THE OBSESSIONS

AND

THE PSYCHASTHÉNIE

I

CLINICAL AND EXPERIMENTAL STUDIES

ON THE OBSESSIVE IDEAS, THE IMPULSIONS, THE MENTAL MANIAS,
THE MADNESS OF DOUBT, THE TICS, THE AGITATIONS, THE PHOBIAS,
THE DELIRIUMS OF CONTACT, THE ANXIETIES, THE SENTIMENTS OF INCOMPLETENESS,
NEURASTHENIA, THE CHANGES OF THE SENSE OF REALITY,
THEIR PATHOGENESIS AND TREATMENT

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TO THE PROFESSOR

Th. RIBOT

MEMBER OF THE INSTITUTE

HOMAGE

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PREFACE TO THE SECOND EDITION

The first edition of this work was published in 1903: I reproduce it now almost without modification. It would have been necessary to augment this volume very much to answer to the various debates that it provoked. I only tried to take into account the most interesting criticisms to supplement certain parts of this study. Also, the description and interpretation of impulsions linked in certain cases to various obsessions was insufficient in the first edition; it has been expanded and clarified on certain points. The study of delusions that develop in the psychasthénique state as well as the descriptions of various clinical types of the disorder are also more complete in this second edition. The clinical conception, by and large, of the illness, the theory of psychological stress and its fluctuations have not been changed. They continue to have some importance for the classification of mental illnesses and for the interpretation of many facts both normal and pathological.

15 March, 1908
INTRODUCTION

This book, like my previous works, is intended for physicians and psychologists. It presents a new application of the method that Mr. Th. Ribot so fortunately taught and that gave a special character to a large part of French psychology. This method consists in uniting mental medicine and psychology, to draw from psychology all clarification that it may provide for the classification and interpretation of the facts presented to us by mental pathology and reciprocally to seek in the morbid alterations of the mind, observations and natural experiences that allow analysis of human thought. This book continues the series of studies in which I proposed to apply this method to the different mental illnesses.

The disorders that are the subject of this study are the obsessions, the impulsions, the mental manias, the madness of doubt, the tics, the agitations, the phobias, the delusions of contact, the anxieties, neurasthenia, bizarre feelings of strangeness and the depersonalization that is often described as cerebrovascular neuropathy or Krishaber’s disease. We see that these cases were designated under very different names: they are sometimes grouped under the heading of “delusional degenerate” and “neurasthenia” and “phrénasthénique;” I have already often referred to them as “scrupulous” because the scruple is an essential characteristic of their thinking or under the more precise name of “psychasthénique” which appears to me to sum up well enough the weakening of their psychological functions. All these patients, very different in appearance, seemed to me to provide
an opportunity for an interesting study from both the medical perspective and the psychological perspective.

From the medical point of view, I try to bring together here the precise description of a large number of symptoms that appear to have rarely been the subject of a comprehensive study; I try to bring some precision into the analysis of all these mental manias, of all these phobias, of all these abnormal feelings that were too often incompletely described and isolated and which seem to become much clearer when one brings them closer to each other.

This rapprochement of various symptoms also allows proposing a combination of various diseases into one and to construct a larger psychoneurosis on the model of epilepsy, hysteria, and psychasthénie, instead of these countless obsessions, manias, tics, phobias, delusions of doubt or of contact, cerebral-vascular neuroses.

I hope also, by the comparison of these various symptoms brought together in the same study, to bring some contribution to the study of the diagnosis, prognosis and treatment of these disorders that play an extremely important role in nervous pathology. Finally, the psychological analysis of these various phenomena allows discovery of the common characteristics that are worthy of interest and to arrive at, if not a theory, at least a provisional interpretation intended primarily to gather the largest possible number of such facts into a general conception.

From the psychological point of view, I think that many of these phenomena present us some remarkable experiences that provide clarification on the most interesting problems. Obsessions, pseudo-hallucinations, and the impulsions that accompany them give us a wealth of information on the various categories of ideas that develop in the mind and concerning the various degrees of their development; mental manias, tics, phobias allow us to approach the study of a major fact, ordinarily left aside, the fact of the agitation and to understand the law of psychological diversion. The feelings that accompany the exercise of our various mental functions are largely unknown, we have barely examined a few of them such as the feeling of effort and the feeling of fatigue. The study of our patients
allows for penetrating far deeper into the study of a large number of these feelings, so-called “intellectual feelings,” and into the study of several social sentiments that are very important for understanding social relations.

Whatever may be the importance of these psychological analyses, I stress a problem the discussion of which returns very often in these pages and whose study forms the main part of this work. I speak of the study of psychological operations that enable humans to be in touch with reality, to act on it and to seize their existence with certainty. The function of the real with the operations of the will, the sense of reality, this feeling of the present occupies first place in the hierarchy of psychological phenomena and their study is as important for metaphysics as for psychology.

This study of psychasthéniques is divided into two volumes. The second which I shall publish in collaboration with Professor Raymond will contain the clinical observations of a very large number of these patients, more than 200; it will contain descriptions, psychological and clinical documents that could not be placed in the more general studies of the first volume; it will try to supply the justification and the proofs of the interpretations introduced by this one.

The first volume contains most of the studies on psychasthéniques, the first part is descriptive and analytical, the second is more theoretical and more general.

In the first part, after some information on the patients studied and on their rather characteristic attitude, the study of their obsessions will be done in an analytical way descending from the most obvious characteristics to the even deeper phenomena upon which the first ones appear to depend. So I will study first the content or substance of these obsessions, that is to say, the subject of the thoughts of the patient. This will be, for example, thinking of the devil, or the idea of murder, suicide, or that which most torments his mind. This aspect, which might be called intellectual obsession, has been, in recent times, a little neglected, since it has been rightly noted that emotion plays an important role in this disease. It does not seem fair to ignore it completely, it
occupies an important place in the symptoms presented by this particular group of obsessives that I group under the name of scrupulous. Perhaps the study will allow us to classify these various obsessions, to notice that there are many analogies between them and that the content of these ideas is far from being insignificant for the interpretation of the illness.

Then, I propose to bring together, under the title “the forced agitations,” the various disturbances associated with obsessive ideas or that replace them. I mean by that all the exaggerated and useless operations that constitute the mental manias, tics, the phobias or the anxieties.

Finally, I would like to search in the analysis for a special psychological state, which does not seem to be precisely an emotion, but that must be put into the large group of intellectual sentiments, in the analysis of the state of anxiety, these special ideas and the various agitations that arise out of this deeper departure point.

It will be easier then, in a second part that is more general and more synthetic, to examine the various hypotheses that were presented to interpret this curious impairment of the mind. I shall search out, in this respect, what these disorders, which are genuine psychological experiences, can teach us about the mechanism of mind, about the importance of any particular phenomenon. These impairments of thought highlight the important role of certain facts that remain confused in the middle of the countless phenomena that fill the course of normal life. Thus, we shall be able to study the “reality function” and the various degrees of “psychological tension.” That same part will also include general studies relating to diagnosis, prognosis, treatment, and the place of psychasthénie amongst the psychoneuroses.

These studies on the psychasthéniques were made on a fairly large number of patients; over a few years I combined 325 observations that, despite a large and interesting diversity, seem comparable enough to constitute a group. One part of these observations was taken from Mr. Jules Falret’s service at the Salpêtrière, and another part, the most important, was collected at the clinic of Professor M. Raymond, but the largest number of these patients were studied outside the hospital. Already it is
interesting to note that this group of patients was encountered a little more often in the patients from the city than in the hospital because, as we shall see, a certain degree of intellectual culture plays a role in its development.

I will not attempt to summarize here all the observations; it suffices to point out some general observations about the group. Of these 325 patients, I count 230 women and 95 men; the greatest frequency of the disease is in females is therefore well demonstrated. The majority of these patients are from 20 to 40 years old; it is at this period of life that the disease takes on a much greater development; six subjects are below 16 years of age and they allow us to witness the first symptoms of the mental disorder, while the 9 patients who are over 60 years of age show us the final forms.

Not being able to accurately describe all these patients, I will choose some that present the phenomena in the most precise and interesting manner and who, moreover, were most carefully studied for long periods and I will group the other cases around these observations taken as types. The patients I will put the most emphasis on are the following five: Claire (Obs. 222)\(^1\) is currently a 28-year-old girl, who I studied and treated for 9 years. She proves that the illness is not easily cured, since this girl is still at least an abnormal, she decided not to get married and one cannot criticize this resolution. She lives in the province and occasionally spends several months in Paris; it is at these times that I normally see her. The alternative phases between the periods of treatment and the periods of interruption delineate interesting alternations in the evolution of the illness that would provide us with some worthwhile findings. Lise (Obs. 223), to keep the name

\(^1\) It is impossible to provide all these observations in a comprehensive manner, I must content myself with pointing out in a summary fashion the facts presented by each patient that have interest for the general discussion. However, as these observations present a certain interest, as they contain certain useful information, the personal or hereditary background, the duration and the evolution of the illness, the results of the treatment, etc., I intend to sum them up in the second volume of this work that I shall publish, I hope, shortly in collaboration with Prof. Raymond. That is why the conventional name or the letters that indicate a patient will be followed in this work by a serial number that will allow one to find the observation again in the second volume.
under which I have already reported her in various studies, is a 30-year-old woman, who I followed regularly, almost without interruption, for 5 years. Her illness, very serious at the beginning, could be amended little by little; she is an intelligent, educated woman, capable of good observation. Jean (Obs. 107) is a man of 31 years, whose mental illness, a mixture of scruple and hypochondria, is the most serious, and though I observed him for one year, I despair of improving him as much as the other patients. Nadia (Obs. 166), this pseudonym was chosen by the patient herself, is a young girl of 28 years, who I observed for more than 6 years and who is particularly well known, since she has the habit, rare in the scrupulous, of writing me long letters, where she notes, with great detail, many incidents of her illness. Gisèle (Obs. 171) is a 30-year-old woman, remarkable for her aptitude for psychological analysis and for her picturesque descriptions that she often consents to write, like the previous one, and who was often a help to me. Whenever possible, these five patients will be cited preferentially, and the others, less studied, will be compared with them.
PREMIERE PART

ANALYSIS OF SYMPTOMS
CHAPTER I

THE OBSESSIVE IDEAS AND IMPULSES

The first problem that presents for consideration in the patients that we study here appears to be an intellectual phenomenon of the highest order, an idea and often it is a rather abstract and complicated idea. These ideas are distinguished in fact from the other psychological phenomena by their abstract and general nature: these are not sentiments or operations solely in connection with the present, particular state of the subject; these are conceptions that apply in a general manner over a period of life or a whole life. The anxiety caused by fear of a knife is a particular feeling. The thought that one is a criminal able to kill with the stab of a knife is a general idea. In this first chapter, I will examine only the ideas of this kind and the disorders that they determine.

These ideas recur in the patient’s mind, despite himself, in a continual and painful way and that compel him to perform acts that he finds unnecessary and wrong. This permanence of the idea and its impulsive character are not justified by its importance and practical utility, also the lack of usefulness in practical life distinguishes these ideas from those of the scientist and inventor and gives them a pathological nature. Ideas of this kind are referred to as impulsive or obsessive ideas.

In our previous studies on patients with obsessions,

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we noticed that the object of these ideas, their content was not very important. The most important phenomena for determining the nature of the idea and its supporting mechanism is constituted by what might be called the form of the idea. That is to say, the psychological character shown in the evolution of the idea. Was the idea consciously, clearly recognized as wrong by the patient, was it impulsive, systematic or not, etc.? These are the most important issues. The content of the idea, that the patient daydreamed of a fire or his dog was run over by a tram, has only secondary importance. On the contrary, the obsessions expressed by the scrupulous patients that we now consider, at first appear strange, as if their content deserves our first attention, because it plays an important role in the evolution of the disease.

I therefore propose, in this chapter, first to study the content of obsessive and impulsive thoughts, the object of thought that fills the mind of the patient. Then, in Part II of this chapter, I will examine the psychological form that takes this idea, that is to say, the psychological characteristics that distinguish these ideas from other normal ideas.

FIRST SECTION

THE CONTENT OF OBSESSIVE AND IMPULSIVE IDEAS

The content of an idea can be known only by the patient’s expressions, by his attitude and language. We must consider briefly the attitude of patients to be aware of the difficulties of observation. The thoughts that fill the obsessions and the corresponding impulses, because I do not think we can separate these two groups of phenomena, can be classified into five classes: the obsessions of sacrilege, the obsessions of crime, the obsessions of being ashamed of oneself, the obsessions of body shame, and obsessions of disease and finally, we can, at the end of this first study, attempt to identify some general characteristics that are always found in the content of obsessive ideas.
I. — The expression of obsessive ideas.

It is much more difficult than generally believed to describe accurately the ideas that torment the obsessed. Almost all these patients have an attitude and manner of expression that seems to stem specifically from their mental condition, but which singularly impedes psychological research.

Without doubt, they are gentle, kind, rather intelligent and do not present the anger, obstinacy, or confusion that interferes in the examination of other subjects, but they have tremendous trouble speaking accurately about what they feel and they express their thoughts in a perpetually incomplete, unclear and confused manner.

The scrupulous, early in his malady, when he realizes that his thinking is confused, begins by carefully concealing his condition from his family circle; his family is ignorant that he is suffering from a mental illness. It takes very special circumstances to persuade him to talk. Ger… (Obs. 214), for example, lets out her secret when, during a short illness, she was to be taken care of by her stepsister: in the delirium, she imagines that several years ago she had killed the mother of this young woman. It is too horrible to now be taken care of by the stepsister and she decides to explain why she refused her care. Or, the disease may have been suspected because of some poorly repressed external behaviors, usually because of the chatter that these patients make in a low voice and the worried family presses the issue. For several days, the family hears Bor… endlessly repeating ‘no, no’ when she is alone. She refuses to explain that word to her husband. Her father must come to beg to get the confession that she resists the devil. Often it also leads patients to the doctor simply because the family is worried about their attitude, but no one could give

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3 The number which follows the name of a patient indicates the number which will bear his observation in the second volume of this work. In that published volume in collaboration with Mr. Professor Raymond we shall study the records of the patient, the evolution of his illness, treatments which could in that case have an influence, clinical studies which cannot all be placed in this first volume.
a precise reason. This confession is so important and most often so late that Legrand du Saulle regarded it as a characteristic event in the evolution of the disease and began what he called the second phase.

When one queries these patients, they take on an extremely embarrassed air. They are hesitant, uncertain themselves about what they feel and what they mean. Some like Lod... (Obs. 132) continually roar out in laughter and make fun of themselves, as if there was nothing serious in their state. The others are sad, ashamed, and ask that we do not insist. All absolutely refuse to make a clear and precise account of their illness; this is a characteristic detail. I have the habit, as much as it is possible, to ask the patients to write for me. The descriptions are more precise by writing than by word and the document is often useful to keep. I gathered handwritten confidences on most mental diseases, after asking about 200 of the scrupulous, despite all my entreaties, I could get these letters from only five patients. We must therefore rely on the interrogation and recognize that it is extremely difficult.

However, these are not ordinary difficulties of the examination of the insane. Persons with persecution complexes often refuse to speak because they take the doctor for an enemy, he is mistrusted; and the scrupulous do not present anything like that. He is not defying the doctor and, as we shall see, he is, on the contrary, willing to seek the doctor’s aid. The melancholic refuses to talk about shame, about humility; the scrupulous almost always knows very well that his ideas, his accusations are false. He knows well enough that he is sick and has no reason to be ashamed. The hysterical cannot talk because she does not know, because she has forgotten; the scrupulous forgets little and what is more annoying in the examination is that he claims to know very well what he has to say and yet he always says it badly. He is hesitant, confused, he repeats himself without advancing, he never finishes the thought that he has started, he never advances without contradicting himself the next moment and he charitably warns you that what he said is inadequate, that he has something
else to say and we can start the questioning again but always get the same result.

Lod... (Obs. 144), in the midst of her laughter, warns you: “No, the more I go, the less I understand my ideas, how do you want me to describe them? When I want to explain an idea, it runs away, it makes me a hole in the head. I can no longer catch up. When I speak to you, it makes me think these things are so small… so small and yet when I leave, they are so serious.” Lise (Obs. 223), when we questioned her for two hours, when we wrote all that she said, ends by declaring: “Do not forget, I say almost the opposite of what I think of and I cannot find my ideas when it is a question of speaking about it. I always say only the half about it. Therefore, do not take into account what I said.” The most remarkable point of view, Claire (Obs. 222) always arrives very busy, because she has important things to be said to me, because she wants to say them and because she will find her calmness only having said everything. We encourage her to start and then she is chattering about the difficulty of speaking, about the problem of knowing where to start. “I’ve said all this, I’ve said it a hundred times, I had to tell you, what worries me is that I did not say the basics” and she cries, and she laughs, and she rolls on her chair in supplication on the one hand, moaning on the other, we spent several hours and then there is despair. “I am again going to leave without having said to you what I had to say, it is so simple, I am going to say it to you” and the scene would begin for several more hours if we had time to listen. She must leave with the consolation that the next time she will say more. I knew this patient for eighteen months before guessing her main obsession.

By exception, we meet conscientious chatterboxes such as Jean (107) or who write a lot like Nadia (106), but our hope to hear clearly about their disease is soon disappointed. It is an inexhaustible flow of words, complaints, moans, but with the same contradictions, the same obscurities. Jean complicates his language with a large quantity of neologisms, the sense of which he has clarified little by little in his mind, yet the neologisms do not make his speech clearer. “Ah! I had my small way since I left you, a fact that has a little scalded bouillaison repigeonnait made any yet, and the obsession of the mind and the
brain laughter that I plowed head. I could not resist the urge to clench my organs, snap, crackle, die thus giving you pleasure. What I have raised repeated number of beams to resist.iii You cannot imagine such a tedious state that is produced throughout the line of nerves.” And he goes on for hours without coming to be understood and especially without getting to satisfy himself. He begs you to listen for another quarter of an hour, because it is so important that he has said everything. He agrees to stop with the promise that the next time he will resume the interrupted narrative. It is interesting to compare Claire and Jean. One cannot say a dozen words; the other speaks abundantly for hours. The result is however exactly the same. Neither one nor the other has reached a satisfactory and precise expression of the disorder they experience.

It is the same for those few who write. Dob... (Obs. 86), a young woman of 29 years, who always has the feeling of having poorly explained herself by speaking, decided to write quite often. However, all her letters, which are similar to the point that they appear the one copied on another, contain only a few vague descriptions and are banal, similar to what the patient already said. Nadia professes to find it extremely difficult to speak: “I think,” she said, “it strangles me” and quickly adopted the system of writing endless letters, first ten or twenty sheets of writing paper, then, as this paper is not enough, five to six large sheets of foolscap. The important words are repeated three or four times, they are underlined many times. Everything seems to come together and have good accuracy and yet Nadia is never satisfied: “my letters are as confused as my ideas.”

Without doubt, this is a false sentiment, an illusion of a patient who is always dissatisfied with what he has said though he seems to have said things in a nearly sufficient manner. We shall study this sentiment in detail and explore up to what point it is wrong and if it does not correspond to a certain reality. For now, note that this patient’s sentiment about his speech, though very exaggerated to some, is generally fairly accurate. This mode of expression seems quite important, the desire to confess, there is no serious reason
why but the patient is unable to clearly express himself; these are the essential characteristics of the language of the obsessed scrupulous.

Some could maintain that this trouble with expression is due to shyness, and will try to link it to other emotional troubles that the patient presents while attempting to reveal intimate details in the doctor’s office. There is some truth to this in a number of cases; this attitude is partly that of being timid. However, I think this is only a partial explanation. Many of these patients are in no way shy with me, we do not want to extend the term of shyness to all disturbances of volition, and there is something more general and more important in their difficulty of expression. It depends on a manner of their mind, linked to a general inability to do something accurately, to end something. We will encounter this inability with all its importance at the end of this study, but as this character is paramount, it was good to note it at the outset, just in how the patient presents and explains his situation.

We understand that this characteristic does not facilitate the study of diseases: in this case, as it almost always takes an enormous amount of time to somewhat clarify the psychological observations, the expenditure of time is the main difficulty of experimental psychology.

2. — The obsession of sacrilege.

Whatever the difficulties that prevent fully capturing the thinking of these patients, we end up realizing a few main ideas that more or less vaguely form the basics of obsessions and impulses.

In the first group, it is obviously religious obsessions, but they are all special religious ideas, having a horrible, monstrous appearance outside of any reasonable belief. Instead of worrying about events of common life, the death of a child, the absence of a beloved person, these patients are considering religious crimes, impractical and fantastic, and think they are compelled to carry them out.
A few examples will help us easily understand this characteristic; I chose two exceptionally typical examples around which it will be easy to group ideas of the same kind made by other patients. On... (Obs. 221), a man of 40, after much procrastination, confessed what torments him day and night. Just two years ago, he lost his father and uncle for whom he had the greatest affection and the greatest reverence: he weeps, it is natural. Will he be obsessed by the image of their face like a hysterical weeping for her father? No, he is obsessed by the thought of the soul of his uncle. However, what is frightening is that he feels compelled to associate, to juxtapose or mix thoroughly (we know that these patients speak very badly) the soul of his uncle with something disgusting: human feces. “This soul, I put it in the bottom of the bathroom, I bring it outside behind Mr. so and so’s, etc., etc.” He made a multitude of variations on this pretty theme and cries out in horror, beats his chest. “Can we imagine such an abomination, to think that the soul of my uncle is m...” The case is interesting for its vulgarity, an idea of what kind of, in my opinion, special touch this is: it already warned the doctor that he will rarely come across this other than in the madness of the scrupulous.

Before describing this characteristic more precisely, let us see another even more typical example. Claire, the girl, whose chastity cannot even be suspected, ended 18 months of examination and questioning by confessing an obsession that follows, at first seemed implausible and that I had later found with frequency among the scrupulous. She claims that it is more than an idea, it is something that she sees and that appears to her suddenly toward the left. Let us accept for the time being this expression of the sick woman: “I see,” we shall have to discuss later if it is about a true hallucination. Claire claims to see a naked man in front of her or more precisely only the genitals of a man, engaged in performing an act, that to defile a consecrated Host.

For years, this young girl has this image before her eyes hundreds of times per day. Occasionally the image undergoes minor changes: there are many virile members perpetrating the Host, or it is a woman who puts the Host on her genitals, sometimes a dog makes his filth on a Host, sometimes the Host is simply mixed.
with mud, excrement. During some periods of great unrest, a priest applied the Host to the genitals of the patient herself or on her anus. Always she feels encouraged to collaborate in this abomination, to do the acts herself or to give her consent to the acts. In addition, these pictures cause a horrible anxiety: they confuse the sick woman; they give her, she says, a kind of hysterics, every time, it takes away from her all other ideas, all her will.

Such thoughts seem at first very strange and very exceptional. However, if one observes these patients, one sees that they occur often. A century ago, Esquirol had already described hallucinations similar to those of Claire. If we examine other patients, we often find ideas very similar to these two examples. It is always impulsive and obsessive thoughts about monstrous attacks against religious matters or that which is infinitely respectable.

Lise speculated for years on this subject: the religious worship of the devil. The obsession is not with her as brutal as in both of the preceding cases, it is not a simple image suddenly appearing, it is a complicated and lengthy meditation turning around a few of the main ideas that I summarized in keeping with the vagueness of expression that characterizes this malady. “There is a principle of evil like a principle of good ... evil is a God as well ... the opposite of God, to worship the opposite of God ... What is the power of the devil... to pray to the devil because of God... if you do not believe in the devil you do not believe in God any more... to ask the devil for services and to give to him in exchange that which you love most... to ask of him all that you want... to give to the devil the souls of your children... etc.” The last idea is the key fixed idea of this sick woman who is always tormented by the thought and wish to dedicate the soul of her children to the devil.

Another patient, Za... (Obs. 21G), a 30-year-old man, dreams about violating an old woman in front of a church. Leb... (Obs. 217), a 35-year-old woman, feels compelled by Satan to masturbate every time that she prepares a confession. We shall see later what to think of the phenomenon itself, genital excitation at the moment of performing a religious act.
For the time being let us point out only that the sick woman has a fixed idea in this respect “I think at all times that the devil encourages me to make dirtiness to prevent me from finding salvation.” For Xy ...(Notes 218), a 55 year old woman, the devil comes in all her actions, she cannot eat soup or change her shirt without thinking that she made at that time an act pleasing to the devil and did not believe that at that time she intended to please him. Lod... cannot see spit on the ground without thinking that it is a Host, cannot give a drink to her dog without thinking that she gives the wine and the water of the Eucharist, cannot herself drink without believing she swallows the wine of mass. Ger... imagines that she wants “to kill the good God.”

Finally, what is commonplace in all of this is the idea of blasphemy, “speaking ill of divine things, to think of the devil by making requests to him and to insult God instead of asking Him, ... to express hate of God in a poor and rude manner, to rebel against God and to curse Him, to say cursings as soon as they think of religion...pig of God, etc.” These are the words that are repeated many times by these patients. These same patients have obsessions of another kind, they mix divinity and religion in their illness, such as Vol...(96), a 21-year-old woman: “I am damned, I struggle against God if I struggle against my ill mind, and I make fun of God if I agree to treat myself.” The idea of sacrilege mingles with other ideas.

