ABNORMAL PSYCHOLOGY.¹

THE sphere of abnormal psychology is not identical with that of mental diseases in general. The connotation of the term has been conventionally limited to one large class of mental diseases known as functional diseases. Our task in the following paper will be to show how these may be explained in psychological terms, and how, on the other hand, facts derived from this field of psychopathology throw new light upon the laws of working of the normal mind.

It is sometimes stated that functional diseases are those in which the brain suffers from no organic injury but, for some reason or other, is working wrongly. The mechanism of the brain and of the mind is intact but it is now functioning abnormally, *i.e.*, in such a way as to be injurious to the individual and to throw him out of harmony with his environment. For my own part, I cannot accept such a view of the divorce of structure from function, and although in these cases no gross lesions of the brain can be demonstrated, it seems almost axiomatic to hold that some material alteration, however recondite and however far transcending the powers of our strongest microscopes to detect, must be present. When the mind begins to show an abnormal working, of whatever kind, the chemical and physical changes in the brain must necessarily be different from what they previously were, unless we abandon the general view held by all reputable psychologists of a detailed correlation of brain change and mental activity. And what are we to understand by matter, if not chemical and physical *changes*? Matter is not something inert. Its essence is its molecular, atomic and intra-atomic activity. In other words, matter is itself "functional."

A better way of drawing the distinction is to say that functional diseases are such as are produced by mental causes and can be cured by mental means. Into this class would fall at the present day cases of psychasthenia, hysteria, anxiety psychosis, alternating and multiple personality, etc., examples of which will be given in the course of our discussion, but there is no *à priori* reason why the class should be permanently limited to just these cases. With improvement of our means of psycho-therapeusis and with deeper insight into the general relation of mind to body, the class may undergo extension. The dividing line is not a fixed one.

In connection with our investigation of these abnormal forms of mental activity it will be necessary for us to consider, however

1. A paper read before the Social Psychology Group of the Sociological Society on June 17, 1913.

briefly, the problems of hypnosis, the hypnoidal state, psychoanalysis, and dreams, and our ultimate aim will be to bring into line the somewhat conflicting views of authorities like Pierre Janet, Morton Prince and Sigmund Freud, and to suggest a form of compromise which may serve as a ground of explanation for all forms of mental activity, normal and abnormal alike.

The work of Pierre Janet in the field of abnormal psychology during the last thirty or more years is well known to everybody. For this reason, despite its great importance, we may content ourselves by the briefest of references to it. The general theory which Janet formed on the basis of his researches was that the personality is a synthesis of mental elements, and that disease of the personality is an interference with this synthesis. The disease or derangement may take one or other of two general forms. There may be, on the one hand, a widespread weakening of the synthesis, which alters the individual's idea of his own personality. This is *psychasthenia*. While the simpler activities of the personality, such as perception and memory, are unimpaired, the individual's judgments on these activities, recognition, reflective thought and volition, may be seriously affected. The psychasthenic says: "It is not I who feel, it is not I who eat, it is not I who speak, it is not I who suffer, it is not I who sleep; I am dead, and it is not I who see clearly," etc. Janet writes: "This incomplete character of the disturbances of the personality is found in all the accidents of these psychasthenic patients; they have obsessions but are not completely insane and always recognise the absurdity of their obsessing ideas; they have impulses but do not carry them out; they have phobias concerning acts but never real inability to perform acts, or real paralyses; they have interminable doubts but no true amnesias. It is the striking trait of their character that they never have any symptom in its completeness, and this incomplete character of the disturbances of their personality falls within a general law."¹ On the other hand, these symptoms may be carried to their completeness, the synthesis of the personality may be not merely weakened but actually destroyed for certain of the mental elements. This is *hysteria*. Sensation from certain areas of the skin, power over certain voluntary muscles, memory for certain ideas or for a certain period of the individual's life, may be completely lost to the personality itself, although by indirect methods they may be proved still to exist. Where the symptom is an anæsthesia, it may occur over an area which corresponds with the uneducated patient's views of anatomical divisions and not with the much more irregular area supplied by definite cutaneous nerves.

1. "A Symposium on the Subconscious," iv, by Pierre Janet. *Journal of Abnormal Psychology*, vol. ii, 1907-8, p. 60.

