PATRICK (H.T.)

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Apparently there is no disease of the nervous system that has fewer terrors for the diagnostician, be he specialist or general practitioner, than hysteria. In the presence of this functional Proteus we are prone to feel a confidence that we could not assume toward even the simpler of the organic affections; but unfortunately a wide and accurate knowledge of hysteria not only "involves a knowledge of the diagnostic symptoms of almost every other disease of the nervous system," † but of many affections not falling within this category, and I think I have seen more straightforward mistakes in diagnosis made in connection with this disease than with any other nervous affection. It might appear to many a work of supererogation to seriously consider the differential diagnosis between hysteria and brain tumor or abscess, between hysteria and acute meningitis or myelitis, between hysteria and angina pectoris, hysteria

* Read before the Mississippi Valley Medical Association at its twenty-first annual meeting.

† Gowers. *Dis. of the Nerv. Syst.*, vol. ii, p. 1019.

and articular rheumatism, cancer of the stomach, Jacksonian epilepsy or tetanus, and yet the most astute diagnosticians have made mistakes in just such cases. It seems unnecessary to insist that occasionally a positive diagnosis is not only exceedingly difficult but absolutely impossible in the present state of our knowledge.

It will be appreciated that in a concise paper, such as this must be, some statements are unavoidably a trifle more dogmatic than a scrupulous exactitude would warrant; nor would it be feasible to attempt a systematic or full treatment of the subject, as that would necessarily embrace a consideration of the diagnosis of an almost interminable multiplicity of medical and surgical diseases. The aim shall be simply to call attention to a few discrete points which seem to merit a wider dissemination or a more respectful attention.

In any consideration of the clinical aspect of hysteria it is well to bear in mind that we have to do with a *disease* —a morbid entity. It seems necessary to occasionally reaffirm the truism that the symptoms of hysteria are real; that an hysterical paralysis is as truly paralysis as that due to cerebral hæmorrhage; that an hysterical anæsthesia is as genuine as that due to division of a nerve trunk, and that a patient may suffer as acutely from hysterical pain as from that due to inflammation. It is not only unjust to the patient and, incidentally, most inimical to therapeutic success to call the symptoms "all imagination," but it is in the highest degree unscientific and inaccurate. There is, too, a tendency, which the facts do not warrant, to consider all symptoms of hysteria to a greater or less degree as simply simulation on the part of the patient. For this reason, although it is convenient to speak of "the simulation of organic disease by hysteria," I prefer to speak of a "similarity of symptoms," or to use some other like phrase, even

though it is not so concise as the word "simulation," which is apt to perpetuate a misapprehension in some minds. Furthermore, in saying that hysteria simulates such and such a disease, we seem to say that it assumes characters that do not properly belong to it; whereas, the symptoms in question—for instance, ataxia, contracture, paraplegia—belong quite as properly to the symptom-complex of hysteria as to the other disease said to be simulated.

A few medical men seem to still cling to the fallacy that the severer—what have been called the more typical—cases of hysteria are practically confined to France. It is probably true that they are more abundant there; but even superficial observation will show that they are far from rare in other European countries and in the United States, and a reasonably careful perusal of the literature will confirm this conclusion. They are certainly sufficiently frequent here to make it incumbent on every practitioner to have a working knowledge of such cases.

Another point worth remembering is that no age beyond infancy is exempt. I have seen a girl of nine with typical hysterical attacks occurring in the initial stage of acute pleurisy with effusion and a child of five with hysterical paresis of the arms following rheumatism. I have now under observation a young girl of fourteen who had a complete and persistent hysterical hemiplegia, and I saw some time since a girl of twelve with typical hysterical polyarthralgia. Lannelongue and Joffroy have reported similar cases in children of six and eleven years. Clopatt * collected two hundred and seventy-two cases of hysteria in children under the age of sixteen, and of these one hundred and seventy-one began under the age of twelve and twenty under the age of three years. Hysteria in children is much the same as in adults, but a few peculiarities are worthy of

* *Études sur l'hystérie infantile*, Helsingfors, 1888.

mention. Of the sensory disturbances children are more apt to exhibit hyperæsthesia than are adults, and the disease is more frequently monosymptomatic. This latter statement applies especially to motor troubles—paralysis, paresis, contracture, etc.—which more often occur without the accompanying anæsthesia generally found in adults.* In the child, too, we may have simple delirium without convulsions or stigmata as the only manifestation of the neurosis, † and closely allied to this state is hysterical somnambulism.‡ It is almost exclusively children who have presented the combination of symptoms called hysterical pseudo-meningitis, which may very closely resemble cerebro-spinal meningitis, but I have seen one striking case in an adult.

Although it was shown generations ago that the uterus had nothing to do with this disease named after it, virile hysteria is often considered to be a rarity. This is a mistake, although statistics as to the relative frequency of hysteria in the two sexes vary enormously. During seven years of general practice I happened to see more cases of hysteria in men than in women. Since then (four years) I have seen many more in women, but I do not know the proportion.# Marie found among those applying for admission to the hospitals of Paris severe hysteria more frequent in men, the mild form more frequent in women.‖

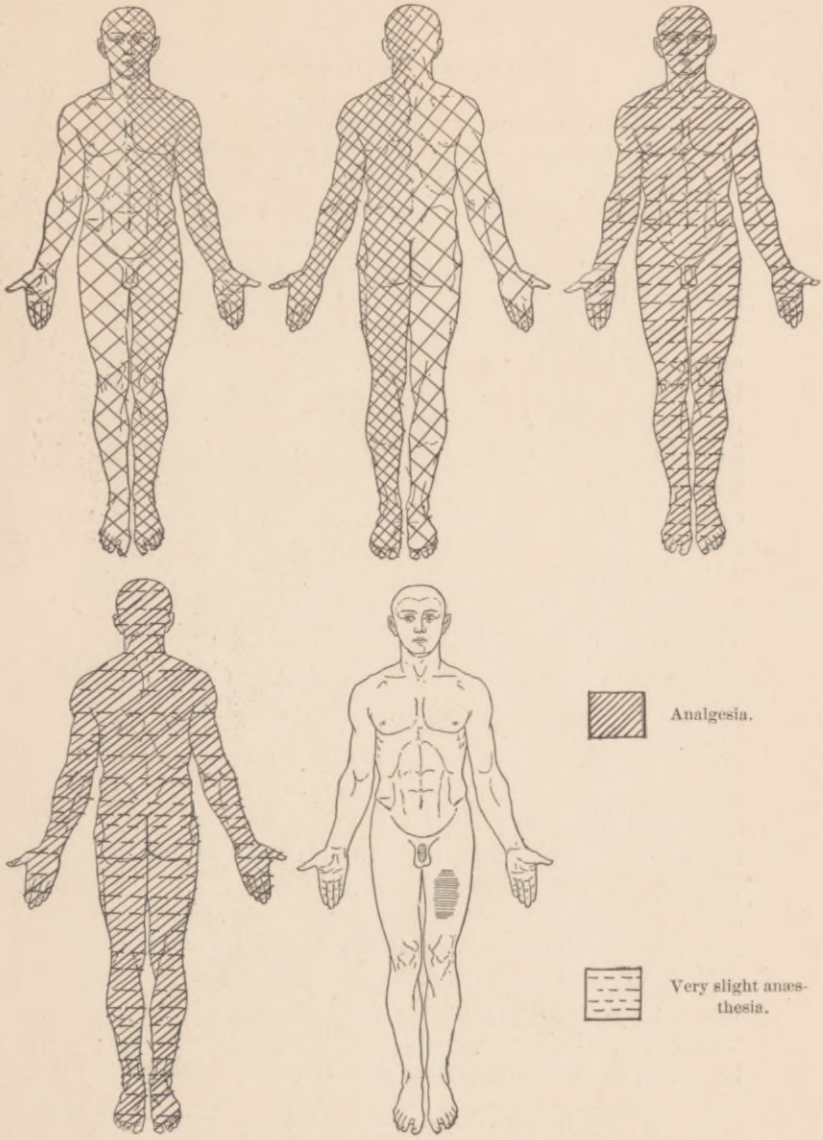
* Riegel. *Zeit. für klin. Med.*, 1883, p. 453.—Huchard. *Thèse de Paris*, 1881.

† Charcot. *Leçons du mardi*, 1887–'88, p. 127.

‡ Although somnambulism is sometimes hysterical, Gilles de la Tourette certainly goes to extremes when he asserts that all cases not epileptic are of hysterical origin.

It is a peculiar fact that almost identical cases occurring in men and women are called hypochondria, neurasthenia, or nervousness in the former and hysteria in the latter.

‖ *Prog. méd.*, July 27, 1889.



FIGS. 1 to 5 are taken from the same person, who had hysterical paralysis of the left leg. When first examined he exhibited, as indicated in Figs. 1 and 2, a well-marked generalized anæsthesia and analgesia which was more

pronounced on the left side. After a few days of treatment the anæsthesia had nearly disappeared, the analgesia persisting, as shown in Figs. 3 and 4. There was still some difference between the two sides, which is not indicated in the cut. After six months there remained only anæsthesia of the penis (and urethra) and of a patch on the front of the left thigh, Fig. 5.

My friend Dr. Souques * found in a general hospital service (Broussais) among four hundred and forty-one male and two hundred and forty female patients, twenty-six cases of hysteria in men and six in women. That is, hysteria was more than twice as frequent in men. Leuch,† reporting eighteen cases of hysteria in men from the service of Eichhorst in Zürich, found the proportion of men to women as one to six and a half. The eighteen cases occurred in a total of 5,234 hospital patients; that is, constituted 0·34 per cent. of the whole number of cases. Gilles de la Tourette says the proportion is about one to three, but some observers put it as low as one to twenty or thirty. This much is certain: that if physicians were more generally on the lookout for the affection in men, more cases would be discovered. One of the manifestations particularly frequent in men is arthralgia, probably on account of the relative frequency of the commonest ætiological factor, traumatism. Hysteria in men is more frequently monosymptomatic, is more persistent, preserves more uniformly the same form, and is more refractory to treatment than in women; the patients are oftener depressed and melancholic. Although, as stated, monosymptomatic hysteria is relatively more frequent in children and men, I would venture to call attention to the fact that it is far from rare in women; convulsions, paralysis, contracture, poor vision, tremor, polyuria, etc., existing quite alone. Indeed, this has seemed to me to be rather more frequent on this side

* *Arch. gén. de méd.*, August, 1890.

