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THE CHARACTERISTICS OF A PSYCHOGENIC HISTORY.

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A FEW years ago the psychogenic theory of certain diseases was undoubtedly popular. The war seemed to have demonstrated clearly enough that experiences which were associated with emotional states could produce symptoms of illness, and no one towards the end of the struggle had much doubt that the most successful methods of treatment for these conditions were those which were openly psychotherapeutic. Concealed psychotherapy such as is provided by massage or electricity was not nearly so successful in its results. The methods of choice were those of vigorous persuasion, abreaction under hypnosis, and psychological analysis and persuasion. As no new phenomena, which had not already been seen in peace time neurotics, were observed among these patients, it was inferred that the future treatment of the psychoneuroses of peace lay in psychotherapy.

For the majority of organic neurologists this view does, I believe, still hold good; but with a considerable number of psychiatrists, with many general physicians and specialist surgeons, and with perhaps the majority of the profession there has been a growing tendency to regard the so-called psychoneuroses as manifestations of physical disorder, as a something which is poisoning or otherwise injuring the higher centres or as a disturbance of endocrine balance, or again as something causing a hurtful reflex such as astigmatism. Now if we were sure of anything in the war cases we were sure of this, viz., that if the patient was allowed to believe that his illness had a physical basis he did not get stably well till he was rid of this belief. If then we were right in our ideas at that time, and if we are right now in thinking that the peace neuroses are identical with those of war, it must be a misfortune that there should be this swing towards organic theory. The history of the neuroses is one which shows continuous alteration between psychological and organic views. It will be evident later that this very alternation is proof that the mental view is the correct one, but in the meantime the object in view will be to discover whether there are criteria which shall enable us to distinguish between psychogenic and psychogenic disease.

There is little doubt that some loose thinking in the matter has arisen from the careless use of certain words—functional and organic, neurotic and psychotic, mental and physical. Functional and organic are commonly used as opposed to each other; functional, neurotic and psychogenic are sometimes considered interchangeable; neurotic is considered a smaller edition of psychotic—*e.g.*, the expression, ‘the minor psychoses’—and so on. It is submitted that many of these uses are productive of confusion of thought. There is no intention of giving definitions here, a procedure that would merely provoke controversy, but a few observations may not be out of place.

‘Functional’ and ‘organic’ are not opposed words at all. Every organic disease produces disturbance of function, and it is this disturbance of function of which the patient complains; thus in heart disease the patient may not complain of his heart at all but of some disturbance of function elsewhere, such as dyspnoea. On the other hand in a purely psychogenic disease, such as hysterical paralysis, there may be physical changes such as cyanosis of the limb.

On many grounds it is not likely that neurosis is a minor edition of psychosis—and why “minor”? A neurosis can be as wrecking to happiness and efficiency as a psychosis. I should say that the difficulties of the neurotic are the exaggerated difficulties of all normal people; the difficulties of the psychotic seem to me to have little affinity with our ordinary conscious difficulties. A speaker not long ago said that he could cite two people, one of whom was in terror at the thought of crossing an open field, the other was in constant though unjustifiable fear that he would be poisoned by some one, and he—the speaker—could see no reason why one should be called neurotic, and the other psychotic. At first blush there is none; but in practice the difference between the two is enormous. The first can be reasoned with on the matter; he will agree that the thing is ridiculous. Such a consideration may not cure him, but it can be discussed with him in the terms we all know and use. The second cannot be reasoned with at all if he is a psychotic; his ideas on the subject are on a plane where none of us can follow. If he can be reasoned with on ordinary lines he is not psychotic on this point.

With the word neurosis there is a further difficulty. A disorder for which no gross lesion can be found is apt to be called a neurosis. Such a disorder may obviously be either psychogenic or physiocogenic. Here the word is used to mean a psychogenic disorder, in which there may be physical changes or not; if there are, they are secondary; the word will here be interchangeable with psychoneurosis.

The ideas underlying the words ‘mental’ and ‘physical’ still seem to cause endless difficulties, but only because certain physicians desire to be metaphysicians. We are told again and again that because certain organic diseases, such as myxoedema and general paralysis, cause mental symptoms, and because all mental operations must be accompanied by physical change, therefore all symptoms must be indicative of physical changes could we only

have means fine enough to detect them. This subject will be dealt with frequently throughout the paper. Here it will suffice to say that the difficulty is a philosophical one. It is however, convenient for practical purposes to treat mind *as if* it existed, to treat mental operations *as if* they really occurred. Everyone does it in daily life without difficulty. It is hoped that this paper will justify this procedure ; we may do so without resorting to any philosophical speculation as to whether the world is really monistic or dualistic.