We see by these examples that the obsessions, so frequent in the scrupulous, have a common trait. They are all constituted, it seems to me, by two associated thoughts: one high-order, mostly religious and in all cases infinitely venerable, the subject’s eyes, God, soul, children, Church, the Host and the other a low thought, disgusting, vile, feces, genitals, the profane, obscene. This association is an insult to the first thought and we can say that all these obsessions consist of a sacrilegious thought: hence, the name under which I had the opportunity to appoint to it, sacrilegious obsessions and impulses. The first fact that we face in our scrupulous is that they are perpetually tormented by the thought of sacrilege.
3. — Obsessions and impulsions of crime.

The peculiar obsessions that constituted a kind of mania of sacrilege do not exist alone in these patients. We can even say that often they arose very late, when the evolution of the illness was already well advanced. Among these same patients, we meet other ideas that are a little different, that exist simultaneously with the sacrilegious obsessions, perhaps they were dominate earlier and are no longer remembered; in other, less severely affected patients who do not have sacrilegious ideas, we encounter only these less serious obsessions.

These patients are tormented for years by preoccupations that are always of the same type relating to religion or to morality. We will look later at what are the reasons that set the mind to similar moral reflections, for the moment we simply observe and describe. These persons seem to be deeply interested in religious and philosophical problems, which is allowed to everybody, but they do it in an absorbing, hard and completely extreme manner.

Lise wondered for entire days and nights on the question of salvation, she was not specifically interested in her own salvation, but that of her father, later of the salvation of her husband, her children. She is speculating now on the problem of good and evil in the world, on the issue of mutual action of souls on each other. She happens to be a kind of philosophical or religious person, mystical and childish, while she completely neglects the official religion. Another patient, Ger... naively examines how it is possible that God descended to the Earth to save men and to save her in particular. Py... (133), a little girl of 15 years, is tormented with anxiety regarding the end of the world, it leads her to examine the theories of creation, miracles, the existence of God. “It would be so terrible,” she repeats, crying in hot tears, “if God did not exist.” We have already seen that Lod... blends religious ideas with even the most common acts; she cannot pass in front of a bakery without wondering about the mystery of
the Eucharist and she cannot undress when she is alone because she is embarrassed by the continuing presence of God. One could multiply these examples to show sufficiently the religious and philosophical reveries of these patients.

Others, still more numerous, and whose study is particularly interesting, occupy themselves instead with problems of morality concerning human behavior. On..., the nice man who saw the soul of his uncle in the bathroom, had been previously tormented for years by problems relating to honesty; he anxiously wondered about the proofs of property rights, about the duty to resist, etc. Nb..., an interesting man of letters, studies, in spite of himself, the nature of love, friendship, charity. We... (170), a 19-year-old girl, has claimed to have resolved the problem of responsibility and wants to measure to what degree she is responsible. A 32-year-old man, Za... (216), entered the seminary at age 20 in order to satisfy his taste for theological questions, he is engrossed in these studies in such an abnormal manner that the Superior reports it to the doctor who then requires his dismissal from the seminary and invites him to change studies. Having barely left the religious speculations, he goes on, as if compelled by an instinct, to choose the study of law and he again starts, with the same furious energy, discussions about good, evil, crime, offence, punishment, rights, etc., so much that they must forbid him these new studies like the previous one. These similar studies seem quite permissible and appear to indicate simply a taste, a rather interesting and particular direction of the mind. However, we shall have to study the form that such thoughts take and see how much of their development is abnormal.

For the time being, let us point out only that these speculations do not remain neutral for these patients, they always mingle in their personal concerns relating to some determined actions. It is not in a theoretical manner that they think of religious acts, good or bad actions, they feel compelled to accomplish them. The evil seems not to be very big when it is a question of good or indifferent actions: Leb... (217), a 35-year-old woman, is continuously compelled to say prayers, to go to mass, We... feels an impulsion to take religious vows, to enter a convent, Dor...
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has a most curious impulse, she cares not about her own actions, but those of others, she is thrust to change the conduct of her husband and in particular to go to confession for ever smaller matters; she has a great anxiety attack because he smoked a cigarette before communion and that he is not going to confession immediately.

Unfortunately, the impulses are rarely of this type. In the vast majority of cases, these are impulses to do evil actions, criminal. The obsessions of crime have thus formed a tendency, an impulse to commit these crimes.

Za… has not only sacrilegious obsessions which compel him, as he says to, “to fulfill all theological sins,” he has impulses about more earthly crimes, for instance to rape a woman on a bench and to slaughter her. Mb… (136), a woman of 57 years, is pursued by the temptation of stabbing people with a long sharp knife, “which punctures eyes, which goes in well.” Ger… is compelled to cut off the head of her little girl, and put it boiling water. Moreover, we cannot count the scrupulous who have impulses to hit people and especially to strike their children with knives. I was at a recent conference at Salpêtrière on these patients; I met five mothers, all in tears repeating exactly the same thing: something that prompted them to strike their children with a small sharp knife. We cannot enumerate all these patients, it suffices to mention a few, Lise, Vod… (203), Wks… (197), Brk… (24), Vi…, Ger… etc., also want to hit their children. Qes… wants to throw himself on his mother, to strangle her and to commit suicide afterward.

These impulsive obsessions that seem to compel patients to homicide are among the most common and best known. Schopenhauer already reported a case of an impulse to murder in a patient who was aware of the absurdity of such an idea and was upset about it. Schopenhauer, Le libre arbitre, trad., p 177. Maudsley reports several examples, Magnan, Saury present numerous examples. In an observation by Mr. Magnan, the patient simply wants to bite and to eat the skin that he will have torn off. Magnan, Arch. de neurologie, 1892, 1, p. 321 (F. Alcan). We can therefore

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4 Schopenhauer, Le libre arbitre, trad., p 177.
5 Magnan, Arch. de neurologie, 1892, 1, p. 321 (F. Alcan).
bring together in one group all obsessions-impulses of any act of violence whatsoever.

The impulse to suicide comes in order of frequency after the impulse to murder; we shall find it in many of our patients, Nadia, for instance, in a romantic daydreaming succeeds in imagining that she drowns in the Baltic Sea. A woman of 30 years, Kl... (211), was for three years obsessed by the image of a hung man whose sad end they told her. What tormented her was indeed not the death of this individual, it was a personal reflection: “Well, I could do the same” and she felt thrust to hang at this point, she had to take precautions to not give in to this wish. She locked her attic and hid the key, because her idea was that she would execute her suicide in the attic.

Genital impulsions are often among the most remarkable. Za... wants, as we have said, to violate an old woman, V..., a married young woman, feels pushed to the window to make signs to the passers-by, to invite them to mount her. A girl of 22 years, Vob... (194) no longer wants to stay in her parents’ apartment, she wants to take refuge “in a prison, or in a convent, or in any place where there are only women,” because she feels compelled to go up to her brothers and to undo their pants. “She could never resist until her marriage, despite herself, her arms are already making small movements, she feels her hands undo the buttons.” We will have to examine whether this is true kinesthetic hallucination, let us only note here the form of the kinesthetic image that the obsession takes, similar to the visual form it took in the sacrilegious ideas of Claire.

Among the obsessions with genital impulsions, it is necessary to note those of Kk..., a 40-year-old man who for twenty years believed he was suffering from sexual inversion and displayed the sad addiction that compels one toward young people. He has no sexual excitement by thinking of men, he recites the poetry of romantic love of men and, at the same time, he fears the fate of a well-known writer convicted for his illegal conduct. I do not discuss the issue of sexual inverts, but I am convinced that too often they made theories on sexual inversion that were more apt to be a simple obsession with this as they would have an impulse to any
crime. In this case, this man was in love with a 17-year-old girl and so he was not always a sexual invert, following many other obsessions he arrived at the idea of this particular genital crime that is now his main obsession.

Impulses to masturbate especially play a major role in tormenting these patients. Deb... (165), 44-years-old, a woman cold with her husband, thinks only of starting again ancient masturbations, the same is true for Loa... (138), for Leb..., etc. This idea forms one of the leading phenomena of the complex illness of the poor man Jean: at any moment and at every turn, he thinks he has the temptation to masturbate. For example, if he encounters a woman in the train, if he is forced by circumstances to touch the woman’s hand and if he feels any emotion even a slight one, he feels he hears a distant voice saying: “Go, tensed up body, masturbate yourself, then die by giving yourself pleasure.” And he feels that his nerves are agitated half involuntarily, half voluntarily. “There is an indulgence in me, to let myself go for all those sexual desires.”

Let us add impulsions to other dishonest actions, for instance, Lod...’s impulse to steal and to lie. This impulse to steal is found very often: it plays a role in a more complex and particularly interesting impulse, the wandering impulsions. Go..., a 15-year-old boy, could not stay still in school when he tried to apply himself to his work; he felt a crazy agitation that led him in childhood to be truant very often. Now he has a mad desire to go anywhere, travel away from school, away from his apprenticeship. This idea takes away any common sense from him and it is necessary that he give in to it: he first takes his parents’ 68 francs, and then another time 304 francs and he leaves. His silver is of use to him only for paying for the railway in a most economical manner, and of assuring him a very thin ration. He lives on 10 pence a day and barely eats. He takes no pleasure in his journey; he travels just to travel, to keep away from his work. He is always discontent about having left and writes letters to friends and to his parents to ask for advice, he tries to return by taking a ticket to Paris, but he is
forced off at a station before arriving in Paris and had to depart going back the other way. He returns when he has no resources, he arrives with his head down, apologizing for his follies and swearing that he will not do that again. It was indeed a full memory he had of the expedition and of the fight he sustained against the obsession. This is a case that should not be confused with hysterical fugues, but which falls within the traveling fugues described by Mr. Régis. It belongs to impulsive obsessions that drive the patient to all sorts of criminal acts.

It is necessary to make a separate place in the impulsions for those that compel subjects to drink some alcohol or to absorb poisons. In certain instances, the impulsion to drink comes into the previous cases: the singular female patient whom I presented in a previous work was compelled to drink some café au lait and to eat small stolen breads. She ended up taking twenty or thirty café au lait during the day and took precautions to be able to make it through the night. Here the absorbed beverage does not have importance by itself, this is an impulse to drink a beverage forbidden by the doctor and regarded as dangerous for her stomach.

Most often, it is a question of drinking some wine, some alcohol, stimulants of any form. This impulsive obsession takes the name of dipsomania. Km... (192), for instance, who already has symptoms of alcoholic neuritis, makes different threats to herself: “If you continue to drink, your boss is going to dismiss you, your legs will be paralyzed, you will suffer horribly, your drinking makes for a genuine suicide, etc.” However, she cannot resist the impulsion. The dipsomania in a case of this type gets closer to obsessions and to criminal impulsions; but most often it is not so and it is linked to the group of hypochondriacal obsessions that we shall see later. All these impulsions to crimes can unite in the same subject who will think at the same time of homicide, suicide, theft or will unite all crimes in a vague way. “It’s as if,” Claire repeats, “I wanted to be allowed to be unwell, to give in to all my caprices, to abandon all morality.”

The impulse may take another well-known form: it will be negative. Patients will be urged to resist,

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6 Raymond et P. Janet, Névroses et idées fixes, 1898, II, p. 194 (F. Alcan).
not to make an action that religion or morals dictate. For Claire, this refusal constitutes a true delirium about religious acts; to refuse to celebrate Easter, to refuse to pray, to consider it impossible, to refuse to go to mass, to refuse to eat, this is perpetually what her impulsion inspires in her. In reality, she only has to think that an action is good so that she has a violent impulsion not to do it. It is because she believes in her duty to speak to me, to entrust me with her torments, it is because of this that she is so unable to do it: an action, which if she would consider it indifferently, would be done much more easily. This type is found in many patients, in Elg... (16), in Tr... (118), who feel pressure to not do their job, but it is less common than the previous type.

Next to these various impulsions, it is necessary to put a more frequent manifestation and an even more important criminal obsession, it is remorse. One could say that this is where the impulse to commit the crime is actually diminished, and what remains is only a reduced idea of crime, attenuated in the form of remembrance. The patient does not feel encouraged to fulfill a criminal act, but he thinks that he fulfilled it in the past and he is racked with remorse.

One can put in the first rank precise remorse, concerning this or that specific act and among these remorse of religious errors is, first of all, despair caused by inadequate confessions or by alleged sacrilegious communions. It is useless to mention names, because all the scrupulous have had this symptom, almost always at the beginning of their illness. For some, this remorse constitutes a genuine bout of delirium, all those who are in charge of mental patients know women thrown into a panic for months, because they believe have got a piece of Host in a hollow between their teeth. The fact is commonplace; it is well known and well described by novelists: you can read a beautiful description of a scrupulous sister in the Museum of Béguine by Georges Rodenbach.7

The doctor would have perhaps to raise some incorrectness in this portrayal regarding the state of

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7 Georges Rodenbach, Musée de béguines, 1894.
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insanity of Sister Mûrie Des Angel, but the first periods of illness are remarkably represented, the attitude of the sister in the confessional and her anxiety after absolution seems to have been copied from our patients. This kind of penitent is no doubt well known to priests who, judging by my patients, must be deafened by complaints relating to old communions.

We note remorse then for all crimes that presented as impulsions. It is remarkable, in fact, that patients who say they feel compelled to do a murder are often the same who, a few days later, will feel remorse as if they had actually committed the act. So, during the lifetime of her stepmother, Ger… felt encouraged to kill her; when this woman died, Ger took the blame for having caused the death. Vi … accuses herself of having completed all the actions that, as we have seen, she felt herself compelled to do. She has caused people’s death, she has strangled, she injured bystanders, sent incriminating letters, poured poison, been unfaithful to her husband, etc. Rob… (119), who is in charge of the cash register in a house of trade, is pursued by the idea that she returned the wrong change, that she stole. We… (170) blames herself for all the sorrows, for all the misfortunes that she sees occurring around her, because she takes the blame for having planned them and desired them in the past. New… (212), a 30-year-old man, invents a genuine madness in retrospect, he blames himself for improper behavior in school and he invents that all his masters abused him, it becomes a rather complicated story. Kl… is pressured to think that her child is not the son of her husband, this problem hides a true obsession of remorse, and it is a way to wonder if she was unfaithful to her husband. Dk… (215) had the idea, a fortnight ago, that he could kill somebody; he goes to the street and comes close to city sergeants and is at the point of asking them to arrest him. Xya… (25) does not treat his children well enough and made them die. Lise, if believed, committed all possible crimes: sacrilegious communions, murders, countless infanticides (she takes the blame for infanticide every time that she has sex with her husband not followed by conception), acts against nature, etc. Rk… at 30 years old remembers that at the age of 3 years he was in
his father’s bed one morning with his sister aged four; he believes he then abused his sister and is terrified at the thought of this incest.

Za... has rather curious remorses of this kind because they are accompanied by innumerable images analogous to the true picture. He has the mania to accuse himself of all the murders of which he hears. Thus, he learns, in the countryside, an 84-year-old man was found dead on a road. He immediately said that it was he who killed him to take his money. Passing by a house, he heard or thought he heard the sound of a gun and then he learns that a man was killed in this house. He immediately concluded that it was he who drew the revolver, shot and killed this individual. The obsession with remorse lasted two years. “I feel,” he said, speaking of the remorse, “all the emotions of the thief, the murderer, all the tortures of remorse for these imaginary crimes. I see the consequences of the crimes, I saw two officers coming to take me, I see the prison, the office of the examining magistrate, the criminal court, and I see myself in the dock, stared at by my colleagues whispering among themselves: they would never have suspected it. I suffered the anxiety of uncertainty before the verdicts of the jury and I work to reproduce in myself the impression of being sentenced to death, bound and taken to the place of execution.”

A second form of the obsession of remorse, more serious than the previous one and which may correspond to a very advanced form of the disease is general remorse about all acts of life almost without exception. Claire was a patient of this kind, she cannot “reflect on any of her actions whatsoever without being overwhelmed with remorse.” We will study this case about obsessions of shame.

In some cases, indeed, the remorse of a particular act may combine with a shame for all actions. Xyb ... (209) for some reason dismissed her laundress, and then decides to take her back. She believes she was unfair by dismissing her and to have lacked decisiveness by taking her back again. Following from this remorse she found all her conduct bad, she may no

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8 An interesting observation that we can compare to this one was published by Mr. Bramwell in the Brain, 1895, 344: “He invents absurd stories about a poisoning he prepares, he represents the tragedy, the child drinking the chocolate and dying in horrible agony, etc. ...”
longer do anything right until she fixes her conduct vis-à-vis her laundress. She takes care to be always tied to the laundress, for example, she always owes a small sum of money so as to not be able to leave that relationship, but she can never erase the guilt of her irreparable action.

A curious obsession I feel should be attached to this group, it is the “remorse of vocation,” the patient complains of having “missed his calling.” I have studied the interesting observation of a woman obsessed with the regret of “not being a teacher” and “not having at least married a schoolteacher.” Much more frequently, women blame themselves for not having entered into a convent, not being religious. This is the typical case of Gisele, a woman 30 years of age (171), who finds that her life is lost, bad, that all her actions are corrupted because she is not religious. To blame herself for an error in the choice of a vocation, it is a way to blame herself in general for all actions in her life.

All these obsessions regarding moral ideas, regarding impulsion to crime and especially regarding remorse certainly have, despite their differences, some common traits. This is what allowed me to put them under the common title: criminal obsessions.

4. — Obsessions and impulsions of the shame of oneself.

Another kind of obsession neighbouring the previous ones, well understood, but a bit simpler perhaps, can be found in the scrupulous, either insulated in comparatively minor cases, or in coexistence with the obsessions of sacrilege and crime in more serious cases. It is difficult to summarize in one word the general character of the ideas in this group. It is not only about remorse properly speaking, but also of contempt, discontent concerning not only the acts, but on the moral faculties, on the person of the subject and more often still on his body. The patient constantly has the idea that what he does, what he is, what he owns is bad. The

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9 Névroses et idées fixes, II, p. 148.
characteristic that seems to me to be the most general is the feeling of shame; though in certain cases shame is a weak word and that it is especially about discontent. That is why we assemble these facts under the generic name: obsession of shame.

Although the various forms of shame combine well enough, it seems useful to distinguish two main groups that have quite different clinical features. In the first group, shame or dissatisfaction remains almost completely in the moral domain and obsessions are more or less of the two previous classes, those of sacrilege and crime. What the subject despises in himself is his mind, his will, his intelligence. In the second group, shame focuses instead on the physical side of the individual and the subject is discontented by his body or by his bodily functions. These new obsessions will bring us closer to more hypochondriacal ideas.

Let us begin with the first group: the moral shame. In the most severe cases, patients present sacrilegious ideas and great scruples, this discontent is not localized to an action, it is absolutely general, and concerns the very person. Claire certainly has this kind of generalized delirium. Her discontent at the beginning, as it often arrives, is applied to religious acts, that is to say about those she wanted to do better: we will see more and more the importance of the contrast for the scrupulous. She still has the feeling that the confessions, the communions were poorly made. Then there were the prayers that she found very insufficient. She sought ways to remedy them: there were endless prayers, confessions prepared in writing for 15 days and then grimaces, contortions for making a good prayer, but soon these systems were impotent and these religious acts became impossible. She is still desperate; she reiterates that being able to pray would be her sign of full recovery. She cries when we talk about religion in front of her but she chose to give up any religious practice, she is convinced that she does them poorly, in an unworthy manner. She is led to mass, from time to time, but does not read, does not make any prayer. She would need such an effort to do one well that she would prefer dying. And the discontent has spread to other acts, anything that seems to have any
moral character, to everything that could be good. Actions indifferent from the moral point of view, or that she believes to be such, are easily done, she has no system to eat or breathe and yet we should not draw her attention to this nor make a medical recommendation on diet because immediately the wish to make herself good through diet would make eating impossible. For everything else she believes she is acting badly, she loves her parents badly, treats her mother badly, works badly, etc.

She expresses, as always, remorse in a very vague way. “It is as if I had committed all crimes... I have remorse as if I had killed someone... all the world makes reproaches against me, they will never do as much to me as I have done to myself, as much as I deserve... I listened to evil, I searched for everything that was bad in me... I did not struggle against evil...crazy dreams, evil thoughts against morality, against God, two hundred times a day... I am in each action as guilty as the greatest criminals.”

If she happens to agree, because she has not lost all common sense, that the act done is in itself a good act, that she has watched her sick mother and that we cannot consider this completed act as reprehensible, she enters into philosophical subtleties and differentiates the act itself and the willful intent from the person who performs it. The will was always bad in this act, or rather, there was not any good will, for, if it had been necessary to do it with good will, the act could never have been accomplished and she remains discontented with herself, even though one showed her that the act was good.

Since coming to see me, there is a special action that locates this feeling of imperfection. This is the action of telling me her illness to make me aware of her history. She desires to do this, but she never imagines that it is done well. There is despair because she said nothing to me and, to say it well, it would be necessary for her to begin again in order from the start; to tell me what she felt yesterday it would be necessary for her to tell what has taken place for ten years. She has already done that a hundred times but this does not count, because it was poorly done, she should do better and she cannot achieve that.

She not only she thinks she is condemned to do everything with imperfection, but she is fond of these guilt feelings, because she
feels that they will compel her to do better, they will encourage her to make efforts. If we took it away from her, she would fall even lower. In effect, the poor girl has the feeling that imperfection is growing. She always uses an image to express her illness: it is a fall into an abyss of which she has long skirted the edge and into which she finally fell. She gives me no news of her health; she simply comes to announce to me that she went down more or less quickly, because she always goes down and she will die rather than to go back up. At the very most, when it goes well, she agrees to admit that that month she went down a little less quickly. The ascent, which would be necessary to go back up, appears to her to be something horrible: it is a mountain, a pyramid to be climbed and it is only through a very difficult process that we can go back a little from time to time.

It is not her only regret, because she is equally dissatisfied with the things for which she can consider herself responsible. It is unnecessary to emphasize each mental function: all the questions we pose to Claire have the same answer, how she speaks of her memory or her reasoning, imagination or even of the acuteness of her vision, it will always be the same thing. She is not good, she is not polite, she is not affectionate enough, she is not smart enough, not active enough, and not more capable of feeling; she is no longer good for anything. If we press too much to show her exaggerations, she always answers by this argument: “You did not know me in the past; I was a hundred times better, softer, more patient, more intelligent, etc. I have not only lost the will and conscience, but I lost everything that made my intelligence.” Taken to this degree, these obsessions bring to mind the madness of melancholy and is, in fact, at least by its content, a melancholic delirium. Only when we study the form taken by these obsessions, shall we see what separates the scrupulous from the melancholic. This can be anticipated here in a word. This is because the melancholic is deeply convinced of its degradation, while Claire is very far from completely believing everything she says or thinks about this subject.

The other patients usually present to a lesser degree the same obsession. Here is the language of Les...: “I imagine that what I am doing is wrong, I still do not know how this offends religion or morality, but it seems to me that I should not do it. Look, I watched you talking, and I
feel that I should not look at you.” Ly... says the same. Dev... is interesting on this point because his assessment, which is rare, is artistic rather than moral. He is a skillful musician and he constantly has the idea that “he plays badly, that it is immoral to play so badly.”

A pretty routine case of dissatisfaction is that of Re... (140), a sentimental girl who, being betrothed, has a feeling that she does not love her fiancée well and is tormented by the search “to love well.” She arrives by the force of perfectionism to loathe him and since it is this way with all her affections that she feels are not perfect enough and seem so bad that they are like hate.

This obsession of discontent, shame of oneself, is linked to a certain number of other obsessive ideas and impulsions seemingly rather different but which have the same psychological nature.

1. Some delusions of doubt are probably related to an obsession of discontent which focuses on the intellectual faculties especially and the illness takes a turn which might mislead the observer. Here, for example, a woman of 57 years, Mb... (136) presents a singular delirium at first glance. She is compelled, despite herself, to study a psychological problem on all its faces: “What is the relationship between the sense of touch and the other senses? In what measure can we say that sight and hearing are distant touches?” Though in reality she is very ignorant on these questions, she discusses the problem fiercely, and wants to establish that there is direct action of the outside world in the sense of touch and indirect action in other senses. This discussion is an ultimate form of a previous obsession that has developed over the years, perhaps since the patient’s childhood. She feels a discontent with her senses “so imperfect, so coarse.” She seeks the least bad of them all, and arrives at granting some confidence to the immediate and direct touch, hence the search for that characteristic to be immediate in the other senses.

We will note well that this delirium of doubt here is not a separate disease, just remember that this same patient Mb... is ashamed of her will, her conduct and she feels
capable of stabbing with a sharp knife “which enters well.” The delirium of doubt and even the singular psychological form it takes in this case seems to me to be only an episode in the obsession with shame and of discontent completely characteristic of these patients.

We can compare this case to the curious obsession of Rk... “who is constantly forced to think of idealism, of the unreality of things... I am ashamed to have come to believe that my father does not exist.” We frequently see this notion of the unreality of things regarding the feelings that torment these patients; in the previous cases, that sentiment has spawned a genuine obsession.

