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HYPOCHONDRIA

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HYPOCHONDRIA

CHAPTER I. HISTORICAL

" So that now, we doe not onely die, but die upon the Rack, die by the torment of sicknesse ; nor that onely, but are preafflicted, super-afflicted with these jelousies and suspicions, and apprehensions of sicknes, before we can call it a sicknes ; we are not sure we are ill ; one hand askes the other by the pulse, and our eye asks our urine, how we do. O multiplied misery ; we die, and cannot enjoy death, because wee die in this torment of sicknes, we are tormented with sicknes, and cannot stay till the torment come, but preapprehensions and presages, prophecy these torments, which induce that death before either come, and our dissolution is conceived in these first changes, quickened in the sicknes it selfe, and borne in death, which beares date from these first changes ". —John Donne.[1]

(1) Humoral Period

Hypochondria has had a curious history. Philologically not less than medically its metamorphoses have been profound. Historical study is salutary, in science as in affairs: the medical history of hypochondria carries the usual lesson in humility to the practitioners of our

day : there is little that is new under the sun.

τὰ ὑποχόνδρια means the soft parts of the body below the costal cartilages (χόνδρος = gristle) and the Latinized singular form 'hypochondrium' meant the viscera situated in the hypochondria, i.e. the liver, gall-bladder and spleen. By a misunderstanding that hypochondria was a feminine substantive singular, and by a transfer of meaning, the term came to be used for the mental distemper which in the humoral doctrine by many writers, from Hippocrates to Galen, and afterwards throughout many centuries, was supposed to depend principally upon a morbid condition of the viscera situated in the upper parts of the abdomen. Willis,[2] writing in 1681, used the primary meaning, when he spoke of a "windy melancholy bred in the hypochondria, whence black phlegm arises that infects the mind". Culpepper[3] on the contrary, when in 1652 he wrote of "the liver, gall-bladder and spleen, and the diseases that arise from them, as the jaundice and the hypochondriac" was employing

the secondary sense. The transformation in meaning is traced in English by the Oxford Dictionary, and evidently the change, so far as English usage was concerned, took place in the seventeenth century. Willis, although in the passage quoted mindful of the etymology of the word, nevertheless wrote also "of the distempers commonly called hypochondriacal", and in this he consciously imitated Hippocrates and Galen, who under the designation ὑποχονδριακὸν πάθος enumerated two kinds of symptom which by nearly all succeeding writers until recently were considered to be characteristic of the condition. These symptoms fell in two groups: complaints of physical discomfort principally referred to the abdomen; and a mental change characterized by gloom, moroseness and the like. For example, Richard Brown, writing in 1729 his "Medicina Musica or a Mechanical Essay on the Effect of Singing, Musick and Dancing on Human Bodies" to which "was annexed a New Essay on the nature and cure of the Spleen and Vapours, or Hypochondriac

and Hysterical affections" enumerated, in imitation of his masters in medicine, the symptoms of hypochondria as follow: pain in the stomach soon after meals; globus, which he attributed to the "ascent of windy effluvia from the stomach"; palpitations, faintings, swoonings, and vertiginous swimmings; together with drowsiness, melancholy and despair. Sir John Hill, in his tract on "Hypochondria or Death's Hobby Horse; a practical treatise on the nature and cure of that disorder called the Hyp or Hypo" (one of Swift's "abbreviations exquisitely refined", suggesting a flippancy that Hill was evidently far from intending to convey) added to the gastric and mental symptoms an appearance of the whole body, which became of a deep and husky hue, "to which men of swift imagination have given the name of blackness". But the essentials of hypochondria from Hippocrates to the eighteenth century were for most authors a flatulent discomfort in the abdomen, and a gloomy mental state.

Medical writings on hypochondria have

from early times contained several sources of confusion which are worthy of remark, since they have not been resolved even now.

Distinction from Melancholy

Hypochondria and melancholy have often been regarded as completely synonymous. Yet in face of so popular a word as melancholy, hypochondria could hardly have attained such terminological independence, if it had not connoted something different from melancholy in its usual sense. Burton[4] describes hypochondria as a sub-type of melancholy. "The usually received division (of melancholy) is into three kinds. The first proceeds from the sole fault of the brain, and is called head melancholy; the second sympathetically proceeds from the whole body; the third ariseth from the bowels, liver, spleen or membrane called mesenterium, named hypochondriacal or windy melancholia". As to the symptoms of hypochondriacal melancholy, Burton ranged himself with Hercules de Saxonia who held that "fear and sorrow are not

general symptoms ; some fear and are not sad ; some be sad and fear not ; some neither fear nor grieve ". The rest, said Burton, " are these, besides fear and sorrow : sharp belchings, fulsome crudities, heat in the bowels, wind, trembling in the guts, vehement gripings, pain in the belly and stomach sometimes, after meat that is hard of concoction, much watering of the stomach, and moist spittle, cold sweat, ' importunus sudor ', sudden unseasonable sweat all over the body, as Octavianus Horationus lib. 2, cap. 5, calls it ; cold joint, indigestion, they cannot endure their own fulsome belchings, continuous wind about their hypochondries, heat and griping in their bowels, ' praecordia sursum convelluntus ' midriff and bands are pulled up, the veins about their eyes look red, and swell from vapours and wind ".

Outspoken mental alteration was therefore not essential to Burton's hypochondriacal melancholy, the fundamental symptoms being referred to the abdomen.

If we turn to the conception current a century later of the relationship of

hypochondria to melancholy, we find Boswell[5] declaring himself the occupant of the title-role in a series of essays which he published weekly (after the fashion of Addison and the *Spectator*) in the London Magazine under the title "The Hypochondriack". Here is his autobiographical description of the author of the essays while in a hypochondriacal mood.

"His opinion of himself is low and desponding. His temporary dejection makes his faculties seem quite feeble. He imagines that everybody think meanly of him. His fancy roves over the variety of characters whom he knows in the world, and except some very bad ones indeed, they seem all better than his own. He envies the condition of numbers whom, when in a sound state of mind, he sees far inferior to him. He regrets having ever attempted distinction and excellence in any way, because the effect of his former exertions now serves only to make his insignificance more vexing to him. Nor has he any prospects of more agreeable days when he looks forward. There is a cloud as far as he can perceive, and

he supposes it will be charged with thicker vapour, the longer it continues ".

Evidently by this time also the emphasis of hypochondria in the view of the literary layman had been displaced to the mental symptoms. It was a century before professional psychiatry struggled to the same conclusion. So often experts follow where they might have led.

Boswell's is a vivid picture of what would until Kraepelin have been called in psychiatric circles melancholia and would since the latter's work be called a depression of the manic-depressive type. Boswell himself discusses whether there is a distinction between melancholy and hypochondria and concludes bluntly that there is not. He says: " Perhaps there is a distinction between Melancholy and Hypochondria, the first gravely dismal as in Armstrong, the other fantastically wretched as in Thomson. In my opinion, however, they are only different shades of the same disease ; for I know that what each of these poets has so strongly painted has been felt by

the same person in the gradations of his combined distress ".

Another point of perplexity which is visible throughout the history of hypochondria is its relationship to hysteria. In the customary usage of many physicians, these were synonymous terms; and although Willis, and much later more decisively, Gull, were convinced of a difference between them, many modern observers fail to observe it. These moderns have distinguished precedents to guide them, as on the other hand they have against them the learned opinions just cited.

Robert Whytt of Edinburgh, in a well-known work called " A Treatise on the Nervous, Hysterical, and Hypochondrial Diseases "—a title which seemed to recognize a distinction—nevertheless concluded that there was none. Sydenham himself declared against a difference. Hypochondria was but hysteria in males.

The older authors also asked themselves, as their successors do in slightly different terms, whether hypochondria was a " disease " at all, or only the patient's

phantasy. Sir John Hill[6] prefaced his " Treatise " with these words :

" To call the Hypochondriasis a fanciful malady, is ignorant and cruel. It is a real, and a sad disease : an obstruction of the spleen by thickened and distempered blood ; extending itself often to the liver, and other parts ; and unhappily is in England very frequent ; physick scarce knows one more fertile in ill, or more difficult to cure ".

All these questions—of the differentiation of hypochondria from melancholy, on the one hand, and from hysteria on the other ; of the distribution of hypochondria between the sexes, and of the separate existence of hypochondria—are still disputed. But before we examine the discussions of the modern era of scientific psychiatry on the place and nature of hypochondria, let us glance at the views of the ancient, the mediaeval and the Renaissance physicians in greater detail. The observations of all these were so much coloured by the humoral doctrine, that a brief statement of the principal tenets of the latter is desirable.

"Corresponding with the four elements, earth, air, fire and water were the qualities dry, cold, hot and moist, according to the scheme:

hot and dry = fire
cold and dry = earth
hot and moist = air
cold and moist = water

Long before Aristotle, probably before Hippocrates, it was held that corresponding to the four elements of Empedocles, fire, air, water, earth and the four qualities, hot, cold, moist, and dry, are the four humours of the body, viz. blood, phlegm, yellow bile, and black bile. These sets of elements, qualities and humours could then be brought by permutation and combination into a complex system of arrangements, based upon the following scheme:

hot plus moist = blood
cold plus moist = phlegm
hot plus dry = yellow bile
cold plus dry = black bile"

(Garrison[7])

Galen elaborated these physiological ideas by combining them with the specula-

tions of Plato. According to Galen, the functions of the human body were maintained by three πνεύματα (whence, remotely, our " vapours "). The lowest of these was the πνευμαφυσικὸν, and developed the natural force in the liver; the second was the πνευμαζωτικὸν which elaborated the vital force in the heart: and the third and highest was the ψυχικὸν which developed animal or soul force in the brain. " The ancient tendency to view every source of functional activity as an entity, almost a personality —to animate it—made it quite consistent for the long succession of Galenist physicians to endow the liver-force with a quasi-consciousness and perception, and even with voluntary activity though of a low kind. Then the absence of any accurate knowledge of the functions of a central nervous system, the recipient of sensory impressions, and the originator of motor acts, induced men to localize in the various organs the source of the functional disturbances which appeared to be manifested therein ". (Gull[8].)