No one denies that mental causes have bodily effects ; everyone agrees that grief causes tears even though great names can be quoted in support of the view that it is the tears which cause the grief ; everyone believes that an unpleasant sight or idea may induce a faint ; it is even common ground that such things may be the starting point in time of a neurosis. The opponents of psychogeny, while granting these things, would say that from the standpoint of practice they are unimportant, that the morbid states would not have continued unless there were some overwhelming physical agent at work, and that the cure of the patient depends on our ability to eliminate the adverse influence of these physical agents. We may concede forthwith that psychic traumata do not account for the continuation of symptoms : they are only precipitating events. But this does not imply the necessity of the presence of the physical if the symptoms are to continue. For proof of the organic view, cases are cited of long-standing nervous disease cured by physical means where psychotherapy had failed ; and those who uphold it do not weary in demonstrating patients where previous observers have been led astray by a ' psychogenic history.' To the first argument the answer is easy, for while psychotherapy sometimes fails it also sometimes succeeds, and therefore its existence is justified ; and further it is certain that the administration of any remedy is accompanied by the suggestion that it will bring about cure. It is, therefore scientifically impossible to eliminate the chance that psychotherapy has been used. But the second argument is worth a more detailed answer. I have often heard reports of cases where the doctor had been led astray by this kind of history, but very little discussion about what constitutes a history of the kind we are postulating. It has usually meant that there was some antecedent shock, worry, or grief, the sort of thing that occurs to everyone. If this were to be the criterion there are no cases of illness of any kind which could not be regarded as psychogenic, for everyone has had shocks ; but we must not forget there is no person living, well or ill, in whom an industrious physiologico-anatomist could not equally find some abnormality. If certain people are finding psychogeny where it does not exist, others are finding physical disease where it is of no importance. The truth about every patient no matter what he is suffering from is that we should study him from both aspects, from the physical and from the mental. We shall find something amiss in both, and then we must exercise judgment, decide what is important and what should be neglected. There are many patients whose mental state will be best aided by physical treatment, e.g., a sufferer from duodenal ulcer who is afraid of what

may happen to him. There are others, such as those suffering from hysterical paraplegia, who are best treated by psychotherapy alone, and for whom the extraction of over twenty teeth—as I have recorded elsewhere—was of no benefit, but decidedly the reverse. Some there may be who will require mental and physical treatments, but there will be very many who will require one or the other, but not both. For the purpose of differential diagnosis thorough and careful clinical examination will be approved by all. But it will not be enough to keep us from error. The presence of a psychogenic history will not assure us that the patient is suffering from a neurosis only, but its absence should make us certain that we are not dealing with such a condition, provided we have taken the trouble to ascertain that it really is absent. It may be laid down as an absolute rule: *Do not diagnose a neurosis in an obscure case unless a psychogenic history is forthcoming.* There are some obvious instances, such as hysterical paralysis, where such a precaution is unnecessary, but the rule should be absolute where there is doubt. Not only will serious error be eliminated by such a rule, but the doctor who observes it will get away from the common conception of neurosis as a negative thing, as a collection of symptoms which are causeless and need never have existed, a view which is most deleterious, and leads to no interest in and diminished chances of cure for these sufferers.

CASE 1. Mrs. N., age 32. A year before coming under observation she became suddenly sleepless and remained without sleep for a week; since then she had never felt well. Her sleep became better but never certain; she became apprehensive and restless. There was some difficulty in eating, which was worse in the presence of other people. Later she became depressed. For some months she presented no physical signs of disease, and on that account it was judged that she was suffering from a psychoneurosis. It was alleged that she had become tired of the management of her house and that this illness was an attempt to escape from it. Her own feeling was that she could not do it, but she thought that the accusation might be just, and she accordingly became more and more depressed.

Why up to one particular day she had been quite happy in the discharge of these duties, and why on the night following that day she had suddenly become so disgusted with them that she could not sleep, was not demonstrated; but of course her dislike might have been of long standing if only it were unconscious. This sort of guessing is apt to be called psychoanalysis, a specialty that has enough sins of its own to carry without this kind of thing being added to its burden.

Now if painstaking physical examination is to be *the* method by which the diagnosis between functional or organic is to be decided, patients like this one will often be labelled neurotic; but indeed there was no justification for the label if the observer had looked further afield. Up to the time of the illness this woman had lived an ordinary healthy life; there were no stories of obscure illnesses; any difficulties she had had she had met adequately. There was no history of any special anxieties or worries at all. The illness had come 'out of the blue.' The most fanatical psychogenist could have

had nothing at all to offer in the way of psychogeny. On the history the case was organic because of this absence of psychogeny ; and so in a few months it proved to be, when the signs of Parkinsonism stamped its encephalitic origin. The patient had been looked at only in transverse section. She had nervous symptoms and no physical signs. Therefore it was held that she was neurotic. We must learn to look at patients in longitudinal section. They have all biographies and we must learn to be biographers. The word biography is used advisedly. It is not a mere history of previous illness or of the family health that is wanted. The biography begins with an account of the family and how they all got on together, what church they went to, and whether they had children's parties, and so on through life. To get an outline does not take as long as it sounds, certainly not longer than the repeated physical examinations that are made in an obscure case.