This criticism of intellectual functions is a special delirium for Mb..., it is more or less attenuated in the other patients, Claire will repeat: “Everything goes on me, I lost all sense of reality, everything is veiled.” Many patients accuse their intelligence even more. Dob... (86) feels flooded by the idea “that she is stupid, that she can understand nothing, that she is going to become mad and that she will go raving in the middle of the street.” This obsession determines, as will be seen, a terror that can be, to a certain point, closer to agoraphobia. Jean, also, is willing to belittle his intelligence; if we took his words seriously, we would think he is an idiot. He repeats continuously that he can neither read nor write, that he can understand nothing of the natural phenomena that surround him. “I am a stranger to all. All that is natural is tainted with a mystery of inaccessibility.” He does not endure it when we ask him for the smallest information, on his properties, on his wealth, on the value of money, on anything practical, because he always repeats that his mind can understand nothing, that he is a stranger to life. Without going as far as this, Lise is always willing to find that she is stupid. She finds in herself something that she criticizes and she can accept no compliment, because she always thinks we are wrong.

It is very clear that these patients’ obsessions pose a very curious psychological problem. To what extent are they right or are they wrong? Are they completely delirious when they claim that they became stupid? We will have to discuss the issue at length when we talk about the psychological state that germinates these obsessions. For the time being, let us note that this obsession is greatly exaggerated, even if only
by its repetition. If they indeed became stupid involuntarily, that is not a sufficient reason to blame oneself all day long, and those who are indeed stupid do not blame themselves this way. There is, therefore, a very particular feeling of shame of oneself that is the same kind as the previous obsessions of sacrilege and crime. The patients who always feel pushed toward crime believe, at the same time, that they are capable of it.

2. **Obsessions relating to madness:** a very large number of these patients, for example the 46-year-old MRC... (178), a woman of 28 years, BYP... (180), etc. are appalled at the thought that they are crazy, that they have had or will have fits of madness and they search themselves for all the signs of what they call madness. “I see houses and people upside down, I say stupid things, I’ll bang my head against the wall, so look at my eyes, and you will see how they are lost.” According to their character and to the psychological evolution of their disease, they stress in their obsession this or that characteristic of madness. Zb... (175) repeats that he sees that everything is odd in the world and that as a result he is crazy. Cas... (177) is afraid to be isolated: “it seems to me that I am alone in the world, I cannot manage myself, I need to be locked up like the madmen.” Léo... (173) repeats that madness will make her “kill her small daughter, and follow the first man to come on the street.” We see the obsession of madness is accompanied by the impulse “to act like the madmen, to perform acts of madness.”

Some claim, like Léo..., that this obsession has been caused by the sight of a crazy woman, but many, particularly Dob..., in whom this obsession was determined by major anxiety attacks, cannot invoke this explanation. The idea of madness seems to me to be attached to this shame, to this mistrust that they have of their own strengths.

3. It is necessary to put, in my view, here the obsessions that often seem very embarrassing, **obsessions of depersonalization.** In recent years, various authors, Messrs. Dugas, Bernard-Lerov, stress the phenomenon reported in the past by Krishaber then by Taine, the feeling and the idea of having lost one’s personality. I already had the opportunity to describe two remarkable cases of these phenomena regarding Ver... and Bei... It seems to me that
we must distinguish two forms of depersonalization: one is a feeling that occurs under specific conditions and we shall study later about all the psychological feelings of inadequacy that play a significant role in the pathogenesis of obsessions. But the other form is a true obsessional idea probably developed during the preceding sentiment. The subject constantly has the idea that he is no longer himself, that he no longer walks, eats, speaks, even when the initial impression of depersonalization has disappeared. He has, in this respect, a true obsession: it will be necessary to take into account this distinction in the study of these patients.

It is the same for a memory problem, related to this one, which has also attracted much attention. 

*The phenomenon of “déjà vu”* is above all a certain intellectual sentiment that falls within the same group as the feeling of depersonalization. In some exceptional cases, the patient can develop a kind of madness regarding this feeling and be obsessed by thinking that everything he sees is the repetition of the past. This is obviously so in the remarkable observation of Mr. Arnaud. The patient, anytime, in any state, cannot fix his attention to any event without having the idea that this event has already happened exactly the same, in similar circumstances, a year ago. Mr. Arnaud strongly maintains that there is an idea superimposed on a sentiment, an idea that is widespread and constant, while the sentiment is probably present in a rare and short-lived manner.

4. Of the more rare and more curious obsessions are the obsessions of envy, Fa... (169), a 34-year-old woman, presents a remarkable example. This woman, whose hereditary history is very burdened and who has already definitely had disturbances, was very tormented by a serious illness of her husband. The obsession, which developed over the past two years, is a thought of envy about everything she sees. She cannot meet any person without envying something immediately: “this one is

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dressed well, this one has good looks, the other works well, this woman has a child, this one a husband, here is a man who knows how to speak, here is one that is strong, here’s a lady that is charitable, this individual who enters a store is honest.” This thought leads each time in her mind to a long speech, and she suffers from a ferocious jealousy. A curious detail, she might even be envious of the misfortunes of others, “they were lucky to mourn their father, here are those who have the happiness to be so shaken by a great misfortune.” Although the expression of the obsession is strange here, it is always the same idea of her own inadequacy that plays the main role. When Fa... envies the intelligence, strength, activity of passersby, it is as if she is repeating that she is herself without intelligence, without strength, without activity, without honesty. It makes her quite easily say: “Why do you envy those people who have had a misfortune and weep? - Because I feel it would be good to cry and I feel unable to do so.”

5. Certain subjects are obsessed by the idea of certain qualities: the idea of modesty, the idea of independence. Voz… (122) repeats that freedom is the sole, the only happiness to aspire to all our life. He is always tormented by idea that he is not free, that he is in captivity, that it is necessary to arrive at deliverance. This idea takes a very curious symbolic form in his mind, to which I will return. But it is obvious that this obsession depends on the same idea of shame. He is ashamed to have lost his independence and is obsessed with the thought of a perfect freedom and he feels compelled to commit a lot of nonsense to achieve that perfect freedom and to prove that he possesses it.

6. It seems fair to attach to the obsessions of shame of oneself, or at least to stand beside them an interesting group, the romantic obsessions and impulses. I have already described among the obsessions of crime, obsessive ideas that dominate in the genital impulse or genital remorse. In these ideas, the idea that the action is wrong, immoral, plays a more important role than love itself, and it was right to bring them closer to the obsessions of suicide, theft.
etc. But there are genital obsessions where the genital phenomenon, if indeed it exists, plays only a secondary role, while the moral love, the need to live with a specific person, constantly thinking of her, to subordinate all actions of life becomes the essence of the obsession. In some cases, this romantic obsession is an expression evidently slightly modified from the obsession of shame, as we have just seen with the obsession of jealousy.

The following case is, in this regard, quite typical: Byl... (181), a girl of 21 years, had a character already abnormal since the age of 10. Extremely stubborn, shy and wild, she has long refused to go out, to see the world. At age 17, she decided to give this explanation of her wildness: “I’m not a girl like the others, I am ugly, I have the face of a cat, you do not see that it is shameful to make a girl like me go out. I am a monster, everyone turns around when I pass, it is torture to let me see that.”

For three years, she retains roughly the same idea: “I am a poor, odd creature, unintelligent, ugly, unable to hold my rank.” In these conditions, she thought awhile of the convent but did not feel a sufficient vocation and then she conceived the idea of an extravagant wedding. She declares to her astounded parents that being over 18 years old and a free woman, she wants to marry the gardener of the house, that she entered into his room in the night, they are engaged. And that marriage should take place as soon as possible. She imagined she could change social situations completely; she wants to present as a maid and to earn her living with him. For several months, she refuses to wash her hands to be more on his level. No reasoning has gripped onto this obviously delusional idea or on this seemingly irresistible impulse, it is possible that she ends up falling in love a bit with this boy, but love is only an expression of the deeper obsession of the shame of oneself here.

Often the relationship between the two groups of obsessions is not so narrow. If patients cannot do without a specific person, they feel alone, they believe they are becoming mad by isolation, when she is the one abandoned, she is or believes herself to be incapable of managing alone, and has an
obsessive need for this leadership, for this very special excitement to come back again. I have already devoted a special study to this group.\footnote{Le besoin de direction, Rev. phil., févr, 1877 p. 113, et Névroses et idées fixes, 1, p 456.}

We still have to study about the sentiments of these patients, for the time being it is enough to add some typical observations to those that I have already reported. Gri... (182), a woman of 28 years, cries for her lover who had taken her out of a chaotic life, she does not know how to behave anymore and obsessive love and is clearly linked to the need for direction. Tkm..., a woman of 39 years, has a similar obsession since her lover was married, “he was tyrannical and occupied my whole life; I was in charge of nothing.” Sim... (185) a 31-year-old woman, her despair is unimaginable, the obsession is perpetual day and night. She still believes she sees this lover who directed her, constantly looking after her “because he alone was able to give her the physical and psychological excitement she needed.” The case of Ck... (184) is reviewed in detail because it is curious. This aboulic, phobic, obsessed 41-year-old woman had found support and guidance in another poor disabled mental patient who herself had tics of uncleanliness and who could not manage herself. These two women have supported each other like the blind and the lame, they have managed to decrease their mutual weaknesses and have lived happily and reasonably for years. A bizarre incident has lost everything: a dismissed servant made a crude joke about the passionate affection of these two women and has raised scruples in these women about their relationship. It is not rare to see these patients develop such scruples about treatments, or management, that cured them. This is one of the difficulties of their treatment. Ck... is obliged to leave her friend, but then she is obsessed over having left her, she would rather die than live without her and very serious disturbances grow from this obsessive love. Finally, at the end of this group one can place a rather strange case, that of Qi... (188), this 36 year old woman is obsessed with the idea that she is a small child, 10 or 12 years old, especially when she is alone, she lets herself go to jump, to dance, to laugh.
radiantly, she undoes her hair, she makes it float upon her shoulders, cuts it at least a little. She would like to surrender completely to this dream, to be a child, “it is so unfortunate that she could not play hide and seek, play tricks in front of the world.” This idea is not as strange, as isolated as it seems: “I would like them,” repeats the patient, “to think I am nice, I’m afraid I am ugly as sin, I want to be loved well, let them caress me, cuddle with me, to be told all the time I am loved, as one loves the little children.” In spite of her apparent extravagance, this is, as in the previous cases, obsessive love, obsession with need to be loved in the form that it often takes in the scrupulous, that of being loved as a child.

By examining many patients, we easily find other varieties of obsessions that at the bottom are only particular forms of the shame of oneself. This is one of the most important groups we have to report.

5. — The obsessions and impulsions of the shame of the body.

This idea of contempt of oneself, this obsession with personal dissatisfaction is often on the physical person, on the body. Patients in whom we find this dissatisfaction with their bodies are very numerous, they form a unique group that we could not suspect the importance of before seeing them frequently. You could call them all “ashamed of their bodies.” The most complete have an obsession on their whole body in all its parts and thus their general obsession is divided into a number of small specific delusions. Others go less far in the same line and their obsession with shame is not primarily the body, but it is systematized on this or that part, this or that function of which they are particularly ashamed. I will first pay particular attention to a remarkable case that gives an overview of the first group, and then I shall choose a few specific examples that show the shame concerning this or that function.

A curious observation, that it is unfortunately impossible to present without going into countless details, is that of Nadia (166), a girl of 27 years, whom I
managed as much as possible for more than five years. This girl came to me with the somewhat superficial diagnosis of hysterical anorexia. This diagnosis was justified simply by a more than bizarre diet that the patient imposed upon her family for years and by the appalling scenes she made when they tried to change her regime. She prescribed to herself two soups a day in a light broth, egg yolk, a tablespoon of vinegar and a cup of an extremely strong tea in which she had put the juice of a whole lemon, carefully pressed. They had been able to discover, which was not difficult, that she had conceived this regime in the fear of getting fat, and they concluded a hysterical anorexia.

Hysterical anorexia is already by itself a very strange disease, which is far from being fully elucidated. In its typical form, it is not as common as we think and confirmed hysterics frequently present this phenomenon among their countless accidents. Vomiting, regurgitation, various spasms of the esophagus, stomach, diaphragm, muscles of the abdomen also determine the eating disorders and are much more common than anorexia itself. In the presence of a case of complete refusal of food, we must, if I do not make a mistake, be wary and think that mental disorders of varying severity may be more likely than hysteria itself.

In any case, we accept for the present this hysterical anorexia; to make the diagnosis it is necessary to find at least a certain number of characteristic symptoms. Of course, it would be good to find clearly hysterical phenomena either currently or in the historical record. Unfortunately, we know that this symptom is frequently isolated, at least in its early stages. If you cannot find the signature of hysteria, it is my opinion that the refusal of food has two main characteristics.

1° You must note the complete or nearly complete suppression of hunger during almost all of the illness. This loss of hunger is often accompanied by considerable disturbances in the feelings of the mouth, either for taste, or even for touch, of anaesthesia of the pharynx, by disturbances of the movements of jaws and cheeks, anaesthesia of the esophagus and probably the stomach with or without the spread of this anaesthesia to the skin of the epigastric region. Is the loss
of hunger directly related to these various anaesthesias of the mouth, the esophagus, the stomach that often but not always accompanies it? It is a problem that I discussed at length in my lectures at the Collège de France on the consciousness of the body and its functions. Without being able to go into this discussion here, I shall say only that the anaesthesia of these organs, when it exists, contributes to the elimination of hunger and, consequently, it plays a role in the diagnosis of hysterical anorexia.

2° A second symptom, more curious and much less analyzed, although it was pointed out long ago, I think is also important: an exaggerated need for physical movement that accompanies true anorexia. Patients move constantly, take great walks, dance in the evenings, push themselves too hard in a thousand ways and there are as many scenes to retain their exaggerated walks as for refusing food. This symptom has been interpreted in various ways. Lasègue sees the result of a calculation: “these people,” he said, “are afraid to be taken as patients; they fear that we might use their weakness as an argument to force them to eat and so they simulate great activity.” Mr. Wallet, regarding two curious observations, sees a technique by the patients to augment their weight loss. They do the exercise, as they drink vinegar, to lose weight. Without denying the role that such reasoning may have played in some special cases, I can accept only that this great, general symptom always depends upon reflections, in fact, quite complicated.

In some interesting observations that I discussed in my classes, I could show that the exaggeration of movement sometimes comes earlier than refusal of food and therefore precedes all these arguments. In a very curious case, a reasonable woman of thirty-five years, comes to me seeking treatment, and therefore does not seek to deceive. In her anorexia, which is very rare, is a repetition and it proceeds by fits and starts. Following an emotion, she feels excited and shaken up as if she was carried off like a feather. She has the need to gesticulate, to speak, to walk. She no longer returns

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12 Wallet, deux cas d’anorexie hystérique, Nouvelle iconographie de la Salpêtrière, 1892, p. 276.
to her home, but she still continues to eat, while saying she does not feel the need for more “because she is strong enough without it.” Then two days later, she was disgusted with “useless” food and she began to refuse to eat.

One approaches the truth by saying that muscular anesthesia and especially the anesthesia to fatigue plays a role in this perpetual motion. I think we must go further and say that in this feeling of euphoria there is a genuine excitement in connection with the emotions of a particular mechanism, if one prefers anatomical language, a true excitement of the cortical motor system. This stimulation seems to play a significant role in the loss of the sentiment of hunger, perhaps more important than that of anesthesia in the stomach, because hunger, before the sentiment of the involvement of various reflexes of nutrition, is a general sentiment related to the impression of weakness and exhaustion. In any event, it does not suffice that a young girl refuses to eat or even that she obviously has the fear of getting fat for us to call her condition a hysterical anorexia. It is also necessary that, in addition to the various symptoms of hysteria that we can see, there is a considerable decrease in the feeling of hunger and an exaggeration of movements. Was it so in this patient, Nadia, to whom I return?

This patient, who was examined many times with great care, never presented the slightest signs of hysteria. She has no decrease of sensitivity, not in the epigastric region or in the rest of the body. In her history there is noted an appalling anger, but she is described as free of attacks of hysteria. What is more important, she has no true anorexia at all. She has perfectly preserved the feeling of hunger. Often, it is true, in the last period of illness, hunger is masked, because there are inevitable stomach problems after years of this regime, but usually Nadia is hungry, she even gets very hungry. This is reflected first by her actions: from time to time, she forgets herself until she greedily devours everything she encounters. In other cases, she cannot resist the urge to eat something, and she takes the cookies secretly. She feels horrible remorse for this act, but she resumes it all the same. This can be seen even better by her very curious secrets. She
acknowledges that she needs to make a great effort to go without eating. “She is a heroine to have been able to resist for so long a time... Sometimes I spent hours thinking only about food, I was so hungry: I swallowed my saliva, I bit my handkerchief, I rolled on the floor, so much did I crave to eat. I was looking in books for descriptions of meals and great feasts, and I tried to cheat my hunger by imagining that I tasted all these good things. Really, I was absolutely starving, and despite some failures with cookies, I know I had a lot of courage.” Is it hysterical anorexia that she speaks of? In addition, in no way does Nadia present the unrest of hysterical movement. It is interesting to note that she makes the precise reasonings of which Lasègue speaks. She sought to work well, to walk to her courses so that her mother was not worried about her refusal of food, and the exercise made her lose weight, but that cost her a painful effort that she did only by necessity; most often, and especially now, she wants to stay quietly in her room and feels no need to walk and spend her strength. The disease is therefore different: the refusal of food is only the result of an idea or a delusion.

This idea, if one considers it in a superficial way, is evidently the fear being fat. Nadia is afraid of becoming strong like her mother; she is anxious to remain lean, pale, only that pleases her, is in harmony with her character: of her continual anxiety, she is afraid of to have a swollen face, to puff, to have big muscles, to get a better complexion. One must take great care to avoid making compliments on her health, a blunder by her father who, seeing again her at the end of some months, said that she looked well, which began a serious relapse. We must be prepared to answer the questions that she constantly poses: “Please, tell me what you really think? Do you find that I have big, round and pink cheeks since I am eating more? Out of the kindness of the heart, tell me and console me, I beg you. Did you find me as thin as other times? Do me the pleasure of telling me that I shall always be thin... Look, today I was in a hansom cab that did not walk, the horse could not drag me, it’s because of these chops you make me eat. I beg you, reassure me.”

But this obsession is not at all an isolated and unexplained obsession,
as sometimes happens in hystericis. It relates to a system of extremely complex thoughts. First, stoutness is not only considered from the point of view of an interest in one’s looks: it presents to the patient something immoral. She always repeats: “I do not want to be pretty, but I would be too ashamed if I became bloated, it horrifies me and if by misfortune I got fat, I would not dare to let anyone see me, neither in the house nor in the street, I’d be too ashamed ...” And notice that it is not the obesity itself that appears shameful to her. She loves people who are very stout and finds that it suits them, but for her it would be immoral and shameful. This is not just stoutness, but also it is all that it is linked with the act of eating that deserves this character.

She began to refuse to eat with other people: she must eat alone, as in secret. Truly, if one can permit such a comparison, she hides to eat, she is embarrassed to do the act in front of someone, as if asking her to urinate in public, and, moreover, she recognizes that the comparison is fair. When she happens to eat a little more, she is still in hiding; there are protests to pardon her as if she had committed an indecency. At the time of the Christmas holidays, she took the liberty of tasting some boxes of chocolate sent by her friends. She wrote me more than ten letters on this subject, confessing as a crime each of her bonbons, trying to explain, by a feeling of greed or curiosity, an act that she regrets so much. She would have been very ashamed if they had surprised her in the act. Not only must they not see her while she eats, but they must not hear her as well. Mastication is something so vile that, if you could hear her, it would make her go underground. Here again, it is not the behavior of eating in general that she despises: you can eat in front of her; she found nothing reprehensible in that, on the contrary, she is happy to offer something to people who come to see her. But it is the chewing to her “that makes a special noise, ridiculous and disgraceful. I am willing to swallow, but do not force me to chew.”

We should not believe that this shame limits itself to being overweight and to the act of eating. Nadia has other torments.
Although she is thin and has rather pretty traits, she is convinced that her face is not only bloated but also red and covered by spots. As I did not succeed in seeing these so-called spots, she declared that “I know nothing and I do not recognize spots that are between the skin and flesh.” Anyway, they give her an abominably ugly face and although she has no vanity, a self-respecting person cannot allow such a face to be seen. Alongside the refusal of food has developed another delusion that has been too little noticed, it is the fear of going out into the street. There are horrible scenes in order to go out for a little while, by closed carriage. It is necessary that the coachman and the housemaid look away when she rushes into the carriage. She goes out more easily in the evening, in deserted places, where there are few risks of her being seen. Even in her room, if I let her do so, she would maintain a semi-darkness and she is always situated in the darkest corner, her back turned to the light. If we did not stop it, she would not delay in, as a patient whom I knew, living in complete darkness.

If her face embarrasses her so, the other parts of her body are left far from indifferent. Since the age of four, she claims, she has been ashamed of her size, because they said to her that she was big for her age. Since the age of eight, she began being ashamed of her hands which she finds long, ridiculous. Towards the age of 11, as she wore short skirts, it seemed to her that everybody looked at her legs and she could no longer endure them. She needed to put on long skirts and then she was ashamed of her feet, then of her too broad hips, of her arms with big muscles, etc. Of course, the arrival of puberty singularly aggravated all these strange feelings. Menarche made her half-mad. When she started growing pubic hair, she was convinced she was alone in the world with this monstrosity and up to the age of 20, she plucked “to remove the savage ornament.” The development of breasts especially aggravated the obsessions, because fears about modesty were added to the old ideas about obesity. At this moment, especially, she began completely refusing
to eat and no longer want to show herself. By all means possible, she tried to conceal her sex, of which she is particularly ashamed: her blouses, her hats, her hairstyles should be closer to the male costume. She cuts her hair half-long and curls it and she would like to have the appearance of a young student. It should not be thought that here is a sexual inversion, as is assumed too quickly in such cases. She would be as ashamed to be a boy as to be a girl. She would like to be without any sex, and she would even like to be without any body, for we see that all parts of the body determine the same feeling of which the refusal of food was just a very partial manifestation.

What is deep down the dominate idea that determines these singular assessments? Modesty certainly plays a considerable role and this feeling is pushed to quite an extreme. Not since the beginning of childhood could she undress in front of her parents and until the age of twenty-seven, she had never consented to be auscultated by a doctor. But she combines with it a crowd of things: vague guilt feelings, reproach relating to greed and all kinds of possible vices. She herself blends in an especially more interesting feeling, that we already noticed about the preceding obsessions and that will become more and more important with our scrupulous. “I did not want,” she says, “to put on weight, nor to grow, nor to resemble a woman because I would have liked to remain always a small girl.” It is obvious that this desire to remain a child played a considerable role, for what she always dreaded is to develop, more than to actually get fat. But why this desire? The reason for this strange desire is summed up in one word that many patients repeat to us: “Because I was afraid of being less loved.” Deep down, this is the idea she has, she is afraid of being ugly, of being ridiculous. “They will laugh at me and love me no more. They will discover that I am not like everybody else and they will love me no longer. If they could see me well in full light, they would be disgusted and not love me anymore.”

This desire to be loved, this worried fear that one does not deserve the affection that one so desires mingles certainly in this case with the ideas of possible faults and fears of modesty to produce this obsession with body shame and all the impulses to refuse food, to lose weight, to hide oneself.
that we have just seen. It will be used again in the following observation.

This is a much less serious case and especially much less comprehensive, in which the obsession that we study does not concern all parts of the body, but as we said at the outset, on a body part and on a particular function. Wye... (160), a young man of 27 years, temporarily had a few criminal obsessions, he felt guilty eating the flesh of animals, he has also had some hypochondriacal obsessions relating to diseases of the throat, but these phenomena have been very temporary. The dominant fact for the last ten years is discontent and shame that is almost exclusively about the movements of his arms and legs.

From childhood, he was preoccupied about the position to give his left arm, he dreaded the summer season, because he had no more reason to keep his hands in his pockets and he did not know where to put them. Little by little, this feeling has grown significantly and has become a serious obsession. “I feel,” he said, “that I lack spontaneity, that my movements are restricted. I am stiff. I do not know to which side to bring my arm or head. I have mechanical movements. They would say the bear of the Garden of Plants.” So I am forced to think at all times of how my arm swings itself, so I straighten the arm.” The slightest of things in his costume can modify this discomfort of his body: clothes well made and a little old put him at his ease, the costume for hunting, which allows some sloppiness of movements makes him happier. On the contrary, a new morning coat, a costume that could not reach perfection increases this obsession for perfection and makes it difficult for him to go out. He has been obsessed for some time with the problem of wrong collars. This concern of collars is far from trivial. In two other patients that I could not study with the same care and who also closely match his obsession, the scrupulous obsession took exclusively the form of an obsession with the collar. In these patients and in Wye... especially, these obsessions impede movement, lead them to make contortions and grimaces to try to make normal movements, or to conceal from others the discomfort they feel. Thus, Wye... will blink when he believes that his eyes do not have a natural movement.
These contortions often give birth to errors in diagnosis. It is generally diagnosed as tics: this is fair but you should not forget the obsession that they manifest. There was a most serious error in one case, in my view. A sick man, about whom we spoke regarding criminal obsessions, was returned from military service at the age of twenty-one years with the diagnosis of Sydenham’s chorea. vii We could already point out that it is peculiar to diagnose chorea in a twenty-one-year-old man. According to Sydenham, true chorea seldom happens after puberty. But here the error was even more serious, because the movements of Za... (216) were only contortions determined by the sentiment of discomfort and shame and by efforts to control himself that we will have to study later with all the scrupulous.