Thus it may be a "bracelet" or "sleeve-anæsthesia," affecting only the wrist or only the forearm. This fact alone is sufficient to indicate that the loss is psychical and not physiological, in the broader sense. But a good method of demonstrating the actual psychical existence of these apparently lost sensations is to distract the patient by getting an assistant to engage him in close conversation and, while his field of attention is limited in this way, to place a pencil in his right hand (hidden from his view by a screen) and whisper in his ear certain questions the answers to which he is asked to write on paper. From these answers it becomes clear that some sensation is aroused when the anæsthetic area is stimulated, even though unnoticed by the personal consciousness. In a similar way, by this method of automatic writing, memories completely lost to the main consciousness may be proved to exist. The hand may, for instance, write a detailed account of the events which accompanied the first onset of the disease, and which the main consciousness has completely forgotten.

Ideas like these which can be shown to exist in independence of the main personality and contemporaneously with it were called by Janet "subconscious," and this is the original meaning of the much misused term "subconsciousness" in the literature of the subject. It would perhaps be less ambiguous and therefore better to call such ideas "co-conscious," as Morton Prince has suggested, but if the original term is preserved at all it should always be used in its original sense. There are of course other senses in which the word has been employed, the most extreme being that in which it is identical with the "subliminal self" of F. W. H. Myers. As everyone knows, Myers regarded the normal waking consciousness with its memories as but a small fraction of the entire personality. Below the threshold of consciousness and the activities of everyday life is a much larger portion, the subliminal self, which comprises aspects of the personality undeveloped in this mundane life though conceivably capable of development under other conditions of existence. This subliminal portion is separated from the supraliminal self (the everyday self) by a semi-permeable "psychical diaphragm," through which ideas and mental powers may pass in either direction. In the anæsthesias and paralyses of hysteria the sensations and powers fall from the supraliminal into the subliminal, while in the inspirations of genius and other super-normal activities of the soul there is a "subliminal uprush of faculty" into the supraliminal. Through the subliminal we may come into closer mental relations with one another and with the spiritual universe. This theory has been subjected to much undeserved criticism at the hands of psychologists. Its main weakness is that it furnishes an over-elaborate explanation of the well-attested facts of abnormal, *i.e.*, supernormal and subnormal, psychology, while

allowing undue weight to the less certain and inadequately-verified facts of telepathy, mediumships, and spirit apparitions. Nevertheless it is not in conflict with known fact, and further insight into the nature of so-called supernormal phenomena may yet give it that compelling force which it at present lacks. The prefix sub- in "subliminal" is unfortunate since there is nothing essentially inferior about it. A more non-committal term is the "Unconscious," which is coming into favour at the present day, especially among German psychologists. Memories, impulses, and motives when not actually before the mind, *i.e.*, conscious, may still retain all their other mental characteristics, and from their place outside of consciousness may continue to exert influences upon consciousness. They form part of the unconscious, but are still psychical in nature. It is not a contradiction in terms to speak of "unconscious psychical processes," unless we identify the psychical with the conscious, for which there is really no justification. Of course there is the alternative view that these processes, when out of consciousness, are merely physiological changes in the brain. Apart from the metaphysical difficulties involved in such a view, difficulties which we cannot go into here, there are scientific reasons which make it more satisfactory to think of the unconscious in mental rather than in physical terms, in most cases. It need hardly be added that these unconscious mental processes have in all probability their own physiological correlates or counterparts in the workings of the brain, but our knowledge of the nature of these brain changes must be even more speculative than that of the unconscious processes themselves.