When the habit of doing this has been acquired it will be found that the psychoneuroses are not so much symptoms of disease as symptoms of a kind of personality. Further it will emerge that though many of the patients had exceptionally unfortunate experiences in life, in others nothing out of the usual had happened ; that sometimes they met their difficulties badly but sometimes well, but with a growing inability to overcome them. On the whole the healthy person tends to find his difficulties lessen as he grows older, for he has acquired skill in dealing with them ; the neurotic seems to find them more and more difficult, as if what he had acquired was loss of confidence. The normal is in increasing degree influenced by his victories, the neurotic by his defeats. The healthy person from time to time has symptoms, lassitude, lack of confidence, headaches, nights of indifferent sleep, but they do not last long ; in the other the symptoms tend to last longer till they get so continuous that the syndrome gets itself called an illness. There is from this point of view no qualitative difference between the normal and the neurotic : the difference lies solely in the mass and duration of the symptoms. The healthy-minded on the whole tends to get over his difficulties by himself, the neurotic to rely more and more on something, on parents, on friends, on dogma, on systems of health, on a doctor. None of these agents need have acted rationally when they succeeded in helping ; it did not matter much what the doctor's treatment was so long as he was felt to be a support ; when he became tired of the case, or in some other way ceased to help, the patient was worse till a new source of aid was forthcoming. And as one does not consult a doctor unless one is ill, the illness aspect of the problem in those who have come to rely on doctors, in those therefore whom we doctors see, tends to become accentuated ; and the aspect which has to deal with difficulties other than those connected with health tends to disappear from the history. Then illness comes to be exploited. It not only brings support but gets one out of difficulties : for one cannot be expected to face them when one is ill.

From what has been said it might be inferred that the difficulties which beset the patient begin in childhood and it is probable that they always do so ;

with ordinary history-taking—and that is all we are discussing at present—this will commonly be found true, but not always. Sometimes childhood appears to have been largely forgotten; it is not forgotten if the patient be kept to the subject for several sittings, but for the purpose of diagnosis at a single interview it may be. But when this history can be obtained it will be found that childhood was unfortunate in one of several directions; the child was spoiled and acquired the habit of dominance which later the man cannot exercise, or was fussed over and so feared this world too much, or was unduly snubbed, or was treated with harshness and became terrified, or was mis-managed in some other way.

A person who gives a history of this sort is a neuropath; he may of course be suffering from organic disease also, but whatever he is suffering from he is the type of person who will require psychotherapy in addition to whatever physiotherapy is indicated.

Before examples are given of psychogenic histories it might be well to give some more which might deceive the unwary.

CASE 2. M., age 50. He had a history of varicose veins in the left leg for years. Six months before coming under observation he had suffered from pain in this limb, said to be due to phlebitis; it was better in two weeks. A few days later he had pain in the back and hypogastrium, and soon after pain in the right calf. He began to be constipated, having previously been regular. The constipation became severe, five or six days being missed. The pain in the abdomen increased. He was sent to a nursing-home for a week's investigation, and was carefully examined by many modern methods. Nothing was found and he was stated to be suffering from functional disease, and was further said to be giving daily proof that this was so. There was no history of previous ill-health, and none of increasing difficulties in his biography. Doubt was therefore expressed about the diagnosis, but the following story was put forward to prove the functional nature of the case.

It appeared that his doctor, when visiting him one day, had observed him through the window reading the paper, and apparently sitting at his ease. A minute later on coming into his room he found the patient writhing on his bed in great pain.

We may agree that this was an exhibition of malingering; we may sympathise with the temptation to label the case as hysterical when this observation was combined with absence of physical signs, and yet if we consider the matter a little further, the incident may have an explanation which it might be difficult for a doctor to appreciate, because it was a rather pungent criticism on doctors in general. Malingering is not a very common mode of reaction. It is practised only by very helpless people in the face of what is to them an overwhelming difficulty. A man must feel himself in a very tight corner before he resorts to it. If we diagnose malingering our first question should be, what is the difficulty from which this person sees no way of escape? This man was involved in no external difficulty. He had only one difficulty at all; he was in great pain and no one would believe it. He was making a poor attempt to prove his case. I think that many of us faced with the denial that we were in great pain, when we knew that we were feeling it, would take steps to assure our informant that he was wrong. There are three great

motives for malingering—getting money for illness, escaping loathsome duty evading punishment; and this man had none of them. He was reacting neuropathically, but this was the only time in his history that such a thing had been shown to have occurred, and everyone reacts emotionally, hysterically, deceitfully, if you like, sometime in his life. It is not normal not to do so ever.

A few weeks later he became jaundiced, and was found to be suffering from cancer of the pancreas.

CASE 3. F., age 27. In 1921 the patient suffered from loss of power in arms and legs, attacks of shortness of breath, sleeplessness. In 1917 a brother was killed; in 1920 her house in Ireland was raided; her father was wounded before her eyes, and she rode ten miles in the night for aid. Later that year she began to sleep badly, came to England and recovered. She returned to Ireland and went on normally. The house was burnt down three months later, but there was no shooting. The sleeplessness returned and she developed the symptoms as above. The illness was regarded as hysterical. There was no previous history of ill-health or of increasing disability to meet the problems of life.

About eighteen months later she was definitely a Parkinsonian.

