THE
MENTAL STATE OF HYSTERICALS

A STUDY OF MENTAL STIGMATA AND MENTAL ACCIDENTS

BY
PIERRE JANET, LITT. D., M.D.
PROFESSOR OF PHILOSOPHY AT THE COLLEGE ROLLIN

WITH A PREFACE BY PROFESSOR J. M. CHARCOT

TRANSLATED BY
CAROLINE ROLLIN CORSON

UNIVERSITY LIBRARY
PRINCETON N.J.

G. P. PUTNAM'S SONS
NEW YORK AND LONDON
The Knickerbocker Press
1901
PREFACE

I AM happy to recommend to the medical public the book of one of my pupils, M. Pierre Janet, on the mental state of hystericals. These studies, begun a long time ago, have been completed in my service and set forth in a few lectures which M. Janet delivered this spring at the Salpêtrière. They confirm a thought often expressed in our lectures, namely, that hysteria is largely a mental malady. This is one of the features of this malady we should never neglect if we wish to understand and treat it.

M. Pierre Janet wished to unite as completely as possible medical studies with philosophical studies; it was necessary to bring together these two kinds of knowledge and these two educations in an effort to analyse clinically the mental state of a patient.

J. M. CHARCOT

PARIS. November 1st, 1892.
CHAPTER II

FIXED IDEAS

The study of suggestion has shown us that the thoughts of hystericals are not equilibrated; that under diverse influences one of them may develop to an extreme extent and live, so to say, isolated, its own life, to the great detriment of the mental organism. This tendency is not only manifested in artificial experiments; it continually gives place to natural phenomena, which are quite analogous to suggestions. Fixed ideas are for us phenomena of this kind; that is to say, psychological phenomena which are developed in the mind in an automatic manner, outside the will and the personal perception of the patient, but which, instead of being, like suggestions, experimentally called forth, are formed naturally under the influence of accidental causes. This difference in the artificial or natural provocation of automatic phenomena has, from a clinical and especially therapeutic point of view, quite grave consequences to justify this distinction. Ideas of this kind have been described at length in the case of patients considered as lunatics. They went under the name of obsessions, impulsions, phobias; they characterise the delirium which develops with some neurasthenics or, as they are often called in France, certain degenerates. We shall repeat here what we have already said in speaking of abulia.

1 Stigmates mentaux de l'hystérie, p. 122.

278

Fixed Ideas

Unquestionably, this characteristic belongs to these patients; we in nowise deny it; we shall only say that it also belongs to hystericals; that with them it is very frequent, and that it is the cause of the great majority of their accidents. After having reviewed the different forms which the fixed idea takes with hystericals perhaps we may be able to prove certain characteristics peculiar to these patients and differentiating these phenomena from other forms of obsession met with among divers lunatics.

§ 1—DESCRIPTION OF FIXED IDEAS AMONG HYSERICALS

A lunatic tormented with fixed ideas, whether he accords them full credence or struggles against the encroaching delirium, has always an exact knowledge of the thoughts which torment him. He expresses them by words, or, if he does not explain them clearly, it is because he seeks to conceal them; if he meant to be sincere he could always express them. It is quite different with the hystericals: it is rare with them to account clearly for a fixed idea which besets them. Generally, they maintain that their mind is perfectly tranquil, without any preoccupation. It is not always possible to accuse them of dissimulation and their sincerity may be tested. It is sometimes found that these patients are very confiding and very sincere, and that they even confess most hidden things. Is it to be supposed that they could conceal a fixed idea much more insignificant? A large number of authors have not thought so; they have remarked that hysterical accidents do not seem connected with the patient's thoughts. These accidents continued to exist even when the patient was quite absent in mind and appeared to think of something else. It has even been demonstrated that these accidents persisted during the night, during a profound sleep, or during attacks; in conditions, in a profound sleep, during attacks; in conditions,
of thinking of his fixed idea. These quite correct observations have led to the denial of fixed ideas in hysteria.

We think that it is necessary to admit the existence of a particular form of fixed ideas peculiar to hystericals, which we would designate as subconscious fixed ideas. The word "consciousness," when applied to fixed ideas and deliriums, has sometimes taken, in the language of alienists, a particular meaning. It means that the subject is aware of his delirium,—recognises its being false. An unconscious delirium is, on the contrary, a delirium to which the patient abandons himself without judging it, and which he accepts as true. We are sorry that we cannot accept this meaning, in reality incorrect, of the word "consciousness," for we have been obliged to use these terms in another sense. A fixed idea, like any kind of psychological phenomena whatever, is conscious, not when it is judged, but simply when it is known by the subject, and it is in this sense that the fixed ideas of those under so-called obsession may be said to be conscious. We believe that it is extremely important, in order to understand hystericals, to know that with them fixed ideas may lose this character and present themselves under the aspect of subconscious phenomena.

