he awoke. He seemed all right immediately and said he felt so.

At this time we took him from work altogether and for a fortnight he was left pretty much to awake as he pleased and generally slept from early evening till 11 a.m. or 2-30 p.m. next day. On one of these days he had two attacks of convulsive sobbing and crying several hours before he awoke: another morning he got up and made as if to go to the lavatory: his mother, seeing him, bade him go back and put on some clothing, which he did, then went to the lavatory, returned, and sitting down in a chair fell fast asleep. He was helped back to bed in that condition and slept for five or six hours more when he awoke of his own accord with no remembrance of having gone out or of having been spoken to. Another evening at this same time when sitting alone with his mother he began suddenly to sob and cry. Seeing her a good deal upset about it, he anxiously asked her not to mind him as there was nothing the matter but he just could not help sobbing. When asked about this by me a few days later he had no recollection of it. Once or twice at this time quiet rhythmic movements of the hands and feet were noticed an hour or two after he fell asleep, but there was no micturition or defaecation during sleep

nor/

nor any incontinence of urine even when he slept for 18 hours. When he got up he did not feel as if he had slept too long and only once did he complain of a headache. There was never any blood on his pillow nor any pain in his tongue as from biting. His appetite for breakfast was always quite good.

At this time we commenced isolation treatment combined with the administration of bromides and Valerianate of Zinc, removing him from his friends and placing him in the care of skilled nurses, and now a crop of fresh symptoms made their appearance.

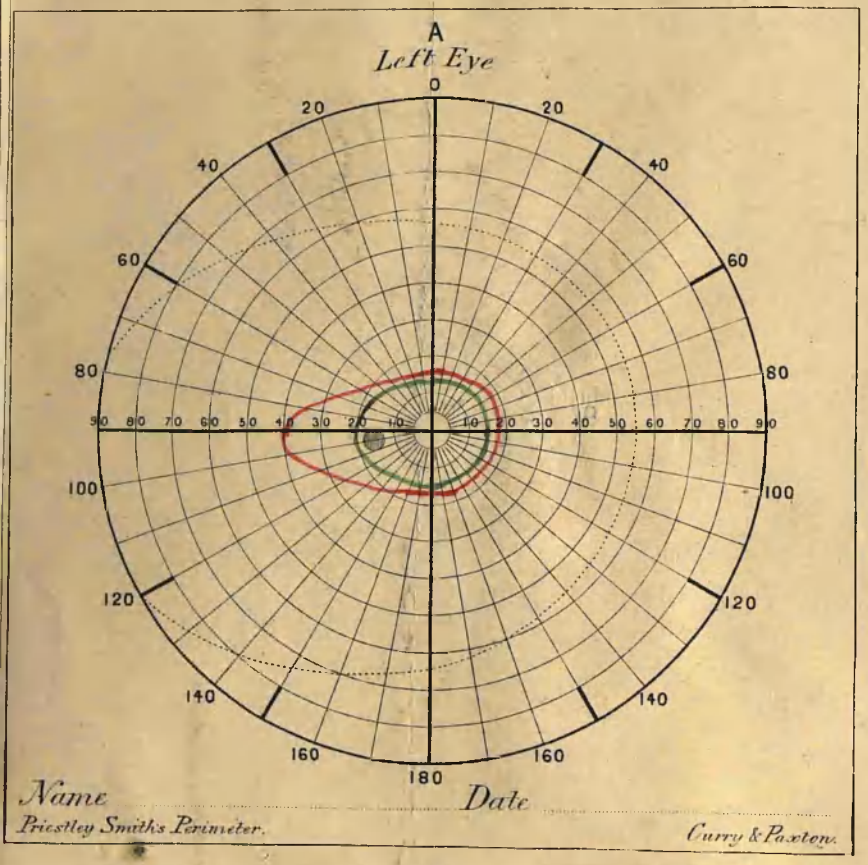
Several patches of his integument were found to be decidedly deficient in feeling, althoughnot completely anaesthetic, the areas affected being the whole of the left foot except the heel, the left hand, left anterior thoracic region, and the bulbar conjunctiva of the left eye. This was associated with a very slight paresis on the same side, but all the reflexes were normal on both sides. The disorders of vision which now appeared were also very typical - the pupils contracted normally to accommodation but to light rather excessively and on ophthalmoscopic examination the left eye felt sore very quickly. There was no actual photophobia however and no retinitis was found.

