Papers and Originals

Diagnosis of "Hysteria"

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It is a unique honour to have been asked to give the first Shorvon Memorial Lecture; and I should like to give thanks to the Hospital and the School who have awarded the privilege to me, and to the family whose generous endowment has established it. At this moment I would not find it easy to embark on a formal biographical sketch of a man who was my close friend and colleague, whose death little more than three years ago left us all with a lasting regret. It is, however, proper to record essential facts. Hyam Joseph Shorvon was born on 16 June 1906. He joined the National Hospital as Clinical Assistant on 1 January 1947, and later became Assistant in the Department of Psychological Medicine, and finally Assistant Physician in Psychological Medicine in 1960. He died all too prematurely on 14 May 1961.

What I should like to express on this occasion is in the nature of a personal tribute, such as from personal knowledge only I can make. I first got to know Joe Shorvon twenty-five years ago, in 1939, at the beginning of the war, when we joined the same hospital of the Emergency Medical Service. He was working then as a general physician, but he soon became interested in the psychiatric work of the neurosis centre. With D-day and the opening of the western front in Normandy he joined us in an acute treatment unit, and began to show his great qualities as an observer and a therapist. These were the days when abreactive methods of treatment were being developed; and they were proving extremely successful in the hyperacute neurotic states we were seeing in men flown direct from the front. These methods depended on the application of Pavlovian principles, which at that time had only just begun to make an impact on psychiatric thought in Britain. When Shorvon eventually joined the psychiatric staff at the National Hospital he brought us the best help of all, that of the naturally gifted healer. As a colleague and a participator in our weekly teaching conference Shorvon made a unique contribution. There was nothing conventional in what he had to say, and his insights were very personally his own.

Joe Shorvon would, I believe, have greatly approved the choice of subject for address. The problems of hysteria are of great subtlety and complexity. He made a worthy contribution to our understanding of the mechanisms; and he was one of those rare therapists who, from the range of experience of a normal soundly constituted personality, can step out to handle with wisdom and decision the thorny and often intractable problems of treatment.

Neurological Diagnosis

It is generally agreed that no one has yet framed a satisfactory definition of "hysteria"; but it is usually claimed that it can be recognized when met with. However, the ease and reliability with which this is done is differently viewed by different authors. "Hysteria" has been called the "mocking-bird of nosology" (Johnson, 1849), and "that strange disease" (Gowers, 1885). "There is scarcely one [nervous disease] which may not be simulated by this Protean malady," observes Gowers (1888a). "There is . . . no symptom-complex of somatic illness that may not have its hysterical 'double,'" says Walshe (1963a).

Hysteria to Gowers is a "morbid state of the nervous system," more common in women than in men, in which the "primary derangement is in the higher cerebral centres, but the functions of the lower centres in the brain, of the spinal cord and of the sympathetic system may be secondarily disordered." He thought the malady was "a real one, occasionally of great severity, and to a large extent beyond the direct influence of the patient's will." To a certain degree he distinguished between symptom and personality, noting that hysteria was "in its slighter forms . . . as much a temperament as a disease" (Gowers, 1888b).

Charlton Bastian, another National Hospital physician, seems to have been aware of the logical indefensibility of making diagnoses by exclusion, since he refers to the diagnosis of "hysterical paralysis" as "a negative verdict." "We merely imply," he says, "that we think we are warranted in saying that the case before us is not one which has been caused by any gross organic disease of the nervous system, and that no causative changes therein would be detectable, even with the aid of the microscope. We leave entirely unanswered the other ordinary problems which go to constitute a complete diagnosis; nothing is implied, that is, as to the part of the nervous system which is at fault, or as to the nature of the process by which its functional activity has been impaired." "To arrive at a thoroughly warranted *positive* diagnosis of 'functional paralysis' is often for a time impossible even to one who has a very extensive acquaintance with nervous diseases; at the most such a diagnosis may be regarded as more or less probable." The diagnosis is, he says, "often a matter of the most extreme difficulty," and "only a half-diagnosis." Moreover, "the more slender and insecure is the practitioner's knowledge of nervous diseases the more prone is he to regard . . . strange or puzzling cases as instances of 'hysterical paralysis'" (Bastian, 1893a). He notes that "cases of hysterical paraplegia, rightly so called, are only encountered with extreme rarity" (Bastian, 1886), whereas cases of organic diseases of the spinal cord associated with hysterical symptoms are not uncommon.