In extreme cases of hysteria, loss of memory and disintegration of personality may go so far as to produce either an alternation or a doubling of personality. Instances of this are a matter of common knowledge, and do not need detailed explanation and illustration here. Suffice it to say that they show all degrees of mental disaggregation, from mere alternation of mood and conflict of motive compatible with mental health to extreme cases where two souls seem to share the tenancy of one body. The best known recent example of the latter case is that of Miss Beauchamp, which Dr. Morton Prince has described with such a wealth of detail in his book *The Dissociation of a Personality*. This individual was at a certain stage of her life possessed of three distinct personalities or centres of consciousness. Two of these alternated with one another, each retaining her own series of memories but amnesic for the experiences of the other, while the third, the now notorious "Sally Beauchamp," not only had a separate consciousness of her own with a cheerful and irresponsible temperament quite alien to those of the others, but claimed that even when not alternating with them she had direct knowledge of the thoughts, feelings and

even the dreams of one of them. Morton Prince eventually cured Miss Beauchamp by hypnotism (the method and significance of which we shall consider presently), suppressing "Sally" entirely and re-synthesising the other two personalities with their separate memories and experiences into a normal individual similar to the original personality as she had been before the emotional epoch which was the cause of all the trouble.

More recently Dr. Morton Prince has met with another case of dissociated personality quite as remarkable as that of Miss Beauchamp, and closely similar in several respects. He calls her B.C.A.¹ C is the normal personality as she was before and after her mental illness, and B and A are the two dissociated personalities into which she disintegrated as the eventual result of several years of severe nervous and emotional strain. B and A alternated with one another, but whereas A had no direct knowledge of B's existence, B was immediately aware of A's thoughts and memories even when herself in abeyance. B and C also shared each other's memories as well as those of A, but A was entirely shut up within her own circle of memories and experiences. Neither C nor A remembered her own dreams, but β , the hypnotic personality corresponding to B, was able to recall the dreams of both. A was neurasthenic and represented the ethical and religious aspects of the original personality. She lived in a continual mental atmosphere of gloomy and apprehensive conscientiousness, and was appalled by the freakish and irresponsible behaviour of B, who lived only for pleasure, was completely egoistic and "emancipated," and during her periods of alternation enjoyed the most robust health. B thus showed a close resemblance to "Sally" in the Beauchamp case, and the importance of this resemblance will perhaps be clearer when we come to consider Freud's theory of hysteria. For the present we may note that B was co-conscious with A, or existed simultaneously as a subconsciousness, in Janet's sense of that term. Morton Prince was able to prove this in various ways, apart from the statements of B herself and of her hypnotic personality β . One illustration will suffice. It was arranged with β (unknown to A) that she should add together certain figures while A was present, and should show that she really had carried out the operation co-consciously by giving the answer immediately upon A being changed to β . She of course was not told what actual figures would be given. A was then brought and was asked to write out some lines of poetry in the middle of a large sheet of paper ($8\frac{1}{2}'' \times 11''$) in the left-hand upper corner of which was written the number 53, and in the right-hand lower corner the number 61. A repeated aloud what she was

1. See *Journal of Abnormal Psychology*, vol. iii, 1908-9, *passim*.

writing and commented upon her mistakes of memory, showing that she was alert and not in a somnambulistic state. On being questioned afterwards she averred that she had noticed no other writing, such as numbers, on the paper. It had appeared quite blank. Even if she had noticed the numbers she would not have known what was to be done with them, since she is amnesic for B and β . A was changed to β . "Immediately on appearing β exclaimed, almost shouted: '114,' which is correct." More complicated arithmetical calculations were carried out under similar circumstances with equal success.

Certain memories of the patient's earlier years, which were lost to all the personalities even in hypnosis, were recovered by automatic writing. In this way it was discovered that her irrational fear of cats took origin from an incident of her childhood, when she was intensely frightened by a white cat she was holding having a fit. Her dreams were frequently of cats, accompanied by a feeling of intense horror.

This case is of especial interest, in that Morton Prince prevailed upon both C (or, rather, B.C.A.) and B to write full introspective records of their experiences during and after the disease.¹ The documents are of the greatest importance, especially as their authenticity and objective accuracy is vouched for by two other distinguished American neurologists besides Morton Prince himself. We learn from B's account how this co-conscious self commenced first as a definite emotionally-tinged complex or system of ideas clearly known by C or B.C.A. She writes: "A very long time ago (she was 20 at the time) C received an emotional shock which it seems to me, as I look at it now, resulted in the first little cleavage of personality. This emotion was one of fright and led to *rebellion* against the conditions of her life, and formed a small vague complex which persisted in the sense that it recurred from time to time, though it was always immediately suppressed. This complex, it seems to me, was the same, though only slightly developed, as that which appeared later and is described as complex B." Twenty years later the sudden and prolonged illness of her husband emphasized the feelings of fright and rebellion, which now showed as "a longing for happiness, a disinclination to give up the pleasures of life which the conditions required; and there was a certain determination to have those pleasures in spite of everything, and this resulted in a constant struggle between C and this complex." After her husband's death, C became thoroughly neurasthenic and the B complex grew stronger. She would find herself doing and enjoying "things that she disapproved of and knew that she disapproved of." Finally, a year after her husband's