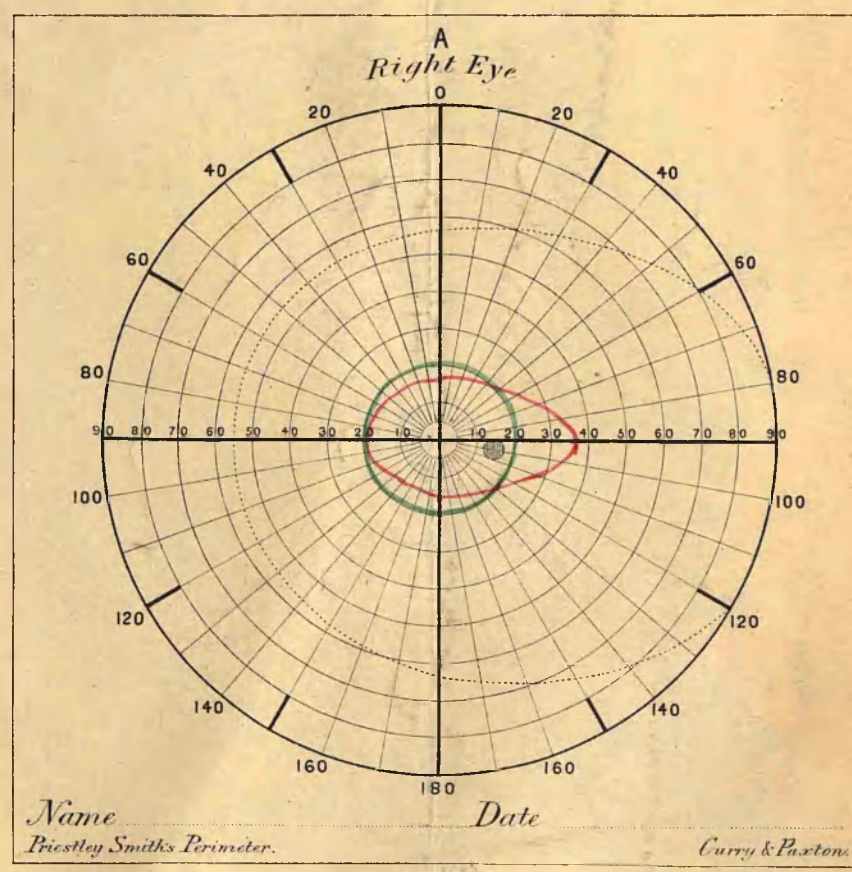
The visual acuity we found to be -

R. $\frac{20}{30}$ ($\frac{20}{20}$ with - 2D): Small Type 2.

L. $\frac{20}{40}$ ($\frac{20}{30}$ with - 2 D): Small Type 3.

The examination of the visual field was a further gain from/





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from the point of view of diagnosis as the accompanying chart shows, the contraction for green and red affecting both eyes but especially the left. At this time there was no disorder of hearing, taste or smell discernible.

One evening at this time patient was complaining of pain in and around the left eye, and as this continued to the prevention of sleep five grains of phenacetin were given him. He soon feel asleep and half an hour later his hands and feet were seen to be moving peculiarly - the hands opening and closing and the ankles being flexed and extended alternately. The hands worked in unison but the feet one after the other so that they rubbed against each other. These movements ceased after a little and were followed by twisting of the body, extension of the arms with heavy breathing at times interrupted, and a low expiratory noise as when one is straining every effort. The movements of the limbs began again, sometimes alternating with the trunk movements, sometimes synchronising with them, until after about 25 minutes, without being interfered with in any way, the patient opened his eyes and looked round. He expressed surprise at being watched but soon feel asleep again with no complaint of headache or pain in any part. He did not pass urine then but next morning there was a larger quantity than usual in his jar. He awoke quite easily in the morning and remembered being awake at 11-30 the night before, and being asked whether he had a headache.