What determines this feeling of embarrassment in these patients and in Wye... especially? It is still the preoccupation that they are not like the others; that they are ridiculous and will not be loved. The wish to be appealing preoccupies them all their life, and it adds to a sense of despair, the inability to achieve that brings about a good deal of shame of the body.

In a neighbouring group, we put those just ashamed of their face, their facial features. TK.... (161), a young man of twenty-four years, son of a mother who committed suicide, is particularly struck by the disease since he contracted syphilis. He is anxious, ashamed of it, but this shame becomes localized and determines only the feeling that his face makes him look ugly, that his jaw became too big, that it is ridiculous, and still, as always, unworthy of being liked. Ul... (45), a 33-year-old woman, imagines “that she has convulsions in the face.” Meu... (163), a woman of 30 years, feels she has convulsions in her eyes, that her eyes are not natural, they look odd. These patients no longer want to see anyone, or enter into any public place. Per... (162), a woman of 38 years, has the same fears because she thinks that “her face is hairy.” Finally, Pol..., a woman of 24 years, is horribly tormented by the thought that she has a small scar on the left wing of her nose: this obsession is one of the most frequent. 13 In short, there is not a trait,

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a slight modification of the face, that cannot lead to an obsession of embarrassment and shame.

When we speak of the scrupulous relative to the face, it is necessary not to forget the group that was considered as the most important, that of patients who are ashamed to blush. I am not talking about the sinking feeling that develops along with the redness, but the obsession about this redness. Patients tormented by this obsession are extremely common and, last year, Messrs. Pitres and Régis have devoted an article to this disease under the name of éreutophobie. These authors have described cases of interest. I have seen for myself five that are completely characteristic, and I pay particular attention to the most important feature: Deb... (165), a woman of forty-four years, Toq... (97), a 27 year old medical doctor, and Vol... (96), a young girl of twenty-one years. In all these patients, the main symptoms are almost the same. They believe they have noticed that their faces, their noses, especially Vol., blush easily, after meals, in a warm room, etc. They have this obsessive thought that their face is red, on fire and that that is really ridiculous, obscene, dishonorable. “I was only thinking about it and suffered agony, I cursed not being like the other girls, I suffered to go out, and I desired to be alone in my room; when I was alone, I wept with despair at the thought of the isolation to which I was perpetually doomed.” In the latter, moreover, this éreutophobie brought Nadia to a refusal of food that has necessitated her confinement in a special house. She had an admiration for a cousin who was very pale and, to become anemic like her, she rationed in her own way. This fear also leads to the refusal to go out and disrupts the whole life by a genuine delusion.

After describing the facts of this genre in a very interesting manner, Messrs. Pitres and Regis make a psychological remark: the erythrophobia is linked, they say, to the congestion of the face, that is to say a vasomotor phenomenon. This congestion, the simple éreutose, preceded the phobia, that is to say the emotion. Can we not see in this case an interesting demonstration

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14 Pitres et Régis, L’obsession de la rougeur, L’ércutophobie, Archives de neurologie 1897, number 13, et. ibid. Mars 1902, p. 177.
of the theories of James and Lange on the mechanism of emotions and a demonstration of the hypothesis that links emotion to a vasomotor disorder? Whatever one’s opinion on Lange and James’ theory, I do not discuss that here, but I am not completely accepting of it, I do not believe that the facts about éreutophobia in this regard play an important role in our discussion.

It is a mistake in my view to attach the obsession with blushing to the fact of the blush itself. Though this seems strange, it is not because they are red that these patients are obsessed with the idea of redness or at least the redness itself plays only a very trifling role in the obsession. First, one may be erythrophobic, like Nadia, without ever having blushed. This patient has a very dull complexion, has always been pale and has no disposition for emotional blushing. She has, however, a terrifying obsession about blushing. Also, the obsession with blushing does not occur only after a true blush. It is too easy to point out that all people who blush are not erythrophobics. It arises after a series of physical qualms that were not in the least linked to vasomotor phenomena of the face.

Toq., a young man of twenty-seven years, currently obsessed by the thought that he has the red cheeks, had a completely different obsession from the age of thirteen years until the age of twenty. He was obsessed by the shame of his mustache and I do not believe that in the mustache there is a vasomotor phenomenon. This shame itself is obviously related to a genital idea. “I imagined,” he said, “I had a sexual defect because my mustache had grown too soon.” Later he reassured himself about his whiskers, because at twenty years of age, they became more natural and his preexisting anxiety concerned itself with another phenomenon, the redness of the face that he had noticed in an examination. Inversely, Per... (162), who started with erythrophobia, replaced it now by the obsession of being “hairy” although the vaso-motors phenomena of the face remained exactly the same. It is, therefore, good, in my opinion, not to consider this symptom in isolation, but to notice that it belongs to a group of obsessions relating to the body and especially to the face that are a part, as I try to show, of one major mental illness, delusions of the scruple. As for the emotional phenomena
that previous authors have clearly highlighted in the erythrophobic, they exist as a starting point in many of these obsessions. We will have the opportunity to study them regarding anxiety.

After the shames relating to the face, I quickly noted obsession relating to the hands and especially those relating to the cleanliness of the hands. It is almost unnecessary to cite examples, because the observations are innumerable. Chy... has fear of grease and especially small grease stains on her hands, she washes 200 times a day. Qei... a young girl of twenty years, believes she has touched something dirty, especially since she had a small suppuration from the ear. She is shameful, she fears transmitting the virus to others and the ideas of crime mingle with the shame of the body. This is the most common form of the disease.

I would like to stress a particular form of one of these obsessions relating to the hand, because it is less known and may give rise to errors in diagnosis. Mr. Séglas studied a patient named L... whom I had seen with him some years ago. This boy of about twenty years, a scrupulous, had most of the previously described obsessions about crimes, some obsessions relating to flight, others relating to food. He had the same scruple about swallowing the microbes in the air. Among the different reproaches that he made, L... found his handwriting was bad. He sought to reform it by systems, we will rediscover that later with all the other patients; but these preoccupations and these efforts did not have any result other than to make his writing more and more formless and impossible. He held his pen in a bizarre manner, tied it with twine and could not succeed in writing more than a few lines. Mr. Séglas pointed out with good reason that he seemed to depict a writer’s cramp, that he had an obsessive delusion relating to writing.

I have since had the occasion to verify the correctness of this remark and I think that in many cases the alleged writer’s cramp

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15 Séglas, Un cas de folie du doute, simulant la crampe des écrivains, Bull. de la Soc. méd. des hôpitaux, avril 1890, et Troubles du langage chez les aliénés, 1892, p 201.
is a manifestation of such scruples. It is also, for example, in the observation of H..., in Po... and in that of Lev..., a 36-year-old man. Po..., not only can no longer write, but she cannot read or even see handwriting, it makes her horrified. Lev... has claimed the cramp if one looks at him or if he suspects that someone can see him. The last case I saw is strange: it is a man, X..., preoccupied by various scruples and for some time writing-related scruples. He cannot try to write without the hand making a strange movement: the index finger, instead of pressing on the pen, rises straight in the air, a singular comportment, because usually the finger tightens in the cramp. One can do a few small, interesting experiments on him. When he takes the pen without writing, the index finger does not rise; much better, if he is told to simulate writing, that is to say to make all the pen movements of writing, but leaving a few millimeters above the paper without actually marking, the fingers feel no discomfort and the patient can write indefinitely. If one prevents him from looking, one can move the paper to the pen to mark the entry slightly and the patient continues to have no cramp: but if he becomes aware that he actually wrote, immediately the index finger raises itself and the pen falls. “I have,” he says, “an apprehension to write since I realized that I wrote poorly.” The scruple simulates the writer’s cramp as those earlier did with chorea. A student is currently preparing a thesis on this subject and I have indicated to him: “The relationship between writer’s cramp and the delirium of scruples.”

It is probable that one could easily gather a lot of facts of the same type relating to walking. Mr. Séglas spoke precisely about baso-phobias. They could show that some of them are only scruples relative to walking. The observation of a 50-year-old, Fu... (73), is completely conclusive on this point: the anxiety, which he felt during a walk along a trench, gave birth little by little to full obsessions on the impossibility of walking. In a recent thesis, Mr. Paul Delarue\textsuperscript{16} emphasizes the obsessive idea

\textsuperscript{16} Paul Delarue, Dela Staso-basophobie, \textit{Thése de Paris}, 1901.
of the weakness of the lower limbs which is added on to the phobias of walking. There is a diagnostic distinction to be made between these scruples of walking and hysterical abasia analogous to the one we just made about anorexia.

With respect to various visceral functions, I will only recall the observation of Rai..., that I have already published in the second volume of neuroses, that individual is scrupulous about digestion and respiration. Convinced that he was not breathing well, he searched for systems to breathe better, to avoid possible suffocation. Then there were systems for food: he had a bottle of water near him to moisten the mouth before each bite. Even without food, he needed a drop of water in his mouth to breathe.17

The obsessive thoughts about food and even the various functions of swallowing, digestion, etc., are the most frequent. We have already had an example of it in the observation of Nadia. But these ideas are almost always closely associated with phenomena of anxiety and it seems preferable to delay their full description until I study the phobias of functions in the next chapter.

One of the digestive functions has the privilege of causing, more than the others, the obsessions of shame. This is the evacuation of intestinal gas. It does not include the state of madness into which some individuals may fall by the fear of farts. I have recently published a nice observation.18 A man aged 31, Ch..., still lives alone, he dwells on the sixth floor to have no neighbors above him, he put his bed in the kitchen because it is not likely that other people go to bed below the kitchen, and yet comes to wanting to kill himself because his mother is coming to surprise him in his retirement. The poor devil cannot have anyone near or in the vicinity because he fears they hear the sound of his abdominal gas, and here it is ten years that he is racked by the same obsession. I just saw two young girls, 20 years old, starting the same delusion. “They are not made, from their point of view, like the others, there are defects in their parts, the gas escapes as soon as they think about it, and they are forced to think about it if they are in public. But this accident is

17 Raymond et P. Janet, Névroses et Idées fixes, II, 387.
18 Id., ibid., II, 147.
monstrous, it would be better to die” and they refuse to go out, dine out, or to marry.

I have seen many similar cases relative to the functions of the bladder. A woman, 55 years of age, an old scrupulous, even at age 18 she had a crisis of criminal obsessions for which Charcot put her in solitary confinement, Vor... (137) was disturbed two years ago by an eczema of the perineum and genitals. Itching, on the one hand, the meticulous cleanliness that the treatment required on the other hand, drew her attention to these parts and after the eczema healed, she has been invaded by a strange obsession, relative to the act of urinating. She had the feeling that she urinated poorly and especially incompletely. She studied to push better, to produce the punch of a piston\textsuperscript{x} and yet she kept thinking she had not finished and that she would leak the urine, so she immediately returned to the bathroom, resumed her efforts and went out, then was forced to come back once again, up to fifty times in succession. It is peculiar to see the scrupulous of the urinary disturbance type.

In all urinary hypochondria, it would not be difficult to find similar cases: I remember observing a poor schoolmaster who renounced his profession, he can no longer attend any courses or attend any meetings because he had always thought that he had not taken enough precautions, and he was ashamed of wetting his pants in public. Allow me to recall in this connection a curious observation reported by Prof. Dr. Guyon to my brother, Dr. Jules Janet, and summarized in his doctoral thesis.\textsuperscript{19} A magistrate has been appointed advisor to the Court of Appeals and consults Dr. Guyon to ask if he should send in his resignation and surrender this high office: “I visited,” he said, “the local headquarters of the Court of Appeals and I noticed that the lavatories are not soundproof enough. It is certain that the chamber can hear me when I urinate, I cannot stay without urinating and it would be monstrous to expose myself to the danger of being heard.” I did not complete the observation of the subject, but it is very probable that we would find all the other symptoms of our scrupulous.

\textsuperscript{19} Jules Janet, \textit{Troubles psychologiques de la miction}, 1890, 14.
It is obvious that the function that is most easily affected by the scruple is the genital function: I have already spoken about the criminal ideas. In some cases, the obsession will not concern precisely the temptation of masturbation or the idea of genital crimes, but of shame of the genitals. The observation of Vg... that I have already published is completely characteristic. Following meditations on adultery he is obsessed by the thought of his own organs, he feels a strange pain there, he comes to think constantly that his genitals were hung to his body as a foreign body and do not belong to him. Here is another observation altogether comparable. Wyb... (164), a young man of 22 years, began with all sorts of religious scruples, and then he felt terrible remorse about some masturbation. The fear of touching his parts made him hold his hands behind his back, in grotesque positions. He is obsessed by the smell of his parts, and believes that everyone smells it, he thinks that his organs by their size or shape have something extraordinary that does not exist for the others.

In this shame of the genital organs, it is necessary of course to link the discontent relating to their function; the scruple is the origin of many of the alleged impotencies. Who knows these young bridegrooms, very ashamed of their fate, who cannot succeed in fulfilling the conjugal act and who are haunted on this subject by an obsession of shame and despair? We attended last year to a most curious tragicomic scene when a wrathful father-in-law dragged his humble and resigned son-in-law to Salpetriere. The father-in-law demanded a medical certificate that would allow him to seek a divorce. The poor boy explained that he once had been good enough, but since his marriage, a feeling of shame and discomfort had made everything impossible. We had difficulty making it clear to the father-in-law how his intervention was useless and unfortunate. These cases are very numerous: they often linked to various neuroses, when that is not arrived at, a great tragedy for the patients, they are talking about diseases of the spinal cord.

This shame of the genitals rather often takes another form that is necessary to report. Deb, a 44-year-old woman, is

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20 Névroses et idées fixes, II, 162.
ashamed of her sex since her youth, she regrets being a woman and imagines that she would be happy to be a man. In relation to this idea, she notices that she has never had complete pleasure with her husband and she would be disposed to love women. We have already seen the same fact in a man with impulsions and obsessions of genital crime. Here, too, it would be too easy to speak of sexual inversion, I repeat that I do not believe these cases are anything of that sort. The incomplete pleasure of Deb. is, as will be seen, a general characteristic of the scrupulous: she would be just as unable to follow through if she had relations with a woman. Her alleged sexual inversion is one of the various aspects that can take the shame of sex.

Note that this form of scruples, obsessions with shame on the body, is one of the most interesting from a clinical perspective. It gives rise to all kinds of mishaps: anorexia, choreas, writer’s cramps, astasias-abasias, urinary incontinence, impotence, etc. These symptoms, as we shall see, are far from complete and cannot mislead a forewarned observer, but it is essential to be informed. From this point of view, the illness of scruples can stretch to all organs and to all functions, to determine various disturbances that are important to diagnose. It becomes a great neurosis in many ways similar to hysteria, but that should not, nevertheless, ever be confused with it. The distinction is also important for the prognosis for treatment.

6. — The hypochondriacal obsessions and impulses.

It necessary to report a third group of obsessions that we meet as frequently as the previous ones in the same subjects. These are concerns that relate to their own health or their own lives, in short, they are hypochondriacal preoccupations. It was often remarked that the scrupulous are also hypochondriacs and I think that this remark should be accompanied by some restrictions. When it comes to young patients, early in their disease, we find in them a jumble of scrupulous ideas and hypochondriacal preoccupations, but when the disease
becomes stronger, when they are fully absorbed by some great criminal or sacrilegious obsessions, they forget to worry about their health. Lise is always thinking about the devil, her children doomed to hell and barely thinks of the troubles in her life: it is necessary for the delirium to diminish so that she notices her physical suffering. It is the same for Claire, who cannot get to worry about her health. I have more concerns about the state of her chest (early stages of tuberculosis) than she has herself. In general, the grand delusions of the scrupulous exclude hypochondriacal delirium.

It is necessary to make an exception for Jean, who is also an extravagant hypocondriac as well as scrupulous. This young man, 30 years of age, very healthy incidentally, is continuously preoccupied by the thought of death. He cannot attend funeral formalities without becoming sick with dread; he cannot see funeral employees without quivering; he cannot pass in front of the town hall of his small city between nine o’clock and five o’clock because at that time the office of declaration of deaths is open and because he would think it is open for the recording of his own death. In addition, he has particular concerns for one or another of his organs. For example, he is very concerned about his heart, he counts the beats for hours and he is upset when he thinks that this beat is irregular: “My heart cloc ... cloc ... poum, cloc ... cloc ... poum, it is not natural, it is distorted.” And he made efforts that will have, he said, the result of replacing the heart. At other times, he cries out in anguish, calling for help, saying he will die, because his heart no longer has “that internal beating.” This same patient always imagines that his brain will be destroyed by his illness, he expects a cerebral hemorrhage and incessantly describes, “a little dot in the brain, you know, the end of the nerve that goes back up, it is there that evil is, there is a fiery circle around something which certainly can burst.” He points out the posterior fontanel\textsuperscript{xii} where the obsessed often locate their headaches. Jean is afraid to have a hernia and he is very pleased when one examines him from time to time, and he watches his diet and drinks only some milk cut by tar-water,\textsuperscript{xiii} etc.

But what he presents to the highest degree, is a terrible
genital hypochondria. For more than six years, he suffered from an alleged illness of the glans that he treated in every manner. He had been thrown into a panic by noting that the foreskin no longer covered the glans and he felt intolerable pain from the friction of clothing. He spent his entire day trying to cover the glans with the foreskin, to brush it with ointments, to take precautions to avoid contact, and he could not alleviate the suffering. He sums up, quite well, his mental state saying: “my body bothers me and constantly obsesses me.”

The same characteristics are found at a less severe level in Za ... (216), the slightest illness puts him beside himself, he is so obsessed by the thought of death. Bal ... (155), a woman of 32 years, seems obsessed with a singular thought, of her age, the age of her husband and in general by the thought of the age of persons who interest her, it is because she counts the years that separate them from death, the thought of death is actually at the bottom of the obsession.

Besides the thought of death, the thought of all possible diseases can become an obsessing idea. We can quote a young girl in this respect, Qei..., who monitors her food for fear of swallowing fragments of a needle, who washes her hands continually from the fear of getting infected by dirty contacts, who blows her nose continuously, managing to free herself of “gnats which go up by the nose up to her brain.”

We rediscover here, of course, the obsessions relating to the genital organs, it is not a matter of the bad deeds they have performed, nor the shame they inspire, but their diseases. We cannot list the patients who have “a burning sensation, exhaustion in the canal ... feelings of strain as if they had pushed a large object into the rectum ... the constant thought that there is in these parts an irreparable injury, an incurable syphilis” (Dea..., etc.).

It suffices to bring to mind the obsessions of consumption (Dua..., 147), the obsessions of blindness (Mv..., 151) Wyc... (160) has anxiety for her tongue whose tip rubs her teeth. Gye... has a pin pulled up behind the breastbone, Lobd ... (Obs. 22) has “something in the nose that seeks to come out, she needs a large nasal bleeding.” Do not believe that this is a disorder of the sensitivity of the nose, it is rather an idea resulting from a singular family remembrance, the patient
is convinced that her aunt suffered from a serious melancholic delirium and was cured after a nose bleed, hence the obsessive desire for a similar accident. Kl... (211) feels a burning in the thigh “which is probably due to the passage of a pin that the patient had swallowed.” Observations of this kind are very ordinary and could be easily multiplied.

At first glance, these obsessions are quite distinct from the preceding ones and seem to form a separate group, that of hypochondriacal obsessions. But I believe that hypochondria is not commonplace and in the scrupulous it takes on interesting characteristics that bring the new ideas closer to its predecessors. These patients do not fear all possible health problems, but only certain determined health problems. They are not afraid of accidents that can happen suddenly, which depend on the outside world and do not depend on themselves. Jean, who speaks constantly of sudden death, does not fear death caused by an accident that was impossible to foresee or avoid: he is not afraid of a railway derailment or of a house falling on his head. When I talk to him about these possible dangers, he says that it is necessary to resign himself to what is inevitable, he can do nothing to protect himself against the falling of a chimney and therefore he cares not. What does he dread then? Only the accidents that would be caused by his own negligence or by his own fault. These strokes, these missteps of the heart, the pain of the glans are always caused in his imagination by the genital stimuli that he has abandoned. What lurks beneath these hypochondriacal ideas, it is a kind of fear of suicide.

It is the same with Qei... whose first idea was the fear that she would throw broken needles into food to kill her parents and who now fears eating foods where she would have put broken needles. If she is afraid of infecting herself, it is that she is afraid of not having monitored her hands that have touched dirty objects. In short, in some of these cases, I dare say all, hypochondria is not merely fear of the disease itself, it is the fear of causing disease by a mistake or carelessness.

This group of obsessions is linked to many of
the most remarkable impulsions. It is easy to see in all the preceding facts that the hypochondriacal preoccupations inspire the patient to desire a host of odd actions. The life instinct, the fear of death, disease and suffering give these desires a particularly irresistible character; the precautions that these patients take, the bizarre treatments to which they continually submit themselves clearly become the object of genuine impulsions.

Some of these impulsions are so remarkable that they were considered only in terms of the action which they inspired, without noticing that they are always associated with hypochondriacal obsessions. Dipsomania is one type of these impulsions, the mind of the patient is invaded at certain times by an idea, the origin of which we shall have to search for, that they are unhappy, desperate, exhausted by an incomprehensible weakness and that alcohol is the only cure for their ills. They do not seek the pleasure of drunkenness, they do not drink in society to have fun; they drink alone, sadly, as though they swallowed a cure into their spirit, alcohol is definitely a cure of which they have a pressing need. That is how dipsomania arises, Dr..., is a woman, 30 years old, from the best of society and the best education, whose observation I discussed in another work. From time to time, at irregular intervals, more and more frequently in recent years, she feels growing in her an intense desire to drink some whiskey. Secretly, she takes at first some drops for she definitely knows that it is dangerous for her: she does not want to yield seriously to her craving, but she wants simply to cheat it while feeling the taste of the liquor. She barely makes herself one drink that then the next moment she has more and thus continues alone, joyless, with shame, in hiding to drink more. She drinks more than half a bottle a day and quickly falls into a complete drunken stupor in the most shameful degradation and she does not pick herself up until after a few days of real illness. She regained consciousness with a deep despair, she talks about killing herself, barely finding consolation by keeping the most solemn promises.

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She is indeed perfectly reasonable, drinking only water until in some weeks or in some months everything begins again. This is the classical form of dipsomania: it is unnecessary to insist, because we could too easily add twenty similar cases here.

The morphine addicts, heroin addicts, cocaine addicts, chloralose addicts, etc. are exactly identical: they are pursued by the thought that they experience infinite discomfort, they are lost forever if they do not yield to their passion, their preferred poison is the only remedy for a desperate situation. Many other impulsions have a similar origin: some erotomaniacs, some fetishists or some sexual inverts are connected to, as we have seen, the group of obsessed criminals. They are driven to action by the thought that this act is forbidden, criminal. But many do not see things from the same point of view: genital arousal, that is determined in a manner normal or abnormal, they see as essential to give them strength, to calm and heal them.

One can observe other unique impulses: let us note for instance the impulsion to eat, bulimia, which is rarer than the impulse to drink. Here is a young woman of 26 years, Qe..., who comes to see us with her big bag and has her pockets very full. What does she take when coming to a consultation? These are simply travel provisions: she has in her bag and in her pockets several pieces of bread, some slices of ham, chocolate bars and some sugar. One could say that she feels that she is going to pass through a desert but she will just cross a few streets. Her provisions are essential, especially in the great outdoors and in places that it is essential to take strength. After a few steps, she feels dazed, dizzy, she suffocates, and she is covered with cold sweat. The hazard would be great if she did not know the cure: it is enough to console her. She eats a piece of ham, puts a sugar cube in her mouth and can take a few steps further. But soon everything begins again and it is only by dint of buns and chocolates that she can go through a square. So when supplies are lacking she is in a miserable situation, she must at all costs, with extraordinary efforts, cross the desert to reach the oasis that is a bakery. In this terrible
journey one supports oneself as one can: what don’t unfortunate travelers eat? She sometimes picked up a raw potato, grabbed an onion or some green leaves: it barely supports her, but it gives strength to reach the bakery. In general, she prefers to stay at home, it is less dangerous: she does nothing more than prepare and eat food all day. Sad and unhappy, she finds relief only in the continual ingestion of food. This lasts for ten or fifteen days, rarely more. At that point, she calms herself, she no longer feels the need to eat much and she is obliged to care for the gastritis than she obtained because of overworking the stomach. She remains reasonable, eating moderately and even too little for a few weeks or months, then suddenly or gradually depending on the case, the same scene begins again. Bulimia is rare in this distinctive form, which is, as we see, quite similar to a fit of dipsomania, but it often exists in an attenuated form in many neurotics. The doctor should be notified and released from these so-called neurasthenics who always want to remain sprawling and are calling on their night table for wine bottles and bits of cold meat to combat their exhaustion. They have really hurt the mind and body of neurotics with beautiful theories about overeating. More often than one believes, their bad digestion, their foul breath, their skin disturbances and even their mental disturbances are maintained by a true food intoxication encouraged by poorly understood advice. When one sees bulimia in its crude form as in the case of Qe..., one better recognizes the role that mental disturbances play in all these needy pathological over-eaters.