1. *Op. cit.* pp. 240-260, 311-334.

death, "a third shock of a strongly emotional nature" produced a sudden change. C disappeared and the B complex became a personality, with the general characteristics we have already recorded. But a month later a fourth emotional shock (felt of course by B) brought back C as the dominant personality, in the neurasthenic and psychasthenic form which we have called A. B subsequently alternated with A and at the same time became also a co-consciousness, and the conflicts between the two now took the form of antagonism between two distinct personalities. C's autobiography gives vivid descriptions of these conflicts. She writes: "I would often wake in the morning, as A, to find a note on my pillow or on the table—usually of a jeering tone—telling me to 'cheer up' or to 'weep no more,' etc.; sometimes these notes would be in rhyme and nearly all advised me not to trouble Dr. Prince so much. These notes were written by B when I 'changed' in the night, but as A, I supposed, when I first found them, that I had written them in my sleep. If my condition had been one of remorse, it was now one of despair. After a time, as A, I destroyed all the notes I found without reading them, hoping in this way to discourage B's fondness for writing. As a result I found one morning a sheet of paper pasted directly in the middle of my mirror. It was fastened at each corner with large red seals and bore the inscription 'READ THIS' and contained information which it was quite necessary A should have. As B my attitude towards myself as A was something like that of a gay, irresponsible, pleasure-loving girl toward an older, more serious-minded sister. I, as B, had no patience with A's scruples and morbid ideas and actually enjoyed doing things which I knew would shock or annoy myself as A, though occasionally as B I felt a little sorry for A." The following are extracts from the joint diary which this curiously assorted pair kept at Morton Prince's request: Under the date July 23, 190-, B writes: "I am here again to-night, B, I am. I may as well tell all I have done, I suppose. For one thing I had a facial massage—there is no need of being a mass of wrinkles. I know A doesn't care how she looks, but I do. The Q's spent the evening here and—if I don't tell, S will, I suppose—I smoked a cigarette. S was *terribly* shocked and angry with me. Now, A, don't go and tell Dr. Prince, you don't have to tell him everything—you do it, though. I *must* have a little fun." The following day A writes: "I have struggled through another day. B has told what she did. How *can* I bear it? How explain? I am so humiliated, so ashamed. Why should I do things which so mortify my pride? Quite ill all day,—I am, as usual, paying for B's 'fun.' It is not to be borne." August 20: "Terrible day—one of the worst for a long time. I *cannot* live this way, it is not to be expected. I am so confused—I have lost so much time

now that I can't seem to catch up. What is the end to be? What will become of me?" August 21, B writes: "Good gracious! how we fly around. A has been ill all day—could not sleep last night. I hope he (Dr. Prince) won't send for us for he will put a quietus on me and as things are now I am gaining on A. Had a gay evening—no discussions of religion or psychology, no dissecting of hearts and souls while I am in the flesh." August 25: "I wonder if A is really dead—for good and all? It seems like it. The thought rather frightens me somehow, as if I had lost my balance-wheel. She wants to die, she really does, for she thinks it to herself all the time. I wish I were myself alone, and neither A nor B; I cannot bear to hear A groan, she cannot bear my glee." August 26th: "Such a day! A got away from me for a little while and tried to write a letter to Dr. Prince. It was a funny looking letter, for I kept saying to her 'you cannot write, you cannot move your hand,' but she had enough will power to write some and directed it. The effort used her up, however, and I came and the letter was not mailed." August 27th, A writes: "I am too much bewildered to write. I have succeeded in writing Dr. Prince, if I can only mail it. Oh, but I am tired! Such an awful struggle!"