Next night he had a similar "turn" lasting 20 minutes, and this time he got up and passed 50 ounces of pale urine of specific/

specific gravity 1009. When he awoke the following morning he did not remember having got up - probably because this time he had not been spoken to.

For fully a fortnight after this, nothing unusual occurred, patient being quite easily awakened for breakfast, and allowed to move about a little during the day.

But at the end of two weeks he had another attack very like those noted above, except that on this occasion arching backwards of the neck was very marked, and the twisting movements of the trunk were so excessive that patient rolled partially out of bed. For a time the head and shoulders were over the bed and unsupported, but ultimately he seemed to be standing on his head with his legs not quite off the bed. No sounds were made, no foaming at the mouth was seen nor biting of the tongue. He could not be roused by slapping or pinching but when a pin was pushed under his finger - or toe-nail he drew away the hand or foot and even used the other to push off the offending party. After a little he got into bed himself and he said afterwards that he remembered nothing except that he awoke to find himself half out of bed. He had a little headache after this attack and did not feel inclined to fall asleep again, but as it had occurred during an after-breakfast sleep the latter fact is scarcely remarkable. The attack lasted only 5 minutes or a little more this time and he passed no urine immediately after it. In a little while he was up and about and felt nothing unusual during the day.

We now determined to try electrical treatment, and faradiz-

ation/

ation was commenced. The reactions were found to be normal and daily applications were made. A few days after embarking on this treatment patient reported that when he awoke that morning at 9 o'clock he found his left arm and left leg somewhat powerless and this had persisted and even increased. He was notincapacitated hpwever, being able to use the arm pretty well and to walk easily enough although feeling the left leg much weaker than the right.

On minute examination again on this day, we found that sensation in all its forms was impaired on the left side - face, arm, trunk, and leg, and the hearing on the same side was decidedly weak now, although this symptom was absent earlier in the history. Taste and smell were still unaffected, while the visual acuteness and the extent of the visual field were about the same as already described. At this time the knee jerks were equal but exaggerated somewhat: there was no ankle-clonus and the plantar reflexes were "flexor" on both sides.

We continued faradization for 3 months while still keeping up the exhibition of bromides and valerian but patient seemed to make no progress - all the symptoms of the functional hemiplegia persisting although the initial symptom, the prolonged hysterical sleep, had certainly been less troublesome. He had now had symptoms more or less for 18 months, and as a last resource, on the advice of a consultant who had seen the case with me, we decided to have hypnotic suggestion tried.

Patient was accordingly handed over to a well-known practitioner who cultivates to some extent that branch of medicine

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and he, agreeing in all respects with our diagnosis of the condition, expressed his willingness to undertake the case.

Writing a few days later this gentleman reports :-

"I hypnotised your patient on Tuesday morning and again yesterday very successfully. The first time I did nothing but ask him to sleep for half an hour - he slept 20 minutes. Next time he seemed suspicious of the business, and to my thinking, rather resisted my attempts, but soon, and not withstanding some unusual noises in the ward, he gave in and passed into a fairly deep hypnosis. I tried to get at a probable cause of his condition by questioning him, but gained nothing more than the information he had given us in the waking state. As nurse reported that he could not be awakened at 5 o'clock that morning, I further suggested his awaking regularly at that time and at any time when aroused."

At subsequent sittings further suggestions were made as to the disappearance of symptoms and after being hypnotised seven times patient was sent home apparently quite cured. He had no trouble after that in getting up in the morning, all his sensory disturbances and paresis disappeared at once, his vision became normal again, and he had no recurrence of the hysterical fits. He has now remained quite well for about four years, working every day, and, beyond some peculiarities of temperament to be referred to later, showing no signs of anything unusual in his nervous organization.