How can the existence of an idea, the definition of which is not known to the patient and cannot be expressed, be clearly demonstrated? We must have recourse to all the processes of observation which the experiments on subconscious acts have brought to our knowledge. Subconscious phenomena are manifested, as we have seen, in various ways: it will be the same for subconscious fixed ideas. 1st. These ideas may develop completely during attacks of hysteria and express themselves then by acts and words. 2nd. In dreams more or less agitated which take place during sleep and natural somnambulisms and which often happen unexpectedly; it is at such moments that fixed ideas are wholly confessed. 3rd. One of the best processes consists in causing the patient to enter artificially into a state similar to the preceding ones—namely, an imposed somnambulism. At one time, abandoned to himself in this artificial condition, he has dreams which he expresses aloud; he gives himself up to acts as in a natural somnambulism, and reveals his thoughts; at another time he talks to us, answers our questions. It is astonishing to see how subjects during their somnambulism find again with precision and clearness recollections, ideas, of which they had no consciousness during their waking state. They explain then most accurately the idea that besets them and give a detailed account of all the sensations, of all the images which have determined and still determine the accidents. 4th. It is known that subconscious thoughts may be manifested even during the waking hours of the patients and without their knowing it. Certain acts which they perform automatically when they are vacant in mind enable us to guess these ideas. But when it is possible to employ it, the process, which consists in utilising automatic writing, is more exact than all the others. It is useless to go back to the description of this writing discovered by the spiritualists; it has to-day no longer the religious character the disciples of Allan Kardec assigned to it, it may in many circumstances subserve a medical purpose. Let us also point out a process, less known, which, in very particular cases, may also serve to bring to light subconscious ideas: the process of "crystal gazing," described especially by English authors. Many patients, hystericals almost always, we think, cannot look fixedly upon a moderately shiny surface without having indubitably hallucinations. They see their own dreams filing off in the mirror, and sometimes they thus happen to perceive and express ideas they could not account for previously. Such are the processes, still very imperfect, which permit us to penetrate a little deeper into the minds
of patients. Allow us to reproduce, as an example, an old observation which we have already published, and which, although lacking precision on certain points, is interesting, for it seems to us, saving possible error, one of the first observations made concerning subconscious fixed ideas in a hysterical:

It would be necessary to pass in review the whole of mental pathology and perhaps even a large portion of physical pathology, to show all the psychological and corporeal disorders which a persistent thought may thus produce outside of personal consciousness.

One of the subjects we have often cited under the name of Marie presents an equally curious disease and cure. This young girl was brought from the country to the Havre hospital because she was thought insane and her cure despaired of.

On the approach of menstruation, Marie's disposition changed; she became sombre and violent, which was not habitual to her; she complained of pains and nervous shocks in all her limbs. Yet matters went on as well as usual during the first day. Twenty hours later, however, the flow stopped suddenly and a severe chill shook her whole body. A sharp pain started slowly from her abdomen to her throat and the great hysterical crisis began. The convulsions, although very violent, did not last long and did not look like epileptic movements, but they were followed by one of the longest and severest deliriums. At one time she would utter cries of terror, talking all the while of blood and fire, and trying to escape the flames; at another again she played like a child, talked to her mother, climbed on the furniture, upsetting everything in the room. This delirium and these convulsions alternated with short moments of repose during forty-eight hours. The scene ended with several blood vomitings, after which there was a return to the usual condition. Marie calmed down, but did not remember anything that happened. In the interval of these great menstrual crises she suffered from small contractures, sometimes in the arms, or in the chest, or in the intercostal muscles, from varied and very changeable

anesthesia, and above all from a complete and continual blindness of the left eye. Besides that, she had from time to time slight attacks which were without much delirium, but which were characterised by manifestations of terror. This illness, so evidently connected with her menstrual periods, seemed wholly physical, and afforded little interest to the psychologist. For this reason we at first paid but little attention to the case; we had but a few experiments with her in hypnotism, and a few studies as to her anesthesia, and we avoided all that might have disturbed her about the time when the great crises occurred. She remained thus seven months at the hospital, the various medications and hydrotherapeutics which were tried doing nothing toward any modification of her case. Besides, the therapeutic measures, particularly the suggestions relative to menstrual periods, had only bad effects and increased the delirium.

Towards the end of the eighth month, she complained of her sad fate and said in a kind of despairing tone that she saw very well that there was no help for her. "Come now," we said to her, impelled largely by curiosity, "explain to us for once what you feel when you are about to menstruate?" "Why, you know it very well: everything stops; I have a big chill, and I don't know any more what happens to me next."

We then asked for correct information as to the manner in which her first menstruation had begun, and how it was interrupted. She did not at once answer clearly; she seemed to have forgotten a great part of the history of it. We then concluded to put her into a deep somnambulic sleep which might possibly restore those recollections. We were not mistaken. We brought back the exact remembrance of an event which had never been fully known.

She had menstruated the first time when she was thirteen years old; but, in consequence of some childish fancy or some talk overheard and not well understood, she took it into her head that there was some shame connected with the affair, and sought some means whereby to stop the flow as soon as possible. In the course of some twenty hours, she went out secretly and plunged into a big tub of cold water. She
succeeded completely; the courses stopped suddenly, and notwithstanding the severe chill which followed, she was able to reach home. She was ill for a considerable time and in delirium for several days. However, all calmed down, but the courses did not reappear for five years. When finally they did, they brought with them the troubles I have described. Now, if we compare the sudden stoppage, the chill, the pains she describes at the present day in her waking state, and the story she tells in her somnambulistic state, we come to the following conclusion: Every month the scene of the cold bath is repeated, brings about the same stoppage of the menses, and a delirium which, to tell the truth, is far more severe than formerly, until a vicarious hemorrhage takes place through the stomach. But she is not normally conscious of anything of this and does not even understand that the chill is the consequence of the hallucination of the cold bath; it is therefore likely that this scene takes place below the surface of consciousness, and is the hidden cause of all the troubles in the case.