† *Deutsche Zeit. f. Nerv.*, Bd. i, p. 506.

of the Atlantic than with our continental brethren. Not only may concomitant symptoms and hysterical stigmata be absent, but the so-called "hysterical disposition" or "hysterical tendency" may be entirely wanting. One might almost make the paradoxical statement that pronounced hysteria may occur in an individual not in the least "hysterical." Manifest loss of will power and self-control, with unbridled impulsiveness (diminished inhibition), are classical; the physician, as a rule, expects to find excessive demands for attention and sympathy and great sensitiveness to annoyance. If these conditions are not found he is apt to decide at once against the presence of hysteria. True, they are often prominent, but they are far from being a *sine qua non* of the affection. With the kind permission of M. Déjerine I examined at the Bicêtre a man, aged sixty years, with hysterical monoplegia brachialis who, except that this was his third attack, had never shown other signs of hysteria. I examined one afternoon in the private hospital of Professor Mendel two cases of hysterical monoplegia of traumatic origin—one in a man over sixty years, the other in a robust young butcher, aged about thirty years, neither of whom had ever shown, as far as could be learned, the least indication of hysteria. The patient from whom Figs. 1 to 5 were made had given no signs of an hysterical tendency up to the time of the onset of the present trouble (when he was thirty-one years old), and even since he has not been at all "hysterical" in the ordinarily accepted sense of the word. I saw recently a young woman, twenty-two years old, with severe hysterical convulsions and paresis, anorexia, and emaciation, who was apparently absolutely normal until the sudden onset, seven weeks before I saw her, occasioned by great mental shock. These cases are mentioned simply as illustrations, not because of their rarity or peculiar characters.

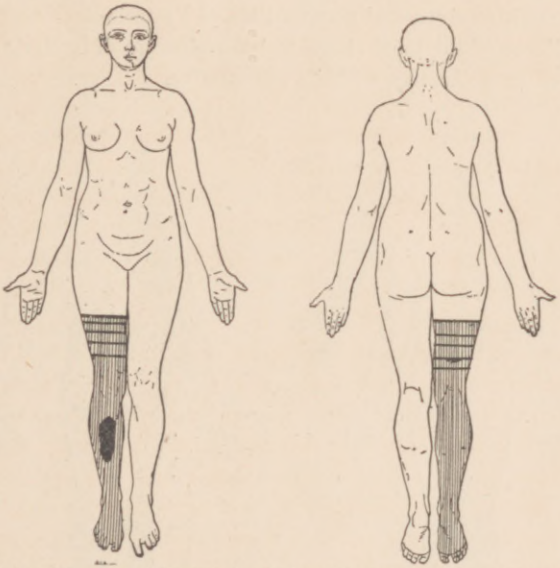
The sudden appearance, fluctuating character, and instability of hysterical symptoms, their sudden disappearance from slight causes, and the palpable influence of observation and of deep mental impression are diagnostically so important that they seem to have taken complete possession of the medical mind to the exclusion of other equally important considerations. A gradual development of symptoms, with stability and long persistence of the condition, does not militate against hysteria. As a corollary to this proposition it may be stated that hysteria may be observed in persons advanced in years, although initial symptoms after the age of fifty are rare. It is a mistake to suppose that an hysterical affection from injury or mental shock must come on suddenly. It is true that the *onset* may be sudden, although it is not necessarily so, but the development is gradual, and probably due to the growth of a subconscious imperative conception (*idée fixe*). The history of numerous shrines, of the "faith cure," and of the host of nostrums, as well as of legitimate medicine, would furnish abundant examples of long-enduring and stable hysteria. I might cite the following: Harlan * has reported a case of hysterical blindness in a healthy man, which existed unchanged for ten years. Charcot had a case of hysteria under constant observation for more than thirty years, and the patient still preserved his hemianæsthesia at the age of seventy-five. In another case an hysterical hemianæsthesia persisted for over forty years, and the negative result of the autopsy confirmed the diagnosis †. I saw in Mendel's Poliklinik a man with an hysterical paraplegia which he had had since 1867, a period of twenty-six years. At the Bicêtre I examined a patient with an hysterical paraplegia of fifteen

* *Medical News*, January 11, 1890.

† Gilles de la Tourette. *Traité de l'hystérie*, etc., vol. i, p. 202. Paris, 1891.

years' duration, and another with hemiplegia of like origin of nineteen years' standing.

Gowers,* speaking of the diagnosis of hysteria, says: "The first and most important consideration is the absence of any unequivocal symptom of organic disease"; but the presence of unequivocal symptoms of hysteria would seem



FIGS. 6 and 7.—Case of hysterical pain simulating sciatica and anterior crura neuralgia. Moderate and varying hyperæsthesia, always with sharp borders. The heavy lines indicate the shifting of the border and the black spot an area of hyperæsthesia more intense and constant than the other. It also had well-defined margins.

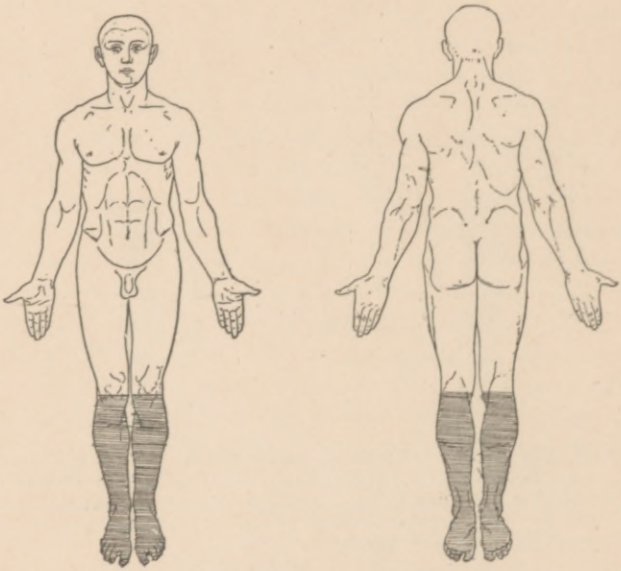
(to me) to be of at least equal importance, for the presence of organic disease does not in the least exclude hysteria any more than the presence of hysteria excludes organic

* *Diseases of the Nervous System*, vol. ii, p. 1019.

disease. One would scarcely say that in the diagnosis of multiple sclerosis the first consideration is the absence of positive signs of hysteria, although either disease may closely imitate the other, and they are not rarely coexistent. Indeed, the combination of hysteria and organic disease in the same patient is of daily occurrence.

I would beg leave, then, to call attention to a few of the positive signs and peculiarities of hysteria.

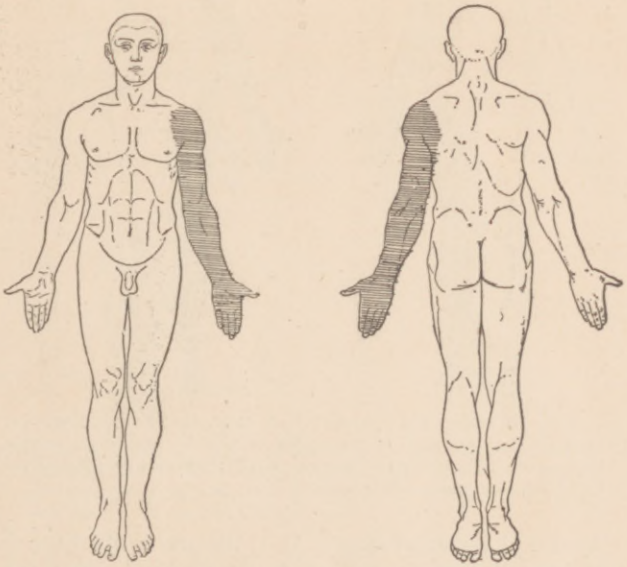
Some of the most characteristic stigmata of hysteria are found in connection with its anæsthesiæ.



FIGS. 8 and 9.—Case of hysterical paraplegia following a slight traumatism. "Stocking anæsthesia" reaching to the knee. Clean-cut border.

In distribution these affect psychic rather than nervous territories—that is, anæsthesia in hysteria is not limited to

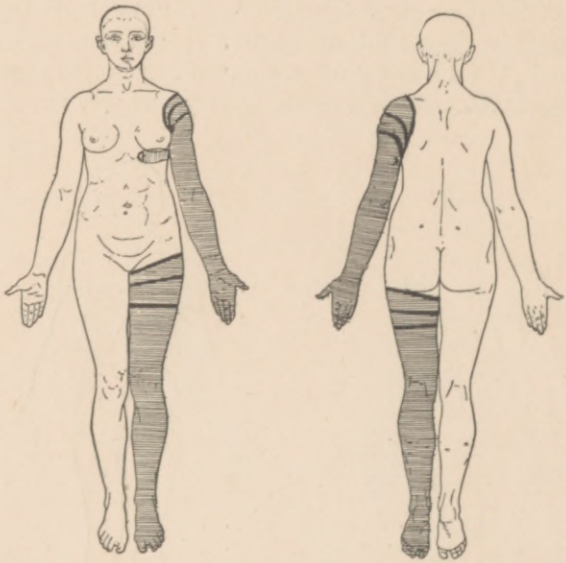
the distribution of a certain nerve, or to the area corresponding to certain spinal segments or trunks of a nerve plexus. When of an extremity, it assumes with wonderful uniformity the "glove," "sleeve," or "stocking" type. We occasionally see this distribution spoken of as pathognomonic, but this is a gross error, as it may occur in locomotor ataxia, multiple neuritis, leprosy, and very rarely in



FIGS. 10 and 11.—Hysterical paresis of left arm following an incomplete sleep-palsy. Characteristic "sleeve" form of anæsthesia, with abrupt border and not corresponding to nerve distribution.