Bastian thought that the diagnosis should depend on considerations of two kinds, severally connected with the grouping of symptoms, and with the mode of onset and past history. This, he says, is "a complicated procedure, and not too calculated to land us in certainties" (Bastian, 1893b), but unfortunately the only safe method of saying whether we have to do with a malady due to a mere functional defect or to an organic lesion.

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The distinction Bastian draws between functional and organic, or at least the use of these words to cover the distinction, he must himself have abandoned a little later. Kinnier Wilson (1930), in the Morison Lectures, notes that, since clinical symptoms are to be considered as representing either excitation or cessation of function, it is meaningless to distinguish "functional" from "organic." He said: "This, so far as I personally am concerned, is an ancient platitude; I date my awakening to a conversation with my old teacher, the late Dr. Charlton Bastian, who, when I told him a patient had been admitted under his care suffering from what I, with the dogmatism of the house-physician, described as 'functional fits,' replied: 'Did you ever see a fit that was not functional?'"

In 1922 Henry Head published his lecture on "The Diagnosis of Hysteria," with which the present lecture so rashly shares a title. He laid it down that "for the diagnosis of hysteria it is necessary, not only that there should be no demonstrable organic cause for the symptoms, but that the positive signs of hysteria should be present." What are the positive signs of "hysteria"? Unfortunately Head could not describe any common characteristic by which these signs could be recognized, and he dealt with them by enumeration. What follows is three pages of the very best clinical observation, showing how one by one a visual defect, a sensory disturbance, a paresis or spasm or tremor or ataxia, are to be recognized as due or not due to an organic state. Hysterical aphonia, for instance, is to be distinguished from an organic state by the preservation of the ability to phonate on coughing. Similar principles apply to all the conditions discussed. No criterion is given for distinguishing the "hysteric" from the normal individual. What is given is a list, which might be enlarged without limit, of rules by which the "hysteric" can be distinguished from the patient with any single named organic impairment of function. What is common to all these rules is their usefulness for disclosing normally preserved functional capacities underlying the superficial appearance of incapacity.

Neurologists of the present day are somewhat reserved in their approach to the theoretical aspects of "hysteria," but two physicians of the National Hospitals are able to help us. Sir Francis Walshe (1963b) discusses the differential diagnosis under two heads—the relation of the symptom to the disability, and the discrepancy between symptoms and anatomical and physiological arrangements in the body. The hysterical patient is interested in his symptoms, while the organically ill patient merely feels that they are a hindrance. The "discrepancies" alluded to are the "positive signs" of Head under a less ambitious name. Walshe does not claim that the diagnosis of "hysteria" rests on positive criteria; but neither does he state explicitly, what is in fact his position, that the clinical differentiae are the coupling of a personality trait or an attitude within normal psychological limits, with the physical signs of physiologically normal function.

In his account of "hysteria" Lord Brain assigns a key position to dissociation in the production of symptoms, unlike Walshe, who considers that the central feature is a loss of bodily function. We owe to Brain (1963) a useful distinction between what he calls adjectival and substantival views of "hysteria." He writes:

> "If hysteria is regarded as a disease . . . it tends to encourage the belief that it is necessary to decide whether a patient is suffering from hysteria or from something else. But if the patient is regarded as a hysteric it allows for the possibility that he may have other things the matter with him as well. He may be reacting hysterically to mental subnormality or depression, or even . . . to anxiety. He may have hysteria and epilepsy, or hysteria and some organic brain disease. On the other hand, the substantival idea of hysteria as a disorder leads to the inquiry as to what abnormality hysterics have in common which leads them to react characteristically. This can be expressed in psychological terms, or . . . in terms of disordered neurophysiology. These two modes of explanation, of course, are complementary and not mutually exclusive."