The temptation to regard a history of this sort as psychogenic is of course very great. There is abundant material for the production of shock, but it is probable that shock in itself does not produce nervous illness, not even shell-shock. If one takes the history of men invalided on account of shell-shock, one will find the story of months of terror preceding the shock. There was no clear history at all that this lady had terror at any part of the proceedings. Her ride in the night for help for her wounded father was indeed proof, so far as it goes, to the contrary. Though she came to England she went back to the front. Did any shell-shock patients who were invalided to England return to the French front? Some were sent back, but it seems probable that none stayed more than a day or two. She on the other hand went back voluntarily and stayed, until there was no house to stay in. The first attack of sleeplessness may have been an anxiety reaction; it disappeared quickly on removal of the disturbing cause. A certain amount of sleeplessness in the presence of anxiety need not be regarded as illness; poor sleep is an ordinary accompaniment of normal anxiety; it is only its prolongation after removal of the precipitating cause that need be considered pathological. The second attack of sleeplessness was probably encephalitic. There was no previous history of inability to meet difficulty.

The next case to be considered has a still more provocative history. It is the sort of history which might be called neurotic if the performance of certain ill-judged and unworthy acts is to be the criterion. Only those conscious of their own invariable wisdom and rectitude will, however, be inclined to say: "that is the sort of conduct that leads to neurosis." The point is not what one does, but how one reacts emotionally to what one does, otherwise the criminal and the psychoneurotic would be the same person.

CASE 4. M., age 38. The patient had been well and active till two and a half years before. Eight years previously he had married a widow ten years older than himself—the ill-judged act; and later had had sexual relations with his step-daughter—the unworthy

one. But he had remained well. Two and a half years before coming under observation he had a sleepless night, and next day had neuritis of the face and wrists. "His mind became a cesspool of all the sexual filth he had ever heard." Two days later he had an attack of vomiting which lasted seventeen days. This was followed by retching and eructations. In three months, though still retching and eructating, he returned to work, but these symptoms continued to be so severe that he had to give up. It was considered possible that they were due to a hernia which had developed in an appendectomy scar. This was operated on with benefit so far as the vomiting was concerned, but not in respect of the eructations. On coming under observation, the patient was exceedingly depressed, confessed his sins without pressure, said that his illness was brought about by them, and that he was unworthy to live. He was then in a well-advanced state of Parkinsonian rigidity.

Now the ready confession of sins is no part of a psychoneurotic history. The psychoneurotic does not confess his sins; not till he knows where he stands with the particular doctor: on the contrary he tends rather to blame other people for the troubles with which he is being overwhelmed. There is nothing here, then, of a history which comes into the category as laid down in an earlier part of this paper; there had been no disability to meet difficult situations till he had actually fallen ill.

So far as physical disease is concerned we have endeavoured to show that there is, in so far as the patient is suffering from the physical disease alone, an absence of a previous history of increasing disability to meet the difficulties of life. In the absence of such history little stress need be laid on trauma, physical or mental, except as a mere precipitating agent, or on the observation that the patient is not reacting courageously to pain. It will be of interest to see whether the biographical method will be of equal service in enabling us to distinguish between the psychoneuroses and two great groups of psychotic disorders with which they are liable to be confused—the depressions and the schizophrenias. I am not entering the lists on either side on the question whether these psychoses are psychogenic or physiocogenic. I am interested to prove that the psychoneuroses are psychogenic, and that they are different conditions from these psychoses, not in degree but in kind. This paper will not afford sufficient proof to dogmatise on the latter question, but it may provide enough to show that if these conditions are psychogenic the histories are not of the kind postulated for the psychoneuroses. In their full-blown state they affect quite different functions of the mind. If then they are psychogenic one should expect a different story about their psychogeny.

If the cross-section method of diagnosis be employed there are stages where the resemblance between these psychoses and the psychoneuroses is considerable, and therefore we must resort once more to the biographical method.

CASE 5. M., age 51. On coming under observation the patient said he was worried about his financial position—on information received, unnecessarily so. He slept badly and could not read because of inability to concentrate. He spoke slowly and deliberately and did not answer at once. He was greatly constipated, and had lost weight. He accounted for his illness by saying that he had been slack and inattentive to business.

(The above is a cross-section diagram of an attack of psychotic depression.)

Eight months previously he had been perfectly well. About that time his only son went abroad, to be away for a long time. He received news that a brother, also abroad, was in serious trouble and this was a great shock. He thought that the two events might have preyed on his mind. He soon began to lose interest in both work and games, and the other symptoms came on gradually. Two months after coming under observation he was well.

When he was better, he told me that during the illness the thought of suicide had often come into his mind, but that some other thought had always driven it out. The story of the attack corresponds therefore to the cross-section diagram. We may consider that the affair of the brother was a precipitating event.

The longer history showed that there had been two similar attacks years apart, each lasting about six months. But between them the patient had been perfectly well. There had been these incidental illnesses, in which there had been complete inability to do anything, rapidly arrived at, and finished in a few months. When he was not ill in this way he was always a singularly effective and successful man. His life had been spent in colonial administration and he had climbed to the top of the tree. His wife described him as energetic, self-reliant, masterful. There is here no picture such as has been laid down as essential to the conception of a psychogenic history. Indeed the biography shows one of quite an opposite nature. When he was well, he was never troubled with nervous doubts or fears; he had no doubts about himself.

The schizophrenic person on the other hand tends to furnish a history which may show pathological happenings early in life and they may be somewhat like those characteristic of the psychoneurotic. Yet no such story may be forthcoming. It will be convenient to give an example of the second kind first.