Hippocrates is credited with the recog-

nition of hypochondria as ὑποχονδριακὸν πάθος when he described patients who in conjunction with gastro-intestinal symptoms exhibited mental distress and panic fear, which caused them to shun their fellow-men and even the light of day.

Diocles of Carysta spoke of a distemper "accruing from the stomach and named by some the melancholic and by others the flatulent disease". "Melancholic" here referred simply to black bile, to which hypochondria was attributed by Galen.

The humoralists from Hippocrates to Galen were concerned both with the humoral pathology of the condition and with the seat of origin of flatulent melancholy. Four groups of humoral theorists were distinguishable. The pure humoralists placed the immediate cause of hypochondria in black bile or some other humour—pituitous, acid bitter, etc., without concerning themselves specially with the place where the morbid humour was engendered: other humoralists of the true kind replaced bile and the corruption

of the humours by salts of tartar or by acid and alkalies, to which they attributed morbific qualities. A third group found the fault principally in the vena porta and its blood, which was held to be viscous, and so on. A fourth class of humoralists admitted the vitiation of the humours, but held that they arose in the stomach and other places of digestion. (Brachet[9].) The essence of hypochondria was thus long a cause of dispute in humoral theory. About the locus of origin of many of the symptoms, there was for a long time no doubt—they were predominantly in the hypochondria. Only with the nineteenth century and the passing of humoralism do we find " hypochondria " applied to describe complaints which are not in the abdomen. In earlier days the strife was altogether round the particular viscus concerned. The spleen was implicated by most: others accused the stomach; others the portal system of vessels; while Paul Zacchias placed the seat of origin everywhere. It is interesting to find that the celebrated Broussais in his work " La Médecine

êclarée por l'ouverture des corps", attributed the malady to gastroenteritis in which he saw a heightened sensitivity of the intestinal nerves, which reacted upon the brain.

(2) The Decay of the Humoral Theories

It took the insight and vigour of Willis[10] to change the focus of interest from the abdominal viscera to the central nervous system. In combating Highmore's theory that the primary lesion was an atony of the stomach fibres, he declared:

"I have know many cruelly affected with this sickness, who have been well enough in the stomach". (He then proceeded to document his contention with an excellent description of a psychoneurotic anxiety-state.) "I have known others, great drunkards, and choosing an evil manner of living, to have contracted a looseness of the stomach with an ill digestion, windiness, and frequent vomiting, who, sound enough about the Precordia and animal faculties, were not at all accounted for Hypochondriacks".

Willis classed hypochondria amongst the convulsive disorders. While retaining the hypothesis of a disordered spleen, which not only failed to perform its supposed function of extracting deleterious substance from the blood, but contributed also a harmful quality, sharp, acid, or otherwise, to the humour which then regulated the whole blood, be added two hypotheses—that the brain was affected by particles not removed by the spleen and so carried into the general circulation; and that it was also damaged more directly by the effect of the disordered spleen upon the intestinal nerves.

Robert Whytt[11] added to the irritability postulated by Willis and Broussais a feebleness of the nervous system: a precise foreshadowing of the irritable weakness by which the "neurasthenia" of a later day has so commonly been described.

The 'nerves' of the writers of these times were the peripheral structures, and did not include the brain. The latter was supposed to be affected secondarily by "sympathy" or by conveyance to

it of morbid spirits along the nerves (cf. Willis supra). The recognition of the close connection between brain and mind led later authors such as Brachet[12] to attribute the "disorders of the imagination" in hypochondriasis, to an affection of the brain", but this affection remained secondary. "The cause acts first in the stomach and on the nervous system in general; of which it increases and modifies the irritability. It is this modification from which arises the direct cause of hypochondria. In providing the imagination with a thousand painful or unpleasant and more or less bizarre sensations, it ends by vitiating the operations of the organ of intelligence and by leading it to transfer into illness not only the multiple sensations it experiences, but ideas which are suggested to it by morose and bizarre reflections" (Brachet[13]). Brachet is emphatic however that while the visceral disturbances are essential they alone do not constitute hypochondria: the latter always consisting in these disturbances together with a "vitiated imagination". The next step was to locate the origin of

the condition in the brain itself. This had been implicitly foreshadowed in the beginning by Hippocrates, when he vividly described the mental symptoms. The inference is that he regarded the brain as disturbed, since on the Pythagorean teaching, which prevailed in his days, the brain was the origin of thought. It was not however till twenty centuries later that Carolus Piso explicitly championed the view that the brain was the prime seat of hypochondria. He was of course a humoralist, in the tradition of his times, and he hypothesized a "colluvies serosa juxta nervorum origines congesta".

But a much more dramatic change in the conception of the nature of hypochondria was made by Sauvages[14], who placed hypochondria among the vesanias (insanity) and said "The hallucination comes from the excessive devotion of the mind to the preservation of the body, by excessive self-love, for life and pleasure, and by the susceptibility which accompanies this love of oneself". Hypochondria had at last ceased to be necessarily

a disease of the body, and became primarily a disorder of mind.

Cullen[15] who was responsible for coining the term "neurosis", placed hypochondria among his second group of neuroses, the adynamias. Pinel also regarded it as a kind of insanity, and remarked the frequent absence of organic lesion. Falret held the same view (according to Brachet, his views on the topic were an almost exact replica of those of Georget). Gerard (Transactions Medicales) formed a similar opinion upon the nature of the cause, which was usually moral or intellectual, and on the nature of the symptoms, which were "nervous" and subject therefore to the control of the brain. The primacy of the body was abandoned in favour of the mind only with reluctance. There ensued a hot discussion, whether the effection of the mind was primary as Dubois and Falret held, or secondary, via the vegetative functions, as Brachet maintained with considerable acerbity. The dispute is curiously reminiscent of the later discussion on the theory of the emotions, carried on by James and

Lange on one side and such writers as Stout on the other. Thus Barras, in combating Dubois'[16] division of hypochondria into six varieties of monomania (e.g. pneumo-cardiac monomania) according to the predominating symptoms, asserted that the mental disorder was secondary to a sympathetic or idiopathic brain lesion, and that the moral symptoms were secondary to the "gastric neurosis". At the time that Barras wrote (1830), a mental disorder without hypothetical brain-lesion was inconceivable. Moreover a mental affection was an intellectual one for the writers of that period; and manifestly most hypochondriacs had no intellectual derangement. It remained for Griesinger[17] (1845) to make the last step but one and to point out that a mental affection was not necessarily characterized by intellectual disorder; and that emotional alteration can exist without derangement of the understanding. "The hypochondriac may reason correctly, setting out from false premises; but this does not in the least invalidate the fact

that hypochondria is a mental affection".

Griesinger classed hypochondria as a mild form of melancholia, and supposed that since no lesion was discoverable, it must depend upon "some swift nervous contraction of the brain, or upon disorders of nutrition that are as yet unknown". Gull[18], not a psychiatrist like Greisinger but a brilliant general physician, and seeing perhaps a different class from that found in asylums, asserted that hypochondriasis was a disorder sui generis, distinct from melancholy. By him it was perhaps for the first time clearly stated that the essence of the condition was a *conviction of disease*, where none existed. Gull believed that some predisposition of the nervous system must be behind the conviction; but clinically the hallmark was the unshakeable conviction of disease. "The most important external feature of hypochondriasis is this—that without any sufficient reason for such conduct, and without any signs of intellectual insanity, the patient is observed to concentrate his attention on some par-

ticular organ of his body, and to fancy that it is seriously diseased. This concentration of attention is often preceded and accompanied by notable depression or variability of high spirits, with a tendency, on the whole, to depression; this is not always the case however, for there is sometimes no antecedent symptoms connected with the general mental state".

How great the changes which these three steps represent—the classification among mental conditions, the admission that no gross physical alteration need exist, and the isolation of hypochondria as a separate type of mental disorder—is shown by contrast with the beliefs of professed psychiatrits which persisted generally until the middle of the last century and remain in some quarters to the present day.