Substantival and Adjectival Views

This brings me at last to my own contribution to this discussion. I shall endeavour to persuade you that, to use Brain's terminology, the adjectival view can be maintained with some qualifications, whereas the substantival view cannot. I think the designation of a patient as a "hysteric" should be avoided, as it implies a qualitative rather than a quantitative distinction for which there is no warrant. But it would be legitimate, I believe, in a given instance to say that a particular symptom was "hysterical"; and the case is also arguable that the so-called "hysterical" traits of personality are not misnamed. In either of these uses, however, one should be aware of the possibilities of error. There is no "hysterical" symptom which cannot be produced by well-defined non-hysterical causes. The patient who coughs but does not speak may be suffering from schizophrenia; and the patient with loss of memory may be a malingerer. With such a caveat, then, the adjectival use may be allowed to pass. However, to suppose that one is making a diagnosis when one says that a patient is suffering from "hysteria" is, as I believe, to delude oneself. The justification for accepting "hysteria" as a syndrome is based entirely on tradition and lacks evidential support. No clearly definable meaning can be attached to it; and as a diagnosis it is used at peril. Both on theoretical and on practical grounds it is a term to be avoided. Let us briefly consider the theoretical aspect first.

All the signs of "hysteria" are the signs not of disease but of health. The patient who cannot speak can phonate; it can be shown that the anaesthetic patient does feel; the patient with the hysterical amnesia can be brought to recall. "Hysteria," one might say, is not an illness, but health, even if from the doctor's point of view it is health in the wrong place. One cannot build up a picture of an illness out of elements which are severally the evidence of absence of illness. No unitary concept is to be reached this way.

On the practical side we have to remember that the diagnosis of "hysteria" is in essence the assertion of a universal negative. If it is shown that one out of a group of symptoms is "hysterical," this is merely to demonstrate that in respect of this symptom the patient is showing a normal and not a pathological reaction. It raises no presumption that the other symptoms exhibited are hysterical likewise, any more than a normal test result in one aspect of bodily function is relevant to a question of malfunction in some other aspect. To maintain the contrary one would have to assert that there is some distinctive feature in which "hysterical" individuals differ from normal ones—for example, in the mechanisms by which symptoms are produced. No one has gone so far as to claim this. The mechanism of dissociation, which by many authors, including Brain, is believed to play a central part in the production of "hysterical" symptoms, is itself entirely normal. As Head pointed out, the neurologist dissociates every time he looks through the ophthalmoscope in order to get the monocular vision he needs for the task. So it is with all the other mechanisms and the physiological and psychological attributes which by various authorities have been associated with "hysteria"; they are all normal.

In diagnosing "hysteria" in a given case one is asserting in fact that not one of the symptoms is caused by disease, and that the probability that the patient is suffering from any disease which might have caused one of the symptoms is negligibly small. The necessity then arises to do what Brain said could be done; one must find the cause of the "hysterical" reaction. Short of that, one has left the patient undiagnosed.

Prognostic Studies

For many practical purposes it is advantageous to frame operational rather than theoretical definitions. As Guze has

emphasized, a diagnosis has an essentially predictive function. If we make a diagnosis of "hysteria" on a group of patients we must expect them to show as a group some uniformity in the later course of the condition, and in the aetiological factors uncovered in the course of time. Follow-up studies can accordingly be expected to provide a useful check. The follow-up studies of "hysteria" show that the later state of patients so classified depends on the mode of selection—that is, on the nature of the operational definition.

Thus the two authors who selected patients by the presence of conversion symptoms in an uncomplicated setting both found favourable recovery rates. Out of the 90 patients with recent onset whom Carter (1949) succeeded in contacting after a lapse of four to six years, 70% were well, and all but seven of them were able to work. However, two of these patients had become schizophrenic. Ljungberg (1957) made a longer follow-up, and the results were not quite so favourable. After a year 62% of his patients were symptom-free, and of those who were not two-thirds were still able to work. However, after the first year, in which most of the recoveries took place, subsequent progress was very slow; after five years a quarter of the patients were still suffering from symptoms, and after 15 years one-fifth. In the course of time 3.1% of his propositi became schizophrenic, 2.4% had a manic-depressive psychosis, and 3.3% developed epilepsy. Similar findings were made in a small study by Gatfield and Guze (1962). During a follow-up period of 3 to 10 years 4 out of 24 patients with conversion symptoms developed clear signs of neurological disease (tabes, motor paresis, basal ganglia disease, cerebral tumour), with an additional case in which the seizures proved to be focal. These authors concluded that conversion symptoms arise with a variety of psychiatric and neurological conditions as cause; and that the prognosis is not good, many patients becoming chronic.