My second case is very different, being one of the mono-symptomatic variety instead of presenting the museum of symptoms occurring in the other. The temperament here too is undoubtedly peculiar and no one would hesitate to designate the patient as nervous or "neurotic". His "fidgety" manner and "fussy" way of talking, his exaggerated facial expressions and pantomimic gestures when relating his story, his fondness of detailing the history and progress of his ailment - all point to some lack of strength in the higher controlling centres of the cerebrum.

Patient is a commercial traveller, aet, 63 and had an attack of acute rheumatism 6 years ago. In the course of this illness he was seized with a severe hiccough which has troubled him ever since, ceasing sometimes for a few hours but recurring without fail after the short respite.

Before treatment by hypnotism was commenced the spasms were repeated, during an attack, every 2 seconds, and an attack generally lasted for several minutes, ending with a crisis, and several of the last spasms being most violent and painful. This was the usual course if nothing was done to cut short the attack and such a natural ending by crisis was very soon followed by a repetition. About a year after the onset, however, patient had himself discovered a remedy of some value. He had tried smoking, sipping cold water, and many other homely cures but with scant relief, till one night in exasperation with the painful condition he pushed the mouthpiece of his pipe up the nostril and smoked through that unnatural orifice, and, to his own surprise, with

good/

good result. Ever since, the same procedure has served to cut short the attacks but of course it is rather an inconvenient means of cure and not quite applicable under all circumstances, as he does not care to smoke thus among strangers or on the street.

During one of his attacks the face becomes congested and the sweat stands out on his forehead, even on the coldest day. The attacks are generally worse during the day than at night, but his nocturnal rest is usually more or less broken. After a very bad attack he has had relief for longer periods than usual, sometimes even a whole day, but after such a long interval of quiescence the next onset is very severe. Patient says that just before the attack commences he has a feeling as if something were gathering in his throat, and the hiccough seems to him to be a series of involuntary attempts to remove this - but nothing is ever expelled. When the spasms continue long there is pain over the praecordium.

The only exciting cause of an attack seems to be talking. Patient cannot converse with one for any time (and he is very fond of talking) without the hiccough beginning. It is quite unaffected by posture, temperature, climate, food (either the mere taking of it or any particular kind) or by muscular exercise.

I think one cannot look upon the unusual mode of relief as anything else than "suggestive". Probably the climax of his attack had been reached that night he made his discovery and the puffing through his nostrils coincided with the natural ending of the spasms. He credited the new method of smoking with the cure, however,/

however, and has such confidence in it, that it has never failed him since.

In this case no other symptoms are to be found at all - it is strictly a case of hysterical singultus or hiccough, occurring certainly in a man with a distinctly neurotic temperament. The latter condition may possibly have originated in a severe attack of Infleunza which he suffered from 15 years ago.

Six months ago he began to wish for as much real amelioration as would enable him to go about and attend his business - he had been five years off work, and his savings were about exhausted - and he was put on Chloral and Bromides with Stramonium cigarettes, but with no effect. The "isolation and feeding" treatment was equally unsuccessful so that after three months trial of these rememdies, patient was handed over to the same medical gentleman as undertook my other case - for hypnotic treatment.

Patient reported to me that for a few weeks he made very satisfactory progress, feeling a decided improvement, but unfortunately he contracted a severe cold and had to stay indoors for some weeks during which time he has retrogressed somewhat. When I saw him last he had not been able to visit the hypnotist for over three weeks and was feeling not quite so well as when he left off the treatment, but the attacks were obviously less severe, the spasms occurring about once in 5 seconds instead of every two seconds as mentioned earlier: his own "reek" cure was still his comfort, however.

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I am sorry not to be able to complete the report of this case, but the treatment is still to be continued and both patient and hypnotist are confident of ultimate cure.