We do not care to show how, by modifying this subconscious, fixed idea, we have been able, quite easily, to cause the attacks and the delirium to disappear; they are questions of therapeutics foreign to our present study; but we must recall to mind that all the other symptoms presented by this patient were of the same nature as the preceding.

After having established this result, it was necessary to study the other conditions. We pass over the details of the psychological research, which was sometimes difficult: we found the crises of terror were the repetition of an emotion she had experienced in seeing, when she was sixteen, an old woman killed by falling down a stairway; the blood of which she always spoke in her crises was a recollection of that scene; the same in regard to the image of the fire: it probably occurred through an association of ideas, for it is not connected with anything exactly definite. By the same process as the one mentioned above, bringing, namely, by suggestion, the subject back to the time of the accident, we succeeded, though not without trouble, in changing the image—in showing to the

patient that the old woman had simply stumbled and was not killed, and in erasing the terrifying conviction. The crisis of terror returned no more.

Finally, we wished to study the blindness of the left eye; but Marie when awake objected, saying that she was so since her birth. It was easy to verify the matter by means of somnambulism, and tell her she was mistaken. By the well-known process we change her into a little child five years old; she resumes the sensitiveness she had at that age, and it becomes manifest that she could see very well then through both her eyes. It is then at six that the blindness began. On what occasion? Marie, when awake, persists in saying that she does not know. During the somnambulistic sleep, and thanks to successive transformations during which we make her rehearse the principal scenes of her life, we discover that the blindness began at a certain moment and as the result of a trifling incident. She had been obliged, despite her cries, to sleep with a child of her age who had the mumps on the whole left side of her face. Marie had subsequently patches of mumps which seemed somewhat identical with the child’s, and were seen at the same place. These patches reappeared for several years at the same time, then were cured, but we failed to notice that from that time she was anesthetic on the left side of her face and blind in the left eye. This anesthesis did not leave her from that time, at least not to go beyond what has been observed at some time previous to that to which we transport her through suggestion; she has still that same anesthesis, although the rest of her body recovers at certain epochs complete sensibility. Her cure was due to the same attempt previously made: we carried her back to the child she had such a horror of; we made her believe that the child was very nice, that it had no mumps at all. She was not quite convinced at first, but after two repetitions of the same scene, we gained our point: she caressed the imaginary child without fear. The sensibility of the left side returned without difficulty, and when we awakened Marie she saw quite plainly with her left eye.

play some part or other and that they invited research. We were able to observe certain significant facts: 1st. Madame D. had at times—rarely, it is true—slight attacks of hysteria. During these attacks she manifested great terror and repeated constantly words like the following: "My husband, my poor children! . . . that poor Jane who has no mourning gown . . . Oh! that man, that miserable man! . . . etc." 2nd. At night, this patient behaved in two very different ways; sometimes, and it was the fact that had been observed in the first instance, although it occurred very seldom, she fell into a deep sleep quite profound; a calm sleep; and then dreamt of the incidents of the day: "The Salpêtrière . . . M. Charcot . . . the physicians in white aprons . . . " But generally she did not sleep at all and for the following reason: as soon as she began to lose herself—doze for but an instant—she would wake with a start, all in a tremble and in a terrible fright. She could not tell what had frightened her, and looked all round as if she had some vague idea that someone had just entered. This terror would return every time she began to doze again, so much so that she preferred keeping her eyes open and would rather not sleep. The other patients, her neighbours, thought her asleep, and were not aware of anything wrong. Once, while in a profound somnambulism, she explained to me these nocturnal terrors: the moment she was asleep, she had an hallucination; she saw entering the room the man who had scared her in the month of August and heard him say distinctly these words: "Prepare a bed, Madame D.; your husband is being brought home dead." 3rd. Even during the somnambulism, she had, when left some time to herself without being spoken to, sudden starts of terror. She would stretch her head as if listening to someone, and murmur a few words between her teeth: "Oh! this man, this miserable fellow! . . . I would rather die, I shall kill myself . . . etc." It was no easy thing to bring her out of this state of reverie when she had once been allowed to sink too far into it, for then she would become insensible, which was not usual with her. 4th. Even during her waking hours, she had frequently sudden starts, gave smothered cries which she imme-
diately repressed, because, she said, she did not know what they meant. In one word, the preceding remarks make us often think that the terrifying event of the 28th of August has not disappeared from Madame D.'s mind; it is repeated in the form of hallucinations much oftener than we think; it possesses her mind during the day and destroys her sleep in the night.