Similar views have been based on investigations along purely clinical lines, without follow-up. Chodoff and Lyons (1958) studied a carefully sifted group of patients with conversion reactions, from which all neurological disorders had been excluded. The personalities of these patients were of all kinds: passive-aggressive, emotionally unstable, inadequate, schizoid, paranoid, etc.; but there was only one example of the hysterical personality, as this term is commonly understood. The authors make the penetrating comment that the traditional description of the "hysterical personality" is a description of women in the words of men, and that it is a caricature of femininity. Ziegler, Imboden, and Meyer (1960) also found that only a minority of patients with conversion reactions showed "hysterical" personalities. On the other hand, they noticed a striking association with depression; 30% of their patients had depressive symptoms, and when they examined a sample of 100 depressives they found conversion symptoms in 28. Stephens and Kamp (1962) also found no predominance of hysterical personalities in patients diagnosed as suffering from hysterical and dissociative syndromes: they thought the commonest personality deviation was of the passive-dependent type.

For research purposes there are great advantages in leaving the selection of cases to the arbitrary decisions of others. "Hysterics" selected in this way prove to be extremely heterogeneous. Ziegler and Paul (1954) took all the women who had been diagnosed as suffering from "psychoneurosis hysteria" at the Boston Psychopathic Hospital from 1927 to 1932. There were 66 of these women, and 22 had been readmitted to hospital later with a psychotic diagnosis, including 12 diagnoses of dementia praecox, 9 of manic-depressive psychosis, and 2 of organic psychosis. The authors conclude: "These cases were thought to have a kind of uniformity twenty-five years ago; now the extreme diversity in mental status raises the question whether the given criteria are not so imprecise as to be non-functional; whether they do not create the illusion of defining an entity where there is none."

A similar conclusion was reached by me (Slater, 1961) on a sample of 24 pairs of twins from the Bethlem and Maudsley Hospitals. The clinical, genetical, and prognostic aspects of this study all converged to indicate that the illnesses classified as hysterical under section 311 of the *International Classification of Diseases* were heterogeneous. Errors of diagnosis were prominent. The "hysterics" in this material included patients suffering from focal brain lesions, epilepsy, schizophrenia, endogenous depression, and anxiety states. Pyschogenic and physical causative factors were varied and non-specific. No specific genetical factor was found to play a part. Whatever may have been the case at the time of diagnosis, no unifying thread of any kind could be found with which this group of patients could be tied together a few years later.

A Unitary Syndrome?

However, some workers take the opposite point of view. Observational support for the existence of "hysteria" as a unitary syndrome has been claimed by Purtell, Robins, and Cohen (1951). The patients were diagnosed by the authors, and were compared with a control series. There were significant differences between the two groups of patients, hysterics and non-hysterics, in the frequencies of a number of clinical findings—for example, the number of past hospitalizations, the variety of symptoms, the degree of social adjustment, etc. The authors think, as Head did, that the clinical picture is sufficiently characteristic for practical use; but no evidence is offered that the case material is homogeneous.

Guze and Perley (1963) define "hysteria" as a syndrome which starts early in life, which occurs mainly in the female, and which is shown by recurrent symptoms in many different organ systems. Conversion symptoms are included, but there are many others: pains of all kinds, menstrual disorders, anxiety symptoms, etc. An excess of hospitalizations and of operations form part of the picture, as also do attention-getting and manipulative behaviour. So defined, this syndrome shows a certain amount of stability (Perley and Guze, 1962), and in two-thirds of the patients so diagnosed (11 out of 17) the diagnosis was confirmed on follow-up. The authors think that a valid and distinct clinical syndrome is defined; but that its chief usefulness is to permit one to refuse to make the diagnosis, let us say, when faced by a case in which conversion symptoms are prominent but which lacks the required characteristics.