(3) Modern Period: Scientific Psychiatry

The belief that hypochondriacal complaints were based always on some physical alteration lingered for a long

time among psychiatrists clinging to the views of the humoralists. In a certain proportion of cases a structural change in the form of organic disease could be demonstrated (e.g. the cases of Vigoroux and Collet,[19] Marie and Bourichet[20]). When gross disease could not be found, the tradition was continued in a search for more minute structural changes; for example, in the "vegetative organs" (Gans[21]) or in the sympathetic ganglia (Laignel-Lavastine[22]). But often no such organic alteration could be demonstrated, and so there arose a distinction foreshadowed by Boerhaeve between "hypochondria cum materia" and "hypochondria sine materia" (Wollenberg[23]), or "corporal" and "mental" hypochondria (Guislain[24]), or put in yet another way, secondary or sympathetic and primary or essential hypochondria. Evidently the former type, hypochondria *cum materia*, was considered to be the more frequent. Birnbaum[25], for example (1907), describing eight cases of hypochondriacal syndromes which had come to autopsy, found long-standing organic disease in

all of them, and concluded that in most cases hypochondriacal ideas depended on misinterpretations of peripheral sensations arising from bodily disease. Even when the complaints referred to an organ which was not diseased, a lesion was sometimes found elsewhere, which might in some way account for the focussing of the attention on the body. It was not unnatural, therefore, that where no physical lesion of any kind could actually be demonstrated, the majority of writers, especially of the French school, hankered after some minute physical basis of a peculiar kind; for example, a disturbance of coenaesthesis (Vigoroux and Collet, Roy,[26] Codet[27]) or "malfunction or parafunction of the somatopsyche" (Demy and Camus[28] after Foerster), or a hyperaesthesia of the sensory nerves (Schule), or a "morbid condition of the cortex, converting physiological stimuli to pathological intensity and quality" (Hitzig). While all writers recognized a mental component in the symptoms, those just mentioned, having a monistic philosophical view of the

matter, looked to a physical substratum for the whole; while others, like Pick, preferred to reserve their judgment. It was not till the advent of psychopathological interpretations on modern lines, relating the symptoms to the personality of the individual, that this mental aspect of hypochondriacal conditions received from professed psychiatrists a fair share of attention in itself. These psychopathological constructions will be described later.

Although, as we have seen, a general physician like Gull was long before convinced of the essentially mental nature of hypochondria, there has been confusion even until the present day among psychiatrists regarding the conception of the nature and basis of hypochondria as well as its nosological position. It has been identified by them with melancholia, as it was by general writers like Boswell. Griesinger regarded it as having all the characteristics of melancholia, but the depression in hypochondria he believed to depend on an altered bodily feeling, which occupied the attention.

The hypochondriacal ideas arising therefrom, with their logical elaboration and clear consciousness, constituted a " folie raisonnante ". Ziehen[29] declared that hypochondriasis was as little a disease as delusional insanity, and that " hypochondria " was either hypochondriacal melancholia or paranoia, or a hypochondriacal form of neurasthenia, or " phrenoleptic insanity ". Wollenberg[30] considered that hypochondriasis was always part of another disease, the latter giving its characteristics to the individual case. He pointed out that some cases of hypochondria were episodic, and he concluded that these were therefore manic-depressive in nature, this being another argument against erecting hypochondria as a nosological entity. Raecke,[31] on the other hand, considered hypochondria to be a separate disease-form ; and Pick[32] in 1903 spoke of the attempt to separate hypochondria from melancholia as a special form, in " most text-books for the last ten years ", especially by the school of Westphal. Sommer[33] in 1910, in opposition to the still prevailing view that hypochondria

was not a special disease-entity (Krankheitsform) but always a phase (Krankheitszustand) of a larger symptom-complex, presented a group of cases under the title "hypochondria" as a special type of psychic origin. He characterized hypochondria as showing delusional ideas on a basis of altered bodily consciousness, and different from the somatic delusions of the paranoic. Moreover, the condition ran a chronic course, but never led to intellectual dementia. He differentiated two types—a milder hypochondriacal neurosis with prominent paraesthesia on the basis of an innate disposition, and a more severe type of hypochondriacal psychosis in late life with a tendency to delusions. Wolffsohn[34] had also in 1906 described a case which supported the view that a clinical entity could usefully be distinguished as hypochondria.

The popularity and comprehensiveness of the neurasthenia-concept introduced an additional element of vagueness, for hypochondria was promptly subsumed as a form of neurasthenia by many

authors. Jolly, for example, regarded hypochondria as a "severe form" of neurasthenia. Loewenfeld considered the milder forms of hypochondria as belonging to the region of neurasthenias and hysterias. Binswanger[35] spoke of the difficulty of distinguishing neurasthenia from hypochondria. He did not doubt that hysteria arose from neurasthenia, and that it was only a further development of the nervous illness towards the psychic side. Kraepelin placed hypochondria (when it was not part of a melancholic or paranoic or other syndrome) among the neurasthenias. Views like these depended obviously on vagueness in the conception of neurasthenia, on false views as to its etiology, and on insufficient clinical differentiation. This insufficient differentiation persists even to this day—so that anxiety-states and hysterias are often mistaken for hypochondria, under certain conditions and with a certain colouring. The conditions of "angst" and hypochondriacal preoccupation are often difficult to distinguish, so that Birnbaum speaks of an "angst-hypochondrish" disposition.

Dejerine and Gauckler[36] recognized that there was a distinction between hypochondriac and neurasthenic states. Clinically, they sought to distinguish a hypochondriac from a neurasthenic by saying that the former would have complaints which he referred to one bodily system after another, declaring when an attempt was made at persuasion, " Then if it is not my heart, it is my stomach, or my bowels, or my kidneys ", etc., returning to his original complaints if the doctor took the trouble to pursue him far enough. Dejerine and Gauckler also said that the neurasthenic had real, although functional disturbances, the false gastropath having dyspepsia, the false cardiopath tachycardia, and so on. It will be generally agreed, I think, that the first criterion mentioned does not hold ; and that the second is of no assured validity. In addition these authors make this theoretical distinction : the hypochondriacal preoccupation constitutes originally a purely intellectual conception, à propos of which, but secondarily, the patient may become emotional, but the conception itself is

not of emotional origin. With the neurasthenic it is the reverse. The localization is always emotionally caused and if intellectual interpretations follow, it is they and not the emotional phenomena that are secondary. Few psychopathologists will be found to support such a conception of the basis of hypochondriacal preoccupations. Nevertheless it is a theory derived from a correct clinical observation; namely, the apparent absence of affective perturbation.

Summarizing the conditions in which hypochondriacal symptoms are found, Roy[37] gives the following list:

(1) Dementias—senile, dementia praecox, alcoholic, arteriosclerotic, general paralytic;

(2) Idiocy;

(3) Toxic—infectious conditions, especially chronic alcoholism;

(4) Paranoias with delusional interpretations and hallucinations—in the group of constitutional psychopathies. He identifies this group with Krafft-Ebing's hypochondriacal neuropsychosis, Schule's systematic hypochondriacal delusional in-

sanity, Séglas' primitive systematized hypochondria, and Wollenberg's constitutional hypochondria. He places the intermittent melancholias among this group. Roy concludes that hypochondria is always part of a larger syndrome.

Schilder[38] on the other hand, also writing recently (1924), concludes in favour of a simple hypochondria not resulting in dementia. He considers, however, that the relation to neurotic depersonalization is a close one (see also Demy and Camus, loc. cit.), and calls attention to the supposed similarities to anxiety-states, phobias and some tiqueurs.

Freud[39] classed hypochondria, along with neurasthenia and the anxiety neurosis, as an " actual neurosis ". The fact that psychoanalysis on the whole has so little to say about hypochondria (some remarks of Freud's and Ferenczi's made passim) may be accounted for partly by the difficulty of the subject and partly by the fact that analysts see very few patients of this kind. Rickman remarks that cases of pure hypochondria " must be very rare ".

CHAPTER II

DEFINITION AND NOSOLOGY OF HYPOCHONDRIA IN THE MODERN SENSE

It is clear that for a discussion of hypochondria we must first delimit as exactly as possible the meaning of the term, and thereafter define its nosological position. Considering the first topic—the meaning of the term—what is assumed by all writers includes three things: a mental preoccupation, a special topic of such preoccupation, namely, bodily malaise (which may or may not be based on gross organic disease), and a discrepancy between the two, the preoccupation exceeding what would be justified by almost any malaise. It is not hypochondria unless the intensity and duration of the complaints and their influence are out of proportion to any physical condition that may be present. This is the meaning of the term, and this is the

concept of hypochondria in its simplest form. It is expressed by Rodiet and Dalmas,[1] who appear to be quoting a definition which is widely accepted by French psychiatrists, in this way: hypochondria is " a preoccupation, exaggerated or without foundation, with the bodily health ".

The concept is seldom, however, used in this pure form. Additions are practically always made. Some of these are legitimate in seeking further to define the concept. For example, the mental preoccupation usually shows itself in elaboration of the topic of disordered health, in all degrees from ingenious theoretical schematization, rational within the limits of the patient's knowledge of physiology, up to delusional fabrication of the type met with specially in involutional melancholia. The attempt to define the concept further by postulating in all cases the presence of a physical alteration has already been described. This is not essential for the concept as a psychiatric term; not is it essential for clinical diagnostic purposes, for it is admitted

that gross structural disease need not be present, the changes, if such exist, being of the molecular or clinically and pathological indecipherable kind. The diagnosis then rests entirely on the mental signs.

Confusion has been introduced from another direction, when an affective component has been invoked. This occurred when there was a failure to distinguish hypochondria from melancholia, and recurred when "neurasthenia" became fashionable, from a neglect to distinguish anxiety-states from hypochondriacal conditions. These errors must frequently have depended upon an insufficient examination of the history, as well as upon a false appraisement of the clinical signs that presented themselves. Overt anxiety is no part of a purely hypochondriacal state of mind in the view adopted in this paper. One of the essentials of the hypochondria concept, if it is to be useful at all, is that hypochondria shall be differentiated from anxious preoccupation by the absence of anxiety or similar affects in the former. Anxiety

is here used in its ordinary clinical sense of " fearfulness ", and not in its special psychoanalytic sense. The affect in hypochondriacal preoccupation is better described as a type of interest, not of a fearful kind. Similarly, depression or affective sadness is no necessary part of the conception: the frequently implied inclusion of depression has arisen partly from the common association of hypochondriacal ideas and melancholia, and from the lack of opportunity of some psychiatrists to observe hypochondria apart from the occurrence of hypochondrical ideas in the setting of some more extensive syndrome.