We arrive at a still more singular impulsion. This young woman, Ms..., cannot be cared for in any nursing home: barely there, she is forced to leave, since none of these homes can put at her disposal a rather large field. What do you want, she needs to exercise and she absolutely must walk 45 to 50 kilometers on a highway every day without exception. The small garden of a nursing home is not enough and a highway with mileposts that can be counted is indispensable. It is only after counting about 46 kilometers
that she begins feeling at ease. Sometimes she is accompanied by the carriage, but she never rides inside, she runs alongside while the horse trots. She barely agrees to stop a moment to eat a piece: she feels hunger, but she does not take care of herself. She is more concerned with thirst because she drinks a lot, 5 to 6 liters of water per day and urinates accordingly. She left immediately with an unconquerable need “to exhaust the forces that are in abundance in the nervous system.”

This mania of walking, to which Mr. Regis gave the name of dromomania, seems very strange: it is, however, more common than previously believed. There are, in Paris, poor patients who are building in the courtyard of their home a cement track upon which they walk for hours when they cannot do the kilometers on the highway. In a more concealed form, the same impulse is very often found today in this mania for sports that stupefies neurotics. There is, as in overeating, a danger that the neurologist should be made aware of and therefore it is advisable to reflect upon cases where madness is as visible as it is in our patient.

Finally, I would like to bring forward previous cases of patients who feel the need to make themselves suffer and to do it well, to cheer themselves. In many such cases there is only a little pain, pinching, pulling the skin, scratches that appear to give them relief. Cha... (105), a young woman of 24 years, removes her beautiful blonde wig in front of us. On her bare skull are only some rare wisps of short hair, separated by broad, absolutely bare plates, especially in front and in the occiput. One is convinced, at first, that it is a remarkable case of alopecia areata: one is astonished to learn that the doctors of the skin diseases refuse to care for her and return her to the neurologists. This is because the hair does not fall on its own: for 18 months this poor girl pulls them out one after another and then eats them. In this short space of time, she devoured a healthy head of hair. This unique need arises only from time to time in a girl who is quite reasonable and seems well balanced but at times she is she no longer is able to resist.
pulling out her hair and to feel the small pain that results from it. This new case could be compared to all those patients that I already described, that pull out their own hair, eyelashes, fingernails, that tear small pieces of the skin, etc., etc.\textsuperscript{22}

Sometimes the impulse to make oneself suffer becomes more interesting when it is a matter of intense pains, which normally one would not want to face. This girl of 20 years, Ne..., has her hands and feet wrapped in bandages and looks more like the seriously wounded than a neurotic. Under the bandages one finds a quantity of serious burns, some recent, with blisters, others in suppuration, others almost healed. The parents of this girl despair of healing these wounds, scarcely is one in the process of healing than another, more serious, occurs nearby, for the girl cannot prevent herself from burning her hands and feet. Her happiness consists in, when she is alone, taking a hot-water bottle of boiling water and dropping the drops one by one onto the skin of her limbs. If she cannot find boiling water, she merely puts her fingers on the stove until the skin is heavily burned. If one undresses her, one notes on her thighs long circular scars that appear keloidal. She had tightened strings around her thighs and had kept them for several weeks until the skin was severed. Before coming to such torture, she had simply tried to abolish food and drink. She stopped herself from defecating or urinating for a very long time, she maintained her arms and legs folded up for hours in tiring and painful positions, etc., little by little, she perfected her methods. She is, you will say, a patient who presents a mystical delirium and is anesthetic. In any case, she is an intelligent and educated girl, who does not present any mental confusion and who preserved all her sensitivities. She hides her face and cries when one discovers her wounds, she says that she is ashamed to allow anyone to see the absurdities that she committed: “But what do you want, I did not believe that this would be so serious, or that the tracks themselves would be visible for so a long time. I hoped that everything would be limited to pain; when I

\textsuperscript{22} Névroses et Idées fixes, 1898, II, p. 388, 390.
start to let myself go, I cannot stop myself. I am desolate that my injuries cause so much torment to my family, I would make, for them, the hard sacrifice to abandon it, but it is so hard for me to resist the taste of hurting myself. I need so much courage not to do it again.” She makes all possible solemn oaths, exactly like a dipsomaniac, but you should not believe her and it is necessary to watch her well, because in a few weeks she is going to start again by making a small pain at first and, as appetite comes with eating, she will not resist the pleasure of making a big wound.

These impulsions, which we have just described above, are apparently different in their purpose: one concerns the desire to drink, the others on the desire to eat, on the need to walk endlessly or on the singular appetite for suffering; but there are already common clinical characteristics, the recurring appearance of this need, the irresistibility, the resulting contentment, the subject’s remorse and the useless good resolutions. There is certainly a psychological unity that conceals itself under these diverse phenomena, and this unity, as we shall see it more and more, depends on the need to excite oneself, to cheer oneself up, to heal oneself, which connects these impulsions to hypochondriacal ideas.

We can summarize the various obsessions and the various impulsions that have just been enumerated and whose content we analyzed in the following table.
CONTENT OF THE OBSESSIONS AND OF THE IMPULSIONS

I. --- Obsessions and impulsions of sacrilege.

II. --- Obsessions and impulsions of crime.
   - Obsessions of religious and moral problems.
   - Obsessions of crime of the impulsive type.
   - Obsessions of crime of the remorseful type.
   - Homicide. Suicide. Theft, etc.
   - Genital crimes. Fugues.
   - Dipsomania, etc. Resistance of obligations

   Of religious sins. Of homicide.
   Of theft, etc. Of genital crimes.
   Of vocational failings.

III. --- Obsessions and impulsions of the shame of oneself.

IV. --- Obsessions and impulsions of the shame of the body.

V. --- Obsessions and impulsions hypochondriacal

Shame of actions.
----- of feelings.
----- of intelligence (a type of folie of doubt).

Obsessions of depersonalization.
----- of déjà vu.
----- of madness.
----- of envy.
----- of love.

Shame of getting fat, of growing up, of building up oneself.
----- of embarrassment of the movements of the body.
----- of the traits of the face, of the moustache.
----- of blushing.
----- of the hands (certain writer's cramps).
----- of walking.
----- of nutritive functions.
----- of urination.
----- of intestinal gas.
----- of the genital functions.

Obsessions of death, of funerals.
----- of genital maladies.
----- of maladies of the chest, etc.

Dipsomania.
Morphine addiction, etc.
Bulimia.
Impulsions to walk.
----- to self-injure, etc.
7. — *Common characteristics of the obsessions.*

By examining the contents of the obsessions of the scrupulous, that is to say only the subject that these obsessions are about, I believed I could divide them into five groups: the sacrilegious obsessions, criminal obsessions, obsessions of shame of oneself, the obsessions with body shame and hypochondriacal obsessions. But one should not conclude that these ideas are completely different from each other and that meeting patients of the same type may be assigned to chance. This is sometimes how it is in the hysteric whose ideas still have very little in common, especially if one considers only the content. The one dreams of a fire, the other of the face of his lover, the third one is obsessed by remembering the taste of the turnips that she ate at boarding school, and the fourth one by the fear of becoming fat like her mother: the subjects of the pathological meditations do not have any common characteristics. With the scrupulous, on the contrary, despite a rather high apparent variety, the subjects of the obsessions are similar.

You can easily link them to each other. Sacrilege is only an exaggeration of crime, the shame of self is naturally similar to the thoughts of crime. Do not believe that the bodily obsessions, for example, the shame of the body, are isolated. In the descriptions of erythrophobia, there is often a moral shame that accompanies the idea of blushing “the patient blushes or has the obsession to blush,” they remarked in an observation, “when one speaks of her indecent acts, or if she is in front of men whom, it seems to her, she could be the mistress of.”

Among our patients, Ul... is afraid of spasms of the face and especially “the fear of appearing crazy.” Hypochondria, as we have seen, is related to the fear of doing foolish things, it is also related to shame. Gbl..., a 36-year-old woman who has an obsession with “rheumatism in her hands,” fears not only the suffering, she was “humiliated at the thought of letting the swollen hands and feet

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be seen.” All these obsessions are, therefore, similar to one another and it is easy to highlight common characteristics.

1° It is easy to see that these ideas do not relate to external objects, but always relate to acts of the subject. A hysterical Ze... saw her father die, she has for two years an obsession that presents itself in the form of a complete hallucination: it is of her father’s head as he was on his deathbed. Her delirium consists in the contemplation of an object, the head of her father, without any other preoccupation. In her attacks, she howls: “The head of Papa, here again,” she looks at me, “Oh! It is yellow...” she makes only these descriptions. Is it the same with our scrupulous? Many authors do not hesitate to accept it, they see these patients in a particular aspect, and they give their full attention to certain external manifestations of delirium rather than to the interior psychological state of the patient. What strikes them especially is that these patients refuse to touch certain objects and show signs of emotion, terror when you want to force them to use these objects. This view is highlighted by the very word the authors use to describe these patients, many of those I have described would be called by them *phobic*. The word *phobia* would highlight in the patient: 1° the emotion he feels and 2° the connection of this emotion with an object from the outside world. It is clear that this observation is largely correct and in the previous descriptions we have already noted many cases of phobias, primarily everyday phobias: Mb..., Vod..., Wlvs..., Brk..., Vis..., Ger..., etc., have a phobia of knives and especially pointed knives; it is also a commonplace manifestation found in all these mothers obsessed by the thought of killing their children; Qei..., Kl..., Gye... have a phobia of needles or pins: these are classic cases of phobia. We find in many previous cases others more curious: Claire, the girl who claims to have the hallucination of the penis, has a phobia of bottles, Lod... has a terror of spit on the sidewalk, Jean, a type of genital scrupulous, has a phobia of cars and especially trams. In the following chapters we will specifically study
the form in which these obsessions present themselves and we will then report many other cases
of phobias, some of which are very strange. It is therefore fair to say, along with the authors that
I alluded to, that these patients are in a certain aspect phobic.

Nevertheless, I prefer to call them *scrupulous* and I believe that this word makes obvious another
point of view. It attracts the attention to the disturbances of the will and to the idea that the
patient makes these disturbances of the will. I believe, in fact, that these phobias are, at least for
the cases that I consider, completely secondary phenomena, that they comprise the sort of
secondary obsessions that I already had the occasion to study. We will see, while examining
these phobias, that they develop by an association of ideas: the outside object here is only
reminding us by its form, like the bottle that makes one think of the penis, like the use of the
knife which makes one think of murder, by contiguity, by consonance of the name, etc., of the
principal idea that obsessed the patient for a long time before he had his phobias. It is better to
have this discussion more completely when I study all the emotions, all the varied disturbances
that combine themselves with the development of the obsession, it suffices now to make a
simpler remark.

The patients come to us presenting a fairly large number of obsessions that they themselves
describe as being the main fact of their disease. It is to these obsessions that, for the moment, we
limit our study. Can we say they regularly concern an external object as happens so often in the
hallucinations of hysteria and obsessions? If we consider the group of criminal obsessions, which
is the most straightforward here, it is evident that the preoccupation only indirectly concerns an
object, but it especially focuses on an action. The subject is always compelled to commit crimes
or believes he has committed one, that is to say that he feels driven to perform certain actions or
believes he has done them. The obsession here is incontestably the obsession of an act of the
subject. I tried to show that it is the same for hypochondriacal obsessions; the patient, at least the
one of whom I am in charge, does not think about independent physical accidents beyond his
control, but always of errors or indiscretions he may commit himself. It is again a preoccupation
connected with acts.
One could believe that it is not quite the same in sacrilegious obsessions where certain subjects, very small in number, have, before their eyes, spectacles with which they do not appear to be involved. On... sees the soul of his uncle in the bathrooms, Claire sees a penis soiling a Host. Let us point out first that these forms of sacrilegious obsessions, which are the most curious, are the least frequent. In other observations, the patients think of devoting their children to the devil, of spitting on communion wafers, of giving the wine of the Mass to a small dog, of acting, in a word. But even in these two cases, the difference is more apparent than real. What On... despairs of is that it is he himself who puts the soul of his uncle in the bathroom: “How can I come to think such a thing... I should imagine that less than any other such things.” In the case of Claire, I do not dare to assert, because her confession on this delicate point is far from clear, but it is very probable that she cooperates with the desecration of communion wafers. She always repeats: “It’s horrible to indulge in such things,” and if it were a pure spectacle she would not be ashamed “of guilty indulgence.” Finally, it should be noted that such images only occur in patients well advanced in their delirium. For a long time, these patients have dreamed of sacrilegious actions: “look in churches for the parts of God, to search for them under the linen which veils Christ, etc.” The image came only later as a symbol that summarizes abhorrent actions.

In a very significant group, we noticed obsessions with shame that do not specifically concern actions, but on the whole physical and moral personality. It seems to me that these obsessions should not be separated from their predecessors. Primarily they appear in patients at the same time as the other more typical obsessions. Claire, who presents so clearly the obsession of shame of her mind, presents at the same time a type of sacrilegious obsession. Mb., at the same time that she is dissatisfied with her intelligence, has criminal obsessions. On the other hand, I hope to show in a forthcoming study that these obsessions are mainly characterized by the form that they take on: they are accompanied by doubt, by questioning, by hesitation, by compensation, by expiation, by promises, by oaths, etc. And yet, these curious forms are found in all these patients. Nadia, whose principal obsession is
the shame of the body, and in relation to that she continuously makes oaths and covenants, like Lise who has distinctly sacrilegious obsessions. Finally, these various ideas relate quite well to each other. The physical personality and moral personality intimately bond in our minds; if one is satisfied with his mind, one is happy with his face and vice versa; on the other hand, we know the close relationship between the will and personality, so criticism of acts quickly became criticism of the person.

I think, therefore, that one can, without hesitating, generalize and say that the delusion of the scrupulous especially concerns their own acts: these are obsessions relating to their will and to their person.

2° It is also interesting to note that these actions are thought of obsessively and at the same time are impulsive evil actions. Most often, when it is about sacrileges and about crimes, this character is incontestable. But one can be embarrassed when it comes to an impulsive act that nothing condemns, like entering the convent and making her husband confess. It is necessary, then, to widen the direction of the word bad: it is a matter not only of acts condemned by morality, but of acts condemned by the subject himself, of actions that are abhorrent to him, that appear to him as ridiculous, in short, that he would not want to do. On this point, the affirmation of all the patients is more precise: one can read in this respect a very interesting study published by Mr. Josiah Royce in the *Psychological Review*, on a great author, John Bunyan, the English mystic who is also a good specimen of the delirium of scruple. Bunyan was “trying” to blaspheme against God, to worship the devil, as he himself has noted, the tempter is a kind of reversal of conscience while emphasizing what is most opposed to his pious intentions. He wants to pray to God, there are distractions, he dreams of bizarre images, of a bull, of a broom, and he is tempted to send them his prayers. The temptation is always to the action most opposed to what he wants to do at that time.

This is so for all our patients. Vi... took her child to school and wants to go look for him, because she is very worried about his return through the streets of Paris. She wonders

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if she did not tell a suspicious woman to go look for him. She loves her husband above all, yet also fears betraying his secrets, of being unfaithful to him with the first comer, making signs by the window to passers-by so that they come up. Vod..., Wks..., love their children, and it is always their children whom they think of killing, of boiling, of giving to the demon. According to the obsessions of these scrupulous women, one can always guess which they prefer, their husbands or their children. I ask Vod... why she always wants to kill her small daughter and does not think of killing her husband, and she cannot help laughing and says: “Oh, my husband, I do not like him enough to think of killing him.”

When it comes to girls, one can guess the degree of their virtuousness according to the nature of their obsessions: when they speak about “parts of God,” contaminated communion wafers, crimes against nature, they are perfectly chaste. Others have no more concerns on this subject and think of killing their mother or of stealing. “It is very simple,” Qes... said to me, “I am compelled to kill what I like the best, I want to kill my mother because I have only her; if I had a husband, I would like to kill him; if I loved a small dog, I would like to kill this small dog.” In a word, they are always obsessed by the thought that most horrifies them.

Mr. Paulhan made a similar remark regarding the delirium of doubt when he said that the ideas of these patients are due to exaggeration of the association by contrast. In a previous work, I had the opportunity to discuss this theory; I must raise a partial error in my discussion today.

Without doubt, I had every reason to point out that the patients analyzed in this study, such as Marcelle, and in one of the following chapters, Justine, did not justify the remark of Mr. Paulhan. Their fixed ideas that correspond to previous emotions, developed by a mechanism similar to that of suggestion, did not comply with the law of contrast and were not at all in opposition to actual wishes of the subjects. But these patients formed a particular group, that of the hysterical suggestibles, and I was wrong to make a general remark which applied to this particular group. The scrupulous that we now study form another group very distinct from

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25 M. Paulhan, L’activité mentale et les éléments de l’esprit, 1889, p. 341-357.
26 Névroses et Idées fixes, 1898, 1, 32.
the first one and we can say that these obsessions make a striking contrast with their dominant tendencies. It remains to be seen if they owe their origin to the associations by contrast. One thing that we must remember, it is that these obsessions concern acts, bad actions, that is to say, in opposition not with common morality, but with the desires and the will of the subject; the patient is obsessed by the thought of an act that he would not want to do.

3° The third characteristic that strikes me about the contents of these obsessions is more difficult to explain, although it is very curious and probably very important in this illness. The actions obsessively thought about by the patients are extreme actions. These are the most dangerous, most criminal, most sacrilegious acts, in short, the most heinous that it is possible for them to conceive. This is a concept which is pushed, in a certain sense, to the most extreme limits.

It is obvious that these poor people always try to clarify, magnify the crime of which they think. It bothers them very much when one keeps a calm and indifferent air as they list their impulsions, they then seek to add horrible circumstances to cause our indignation. Z..., who is a man of thirty years, tremulously admits that he is compelled to commit the sin of love with a woman. I replied quietly that at his age it seems quite natural. He hastens to add: “But, sir, I represent something that happens on a bench.” - Well, all right. - But you forget,” he replied angrily, “that the bench is in front of a church.” Jean, who has the same genital impulsions, would find consolation if he was only compelled to love young women who are pretty, but he has erotic impulsions for sleazy, ugly and very old women. “One day, two girls came to see us, I really liked one of them and after she left I was tormented by the thought that I was married to her. - There is no harm in that. - But, sir, you do not imagine what terrible impulses it gave me: I dreamed I had sex with her mother, my mother-in-law!!” After some time, however, the impulsion is still growing in the same direction and he is sorry because he now thinks of his own mother. When it comes to murder, it is crimes
“against small defenseless children that the devil advises me,” said Brk... or “the assassination of an old man of eighty-four years,” said Za... and they invent refinements of cruelty and cowardice. They always try to go as far as possible in this design of crime.

Some of them are aware of this unique need. I asked Lise why, for some years, she always kept the same idea, that of devoting her children to the devil, whereas before she changed obsessions rather often. “That,” she said to me, “I cannot do better, as I always push my ideas to infinity, if there was something more terrible, I would think it. Devoting my children to the devil, is the most I can do for now.” Another patient shows a curious example of this effort to go to the extreme. Ger... repeats to me continuously that she is compelled to offend God by a horrible sin and she never specifies this sin. I strongly insist to know what it is about and I list crimes confessed ordinarily by the scrupulous. “Do you want to cook your children? — No, it is not that. — To be unfaithful to her husband with the devil? — No, that would be nothing. — To steal and to soil consecrated Hosts? — But no, worse than that. — Then I surrender; tell me what is this crime. — It is a sin that never existed, that no one yet, which nobody could even think, oh well, it is this sin that I am compelled to do. - But what is this sin? - I do not know.” Can they confess more naively this impotent effort of the imagination?

These are people who are making desperate efforts, who torture the imagination to arrive at the abominable, although they almost always end up in the ridiculous. This frame of mind is well enough described by the author of “A Rebours” and “Là-bas.” By listening to our sacrilegious, we think of this canon “who nourishes white mice with consecrated hosts and that tattooed on the soles of his feet, the image of the cross, in order to always walk on the Savior.”

27 Huysmans, Là-bas, p. 297. In the same book, a curious passage on the imagination of new crimes, complicated incest, crimes against nature and sacrilegious, refers to the same state of mind (p. 258).
to be an essential characteristic to note before trying to interpret it.

4° To these is added another characteristic which appears to me to result from the previous ones, but since it concerns the origin of the ideas and that this entire work is designed to put this origin into evidence, it is necessary to confine oneself to enunciating it now in a hypothetical way. The fixed ideas we have studied previously in hystericś had a content determined by external circumstances. Without doubt, the essential condition of the fixed idea was a certain state of the subject’s mind which made him eminently suggestible; this numbness, this decline in brain function that caused the narrowing of the mind and the suggestibility was the essential character of the mental condition of hysteria. But the particular nature of the obsession, the thought of a fire or an image of death was the result of external circumstances which had induced an emotion and a suggestion of a fire or of a death. Such ideas determined by the mechanism of suggestion could be called *exogenous fixed ideas*.

Ah well, can the same origin be attributed to the contents of obsessions in the scrupulous? This is what the patients or their parents often assume: Ls... thinks that his sacrilegious ideas were born from the philosophical dialogues that he liked to make with his father. We...’s parents remain persuaded, despite her claims, that their daughter’s illness was created in the convent by the education from the nuns. I hesitate very much to accept this interpretation. Without doubt, the external circumstances play a role: women who have no children do not think to devote them to the devil. But, these trivial matters which consist in having children, to hear a philosophical dialogue from time to time, to be raised by nuns, are they enough to give rise to such a delirium? On the other hand, if the delirium came chiefly from the outside, how could it have common characteristics so remarkable in all patients, why would it always concern actions, bad actions, extreme actions, and how would it be

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28 See in this respect numerous examples of these accidental fixed ideas by suggestibility: Névroses et Idées fixes, on 1898, 1, 173.
closely related to the individual character of the subject? The content of obsessions, while retaining their common characteristics, is not the same in the mother of a family, an adult man or a young girl. If I use a common expression, it seems that these individuals play the game of the height of injustice and to the same question, all respond differently according to gender, age, social conditions. “What is for you the crime of the height of injustice? — To throw my small daughter who is on fire into the scalding water, answers the mother accustomed to the work of the household; to dedicate my children to the devil, answered the mother from a higher social background. — And for you what is the crime of the height of injustice? — To put the soul of my uncle in bathrooms, answers the thankful man; to soil Hosts by the sexual act, answers the girl.” This modification in the response keeps the same characteristics in common, while adapting itself so well to the individual character, can it be explained by the action of external circumstances on a suggestible mind?

One might ask whether the fixed ideas are always exogenous and if certain categories of fixed ideas do not merit the name of *endogenous*. Could not their content be invented by the subject himself, by virtue of certain laws different from those of suggestibility? Could not these ideas be the *expressions* of a profound disorder in brain functioning felt by the patient and that he translated first by special sentiments and then by obsessive ideas that summarize and express this sentiment? In the case of the delirium of the scruple in particular, is not the patient obsessed by particular thoughts relative to his acts, because he really has disorders of the will and because he has a certain consciousness of these changes of the will?

The study of the content of obsessions in the scrupulous brings us simply to raise these problems; it is necessary to continue the study of the form taken by these obsessions and of the psychological state in which they develop, to prepare for some solution.
To establish the diagnosis of a mental disease it is not enough to know the ordinary subject of the concerns of the patient, that is to say, the contents of obsessions, it is again necessary to study in what manner these preoccupations present themselves, which laws they obey in their appearance and in their evolution; in sum, it is necessary to examine the psychological form that clothes these obsessive thoughts. To understand this problem, let us consider certain fixed ideas of the hysterical which determine major fugues of several months, completely forgotten by the patients after their execution. These ideas are only manifested during somnambulism or in subconscious writings, they seem completely absent from the normal consciousness of the subject who ignores them. These fixed ideas are not totally different in their psychological form than those of the persecuted who fully knows his delusion, who is convinced of its reality and has systematized his thoughts and all his actions around the belief in this or that persecution. This opposition between dissociated ideas that develop in isolation outside of the conscious life of the subject and these completely systematized ideas that, on the contrary, have become the focus of every thought is of paramount importance to interpret the illness. Thus, we must apply this research to the obsessions of the scrupulous and see what place they occupy in their thought, and the degree and form of their development.

To study the psychological characteristics that clothe the obsessions, the laws of their appearance and their development, it is necessary to make some distinctions. Patients do not always stay in the same period of their illness; they may pass through states of great disorder or come closer to the normal state. In these various periods, their obsessions do not always preserve the same characteristics and a description
could not be applied with impunity to all accidents of the scrupulous. I will, therefore, put them aside to examine them more completely when I shall study the evolution and the complications of the disease, the extreme states, and the periods of severe delirium that unfortunately can arise during the disease. The main character of such states is that the patient almost completely loses the power to critique his obsessions, to resist them, that he abandons himself to his delirium. These states resemble anxious melancholia or the various forms of mental confusion: they allow us to enter the domain of other mental illnesses. These states can also result from the very exaggerated development of the disease of the obsessions in certain subjects, particularly those who have been ill for a long time; for there are a small number of patients with a true psychasthénique delirium. I believe that it is necessary to consider these delirious states as accidents arising during the disease of the scruple, accidents of which it is necessary to discuss their possibility and the frequency, but that do not constitute the normal state of these patients.