"Hysteria" in this sense is a serious illness which runs a chronic course, lasting many years without remission; and it is a very rare one. It reminds one of that mythical disease "paranoia," which was defined by Kraepelin in much the same way. All the stability in the syndrome is supplied by the criteria of selection. If one accepts only patients who have been ill for a long time, one learns little from finding them still ill some years later. From this consistency alone no guarantee is provided that the group, small as it is, is homogeneous.

Follow-up Study at the National Hospital

Having carried out a follow-up survey of patients diagnosed as suffering from "hysteria" at the Bethlem–Maudsley Hospitals, I thought it would be interesting to do a comparable job at the National Hospital. Historically "hysteria" is more a neurological than a psychiatric diagnosis; and it is neurologists who have developed the clinical acumen and the subtleties of observation by which the condition may be distinguished, if it is possible to distinguish it at all. In 1962 Mr. Eric Glithero and I began the survey, following up patients who had been in Queen Square in 1951, 1953, and 1955 and who had received a diagnosis of "hysteria." There were 112 of these patients; but in five cases no trace could be found of the medical notes, and a further eight cases were excluded at the request of the consultant under whose care the patient had been, or of his

family doctor. I would like to say here how very grateful I am to my colleagues for permission to approach their patients in this way. We were left with the records of 99 patients. All effort to trace the patient failed in six cases, and a further eight patients when contacted refused co-operation. We were finally able to get adequate follow-up information, as far as possible by personal contact, about 85 patients—32 men and 53 women. One-quarter of the men and one-third of the women had been diagnosed as "hysterical" by one or other of the hospital's psychiatrists, including myself. The most important and the most surprising findings which resulted from the inquiry were the gravity of the after-history and the frequency of misdiagnoses.

Frequency of Misdiagnosis

These men and women at the time of admission were mainly young or middle-aged; the mean age for men was 42 and for women 37. Yet during a follow-up period which averaged about nine years, 12 died, 14 became totally disabled and 16 partially disabled; and only 43 (50%) remained independent. Only 19 of these patients were actually symptom-free at the time of follow-up.

Four of the deaths were by suicide, but in two of them it is noteworthy that organic disease was missed while the patient was in the National Hospital. One of these was a man (38985) with weakness of the legs, thought to be hysterical because of a clear history of psychogenesis, who on a later readmission was rediagnosed as having an atypical myopathy. The other was a man (47531) admitted to the National Hospital at the age of 52 with unsteadiness of gait, pain in the legs, urgency of micturition, and impotence. There were no abnormal physical signs, and both the neurologist, who was the late Dr. Hamilton Paterson, and I agreed in a diagnosis of "hysteria." The patient was subsequently admitted to the Maudsley Hospital on two occasions, both times being diagnosed as suffering from disseminated sclerosis with hysterical elaboration.

There were eight deaths from natural causes. In three of them (57756, 35530, 28227) death took place from vascular disease unrecognized at the time of admission. One of these was a man of 43 (28227) admitted to hospital after a year of illness with three attacks of right-sided weakness accompanied by vomiting and indistinct speech. During that time he had slowed down mentally, and had had difficulties with recent memory. In hospital there were variable right-sided signs; but the patient's breezy manner told against him, and it was decided he was suffering from "hysteria." He went home to attend a psychiatric clinic, and died 10 months later of gangrene of the caecum, caused by mesenteric artery thrombosis.