CASE 6. F., age 29. She came under observation in 1924. Her complaints were like those of a patient suffering from an anxiety state: they were occasional headache, fatigue, nervousness in company, starting on going to sleep, poor sleep if worried, eructations. On examination nothing was found to suggest anything but the presence of a psychoneurosis, except that she was very listless.

At the first interview the psychoneurotic is not usually listless. If she says she is exhausted she often appears to let the doctor see it in a very thorough fashion—she will be deep in the bed, hardly able to articulate, but more usually the first meeting with such a patient is a pleasant social affair. But this lady gave one the impression that she was quite uninterested.

Her recent history was somewhat suggestive of an anxiety state. Her mother had been ill for some years with paralysis agitans; after an air raid the patient had become nervous, depressed, could not sleep well. She left town and was well in three weeks. She remained well and at work till about a year before she came under care. At that time she had an attack of chickenpox. Since then though she improved a little she never became quite well, and of late her symptoms, chiefly those of fatigue, had become worse. Previously to the air raid she never showed any signs of finding life difficult.

In hospital all she wanted to do was to lie in bed. She would talk when spoken to and answer intelligently, but she had little to say, and nothing of much importance to relate. When she had been six weeks under observation she confided one day that when she was in Switzerland convalescing from chickenpox she had been lying in bed one night looking out on to a balcony, when suddenly a panther appeared outside the window and stared in at her. She did not call for help, but next morning she saw the marks of its pads on the matting of the corridor outside her door. A few days later while menstruating she said she was much troubled because she was about four months pregnant. When asked if she knew that this state of affairs was hardly compatible with her menstrual regularity, she ignored the point, and proceeded with her confidences, which were that even in hospital she was nightly visited by a lover whom she had never seen, for he always came in the dark, but whom she had always been able to touch. This fantasy persisted, and soon after she was removed from my care. I have ascertained, however, that the case proceeded to certification and that the patient is still, four years later, in a mental hospital.

Both in cross and longitudinal section this case differs from the anxiety state. Apathy is not a characteristic of the latter condition. No history of abnormality was discovered in the early years.

CASE 7. M., age 20. When the patient came under observation his condition was frankly schizophrenic, with auditory hallucinations and ideas of persecution. His history was not that of a normal person, but it was not exactly that of one who had often been overcome by difficulties. He was stated to have been always nervous; on closer inquiry what this meant was that he had never made friends easily, that he was always a silent person who had kept himself to himself. He had done quite well with work. He had been introverted.

There is no real history here of increasing difficulties till he fell ill; but this is the sort of history which is a little difficult to distinguish from that of the psychoneurotic, and schizophrenic patients are the most difficult to distinguish from the neurotic in the earlier phases of the disease.

We are now in a position to consider the history of some patients with anxiety states. We shall begin with one where the diagnosis of a functional nervous disorder and also of a physical illness is clear on cross section, and observe how the history will enable us to distinguish between the physical and psychic elements.

CASE 8. The patient, a childless married woman of 46, complained of utter exhaustion and of attacks during which as a rule she did not lose consciousness, though sometimes she did. She became stiff, the neck jerked, then the head and neck turned to the right, sometimes the whole body did so too; the arms were stiffly extended and pronated; the legs were stiff and extended. Sometimes the arms then went up in a crucifixion attitude; both legs might swing out to the left. She had sometimes fallen out of bed; she had had opisthotonos. The attacks lasted a few minutes, but one had continued for at least twenty minutes. She had sometimes been held down by nurses and then the attacks lasted much longer. They had been present off and on for years. She complained also of indigestion. There was complaint further of œdema of the legs on both sides when she was especially over-tired.

A day or two after she came under observation I had the opportunity of seeing an attack and was able to confirm—what her own description had suggested—that they were of hysterical nature.

The patient was asked when the first attack occurred and she said that it was seventeen years before, when she was 29 years of age. She had come home on leave from Canada

where she was employed as a schoolmistress. One day a favourite uncle had called. She thought he looked very ill, but was unable to persuade her mother and sister that he was. A few days later he was dead ; and a few days after that she had the fit.

It may seem here that stress is being laid on the occurrence of what it was promised that stress should not be laid on, viz., the presence of shock in the history ; but it may be noted that she had no more of these fits for several years, and it was only within the last two that they had reappeared. She did not therefore become hysterical in consequence of this shock, but, as happens to all hysterics, she reacted more violently to shock than does the ordinary person. We shall find evidence of hysteria long before this event happened. We shall find also that this particular shock had a special signification.

As a child she was not happy ; her father terrified them all ; her mother made a favourite of a younger sister. As a quite young child she remembered having frequent abdominal pains. For these she would steal out of bed and stand in front of the kitchen fire and warm her abdomen, which comforted them. She would get whipped for doing so if caught. She remembers the agony of the knee over which she was turned pressing into the abdomen. At the same period she was terrified of the dark, because she sometimes had a visual hallucination of a white coffin being carried out of her own bedroom.