Leaving now the chronological sketch of these cases, I would comment a little further on some of the more prominent symptoms presented and would refer to -

1. The hysterical temperament. There is undoubtedly justification for the use of such a term in connection with the majority of cases of hysteria and yet the definition of it is most difficult, as would be expected when we consider the wide scope of hysterical symptoms. In the two cases under discussion, for instance, there is great diversity of temperament - the young lad shy and reticent, disinclined to give information about himself or his illness, yet gentle and unselfish and appreciative of any kindly interest taken in him; the elderly man likewise appreciative of attention but evidently more for the gratification of his love of telling his tale of suffering: the elder patient excitable in manner and jerky in movement while the younger is quiet and decidedly lethargic.

Some points in the later history of the earlier patient serve to show the persistence of his susceptible temperament after the cure of the hemiplegic symptoms and the drowsiness. Two years after his successful hypnotic treatment, he had some little trouble over an "affaire du coeur" which did not run quite smoothly, and although only 19 years of age, showed great depression of mind/

mihd, his mother finding him sometimes crying bitterly in his room. Then he took a fancy to study music and an organ was procured for him, but although he showed a fair amount of talent he did not persevere for any time. This instability of purpose is said to be quite characteristic and in his case is evidenced continually in his inability to finish a book or settle down to any hobby.

This persistence of temperament as a permanent substratum on which fresh symptoms might quite conceivably be grafted again, brings us to consider next -

11. The Etiology of the condition. There is undoubtedly a strong hereditary element in very many cases and yet it is absent, as far as I can determine, in both of these. Both belong to thoroughly healthy families with no history of nervous disease of any kind.

But a less remote cause is readily to hand for both. The young lad, as an apprentice-joiner was doing work a pony should have been employed at - drawing barrow loads of a weight far exceeding his powers, but his quiet obdurate temper made him persevere where most boys would have given in. The result was a general weakening of the nervous system with diminished power of the highest cortical centres.

Masturbation was denied and patient's habits were very exemplary but of course the physiological change of puberty may have been an agent in the production of the disorder. There was

no/

no history of any previous weakening illness in his case but in boyhood he had a frequently recurring supra-orbital neuralgia which perhaps may be taken as an indication of an irritable nervous system. This has not troubled him since the other symptoms disappeared.

In the case of the elder patient again, the history of influenza 15 years ago is very suggestive, influenza being notorious as a causative agent in quite a large proportion of functional nervous diseases, and the exhaustion from his attack of acute rheumatism would determine the onset. It would be interesting to speculate how the hiccough really originated - probably some flatulence set up the common transitory condition but the susceptible nerve centres once excited developed the habit which they repeated on the slightest aggravation.

III. I would now refer again to the -
Paroxysmal Manifestations and under this heading, although it certainly seems an unwonted straining of Etymology, I would include -

a. the hysterical sleep, as this, being periodic in occurrence is better classed here than with the more lasting hemiplegic disorders.

The attacks in this case were of the kind where the patient passes from the natural to the hysterical sleep - on no occasion was he ever known to fall asleep suddenly in the middle of doing any work. The duration was only moderately long -
never/

never more than 18 hours, but the degree seemed very profound. Michell Clarke says - "It is rare for consciousness to be completely lost: although the patient cannot speak and makes no sign, (she) is cognizant to a variable degree of what is going on around (her)," but in this instance consciousness was apparently completely absent and patient made no response to auditory stimuli nor had he any recollection afterwards of any attempts to rouse him.

Pulse and respiration were unaffected during sleep although in the "fits" to be referred to again, the respirations assumed a"grunting" character at times. The awaking was as from a natural sleep, whether patient was aroused or awoke spontaneously - there was nothing of the confused, dazed condition so often seen, nor was the process of awaking accomplished gradually as in some cases, with repeated lapses into lethargy.

b. Catalepsy can only be said to have been present in very slight degree, during the last "fit" described, when patient seemed to be standing on his head with his trunk strongly arched backwards. But there was no continuance of the condition as seen in typical catalepsy, nor any excessive rigidity with its succeeding "flexibilitas cerea" when the limbs are so movable as to be capable to being put into most constrained and unnatural positions, so that perhaps it ought to be inferred rather that the unusual position was merely the result of the torsion- movements of the trunk.

c. Somnambulism occurred only once to my knowledge in this

case - when he got up and made to go from his room, returned for more clothing when told to do so, and had no recollection afterwards of the occurrence.

d. The sobbing in the waking state is very characteristic and the twitching seen once or twice during sleep though not so commonly present was also a note-worthy occurrence.

e. The hysterical "fits" coming on during natural sleep have been described in detail already, but I might mention here the valuable help obtained, from a diagnostic point of view, when polyuria was noticed, in one instance immediately after the attack and in another after a few hours.