On the other hand, sometimes by the natural evolution of the disease, sometimes under the influence of certain treatments, these fixed ideas can be reduced, diminish their importance or lose their precision. The patient still feels he is tormented by something, that he is obsessed. He could by a little effort find the idea that torments him, but he knows he must avoid such a search and has only a vague notion of the idea that obsesses him, this is the vague state of Lise, it is Jean’s implicit state. This state is still part of the illness, but it is faded one degree, blurred so that one cannot take it as the main object of study.

In this description of the psychological characteristics of scrupulous obsession, I first considered the average degree of development of these ideas, which is also by far the most common and most important. We recognize the following characteristics. The idea is rather clear and rather specific so that the subject knows very well what obsesses him, and nevertheless the intelligence of the patient remains quite intact so that he can criticize the obsession and recognize, at least in part, its absurdity.

In fact, the essential character of these pathological ideas is so striking that it is often
brought to light by the very terms used to designate them. One often describes this disorder with two linked words, it is, they say, a *lucid madness*, a *delirium with consciousness*, a *conscious obsession*.

This combination of “madness” and “lucidity” once provoked the indignation of Dr. Thulé\(^{29}\) when he criticized the “mania reasoning” of Dr. Campagne; he is, however, legitimate and accurate. The first of these terms can be easily understood, it refers to an idea imposed on the patient and that develops in an automatic way without any relation to external circumstances or the subject’s will. The second, the word “conscious” is, as I have often pointed out, rather unfortunate because of the ambiguity of the word consciousness: this word in psychological language indicates that the subject knows his idea, that he has a personal perception of it, it is in opposition to the terms “unconscious, subconscious” which apply to phenomena unknown to the patient. But, in this case, one wants to say that the patient judges his idea, appreciates it from the point of view of its reality, its relationship with his other beliefs. One wants, therefore, to designate an intellectual operation much higher than mere psychological consciousness: if one could change the practice, it would be better to say that it is an obsession with judgement, obsession controlled or criticized by the patient.

Anyway, these two words applied to the scrupulous is extremely fair. The patient is obsessed, tormented by an idea which is imposed on him without being justified by the circumstances and without the subject looking for it himself. It is an intrusive idea like a delusion or a suggestion, however, the patient does not accept this idea with the conviction of a persecution mania or of an individual influenced by suggestion. At least to a certain point, he has a feeling, like we do, that the idea is absurd, he judges it and pushes it back, is an *obsession with criticism*.

It follows from this general remark that these ideas can be examined from two points of view: 1° the positive point of view, presents their obsessive and pathological character, their power to torment the patient; 2° the negative point of view shows the arrest of these ideas, the point at which this power ends. We find these two points of view in all the characteristics of obsessions, in their *permanence*, in their *impulsive power*,

\(^{29}\) Dr. Thulé, *La manie raisonnante du D’Campagne*, 1870.
in their *hallucinatory representation*, in the *degree of belief* which accompanies them.

### 1- The permanence and the evocation of obsession.

A certain number of characteristics separate the pathological ideas of our scrupulous from the ideas or thoughts of a normal man, it is these characteristics which make them obsessive.

To the first rank we must place the duration of these concerns. The duration of these obsessions in the scrupulous can be extremely long. The idea of the devil to Lise, the sacrilegious and indecent idea for Claire, each has existed for at least 11 years. The same is true of for most of the obsessions that I have reported; their duration is always counted by years. Besides, if we believe Mr. J. Falret, the obsessed of this type retain the same idea for their whole life, despite apparent remissions. One can say that certain ideas persist with us all and that a scholar can pursue a problem for 20 years. This characteristic is, therefore, not absolutely decisive. However, it has a certain relative importance: given the nature of minds and the subject of these ideas, one must acknowledge that ordinarily to minds of this type, such idea should not last 10 years. Lise is an intelligent and educated woman: it is not likely that her attention is naturally employed for 10 years to meditate on the idea of giving her children to the devil. Besides all these patients are surprised at it themselves and do not understand why they stay so for a long time on the same subject which they themselves find trivial and grotesque. There is, therefore, already in the duration a pathological element that gives the idea a painful and obsessive character.

The second characteristic, the *frequency of repetitions* is even clearer here. Claire claims that she has her image of the Host and the penis 200 times a day. Lise is convinced that her preoccupation is perpetual and it does not even leave during the night. She has, in effect, the feeling that all night she dreams of the same problem and she wakes up in the morning with the feeling of not having stopped thinking of it. We shall see by the study of certain patients, like Jean, that even at the moment when the idea seems to have
disappeared from consciousness, it remains nonetheless. This patient tells us that he thinks of his lady in a “implicit” manner. Even when she is almost cured and quiet, Gisèle well knows that her idea, her remorse of vocation is not far, “this idea always scratches me, the regret of the religious vocation is the cat who sleeps, you would not have to lead me to think of it a bit, everything asks only to begin again.” We see, therefore, that these ideas reappear very often in the mind, and never disappear in a complete manner.

Here again we can say that voluntary attention can keep our mind on one subject. This is very rare and it would take at least that by its interest, by the importance which the mind grants it, such an extension of the attention might be warranted. It is far from being so in our examples.

This duration, this permanence of the idea nevertheless must not be considered as a completely automatic phenomenon that extends of itself. The subject claims that although the idea comes from himself, it persists though he does nothing to preserve it, although he wishes with all his might for its disappearance. In reality, he is deceiving us or he deceives himself. Lise wants to be treated and cured, nevertheless she is very shaken at the thought that she could be hypnotized. It is because she is afraid that, during the hypnotic sleep, we will completely erase her obsession; she is fond of it at the bottom and wants to sacrifice only that “which she has exaggerated.” When she does indeed get better and the idea has a tendency to fade “she must try to rethink it to be calm. I cannot decide not to think it anymore.” In reality, while I strove to erase these ideas, she made “a horrible effort not to lose them and she cannot help being happy when I do not succeed.” In a light hypnotic state, which we induce in her and that I shall discuss again, I try to contradict her fixed ideas, to dissociate them, to change them. That provokes curious crises of excessive resistance. She moves away from me with horror, she stiffens herself into types of contractions, she clenches her teeth in order not to repeat the words that I suggest to her. She pleads that one does not take away from her the ideas taught by the Church. If she obeys a little, it is with all sorts of reservations. She says definitely, to explain her resistance, that it is the devil who resists and not her, but, in fact, she is very much in control of herself. “When one has lived ten years with an idea, one cannot
go without it.” So she only gives in a little and for a moment only, with a great fear of committing to the future. She resigns herself to simply delay her idea until later and finds consolation by telling herself “when I shall want it, I shall rethink it.”

The same obstinacies and the same resistance are reproduced in Claire and bring stages that are really funny. Claire has just said to me that she is sorry to accuse herself of immorality, because she knows that, at the bottom, it is not true. I reply to her profusely in that direction, saying to her that she is a very estimable girl and that I know she is incapable of any dishonesty. Here she is furious with me, saying that I make fun of her, that I do not believe a word of it, that she will not tolerate that one contradicts her so. She starts to cry and she pleads that we do not take away her last hope. “If I did not believe I was immoral, I would make no more efforts to succeed in changing myself, I would be absolutely lost.” She, at heart, would never tolerate that one contradicts her delirium. In reality, for the scrupulous, the permanence of the idea is not so automatically a fact as with the hysterics; it results from a permanent effort to maintain attention on the same idea; it is a kind of mania of the fixity of ideas.

The frequency of the idea is related to another important characteristic, the ease of reproduction. If the idea returns so often in the mind, it is because it is evoked by innumerable phenomena apparently without much relationship to it. There is a whole category of patients who summarize their many illnesses by saying that they are afraid of knives. This means that the sight of a knife or a dangerous instrument immediately awakens in their minds the thought to strike, to kill, by stabbing, the person they like best. This is, as we have seen, a highly criminal obsession, frequent in the scrupulous. It will be so for all objects, for all the phenomena that can be considered part of the obsession in any capacity, as an object, as an instrument of crime, as part of the virtuous or bad action that the patient daydreams. Qes... abhors stairs, windows because we know she is thinking about suicide. Vi... cannot see a well or a river. Bor... feared religious images,
churches, communion wafers because she has immediate sacrilegious ideas. Brk... cannot see children anymore, that awakens the idea of killing them. Qd., a scrupulous who reproaches herself for not taking good care of her husband, is obsessed by the thought that she will have pneumonia; her obsession takes her when she coughs or when she touches her handkerchief. Za... who feels compelled to swallow pins or to throw them into other people’s food, is tormented by her obsession when she must eat or when she must touch a milk canister. Gisele, who has remorse of vocation, because she is not religious, suffers from this idea about all her “duties of the state.” The fact of sewing on a button makes her think that she has a household, that she is married, that she is not religious. “My child is before me as a living remorse, seeing him hurts me.”

The starting point of the association may be less determined. It will not be an object that enters as an integral part in the idea, it will be an object that, by its form or simply by its name, resembles one of the previous objects: the association will be made by remote resemblance. Xa... (204) is terrified because one of his maid’s name is Antoinette, which is reminiscent of the scaffold and crime. Claire can no longer see bottles or long objects, without seeing the penis that defiles the Host.

An association of contiguity in time or in place will even be enough. If the object was seen at a time when an idea obsessed the mind, then by the fact of this contiguity in time, from then on that [object] becomes capable of evoking it [the obsessive idea]. “If I had an idea while washing my hands, it will always come back as soon as I shall see a bowl.” “I thought of my rabid dog while crossing la Place de la Concorde,” says Fi... (83) “and ever since this place is odious to me and I cannot tolerate anything that reminds me of it.” He does not want to enter his study anymore because his wife entered it wearing a dress that she previously had on when crossing la Place de la Concorde. Thus, Lod… and Lise acquired a terror of their furniture, because they were on this or that chair when they had this or that idea. This is the reason why some of these scrupulous improved, one must know, simply by changing their environment because all the objects of their usual environment took on an evocative influence. This is the reason why, in short, they fall ill again when they go back to their home. “I rediscover all my ideas while returning to my home, like an installed package,”
says Gisèle, “every piece of furniture in it is a true nest.” She remembers places and times by the obsessions that she had in those circumstances, and by recalling such a period of her life, she falls again into a corresponding obsession.

The ease and complexity of these associations of ideas can go even further, and Jean’s history is quite instructive in this regard. He has obsessions relating to masturbation, everything reminds him of masturbation. The nose, for example, seemed to have a relationship with the genitals because the smells are exciting and he cannot wear glasses, “it is as if that compressed my organs.” He cannot blow his nose any more just like he cannot urinate any more “for blowing the nose or urinating brings me the same effect as masturbation.”

We have already seen that his genital scruples became localized particularly on two women he knew. Anything that can remind him of one or the other of these two women will evoke the delirium and we are surprised by the subtlety of the association. He cannot walk anymore with certain ankle-boots because he once noticed there was the number 49 on them. Now the lady of his thoughts was 49 years old when the obsession began. He has a fear of the number 58 because another lady was born in 1858. He cannot write letters because correspondence is reminiscent of a post office where he saw this person. He cannot sleep in his bed because the bed is positioned so that the head is in the direction of the province where one of these ladies is; he cannot eat at the table when he turns his back to Montmartre where he met the other. He is terrified by all the names that begin with A, because these names evoke thoughts of one of their names. The latest incident can provide a list of all these associations of ideas. He is served at the table a cake that he finds good, and unfortunately he asks for the name. His mother replied: “It is a Charlotte.” A terrible crisis ensued: He had swallowed Charlotte, he had the head in his stomach, he had it in his blood, and all the erotic ideas were frighteningly overstimulating by the continuous presence of Charlotte inside himself.

Soon the association seems to generalize itself. It does not take the least consonance for him to come to think of one of these two people. Any woman, any object of feminine toiletries and even the presence of his poor mother is enough to evoke the whole
delirium. Any detail that can evoke any thought of loose living brings the same result. It suffices that he heard it said that a political figure did not have an exemplary death so that he cannot see the Élysée anymore, or the Chamber of Deputies, or anything that reminds him of politics, so that the sight of a newspaper kiosk becomes the starting point of all his meditations on the two women who persecute him.

His associations of ideas are not necessarily direct, they can be completely indirect and create genuine cascades. He is tormented because he has in his pocket a directory of courses that are in Paris. This directory seems to contain nothing very critical in itself, but it contains an indication of the hours of the lesson of Mr. D... which Charlotte was to attend when she came to Paris three years ago. The incident caused by the cake that was called a Charlotte begins again in more complex circumstances: Jean is very tormented because: 1° he ate some bread; 2° that this bread comes from a certain baker; 3° which baker was recommended to his mother by a friend; 4° whose wife died recently on a certain day; 5° which was precisely the anniversary of the day; 6° when he began to be tormented in respect to Charlotte. In these conditions, one wonders if there is any object that Jean can look at without awakening, by association, his delirium.

I stress this phenomenon of the evocation of obsession by the association of ideas because it plays a very important role in the evolution of the disease. It is there that disorder extends itself and spreads in the way of an oil stain. The obsession that was only localized and that determined disturbances only on the single thought seems by the association of ideas to stretch to all other thoughts and to disrupt all of the subject’s actions.

Precisely because of their importance we must give an account of these associations. They are obviously unique and do not resemble the associations that we are accustomed to observe in the suggestions of the hysterical, for example. If anyone suggests to a hysterical that she see a portrait on a card, the hallucination of the portrait appears when she sees the given, recognizable card with clear signs, and
it does not appear on another card and especially it does not appear arbitrarily regarding just anything. It is exactly this precision of the association that makes the experience possible. Just the sight of a flame causes the hallucination of the fire and the crisis of hysteria for a young man, one provokes the crisis again by showing him a burning match, but one does not provoke it by showing him a packet of cigarettes or a syringe, although if need be, from what we pointed out in Jean, the cigarette package or the syringe could make him think of fire. In short, in these cases the association of ideas is precise, because it is organized beforehand, it is made part of the design, of a coordinated system of images that constitutes the fixed idea and that is invariable.

On the contrary, with the scrupulous, any object seems to be able to play the role of évocateur. Which is the object, which is even the word that one could present to Jean without him managing to relate it to his erotic obsession? It seems really that the association is only a pretext, a justification that the patient gives himself in retrospect. Things happen as if the patient started to think to himself almost the whole time of his obsession and then cleverly looked for distant connections that could well exist between his perpetual obsession and the exterior objects in order to justify his constant preoccupation.

Cs... (41), a woman of 38 years, a great hypochondriac, complains about being unlucky because all the time she encounters the objects that make her think about the disease “a bottle from the chemist’s shop thrown into the Boulogne Woods, you see that I do not have any luck!” I take some precautions with the persons who oversee her so that they absolutely avoid speaking in front of her about diseases, of showing the patients to her. She escapes the supervision to go to look for patients and to question them about their disease, then she screams out in despair complaining that a conversation has again recalled her obsession. It is obviously the same for Jean, who works to discover these strange associations of ideas of which he complains. He is very preoccupied by the chambermaids who go to his parents and when they have to choose a new chambermaid, he investigates very carefully if she will awaken in him any association of dangerous ideas before granting his consent. One day, his parents offer to get him a
chambermaid for the house and they ask him if he finds any objection to their choice. He meticulously examines the surname, first name, country and date of birth, face, previous work history and finds nothing to criticize: the chambermaid is therefore admitted. Jean remains very anxious on this subject, he examines everyday all that he learns about her and nevertheless after fifteen days he is forced to admit that nothing about her reminds him of Charlotte. But just days afterwards he desperately rushes up to me saying, “a great misfortune happens to him, quite by chance: he knew since the chambermaid’s entrance that she had been a servant to Mrs. Pâtissier and it had not flustered him, but brutally, like a blow from a stick, Pâtissier [bakery] reminded him of Galette [pancake], now among the friends of Charlotte there is a Mrs. Galette of whom she often spoke. Is it not unfortunate that his parents have chosen precisely a maid who is reminiscent of Charlotte?”

In this form of association, the point is not that everything is similar to that which characterizes the suggestions of hysterics. This is not an automatic association arising from links of ideas previously established, it is an association that is currently sought and built by the subject. It is a mania of association that is a consequence of the fixity, the permanence of the idea or, rather, as we have seen, the mania relating to this permanence. We already rediscover, therefore, in these first characteristics of the permanence and evocation of ideas, the two characteristic tendencies of obsession. There is an exaggeration of the permanence and evocation, but this exaggeration does not consist of a complete necessity that imposes itself on the subject, there is something voluntary in these phenomena and it is this double phenomenon that constitutes a sort of tic or mania.

2. — The tendency toward action, the absence of execution.

The second characteristic that introduces us to the obsessions is the impulsion, that is to say, its tendency to act. This characteristic is, of course, the most important from the practical standpoint, since it constitutes the social danger of this illness. The criminal obsessions especially are very serious and whereas they compel the patient
to actually accomplish the murders, the suicide, the crimes against nature of which they dream. It is also the characteristic that interests the patient the most, because he is scared at the thought that he is going to carry out these crimes and a big part of his illness is caused by this dread of the execution.

On the other hand, this characteristic of the tendency to action is so real in these ideas that many authors have even acknowledged a particular class of these pathological ideas which they designated by the word impulsion, to distinguish them from other obsessions. Those who, like Mr. Arnaud, combine all these ideas under the common name of obsessions still accept among the obsessions a group that would be specifically the impulsive obsessions. I think that it is necessary to go even farther and recognize that the impulsion is a characteristic common to all these obsessions, though it has quite variable degrees.

It is clear that this characteristic will be more distinct in the group that I called the criminal obsessions. “All my ideas,” says Du..., “have a tendency to transform themselves into acts, I am going to throw my dog through the window, I am going to burn a banknote, hit a child, etc.;” “when I think of the rabid dog, I really want to throw myself on people and to bite them.” “I am compelled to rob people, to organize plans to rob some people, to do the sacrilege of breaking communion wafers, to do improper things at night etc.” These words, “I’ll do, I want to do, I am driven to do,” return continuously in the language of these patients. It has often been demonstrated, and one can still verify it by studying the performance of hypnotic suggestions, that these expressions and feelings correspond to the start of the actual execution, they result from the sensation from small muscle contractions, small movements begun in some direction. “My hands direct themselves towards the jar with tobacco,” said Delbeuf when he described the craving to roll a cigarette. “My hands begin squeezing and to hit,” say all these impulsive ones,” “my hands are advancing to unbutton the pants of my father,” said Vob... One can, moreover, also notice it in many of these movements of the body, these changes in appearance that constitute the beginning of the action.

It would not be necessary to believe that in the other obsessions, this impulsive characteristic is absent. “Between the obsessions of remorse or
the fear of an act and the impulsive obsession there is no clear-cut boundary, they are all accompanied by a tendency to act.”30 “The phobia of an act has a great deal of connection with the impulse to an act: in all, there is a coexistence of phobia and the impulsive propensity…”31 Also, one finds this impulsive characteristic everywhere: in the sacrilegious impulses, there are movements to spit out the Hosts, to tear them, of words to blaspheme, of gestures to express contempt. In the obsessions of shame, Claire lets herself go to cry aloud all her thoughts of shame: “Oh, I am guilty, my head is full of ugly thoughts, it is terrible…” She rolls on the ground for hours, she tears up her handkerchief, she wears out about forty in a month, she eats her bed sheets, etc., she is obsessed by the thought that a priest put consecrated a Host in her parts and she refuses to go to the bathroom, etc. We do not currently consider the many more numerous actions that the patients make to resist their obsessions. We note only that they make some [actions] to give in to them [the obsessions].

In the shame of the body, the patients are so very compelled to hide, to not eat, that they change their entire lives, they remain shut away for years, and some come to states of frightening thinness. Finally, hypochondriacs are compelled to take improbable precautions and Jean justifiably boasts to have arrived at an ascetic’s life. We will have to go back over the very curious asceticism that results from the illness of the scruple. More often, they are compelled to absorb poisons or to execute actions that they judge necessary for the healing of their suffering. It is therefore incontestable that, in all these obsessions, there is a distinctly impulsive character. On this point, moreover, it confirms the general law that requires that in any predominate idea, there is a tendency to movement.

The important problem consists in knowing up to which point this tendency to act is strong. Many authors and

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30 L. Groignac, Des impulsions et en particulier des obsessions impulsives. Thèse de Bordeaux, 1897-95.

31 Pitres ut Régis, Rapport sur les obsessions au Congrès de médecine de Moscou, 1897, p. 47.
particularly Westphal, who described one of the first of these ideas, call them irresistible impulses, and many people make the irresistibility one of the essential characteristics so as to call these phenomena *anancasmes*.\(^{32}\) “The impulse,” says Mr. Bourdin, “is a mode of cerebral activity that uncontrollably, inevitably determines the production of a movement, an act simple or complex.”\(^{33}\) The irresistibility seems to present itself in the hypnotic suggestions, in the hysterical somnambulism when the subject performs strictly and without hesitation the actions that he dreams. Is it the same in these obsessions of the scrupulous?

For a first group of observations, the most important, because it contains two-thirds of the patients, the answer raises no difficulty. These obsessives who, if we believe their language, feel the most dreadful impulsions, execute in reality nothing at all. Is it not curious that in so much observation of criminal obsessions concerning more than 200 patients, gathered during a dozen years, I can note no real event. I have never seen any crime committed, no suicide was accomplished by any of these obsessives. This cannot be a fact due to accident: it is necessary that there is in these obsessions a very weak tendency to pass over to action. It is evidently while joking that Ball describes to us his emotion in the presence of a patient of this kind. “At the moment when I speak to you,” said his patient, “I feel a strong desire to strangle you, but I stop myself. - This sincere confession coming from a man carved like Hercules made me think....” says the author. Who then has ever taken seriously similar speeches of the obsessives? Besides Ball adds right away: “The interesting point of this curious observation is that this man has never committed a reprehensible act; he always remained correct and could always stop himself at the critical moment. He was definitely on the border of madness.”\(^{34}\)

These patients say, it is true, that they resist the impulsion with a lot of effort; they employ all sorts of processes, more or less curious, to resist. A famous patient connected

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\(^{33}\) V. Bourdin, *De l’impulsion spécialement dans ses rapports avec le crime*. Thèse de Paris, 1894.

his thumbs with a ribbon to resist the impulsion of murder. Our patients all have similar techniques that we shall have to study. It suffices now to notice that impulsions do not have to be very terrible since the same pretences are enough for stopping them all. Morel\textsuperscript{35} had already noted that impulsions to suicide never lead to a fatal ending. Ladame points out that such impulsions remain almost always theoretical, we see that this conclusion is accurate in the largest number of cases.

A second group, already much smaller, contains the patients who really execute something, that is to say who make some actions having a certain connection with their obsession. Pr... (210), a 32-year-old woman, was very upset by meeting a man in a dark hallway, she remains obsessed by the thought that this man actually abused her, that she is pregnant and that she wants to have an abortion. She despairs of not being able to resist this impulsion any longer; she gave up and took... a spoonful of oil of ricin in coffee. Ger... to prove to me that she cannot resist the idea of killing her child, tells me that she pushed him with her hand. She wanted “to destroy herself and knew that a flask of laudanum would kill her, so she took three drops. It is definitely proof, she says, that another time she will take the entire flask.” Qes... who wants to throw himself through the window, contents himself with throwing himself to the ground in his room. Vi... actually does not buy the poison, as she dreams it, but she is, however, at the chemist and buys two pence of violets, to take something. Jean does not seems to yield in any way to the countless erotic impulsions; but he himself points out that he does not completely close the fly of his trousers, that is all that he can do as a genital crime. The sacrilegious who think of soiling the altars, all limit themselves, at most, to say at the tips of their lips the word “pig” while thinking about the good God. Indeed, they could consider words as incomplete actions of this type and these patients who do not kill begin to realize their obsession a little in speaking of killing.

Next to these, others seem to fulfill more of their idea, but it is necessary to note that they take their own curious precautions.

\textsuperscript{35} Morel, \textit{Délire émotif}, p. 400.
so that their action has no consequence and remains insignificant. Such is the interesting case reported by Ball: “they cite,” he says, “the case of a famous man of State, who filled the highest political office in his region, and who, when he dines in the city, is invariably accompanied by a domestic servant especially responsible for bringing back home the silver place settings which his master never fails to steal.”36 I am disposed to believe that if this personage really took place settings it is because he counted on the presence of his domestic. Here is a case of the same type: Bs... (187), a man of 41 years, who has the impulsion to suicide following an amorous obsession, who begins by getting on the telephone, calls his mother and his doctor, verifies that they are listening to him and announces to them that he is finished now and that he is swallowing chloroform. Naturally, they run to his assistance and they note that he indeed took a certain dose of chloroform: he is, moreover, very happy to allow himself to be looked after.