There were three deaths from neoplasms (31797, 42556, 37769)—a glioma, a carcinoma of the kidney, and an angioma. The glioma was recognized at the time of the diagnosis, which was in fact that of "left temporal lobe glioma plus hysteria." In both the other cases the existence of the neoplasm was unsuspected. One of these patients was a woman of 37 (4672) who was in the National Hospital with complaints of severe headache and poor vision. She was diagnosed as suffering from "drug addiction and hysteria," and was transferred to the Maudsley Hospital. She took her discharge from there a fortnight later, and left under a diagnosis of "conversion hysteria." She died two years later of an angioma of the brain stem. One more misdiagnosis in this group is that of a woman of 31 (37769) admitted with pains in the back, unsteady gait, failing vision, headache, thirst, polyuria, and fits. Vision improved strikingly under persuasion, and her walking to some extent also. It was thought that her fits were organic but her disabilities largely hysterical. Her illness was a chronic one, and took her into a mental hospital, where she died five years later. The post-mortem diagnosis was chronic arachnoiditis, traumatic epilepsy, and terminal bronchopneumonia.

Basic Organic Disabilities

Altogether 11 men and 13 women were given an organic diagnosis coupled with the diagnosis of "hysteria." In some of these cases there appears to have been at the time some hysterical exaggeration of organically determined symptoms. This overlay was of temporary duration, and in the long run the course of the illness was that of the basic organic process, so that at a later stage one finds the organic disability persisting, all hysterical quality to the picture having faded away long ago. Sometimes the diagnosis of "hysteria" was based on the disproportion between the degree of disability and the physical signs. In a number of these cases (57101, 31797, 39849, 18025) organic personality changes or oncoming dementia have contributed to this disproportion, or have provided the indications of an altered mental state, which came to be interpreted as "hysterical." In such cases one wonders what the clinician had in mind which led him to speak of "hysteria." The semantic difficulty is exemplified strikingly in the case of a patient (42239) who suffered from unsteadiness in walking, giddiness, and visual hallucinations ever since an attack of meningitis. The physician noted that there was a basis for the hallucinations, depersonalization, etc., in the old meningeal infection, but added: "It is however my view that her failure to accept any responsibility in rehabilitation with consequent dependence on doctors and institutions is hysterical."

In this group other organic diagnoses which were missed on the first occasion include patients whose black-outs, fits, or post-ictal symptoms were thought to be hysterical, and who were later rediagnosed as epileptics; patients whose "hysterical" symptoms were later shown to be associated with drug intoxication; and a woman with atypical migrainous headaches, later rediagnosed as a basilar vessel migraine.

The next group of patients we have to discuss are those diagnosed simply as "hysteria," with no mention of any other factor, but who have eventually been found to have organic disease. Twelve men and 16 women fall into this group, which is a very mixed one. Two patients suffered from facial pain and were later rediagnosed as having trigeminal neuralgia and operated on with success, one at the National Hospital (32788) and one by Mr. Pennybacker at Oxford (48555). A girl (44595) with pain in the neck and paraesthesiae and weakness in the hands, diagnosed as hysterical in 1953, has recently been rediagnosed by Dr. Critchley as having a thoracic inlet syndrome. Patients whose fits were first thought to be hysterical have since been treated for epilepsy; an anomalous unsteadiness of gait has been diagnosed as the result of a vestibular lesion. As a rule the result of follow-up has been to change the interpretation of facts that have not changed; but there is also a small group of patients whose hysteria-like symptoms proved so deceptive that serious organic disease was entirely missed—an error not so much in interpretation as in observation.

One may, for instance, mention the following cases. A woman (40838) with pain in the right shoulder and arm, numbness and paraesthesiae in the right arm and leg, and intermittent loss of consciousness, later proved to be a case of Takayasu's syndrome. A man of 65 (44098) with weakness of both legs and lack of normal sensation up to the waist, was later admitted to the Guy's–Maudsley Neurosurgical Unit, where they found upgoing toes and a sensory level at the fourth dorsal segment; there were positive myelographic findings, and a decompressive laminectomy was carried out; since then the patient has made steady if partial improvement. Two elderly men (46411, 42995) with unexplained neurological symptoms have steadily deteriorated into dementia; and a girl of 23

(43309) has subsequently developed the radiological picture of cortical atrophy.