The question naturally arose whether the fits might be epileptic in character - the nocturnal occurrence, the apparently complete loss of consciousness and absolute lack of remembrance of the event being rather suggestive of the more serious condition; but the polyuria, the absence of any degree of stupor after the fit, and the association of the other symptoms made the diagnosis more easy.

f. The attacks of singultus which formed the only symptom of the second case have also been described in some detail. Referring again to the patient's very original means of relief - smoking through his nostril - it might be suggested that possibly the activity of the centre controlling (or failing to control) the painful spasms could be influenced through the medium of the olfactory nerves: but it seems to me that the explanation already offered is more likely to be correct - the idea that the first attempt/

attempt coincided very fortunately with an already commenced amelioration of the attack and this apparent success led the patient to expect the same relief afterwards.

IV:- We might now review those of the symptoms which might be called, in contradistinction to the last class, the Non-paroxysmal, and, might note to begin with,

(a) the disorders of sensation:-

Like the "fits" already referred to, these did not make their appearance till later on, when we had begun isolation treatment. The anaesthesia, as is quite common, was only partial in degree and patchy in its distribution, the areas being confined to the left side, but all the varieties of sensation were affected - touch, pain, heat, cold and the muscular sense. Some cases resemble syringo-myelia in presenting dissociation of the forms of sensation but not so this patient. The line of demarcation was distinct down the middle of the body, the right side not being affected in the least as regards sensation. There were no hyperaesthetic areas and no "hysterogenic zones".

(b) The motor symptoms were not so decided as the sensory, but from the very onset of the latter there was some slight paresis of the left limbs. Later, however, as already mentioned, it developed in greater degree and persisted so until his cure by hypnotism. There was no muscular wasting, no contractions, spasms or tremors. The gait was never distinctly hemiplegic and the kneejerks were always somewhat exaggerated on both sides.

(c) The disorders of vision were also very characteristic in this case. The most common visual disorder in hysteria is this contraction of the field for certain colours - sometimes associated with amblyopia for some colours, but the latter condition was not present here. The colours affected here, and the relative degree of their limitation were/

were also quite characteristic.

The conjunctival anaesthesia was peculiar, as being the only part of the face affected. There was no spasm of the eyelids, nor any strabismus, no polyopia, micropsia or macropsia.

(d) Hearing was affected later than vision and only in slight degree, the left side again being affected alone. The diminished acuteness was detectable by the ordinary tests but was not sufficient to make the patient himself aware of it.

Suggestion-Therapeutics:-

We might now consider in greater detail the subject of suggestion-therapy which has seemed to be so successful in these two cases.

When we remember that hysteria may be said to depend on some unusual excitability - inherent or hereditary - of the nervous system, with something acting on this predisposed organ either suddenly (as in cases due to mental shock) or protractedly (as after wasting diseases), in such a way as to upset the balance of the highest functions, as for example those of self-control and self-respect - one is not surprised to find that in some cases the cure is eventually found, not in drugs or tonics, hygiene or dietetics, but in some treatment acting more directly on the patient's mind.

Very many cases are successfully treated along the usual lines of sedative and tonic measures, but in these also we may have to ascribe most of the credit to "suggestion" - the inspired hope and confidence bracing up the delinquent psychic centres, and restoring them to their normal function. How many patients one (we see) sees in the course of our ordinary work, in whose cases we prescribe merely a simple tonic, knowing full well that it matters little what we give - the remedial effect will be produced by the fact that we have been able to inspire confidence and the belief that the medicine will do good!