Closely connected with the affective attitude is the reality-value for the patient of his hypochondriacal notions. It may be said of the merely anxious patient that he fears but does not believe that he suffers from the malady which he professes to apprehend, and that in fact he chooses something to worry about, which he knows in his heart to be a perfectly safe topic upon which he can always get dogmatic reassurance. On

the other hand, for the hypochondriac the fancied ailment is real. He has a conviction and not a fear, of disease—it may be simply of malfunction, or it may be of morbid structural alteration. The reason for relating the status of the ideas to the affective attitude is clear enough. "In its inner nature, belief, or the sense of reality is a sort of feeling more allied to the emotions than to anything else. M. Bagehot distinctly calls it the 'emotional' of conviction" (James[2]).

The source of confusion with one type of so-called "neurasthenic" syndrome is then removed. From hysteria, on the other hand, hypochrondria in the strict sense is clinically differentiated partly by the fact that it is not associated with the occurrence of disturbances of voluntary innervation, like those that produce paralysis and ties. "Hysterical hypochondria" is then a self-contradictory expression, although frequently used when the hysteric instead of displaying the frequent "belle indifférence", seems to cover it by harping on her physical

disabilities. Hutchison[3] gives one of the best descriptions of this type of hysteric under the designation of the " abdominal woman ". " There is notable in the first place ", he says, " a general discontent, ' disgruntlement ', and peevishness, added to which is an intense egotism, which leads the patient to regard herself and her symptoms as of the utmost importance. Needless to say, the patient is intensely introspective and hypochondriacal. She studies and catalogues her symptoms with minute care ".

Another criterion, however, besides the attitude to supposed disabilities, enters to complete the distinction between hysteria and hypochondria, and that is the affective orientation of the patient to his environment. The hysteria and the person with an anxiety-state alike seek sympathy, the one by a dramatic display, the other by pleas for reassurance which to a greater or less extent he accepts. " Most trying of all is an intense craving for sympathy, which must be satisfied at all costs, and it is noteworthy that there is usually someone in her entourage who

is always ready to supply the need. Sometimes an unmarried daughter is the victim; sometimes it is an over-devoted husband. Her incessant demand for sympathy and understanding makes the abdominal woman a veritable vampire, sucking the vitality of all who come near her" (Hutchison).

The hypochondriac, on the other hand, having a conviction, takes no reassurance, and the sympathy he seeks does not involve the type of affectionate dependence on the physician that is met with in the hysteric. Ferenczi has described a case as "hysterical hypochondria" which responded to psychotherapy with striking success. But he admits that it was not an example of pure hypochondria, and that it bore many of the marks of an hysterical condition.

Finally, there is a therapeutic criterion which is really another aspect of the orientation to the environment. Hypochondria seems to be usually inaccessible to psychotherapy.

Summarizing what, according to this analysis, constitute the clinical grounds

for regarding a condition as essentially hypochondriacal, the following criteria may be stated: a mental preoccupation with a real or supposititious physical or mental disorder; a discrepancy between the degree of preoccupation and the grounds for it so that the former is far in excess of what is justified; and an affective condition best characterized as interest with conviction and consequent concern, and with indifference to the opinion to the environment, including irresponsiveness to persuasion.

The complete differentiation from what is more properly called "hysteria", including most cases of Hutchison's "abdominal woman", would then involve the following points.

Hypochondria affects males chiefly, while hysteria is on the whole more common in women. Hypochondria is a disorder as a rule of later life (although examples can be found in quite young men). Hysteria occurs initially before middle life, and in the history of the hysteric there have usually been earlier episodes of a similar kind. In the

hypochondriac, on the other hand, what is found in the previous history as a rule is not previous similar attacks, but as we shall see, a record of temperamental and characterological peculiarity. The hypochondriac's chief concern is with paraaesthesiae ; the hysteric tends more often to exhibit actual disorders of function such as paralysis or vomiting. The affective attitude of the hypochondriac is mingled of interest and conviction, with excessive concern shown in his repeated affirmation of his discomforts ; while the hysteric either shows the classical " belle indifférence ", or is querulously insistent on her complaints. But she will take reassurance for the time being at least, while the hypochondriac will not. On the whole, the hypochondriac's emphasis is on the supposed disease which he has, the hysteric's on her discomforts and disabilities. The hysteric depends more on the physician or on any relative whose sympathy she can consistently rely upon : the hypochondriac is more wrapped up in himself. The hypochondriac seldom responds to

therapy, except perhaps transiently. It might even be said that to psychotherapy in particular he is usually inaccessible. The hysteric, on the other hand, will respond for a time to almost any form of treatment, usually lends herself, but not always, to psychological investigation and treatment, and in a considerable proportion of cases recovers symptomatically at least. The hypochondriac seldom recovers.

It now becomes possible to consider whether such a condition of hypochondria as above defined exists in pure form as a reaction-type, or whether it is invariably found as part of a larger syndrome. In delimiting the concept of hypochondria, we have practically furnished also a nosological description, for it has been found that certain cases which have been observed, conform to this description and require nothing else for their characterization, except what follows in part from the inaccessibility to therapy, namely, their very chronic course, which does not however involve any deterioration towards dementia.

Here is a typical clinical picture: the patient was a man of middle age, very "dressy" in his appearance, wearing gaily-coloured pyjamas and garish expensive clothes.

When asked what his complaints were he rattled on in this way:

"I feel I have something in the nature of a catarrh, or a colitic complaint, which is giving me a sort of infection, and upsetting the whole of my nervous system. Arising out of these I get a sort of general debility, and all things pertaining to that. I have no taste—damp and cold affect me very much indeed. If I get into bed in a damp house I stand sweating and the beat of my heart is stimulated. My circulation is all wrong—my extremities are rather cold, and I get a blown-out distension of the abdomen. Sometimes I am constipated. Other times, my motions slip through me twice a day in a solid form. I have no rheumatism of my joints, but my arms get warm. I have a gland in the axilla; don't know whether its a lymphatic gland. I am

practically always tender here" (indicating the ninth cartilage), "and I have a pain right through to the back" (indicating the spot). "Every three weeks I get a flooding of my whole system; my whole nervous system gets upset—sighing and dragged-down feeling; I get absolutely tired out; I feel as if I could sleep all day as well as all night. I always have a catarrh from my right nostril . . . My bowels are inflamed again. Over twelve years ago I got a terrible weakness —my bowels must have been inflamed—there was nothing in my guts but slime every day. There was a feeling of burning heat in my blood. I got a feeling of faintness in my right side. If I scrape my tongue, it gets sore, and my stomach itself gets sore. If I take a glass of cold water, I get a terrible taste in my mouth . . . I feel shaky in my legs occasionally. My left toe and left knee ache badly . . . At times my eyes get very jaundiced. But when my stools begin to slide through me, my eyes clear up, and I get that weakness. The other night I took cascara and it upset me very

badly . . . I have been patched up once or twice, but when I try to get on with my work, down I come again. When I touch here" (indicating the right side of neck) "it is painful . . . Whether the nervous condition has gone wrong or there is some colitic or catarrhal infection, I don't know. Here, in the transverse and ascending colon, I feel tightened up. . ." (Do you ever have a headache?) "If I do get a headache, I get a terrible headache and have to fast. If I fast, I get a dragging feeling but my tongue clears up . . . if I lie in bed, I get depressed. When I first went down, I was stricken with an acute pain.—After overwork I had a breakdown—got dysentery, with casts from the bowels and stools as hard as a rock and pale. Then I got someone to open me up—I said, 'Open me right up the middle'—I've never been operated on before . . . I got an awful burning up my rectum—like hot fire—then it leaves there and goes to my gall-bladder region, then to my arms—and down my spine—it affects the nerve-centres . . . I have never had anything like this in

my life . . . I used to get very yellow, and before, I used to get very grey. My weight is more than it was, but I am putting it on my tummy instead of my shoulders, where it used to go . . . I am careful with my food. I take very little alcohol. It doesn't appeal to me".

Formerly all kinds of sport had interested him and he had taken part in most outdoor games. At school he had taken great pride in his prowess. His pride in his body was shown in conversation—he would roll up his sleeves repeatedly, and show his chest by leaving his pyjama jacket open. In adult life he frequently complained of fatigue.

His references to his bowel function were specially frequent and striking. He mentioned what "magnificent stools" a certain specialist had procured for him —"like porridge; no straining": and during a voyage to Australia for his health he had "three big stools" a day—"sliding through". In Australia he felt a "burning inflammation" inside.

He remarked on his own fastidiousness, ranging from his violent objection to dirty

forks, to annoyance at small losses in business. His ambition had been very great in the beginning; in later years he had felt that he should relax his efforts, on account of his health. He had never married.

Although very sound physically he would not believe it, and as no physical treatment was offered, he left hospital after a short stay.

But hypochondria in the strict sense is not confined to the middle aged or elderly. Hypochondriacal symptoms are not uncommon in children—usually as the result of parental fussiness—and in young people, for similar or deeper reasons, such as an oncoming schizophrenic psychosis. The following young man of twenty-four presented a fairly typical example of hypochondria as it has been defined in this book, with its emphasis on Gull's "conviction of disease" as the central feature.