In studying separately the various accidents of hysteria, we shall often have occasion to adduce other examples of subconscious fixed ideas; we must point out here only the most characteristic cases to give a comprehensive idea of the general characteristics of the phenomenon. One of the observations which appear to us worth briefly recalling here is that of a patient whom we have often alluded to by the name of Isabella. She arrived at the Salpêtrière in an extremely weak condition, for she had been refusing to eat anything for six weeks. The injected food was never thrown up and was perfectly digested; it seemed evidently a case of purely mental anorexia. However, neither exhortations, nor begging, nor threats have been of any avail; the patient tries to eat, but at the sight of the first mouthful she pushes all the rest away with loathing. Of course, it will be said, this is a fixed idea; unfortunately it seems impossible to discover the cause of it. Isabella has been questioned on all sides by many people and in all sorts of ways; she does not appear to be a dissembler, and when she is urged she confesses to much graver things, things she would have every reason to conceal, but she has no explanation for her refusing to eat. “I assure you,” she said, “I am not at all possessed with the idea of not eating; it seems to me even that I should like to eat; but at the moment of beginning, the thought of it chokes me, disgusts me, and I cannot. Why? I don't know; I assure you it is not that I wish to die; I begin even to be afraid that I may; but despite all my efforts to eat there is something that prevents me.” If we stop at this we shall let her die of hunger indeed, not understanding her case. This must not be. We examine her in all her subconscious states: in her sleep, during the delirium of the attack, in her somnambulism, her automatic writing, etc.; but we always get the same answer. Her mother, who is dead, appears to her during the attacks, blames her for some fault she has committed, tells her that she is not worthy to live and that she ought to join her in heaven, and bids her for this reason not to eat. This hallucination is connected with a whole succession of anterior events and it is evident that it does not alone constitute the whole of the disease. But at least it keeps under its mastery the symptom of the anorexia, for it is enough to modify it for the symptom to disappear. The patient when awake is quite surprised to find herself eating easily without feeling “that something which prevented her before.” True, after the next attack the anorexia begins again, because the hallucination has again taken place and persisted under the form of subconscious suggestion. It is for this subconscious delirium that she will have to be treated.

Isabella presents constantly conditions which have the same character; we shall cite but one other in the interest of the study of dementia. For a week or so she has been gloomy and sad; she hides and will not speak to anyone. We have trouble in getting a few words from her, and these she says very low, casting her eyes down: “I am not worthy to speak with other people. . . . I am very much ashamed, I have a crushing load on my mind like a terrible gnawing remorse. . . .” —“A remorse about what?”—“Ah! that’s just it. I am trying to find it out day and night. What is it that I could have done last week? for before I was not thus.”

Tell me candidly, did I do something very bad last

Mental State of Hystericals

week?" This time, as will be seen, the question is no longer about an act, but about a feeling, a general emotional state which she interprets as remorse; she is equally incapable of understanding and expressing the fixed idea which determines this feeling. If you divert the subject's attention, you can obtain the automatic writing, and you will see that the hand of the patient constantly writes the same name, that of Isabella's sister, who died a short time ago. During the attacks and the somnambulic sleep, we establish a very complicated dream in which this poor young girl thinks she murdered her sister. That is quite a common delirium, you will say; perhaps so; but for a hysteric it presents itself in a rather curious manner. She suffers only from its rebound, experiences only the emotional side of it; of the delirium itself she is wholly ignorant; the latter remains subconscious. There are many other phenomena exhibited by this young girl which it were well to describe; we shall come upon them again in the treatment of hysterical deliriums; quite a number of other examples will gradually confirm this first description. We are glad to find that several authors, particularly MM. Breuer and Freud, have recently verified our interpretation, already somewhat old, of subconscious fixed ideas with hystericals.¹

It will be seen by this last example that, in some cases, a small portion of the fixed idea may be conscious. Isabella feels that she is troubled by some remorse, she knows not what. It thus frequently happens that hystericals, during their normal waking time, complain of a certain mental trouble, so much so that they partly look as if obsessed. Célestine experiences thus feelings of anger which she cannot explain. Bertha has sudden hallucinations "which," she says, "come upon me I know not whence." All at once she sees her uncle or her cousin before her, of whom she had no thought a moment before. Catherine hears an inner voice constantly saying to her: "I am consumptive; I shall no longer be able to walk; all is over," etc. These apparent phenomena constitute but a small part of the fixed idea. In reality these patients have complete dreams, connected, in the case of one, with an insult; in the case of another with misfortunes brought upon her family by an uncle; in the case of Catherine, with a consumptive aunt whom she nursed at night. These dreams are subconscious and manifest themselves clearly only by the foregoing processes; they send "messages" to the normal consciousness and disturb it. At times the fixed ideas seem to fill the whole consciousness, but that happens only in abnormal states of somnambulism, or attacks separate from the normal-consciousness. These characteristics of the fixed idea are clear and frequent enough to characterise hystericals. We shall meet them again in most of their attacks.

§ 2—DYSÆSTHESIAS AND HYPERÆSTHESIAS

Among the many conditions in hysteria the simplest are disorders of sensation. We do not mean by this those diminutions of sensation which have already been studied under the name of anaesthesia, but more accidental disorders, and for the patient more inconvenient. They are mostly alterations or exaggerations of the normal sensibility: dysæstheasias and hyperæstheasias. Many hystericals seem to have imperfect perceptions of the impressions which strike their senses. This is sometimes simply the consequence of anaesthesia; they say, for example, that their food has no taste, that it tastes like sand, and they call for vinegar and very spicy condiments. But the transformation is often more complete.

kind of excitation, even the slightest, induces these contractures. We do not pretend fully to explain this phenomenon, to say what share the cord or the brain takes in it; we simply know that there are mixed with it incontestable psychological phenomena, and that, notwithstanding the anaesthesia of a member, the diverse excitations provoke distinct sensations. Is it not natural that excitations of the same kind should develop contractures upon these anaesthetic and paralysed limbs, abandoned by the personality and given up to subconscious phenomena? We see, in certain cases, as in the observation of Barb., legs completely anaesthetic present alternately phenomena either of rhythmic chorea, or of contractures, or of partial catalepsy, or of paralysis. The reason is that, in fact, these different phenomena are so closely allied that they mingle intimately.