Here we have the recollection of physical disease—appendicitis probably, in the light of subsequent history—treated by methods of terror, so that a neurosis (hysterical hallucination) was induced. The organic indeed caused the functional, not by toxins or even by physical pain, but through the psychological route of fear. Here too is the genesis of something which pervaded her history from childhood onwards, that whenever she was ill she had a feeling of guilt, that as she was punished for being ill, it must be her fault. The reasoning is illogical, but children are often illogical. A number of other ideas besides those of guilt seemed to result from this treatment also, and it need not surprise us if these were incompatible with it. One of them was a feeling of injustice. That a person may feel guilty and at the same time feel that the treatment meted out is unjust is not remarkable. We all tend to feel that way ; one might put it that one part of us accepts the punishment and another part resents it. And if we have felt injustice frequently we shall soon see injustice in places where it has not really been dealt to us.

It came about therefore that this patient began to think that her somewhat younger sister was receiving far more benefits than she was ; it seemed to her that their mother was always heaping good things on her, and she therefore became jealous and resentful towards her. She soon got the reputation of being sullen and bad-tempered, and as this was in marked contrast to the sweet gentleness of the sister, it probably became true sooner or later that the latter did in fact get more privileges than she did ; for this was one of these Scottish households where the naughty child is not allowed to rule, but is perpetually and unweariedly put in her place. We can now see how this child was almost bound to go on making bad adaptations, and we may learn by the way how difficult it may be to solve the problem of the naughty child unless the whole family will submit to a searching interrogation.

The patient therefore became a misfit at home, and as soon as she grew up she was glad to take a post overseas. When she came home for her first holiday the death of the uncle occurred which was followed by the fit. While she was abroad she had had endless difficulties with her employers, who had constantly overworked her; she had had several love affairs, all with wrong persons—one of them, for example, was sent to jail for swindling.

A series of unfortunate love affairs must I think be regarded as something more than accidental. It argues bad management. In this case I consider it signifies that the patient was so desirous of matrimony that she would think of it in connection with anyone rather than not have it. And for her the reason for the desire of matrimony was not hard to seek. It does not seem as if she had had any very strong sex urges. In the history there was nothing to suggest them. But she had a passionate desire for certain things she had never had—to be cared for and to be supported. The instinct that was threatened was probably more that of self-preservation than that of sex.

At the same time there were frequent attacks of abdominal pain and other abdominal symptoms so that when she came home a second time in 1914 it was decided to open the abdomen. An appendix buried in dense old adhesions was discovered and dealt with. The operation was a grave one, was followed by phlebitis of both limbs with permanent double varix. These adhesions had been the source of much delay in the passage of the intestinal contents—this appeared to have been benefited by the operation. In later years, at any rate, there was no stasis.

Here, then, we have sufficient proof of the organic nature of the childhood pains, and the foundation of the subsequent oedema of the legs.

We begin to perceive how history aids us in disentangling the organic from the psychogenic. We see why the child became ill-adapted and why she was likely to find the ordinary difficulties of life greater than most people do. We see also why she had organic symptoms. Of course no one is likely to think of oedema as functional; but in a complex case like this it is essential that the patient should be able to distinguish between what parts are in the one category and what parts are in the other. She may or may not accept the doctor's statement on the matter; this patient was not apt in doing so, for she had had many opinions from many doctors, and she had almost given up believing in any; but as she assisted in the dissections of her symptoms she began to see for herself that they were in two categories, and that it was not very hard to make a distinction. Thus she knew that the hallucination of coffins was not likely to be caused by appendicitis, for she had known other people with that disease, and they did not suffer from hallucinations. She could see that prolonged jealousy was likely to be followed by symptoms of some kind, and she could see that the death of an uncle was not likely to cause an organic affection. While making these considerations she was able to supply a reason why the death of this particular person had affected her so much. He it was who administered the corporal punishment referred to in her childhood, and she had often wished him dead: later he had been kind to her and she had liked him, and had perhaps been unhappy in the knowledge that she had wished him dead. This is however a psychoanalytic hypothesis

and not a historical fact, but it is not very far-fetched to postulate that when anyone against whom we have had death wishes at one time and yet liked at another time, does die, we shall feel specially upset about it.

Time went on and at the age of 40 she married; and marriage failed to give her all she wanted. It gave her money, it gave her leisure, but it did not give her what she had craved for all her life, viz., the gratification of her desire to obtain attention and affection from somebody. Her husband was quite kind but he was very busy, and gave her very little attention, and if there is no attention affection is not worth much. They lived in the East and had innumerable servants who left her nothing to do; they came home and for the first time in her life she tried to manage a large London house; she came to grief, and retired to bed exhausted. Unfortunately massage was prescribed; and soon she had phlebitis once more in the old damaged veins. This was followed by pulmonary embolism and she had a fight for life. In this fight the fits recurred.

She knew she might die. Death had always been a source of terror. The hallucination of the white coffin in childhood—white for a child, white for herself, therefore—may be adduced in support. The first fit had occurred in connection with a death. It is of some interest that for some weeks the fits occurred only in the presence of the doctor. It might be natural to suppose that here we have a desire to gain the doctor's attention; that would accord with the ordinary banal view of hysteria; but the patient maintained that she had by this time got so terrified of doctors that this one appeared to her as the minister of death. She had herself associated the onset of the phlebitis with the massage; the rubbing had hurt the veins; then they were declared inflamed; then she had become more ill with the embolus than she had ever felt in her life. The doctor had been the agent in bringing all this about.