syringomyelia and limited lesions of the cerebral cortex. But there is a distinguishing trait that will ordinarily differentiate the one from the other without the aid of other signs. The border of the hysterical anæsthesia is sharply

defined, while that due to the organic diseases named shades off gradually into the normal. This applies almost equally



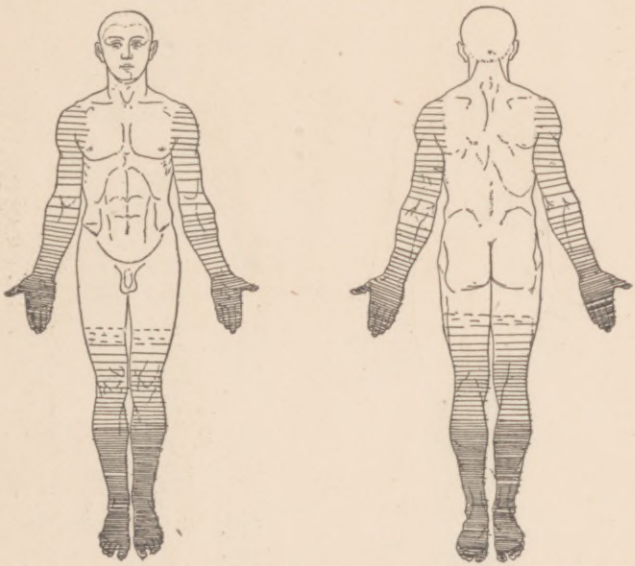
FIGS. 12 and 13.—Hysterical hemiplegia with most exquisite hyperæsthesia. Although the hyperæsthesia was so intense and the limits were sharply marked, the shifting of these limits could be demonstrated during the examination, as indicated by the heavy lines.

to hysterical hyperæsthesiæ. It is illustrated by Figs. 5 to 17.

The distribution in a band around the limb is pathognomonic of hysteria. It generally occurs in connection with hysterical joint disease.

Another peculiar distribution of hysterical anæsthesia is that in disseminated patches and irregular areas, again without any relation to the nerve supply. This disseminated arrangement is also occasionally found in tabes (Figs.

18 and 19),* syringomyelia, beri-beri, alcohol and lead poisoning, and perhaps in multiple sclerosis and dementia paralytica. But here again the law of sharp borders holds



FIGS. 14 and 15.—Case of severe multiple neuritis. The anæsthesia was marked, gradually diminishing in degree from the extremities of the limbs toward the trunk, where it imperceptibly passed into the normal, but its extent was constant; there was no shifting.

good, and, furthermore, as in the first-mentioned cases, the hysterical anæsthesia is apt to be much more complete than that due to the organic affections. These patches are, perhaps, most frequent on the forearms and in the mammary

* I examined this case in the service of Professor Gowers at the National Hospital for the Paralyzed and Epileptic, and I am indebted to him for permission to publish it. The borders of the anæsthetic areas were not so sharply defined as indicated in the figures.

and submammary regions, but their location is often determined by the ætiology, or the seat of the concomitant

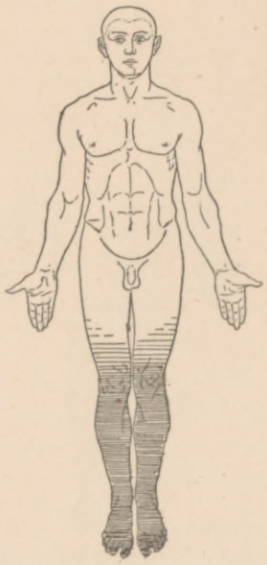
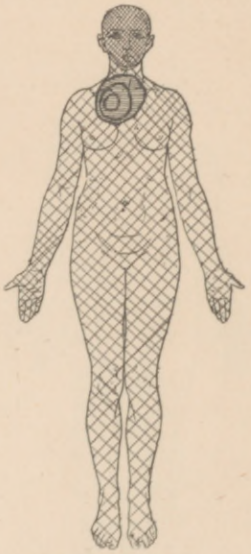


FIG. 16.—Alcoholic neuritis, moderate in degree, of the lower extremities. Approximately a "stocking" anæsthesia, but it shades off gradually into the normal, and the borders, though ill defined, are constant.



Intense hyperæsthesia.

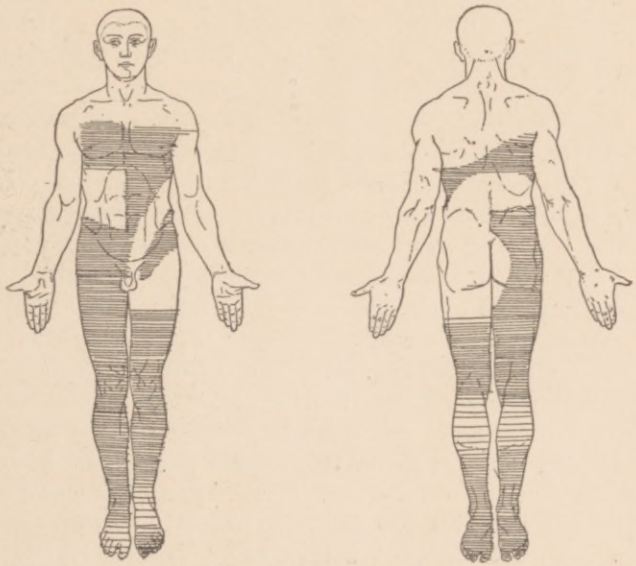
Distinct hyperæsthesia.

Anæsthesia.

FIG. 17.—Severe hysteria, simulating cerebro-spinal meningitis. Amaurosis. The heavy circular lines are intended to show how the patch of anæsthesia grew during the first examination.

paralysis. Above all, it is to be remembered that they must be sought for. As a rule, the patient is entirely un-

conscious of their presence until discovered by the examiner, or by himself accidentally. This applies equally to the most extensive and absolute anæsthesia. To discover the patch of anæsthesia indicated in Fig. 17 required a careful and prolonged search.



FIGS. 18 and 19.—Case of locomotor ataxia with rather unusual distribution of anæsthesia.

Another peculiarity which I consider of extreme diagnostic importance, but which I have never seen emphasized, is the mobility of the line of demarcation between the anæsthetic and normal surfaces. The variability in extent and intensity of hysterical anæsthesia has long been recognized, and Figs. 1 to 5, taken from a patient kindly referred to me by Dr. E. M. Smith, may serve as an illustration. But I allude now to a shiftiness of the borders that

can be demonstrated during the same examination. If the observer start on the normal skin (the patient's eyes, of course, being closed) with the finger, a camel's-hair brush, or a pinhead, in testing for anæsthesia, and a pin point in testing for analgesia, and approach the anæsthetic area in steps of about a quarter to three quarters of an inch every one half to three quarters of a second, he will suddenly reach a point where the object is not felt, or is felt with decidedly less distinctness, according to the degree of sen sory blunting. This point is then accurately defined and marked. For this a very soft, colored pencil is best. Ink and tincture of iodine are not well adapted for this purpose, because the evaporation may cause a persisting sensa tion which interferes with the result of the examination. For the same reason a hard pencil is not to be used. An ordinary lead pencil may be employed, if the lead is first rubbed over some rough surface, so that a mark can be ma le with very slight pressure. In the same way the examination is continued until the border of the anæsthetic (or hyperæsthetic) area is carefully outlined. The examiner's attention is then directed to other regions—the heart, eyes, other extremities, etc.—for a few minutes, the patient in the meantime not being allowed to inspect the outlined boundary, when the same process is repeated. It will then generally be found, if the case is hysterical, that the border has shifted more or less—one half to four inches.

This sign I consider to be pathognomonic of hysteria, or at least of functional disease. It applies to areas of hyperæsthesia as well as to anæsthesia. In Figs. 6, 7, 12, 13, and 17 the heavy lines are designed to indicate not only the rule of this mobility, but that which actually occurred during the examination of each case. In the cases illustrated by Figs. 8, 9, 10, and 11 the sharp border was dem-

onstrated, but the shifting was not especially examined for, and hence is not indicated in the diagrams.

There is another sign which, malingering being excluded, is pathognomonic of hysterical anæsthesia, when it can be elicited. This is getting the patient to designate when the anæsthetic area is touched. The manœuvre requires a little tact, but can, not infrequently, be managed. The patient's eyes being closed, he is told to say "Yes" promptly whenever he is touched. He is first drilled by rapidly touching the normal surfaces a number of times, and then the anæsthetic surface is touched. Asked if he did not feel that, he naturally says "No." The procedure is repeated a number of times; first, the normal, then the anæsthetic, areas being touched, and to the same question he uniformly answers "No." Finally, he is told hurriedly and rather impatiently, "Well, if you don't feel it, say 'No,'" and the process is quickly repeated, when the patient will not rarely say "No" as promptly when the anæsthetic surface is touched as he says "Yes" for the normal parts. Without going into a discussion of how and why, which would be out of place in this paper, I wish emphatically to say that "catching" a patient in this way is not necessarily evidence of simulation. In other words, we make the response automatic.

And here we touch another striking and almost pathognomonic peculiarity of hysterical anæsthesia. It does not ordinarily affect the reflex and automatic actions. A patient will take a pen in a completely anæsthetic hand, adjust it properly, and write. I saw in Jolly's wards in Berlin a man with complete anæsthesia of the entire mucous membrane of the mouth, and yet he had no difficulty in manipulating the bolus of food. I once examined a woman who had absolute anæsthesia and analgesia of the left arm and hand. In dressing after the examination, she tied a

ribbon beneath her chin and inserted pins in her clothing with the usual feminine dexterity. Through the kindness of M. Déjerine, I examined, at the Bicêtre, a man who was blind from atrophy of the optic nerves, and had in addition an hysterical anæsthesia of the hands. To pass the time and earn a trifle, he busied himself in knitting nets, which he did with great rapidity and accuracy. These acts are guided, of course, solely * by the sense of touch, and would all be impossible in organic anæsthesia. This will be again alluded to in connection with the ocular symptoms of hysteria.