This explanation appears to us applicable to a group of conditions quite clear—namely, the paralyses and contractures which we have qualified as general; those that take the paraplegic and especially the hemiplegic form. They present a characteristic aspect and claim a distinct interpretation.

5. Theory of paralyses and contractures through a fixed idea.—It is quite evident that there can be no question as to applying the preceding theories to all paralyses. Many are developed in subjects who formerly had neither anaesthesia nor amyotrophy. These form rapidly, and they have a very different aspect. Instead of striking one side of the body, they affect a single member that has been the seat of a traumatism. They are monoplegias. In a few cases traumatism may accidentally bear upon the two members of one and the same side and produce an apparent hemiplegia, which, however, will not be identical with the preceding ones. M. Charcot, after having related the case of a man who became hemiplegic on the left side after having lain on that side at the bottom of a

well, proposes, and very justly so, we think, to call such phenomena double monoplegias.'

It is paralyses of this kind which M. Charcot lectured on in 1884–1885, and which he connected, as did M. Rus sel Reynolds, with phenomena of auto-suggestion, with fixed ideas. This conception evidently raises very great difficulties and does not pretend to explain all the details; but it still seems to us to-day the truest and the most general. We will try to make evident the existence of these fixed ideas.

1. These accidents, as has been seen, have a very clear beginning; they date from an accident, from some emotion which can be clearly represented in the mind of the patient. As a general thing, there was at the beginning a contusion or even a real nervous exhaustion, due to overwork. But the local nervous exhaustion is not indefinitely prolonged. If prolonged, we ask an explanation of this abnormal duration; and the fixed idea, provoked perhaps by this momentary exhaustion, intervenes to play a predominant rôle. In certain cases, even, it may be demonstrated that a small cerebral lesion took place at the beginning of the paralysis. If hysteria is the great simulator it is also the great exaggerator, and the fixed idea develops concurrently with the motor trouble, and the discomfort brought about by the lesion. It is a very fertile idea in clinics, that of the associations of hysteria and minute encephalic lesions.

2. This fixed idea, of which we have seen the starting-point, often asserts a permanent sway. It explains how paralysis or spasm may continue when 'all signs of the original irritation have disappeared.' It gives to paralyses, and especially to contractures, their systematic aspect. What phenomenon, if not an idea, could determine those strange positions of

1 Charcot, Tuesday Lectures, i.
2 Lacassia, Études, ii., p. 75.
the hand, of the trunk, which seem to be the continuation of an action? When Lem. is always bent forward, does he not retain the attitude he had when the barrel, rolling on the deck, struck him on the thorax? In certain cases, one may still better catch the action of a fixed idea on the spot. Contractures seem absolutely permanent contractions of the muscles, yet in reality it is not so. Generally, in accordance with our view, when the leg is lying on the bed, when no one touches it, when the subject does not try to move it, the muscles are at rest and are perfectly relaxed. One can see and even feel under the hand the instantaneous contraction of the muscles at the moment of trying, or when the subject himself tries, to displace the limb. There is, as it were, an obstinacy in maintaining the limb in a determined position. Sometimes this fixed idea is conscious, and it is necessary to deceive the subject to stop the phenomenon. Lucy had a spasm of the jaws, for which we could do nothing. Someone told her to put out her tongue to us when we should enter. The notion amused her, and we found her forgetting to keep her mouth shut, and putting her tongue out to us. M. Gilles de la Tourette relates a curious example of the same kind:

M. Straussbridge—he says—cured a hysterical blepharospasm by keeping perforce the eyelids raised by means of strips of adhesive plaster. The moral was as great as the physical effect; several times when the dressing became loose, to the knowledge of the patient, the eye remained open, whereas after the plaster was taken away, the spasm returned immediately.

3. But generally the idea is subconscious and the subject is quite astonished at this stubbornness of his limbs. We must then try to penetrate into the knowledge of these psychological phenomena of which the patient is

---


---

**Fixed Ideas**

himself ignorant. In dreams, in crises, in somnambulism, we find again the initial terror, the repetition of the same accident, the same attitude of the limb. Alz. was wounded in the left shoulder by the fall of an elevator, and his arm is paralysed; but he has besides terrible attacks in which he keeps his left arm propped against the floor, while he defends himself with his right arm and casts terrified looks on his left side. He keeps exactly the attitude in which he was picked up after his fall. Pasq. presented hysterical mutism for the first time after a quarrel with his wife; his mutism is intermittent; it lasts for a few days, then disappears; but, during his periods of speechlessness, he is sombre and weeps. He has constantly before his eyes the image of his wife and experiences the same emotion, as he explains it himself very well, when in the somnambulistic state, for in that state he can speak. Cap. had her thumb caught in a door and drawn in. She presented a thumb flexed and contracted, but it was curable. Very often in the morning on waking she presents the same contracture without knowing why. It is because she dreams about her accident, as we very soon ascertain in putting her into a somnambulistic sleep. It is useless to insist on examples which are all similar.

If we give up the observation, properly so called, we can verify by experimentation the rôle of the fixed ideas in the production of the accidents. With these very patients or with others we can reproduce the same accidents through suggestion or by a shock which will awaken in the mind equivalent ideas. It is not enough to say that suggestion acts like a depressing emotion, because it induces resistance in the subject. It is thus with all suggestions, even the most cheery. The depressing emotion, if produced, and the paralysis, are consequences of the suggested idea, of the psycho-physiological states

---

which it brings along with its development, and it is always the suggested and invading idea that plays the principal rôle. Whatever standpoint you take, you find fixed ideas, more or less conscious, accompanying these paralyses and contractures.

