

"THE TREATMENT OF HYSTERIA"

To the Editor:—There is so much that is good in Capt. J. M. Wolfsohn's contribution concerning the treatment of hysteria (*THE JOURNAL*, Dec. 21, 1918, p. 2057) that it is regrettable that he has added statements which negative a great deal of the positive part of his paper. His statement that "very little has ever been contributed to the treatment but volumes on the classification of hysterical disabilities" sounds peculiar when one remembers the volumes that have been written concerning hypnotism, reeducation and psychoanalysis in the treatment of hysteria. He is modest enough at the beginning to say that the symptom is merely the outward sign, and that we wrongly say we have cured hysteria when we merely cure the hysterical symptom. Yet a little later he states that he cures more than 90 per cent. of the cases within the first twenty-four hours. The old methods of reeducation, combined with the use of mechanical adjuvants, he speaks of with kindly tolerance. He states that he cures in from one-half to one hour the same patients who had electrical treatment for six months by these old methods. Arousing our interest in this way, it comes as a disappointment when we later read that his methods consist also in the use of these mechanical measures coupled with peremptory commands. To quote from one of his cases: "He was finally treated with a mild faradic current and cured after three hours of treatment." To make matters worse, Captain Wolfsohn in his rules of treatment says that every case must be studied fully, and especially psychologically, before treatment is begun, and that this can even take the form of psychoanalysis. How inconsistent this sounds in connection with his remarks in the earlier part of his paper that "he cures and completely cures more than 90 per cent. in twenty-four hours." If Captain Wolfsohn can make a complete psychologic study of every hysterical patient in one day, he is doing more than has heretofore been thought possible. However, I am sure he does not mean this but that he has allowed his enthusiasm to overrun his form of expression. Exaggeration and overvaluation of one's efforts is a hysterical trait, one of those often untouched and untreated manifestations of the hysterical psyche which the Captain speaks about in the earlier part of his paper. The importance of suggestion and the stronger influence that suggestion furnishes under military discipline perhaps explain the remarkable proportion of cure of symptoms he has effected. One gathers from his paper that he is a disciple of Babinski and a believer in the Déjerine isolation treatment but since "very little has ever been contributed to the treatment" he ignores those sources upon whose methods his own are based. In military circles one can do more than in civil life. "When the patient resists the cure," the Captain says, "this must be broken down by strong persuasion or by faradism." In civil practice, when the patient resists a cure the physician must desist because, as a rule, the patient goes to some other physician. This negatives also some short roads to a successful treatment which the Captain offers, such, for instance, as: "Do not discontinue the treatment until the cure is accomplished." And we feel that Rule 25, which says that "the secret of psychotherapy is a mental combat between the physician and the patient," is, to say the least, a rather unscientific and certainly unpsychologic point of view.

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To the Editor:—I have read the article on "The Treatment of Hysteria," by Capt. Julian M. Wolfsohn, with the hope of getting some new and really advanced ideas on the treatment of hysterical cases known on the firing line as shell shock cases. Many of these cases have been treated here in American base hospitals, with the exception that the injuries causing the condition were not received on the firing line; but these cases demonstrated all the points of interest that Captain Wolfsohn set forth in his interesting paper. In his final analysis, however, in laying down the cardinal principles of treatment, he fails, in my opinion, to state at least two, if not three, very important factors:

First, it would seem that at least many of these patients sustained some physical injury in combination with the hysteria, and that in all the cases he reports there was not

one with a purely psychoneurotic disturbance alone. It has been demonstrated beyond a doubt that the patient who originally received a physical injury followed by some form of psychoneurotic symptoms is more easily cured: there is a physical fact from which one may convince the patient that he has recovered; and now that he is physically normal, he must be nervously normal as well.

Second, in the cases reported, all the patients were ill from a few weeks to many months. During that time, while waiting for the physical disturbance to clear up, the patient has been receiving subconscious mental treatment that has not been stimulated from the standpoint of intensive mental treatment by reeducation, which is a real fundamental principle in the treatment of all psychasthenic or psychoneurotic cases. In other words, the patient has undergone a real physical treatment with nervous and mental rest, and when the psychologic time arrives, he is cured almost instantly. This is beautifully illustrated by Wolfsohn's statement that some patients were cured in a few minutes, others in several or many hours, and others after days of anxious observation, waiting for that psychologic moment to arrive. The mental attitude of the patient has everything to do with this so-called spontaneous cure.

I simply make this criticism because the ordinary practitioner will not take into consideration the fact that hysteria without an actual physical cause is not as a rule cured in this way, and as easily as those cases in which some physical violence has been demonstrated or sustained. I could add a number of almost similar results, but it would be a repetition of what has been set forth in this interesting and valuable paper.

These two points, then, should be added to the twenty-seven general rules laid down: First, that the physical condition of the patient must be perfect ere treatment is begun for spontaneous cure, and second, that the long hospital treatment makes it possible to distinguish between a hysterical case with actual physical trauma and a case of purely nervous trauma.

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**ACTION OF DIGITALIS AND ATROPIN, WITH
ESPECIAL REFERENCE TO THE HEART**

To the Editor:—Digitalis affects the heart mainly in two ways: 1. It stimulates the pneumogastric center in the medulla, the resultant inhibition lessening the number of beats of the heart by prolonging the pause in diastole. Relaxation of fibers is increased; added rest is secured. Inhibition of some impulses from auricle to ventricle occurs—hence its value in auricular fibrillation. 2. It affects the heart muscle directly, increasing the strength of the ventricular contractions.

Atropin, in sufficient dose, paralyzes the inhibitory terminations of the pneumogastric in the heart, and stimulation of this nerve therefore causes no change in the pulse after its administration. Drugs have no effect in stimulating the pneumogastric after atropin has been given in sufficient dose to paralyze the inhibitory terminations. What is the sufficient dose? Cushny says 1 mg. (about $\frac{1}{65}$ grain), and that the administration of sufficient atropin to paralyze the pneumogastric involves unpleasant dryness of the throat and difficulty in swallowing. The usual therapeutic dose of from $\frac{1}{150}$ to $\frac{1}{100}$ grain would apparently be insufficient to cause the paralysis. There is some uncertainty about this, however, as the susceptibility of individuals varies greatly.

If we grant, however, that the therapeutic dose of atropin has this effect in causing the paralysis of the inhibitory apparatus of the pneumogastric, are we justified in using it when we are using digitalis? Before answering this question we must consider what we expect or hope to accomplish with atropin. I am thinking of its indications in the extensive and progressive type of bronchopneumonia, lately so common. There is an impression among many clinicians that these patients are often relieved of cyanosis after using atropin. The cyanosis may be due to a moderate narrowing of the bronchioles already filled with mucous secretion, as