In the next two years there had been apparently considerable doubt about the nature of these attacks. They had been considered epileptic; if not epileptic they had been considered toxic, because she had had attacks of coli pyelitis; fancy osteopathic diagnoses had been gone in for. No doctor after the first one had seen an attack. After she had left him she had not had them in the presence of doctors. The description seemed clear enough; but the history would have decided the matter.

Now the proof that these fits were psychogenic lies in the fact that they disappeared when her mind was relieved, which happened after this history had been gone into. She had been called "functional"; she had been called "organic." It had not presented itself to her mind that she was clearly both, and that separately; the one did not depend on the other, except through the channel of the mind. The organic diseases which she had were admitted, and shown not to be fatal. The mental cravings and self-reproaches were put by her in their proper light after she had discussed them.

It must be admitted that this history was not obtained in one or two interviews; it took many, and it will be objected that no one can find time to obtain a history of this kind. In a diagnostic clinic, by the time a patient has had all the routine examinations (chemical, bacteriological, radiological, etc.), the aggregate number of hours consumed must be very great, quite as

great as that consumed in the thorough taking of a history in a doubtful case, and from the latter investigation the therapeutic advantage is sometimes greater than from the former. The trouble is that one man must do the latter alone without assistants; in the former the chief waves a wand and an army of helpers does the rest; and nobody becomes tired. But a diagnostic team for doubtful cases should include someone who could be taking history, while other people are developing their films and staining their slides. In ordinary practice such lengthy procedures are not often called for, and even in doubtful cases sufficient indications that neurosis is present—which, after the example just given, is not to be confused with “organic disease absent”—will often be found at a single sitting.

CASE 9. A single woman of 22 complained of aching in the eyes, worse on reading, so that she had almost given up reading altogether, and of headaches. The eyes often became red and inflamed. Her own doctor said she had strained her eyes, prescribed glasses and said the pains would soon be better; they became worse. She went to an ophthalmic hospital where they gave her glasses (but said she need not wear them much), an eye-wash and an ointment. There was almost immediately complete recovery from the symptoms. A few months later the headaches and the ocular symptoms returned suddenly. The headaches became so bad that her doctor sent her to bed for six weeks. There was no improvement. Then she was sent to a general teaching hospital where she was given further rest, her eyes painted with a silver preparation, and irrigated night and morning. No improvement followed. She then saw the ophthalmologist to the hospital, who said there was nothing wrong with the eyes.

This in itself is a neurotic history. The first ophthalmologist evidently did not think there was much wrong or he would not have ordered only occasional use of the glasses. The second said there was nothing. We are entitled to suppose that the first one corrected a normal astigmatism; his doing so would give the patient some hope, the greatest of all the methods of temporarily improving neurosis. It is clear however that the patient reacted in a faulty way. She did not react well to her own doctor who was “not a specialist”; she did react to the special hospital: she reacted favourably to prestige. Consequently when the doctor, who had failed once, tried to improve her by putting her to bed he failed again. The whole series of reactions is faulty. However, if this is not enough, a very cursory inquiry into the history reveals that the relapse coincided with a grave annoyance which had happened. The patient had contrived to get a sister a post in the business in which she worked herself; and this sister was very quickly promoted over her head, and she did not like it. Therefore the relapse also was a faulty reaction. Her jealousy was intensified because she knew nobody but her sisters with any degree of intimacy; she had no outlet outside the family. There were four sisters. They never went to other people’s houses and no one came to theirs. This had always been so. And this represents a mass faulty reaction which this family had made. The father had been a drunkard, and had attempted suicide long before the patient was old enough to know anything about it; the mother became very sensitive and had told the girls about it; and they all kept themselves to themselves.

This history as stated above was all obtained in one sitting. It is free from any great shocks or great strains. It is clearly however a history of faulty methods.

In the first of these two histories (Case 8) the psychogenic part is easily separable from the psychogenic by cross-section methods. The interest in the detail of the case lies in this, that the history shows that mental factors clearly accounted for what is called hysteria, physical factors for organic symptoms like oedema. The second case (Case 9) is of interest because it is of the kind which are often quoted as proof that physical changes are the important thing in functional disease. The important physical thing was a slight astigmatism, evidently one not more than that which occurs in most people; and the subsequent events exemplify what often happens when normal astigmatism is successfully exploited in the treatment of neurosis. There is immediate improvement, and then relapse at the first breath of misfortune. It is no argument against a psychical view of the neurosis if such relapse occurs after psychotherapy; but relapse after successful physical therapy is wholly damnatory to the physical view. One's sister getting a better post than oneself could not alter one's astigmatism; it might alter self-confidence even if that had been temporarily restored by mental means.

The first patient we see is easily recognised as a probable neuropath, the second as a likely one by cross-section examination. We must study finally a patient where the diagnosis was not obvious or simple, and where the history at first sight does not seem to yield the series of faulty adaptations which are imperative if the thesis of this paper is to be upheld.