4. What is the nature of these fixed ideas? M. Charcot has described the simplest and certainly the most frequent—the simple idea of numbness, of impotency, of paralysis. The subject thinks that he is paralysed, and he behaves like a paralysed person. He realises his condition as he conceives it, with or even without anaesthesia, according to his idea. We think that this very simple explanation is also the most true. However, other ideas may intervene and bring about paralysis in a less direct manner. Strong emotions, timidity, fright, paralyse legs without anyone expressly thinking of being paralysed. A young man, whose history M. Charcot relates, is paralysed at the moment of reading verses at an academic ceremony—a distribution of prizes. Let the representation of the scene, let the emotional state persist in the mind in a more or less conscious manner, and the paralysis will persist also.

Finally, we propose, though with more hesitancy, a third supposition. Every subconscious idea robs the principal personality of sensations and images. The medium no longer feels her hand and can no longer move it while writing automatically. Bertha is obsessed by a song she sings "within her," despite herself. During this period of time, she can no longer speak. A dream, subconsciously persistent, in which the motion of a member is represented, invades her in some sort and robs the principal consciousness of the mastery of this member. I.e., dreams that he is struggling with a thief and repulses the assailant with his right hand, while the intruder puts his knee on the left hypochondrium and tightens his hand about his neck. He shows, on awaking, a hyperesthetic point on his left side—a point which, if hard pressed, will bring back the complete hallucination of the scene, but it shows, besides, a plaque of anaesthesia at the neck, a complete insensibility, and an almost complete paralysis of the right arm. Why these two symptoms? Because these sensations of pressure about the neck and movement of the right arm form, so to say, a portion of the dream, are absorbed by it, and are no longer within the control of the personality. This is only an hypothesis. It bears on only very particular cases, on the manner in which such or such a fixed idea brings about paralysis, and not on the rôle the fixed idea plays in general in these accidents.

A few objections have been made. One may, it has been said, provoke paralyses in hystericals, while they are in a crisis, or asleep, or even while acting on their anesthetic side. These provocations act, then, physically and not morally. We are convinced, on the contrary, that a hysterical feels and presents psychological phenomena during the crisis, during the sleep, and even when she is struck on the anesthetic side. In acting thus, the operator is put in the best conditions to make suggestions. One may, it is said again, paralyse hystericals in exhausting them by the application of a magnet or by the application of a vibrating tuning-fork on the hysterical points. We may be excused from demonstrating the enormous part which suggestion plays in such experiments, and simply refer the student to what we have already said touching the magnet and hyperesthetic points. A more important objection is M. Grasset's, namely, that experimental suggestion is not always able to undo the natural accidents of hysteria. This is unfortunately true, but we are not sufficiently acquainted

---


---

D’après Guillon, Agents provocateurs, p. 354.
with the idea which induces the delirium and which keeps up the paralysis, the state in which the subject should be placed to reach it, the means to modify it, to cause it always to disappear. There are also experimental suggestions made in determined conditions which another operator will not be able to remove, unless he exactly knows how to place himself in the same conditions. This very just remark shows unfortunately that we have yet much to learn about the mechanism of fixed ideas; but it does not do away with their existence, and the problem invites further study.

We have thought proper to insist on these curious conditions and on the difficult questions they involve, which we are very far from having solved. Yet it seems that by borrowing from the different authors their most correct conceptions, in completing them, the one by the other, instead of contradicting them, we have been able to indicate how paralyses and contractures approximate other conditions. Local exhaustion at the beginning of the accident, general exhaustion during the whole duration of the malady which engenders suggestibility and fixed ideas, the development of certain stigmata, as amnesia and the diathesis of contracture, and especially the fixed ideas which alter the movements in a direct or indirect way, permit at least their partial resumption.

§ 5—GENERAL EFFECTS OF FIXED IDEAS; MODIFICATION OF THE STIGMATA

We have now reviewed some of the particular effects, effects which might be called local, of fixed ideas, and we have seen that they can produce on such or such a point of the body hyperesthesia, choreic movements, paralyses, contractures, etc. But their action extends still farther; they are not confined to an isolated modification of a phenomenon or function; they have a most serious influence upon all the other psychological phenomena and transform the whole train of thought.

This opinion has already been partially expressed by those who have pretended to explain the stigmata of hysteria by fixed ideas. Certain patients seem, in fact, to have a more or less clear idea connected with their amnesias or their motor weakness. Marcelle, whose abulia was so characteristic, dreamt that she was paralysed. Others, again (it has been readily noticed), present their stigmata only at the moment when they appear to have become aware of them, and they no longer show them when they are not thinking of them. We think we catch them off their guard; that they have given up playing the comedy of insensibility or of amnesia, and we conclude easily that these stigmata are a sort of fixed ideas which happened by accident.