C was eventually resynthesised by means of hypnosis. After many fruitless attempts, the corresponding hypnotic personality γ was obtained, and, as Morton Prince says, "on being waked up, a personality was found which possessed the combined memories of A and B and was free from the pathological stigmata which respectively characterised each."

We may now conveniently consider the general nature of hypnosis and allied therapeutic methods. A typical way of inducing hypnosis is as follows: The patient is first disabused of certain misconceptions of the nature of the process which are so commonly held even by educated people. He is told that the hypnotic state need not, and as a rule does not, involve actual loss of consciousness, and that one essential condition of success is that he should be willing and anxious to be hypnotized. No one can be hypnotized against his will, and even when hypnotized he cannot be made to do anything in violation of his ethical principles. Finally the patient is told that he must not be discouraged by a failure at the first attempt, and that when the novelty of the experience wears off, success is more likely to come. Dr. F. H. Gerrish¹ has given an admirable and concise description of the method of producing hypnosis which I here quote: "The patient, thus instructed, then lies down on a couch, or seats himself in a lounging chair, in which

1. "The Therapeutic Value of Hypnotic Suggestion," by F. H. Gerrish. *Journal of Abnormal Psychology*, vol. iv, p. 103, 1909.

he has a comfortable rest for his head. He is told to concentrate his attention upon sleep, to try to go to sleep; and to assist him in this effort by preventing his taking in distracting ideas through his eyes, as they wander around the room . . . he is asked to fix his gaze upon some indifferent object, as, for example, the finger of the physician, which is held a foot or so from the face of the patient. He is instructed not to try to keep his eyes open, and not to close them voluntarily, but merely to let the lids go as they will. The physician places his free hand upon the forehead of the patient, and, by a continuous stream of quiet, monotonous talk, encourages the patient in his effort to go to sleep. For example, he says, 'Try to sleep, think of nothing but sleep, keep your thoughts fixed upon going to sleep. Your lids are heavy, they are drooping, you are going to sleep. Every moment you are getting more drowsy; you feel the sleep stealing over you. The lids are closing; you are almost asleep. Now the eyes have closed; you have gone to sleep.' Meantime a little pressure has been made upon the brows; and, when the lids slip down and cover the eyes, they are gently stroked. The hand is kept upon the forehead, and the physician enforces his assurances by some such words as these: 'You are asleep, though you have not lost consciousness. You hear my voice, the sounds in the house, the noises in the street—and yet you are asleep. You feel the sleep all through you—head, body, and limbs are all heavy with sleep. Your nerves are all relaxed, there is no tension anywhere, you are perfectly tranquilized. You will not move a muscle, except to breathe, until I bid you wake.' This is the method of hypnotisation employed by a very successful hypnotist, but of course there are other methods equally effective, and each operator tends to adopt an individual style suitable to himself. By questioning the patient while in hypnosis, the physician may penetrate to memories and strata of personality unknown to the patient in his waking life. Statements or suggestions made to him are accepted with unquestioning belief. The critical faculty is in abeyance, primitive credulity holds undisputed sway, and the inculcated ideas therefore gain an unwonted power both psychical and physiological. The analogy of "persuasion" in normal life helps us to comprehend these results in some degree, but the more extreme effects, especially those of a physiological order, still await explanation at the hands of science. To say that they are due to "suggestion" is to make a mere word do duty for a theory.

A state closely allied to that of hypnosis is the "hypnoidal state," first described by Dr. Boris Sidis. It is a kind of sub-waking condition similar to, if not identical with, that of light hypnosis, and has been found to be of great therapeutic value in the cases of patients who cannot be hypnotised or who object to hypnosis. The patient reclines in as comfortable a position as