The degree of anæsthesia may sometimes be diminished by concentrating the patient's attention on some other detail than the intensity of the sensory stimulus while requiring him to indicate each stimulus. For example: The man who furnished Figs. 1 to 5 had, as indicated, a general anæsthesia that was much more pronounced on the left side, but was well marked on the right also. His attention was fixed on the difference by a careful comparison of the two sides. I would prick first one side, then the other, sometimes more severely on the right, sometimes on the left, and ask him which he felt the more distinctly. Gradually I diminished the intensity of the pricks to mere touches, his attention being concentrated all the time on noting the difference, when I found he was recognizing a stimulus probably a sixth or an eighth as intense as that originally required to produce a sensation. This manœuvre is really only a variation of the one just described, and every thoughtful observer of tact will soon hit upon similar devices to suit individual cases.

An old hemianæsthesia, very marked, and stopping sharply at the middle line, is pretty sure to be hysterical,

* This is not strictly true, as sense of position, sense of motion, and sense of resistance are all involved.

and if the special senses are affected on the same side there is scarcely room for doubt.

Anæsthesia of the trunk which reaches to the middle line in front and not posteriorly is hysterical.

Anæsthesia dolorosa, that is, anæsthesia in an area affected by severe spontaneous pain, means organic disease.

In hysteria we may have dissociation of sensation of all varieties; even analgesia with hyperæsthesia to touch. Figs. 2 and 3 show the dissociation usually found in syringomyelia—that is, loss of pain sense with preservation of that for touch.

Loss of the muscular sense and the sense of fatigue may also be lost in hysteria as well as in locomotor ataxia. About eighty per cent. of hysterical anæsthseias affect the left side.

I wish to mention but briefly the hysterical hyperæsthesiæ. Perhaps the most frequent of these are the tender spots along the spine. They will be found to be inconstant in position exactly as are the borders of the anæsthetic or hyperæsthetic areas, and this is shown in the same way. In this examination care must be exercised not to press too forcibly or too frequently on the painful points. Light pressure or percussion suffices. A rubber-tipped pencil is a convenient implement for the purpose. If the painful impression made is too intense, the sensation persists and the mobility of the points can not be demonstrated. Too frequent pressure or percussion defeats the object in the same way. Points tender on pressure are particularly frequent to the left of the spinous processes in the cervico-dorsal, mid-dorsal, and dorso-lumbar regions, in the left submammary region, and the so-called ovarian regions. In men, the scrotum or testicle, more usually on the left side, is a frequent seat.

In hysteria we may have a hyperæsthetic zone corre-

sponding to a girdle sensation, with gastric crises, almost exactly as found in some cases of locomotor ataxia, but this hyperæsthetic zone may be at some point hysterogenic. It may be worthy of note that hysterogenic points are sometimes to be found in anæsthetic areas. They are of some practical therapeutic value, for in cases of chronic paralysis, contracture, tremor, and the like, if an hysterical attack can be induced by pressure on one of these points, after the attack has passed the chronic affection will often be found to have disappeared or to be much improved, which may be the first difficult step in a complete cure.

General hyperæsthesia is very rare in hysteria. I have seen one case which was acute and closely imitated cerebro-spinal meningitis (Fig. 17).

Among the hyperæsthesias may be classed hysterical joints, long ago so graphically described by Brodie. These cases are far from rare, and many a patient is confined to bed or limps about with a supposititous "sprain," "chronic rheumatism," "gout," or "flat-foot" which is purely hysterical. Indeed, Brodie* asserted that four fifths of the women of the upper classes, complaining of articular trouble, had an hysterical affection, and Paget has supported this opinion.

The joints most frequently affected are the knee, hip, and ankle, but any articulation may be the seat of this hysterical manifestation. Briquet believed that hysterical arthralgia was never the initial symptom of hysteria, but Charcot showed that it may be the primary manifestation, and I have seen several instances. For the sake of brevity, I shall confine myself to the mention of some of the traits of hysterical coxalgia, as it will serve well as a type of the class. It may present all the prominent symptoms of

* *Lectures Illustrative of Certain Local Nervous Affections*, London, 1837, p. 37

tubercular hip-joint disease: pain, spontaneous and on motion; the same deformity—flexion, adduction, and inward rotation, even to the most extreme degree; fixation of the thigh from muscular rigidity, and pain on percussion over the trochanter. But the hysterical affection is more uniform in its development and progress than is the other. It does not show the free intervals at first and the temporary improvement from use. Although striking forcibly on the sole of the foot or over the trochanter causes pain, it will be found that light percussion with the tip of the finger, quite insufficient to disturb the joint, is also painful, or even slight pinching of the skin or lightest pin-pricks. This superficial hyperæsthesia is one of the distinctive traits of the hysterical joint, but occasionally there is anæsthesia instead. At the knee, ankle, wrist, and elbow, the anæsthesia or hyperæsthesia is prone to take the form of a band about the limb, extending a couple of inches above and below the joint. In the case of the hip joint the area often assumes the shape of a triangle, the apex at the root of the scrotum or mons Veneris, the base over the sacrum. But the tenderness on pressure may be found over the coccyx, lumbar spine, pubes, ischium, or entire limb. The pain is more diffuse than in morbus coxarius, affecting the back, loins, and the extremity as a whole, and the muscular contraction is more apt to affect neighboring articulations. In hysterical hip-joint disease, for instance, the ankle and knee may be as rigid as the hip. A very important negative sign of the hysterical affection is that it does not keep the patient awake at night. Children do not awaken with the sudden start and cry that bear the stamp of organic mischief.

The gait may at once betray the character of the case by showing some inconsistency. It is apt to be peculiar and exaggerated in such a way as to demonstrate clearly

that it does not spare the joint. Indeed, it may be such as to throw unnatural strain upon it. Or the patient in walking will find it impossible to place the limb in a position that is readily assumed in the recumbent posture, or to perform some movement that he can execute against considerable resistance when sitting or lying down. He sometimes walks with a jerky, jumping motion, or shows some of the characteristics of the hysterical paralytic gait presently to be noted. If the patient is anæsthetized, the order of the reappearance of the symptoms on emerging from the narcosis is peculiar. The muscular rigidity and superficial tenderness return before pain on heavy percussion over the trochanter can be elicited. In organic disease of the joint, the deep tenderness returns first. The external appearance is usually normal, although there may be redness, swelling, œdema, or wasting of the muscles.*

The association of an organic and hysterical joint affection has been observed a number of times.

The so-called hysterical "attacks" or "fits" are not considered in this paper, but there is one kind of attack that might be mentioned in connection with hysterical hyperæsthesia, of which the following case is apropos:

About seven years ago I was hastily summoned to a middle aged woman, who had been passing through a period of family trouble of the most harassing kind, combined with severe physical strain. On the way the messenger hurriedly informed me that the woman had been for a number of years the subject of heart disease, that she had had a number of attacks similar to the present one, but they were afraid this

* Gilles de la Tourette et Dutil. *Nouvelle iconog. de la Salpêtrière*, 1889, p. 251.—Ballet. *Soc. méd. des hôpitaux*, June 28, 1889.—Bœckel. *Gaz. méd. de Strasbourg*, 1870.—Charcot. *Lectures on Diseases of the Nervous System*, Sydenham Soc., vol. iii, p. 447.—Babinski. *Arch. de neurol.*, 1886, vol. xii, pp. 1 and 154.

one would carry her off. I found a rather gaunt patient sitting in a chair, greatly agitated and anxious, respiration rapid, rather loud, and gasping. She was by turns tossing the arms about, clutching at her throat, or pressing a hand over the præcordia. She was calling for air, for water, and exclaimed that she would die. Satisfactory auscultation was impossible because of the agitation of the patient and the noisy respiration. I made out some bronchial râles and a rapid pulse. From the actions of the patient and the known psychic influences, I made a diagnosis of hysteria and sent for some simple remedies. But a moment later I noticed the woman gasping in a way that was anything but hysterical, and I had just time to let her easily to the floor as she expired.

In spite of this most egregious error, there is such a thing as hysterical angina pectoris, or, perhaps, I should better say, hysterical pseudo-angina pectoris. I might add that in making this mistake I had the honor of being in good company. Professor Brissaud, of Paris, than whom there is no more astute diagnostician, told me of a case diagnosticated by Charcot, Debove, Potain, and himself as hysterical angina, and the patient died in one of her attacks while in Potain's care. Rigal, cited by Huchard, reported a case in which over two hundred attacks, very intense and accompanied by the characteristic agony and anxiety, occurred within a period of two years.

Hysterical angina occurs more frequently in women under forty, tends to periodicity, to become nocturnal, and the attacks are induced by violent emotion. True angina is more frequent in men beyond the age of forty, the paroxysms are diurnal, not periodical, and are caused by sudden exertion—walking against the wind, uphill, etc. In the former there is often a hyperæsthetic zone around the trunk at the level of the præcordium, but since the investigations of Head regarding referred pain and tenderness in organic

heart disease this area loses some of its diagnostic value. The attack may begin with pain in this hyperæsthetic area or elsewhere—in the testicle, fingers, or toes. This is called the neuralgic type. In the vaso-motor form the face may be pale, cold, livid, or red, and like changes may affect the left arm. The duration of the attacks is from a few minutes to several hours. There is marked erethism of the heart and of the individual. The pulse varies from 90 to 150, may be irregular or intermittent, and the cardiac impulse is apt to be out of all proportion to the force of the pulse—the same as occurs in Graves's disease. The patient is agitated, restless, there is tachypnœa, and the attack may terminate in an hysterical faint or spasmodic laughter and weeping, with the evacuation of a large amount of limpid urine, eructations, or emesis. In the vaso-motor form the ejecta may contain blood. In true angina the pulse may be normal, respiration is generally normal, and the patient remains motionless in speechless agony. In the hysterical affection there is sometimes a mental condition approaching the dream state with visual hallucinations. The pupils may be dilated or contracted. The phrenic nerve seems to be always tender to pressure at the level of the scaleni muscles. An attack may be determined by pressure on a hysterogenic point if any are present. The crucial test would be the quantitative examination of the urine for the inversion of the phosphatic ratio, which Gilles de la Tourette and Cathelineau have found to be present after all hysterical paroxysms. The phosphoric acid is diminished twenty-five per cent., and the ratio of the earthy to the alkaline phosphates is as one to one instead of as one to three, the normal. But the subject is still in its infancy; there are exceptions to all diagnostic rules as yet discovered, and in a given case a positive diagnosis may be impossible.