This explanation would be simple enough. The subject does not feel, does not remember, because he suggested to himself the idea of not feeling, not remembering. Unfortunately, we have not seen so direct an influence of fixed ideas upon stigmata; the observation of a great number of very regular facts, facts easily proved, prevent our likening stigmata—anaesthesia, for example—to accidental symptoms. (1) There is always a precise event at the beginning of the accident due to the fixed idea; here we see nothing in the history of the patients which could have put into their heads the idea of not feeling anything on their left side, or of having their visual field restricted. (2) The accidents from fixed ideas are known by the patients; the stigmata are so much a matter of indifference to the patient that they are generally ignored. (3) It is true that certain fixed ideas are subconscious, but we find the thought of them in somnambulistic states or by processes which permit us to prove the subconscious phenomena. Never did any of these processes enable us to establish a fixed idea concerning
stigmata. (4) The thought of the accident determines the nature of the symptom; in other terms, the patient realises a symptom as he conceives it. On the contrary, we find in the stigma complicated characteristics of which the subject has no idea whatsoever. Has he any suspicion of the strange disturbances of the movements which muscular anaesthesia brings with it? Had he a notion of this syndrome of Lasègue's, which we sometimes discover in him when he is brought to the hospital? (5) Fixed ideas, being accidental and personal, are very variable; we can not enumerate the curious tics we meet with, and we may always expect a still greater number which we had not foreseen. Stigmata are perfectly regular and have remained the same since the Middle Ages to our own time in all the countries where they have been observed. (6) Finally, we have already remarked that fixed ideas are not habitually developed, except in quite particular cases, and only at a period of the disease already well advanced. This disposition to suggestibility, to the division of consciousness, is not complete at the beginning. Now, stigmata often show themselves very soon at a period when the fixed ideas cannot have this strength and persistency.

To be sure, in certain cases, characteristics partially analogous to stigmata, anaesthesias, or disturbances of motion may be determined by suggestion. But we believe that it is not the natural development of these symptoms. As a general thing, they are not accidental, but they are the expression of a cerebral weakness, of a narrowing of the field of consciousness whose general laws we have tried to indicate.

The influence of the fixed ideas upon stigmata is of another nature; it is indirect. An idea of any kind, which seems to have no connection with sensibility or memory, determines by its presence alone a weakening of personal perception, which betrays itself outwardly by an increase of the stigmata. The fact is quite evident and very simple if we consider conscious fixed ideas—that is to say, known and avowed by the subject—and their influence on the will and the attention. We shall indicate only one example of intense abulia kept up by a fixed idea in an hysterical. Ger. had for ten years exercised the functions of a concierge (doorkeeper) in the same house, and she had always shown much activity and attention to her work, although she had already had a few hysterical crises on account of violent emotions. Now, for six months, her disposition and her conduct completely changed. She gradually gave up all work; she is nearly always lying down, even in the daytime; she seems to suffer excruciatingly as soon as the least service is asked of her. Besides, she forgets about things, answers at random, and does not seem to understand anything longer what you either say or write to her. She has got so far as completely to neglect her child and no longer to recognise him. Of course, all possible maladies were supposed. A physician even attributed her difficulty of motion to rheumatism, and explained all by the dampness of the yard. When we tried to account for what was inducing so intense a case of abulia we became soon aware that the patient tried to conceal something. Taking her aside, and insisting somewhat, the confession was not hard to obtain. Ger. had met a swindler who had taken full possession of her. Either by means of hypnotism, as she contends, though without proofs, or by more natural means, he had made himself thoroughly master of this very feeble hysterical. Gradually, by various pretexts, he had made her entrust him with all the money she had laid by, and then he disappeared. Ger. thought day and night of her thief, believing herself in his power, and, though robbed herself, she expected every moment to be arrested by the police. This continuous preoccupation had brought about a number of nervous disorders
and especially a complete abulia. We hypnotised this patient—less to know about her fixed idea, about which there could be no question, than to find out what the thief's former successes might have been. The woman is, in fact, very easily hypnotised, but we do not think that the thief put her really to sleep. Besides, she is so suggestible when awake that any complicated process was perfectly useless. All that was wanted was a few suggestions and, above all, sound, practical advice to put everything in shape again. The proprietor of the house undertook the detection of the thief, and Ger. was at once relieved of all preoccupation. Immediately her laziness, her fatigue, mental troubles, and even the pretended rheumatism disappeared as by enchantment. Ger. began again to take care of her child and house and recovered all her attentiveness as concierge.

The same observation is more difficult to make when fixed ideas are not known to the patient, but remain subconscious. Here is a rather curious example, which shows at the same time one of the dangers of post-hypnotic suggestion. M. came to see us one evening about various troubles. It was after having caused her to pass into this second state that we talked with her and gave her some advice. Then we walked her without thinking of repeating to her the same advice during the waking state. A few days later she wrote us the following letter:

I cannot understand the state I am in; I must appear very odd to people. It is so difficult for me to understand; I fancy everybody is looking at me. I have absolutely no feeling; I drop everything, which makes me look very stupid; I cannot work any more, and if they become aware of it in the house I shall be indeed badly off . . . I do not know if I am in the wrong; I have a vague remembrance that I have some work to do. I have tried for two days to find out what it all means. . . . I cannot; probably I am all mistaken. . . .

As may be guessed, it was enough to put her to sleep again to free her from this ill-made suggestion, and give her back her tranquillity and free disposal of her attention. The fixed idea belonged only to the second consciousness, since M., when awake, could not find it again and yet it provoked a general abulia. Besides, in all cases of a subconscious fixed idea, which we have described, that same perturbation of the will and of the attention reappeared.