possible, with all muscles relaxed, and is asked to close his eyes and listen to the rhythmic beating of a metronome or the buzzing of an inductorium. "When respiration and pulse become reduced, sensory-motor reaction diminished, sensory hypoaesthesia becoming occasionally hyperaesthesia, with occasional disturbances of pulse and respiration, with sudden apparently unaccountable starts, with tendencies of retention of position of limbs, and now and then with a slight tendency to resist actively any change of posture of limbs or of body without the actual presence of catalepsy, the whole feeling-tone becoming one of acquiescence and indifference, while memory with amnesic gaps begins to find the lost links and even to become hypermnesic,—when," says Boris Sidis, "we observe all these symptoms we know we have before us the subconscious hypnoidal state."¹ It is a state of greatly increased suggestibility and exalted memory, and to these two features it partly owes its therapeutic value; for the patient is able (and is invited by the physician) to live over again in memory the incident in his past life which occasioned his mental disease and obsession, and by being encouraged to scrutinize closely the exact course of development of the pathological complex of ideas learns to see it in its true relations with the rest of his mental life. In this he is helped by the arguments and exhortations of the physician. But the most important factor of the cure, in Boris Sidis' view, remains still to be mentioned. As the result of a long series of experiments on the induction of sleep in animals, children, and adults, Sidis came to the conclusion that in sleep and the sub-waking state we obtain access to a reserve fund of stored-up energy which is unavailable under ordinary circumstances in the waking life. Natural selection seems to have been instrumental in developing this reserve fund since, like nations possessed of a large reserve capital, individuals possessing the power of storing up reserve energy must have competed at an advantage with their less fortunate neighbours. We shall see presently that Freud holds a somewhat similar view of a reserve of energy in the unconscious upon which the conscious, or rather the preconscious, can draw on certain occasions. It is from this reserve store that the additional energy is derived which is requisite in the re-synthesis of the dissociating personality carried out by hypnoidization. Some remarkable cures by this method are on record. Dr. J. E. Donley² reports the case of a young American undergraduate, very intelligent but of a high-strung temperament, who, after reading a magazine article on comets, was suddenly obsessed with the fear that a comet might strike the earth,

1. Boris Sidis, "The Psychotherapeutic Value of the Hypnoidal State." *Journal of Abnormal Psychology*, vol. iv, pp. 161, 162, 1909.

2. J. E. Donley, "The Clinical Use of Hypnoidization." *Journal of Abnormal Psychology*, vol. iii, 1908.

with dire results. In the hope of calming this fear, he worked out the mathematical chances of such a mishap for himself and also got a friend who was an eminent mathematician to calculate them for him. The results he obtained calmed him somewhat, but only for a time. Although realizing the absolute absurdity of his fear, he could not shake himself free of it. He dreamt of comets constantly, feared to read his morning paper lest it might contain the news that a comet had struck the earth, and began to fear also that his obsession might set up a diseased condition of the brain. Two seances of hypnoidization, carried out according to the method just described, sufficed to produce a complete cure. The method has also been used with success in the case of a broken engagement where the man could not free himself from obsessing thoughts of his one-time fiancée, lost the power of attending to his work, and was brought to the brink of suicide. A fortnight's daily hypnoidization, in which he was encouraged to recall in detail the exact circumstances of the jilting, with all its depressing emotions, sufficed to make him "his own man" again.

The time has now come to keep our promise and give a brief sketch of Professor Sigmund Freud's views, in terms of which many of the phenomena above described seem capable of a fair degree of explanation.¹ Freud's theory is of course founded on his own observations and those of his disciples, but our confidence in the truth of its main outlines is increased when we find that cases reported by scientists who are not followers of Freud and have their own theories on the nature of hysteria and other mental diseases, fall into line with it. Freud distinguishes two forms of the unconscious (or the out-of-consciousness), viz., the unconscious proper and the preconscious. The distinction is, put briefly, one between repressed and unrepressed memories and mental activities, and does not exist in the early years of childhood, but gradually takes shape as the child passes through the various stages of ethical, social and conventional education. This course of education, together with the natural development of the mental life, involves the repeated process of repression. Primitive tendencies are held in check and driven out of consciousness by the activity of the ethical ideas of later development.