He was a single young man, the eldest of three children and was employed as a clerk. When admitted to hospital he complained of "indigestion" consisting

in a feeling of being "full-up" always, made worse by meals; feeling "rotten" at times; and loss of weight.

As an infant three days old he had convulsive seizures with a good deal of facial twitching in the intervals. He was a very ugly baby, and was nicknamed "Monkey" because of his facial resemblance to an anthropoid ape. In childhood he suffered from "nightmares" (? night-terrors). At the age of three his curls were much admired. He was a happy child, but fond of playing by himself. On leaving school at seventeen years of age he entered as a clerk and had remained there ever since. He did not distinguish himself in any way, receiving merely the usual automatic promotion. His work was monotonous, and he worked overtime every night in his first year; but he liked the work well enough. In subsequent years there had been very little overtime.

The illness began with a complaint of "indigestion" two and half years before admission. He lost weight and looked pale, and his nose was red. He complained

more and more that he could not eat, and rubbed his chest a good deal, ostensibly to assuage the discomfort he felt there. Soon after the symptoms began he moved to another department of the company. He did not like the head of this department, the work was more difficult, and his symptoms became worse. He lost interest in anything but his digestive functions, and saw a consulting physician who pronounced him physically sound. Eighteen months after his symptoms first appeared, he was moved to an easier task in the office, with some temporary improvement. At home he frequently howled and wept over his discomforts, but none of this was apparent at the office. There he sometimes left his work for ten or fifteen minutes, going to the lavatory to smoke while he felt depressed. He reduced his diet until he was having only bread and tea for breakfast, no lunch, and a little meat and a small quantity of potatoes at dinner. For a time after this reduction he declared that he felt much better, but he still complained of a feeling of fullness, and soon he wailed about his

condition as loudly as ever. After a meal he worried about having taken it, saying that he ought not to have done so. He complained of fits of depression and was afraid sometimes that he might be going off his head. He remained at work, however, until he entered hospital, having lost 28 lbs. since the beginning of his illness.

He had a curious "old-fashioned" manner with a serious owl-like facies. He had never been noted for his energy, but was regarded as a patient unenterprising plodder. Games he played to a moderate degree and with very moderate skill. Swimming was one of his few recreations. For the most part he was content to be with his father, sitting with him in the evenings while they played gramophone records, and showing no desire to go out and mix with his coevals. He was very shy and made no friends, never having had a chum or confidant. He was amiable enough, but placid rather than cheerful. His colourless placid attitude and his peculiar appearance combined to bestow on him a mild popularity

among his fellow-clerks, who looked upon him, especially after his symptoms developed, as a little mad. Reading occupied a considerable portion of his spare time, and he was specially interested in history. Tales of fighting and of knights in armour had a special fascination for him. He had never been known to show any interest in girls.

He spoke with a great deal of "humming and hawing" and with considerable repetition (v. infra). An affected kind of ponderousness was the striking thing in his manner. He said he had fits of depression, but denied any difficulty in thinking. His only spontaneous topic of conversation was his "indigestion". He talked about it in a monotonous way, repeating the same vague phrases sometimes almost mechanically, as if he were talking for the sake of covering up the poverty of his ideas. He had become concerned lest several days' accumulation of food should remain in his intestines. His insight was peculiar. Although he elaborated his symptoms, he said that his own miserable attitude was at fault

in part and referred to his belief in his digestive difficulty as a "delusion". This was probably a concession, however, to what had been impressed upon him, especially at home where his mother had been firm. There was no sensorial or intellectual defect.

His muscular development and state of nourishment were poor. He looked much younger than his years, the facial and body hair being scanty. His build was of the "asthenic" type. There was splashing in the region of the caecum but no tenderness. Radiographs of his abdomen showed an atonic stomach with some delay in emptying, there being still some barium in the stomach six hours after the meal. He suffered from a moderate degree of myopia. Otherwise no physical abnormality could be detected.

At first he endeavoured to avoid taking food. Offered ordinary diet at first, he took very little of it. Reproached with this, he said that he did not understand that he had to eat everything given to him. He was accused of deliberate misunderstanding, and he thereupon promised

to eat whatever was offered. On a special diet of two-hourly feeds he ate everything, with occasional attempts to refuse, which could be overcome by firm insistence. In the first week of this diet he put on 3 lbs. in weight, and in the second week 2 lbs., but in both instances he expressed surprise, saying he had expected his weight to increase more rapidly than that. His total increase in weight while in hospital was 14 lbs. During his entire stay he persisted in stating that he had considerable gastric discomfort. His attitude was a duplex one. Although he was writing home in discontented strain, he professed in conversation with the doctor to be able to " see it all now : I sort of worried myself ill ". Asked how he came to think it was his stomach, he said, " I dunno. I found I got off my meals, and I somehow got into my head that my stomach wouldn't take food. I thought I had irretrievably damaged myself. I have learned a lot here ". The following is another sample of his talk towards the end of his stay.

"You may have thought me an obstinate sort of devil. I sort of, sort of now realize that I should eat. As I say for some time, I feel sure I shall not be able to say that food is doing me good. I realize it may take time, and when I do eat then in some mysterious way I get better. I do feel somehow, I mean, that my nerves and depression should go if I eat my meals".

"Yes, yes, I am taking my grub. I still get that horrible feeling I have eaten too much, but as a matter of fact I am enjoying all my meals. As I say, I feel a chap must need food. Looking at myself in the bath yesterday, I said to myself 'A person as thin as you must want food'. Somebody told me the other day I was getting fatter. I haven't played, I haven't played tennis yet. I have not the courage, the courage to go on the courts. After a bit of golf I seem to go slump. I get a frightful tired feeling".

The principal impression was that his obsessive hypochondriasis was the direct outcome of his schizoid personality, which had always been secretive, dull, and apathetic, with an affective attachment

of a very limited kind. Apparently his father was the only person who had much importance for him.

The length to which hypochondriacs will exert themselves to safeguard their health are notorious. An elderly patient[4], not at bottom a true hypochondriac, but bearing an excessive resemblance to the type, had found from experience (he said) that if he went out-of-doors with headgear that was not sufficiently warm, a headache was produced which lasted a day or two. Indoors he wore always a velvet cap to protect his head from draughts At night he wore a complicated night-cap of three layers of thickness, the particular number of layers worn depending on the weather. Anything that appeared to have a bad effect on he made a note of, for its future avoidance. Sometimes, however, he " gave way to temptation " and invariably suffered for it afterwards.

He carried everywhere with him a thermometer which he placed in any room in which he proposed to remain, and before venturing to sit in the room

he would take a reading of the temperature of its atmosphere. He showed little consideration for the rights of others. If he desired to sit in the billiard-room of the hospital, it was upon the table itself that he placed his thermometer. There " the air circulated better ", and so he obtained a more accurate reading.

Another man complained of fatigue, disabling him from walking more than 500 yards. A walk of any length beyond this would produce a prostrating fatigue. As the distance from his room to his work-place was further than he could walk he explained that he was obliged to run it ! " He had also a curious feeling of thermal instability. He would sit and talk while in a chair leaning his head against an empty cigarette-tin in order to avoid getting his head hot against the back of a chair, as he stoutly maintained this would produce an intense local headache. From his school days he had suffered from a sensation of cold at night and to avoid this had recently been sleeping under two eiderdowns, five blankets, and has worn over his pyjamas

five cardigans—this, with a fire in his room and the room between 50° and 60°. With all these precautions to keep warm, he had his head on a hot-water bottle filled with cold water covered with a silk handkerchief in order to avoid getting any portion of his head hot by being in contact with the pillow". If he omitted these precautions he suffered a local headache next day.

CHAPTER III

PSYCHOPATHOLOGY OF HYPOCHONDRIA

" Do not be like the spider, man, and spin conversation incessantly out of thine own bowels ".—Dr. Johnson to a valetudinarian clergyman.

" Through very love of self himself he slew ". —Meredith " The Egoist ".

With the delimitation of hypochondria as a nosological entity, another line of investigation remains to be pursued—the causes of the occurrence of such a syndrome. It is desirable to confine the present inquiry mainly to the possible psychopathological origins. The possible physiogeny has been sufficiently dealt with in the past (vide supra). Apart from the cases in which the hypochondriacal mental reaction has been superimposed upon definite physical disease, the physical hypotheses advanced have been of a highly speculative and not very helpful kind.

The problem of the psychological basis may be approached from three aspects—in a more general way, from the study of the type of personality in which the condition develops, and from a consideration of the syndromes in which hypochondriacal preoccupations may appear; and more specifically and minutely, from examining the indications of the specific process of development of the hypochondriacal symptoms in the individual patient.

The type of personality prone to develop hypochondriacal symptoms has been recognised as egocentric (Schott[1]). Fleury[2] adds to egocentricity, pride " of a defiant kind ", and miserliness. Savage[3] however speaks of a change of personality which occurs in some middle-aged persons who from being kindly and unselfish become self-centred and complaining; but he also mentions that hypochondria develops in people who have led " solitary and subjective " lives. There is room for further investigation on this topic.

Freud[4] has described three character-traits as very closely and constantly

associated. As they are supposed by him to be reactions to an unconscious anal-erotism, and as the latter is considered by Ferenczi[5] (vide infra) to be at the bottom of hypochondria, it is necessary to mention them here. These three traits are orderliness, parsimoniousness, and obstinacy. Orderliness comprises bodily cleanliness, reliability and conscientiousness in the performance of petty duties, and obstinacy may amount to defiance, with which irascibility and vindictiveness may easily be associated.