In many cases of hysteria, the patient's amenability to suggestion is abnormally great, and one needs to be careful in conversation with them. The very interrogation about symptoms not complained of, but sometimes found in like cases, may be sufficient to guarantee their being present at our next visit. It is undoubtedly this increased

suggestibility/

suggestibility that determines the hysterical outbursts of the subjects - any circumstance of the slightest importance - an event which would make little or no impression on a normal brain, is in their case the occasion of quite an upheaval.

But in this very amenability to suggestion lies their hope of salvation, for as I have just stated, whether the treatment is professedly suggestive or not, the element of suggestion plays a great part in most cures. The practitioner uses every opportunity to instil his own optimism into the patient's mind and to remove from the psychic centres of the latter the depression and disorder reigning there. The slightest improvement in the most trivial symptom becomes, in the hands of the judicious attendant, a new source of hope of a general amelioration to the patient; while the studied ignoring of an oft-repeated complaint may lead to its disappearance, the patient learning to discount it when the doctor seems to think it of no importance.

Sometimes it is difficult to know how far it is safe to go with suggestion of this simple kind. It is a great accomplishment to be able to lift from her bed a paraplegic who has not moved her limbs for months, set her on the floor and with satisfactory result bid her walk to the other side of the room, but great would be our discomfiture if our confidence had been misplaced and the attempt failed. Suggestion, in the same hands, would likely be of little use with that patient again. The case must be studied with care before embarking on the attempt. Quite apart from an incomplete gaining of the patient's trust, some mechanical secondary condition may exist to spoil the result, for example/

ample contractures or wasting of muscles as a result of long-continued mal-position.

Hypnotic suggestion:-

But to be successful in the most obstinate cases of hysteria, suggestion-therapy musy be conducted in a more advanced style. Treatment by hypnotic suggestion aims at securing to the healthy-minded operator a still greater control than has been spoken of above, over the subject of the diseased condition, and a greater control than could be possible with the subject in the normal waking state. This mode of treatment is still in all countries looked upon with suspicion by a certain proportion of the members of the profession and the public, and certainly, considering the nature of it, (one mind being allowed for the time being such an unwonted supremacy over the other), it should be resorted to only when all other means have failed. But if its practice can be restricted to qualified medical men, it seems to me to be a branch of our science which could with profit be much more earnestly cultivated. Unfortunately the knowledge that most people have of hyponotism has come from the public entertainer; but when one reads of the work of Liebault, Bernheim, Wetterstrand, Moll and Berillon on the Continent, and of Milne Bramwell, Lloyd Tuckey and others in our own country, one becomes convinced that we have here a remedial measure which it is not fair to keep our unimproved patients in ignorance of.

Principles:-

The principle underlying the treatment may be thus roughly defined; It is assumed that all the functions of the body are regulated by "psychic/

"psychic centres" in the brain: that in hysteria we have these highest centres disordered: that naturally, and in the condition known as the hypnotic state, to a greater extent than naturally, these centres are capable of responding to suggestion from another brain: and that if this suggestion be towards order and restoration of function, the subject may be cured thereby.

ProfessorMorselli of Geneva holds that "every mental state and every act of intelligence has its centrifugal equivalent .....
The mental functions act as supreme and constant regulators of all the nervous processes, even of those which are purely automatic and are not attended with consciousness. Though they are withdrawn from the direct influence of psychic activity, they are nevertheless dependent on it".

ProfessorBernheim of Nancy goes further in his theory and contends that "the brain controls all the organs and every function, and each part of the organism has its ultimate representation in a brain cell which is its primum novens. Each movement is realized by a cortical motor centre and each tactile, visceral and muscular sensation by a cortical sensory cell". And he goes on further to state that all the organs and functions are subordinate to psychic states, by determining which we can influence function.

In support of the contention that even the reflexes are subject to cortical cells may be mentioned Sir T. Lauder Brunton's reported case of erysipelas spreading intracranially. The reflexes were lost early and post-mortem, degeneration changes in the cortex were found. Mercier and other writers on insanity have also shown the influence of/

of cortical degeneration on the general nutrition.