These last cases allow us to understand how, from time to time, in an exceptional way, it might happen by accident. The obsessed, who wanted to execute only an imitation, poorly took his precautions and, if the act executes itself completely, this is wholly against the patient’s intentions. Mr. Séglaś37 very correctly points out that the obsessed can allow themselves to go to extreme acts without giving in to these impulsions. They arrive, rather seldomly in my view, at suicide, not because of an impulsive obsession that they fulfill, but because they give up hope about their illness and because they kill themselves in cold blood. Mr. Nicoulau38, in an interesting article, presents a woman obsessed by the idea and terror of death who comes to suicide attempts to escape the anxiety caused by the fear of death, for those outside of these special cases, the realization of the impulsion by patients in this group is completely insignificant.

It seems necessary to me to admit a third group, composed of a small number of patients who seem to execute acts completely, or at least in a rather serious way,

36 Ball, Revue scientifique. 1883, I, p. 2.
37 Séglaś, Leçons sur les maladies mentales, 1895, p. 87.
in connection with their obsessions. These will be, to take some examples, those ashamed of
t heir body who really refuse to eat, dipsomaniacs, the morphine addicts and the patients of the
same type who indeed intoxicate themselves, the bulimics who eat too much, the dromomaniacs
that walk for hours, the erotomaniacs who give in to their passion, the individuals compelled to
search for suffering and who really burn themselves or hurt themselves.

We have already seen the typical case of Nadia who, from fear of putting on weight, of growing
up, ate no more than a little bouillon each day, a yolk of egg, some tea and some vinegar. Here is
a second case of the same type: Red..., a girl who always had been very emotional and very
scrupulous, has, at about 18 years, a first crisis of refusal of food. She was examined at this point
in time by Messrs. Brissaud and Souques\(^39\) who published an observation in the new
Iconography of the Salpêtrière under the title *Delusions of Thinness*. She was, in fact, of a
skeletal thinness, she recovers, however, in the sense that she rapidly consents to eat and took
back her strength and her portliness. But at age 20 the same incident reappeared, rather more
serious; she started again to refuse to eat and in addition she strove to provoke vomiting when
she had eaten and developed the habit of vomiting very easily. Thinness and weakness became
again, once more, very worrying and she was escorted to the Salpêtrière where I could study this
second crisis.

She was in a very advanced state of starvation, very thin, dry skin, rough, cold, the tongue dry
and red, the breathing rapid, the pulse slight and rapid; she had certainly pushed her refusal of
food and efforts of vomiting very far. I hesitate however, as with Nadia and for the same reasons
to make this patient a hysterical anorexic. Throughout her history, before and after this accident,
Red... has never presented any hysterical phenomenon; for a long time, before the appearance of
serious accidents, she had preserved the feeling of hunger; she has never had

\(^{39}\) Brissaut et Souques, Délire de maigreur. *Nouvelle Iconographie de la Salpêtrière*, 1896.
imagined forcing upon herself many superstitious practices and, in spite of her efforts, she was continuously anxious and tormented. She was obsessed by the sight of miseries, of diseases, by the very state of the weather: “it was her fault if there were so many sick, it was her fault if it was bad weather and if the poor people suffered from it. In these conditions, she believed she saw a circle of fire and interpreted that as saying that she was damned. She remained obsessed by the thought that her damnation rendered her unworthy to eat. This is what had determined the first crisis of refusal of foods, at 18 years. This refusal had ceased at the hospital by virtue of this reasoning: “here one forces me to eat, I am therefore not responsible if I do it.” The second crisis at the age of 20 years was also linked to the scruple in a very marked, although different way: she come to be ashamed of herself, following all the previous reflections, she imagined that her digestion was ridiculous, that it caused her face to blush and to have especially loud burps. She had all the more shame of these things as she had made herself throw up after her meal with a professor with whom she was completely in love. It is at this moment when she felt compelled not to eat any more and to vomit to clear out the stomach. I cite quickly, to show the frequency of the fact, the case of a young man of 26 years, As... (102), he also reached, as it shows in his photograph, a state of improbable thinness. He had developed the habit of vomiting, provoked for reasons of the same type pertaining to shame of the body and to hypochondria. In these cases, the impulsion seems, therefore, to realize itself in a serious way by the refusal of food and starvation.

To these observations, I would want to add a more curious case where the scruple also brings a patient to do great absurdities. We have seen the love obsession of Byl. ..., this young girl who, due to shame of herself, by dint of imagining that she was ugly, unworthy to hold her rank, had become enamored with a gardener of the house. What is curious is that the act seems to have followed her obsession: she waits until she is 21 years old to have her freedom, at night with the aid of a ladder she goes up into the room of this boy, makes her declaration to him, embraces him, and makes him promise to ask her parents for her.

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40 Cf. 2° volume of this work, observation 102.
The following day she tells her parents and, equipped with a tremendous stubbornness, persists in her wedding plan. Can one not consider this case again as a considerable execution of a scrupulous obsession? These facts show us, therefore, to the contrary of the previous ones, which in certain cases, which are not frequent, these impulses present a certain force sufficient to determine real acts.

Nevertheless, I do not believe that one is able, according to these examples only, to compare these obsessions to the suggestions or the hysterical impulses that execute themselves automatically. The execution, although advanced, is not in reality complete, these patients do not completely refuse to eat, they only tremendously reduce their diet. Byl..., in the coachman’s room, limits herself to allowing herself to embrace, but all in all does not yield to him. Once healed, she confesses to us that she was not very sure of going through to the end with this marriage and that she would have been very embarrassed if her parents had not resisted. A second remark shows us that these patients who refuse to eat go, on the whole, further than they believe they go. They are young people quite ignorant of the basic concepts of hygiene, who do not realize the danger of their insufficient nutrition. Nadia assures me that she had never had an intention to die from hunger and that she would have stopped if she had believed her life was in danger. These patients who, as we shall see, cannot come to believe and are not persuaded by the assertions of their family circle, they behave a bit like the obsessives about whom we have just spoken who really commit suicide, when they believe they make only a pretence. Let us add that once they enter this path, they introduce disturbances of the stomach and perhaps some delirium from starvation that changes the character of the illness. I do not believe, therefore, that these obviously more puzzling cases have to change our original conception, on the little strength of these impulsions.

There still remain obscurities in this difficult problem: certain impulsive obsessions seem to have the singular privilege to pass to action much more regularly than the others. I shall name, for instance, the morphine addiction and dipsomania: I wonder if the absorption of poison does not change the conditions in which ones develops the obsession. After the first drink, the mental state of the scrupulous, ordinarily
indecisive, hesitant, unable to finish anything, is changed. The fact is evident, and one knows these patients with erythrophobia that need to intoxicate themselves to be able to withstand your gaze. One knows that as the morphine leaves from the organism some substances are able to provoke the intense need of the original poison: it is possible that these modifications of the organism account for a certain part in the abnormal realization of these impulses.

Other impulsions are followed more frequently by execution, these are the impulsions of the hypochondriacs who pretend to find healing in any practice, or that of the erotomaniacs who acquire voluptuous emotion only thanks to very special practices. It seems to me that in these cases the impulse becomes more complicated by bringing into play very powerful instincts such as the life instinct, the fear of death and the genital instinct. These instincts are always very powerful and always are determining when they awaken a crowd of real actions. They give to the impulse a force that it does not have ordinarily.

Finally, it is necessary to remember that I speak here of the common obsessions, such as they present themselves in the majority of patients, of obsessions strictly speaking that remain accompanied by criticism. I pointed out that there could be in some of these patients a psychasthénique delirium after a certain evolution of the illness, in which the patient seems to abandon the criticism of his obsession. He appears to be convinced of his delirious ideas and of course he puts his actions as much as possible in accord with the ideas that he accepts as true. Subjects of this kind strictly confine themselves to punishing themselves or to preventing themselves from committing crimes; they subject themselves to veritable tortures. Ek... claims to be able to escape tuberculosis only through obedience to the counsels given by the spirits and she goes around barefoot in sandals, covered with a simple black cotton shirt despite the cold of the winter. These executions of the impulse are not so complete, as automatic as they appear. There is there “a sort of assented training, something artificial, like a mania for logic” very well said by Messrs. Raymond and Arnaud regarding this matter. The patient is stubborn in being logical with himself, he executes the most that he can, he exposes himself to a great extent to the risk of ridicule and suffering consistent with his obsession. He is not, however, so very
certain that he will go completely right to the end: to follow the counsel of the spirits Ek... shaves her hair and all the hairs of the body, because it is hidden quite easily, she does not shave her eyebrows because that would be too visible. These patients do very serious things and it is necessary to be much more wary of them than others. But they form a group somewhat distinct in that the obsession does not follow its ordinary laws.

There is in the previous cases a transformation, a complication of the illness. It is what can happen in other circumstances. Here is a curious observation of Mr. Vallon: an individual obsessed for a long time by the idea of killing a prostitute ends up firing several shots from a revolver at a woman.\textsuperscript{41} I cannot help doubting in these cases the accuracy of the diagnosis: it seems to me probable that other factors: alcoholic epilepsy, intellectual weakening, imbecility must have intervened and changed the usual prognosis of obsessions. This is, moreover, the opinion already defended in the report of Messrs. Pitres and Régis\textsuperscript{42} and in the thesis of Mr. Le Groignac about the impulsions.\textsuperscript{43}

All of the times that I had the occasion to examine a patient who had yielded to this type of obsession, I had to note that this was not a typical obsessive linked to the psychasthéniques whom I study in this work; but that it was a matter of another mental illness. Here is, for example, a famous person, a person named Mau..., who was studied by Chambard, by Luys, by many others and that ended up at the Salpêtrière for some time. Among his innumerable obsessions, he has now the one of the “small hair.” It is necessary for him to cut the small curls on women’s necks, or the hairs of the pubis, and when he has them in his possession he arrives at ejaculation. This impulse is really for him completely irresistible; he becomes, as he says it, a sleepwalker and really takes for himself the “small hair” despite the greatest dangers.

In this case, as in other cases of the same type, the impulsion realizes itself completely in an irresistible way. It is in

\textsuperscript{41} Vallon, \textit{Société médico-psychologique}, 28 avril 1895.

\textsuperscript{42} Pitres et Régis, \textit{op. cit.}, 1897, p. 51.

\textsuperscript{43} Le Groignac, \textit{Des impulsions et en particulier des obsessions impulsives}. Thèse de Bordeaux, 1897-98.
my opinion that the psychological terrain is no longer not at all the same and that the disease is different. Mau... has a general tactile anaesthesia, a constriction of the visual field to 30°, he has somnambulism, fugues followed by amnesia, etc. In short, this is a hysterical; we fall again into the mechanism of suggestion and the hysterical obsession. It is necessary to know that these mental diseases are not characterized by the content of the obsession but by the psychological form that they take. A hysterical can be erotomaniac like Jean, but he will realize his impulsion in a very different manner. Therefore, I believe that if one encounters impulses that execute themselves differently than has just been described, it is best to attach them to other illnesses: epilepsy or hysteria, for example, and not to the psychasthenique mental state that we currently study.

In summary, the obsessions of the scrupulous always present a certain impulsive tendency, a certain disposition to pass into action. But this disposition, far from being overpowering as they wrongly say of it, is never complete; the patient himself is more frightened of his impulsion than he is frightened of not obeying it. He experiences an unusual need to think the terrible and irresistible; it is like a vanity of crime, like a secret desire to believe himself compelled to the crime that makes him, more or less, carry out certain beginnings of the action. When the execution is more complete, it is that other factors, intoxications, powerful instincts, delusions came to add their force to that of the actual obsession. The actual impulsion, left to itself, determines only simulacrum of action. Here still, it is more a mania of belief in the impulsion than the actual impulsion itself.

3. — The tendency to representation, the symbolic hallucination.

Next to the development of the driving forces and the tendency to action, it is necessary to put the development of the representative elements and the tendency to hallucination. Are the obsessives that we study likely to have
true hallucinations during the course of their obsessions? The question has raised several controversies. Mr. Julius Falret had previously argued\(^4^4\) that one of the distinguishing characters of these obsessives is that they never arrive at true hallucination: this overly absolute proposition was strongly contradicted. Buccola, Tamburini, Séglas,\(^4^5\) Stefani,\(^4^6\) Catsaras,\(^4^7\) Larroussinie,\(^4^8\) Raymond and Arnaud\(^4^9\) supported the existence of “the hallucinatory obsession.” I have myself repeatedly insisted, especially by studying Justine’s fixed ideas about the remarkable hallucinations that accompanied her obsessions.\(^5^0\) It seems, therefore, that there are two completely contradictory opinions on this point.

This contradiction can at first be explained in a simple manner. In certain cases, the authors do not speak about the same patients. I acknowledge, for my part, that the hallucinating obsessives that I represented as Marcelle and Justine were hysterical. It is probable that, given the frequency and importance of obsessions in the hystERICs, it must be the same for some of the patients having hallucinations described by other authors. Mr. Falret’s proposal would remain true for the obsessives per se of the psychasthenique type.

The question remains, however embarrassing, because at least a certain number of these latter patients present phenomena very similar to hallucination whose nature must be discussed. The hypochondriacs come to represent to themselves certain pathological phenomena as though they had hallucinations of the organic sense. I do not speak of their dysesthesias\(^xviii\) that I will study later regarding the emotional disturbances. I talk about visceral and tactile representations that seem rather intense although imaginary. One of Wernicke’s patients, cited by Messrs. Pitres and Govern, had the sensation of being covered with


\(^{49}\) Raymond et Arnaud, *Ann. méd. psychol.*, 1892, II, 204.

\(^{50}\) *Revue philosophique*, février 1894. — *Névroses et Idées fixes*, 1898, I, p. 161, 164.
lice, she saw them and heard their rustle. One of our patients, Mae., a 50 year old woman, who gave birth at the age of 22 years, has long suffered with her stomach. It takes her now at any instant, “the crises of delivery;” she claims to feel everything with precision in the kidneys, in the stomach, in the legs as though she gave birth: “It is so perfect that it is hard to tell them apart,” she says. Two others have the obsession of an intestinal worm: with Mort., a woman of 63 years, “the worm climbs back up the throat, it comes to give her a small knock in the mouth then it goes back down: it is sometimes in the back, sometimes in the stomach.” Bé... has a solitary worm in the stomach “she feels by its cold slidings that it winds up into a ball at the epigastrum. It is a worm spider that has big legs, as hairy as a spider.” Like a type of tactile hallucination, one can study Jean’s fluids. He always knows exactly in which direction, in relation to him, his ladylove is located. If he walks in this direction or if he has the turned to face towards this point, all is well: he can hold out against it if need be. But what is terrible is when he turns his back to this point in space; then the phantom is in his back and allows itself a thousand extravagances. It leads to ticklings, shivers, “fluids” and the situation is unbearable. Also, Jean is enormously preoccupied by the orientation of his bed in the room, of his chair at the table. He changes position until he finds a position where he no longer turns his back on this dangerous ghost. It is misfortune when there is another person situated in another direction who exercises almost the same influence and it is very difficult to find a position that would expose neither the one nor the other.

Auditory hallucinations are rather rare: here are some examples. John Bunyan, English mystical author, who evidently reached the delirium of the scruple, one day hears a voice that says to him: “Do you want to leave your sins and have heaven or keep your sins and have Hell” and he sees Jesus in the sky. Mr. Lépine

Wernicke, Deutsche med. Wochensch., 23 juin 1892; Pitres et Régis, op. cit., p. 58.
cites a singular observation of an obsessed patient who is constrained to always hear a voice repeating a series of 25 words. The observation seems a bit short, however, it is similar to our patients. Mr. de Sanctis reports a unique musical obsession, an obsession that gradually becomes impulsive and forced the subject to sing inwardly the same tune. In an observation by Mr. Larroussinie, voices come in support of the patient’s thinking and make the same criticisms as the obsession. One of our patients, Per., obsessed by a shame of the body relating to the hairs on his face, hears his neighbors murmuring through the wall: “Hairy, hairy!” Jean also has these auditory hallucinations: he is obsessed by the memory of a chambermaid in honor of which he had, he believes, his first ejaculations. The very ugly face, we already know that Jean is obsessed by the thought of old or very ugly women, emerges in profile. She is animated by movements, the mouth can open and the ghost starts to laugh. This laugh, at first moderate, in a few years became absolutely enormous, it is a crazy, excessive laugh that opens her mouth up to the ears. This laugh is determined by the actions of poor Jean, because the chambermaid watches him and makes fun of him in a manner not merited in any way by how he conducts himself. He enters into a tram where he risks finding himself sitting next to a woman, the image of the chambermaid makes him laugh because he is tormented by being next to her. He leaves the tram and he takes a hackney cab to be alone, the chambermaid absolutely bursts out and says to him: “You spend forty pence not to find yourself in a tram with women, hi, hi, hi.” It is difficult to find, by all appearances, more complete hallucinations; complex visual pictures, in movement, accompanied by tactile imagery in the back and in certain cases of auditory imagery.

Purely visual representations are by far the most frequent ones; we find them first with the sacrileges. A patient of Mr. Féré saw a masculine member materialize. This is also

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53 Lépine, Obsession verbale et auditive. Société de médecine de Lyon, 12 juillet 1894.


56 Féré, Pathologie des émotions, p. 416 (F. Alçan).
what characterizes Claire’s obsessions. She claims to see suddenly materialize in front of her a nude man or rather the sexual parts of a man in the process of soiling a consecrated Host and many other images of the same kind. Lod... and Lise also saw the Host on the ground, especially when they noticed some spit. We... claims that she sees crosses and saints in the sky. Among the patients that have criminal obsessions, Xa... one of the women obsessed by the idea of committing murder, sees in front of her, to the left, a face crossed at eye level by a long kitchen knife (fig. 1). Moreover, this hallucination

Fig. 1. — Drawing done by the patient herself to represent her hallucination, the knife is seen in a much more clear manner than she treated the face.

of the pointed knife is frequent, one finds it again with Mb... and with several others. Vod... sees herself cutting the neck of her little girl. “I saw myself bleeding her, putting her in a coffin and throwing the box into a big pool of dirty water.” Fa... who is believed to have erotic impulsions, “sees all the men on the street unbuttoning themselves and running after her.” Jean sees not only the maidservant with the crazy laugh appearing to him but his ladylove Charlotte perpetually ahead of him or in his head.

In the group of the ashamed, the hallucinations are particularly curious. A very frequent hallucination is the one of a hole, of a precipice into which they are going to fall or into which they fell. Claire has long rubbed elbows with a great precipice, now she is at the bottom of the hole and she definitely sees that it is impossible for her to go back up. Hi..., a 47-year-old woman, “psychologically sees a hole into which she appears to fall; if she does not manage to come through it, she will kill herself rather than to stay at the bottom.” One remembers that Pascal, who also had many
symptoms of the illness of the scruple, saw a precipice beside him. There was much discussion on Pascal’s hallucination: if it is historical, which is very doubtful, it should be closer to other hallucinations of the same type in the scrupulous, which would be the best means of understanding its nature.

It is also necessary to attach to the same group the following cases that appear to me particularly interesting. A 20-year-old young man, Voz..., comes to complain about a peculiar disorder: he is distracted in his studies and in his pleasures by an embarrassing sight, he always sees a wall in front of him, and he definitely recognizes this wall: it is in the school’s first courtyard. He is also embarrassed in his strolls, because he continuously walks closely surrounded by four trees, two in front and two behind him. These are four well-known trees in the school’s courtyard. Finally he is even more embarrassed when he sees chains or ropes which are stretched in front of him, that wind around the trees in front of him and that block his way.\textsuperscript{57} Rp..., a man around thirty years old, who I have just studied with Professor Raymond, sees a figure passing in front of him at a distance of almost five meters. This person, who is almost always the headmaster of a large school, sometimes has a welcoming expression, sometimes the attitude and the face are angry and threatening. These cases could be easily multiplied, because they are actually quite numerous.

These phenomena present themselves with the appearance of hallucinations: they are psychological phenomena that appear in the subject’s consciousness and become confused with the phenomenon of external perception, although for an observer located outside the subject, there is no real object in relation to this perception. They seem to represent a system of images corresponding to an object; they appear to have the appearance of being exterior, and to impose themselves in an irresistible manner. Also, the subject himself creates the hallucinations. The young person Voz..., Claire and Rp... come to consult the doctor, asking to be cured of their hallucinations and, if one limits oneself to a superficial observation, one will of course take them to suffer from hallucinations. However, the existence of complete hallucinations would be a peculiar fact in the scrupulous. How did these patients, who did not come to the complete impulsion,

\textsuperscript{57} J’ai déjà présenté ce cas à la Société de psychologie. \textit{Bulletin de l’Institut psychologique}, juin 1901, p. 188.
to the actual execution of their ideas, arrive at the full representation which is a phenomenon of the same type? One should accept this only after a demonstrative examination.

And yet with most of these patients, these alleged hallucinations do not withstand examination. “Any white object,” said Lod, “makes me think of the Host, especially when it is dirty, it forces me to look twice, but, when I look, I definitely see that I made a mistake. It was only spit on the ground.” Lise very much acknowledges the same, that she moves herself ahead in her delirium almost to the point of having hallucinations, but that she stops herself on this side. “In my great fears of the devil, I felt that I was going to begin to see something, but at that instant I stopped myself.” One should not make a mistake in the language of We...: she does not see crucifixes and saints in the sky, she explores whether or not she sees them, which is not the same thing. “I am afraid to see them, I want to see if I really see them.” All of that does not resemble hallucination.

In reality, there is only a small number of confusing cases. But one can then make the following comments on these hallucinations. 1° These hallucinations are not complete and are far from presenting all the colors, all the details which one would see in a real object, it follows that they are vague and lack clarity. It is necessary to insist a bit, and not to worry too much about the patients, by calling into question their hallucinations, to acquire all confessions on this point. Xa…, who drew the knife across the face, points out that the face is guessed rather than seen. “I need,” she says naively, “to draw this picture to make me fully aware of just what it depicts.” Although Claire seems to see the most terrible images, it is easy to see that this scene lacks a lot of detail. It is impossible to make her describe the form of this alleged virile member, the place that it occupies in relationship to the Host. Mademoiselle has never known how to say me if it was to the right or to the left of the Host and in several cases, she confuses herself even more: “This is something that must be like a male organ without me knowing definitely what it is... In any case, I am quite convinced that it is something dirty.” For a visual image, it is not very clear.

The last young man Rp... would be extremely embarrassed to
describe the figure whom he sees, because he is too afraid to look at it, he knows that he sees it, but in reality, he has never seen it well. Jean’s hallucinations, in spite of their apparent detail, are completely of the same type. These figures are vague, effaced, “it’s as if I saw it, it’s as if she spoke to me.” These are images without colors and words without sound. Most often, these images even seem to efface themselves even more. “I do not see the ghost of M... since she is behind my back, but I know that she is there.” He happens to use a word in this context that is interesting. “I do not quite see,” he said, “it remains implicit.” By this he means that there is no precise image, there is barely a small, vague sign that suffices to inform him. “I have nothing in the idea that is accurate, I do not see her face, I do not hear her voice, I do not murmur her name and, nevertheless, I know I am always thinking of her.” As I was hardly able to satisfy myself with this persistent, odious obsession, that was nothing, which consisted in no psychological fact, I have insisted, and Jean claims to have, in some cases, made this curious remark. “Charlotte has, in reality, a very strong voice and makes the ‘r’ roll. This pronunciation struck me and, when I am obsessed implicitly, I feel in the mouth, on the tongue, like a very small rumble of ‘r.’ That suffices, I know that I constantly think about Charlotte.” In other cases, he feels on his forehead as though a letter of her name was written. It is to these very small images that the obsessions will reduce to and it is he who draws as conclusions all these alleged hallucinations. An interesting note is that these implicit hallucinations make the patients suffer very much, “the more vague and implicit it is, the more odious it is.” The defect of detail, Hoffding has already said, gives a very distinctive feeling of dread: we shall have to study it more carefully when speaking about the anxiety of these patients.

It is not a pure decrease in the intensity of the images, it is a defect of complexity, the essential categories of the images are absolutely lacking. It is impossible to add up the flawed images and have the hallucination become clear. In the hypnotizable hysteric, one can give rise to hallucination by stimulating the images in the subject’s mind one after another. I have shown before that this growing complexity, this automatic development of the elements of the idea played a big
role in hallucination. But here, the patients do not come to see it better and instead the attention abolishes the little that they saw.

2° Many authors, and particularly Mr. Séglas, also noticed that these hallucinations did not have the characteristic of exteriority so important in perception and in full hallucinations. This remark is only for a certain number of patients.

If Jean’s hallucinations lack precision, they also lack exteriority: he is willing to localize them in “the cerebellum” or in the forehead “in the summit to the right, where they ended up to determine a projection of the bone.” Also, he himself acknowledges the nature of this phenomenon, “it is,” he says, “my crazy cerebral laugh.” Claire is very embarrassed when we want to make her specify the external position of her image, she believes that the group is to the left, but she does not know exactly where. “Besides, if she cannot definitely specify the place, it is not her fault, the object is too far... not too far away... it is in the distance as though it was another person who sees it... This other person would see that it is definitely a virile member, would see its place definitely, me I do not see it.” Without speaking here about the personality disorders that this sentence reveals, we shall note only how much the outside location remains vague.