Fixed ideas have an analogous effect on sensibility; we do not believe that, except in very rare cases, the fixed idea provokes directly anaesthesia, but it provokes it often in an indirect way. Justine has not usually a very clear anaesthesia or contraction of the visual field. She comes one day with a gloomy and ill-natured face; she answers badly to the questions put to her and does not react when pricked. We perceive that she is totally anaesthetic and that she has her visual field contracted to twenty degrees. We can obtain but little information concerning what has happened, for she tells us only that she is angry with her husband and that she had wanted to strike him with a knife. She is ashamed of the thing and cannot understand how she could have allowed herself to yield to such violence. When she is sound asleep, she relates that yesterday morning, while she was waiting for her douche, she heard about a patient who came generally with her and who had been shut up in an asylum because she wished to kill her husband; "and I also," she said,—"I am crazy and want to kill," etc. The fixed idea of the somnambulic sleep was destroyed. On waking Justine was quiet; she had at the same time recovered complete sensibility and her normal visual field. Yet we are sure we had made no allusion to her anaesthesia, but it had spontaneously disappeared along with the dream. This observation is exactly repeated in the same manner with other patients—in particular with.
Maria—with this difference, that with her it is always the same fixed idea that reappears. When she is found anæsthetic we are sure that she, more or less consciously, dreams of drinking ether. The fixed idea is with many patients a great cause of anæsthesia, especially with those who are not regularly and constantly anæsthetic, and who become so only by accident or in consequence of an emotion.

Finally, the fixed idea plays a rôle still more curious in the formation of another stigma, of amnesia, and especially the variety which we have called continuous. We noticed a long time since that all patients who presented in a very clear manner this complete oblivion of recent events in the course of their development, Marcelle, for instance, Justine or Maria,1 were at the same time obsessed by fixed ideas, generally latent, and we wondered what influence these two phenomena might have one upon the other. The study of a patient extremely remarkable from this point of view, whom we have already described under the name of Mme. D.,2 cut short our hesitations. We shall sum up these researches in a few words to complete an important observation. Mme. D., after nine months' illness, still forgot all recent events a few minutes after they had occurred. On the other hand, she pretended, when questioned on this point, to be troubled by no dream, by no idea, and that her mind, except its lack of memory, was as free as it was in the past. We wanted to assure ourselves of this detail and ascertain if really Mme. D. had, unlike the other patients, this continuous amnesia without fixed ideas. We were not long establishing, in her case, obsessions of the gravest sort, unknown to herself, which, nevertheless, disturbed completely the cerebral function. These fixed

1 L'amnésie continue. Communication au Congrès de psychologie expérimentale de Londres, August t. 1892; Revue générale des sciences, 1893 p. 167.

2 Stigmata mentaux de l'hystérie, 1892, p. 94.
between continuous amnesia and fixed ideas. When the latter waned, memory improved; when the fixed ideas again were predominant, which, unfortunately, was but too frequent, the continued amnesia became completely restored. These new stigmata may, then, as the first, be an indirect consequence of the existence of fixed ideas.

How shall we interpret facts of this kind? Very simply, if we but remember what we have supposed while studying stigmata. They were for us nothing more than the manifestation of a great absence of mind; of the narrowing of the field of consciousness incapable of holding all the psychological phenomena. Now, fixed ideas, it will be conceded, are one of the great causes of distraction. It is very evident, even in the case of the normal man, that a mind possessed by a persistent thought is less apt to perceive new sensations and images. With hysterics, whose power of thought and perception is already reduced, a fixed idea will be still more in the way, for it absorbs what little attention the subject has to dispose of, and leaves him more absent-minded, more anaesthetic and amnesic than before.

Let us add that these fixed ideas often deprive the patients of sleep, which is by no means insignificant in maladies caused by the enfeeblement of the psychological synthesis. "Memory," said the physiologist, M. Lesage, of Geneva,1 "is the intellectual faculty which the want of sleep most affects." Let us also add that fixed ideas, like suggestions, are encroaching in character, that they seem to seize and attract certain sensations and certain images taken from the normal consciousness, and we shall understand how they increase the stigmata of hysteria. This influence of fixed ideas may be considered as a verification of the hypotheses which we have presented on the nature of stigmata. The particular

1 Quoted in the notes of the translation of Dugald Stewart, by Prévost, Genève, 1808, ii., p. 450.

Fixed Ideas

form which this weakening of perception takes, according to the case, we cannot explain. We shall remark only that the general effect of fixed ideas among the patients is about the same with all. At the moment when the fixed idea develops more or less subconsciously, all become abulic, anaesthetic, amnesic. Mme. D. is absolutely anaesthetic during the dreams we have described, and Maria becomes amnesic when she thinks of ether. But, besides this general effect, there is a special localisation of the weakness of perception of the motor images, of the images of remembrance, or of the sensations, which is the reason that Marcelle is generally more abulic, Mme. D. more amnesic, and Maria more anaesthetic. These differences are due to particular conditions which we cannot always explain.

CONCLUSION

"Many conditions of hysteria," said M. Charcot formerly, "are accidents of a psychological order, and are due to the patient's thoughts." This idea has been adopted and repeated by most authors.

We have endeavoured to confirm these hypotheses by analysing the mental state of the patients who presented hysterical disorders, showing that the fixed ideas were sometimes misunderstood because they were concealed, but that they always played a principal part. Finally, we have shown that such phenomena intervened even in hysterical stigmata, and that they produced them in an indirect manner by diminishing the force of personal perception. Before studying the laws of these fixed ideas and the conditions of their formation, we must examine one other of their effects, one of their most remarkable consequences, the hysterical crisis. For the present we shall be content with studying their frequency and their importance.