The distinction is also one between two different forms of mental activity, a primary process and a secondary process, as Freud calls them. The primary process is characteristic of the mental activity of early childhood. The young child turns away from pain instead of facing it, and tends to cling to the memories of earlier pleasurable experiences, and to seek the satisfaction of its clamouring desires or wishes in the form of intensified memories of previous

1. For a more detailed account of Freud's theory of dreams, see two papers by me in *The Lancet*, April 19 and 26, 1913.

satisfactions. This is what Freud means when he says that the unconscious can do nothing but *wish*. So soon as the power of freeing oneself from the exclusive influence of the memories of previous satisfactions and of turning to seek means of bringing about a new and objectively-satisfying experience by changes in the external world arises, the secondary process has set in. The secondary process, which is the characteristic form of activity of the preconscious, can face painful experiences and memories and make use of them in bringing about desirable changes in the outer world instead of merely turning away from them. It is this "turning away" in early life which is the beginning of repression and the pre-condition of all later repressions. The abandoned memories and desires in the unconscious persist in all their pristine vigour and serve as a nucleus of attraction for later suppressed tendencies of the preconscious that happen to be at all analogous to themselves. These are thus drawn into the unconscious and fall under the sway of the primary process. The repressing force of the secondary process is known metaphorically as the *endopsychic censor*, and constitutes a *resistance* placed "like a screen" between the unconscious and the preconscious. The repressed tendencies and ideas of the unconscious can only reach consciousness after first overcoming this resistance, undergoing certain changes in the process, whereas the tendencies and memories of the preconscious can pass unchanged into consciousness so soon as an appropriate distribution of the mental function known as attention is secured.

There is thus a species of "dissociation" present even in the normal mind, and mental disease instead of producing this dissociation merely emphasizes it in certain cases by disturbing the equilibrium of psychic forces interacting between the two systems of the unconscious and the preconscious. The proof of this is to be found in the phenomenon of *dreaming*, which is a normal function of the mind. Freud has shown that in dreams the wishes of the unconscious succeed in reaching consciousness in a disguised form owing to the diminished efficiency of the censor during sleep. The manifest dream content consists of a patchwork of memories, some of them in every case coming from the previous day, showing peculiarities known as condensation, displacement, dramatisation, and secondary elaboration, the exact nature of which we cannot go into here. The meaning of the dream, or the system of latent dream thoughts, is very different from this, and is, in Freud's view, invariably the fulfilment of a repressed wish from the unconscious. The method employed to discover the latent dream thoughts is the now famous method of *psychoanalysis*. The dreamer directs his attention to the different parts of the manifest content, in succession, and follows the train of associated ideas that arise in his mind from each, carefully avoiding any criticism of them, but recording

them faithfully as they appear in consciousness, however objectionable or painful some of them may be. He will then find that all these trains of "free" associations converge to one system of ideas which originates from the unconscious and consists of repressed wishes. In every dream there is also fulfilled the wish of the preconscious to sleep, so that every dream is a compromise between the wish to sleep of the preconscious and one or more wishes emanating from the unconscious. Both wishes are fulfilled by the dream. Now, in Freud's theory, the symptoms of hysteria are exactly analogous to the dreams of normal persons. They, too, are the disguised fulfilment of repressed wishes in the unconscious, but so chosen that they also fulfil a counter-wish from the preconscious, generally of the nature of a self-punishment. By means of psychoanalysis, these wishes may be brought to consciousness in their true form. Success in this means the cure of the patient, since he is now able to deal with these repressed tendencies more rationally, and either "sublimate" them, *i.e.*, direct them to higher and more social ends, or give them moderate satisfaction. His personality is stronger and more completely developed now than it was when the repressions first took place, and is therefore better able to deal with them.

If the repressed tendencies are sufficiently strong they may, by gathering appropriate ideas around them, form a secondary personality and reach consciousness independently of the repressing factors of the mind. The cases of Miss Beauchamp and B.C.A. seem intelligible in terms of this hypothesis. Moreover, the hypnoidal state, which seems to be almost identical with the state of the patient's mind during psychoanalysis, in all probability produces its beneficial effect by liberating mental energy which had previously been "fixed" to the repressed tendencies. So that the essential elements in the views of both Morton Prince and Boris Sidis seem capable of being harmonised with Freud's general theory. In C. G. Jung's recent modification of this theory,¹ where justice is done not only to the repressed tendencies of earlier life but also to the failure of adaptation to present requirements owing to mental weakness, we have probably the most complete general theory of functional disease which it is possible to give up-to-date.

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1. See *Proceedings of International Congress of Medicine*, London, 1913, section xii, pp. 65-71.