CASE 10. M., age 53. The patient complained of slight tremor of the left arm and leg, headache worse after greasy food, buzzing in the ears, concentration not so good as it was, but not preventing him from going on with his work, and nervousness. These symptoms had been present for about two years. He had never been a good sleeper. He had had an illness towards the end of the war characterised chiefly by exhaustion; without doubt he had worked unusually hard during the war. Since then he had had a good many minor manifestations of ill-health at times, with symptoms of dyspepsia, shivering attacks without much temperature. He had been operated on for a duodenal ulcer which was not there, and the surgeon had thereupon removed the appendix and gall-bladder, but the dyspeptic tendencies had remained.

(All this story is explicable on an organic basis. There might have been toxæmia; latterly there might have been encephalitis.)

The man himself was a highly successful person. At about the age of 20 he had quarrelled with his father. When he did this he was thrown wholly on his own resources. He became a schoolmaster, then supported himself by journalism, was called to the bar, took up business and was made director in an undertaking of great importance, a post he now holds; later on he took up public affairs and has been highly successful.

Here then seems to be a man who gives the lie direct to the conception of the neurotic individual whose fancy portrait was painted at the opening of this paper. Let us see. It was never said here that the neurotic lacked courage, or ability, or energy. It was said that he made more faulty reactions than most of us, that he came to rely on something, and that he came to exploit

illness. Many neurotics have marked ability, but in important ways they seem to have lost the art of living. This man's ability helped him to overcome many things, but there was much in his history that suggested faulty reactions in excess. As a child he could not be left alone. He had not got on badly with his father in youth, and then he quarrelled so hopelessly with him that he refused to take further help from him; the father wanted him to understand that he expected him to pursue a certain career when his education was finished; and as he felt he could not follow his wishes he would accept nothing more from him. It is very magnificent, but it is questionable if it was healthy. Later he was twice engaged to be married. The first engagement was given up on financial grounds, the second because of incompatibility. After that he seemed to lose interest in the subject. There is more than one faulty reaction here. The cost of marriage if it is to be counted at all should be counted before engagement, not after. The normal person does not usually count it very much; the dropping of the subject argues a failure of a normal instinctive 'drive.'

Up to this point the reactions had not resulted in symptoms of illness, but the illness at the end of the war was a suspicious one; certainly after it he never ceased to consult doctors and undoubtedly there was exploitation. During the war he had intense misery because he had not been permitted to join the army. Both his private and public work was too important for the authorities to allow him to do so. He felt ashamed and disgraced. This may be seen as a development of that early over-scrupulousness which had inhibited him from accepting further parental assistance. When the war was over he was often disgusted at the sordid nature of public work, and once he retired from it for a year, not sorry that he was too ill to attend to it. He had returned to it from a sense of duty, but when he came under care he was heartily sick of it, and at the same time not well enough to do himself justice at it.

Here then we have a man with a perfectly conscious conflict which he felt unable to solve, but which illness from time to time shelved, a man, who, as soon as we have penetrated his superficialities, presents us with exactly the psychological characteristics which were laid down as those we might expect to find in the history of a neuropath. Here amidst seeming success and self-reliance we have increasing dependence on doctors and exploitation of illness. And it must be emphasised that neurotic manifestations began long before there were likely to be infective causes, and that they continued after likely causes were abolished; nay more, they grew worse. It is easier to explain events like this on mental than on physical grounds and though it is easier that does not mean that the explanation is facile. It is difficult to conceive of the toxæmia that could have made him over-scrupulous for thirty years, and yet left everyone unable to find where it was at the end of that time.

The study of these cases seems to demonstrate that there is such a thing as a psychogenic history, that illness does seem to be definitely correlated with mental states, and that these states are of very early origin. They show that

shocks and strains are not the essential points of such a history. Their importance lies only in the fact that shocks provide a time of testing for the weaker vessel, so that they seem to the casual observer to be of greater importance than they are. The psychogenist will say that even if such histories are true, and if we can recognise them—for it does require practice to use the instrument of biography as it does to use any other special instrument—then we have got back to the physical after all; for what kind of person we are is probably determined chemically. This cannot be wholly true. If it were true it would not matter in the least how we were brought up, and all the thought expended on education in the broadest sense would be wasted. It is moreover true that psychotherapy does sometimes seem to make people well who were chronic invalids before it was administered. We all admit that there are endocrine changes in neuropaths, but this is not to admit that therefore endocrine therapy is the best. We knew that the blood-vessels of the skin dilated easily in neuropathic persons long before internal secretions were thought of; we knew, that is to say, that mental changes coincided in time with physical changes and that the changes were correlated. We even knew that these people sometimes said that their blushing made them nervous; but it was often easy to show them that it was first of all their nervousness that made them blush, though the blushing increased the nervousness in its turn. It is nothing new, then, to know that there are definite physical changes in mental states. The question remains open—which came first? and it is unanswerable. But it is probable that at our present stage the mental attack is the more likely to succeed, and it is likely that often when we think we are attacking physically we are doing so mentally. The mental is the more difficult form of attack. It often becomes incredibly tedious to both physician and patient; and one cannot help wondering whether this may not be one of the reasons for its periodical partial eclipse.