The especially frequent occurrence of hypochondriacal complaints in paranoic conditions and in melancholia cannot be an accident, and is suggestive of the importance of certain psychological patterns to be discussed below. The fact that hypochondriacal ideas are common in various organic dementias—senile, arterio-sclerotic, general paralytic, and alcoholic—speaks for the importance of a morbid condition of the organs in predisposing to the disease. In senile cases, and in involutional cases without gross structural change, there is clearly also

the factor of the egocentric alteration in the psychological outlook with advancing years.

The common-sense view of hypochondria is that like most other abnormal reactions, not the direct expression of organic brain disease, it is a mode of reaction to difficulties, external or internal —an excuse or an avoidance. The peculiar intensity and fixity of the symptoms is attributed to an habitual self-centredness on the one hand, and on the other to the insoluble difficulty of the external circumstances—insoluble at least by the patient in question in view of his peculiar self-centredness. Also it is recognized that the condition usually arises in later life, during which, for obvious reasons, there is an increasing tendency to become interested in the bodily health. This common-sense view leaves some problems untouched: for example, the self-centredness itself, the fixity of the hypochondriacal beliefs in spite of the fact that the external circumstances may not appear to present special difficulty, and the preponderance of

hypochondria in the male sex. One reply to the last difficulty is that it is only apparent, and that what is called hypochondria in men is called hysteria in women. But it is a contention of this paper that clinically and psychopathologically hypochondria differs from hysteria; and no one denies the difference in therapeutic accessibility.

Of psychoanalysts, Ferenczi appears to have been among the first to devote attention to the details of the psychogenesis of hypochondria. In one place[6] he speaks of "hypochondria" resulting from a sense of genital inferiority. But in a later paper[7] he feels "convinced that in many cases hypochondria is really a fermentative product of anal-erotism, a displacement of unsublimated coprophilic interests from their original objects on to other organs and products of the body with an alteration of the qualifying pleasure". The choice of the organ towards which the hypochondriasis is directed is determined by special factors (such as "somatic disposition"). Anal-erotism, according to Ferenczi takes part

in the following functions: (1) the anal-character-traits in Freud's sense, (2) contributions to artistic interests, (3) hypochondria, and (4) unmodified anal interests. Ferenczi elsewhere considers that whether a patient develops conversion-hysteria or a hypochondria depends on his psychosexual constitution—hypochondria resulting where there is a narcissistic (? autoerotic) preference for his own body; and hysteria where a stage when object-love is possible has been reached. Evidently anal-erotism is not enough.

Freud[8] has regarded hypochondria as an "actual neurosis", by which in general he means that the symptoms are, in fact, the direct physical result of sexual excitement and have "no meaning for the mind". This physical result is said to be completely homologous with the state of the turgid genital. The distressing bodily sensations which result from the sexual excitation are the object of the hypochondriacal preoccupation. But the latter is also determined by a reflex of libido from objects to the organ affected,

with a parallel rearrangement in the distribution of ego-libido. "The hypochondriac withdraws both interest and libido—the latter especially markedly—from the objects in the outer world and concentrates both upon the organ which engages his attention. A change in the erotogenicity of the organs is necessarily accompanied by a change of hypochondria". In paraphrenia, hypochondriacal symptoms are said to be the result of this failure to master the quantity of libido that has returned to the ego, and to its overflow on to the bodily organ. Obviously, although his meaning to the ordinary reader is obscure in detail, Freud regards hypochondria as a narcissitic regression of a particular kind. Rickman[9] interprets him in this way, adding that there is an element of masochistic compensation. There is no mention here of the anal-erotism which Ferenczi emphasized. Some patients under my observation have supported Ferenczi's views. Nor is there any mention, in the writings, just quoted, of Freud and Ferenczi, of the possible role

of a feeling of guilt, sometimes based on anal-erotic phantasies, sometimes on more consciously recollected events such as infection by syphilis; both of which substrata are suggested by some cases I have observed.

The psychoanalytic theories of hypochondria, therefore, include narcissistic regression (Freud, Ferenczi) with masochistic compensation (Rickman): anal-erotism with analogous displacement to other organs; and direct physical excitation of the turgid genital.

One of the reasons for the apparent discrepancies in psychoanalytic interpretation may well be the difficulty or (in many cases) impossibility of an investigation in the course of treatment by a psychoanalytic technique in hypochondria. Few cases with a true hypochondriacal colouring lend themselves to anything but a superficial investigation; but from an examination of the clinical discernible facts, some inferences can be made as to the probable basis of the condition.

They are nearly all men. This preponderance of the male sex is in accord

with the traditional description of hypochondria. It is perhaps explicable on a psychopathological basis (vide infra). The ages of a series examined by the writer extend from 19 to 60. Inaccessibility to therapy is the clinical aspect of the firmness of the conviction. This is also illuminated by the psychopathological analysis. Exact nosological definition enables a distinction to be made from what can now be called pseudo-hypochondria, hysteria, and anxiety-states. Also it enables us to speak of a hypochondriacal development of an abnormal personality; it is still hypochondria, and it is not correct to consider the hypochondriacal ideas in such instances as part of a larger syndrome. It is more accurate to speak of hypochondria in a schizoid personality—see the second case quoted in the previous chapter, the additions to the pure hypochondriacal picture depending not on a new concurrent development but on pre-existing oddities of personality e.g., his aimless talkativeness. Other cases however exhibit developments concurrent with the appearance of the

hypochondriacal ideas which make it necessary to consider the hypochondriasis simply as part of a schizophrenic syndrome.

Psychopathologically, from the content of the hypochondriacal complaints (their localization, etc.), and, from the patient's other statements, an anal-erotic basis for some hypochondrias is strongly suggested by the utterances in the first case quoted ; and the role of guilt-feelings in general, not clearly associated with anal-erotism, is shown in other instances. There is a frequent association of hypochondriacal and paranoid ideas, which have evidently in some cases at least a common basis in feelings of guilt. It is suggested that the strong usually unconscious feeling of guilt is in some cases the component which clinically makes the conviction of disease so profound, and produces the therapeutic inaccessibility. The homosexual aspect of anal-erotism may serve also to explain the preponderance of men among hypochondriacs. Homosexuality in men undergoes much more repression than the same component in women.

The consideration of the surface signs of possible unconscious trends in certain hypochondriacs helps therefore to explain not only the fixity of the hypochondriacal beliefs, but their nature (damage to the bodily health) and in some instances, the actual localization of the physical complaints.

An investigation of the personal characteristics that existed before the outbreak of symptoms in some cases of mine showed a number of abnormal traits, some of which resembled those described by Freud and Ferenczi as depending on anal-erotism; but there is not sufficient evidence in these cases to connect the actual symptoms definitely and directly with any particular traits, although some interesting associations suggest themselves. This at least can be asserted of the five cases I have in mind, that all of them showed distinctly abnormal characteristics before the hypochondria developed. They had not a sufficient number of prominent premorbid traits in common to enable them to be described as a distinctive group of personalities. On the whole, the impression

was of the very considerable endogenous factor in all of them, and except in one instance, of the slight importance of environmental stresses (bodily or external).

Looking at the patient first mentioned, in the light of these observations, one is impressed by his dressiness, his exposure of his body, and his emphasis on his physical prowess, suggesting a considerable "body-worship". This impression is strengthened by the objects of his hypochondriacal preoccupation, in which his bowel-function, and the manner in which he dwelt upon his stools, were the most frequently recurring items. His minute description of the nature of his stools was in striking contrast to his revulsion from dirt, and the fastidiousness which in general he professed. His single state and his admiration of his father and the great attachment to his younger brother, were indicative of the condition of his affective life.

Translating these facts into psychoanalytic terms, he showed strong anal-erotic interests, together with some reaction formations against them (fastidious-

ness and the like) ; strong narcissism both in regard to his body and his career ; and attachments which may have been unconsciously homosexual.

Whether these psychological factors had found at one time a material focus in some organic disease it is not possible to say. But although some of the complaints recorded in his history pointed to an affection of the gall-bladder, there was no evidence of any morbid condition of the latter during the time he was under observation.

The following instance, brief as it is, exhibits some of these points even more distinctly. He was a married man of 30, who complained of a " terrible stench " at the back of the throat, burning at the right side of the tongue, and noises in his ears and in the back of his head. He felt obliged to keep swallowing, and his palate " squeaked " when he swallowed. His left ear throbbed and he had " grit " among his teeth. There was a sensation of " bubbling " in his body and legs, and he felt as if a knife were sticking in his hands.

In June 1926 he had picked his nose and made it bleed. This worried him a great deal, and he believed that he might have done himself serious harm. From that time onward he had a feeling of not being able to do anything, and in January 1927 he left off work and had not worked since (July 1927). He had visited numerous hospitals and taken many bottles of medicine.

He had left school in the VIth Standard at the age of 14. He worked always as a labourer, was married and has four children.

He was very voluble in the enumeration of his symptoms, and totally convinced of their material foundation. There was no mood disorder. He recounted his paraesthesia with earnestness, but with an occasional apologetic smile. At the end of his recital and after some criticism (to which he hardly listened) of the physical origin which he assumed for his symptoms, he suddenly declared that "he could not help tearing himself" at the anus. No inquiry had been made of him regarding that region.