Whether or not it may yet be proved that hysteria is due to actual degeneration of these regulative cortical cells, it seems to be accepted that some "disorder" of them is always present, and the possibility of cure in most cases - and such speedy cure - certainly seems to indicate a mere disorder - commonly called "functional".

Granting that this is the true explanation, we can understand how the hope of cure lies in some means of reducing to a state of order these regulating centres. In the more simple suggestive methods referred to above, this is accomplished merely by the over-influencing of a stronger mind, the subject being in the normal waking state, but in the more obstinate cases, sufficient power over the patient's psychic centres can only be obtained by putting him in the hypnotic state.

The hypnotic state:-

When we proceed to attempt some explanation of hypnosis we find ourselves in deep waters and in danger of sinking in a sea of unconfirmed theories: and yet may not as much be said of any pretence at explaining the ultimate action of many of the drugs we use every day, just because we have abundantly proved empirically their real value?

The hypnotic state has much in common with some natural conditions - sleep, concentration of mind, reverie, and intoxication with alcohol and some other drugs, but its phenomena differ materially from them all.

The theories explanatory of sleep have been used also to elucidate hypnotism but carry us only a little way towards understanding it.

The "chemical" theory which makes sleep an auto-narcosis of the cortical/

cortical cells from the accumulated products of nerve-energy may seem to be supported by Braid's system of hypnosis where the subject's eyes are concentrated on one object till exhaustion of the visual centre is produced, and presumably spreads to the other cortical centres; but it is well known that after a person has been hypnotized several times he is generally so easily and quickly influenced again that the idea of exhaustion of any centre can scarcely be entertained.

The "inhibition" theory which explains sleep by saying that the highest cortical centres are inhibited or put out of action by some influence proceeding from the medulla would better explain these latter and also all cases in whom hypnotism is induced by Bernheim's method, in which no exhaustion is aimed at, but the operator's monotonous speaking, with direct verbal suggestion of drowsiness and gentle soothing movements, all conduce to the onset of sleep.

The "anaemic" theory so largely held may be considered as a modification of the "inhibition" theory, the inhibitive influence from the medulla producing its effect on functional activity by limiting the blood supply.

The suggestibility of the subject during hypnosis distinguishes this state entirely from that of sleep and yet the two conditions have so much in common that the hypnotic state may pass into the natural sleep and vice versa. In hypnosis consciousness is not usually completely lost - both of my cases aver that each time they were hypnotized they were conscious of all the operator said and did, and still remember it, but that they had no power to withstand his suggestions. The complete loss of consciousness is a more advanced state to which it is/

is not as a rule necessary to carry the treatment. Memory depends on vivid consciousness and patients remember the suggestions made to them if the degree of hypnosis has not been deep.

The whole matter seems to hang on some power the operator finds it possible to gain over the psychic centres which control all the functions of the body. Some speak as if these centres were inhibited completely, the hypnotist substituting his own will for them and assuming their function; but in many cases, as for instance in the treatment of dipsomaniacs, the suggestions made are towards the increase of moral courage and self-control, and surely these must be situated in the very highest centres, so that there the process would seem to be one of "influencing towards order" rather than "inhibition of function". As regards the duration of treatment, that must depend on the length of time the condition has existed. If the psychic centres have been long habituated to a disordered condition, the process of restoring them, - opening up the proper paths of association and obliterating the vicious - must of necessity be a slow one. The speedy response of my first case to the treatment was doubtless due to the fact that although the primary symptom had lasted more or less for 18 months the later developments were only of a few months' standing. The slower progress of the second case was to be expected considering the fact that he has suffered from his hiccough for six years.

In the meantime, although fair progress is being made in the practice of hypnotism for therapeutic purposes, we have almost everything to learn about the real mode of action. But yet the discovery of the true rationale may more likely come through observation of its empirical use, and the latter is surely justified by its results.

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