Haphalgesia, first described by Pitres,* is exclusively a symptom of hysteria, but is infrequent. It "is a variety of paræsthesia characterized by the production of an intensely painful sensation by the simple application on the skin of certain substances which in the normal individual cause only the ordinary sensation of contact." These substances have ordinarily been certain metals.

The motor manifestations of hysteria are countless, and of these the paralyses are as various as those due to organic disease.

Although the general characteristics of hysterical paralysis were well described by Todd thirty-five years ago, and are nearly as distinctive as the general traits of hysterical anæsthesia, a wider knowledge of them seems to be desirable.

In hysterical hemiplegia or hemiparaplegia the gait alone is often a sufficient basis for the diagnosis. There is never the typical mowing gait of the ordinary hemiplegic —the pelvis elevated on the affected side, the leg stiff and swung round in a curve, the toe turned in (or may be out) and catching the floor on the forward swing, and the foot set down flat or slightly on the toe. Neither is there the high step with foot drop of infantile paralysis and multiple neuritis, nor the typical spastic gait—knees approximated, the legs rigid and hitched along with a jerk. The gait *may* be typically ataxic, as will be seen later.

In general, the hysterical gait is a careful one. The steps are small and slow; one foot is dragged after the other or carefully and laboriously shoved a little in advance. There is apt to be a deal of swaying and balancing, a constant threat of falling, like a boy trying to walk a fence, with a tendency to fall toward the observer if he be

* *Leçons sur l'hystérie*, etc., vol. i, p. 65; Binet, *Rev. phil.*, August, 1889.

near. No one group of muscles seems to be much weaker than the others, for hysterical paralysis is never neatly localized. Like the anæsthesia, its area of distribution is psychic rather than nervous. For instance, the flexors of an extremity are never paralyzed to the exclusion of the extensors, or the muscles supplied by the sciatic nerve to the exclusion of those supplied by the anterior crural.

Perhaps the most unmistakable characteristic of the hysterical gait—one that belongs solely to hysterical paralysis—is that the patient walks in such a way as to make

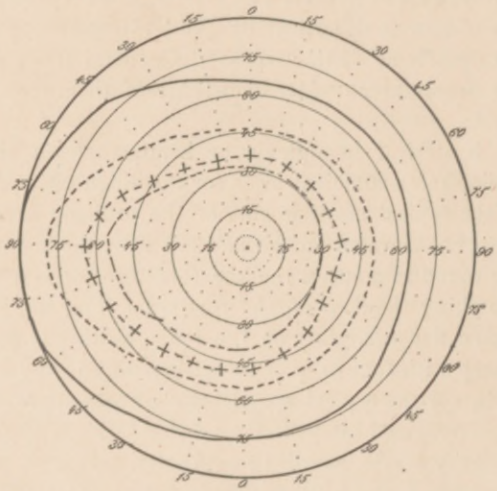


FIG. 20.—Normal fields of vision.
———— = white (form).
— — — — = blue.
— + — + = red.
—— — — = green.

unnecessary demands upon his muscles. He will walk only with the leg in extreme outward rotation, which is a tiresome way to walk, or with the knee flexed almost to a

right angle, which is also far from easy. Some walk on the inner, some on the outer border of the foot. If the paresis is marked, the patient, instead of giving each foot a comparatively quick, short hitch forward, as it were, from the shoulder, will balance and sway and slowly raise the foot to slowly and carefully advance it, all of which requires considerable muscular activity. The young girl before mentioned, with hysterical hemiplegia, on first attempting to go up stairs, first advanced the paretic leg one step and then dragged the normal foot up to it. (In organic hemiplegia the patient invariably steps up with the good leg.) When told to step up first with the normal foot, she had equal if not more difficulty in dragging up the bad leg, a movement depending almost entirely on the action of the normal side. Such *bizarrerie* could be seen only in hysterical paralysis. I once saw a young man with traumatic hysteria who was utterly unable to walk in any way except with a painfully long and measured stride.

In 1888 Blocq fully described what he called astasia-abasia. It had been briefly described by Charcot and Richer five years previously, and was noticed by Briquet nearly forty years ago. The essential feature of this syndrome is that the patient can neither stand nor walk, but can execute all movements of the lower extremities with freedom and strength when lying down. The cases are nearly all hysterical, and the affection should never be considered as a nosological entity, as it is simply the exhibition in a high degree of a common trait of hysterical paralysis.

At the request of Dr. F. Henrotin I examined some months ago a young lady who was thought to have received a heavy electric discharge from a lightning stroke. She had peculiar convulsive attacks, and was, besides, unable to stand or walk. An examination in bed found her able to perform all movements with fair strength, and a positive assurance

and insistance on my part then sufficed to make her walk. A short time since Dr. Edwin R. Bennett brought to me a gentleman who did not walk well, the trouble dating from an accident some time before. He could not raise the foot perfectly, and the toe caught on rugs, the steps, curbstone, etc. Yet in the recumbent posture he executed every movement with normal freedom and strength. That stamped his trouble as functional. Last May Dr. Kreider, of Springfield, asked me to examine a lady with some obscure trouble of the right ankle joint. A number of months before she had met with an accident in which she was greatly frightened and her feet bruised to some extent. In standing or walking the toe was turned directly out; she could not take a step with the foot in any other position, and it was only with great difficulty that I could rotate the leg so as to point the toe forward. But examined in the recumbent position she not only turned the foot and leg in every direction, but executed these movements against considerable resistance. A single application of the cautery with a positive assurance of its immediate effect caused a marked improvement at once—enabled her to walk with the foot in the natural position. I have heard nothing of her since.

In the same general category belong the patients who can not walk but can climb a tree, or "go on all fours," or jump along with both feet together, or hop on one leg. The exact converse of astasia-abasia has been described —that is, the patient can use the lower extremities for absolutely nothing but standing and walking.* Such disability can be nothing but hysterical.

This peculiarity of a muscle being paralyzed for one purpose and not for another is to be utilized in the examination when hysteria is suspected. Especially are automatic actions to be evoked, as these are the least liable to suffer.

In short, we are to proceed much as we would to detect a simulator in some inconsistency.

* Babinski. *Soc. méd. des hôp.*, July 8, 1882.

Walking is sometimes attended with a sudden, quick jerkiness up and down—a sort of saltatory spasm; but it is irregular in rate and amplitude—choreiform in type rather than the regular clonic spasm which is occasionally seen in spastic paraplegia.

A sudden giving way of the knees is frequent in hysteria, rare in organic disease, except locomotor ataxia. It also occurs in exophthalmic goître.

Pitres says that ordinary hemiplegics never use crutches or carry the paretic leg in a sling, while such devices are frequent in hysteria.

A paraplegia or, indeed, any paralysis that shows marked rigidity or contracture within a few days of the onset is hysterical. An old hemiplegia with marked anæsthesia sharply limited by the middle line is hysterical ninety-nine times in a hundred, and if the special senses are affected on the same side the strong probability becomes a practical certainty—a combination of organic hemiplegia with hysteria being excluded.

A striking disparity in the distribution of the paralysis and any concomitant anæsthesia points distinctly to hysteria. For instance, paralysis of an entire extremity, with anæsthesia of the distal half only (Fig. 6)—hemiplegia with anæsthesia of both sides. Fig. 1 illustrates a more striking combination—monoplegia, with general anæsthesia and analgesia. Indeed, any case of marked anæsthesia of the entire body is almost sure to be hysterical.

Paralysis of one arm or of one leg, or of arm and leg on the same side, with well-defined anæsthesia of the same members, is not due to a spinal lesion.

Another aphoristic statement that will hold good in this diagnostic question is that an old paralysis without atrophy or marked changes in the reflexes is hysterical. This does not apply to facial paralysis.

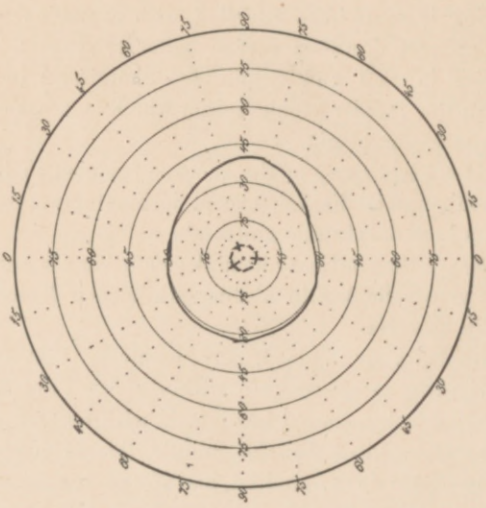


FIG. 22.

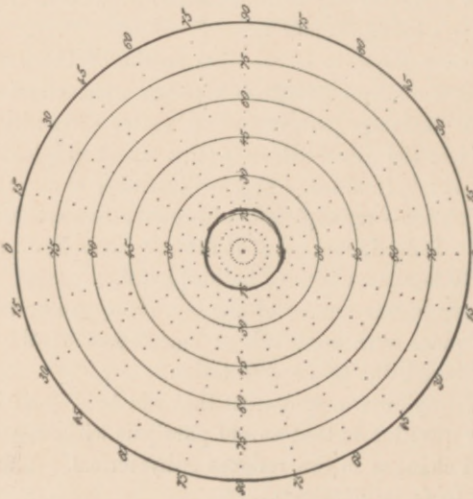


FIG. 21.