Physically there was no evidence of disease, and no local condition to account for his anal irritation.

This man's inclination to " tear himself at the anus " is further illumined by reference to another case of hypochondriacal preoccupation (complicated however by delusion of a different kind). He had an excuriated right buttock and complained volubly of irritation there. He was very eager to display his buttocks on every occasion and with no real excuse. The perianal irritation was evidently assuaged by scratching the right buttock only, and there was no evidence of any antecedent lesion. This was associated not only with the willing exposure mentioned, but with hypochondriacal and persecutory ideas of a peculiar kind, referring to his gullet and his genital organs. There was in addition a complete absence of heterosexual activity.

It is interesting that " the English word ' itch ' and the Latin ' prurio ' in their secondary significance convey the idea of a longing and tearing despair "

(O'Donovan, quoting Bronson). Pruritus was used by the Romans as a synonym for lasciviousness. It is said that the violent movements of a dog when scratching betray an agitation "not unlike the excitement of the sexual orgasm".

Describing cases of pruritis, O'Donovan[10] says: "The itching and the scratching come on in paroxysms at night, working up to a lurid climax and often leaving the patient suddenly weak and listless for a short period. . . . In cases where the attacks have come and gone for a number of years, the patient will often definitely state that it coincided with periods of particular stress". . . . He also remarks their desire upon any and every occasion to exhibit their excoriated region.

These illustrations, brief as they are, will serve as examples of the kind of evidence upon which the psychopathological views already elaborated have to be founded. From a piece of evidence here, and another there, it is possible to build up a theory of the psychic origin of some cases of this difficult and usually

inaccessible condition. In other instances, the principal factors are probably those of egocentricity and the like, associated especially with advancing years.

CHAPTER IV

HYPOCHONDRIA IN HISTORY AND LITERATURE

Of hypochondria in its loose and formerly popular sense of melancholy moodiness, a fair number of examples can be found among historical and literary personages, at least if we include a "gentle melancholy" or, as the Scots law says, "if the malady be not confirmed". Aristotle himself went so far as to say that melancholy was exceptionally frequent among men of genius, an opinion which is commonly held to this day. Some there have been who rejected this opinion. Boswell,[1] himself a sufferer, denied the special susceptibility of able men. The reasons for his denial were partly based on ethical grounds; partly perhaps on an affected modesty.

"I think it is of importance" he said, "that the proposition should not be believed—because I am certain that many

who might have prevented the disease from coming to any height had they checked its first appearances, have not only not resisted it but have truly cherished it, from the erroneous flattering notion that they were making sure of the undoubted though painful characteristic of excellence, as young ladies submit without complaint to have their ears pierced that they may be decorated with brilliant ornaments". He goes on to observe that, "Melancholy, or Hypochondria, like the fever or gout, or any other disease, is incident to all sorts of men, from the wisest to the most foolish". His last observation is not in dispute. The question is, whether melancholy preponderates among the more distinguished examples of mankind. It is part of the older and larger question of the relationship of genius to madness. Contrary to the general belief, some now hold that "all the scientific evidence at hand points to the conclusion that gifted children are superior to unselected children in physical and non-intellectual mental traits as well as in intelligence, and that they carry this advantage into adult

life" (Terman[2]). Havelock Ellis[3] favours a similar conclusion, that between great ability and insanity there is no special affinity. Mental distempers may not be uncommon among first-rate minds, but they are far commoner also among the general populace than almost anyone imagines. Clouston,[4] surveying eighty-three average healthy families known to him through three generations in a country district in Scotland, saw mental disorders in forty-one of them; none sufficiently pronounced to cause the subject of it to be removed to hospital, but all readily recognized by his experienced eye. Of a disproportionate incidence of more severe types of mental illness among persons of supreme ability, there is in Havelock Ellis' statistics no very good evidence. Insanity of all kinds was recorded at one time or another in the lives of five per cent. of the British men of ability whose biographies he examined. This is a good deal higher than the incidence of certified insanity among the general population, which is about two per thousand; but the comparison

should rather be with Clouston's observations. Moreover Ellis' figures include such minor degrees of disturbance as mere eccentricity. In other instances, such as Oliver Cromwell, the historical evidence of mental disorder is of doubtful value.

Of these able men who did suffer from mental illness, a considerable proportion were to some degree melancholic, if the word be used not too strictly. There was of course Richard Burton himself: "I have laid myself open in this treatise, turned my inside outward" (in his Anatomy of Melancholy). Cowper and Lamb are well-known examples among literary men; Schopenhauer in a somewhat different way among philosophers. Bunyan's religious melancholy lasted for years. Boswell left an excellent autobiographical description. In the pathological museum that comprised so much of the body and personality of Johnson, fits of melancholy were not the least prominent exhibits. "But let not little men triumph", says Boswell, "in knowing that Johnson was hypochondriacal". "He had dreadful fits of depres-

sion, said to be caused by remorse for venial or fancied sins, or fear of madness or of death. He fought his cross vigorously by walking, work and other forms of distraction. . . . Thus in 1729, when submerged in morbid melancholy, he often walked the thirty-two miles from Litchfield to Birmingham and back in hopes of relief " (Rolleston[5]).

" Hypochondriacal melancholy " in the ancient sense seems to have been one of the most frequent kinds of mental disorder among able men. Froude[6] records of Carlyle that at the age of 23 " he was attacked by dyspepsia which never wholly left him, and in the early years soon assumed its most torturing form, like a rat gnawing at the pit of his stomach ". Carlyle referred to this time spent as a student at Edinburgh, as " those most miserable years of my life, a prey to nameless struggle and miseries ". He recorded that a " long hairy-eared jackass " (referring to an eminent Edinburgh physician of the period) had ordered him to give up tobacco, as well as to take " whole hogsheads " of castor

oil—" that oil of sorrow ". Later he spoke of himself as " mad, tragical, gloomy as one forsaken ".

Huxley's condition was curiously similar.[7] From the age of 13—14, " my constant friend, hypochondriacal dyspepsia, commenced his co-tenancy of my fleshy tabernacle ". At the age of 50 he experienced his conviction that " the prophet Jeremiah must have been a flatulent dyspeptic—there is so much agreement between his views and mine ". " I have been worried to death with dyspepsia, and the hypochondriacal bedevilments that follow in its train ". At 60 he was just the same—" Blue devils and funk ; funk and blue devils ".

Yet these men were far from being hypochondriacs in the other senses in which we have used the word. They were among the great workers of the world. Carlyle's notion of a day's dalliance was the average man's notion of a day's work. Similarly de Quincey who complained of " incapacity for food ", " utter prostration " and " utter nervousness ", as frequently recurring complaints,

displayed a childlike indifference to himself and the care of his person, together with a self-forgetful generosity. Here is the attitude of Nietzsche, another in whose biography there is much record of sickness, although it did not conform closely to the anciently classical hypochondria. He would record as many as 200 days of sickness, principally headaches, in one year: but he wrote nevertheless, "All true symptoms of disease are wanting in me. Even in the time of the most severe illness, I am really not sick. One will seek in vain in me for any trait of fanaticism. One must have no nerves".

Some of these men were "malades imaginaires" in the sense at least that no physical basis existed for their complaints, (Wagner's stomach, which was reputed to be dilated inches to the right —a phenomenon of which the oddity did not escape him—was reputed also to come back to normal dimensions in the course of a few weeks' "water-cure"). But Montaigne, with the double burden of gout and the stone, might excusably

have become a hypochondriac "cum materia". Horace Walpole indeed accuses him of having so succumbed. The diaries of his journey to Italy, undertaken in 1580 and 1581, "had little in them" said Walpole "but the baths and medicines he took, and what he had everywhere for dinner". But there was much more than that in the diaries—much of observation of other persons and things, which could hardly ever have been possible to a full-blown hypochondriac, material or not.

Grimm,[8] the writer of fairy tales, is one of the few famous literary men who were nearly hypochondriacs in the true sense. All his travels and amusements, he said, did not serve to take from him the fancy that he was dead or dying: and "if you ventured to suggest that he was well and strong, he flew into violent fits of rage".

This is as near as we come in the halls of fame to a hypochondriac in the stricter sense. Our examples, such as they are, are all literary men and not men of action. The latter do not easily appear in the list; partly because they were not

so accustomed to write personal diaries, which again is largely a matter of temperament; partly because a man of action who indulged in morbid preoccupation would soon be ignobly out of action. Napoleon's fits of torpor, which impaired his conduct of the battles of Borodino, of Leipsig, and of the advance after defeating Blucher at Ligny and which have been attributed by some to epilepsy, are thought by others to have been due to piles (Rolleston[9]). If this was so, the torpor must have been due to preoccupation rather than to haemorrhage; and by throwing wide the net, Napoleon might be quoted as a hypochondriac cum materia—upon occasion.

CHAPTER V

HYPOCHONDRIA EPIDEMICA

" But to make a trade of trying,
" Drugs and doses always pruning,
" Is to die for fear of dying,
" He's untuned that's always tuning.
(Frances Quarles', 1592—1644.)[1]

In recent years—it is difficult to say when it began—hypochondria has had a popular currency as meaning an excessive preoccupation with the bodily health. Such a preoccupation may characterize communities as well as individuals, just as did hypochondria in the older sense of melancholy. Of the latter Sir John Hill[2] wrote : " Besides the Greeks already mentioned, the Jews of old times were heavily afflicted with the disease, and in their descendants to this day it is often constitutional : the Spaniards have it almost to a man ; and so have the American Indians ". The writer's certainty as well as the distribution he imputes have a quaint sound ; it would

be interesting to know the sources from which he gathered his convictions in the field of comparative psychopathology.