We are finally left with 9 men and 24 women, approximately 40% of the follow-up group with which we started, in whose cases no evidence for organic disease has yet been found. But even here the concept of "hysteria" fragments as we touch it. Among this group we find two schizophrenics (57425, 29010), a chronically anxious obsessional, and seven patients with recurrent endogenous depressions. Sift these out, and we are finally left, not with any single homogeneous group of nuclear hysterics, but with two groups of patients, each of them classifiable as suffering from hysterical conditions by current standards, but differing sharply from each other. We have in fact seven patients, mostly very young, who had acute psychogenic reactions in the form of a conversion syndrome conforming to the group of patients investigated by Carter; and 14 patients suffering from a lasting personality disorder who come somewhere near to satisfying the criteria proposed by Guze.

Subjective Aspects of Diagnosis

If there is nothing at all consistent in the medical condition of the patients who get diagnosed as "hysterics," are there other non-medical characteristics which get taken into account? What are the qualities in the patient which make the doctor call him a "hysteric"? It was possible to get some idea of this from the medical records; and these characteristics could then be listed in order of frequency, and seen in relation to the presence or absence of organic disorder on follow-up.

Absence of relevant physical findings is, of course, one of the commonest. Nevertheless, as we have seen, the presence of some physical findings does not deter the doctor from diagnosing "hysteria" if he thinks they are non-relevant. This characteristic stands low in reliability. Physical findings which appear non-relevant at first may show their relevance later on, when the case is looked at with fresh eyes; and absence of physical findings applies universally to a stage in the development of all diseases.

The motivating factor which comes second in frequency is the presence of a multitude of symptoms. Since it is unlikely that all the complaints of the polysymptomatic patient can be accounted for by any organic condition, it follows that some of them must be non-organic. But if some of them are non-organic, why not all of them? This, of course, is a very dangerous presumption; and one that ignores the effect of disturbances of bodily function on the emotional state.

Next in frequency in the material studied was the existence of some evidence of psychogenesis. This was found about twice as commonly in the non-organic patients as in the organic ones, but in the latter it was far from infrequent. Unfortunately we have to recognize that trouble, discord, anxiety, and frustration are so prevalent at all stages of life that their mere occurrence near to the time of onset of an illness does not mean very much.

Next in frequency is what might be called the suspect symptom, such as a history of aphonia or amnesia. Oddly enough these symptoms were about as frequent in the organic as in the non-organic patients. We need not be unduly surprised. As Guze and others have shown, conversion symptoms not infrequently arise on an organic basis. The difficulty for the clinician comes from the fact that these symptoms are very striking, and can often be removed by simple psychotherapeutic measures. Unfortunately, as it seems, the symptom may go, while the disordered state of the nervous system which made it possible persists unrecognized.

Strong motivations for the diagnosis of "hysteria" are provided by the signs of certain personality traits. These may be shown in any tendency on the part of the patient to seek more attention than he is thought to deserve; any tendency to play up or to exaggerate symptoms; extraverted manners and lively phraseology; self-pity and self-concern; dependence and immaturity; any tendency either to over-react emotionally or to show what is thought to be *belle indifférence*. All these phenomena seem to be entirely irrelevant to the formulation of a trustworthy diagnosis. People with, say, a histrionic temperament naturally lend the stamp of their personality to their symptoms, whether they are suffering from an organic or a neurotic disorder. All that one can say is that these modes of behaviour seem to constitute part of a stimulus-response system between patient and doctor. Unwittingly, inevitably, from his very nature, the patient applies the hystero-diagnostic stimulus; unwittingly, inevitably, from the long process of conditioned training through which he has gone the doctor reacts with the hystero-diagnostic response.

Conclusion

What, then, is our conclusion? Looking back over the long history of "hysteria" we see that the null hypothesis has never been disproved. No evidence has yet been offered that the patients diagnosed as suffering from "hysteria" are in medically significant terms anything more than a random selection. Attempts at rehabilitation of the syndrome, such as those by Carter and by Guze, lead to mutually irreconcilable formulations, each of them determined by their terms of reference. The only thing that "hysterical" patients can be shown to have in common is that they are all patients. The malady of the wandering womb began as a myth, and a myth it yet survives. But, like all unwarranted beliefs which still attract credence, it is dangerous. The diagnosis of "hysteria" is a disguise for ignorance and a fertile source of clinical error. It is in fact not only a delusion but also a snare.

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