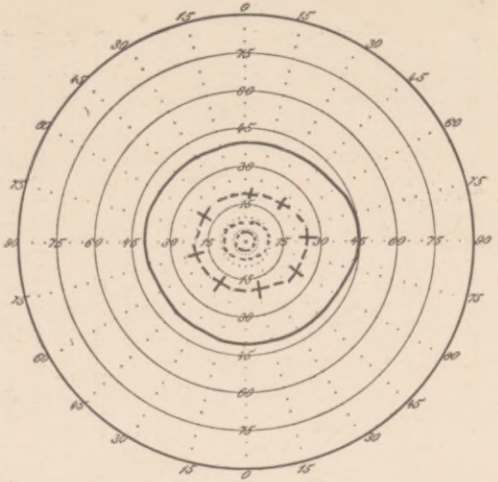


FIG. 23.

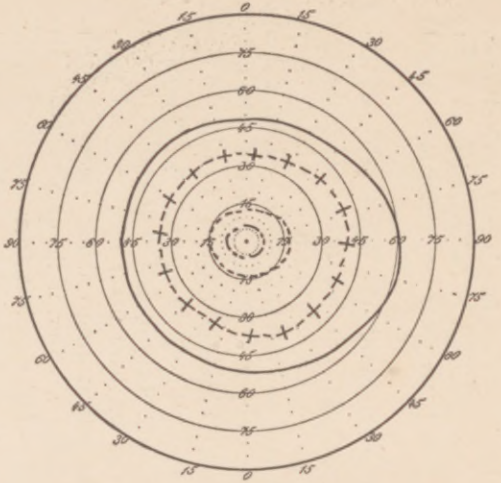


FIG. 24.

FIGS. 21, 22, 23, and 24 are all taken (estimated) at different times from the left eye of a patient with hysterical amblyopia, and show very well the different degrees of contraction of the visual fields, as well as the progressive improvement. At Fig. 21 the color fields are wanting—*i. e.*, the patient was color-blind for blue, red, and green, and the field for white is exceedingly small, almost reduced to central vision. At Fig. 22 the field for white is a little larger and red makes its appearance, but only for central vision. At Fig. 23 the field for white is still larger, there is a distinct field for red, although markedly contracted, and there is recognition of blue and green, the latter for exactly central vision only. Fig. 24 shows the fields all concentrically contracted with marked inversion of the red and blue fields—*i. e.*, the former is distinctly larger than the latter, whereas in the normal order it is smaller.

In hysterical hemiplegia the face is very rarely, if ever, paralyzed. The accompaniment of facial hemispasm is not quite so rare. These latter cases may simulate a crossed paralysis.

In hysterical weakness of the upper extremity the hand, as a rule, does not flex at the wrist whenever the patient attempts to grasp strongly, as it does in so many organic cases. I have seen this but once in hysteria, and in that case the grasp was just as strong with the wrist fully flexed as it was when I held the hand in extension—a circumstance that could not occur in a purely organic paresis.

Another peculiarity of the hysterical grasp that I have repeatedly observed, but have never seen or heard mentioned, is that the patient grasps almost exclusively with the thumb and forefinger. Now, if the observer places his fingers in the hand of the patient from the ulnar side, allowing them to reach no farther than to the metacarpal bone of the index finger, the patient will be found to grasp with the last three fingers, which were before apparently powerless.

One of the classical stigmata of hysteria is the diathesis of contracture, about which considerable was written some ten years ago, but which is now seldom mentioned in the literature, and which, according to my observation, is rarely sought for, even by neurologists. The condition scarcely merits the name of diathesis, and is simply a tendency to develop a transient contracture from slight causes. During its continuance this contracture resembles in every way permanent hysterical contracture. It is evoked in many ways. The patient, after grasping an object firmly, is unable to relax his grasp at once or until the muscles are gently stroked; repeated percussion of the tendons, traction on the fingers, faradization, and other manœuvres have been employed to produce the contracture, but the most

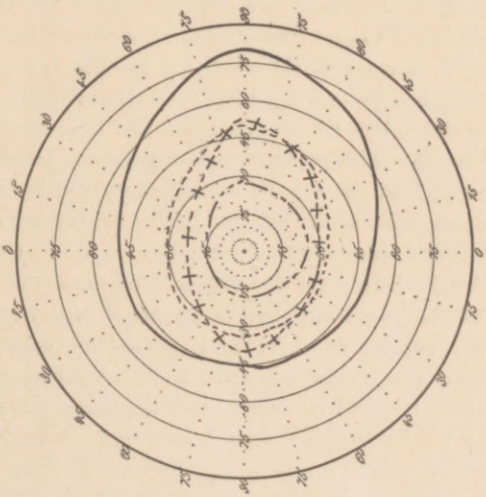


FIG. 24.—Left eye.

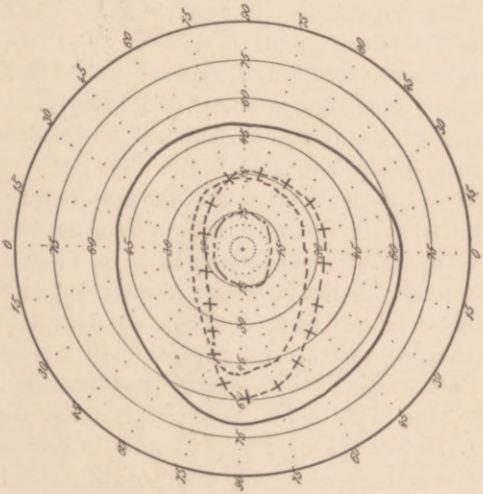


FIG. 25.—Right eye.

generally efficient means is two or three turns of an elastic band or Esmarch bandage about the extremity. Berbez * in this way demonstrated the condition in fifty two out of seventy confirmed hysterics. I have seen the symptom only a very few times, but I must confess that I have not often examined for it. The patient from whom Figs. 12 and 13 were taken (a hemiplegic with extreme hyperæsthesia and rigidity in extension of the affected limbs), on being carried into the hospital, developed a contracture of the right (unaffected) hand which drew the fingers into much the same position as that produced by the spasm of tetany. This contracture, which was very rigid, passed off within an hour, but we can easily realize that, in accordance with what has been taught by Charcot, had the cause persisted, this temporary tonic spasm would have passed on into a permanent hysterical contracture. In other words, the diathesis of contracture is the as yet latent proneness of part or parts of the muscular system to take on this peculiar form of spasm, and if this be artificially produced an objective symptom of hysteria is elicited. The only other diseases to be considered in the diagnosis would be Thomsen's disease, tetany, and ordinary muscular cramp, with possibly some of the occupation cramps—affections which would present but little diagnostic difficulty.

The more permanent contracture is found of all degrees, but in old and very persistent cases it is ordinarily very marked—more pronounced and unyielding than that due to organic nervous disease. Contrary to what we might expect, the latter relaxes more during sleep than does the former, and, as is well known, it is ordinarily somewhat improved after a good night's rest. Bad hysterical contracture persists unabated during sleep, is not relieved thereby, and requires the deepest narcosis to produce relaxation. Contraction of organic origin, on the other hand,

* *Prog. méd.*, October 9, 1886.

does not disappear under an anæsthetic. Exsanguinating an hysterically contractured extremity by the application of an Esmarch bandage will sometimes cause the contracture to disappear, as may also pressure on an hysterogenic zone or painful point, or on any indifferent point coupled with a positive assurance as to the result. These hysterical contractures may produce deformities precisely like those the result of various injuries, and the diagnosis of such cases is the more important as they are peculiarly liable to follow traumatism. Furthermore, as Charcot has shown, the application of bandages to a patient with the diathesis of contracture may serve to develop a permanent contracture that is purely hysterical, but which may be attributed to the injury for which the bandaging was done—for instance, a fracture or dislocation. When this functional contracture (or perhaps it were better called contraction) has existed for a long time, organic changes may take place in the muscular, tendinous, and circumarticular structures which do not yield during anæsthesia and can not be cured by curing the neurosis, but which require operation.* One of the peculiarities of hysterical contracture of the lesser degrees is that it yields to passive motion irregularly by steps or jerks, the tension varying suddenly. Sometimes an attempt to overcome it causes a marked, coarse tremor and occasionally a decided increase in the tension, a contracture of moderate degree suddenly becoming absolute. The degree of contracture is not affected by change of position of the extremity; for example, fingers strongly con-

* Charcot, *Leçons du mardi*, 1888–'89, p. 542; Terrillon, *Nouv. conographie de la Salp.*, vol. i, p. 93. This is the accepted teaching, but I am forced to believe that the organic changes are not due to the hysteria, nor simply to the prolonged contracture, but directly to organic disease (rheumatism, arthritis, traumatism, etc.), which was the exciting cause of the hysterical affection or occurred independent of it. But it is rational to suppose that prolonged fixation might aid materially in the production of ankylosis by this organic affection.

tracted into the palm are not in a measure relaxed by strong flexion of the wrist. These signs are all contrary to what is found in organic contracture. Contracture immediately following a fit is hysterical, as after attacks of idiopathic epilepsy there is a general relaxation and following Jacksonian fits a localized weakness.

It may be a matter of surprise to some that the symptom-complex of hysteria may so closely resemble that of locomotor ataxia as to confuse the diagnostician, but hysterical pseudo-tabes has frequently been observed and described,* and to this category, if not to hypochondria or simulation, are to be referred all the instances of remarkable cure of locomotor ataxia by charlatans and others.† The hysterical affection may present the typical ataxic gait of tabes with marked disturbances of co-ordination, lightning pains, gastric crises, girdle sensation, vesical and rectal trouble, visual difficulties, and loss of the muscular sense. In short, hysteria may duplicate this particular organic disease in all the more prominent motor and sensory symptoms, but the Argyll-Robertson pupil has never been observed, and with three exceptions the knee-jerk has been preserved. In Ferré's case it was temporarily absent, in one of the

* Pitres. *Arch. de neurol.*, 1886, p. 337; *Gaz. méd. de Paris*, September 20, 1890; *Leçons sur l'hyst. et l'hyp.*, Paris, 1891, vol. i, p. 465.—Webb. *Am. Jour. of the Med. Sci.*, 1876, p. 119.—Leval-Picquechef. Des pseudo-tabes. *Thèse de Paris*, 1890.—Lecorché et Talamon. *Études méd. faites à la maison Dubois*, Paris, 1881, p. 550.—Michaut. Contrib. à l'étude de l'hyst. chez l'homme. *Thèse de Paris*, 1890.—Mader. *Wien. med. Presse*, 1885, p. 143.—Souques. Étude des syndromes hyst. simulateurs, etc. *Thèse de Paris*, 1891, p. 129.—Rendu. Accidents hyst. à forme pseudo-tabet. *Jour. de méd. et de chir. prat.*, 1891, p. 513.