The Romans knew of hypochondria in the wider sense, although not under that name. Virgil spoke of one who " destroys his health by his anxiety to preserve it ", while Seneca advised a friend " not to be over careful of the carcase ". But it is not till we come to the England of the eighteenth century that we find hypochondria in any sense reach its highest social status. Hypochondria in the meaning of melancholy was known then and in the next century as the " English Disease ". The *Spectator* of 1711-12, and 1714 contains numerous references to that gloominess and melancholy of temper which is so frequent in our nation ". " When the men of England are once turned thirty, they retire every year at proper intervals, to lie in the spleen " (Goldsmith)[3]. Congreve asked, " Is there in this world a climate more uncertain than our own? and which is a natural consequence; is there anywhere a people more unsteady, more apt to discontent,

more dark and melancholic than ourselves? Are we not of all people the most unfit to be alone and the most unsafe to be trusted with ourselves? Are there not more self-murderers and melancholic lunatics in England heard of in one year, than in a great part of Europe besides?" (Amendments of Mr. Collier's False and Imperfect Citations, 1698). Congreve defended Collier's attacks upon Restoration Comedy, by asserting the Englishman's need of a broader and stronger comedy than that of other nations by reason of his prevailing melancholy!

This melancholy covered not only the poetry, but even the landscape gardening of the times. Blair wrote "the Grave", and Collins, the Wartons, Akenside, and Butler all wrote dolorously. Young's "Night Thoughts" contained the cacophonous line "O Britain, infamous for suicide!". Green dealt directly with hypochondriacal melancholy in his poem called "The Spleen", which met with Boswell's approval in this superior fashion.[4]

"Mr. Green in his poem entitled The Spleen, of which I have heard Mr. Robert

Dodsley boast as a capital piece of the present age preserved in his collection, has enumerated exceedingly well the effects of Hypochondria upon a mind of that light structure which his seems to have been. Like one who describes the stingings of thousands of insects but has not known the gnawings of a wolf, or other such fierce animal, he brings together with truth and vivacity the minute fretful pains which are generally suffered by Hypochondriacks ; but he has not had mind enough to be capable of being afflicted by its more horrible torments. Yet is must be allowed that The Spleen is both an elegant and a most useful didactick poem, as it not only points out in a very lively manner the ordinary effects of the disease, but also suggests excellent methods of cure, so smartly, and at the same time so pleasingly, that the patients cannot fail to take them ".

In the past it seems to have been the custom where a disease was especially contemned, to attribute its origin and its natural habit to some other country ;

so that in England syphilis was known as the " French Disease ", while in France the balance was restored by calling Hypochondria the " English malady ". Some Frenchmen like Voltaire and Montesquieu found a sentimental fascination in the English melancholy; but others found it ridiculous. Saurin[5] wrote of " l'Anglomanie " of his countrymen in this dialogue :

Domus : " Jamais je ne ris.

Eraste : " O, cet homme est bien Anglais. Bien bon.

Domus : " On rit de dont chez les francais. Sachez, monsieur, qu'en Angleterre, on se pend quelquefois : mais n'y rit jamais.

Eraste : " Ah ! si dans ce pays j'avais un coin de terre ".

What were the causes of this complexion of the age? Miss Margery Bailey,[6] to whose annotations of Boswell's " Hypochondriack " papers I am much indebted, attributes it to the loss of a central authority, either of Church or State; to the sceptical mental attitude engendered by the Baconian experimental philosophy;

to the lingering heritage of Puritanism; and to the Deism which said " Whatever is, is right ". " Helplessly lost in a rapidly changing age, they were over-sensitive, self-pitying, and full of sickly sentiment ".

Something very like that afflicts us now: the age is hypochondriac but in the newer sense. Even the daily press is morbidly preoccupied with health: not merely advertisements for patent medicines but the lucubrations of " Harley Street doctors " fill the columns of the popular papers. The eighteenth century hypochondriac developed a passion for simplicity and sought to emulate the noble savage in his unsophisticated ways. Hence Robinson Crusoe's man Friday and the hero of Mrs. Behn's " Oronooko ". To-day we are again exhorted to imitate him; but this time with the movements of our bowels, which (so we are told) should occur as with the savage, three times a day, after meals.

A well-known restaurant proprietor in America recently lost his job as director of the business run in his name. This

was the result of the importation of hypochondriacal preoccupation into business. He " became converted within recent years to the dangers of eating meat, and having a large clientele of eaters under his care, decided to convert them in time ". His restaurants were accordingly placarded with exhortations to be " vegetable-wise " ; and meats were banished from the bill of fare. At a shareholders' meeting in 1928 the result appeared. The earnings were only half that they had been in the previous year. " Shareholder M—— said that the loss was due to the restaurants' failure to serve meat, and to the pushing of vegetable and health foods ". The founder was ejected from the board of directors, thus dying financially for his cause.[7]

The same hypochondriacal faddism colours the daily round of a large proportion of the population. The " daily dozen " is one of the commonest as it is one of the mystifying phases that greets the newcomer to America. It refers to what the casual traveller would conclude to be a national habit—physical evolutions

on rising in the morning, by old and young, men and women, boys and girls, after the manner prescribed by Sandow or Muller or some other muscular prodigy, pictures of whose biceps and torso adorn the advertisement pages of the monthly magazines. " Games, exercise, diet cure, water cures, fruit cures " (fruit juice only for weeks, and so starvation to the point of death), massage, beauty parlours, and health-cream are enlisted in this war against the corruption of the body. The advertisers of toothpaste and underwear, of socks and baking-powder, do not suggest that these goods will give us pleasure, so much as they will make us well " (Holtby[8]).

What lies behind this tendency of the age? Are we fonder of life than our grandfathers ever were? Have the benefits of civilization made life so much more attractive that it is more to be clung to than ever? Behind the hypochondriasis of the eighteenth century, in its eighteenth century significance, lay as we have seen a disillusionment, a lack of fixed standards, and a pathetic clinging

to the old ones that seemed to have been lost. Our age is in some way similar. We too are the inheritors of a puritanical tradition, which we have thrown over and have not replaced; we are the witnesses of new discoveries which fundamentally affect our conception of the world and of life; and we have seen the overthrow of kings and dynasties. But more important than the witnessing of such temporal changes for determining the price we put upon sound health, is a shaken belief in our own immortality. An increasing doubt of the perpetuation of individual existence in some form consciously and unconsciously influences us to cling more closely to the present life. The increase of scientific discovery, the experimental control of forces that superficially seem ultimate, and the false appearance of the solution of mystery has exalted everyman's opinion of his own perspicacity, at the heavy cost of his feeling of security and individual indestructibility. The new psychophysiology has ventured to express the most precious emotion as ultimately a neuromuscular

pattern in action; mind and spirit without body became impossible abstractions. The contemplation of a disease like epidemic encephalitis, which hits the nerve centres where the emotions are supposed by some to have their seat, and which can reduce the child to an irresponsible demon, and the adult to a vegetating lout, engenders in some a melancholy conviction of the truth of these views. "It is not for the most part that brains wear out in old age, many times they would go on longer if they were properly fed with energy from below, but the organic functions decay and fail; it is their failure which causes desire to wane and the grasshopper to be a burden; they are the source of life's energy and relish, and in their integrity and vigour lies the secret of a fresh and active old age. To live for ever, having got rid of the flesh with its appetites and lusts, would be to have a vapid and joyless immortality, the one long bootless desire of which would be an impossible suicide".

Thus wrote Dr. Maudsley,[9] and left his fortune to establish a hospital.

Little wonder perhaps that the thought of anything, germ or toxin or endogenous disease, that will assail or undermine the citadel, fills everyman with alarm and turns him to feverish precautions.

" Is this the honour which Man hath by being a little world? That he hath these earthquakes in him self, sodaine shakings ; these lightnings, sodaine flashes, these thunders, sodaine noises ; these Eclypses, sodaine offuscations, and darknings of his senses ; these Blazing stars, sodaine fiery exhaltations ; these Rivers of blood, sodaine red waters? is he a world to himselfe onely therefore, that he hath inough in himselfe, not only to destroy, and execute himselfe, but to presage that execution upon himselfe ; to assist the sickness, to antidate the sickness, to make the sickness the more irremediable, by apprehension and as if he would make a fire the more vehement by sprinkling water upon the coales, so to wrap a hote fever in cold Melancholy, least the fever alone should not destroy fast enough, without this contribution, nor perfit the work (which destruction) except we joynd

an artificial sickness, of our owne melancholy, to our natural, our unnatural fever. O perplex'd discomposition, O ridding distemper, O miserable condition of Man ".[10]

But behold the physicist, whose handiwork it is that has seemed to confirm Donne's intuitions of miserable extinction, and who has been leader in the discoveries that breed discouragement and loss of the sense of mystery in his fellows: he it is who turns away from his vacuum tubes, his kathode rays, his mathematics, and his untramicroscope to " the substance of things hoped for, the evidence of things not seen "; sees acts of creation in the story of the astronomical universe, and introduces a " principle of indeterminacy " into his very atom. Discovering in the end of all this order, disorder, he turns himself hopefully towards freewill.

On the one hand hypochondria; on the other, mysticism. Fortunate it is that the choice is not between these two only.

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