† *Arch. de neurol.*, October, 1895, p. 347.—Kowalewski. *Centralbl. für Nerv.*, August 1, 1885.—Rockwell. *N. Y. Med. Jour.*, 1881.—Hurd. *Boston Med. Jour.*, 1877.—Védrène. *Soc. de chir.*, 1878.—Petit. *Annales de Notre Dame de Lourdes*, twenty-second year, parts 8, 9, and 10.

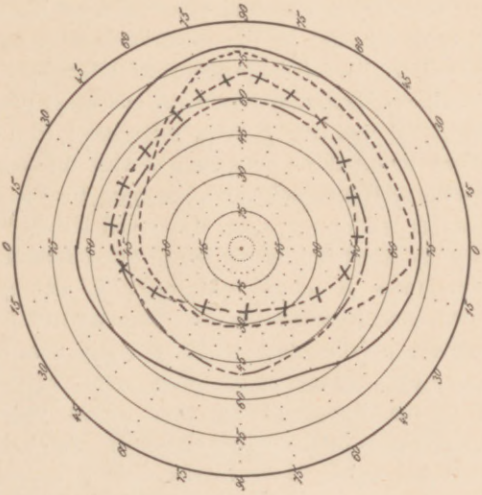


Fig. 28.—Left eye.

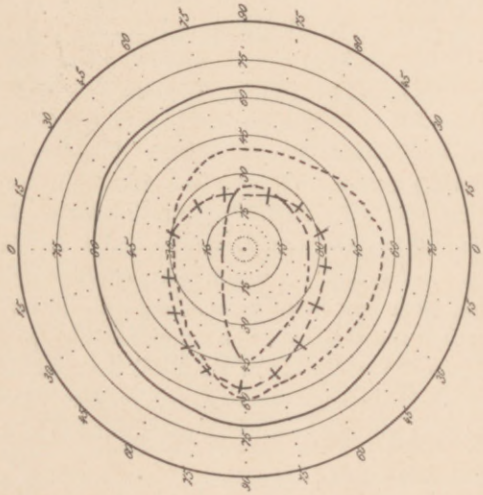


Fig. 27.—Right eye.

cases of Souques (not observed personally by him) it was wanting, as it was also in the remarkable case of Petit, which is said to have been pronounced tabes by Charcot, Ball, Féréol, Sée, Dujardin-Beaumetz, and other prominent physicians, and was cured by a pilgrimage to Lourdes. The patient reported by Souques was also the subject of exophthalmic goître, which might account for the absence of the patellar tendon reflex, as Marie and Maude * find it frequently abolished in this disease.† Of course, the more severe symptoms of tabes—optic atrophy, arthropathies, and spontaneous fractures—make up no part of hysteria, and analgesia of the ulnar trunk, recently described by Biernacke ‡ as a symptom of tabes, would certainly be missing in the hysterical affection unless there were marked anæsthesia of the entire extremity, which does not occur in tabes unless it be in the most advanced stage. The inco-ordination in the hysterical cases may be much more aggravated by closure of the eyes than it is in the tabetic ones, and often the hysterical patient, if he attempt to stand with the eyes closed, will fall invariably in the same direction (not rarely this direction is toward the observer) and as one rigid piece, like a falling pillar, or the acrobats who mount on each other's shoulders and then fall forward together until near the floor. In accordance with what was said regarding astasia-abasia, the inco-ordination of hysteria may disappear under certain conditions; for instance, in the recumbent posture, which would, of course, settle any doubt as to its nature. In *résumé*, we may say that the diagnosis will rest principally upon the absence of the eye symptoms of tabes and the presence of the knee-jerks and of positive evidences of hysteria. Ordinarily the diagnosis will not be difficult if the patient be carefully

* *Brain*, 1894, p. 229.

† This finding, however, does not accord with my experience.

‡ *Neurolog. Centralbl.*, April 1, 1894, and June 15, 1894.

examined, for although hysteria may present some of the prominent symptoms of locomotor ataxia, especially incoordination, the tabetic picture is never complete, and there are present besides symptoms not pertaining to this disease. But it is not to be forgotten that a hystero-tabetic combination is not very rare, the presence of tabes by no means excluding hysteria, nor the neurosis excluding the organic disease.

The following diagnostic table of ocular symptoms is from Charcot:*

	Tabes.	Hysteria.
Motor apparatus of the eye.	Paralysis from lesion of a motor nerve of the eye (bulbar or peripheral; consequent diplopia).	1. Sometimes associated paralysis. 2. Blepharospasm. 3. Monocular diplopia; micropsia and macropsia.
Pupillary disturbances.	Argyll-Robertson pupil.	
Optic disc.	Atrophy.	
Symptoms due to affection of the optic nerve or visual centres.	1. Irregular concentric contraction of the visual fields. 2. *Tabetic* achromatopsia or dyschromatopsia, affecting first green and red, yellow and blue being preserved to the last. 3. Progressive blindness.	1. Regular concentric contraction of the visual fields. 2. Dyschromatopsia from simple contraction of the visual fields for colors. Frequently perception of red alone persists. 3. Transitory amblyopia or amaurosis.

In connection with the special senses and some other highly specialized functions there are important symptoms characteristic of hysteria that, for the sake of brevity, may be presented in a rather conglomerate group. Of these, probably none is more frequent or important than a concentric contraction of the field of vision, especially for colors. Fig. 20 represents average normal fields, although those for colors are not rarely larger than represented. In

* *Leçons du mardi*, 1888–'89, p. 163.

hysteria there may be a simple contraction of all the fields, the order of size remaining unchanged; one or more fields may be contracted, the others remaining normal; there may be concentric contraction with inversion of the color fields; for instance, the field for red may be larger than that for blue, or the color fields may be so contracted that they disappear entirely or in part, constituting partial or complete achromatopsia. When one color only shows a contracted field it is generally green, and red is almost always the last color to disappear. Figs. 22 to 29, taken from cases examined within the last year, illustrate the various kinds of hysterical fields. With a moderate contraction the visual acuity is ordinarily not affected, but when the field is very much reduced for form I have generally found some amblyopia. Instead of a distinct inversion of the color fields an irregular overlapping is often found, as shown in Figs. 25 to 28. Contraction of the visual fields is by no means constant in hysteria, but it is frequent, and may be found in mild cases and in those in which eye symptoms apparently form no part of the expression of the disease. I saw some days ago a case of "weak back" with lumbar pain from supposed "spinal trouble" which showed as stigmata only the shifting of tender points, before spoken of, and a concentric contraction of the visual field for green. A few applications of static electricity with (additional) proper mental treatment relieved all the symptoms, which had been of long duration. A few days later another case was sent to me by Dr. Rumpf, in which the principal complaint was of "fainting spells." Examination showed a distinctly contracted field for green, and search revealed a hysterogenic zone, pressure on which produced one of the aforesaid "spells," which proved to be a typical hysterical attack.

Janet has shown that in hysteria when the visual field is practically normal a contraction may often be induced

by causing the patient to concentrate the attention more strongly on the central fixation point.

The abnormal fields of vision of organic disease very rarely present this regular concentric contraction, but fields

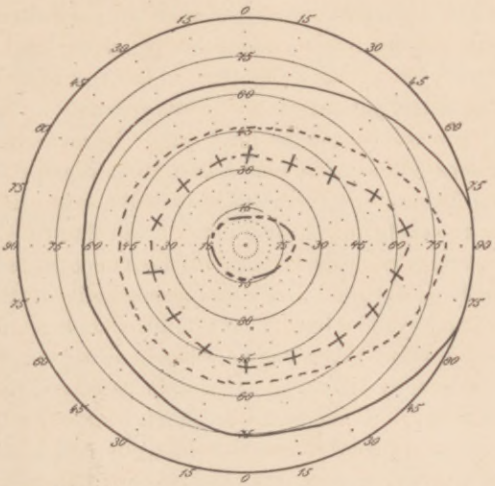


FIG. 29.—The fields for white, blue, and red are normal; that for green is decidedly contracted.

of hemiopic type or an irregular concentric contraction with re-entering angles. Occasionally optic atrophy causes a rather regular contraction of the fields with dyschromatopsia, but there is also markedly impaired central vision; red is among the first colors to disappear instead of the last, and an ophthalmoscopic examination at once reveals the source of the trouble. A regular contraction of the fields has been found after epileptic fits, but it is transient, and continued contraction in epileptic subjects is probably always due to coincident hysteria. Charcot taught that a lesion of the posterior part of the posterior limb of the internal capsule caused, with the hemianæsthesia, a concentric

contraction of the field of vision, but in this he was probably mistaken; at least the instances of such contraction belong to clinical curiosities.

A peculiar characteristic of the contracted field of hysteria is that it does not ordinarily interfere with getting about and customary pursuits. The patient does not collide with objects lying without his visual field but within the normal, the result being that, as in cases of hysterical anæsthesia, the patient is often not aware of his sensory defect; it must be sought for.* This freedom from disability does not occur in contraction from organic disease, although binasal or bitemporal hemianopia may exist without the knowledge of the patient. According to Gilles de la Tourette,† in hysteria with markedly contracted fields and amblyopia there is frequently anæsthesia of the conjunctiva and eyelids, but I have rarely found it. It must be borne in mind that a comparative insensitiveness of the ocular conjunctiva is not at all rare in healthy individuals. (It has seemed to me more frequent on the nasal side.) The head of a pin may often be lightly tapped against the eyeball without causing inconvenience or reflex nictitation. In hysterical amblyopia visual acuity is said to suffer less than luminous perception, while the reverse holds good in optic atrophy, but I have no personal experience regarding this symptom, and think the routine examination for it would scarcely be profitable, although the charts of De Wecker make such an examination easy and probably sufficiently accurate. Hysterical hemianopia and central scotoma have been observed, but are exceedingly rare.

* For ordinary rapid work, when a chart is not prepared, I do not use a perimeter, but simply a pocket color-carrier by means of which the fields for form, blue, red, and green may be estimated with sufficient accuracy in about two minutes. See *New York Med. Journal*, April 27, 1895.

† *Nouv. iconog. de la Salpêtrière*, 1889, p. 107.

Eye symptoms that are met only in hysteria, as a rule in connection with amblyopia and contracted fields, are diplopia or polyopia monocularis, macropsia, and micropsia. They are frequently only to be found by examining at different distances, in different directions, and in different parts of the visual field. An object that is seen single

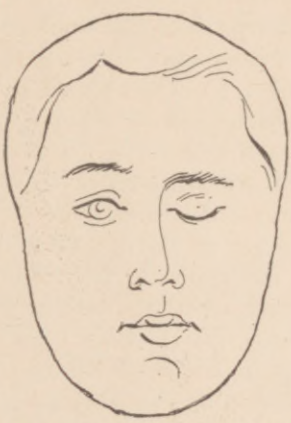


FIG. 30.—Spasmodic ptosis, hysterical.

FIG. 31.—Paralytic ptosis, organic.

at one foot may be seen double or triple at three or five feet; one that appears of normal size at three feet may apparently increase in dimensions as the distance increases. I have examined one case in which a diplopia of the right eye was present only when the patient looked to the right.

Hysterical strabismus is rare, always spasmodic—never paralytic—and not infrequently associated with palpebral spasm. The ordinary tests of the field of fixation and inclination of the images, as well as the administration of chloroform, which relaxes this as it does all hysterical spasm, will serve to distinguish the spasmodic from the paralytic form.

To Parinaud we are indebted for the investigation of

hysterical spasm of accommodation. It may be so pronounced as to make all objects indistinct except at a certain distance. One of his patients, for instance, required convex glasses of two dioptres for reading and concave glasses of the same strength for distance.

There is an hysterical ptosis, aside from the more common hysterical blepharospasm, from which it differs, in my opinion, principally in degree, as it is really spasmodic and not paralytic. It may be painful or non-painful; in the former case apt to be accompanied by hyperæsthesia, and in the latter by anæsthesia. Figs. 30 and 31, taken from Charcot,* show one of the characteristics of the hysterical as distinguished from the organic affection—viz., a depression of the eyebrow corresponding to the drooping lid.

Nystagmus is never a symptom of hysteria, although occasionally a few nystagmoid jerkings may occur in extreme abduction in this as in a number of other nervous affections, and indeed in normal individuals.† I have, however, seen one case in which a spurious nystagmus occurred on convergence, but the movements were jerkier in rhythm and smaller in excursion than true nystagmus—more like tremor.

We are not to forget that a disturbance of vision purely hysterical may be superimposed on organic disease of the eye.‡

Hysterical disturbances referred to the ear are far less frequent than those involving the eye, but hysterical tinnitus and deafness have been repeatedly observed. The latter is unilateral as a rule, and, as in hysterical uniocular amaurosis it can often be demonstrated that the patient

* *Clinique des mal. nerv.*, vol. i, p. 325, Paris, 1892; *Arch. de neurol.*, vol. xxi, p. 338.

† Schultze. Ueber die Friedreich'sche Krankheit, etc. *Deutsche Zeitsch. für Nerv.*, Bd. v, pp. 27 and 103.

‡ Parinaud. *Arch. de neurol.*, 1889, p. 447.

sees with the blind eye,* so in unilateral deafness it may be shown that the patient unconsciously uses the deaf ear; that is, deaf to all ordinary tests. The patient does not carry the head to one side nor instinctively turn the good ear toward the source of sounds. As might be expected, the deafness is as pronounced for bone as for aerial conduction. The possibility of hysterical deafness complicating organic ear disease is not to be lost sight of. †

In addition to the more ordinary hysterical disturbances of the sense of taste, hemiageusia being the most frequent, Lichtwitz‡ has observed a "contraction of the field of taste" analogous to the contraction of the field of vision. Only one or two of the ordinary test substances (sweet, salt, sour, bitter) could be recognized, or they were recognized only on part of the tongue, the posterior third retaining its function the longest. The presence of this symptom must be affirmed with caution, as acuity of taste varies enormously in different individuals.

Hysterical aphonia is caused, as is that of organic disease, by a failure to perfectly approximate the vocal cords. With local disease of the larynx it can scarcely be confused as all subjective and objective signs of inflammation, tumor, etc., are wanting. The exclusion of organic paralysis may be more difficult, but the mode of onset, vacillating course, sudden disappearance, with perhaps sudden relapse, the influence of emotion, the lack of other signs of organic disease, and the presence of those indicative of hysteria, will generally establish the diagnosis. In accordance with what has been said of hysterical paralyses, the

* More strange than this, I have seen one case in which there was absolute achromatopsia of either eye when examined alone, but good recognition of colors when both eyes were used. Such a condition could be nothing but hysteria or simulation.

† Habermann. *Prag. med. Wochensch.*, 1880, Nos. 22, 23, and 24.

‡ Les anes. hyst. des muqueuses et des org. des sens, etc. *Thèse de Bordeaux*, 1887.

subject may be able to sing or cough with a loud voice, or to talk during sleep. The hysterical disability is always bilateral; paralysis of one vocal cord is positive evidence of organic mischief. Hysterical paralysis of the abductors of the larynx is a medical curiosity.

Besides aphonia, mutism, and stuttering, which are not rare, hysteria sometimes causes aphasia. I saw a striking instance in the clinic of Ballet. The aphasia had come on suddenly, following mental shock, and was accompanied with a hemiplegia of the right side. One of the distinguishing traits of the hysterical affection is its purity of the motor type. Purely motor aphasia from organic disease is of rare occurrence; a careful and intelligent examination will nearly always reveal some degree of mind blindness, mind deafness, agraphia, etc. In hysterical aphasia they are the great exception. I know of but one case of hysterical aphasia with agraphia.* In organic aphasia the patient is nearly always depressed, worried, exasperated by his condition, and prone to tears; not so the hysteric. Hysterical aphasia generally occurs in younger subjects than that of organic origin and is apt to be complicated with aphonia, stuttering, or other difficulty in articulation.

As a knowledge of hysteria has increased in breadth and exactness, some symptoms currently but erroneously supposed to exclude this neurosis or, to speak more accurately, to be due only to organic disease, have been added to its semeiology.

One of these is ankle clonus.† But the clonus of hysteria is not exactly the same as that of organic disease. I have taken the rate of oscillation in a number of cases and find that of organic clonus to be about six to the second,

* Ballet. *Rev. de méd.*, June and July, 1893. Since this was written I have seen a reference to an additional case, but am not now able to find it.

† I have even seen glutæus-clonus in a case of traumatic hysteria.

occasionally somewhat more rapid,* while the hysterical clonus varies from three and a third to four and a sixth, or possibly as high as five to the second. Not only does the hysterical clonus vary in different cases between these wide limits, but, what is distinctive, it varies greatly in the same case, and of even greater importance is the fact that it vacillates greatly during the course of the same test. For instance, as the foot is flexed, the oscillations may start at the rate of two hundred a minute, quickly increase to two hundred and eighty a minute, and as they die away fall even below two hundred. At the same time the amplitude of the excursions is very irregular; at different moments of the same test it will vary even two or three fold, while in organic clonus it is constant. Gowers † says that the clonus of hysteria does not begin immediately on bending the foot back, but starts only after an appreciable interval. This delay I have not found constant, although frequent. But it is certainly true that the muscular contractions in the hysterical cases have not the prompt, shocklike character found in organic disease, and give the impression of semi-voluntary movements. I have not made tracings, but should expect the apex of the "hysterical" curve to be much broader and more irregular than that of the "organic."

The occurrence of facial paralysis, strabismus, central scotoma, and hemianopia, for a long time supposed to arise only from organic disease, has already been alluded to. Loss of pupillary reflex to light may also occur as a symptom of hysteria.‡ Retention of urine and polyuria are common in hysteria, while suppression or marked diminution of the urinary secretion, as well as incontinence, are

* Gowers says six to nine to the second, but I have not found it so fast as indicated by the second figure.

† *Diseases of the Nervous System*, vol. ii, p. 996.

‡ I have seen a case since writing this.

generally regarded as infallible signs of organic disturbance; still they do occur as symptoms of hysteria.* Loss of sexual desire and power may also be due to hysteria. I have had such a case recently under observation. Muscular atrophy from hysteria has been described, and cases have been reported in which there was diminished electric reaction and even reaction of degeneration, but we are here upon ground that is still debatable, and the decision turns upon cases few in number and bizarre in the extreme. Reaction of degeneration can certainly not occur without organic change of a certain rapidity in the nerve and muscle fibre, and whether such change can be produced by hysteria alone must be considered very doubtful.

It seems unnecessary to state that, to a certain extent, elevation of the temperature and, to a very marked degree, increase of pulse and respiration may be due to hysteria. Subnormal temperature, pulse, and respiration are more exceptional, but do occur.

In conclusion, I would venture to caution against drawing diagnostic conclusions from negative therapeutic results. Because a convulsion is not controlled by the ordinarily efficacious cold douche is no reason for declaring it to be epileptic. Because a paralytic woman does not walk on being imperiously commanded to do so, her affection is not necessarily organic. The utter failure of suggestion in deep hypnosis does not in the least militate against the diagnosis, hysteria. A given case may pass uninfluenced through many modes of treatment, all more or less impressive, all undertaken with hope, or even apparently absolute faith, on the part of the patient, and the case still be one of hysteria, pure and simple, and amenable, moreover, to appropriate mental treatment.

Venetian Building.

* Gilles de la Tourette. *Traité de l'hystérie*, vol. iii, p. 378.—Levy *Arch. de neurol.*, January, February, March, 1895.