However, I shall not dare to say that these hallucinations completely lack exteriority, as Mr. Séglas said to the Psychological Society. There are some patients with the feeling of this exteriority. Voz... sees trees, the wall, chains, outside of him: “it is definitely outside me since it prevents me from advancing, it seems to me that it blocks my way.” Rp... maintains that the image of his manager is five meters in front of him. Even for the previous patients, Jean and Claire who end up placing the hallucination in the head, one should not conclude too quickly. It is when one questions them, when one forces them to reflect that they hesitate to consider their image as external. At the beginning, when they speak spontaneously they assert that the image appears “in front of them, outside.” Why, therefore, do they change their opinion after reflection; it is that they are astonished themselves that an image

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58 Automatisme psychologique, 1889, p. 201, Accidents mentaux des hystériques, p. 27.
can be external when it lacks an essential characteristic of the external things.

3° The most important fact, certainly, it is not precisely that these pictures lack exteriority, it is that they lack reality. This very important characteristic is linked to the sentiment of belief, of certainty. An object seems real to us when we put all our acts, all our feelings in harmony with the image that it presents. And yet, our subjects realize that this hallucination is not a reality for them. They say themselves that these are “kinds of hallucinations,” “unrealities.” Their torment consists precisely in doubting the reality of these images, in wondering about their existence. One of these patients wonders continuously if she has a religious vocation; she assumes that this vocation, if it existed, would manifest itself by divine signs, by the vision of saints in the sky. Also she wonders all the time if she saw saints in the sky: one instant she tells you yes, and the next moment she recognizes that she would be made very angry by seeing it. The patient who sees the school headmaster go past is in the same circumstances; he has the mania of omens, so to decide to act in one way or in the other, despite his abouilia, he wants to see his smiling or menacing headmaster go by, and he wonders whether he saw it clearly. Not only is this feeling of external reality lacking, but it is curious to point out that it will never appear. If this phenomenon differed from ordinary hallucination only by a lesser degree, it should, by the progress of the illness, get closer to the feeling of reality. Oh well, if these patients ever arrived at the conviction of their hallucinations, they would be cured, or at least they would change the nature of their illness, which we do not observe. These same images, if they appear vaguely external before reflection, they always remain unreal and doubtful for them.

4° These hallucinations present again another important characteristic, it is that they are symbolic: they are not constituted by the perception of an interesting object in itself, but by the evocation of a sign that summarizes a quantity of other thoughts. The mania of the symbol is so important to the scrupulous that we cannot study it in an incidental way here; it is enough to point out this characteristic that it gives to the hallucination.

One sees, according to these observations, that the hallucinations of the scrupulous are far from being identical to the complete hallucinations
of the hysterics and of the alcoholics. This is the conclusion that numerous authors reach, particularly Mr. Pick and Mr. Francotte. One could apply to them the word pseudo-hallucinations that was proposed by Dr. Kandinsky regarding the same kind of patients. A patient believes he changed nationality and became an English subject, in this connection, he sees a lion appear that puts its paws on his shoulders. He himself remarks that he was not as scared as he would have been by a real lion, he definitely understood that it was a British national emblem. Our patients understand as well that these alleged images are only emblems, some symbols to sum up long meditations and to return the idea in some sort of plastic way, he does not take them for realities as that would make them true hallucinations.

We can then reply, in a more complete manner, to the problem posed at the beginning of this subsection. If we leave aside the obsessed hysterics that have undisputable hallucinations, can the scrupulous themselves present this phenomenon? They present, without doubt, a certain appearance of hallucination, the pseudo-hallucinations or the symbolic hallucinations, but Mr. Falret was justified in observing that they do not present hallucinations strictly speaking. Here, again, we see a tendency towards the hallucinatory representation that does not completely succeed. The subject seems to push the representation as far as possible. He digs in his heels to see the image materialize externally and real, he searches for it, but he really does not see it, it is still a kind of mania of hallucination more than a real hallucination.

4. — The tendency to belief and the criticism of the obsession.

If the obsession is far from realizing itself completely, if the

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59 A. Pick (Prague, Ueber) die Beziehung zwischen Zwangsvortellungen und Hallucinationen. Prager med. Wochenschr., 1895.


hallucinations that sometimes accompany it are far from being complete, does the patient accept, at least as a belief, the ideas that he has just expressed? It is easy to note that this new characteristic is no more complete than previous ones. We very easily note, in fact, that almost always it is the patient who first calls into question the sacrileges, the accusations of which seem to preoccupy him.

This characteristic already manifests itself by traits of the patient’s behavior. One sees them come voluntarily, alone, to the doctor and to the alienist; they ask to be treated because of certain ideas that they point out. They know very well, therefore, that they have distorted ideas and they know which are the wrong ideas; for they will never speak about the other ideas to the doctor. On the other hand, it is easy to point out that in the presence of outsiders, they superbly know how to conceal these same ideas, which they would obviously not do, if they thought they were accurate. Claire, who accuses herself of everything with such a despair, who rolls herself on the ground while wailing, picks herself up again as soon as she hears the doorbell ring, she quickly readjusts her dress, she shows herself to be polite and to be even joyful with the other persons who have just come in during one of her crises: she even accepts compliments on her conduct. Lise, in her living room, would never allow for suspicion of what she thinks: much better, she plays a sort of comedy, because she pretends to make fun of superstitious people and it seems that many persons find that she tips with exaggeration into the camp of the freethinkers. Rob... accuses herself of not returning the exact change to the customers who came to the cash register. They offered to her one hundred times, when she is in a big crisis, to send an employee to the customer’s address to verify the count and to offer him compensation; she never wanted to accept. Is this not an obvious proof that she well knows, at heart, that she made an exact count?

The patients’ statements are also in perfect agreement with these observations relating to their behavior. These persons will not hesitate to say to you: “I know very well that I did not do any evil. It is unnecessary to interview anyone to check.” Lod... or Claire, who declare themselves miserable, more guilty than the worst criminals cannot, if one insists, find a specific sin to confess; they end up getting angry if I review before them the errors that a young girl may commit
and ask them seriously if they committed them. “If a person,” said Lise, “told me half of the things that I come to say to you, I would think they would be absolutely crazy.” A very curious detail about her is that she has an older sister who begins exactly the same delirium. Lise recognizes it perfectly, she follows with grief the progress of her sister’s mental illness: “God, my sister is stupid to think the same foolishness as me.”

Nadia repeats continuously in the middle of her greatest agitations: “I find these ideas ridiculous, I despise them myself, I would so much like to be apart from these small miseries that torment me so much, I could, therefore, never echo these ideas which I detest, it is my destiny that wants it so. It is even more sad to know what all these beautiful ideas are worth and not be able to rid myself of them, while recognizing how very foolish they are.” Jean cannot help thinking that he is ridiculous: “the odiousness, the absurdity, the ridiculousness of an illness like that one,” he often says, “is unspeakable.” “The second man who is in me,” says Rk...., “makes terrible fun of me and of my foolishness.”

After these findings, it is, however, necessary to make reservations that are not always sufficiently made when one speaks about the awareness of these obsessions. You should not go to the point of saying that these patients in no way believe in the reality of their obsessions. If that was so, they would have no suffering, no illness.

When on a particular point, one can bring them to better understand the absurdity of their idea, they are, for more or less of a time, cleared out. For instance, I explain to Lise, with great difficulty, that children are not responsible for the errors of their parents, she ends up acknowledging that she understands and that I am right; following this demonstration, for several months, she abandons the idea of dedicating her children to the devil. This happy effect of an explanation shows well that these patients did not have very clear thoughts on this point and that they granted a certain belief to their obsessions while seeming to turn them into ridiculousness.

Besides, with a little patience, one ends up making them confess this feeling. Lise perfectly acknowledges that there is in her
religious ideas about the devil a mysterious depth of absurdity that she does not understand well; she understands poorly what one says to her about the devil, or understands it for only an instant. Jean and Claire, themselves, are quite willing to declare that their illness is ridiculous, but they do not admit it if someone else says it about them. If one insists on the negation of their ideas, they turn to the affirmative side and begin again to present us from the beginning the actions and the hallucinatory images which were already described. It would be necessary, in this connection, to go back over all the positive characteristics of the obsession, because they show us that the absurd idea definitely has a certain reality, a certain potency in the patient’s mind and as a result that it does not exist without being accompanied by a certain belief.

How do they combine and juxtapose this criticism that seems to go right up to the lack of belief, up to denial and this tendency to action, to the representation that forms a belief? First, one can say that the two phenomena do not exist simultaneously. Belief would exist only for the periods of crisis and the criticism for the periods of lucidity. It is partly true and there are moments of crisis that we shall study more especially where belief is certainly greater. But I do not think that the difference between the crisis and the state of lucidity is ever resolved as it is with the hysterics. These patients never succeed either in absolutely believing or in absolutely repudiating their delirium. They remain in an intermediate state replete with contradictions: they recognize that their idea does not conform to general opinion and that they should not express it publicly in front of people “a bit aware of their situation,” they are quite willing to be sick up to a point but not about everything and most often they vacillate in accordance with the different moments of time.

They stay therefore in a state of extremely painful doubt, a type of which we find in the case of Je... This 51-year-old woman has a humble, anxious attitude and, however, is agitated. “I have not been able to do anything for three months, I have no interest in anything, I do not go out, I cannot get dressed, it is because of this unfortunate hat. I stole the hat from one of my neighbors... But,” she said, “no, I definitely know that I did not steal it, I am incapable... I believe I have not stolen it to keep it, but to throw it into the fire... But there is a grid around the stove and I
had no key to open it ... etc.” She remains in doubt indefinitely. This state of doubt, moreover, is linked very closely to the previously studied facts: the belief results from the fact that an entirely developed idea has reached action and perception, true belief makes action and makes one see. These two major characteristics of belief being absent, it is very natural that the subject does not succeed.

They wanted to make a special illness of this doubt under the name of delirium of doubt (Legrand du Saulle), then one made a special obsession (Arnaud). I think that doubt is not an obsession, it is a form which this or that obsession can assume. Je... has doubt about the stolen hat, as does Lise regarding devoting children to the devil, as does Claire regarding her immorality, as Jean doubts the meningitis that he had given himself by reading a newspaper column. It is a general form taken on by the obsession with incomplete development in the scrupulous.

This generalized doubt is more or less marked with some and can take more distinctive forms that constitute the others forms of scruple.

5. - Incomplete development of the obsessive idea.

I have just studied four characteristics of the scrupulous obsession: the length and the easy reproduction of the idea, the tendency to action, the tendency to hallucinatory perception, the belief, because these characteristics determine the importance and the role of the ideas and indicate the degree of their development.

One easily understands the meaning of these characteristics by studying hypnotic suggestions or certain fixed ideas of the hysterics. To show it, I shall recall in a few words a remarkable case upon which I have already dwelt at length. For twenty years, Justine is obsessed by the idea of an illness, cholera. She only has to think of an illness, to see a hospital, to smell the smell of carbolic acid so that her mind is invaded by this idea. She then lets out screams of dread, her legs spasm,
she vomits and voids her urine and stool. At the same time, she hears the tolling of bells, hears voices shouting “cholera, cholera,” sees corpses of cholera victims, smells their odor, etc.; she is convinced that she is suffering from cholera, she even has it in reality as much as that is possible.

To this old example, I would like to add a similar fact equally characteristic. Lee..., a 25-year-old young woman, already gravely ill with hysteria, who has had attacks and chorea by way of simulating St. Vitus’ dance,xxiii one day discovered her lover was unfaithful to her with a girl whom she knew well. From there, she developed a fierce jealousy and an obsession of revenge: she constantly thinks about this revenge, she imagines all events beforehand; she wants to kill her rival in the arms of the guilty lover and, to avoid the consequences, she wants to kill herself. This idea grows, becomes more and more definite, so much so that one day Lee... a revolver in hand, lays in ambush in a window and when she sees her rival passing in a car near her lover, she fires two shots at them, she runs away and goes to throw herself into the river. These very real acts happily had no serious consequence: nobody was hit and Lee... was withdrawn from the river and simply fainted. As they recognized her condition, they contented themselves with transporting her to Salpêtrière in the service of Mr. Raymond. There she presents ever since the mishap: regarding the slightest thing, because she looks into the courtyard, because she sees a patient talking to a man, because one pronounces a word in front of her, it is here is that she becomes disturbed, she stops speaking and keeps her eyes fixed. She goes to a cupboard and seems to take out an object that she keeps in her right hand; she approaches the window, looks into the courtyard with an air of rage; she extends her right arm, she seems to discharge a revolver with a scream, then she runs across the room, she ends up by throwing herself to the floor and remains there in a faint. In brief, she replays anew, but this time without external reality, the scene of the murder and suicide. Numerous hallucinations simply replaced the absent perceptions because the circumstances changed.

In these observations, one can note, among other important facts, the following characteristics: 1° for a long period, more than twenty years with Justine, the idea suddenly reappears regarding
certain associations of ideas, as if one released a spring mechanism that works without any effort by the subject. 2° The transition from idea to action is surprisingly fast and complete. The movements and actions in connection with the fixed idea are executed immediately and as fully as possible, given the circumstances. 3° There is also the equally rapid and complete passage of the idea to the hallucination that pervades all the senses and presents with the greatest degree of complexity and reality. 4° The subject, at least for a specified period, is absolutely convinced of the reality of his obsession.

I have often tried to summarize the essential characteristics of hysterical suggestion by the notion of the development of ideas. An idea, in effect, can be considered as a group, a system of images borrowed from the various senses, each with special properties and variously coordinated with each other. The thought of a bouquet of roses or the thought of a cat, even the thought of committing assassination or of giving her children to the devil is always at the root of such a more or less complicated system. What gives the ideas very particular and distinct aspects is the degree of development that this system can introduce. Most often, these systems are reproduced in our minds in a completely special or abridged manner; for example, the audio or kinesthetic image of the word ‘flower’ or the word ‘cat’ will reproduce only itself or nearly so and will suffice to represent the whole complex system of which it is only a small element. The effort of the thought consists, in this case, not in developing the idea of the flower or the idea of the cat, but to adapt, to rapidly coordinate this image with the new and current sensations so as to form and to develop it throughout the other systems of images, of which the former is only a component.

Rather, an idea can be developed completely when the entire system of images that it potentially incorporates is fully realized, so that the various images appear simultaneously or one after the other while retaining their coordination. In effect, these images are linked to each other so that the presence of one of them

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63 Automatisme psychologique, 1889, p. 200. Accidents mentaux des hystériques, 1893, p. 23 ; Névroses et Idées Fixes, 1898, 1, 162.
is sufficient to evoke the others in a predetermined order. Each image carries with it psychological or physiological consequences that depend on it, one determines muscle movements, another the movements of the sensory organs, others the vascular modifications and states of emotion. It is easy to note that all the ideas that reach this second form full of development completely pervade the subject’s mind and are accompanied by a deep, firm belief. Contrariwise, the ideas that stay in the first form are vague, they occupy only a small part of the mind and cannot be accompanied by any belief.

One sees very well through the experiments of suggestion, the gradual passage of the first form into the second when in the subject’s mind the idea develops, that is to say, unfolds all the elements that it implicitly contained thanks to earlier training and tends more and more to complete itself. The subject moves from the abstract idea to the concrete idea that seems more real, which he grants more and more belief.

In describing how the idea of cholera arose in Justine’s obsession, I was able to show it was due to the perfect development of all the elements contained in this idea that she could take this great strength of conviction and transform it into an undeniable reality. In short, all these earlier, briefly summarized studies lead us to believe that firm belief is related to the development that the ideas currently acquire and that, on the contrary, the lack of belief is related to a quite incomplete development of these ideas.

Without completely discussing the question of the nature of belief, we cannot apply the results of these earlier studies to our scrupulous patients, nor can we suspect that their obsessions would lead to conviction because these ideas are very incompletely developed. It is this key difference, well known for a long time, that gave rise to the important differentiation between fixed ideas absolutely accepted by the patient and obsessions which always remain incomplete and that do not induce firm belief.
The study we have just finished does not show us that, from this point of view, the obsession of the scrupulous does not present in the same form as that of the hysteric. The emergence of the idea is much less clear: the association of ideas that bring it about is much broader and more vague. It is not due to the automatic triggering of a spring, but to a search by the subject. The execution is very far from complete and the actions, when they do exist, are only sketched. The hallucination only resembles one and the representation is not complete enough to take on the character of external reality. We can briefly summarize these characteristics. The obsession of the scrupulous is characterized by a very incomplete development of the elements contained in the idea and it differs on this point from hysterical suggestion and the fixed idea where this development is as complete as possible.

It follows that, on this point, the scrupulous’ obsession comes closer to normal ideas also characterized by an incomplete development. Without doubt, we have observed that there is more duration, greater ease of evocation, a greater tendency to action and to perception than in average, normal ideas, especially if one takes into account the content of these ideas and the lack of importance attached to them by a normal person. The degree of development is, therefore, greater than in normal life, it may vary according to circumstances, but it is still intermediate between weak normal development and the full development of hysterical suggestions, without ever arriving at either one or the other end. The most abnormal fact from this point of view is, as we have noted, the duration and frequency of such ideas rather than their general development.

It is nonetheless true that, after this review, we cannot help noting that in their strength, their degree of development, their positive elements, these obsessions do not differ greatly from normal thoughts and one remains astonished by the trouble that they bring to patients’ lives. To understand this disorder, it is therefore necessary to examine these patients from still other points of view, to search for other symptoms that accompany their obsessive ideas and to see if these new symptoms do not give the obsession its pathological character and its essential purpose.
CHAPTER II

THE FORCED AGITATIONS

The obsessions strictly speaking, that is to say, the ideas in the subject’s mind representing events, objects and especially actions in general, did not have a sufficient development to explain the illness. There are, of course, other pathological phenomena that add to the obsession and that determine its painful and pathological character. We note that when the same patients are tormented by another group of symptoms, one should not confuse that with obsession itself. They complain that without imagining a specific idea, they are, however, forced to think in an excessive way, that the mind works against their will, that they are forced to perform useless movements and to move without any need; finally, they feel violent, irresistible emotions without these being sufficiently justified by the present circumstances. These very diverse operations sometimes seem to be completed in relation to the obsessions, but they often exist without being linked to an obsession, in other words, to a very specific general idea; they constitute another group of symptoms that are simpler than the first ones. In addition to obsessive thoughts (Zwangsvorstellungen), as rightly said by the German author Mr. Thomsen, there are obsessive processes (Zwangsvorgänge)\textsuperscript{64} whose framework is much broader.

These obsessive processes have an essential characteristic, at least apparently so, to develop in an almost overpowering way, without the express consent of the patient. Although this characteristic will be examined and discussed, one can first admit

\textsuperscript{64}Thomsen (Bonn). Contribution a l’étude clinique des idées obsédantes. \textit{Arch. f. Psychiatr. and Nervenkrankh.}, XXVII, 1895.
the importance of this appearance and consider it in the designation of this group of phenomena. I am very embarrassed to adopt a general term for all these phenomena of mental mania, of mental rumination, tics, motor agitations, phobias, anxiety, and nevertheless I believe it essential to unite them in a unique group. Mr. J. Donath, of Budapest, faced with the same difficulty, suggested the word “anancasmes” (to force). The word is not without interest, but it is so strange and so infrequently used that I hesitate to adopt it for the title of this chapter. The Germans have the rather happy expressions, “Zwangsprocessus, Zwangsvorgänge”: I content myself to translating them while, nevertheless, adding a detail. These forced operations are not normal operations; they are operations of thought, action, emotion that are at the same time extreme, sterile and of lower order. At the end of this chapter, when we shall know these operations better, we shall see how these characteristics are important. It seems to me, that the word “agitation” unites these various characteristics: so, for want of anything better, I shall unite this second group of symptoms under the name of “the forced agitations.”

The forced agitations can be divided into three groups depending on whether it is especially a matter of thoughts, of movements or of emotional phenomena, while noticing that in every group the agitation can present itself in a systematic manner or in a diffuse manner. One can, therefore, at the beginning of this study and, in a completely brief manner, classify these forced agitations according to the following table whose titles will be justified later.

In the final section, we shall combine the common characteristics in these different groups.

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The most notable of the agitations, those which have the closest relationship with the obsessions, are the mental agitations, the intellectual operations, reflections, comparisons, searches that develop rapidly and last for hours in the subject’s mind or that seem to be imposed on him in an irresistible way. When these agitations of thought are systematic they constitute the intellectualistics of which Azam spoke, the psychological stigmata, as Grasset called them or simply the mental manias, following the common expression that seems to me sufficiently clear. It may be noted that these operations almost always deserve the name of mental mania of the scruple, for it is always a matter of interminable intellectual operations regarding very small things that occupy in the subject’s mind a completely disproportional place compared to their real importance.

When these forced agitations of thought are diffuse, they form the known phenomena under the name of flight of ideas, of mentism, of mental rumination.

1. — The mental manias of oscillation.

The first and the most typical of these manias, those that lack belief, which is characteristic of obsessions, are the manias of oscillation. The mind does not arrive at a
complete conviction, at a unique decision, but continues to oscillate indefinitely between two terms. This state of doubt, that Montaigne called a soft pillow for a good mind, becomes for the heads of our patients an instrument of torture. If mania concerns ideas, then the representations take the form of mania of doubt or questioning; if it relates to actions, then it becomes the mania of deliberation or hesitation.

1. — The mania of questioning.

Many patients question themselves about their sensations: Nadia looks at herself in the mirror and wonders if she is pale or not, if she is as pale as yesterday. Vi... trying the soup wonders whether or not it tastes of poison. “I doubt the evidence,” said Za... “When I do something, I will start it again twenty times and the twentieth time I won’t be sure I did it and of not having made a crime instead.”

They also wonder about their sentiments, Fa... (169), who has criminal obsessions and impulses to deceive her husband, wonders if she finds other men better than her husband or vice versa, and Re... (140) eternally seeks to see whether or not she loves her fiancé.

Naturally, the questions focus more often on memories. Lise, did she dedicate her child to the devil? It would be essential to know: certain circumstances compel her to believe yes, certain others to think no. As soon as she is inclined to one opinion, the others present themselves with more force and the swaying continues for hours about these memories. Bor..., did she say blasphemies in church? It is neither yes nor no: she never decides. Lod... does she have bad thoughts, yes or no? It is impossible for her to know. “I think I am murderer,” says Za..., “a poisoner, the worst of the criminals and I spend my days and nights proving to myself that it is not possible, the sensible person in me repeats that it is the height of absurdity, and, however, I am calmed only for a moment and I come to no longer knowing whether or not I committed this crime.” Zo... investigates if she put pins in people’s backs and scrutinizes every movement she made.
We... tries to remember if she made religious vows, Bor..., if during communion, she pushed her neighbor’s elbow, Je..., if she took a stamp two years ago. “I definitely remember entering the room where the stamp was, but I do not remember the position that I kept my hands in and that is what is necessary to remember.” It is always the essential moment that is forgotten and it is necessary to search for it while moaning.

We will rediscover this very important searching again in other, more complete, mental manias. Here we note only the indecision, the doubt and the mania of the oscillation between two solutions.

2. — The manias of hesitation, of deliberation.

When the doubt concerns actions, it takes the aspect of a hesitation, of a never-ending deliberation.

Tr... (118), a young girl of 26 years, presented at the beginning of her illness, around the age of 20 years, with a very curious oscillation mania by way of her neatness. Her trade consisted in making flowers in porcelain, she had to make a petal in pre-made paste and to produce with her finger a curvature, an elegant embossing. For a long time, she successfully and rapidly did this work. They saw that she worked more and more slowly, that she could no longer finish a petal. When making the curvature in the dough, she thought about a possible form, then about another that might be more elegant, she came back to the first form, then to the second and so on for eternity without managing to finish a petal.

Loy..., aged 56 years, must relinquish his position as a notary, because he failed to sign a deed. Every signature that he must make suggests the idea of a dishonesty that he could accomplish, he questions whether he can go ahead and carry out the dishonest act, if he should not let himself do it, if he must believe that the act is insignificant, if he has to consult before signing, etc., etc.

Nadia does not want to eat for fear of getting fat and not being loved any more, on the other hand, she admitted to her mother that the idea was absurd, and she promised to eat. She therefore made two promises: one to herself, the other one to her mother: which one should she keep? If she eats, she will be ashamed of not having had the strength,
she will indeed deserve to get fat; if she does not eat, she will have remorse about having broken her word to her mother... and her hesitancy will continue for eternity. “Is it necessary for her to decide to go out, Lise wonders in the same way, and thereby run the risk of giving her children’s souls to the devil or should she stay at home and forgo a worthwhile outing.”

Jean presents the most curious examples of these interminable deliberations, because to him both sides of the deliberation seem to be personified by two women who are the main object of his obsessions. Should he, yes or no, board a trolley car? If he does, being near women will bring back the obsession of Charlotte. The thought of Charlotte will lead to flowing in all his limbs, to temptations of masturbation, to tension of his organs, etc. If he does not get on the trolley car and if he takes a hackney cab, can he avoid all that and feel at peace? By no means: he will have an obsession about the other person, that of the housemaid Elise, whose head will appear to him with a mocking expression. This head will start to laugh more and more, and seem to speak to him and to make fun of him. “You do not take the trolley car, you are going to pay a cab forty pence all because you are afraid of women, hi, hi, hi.” How to choose without falling from the frying pan and into the fire?

The same is true of all actions. If he plays the piano near his mother, Charlotte sends fluids and Elise makes fun of him: “You want to stop when the mother is there because she gives excitations, oh well, wait a minute, snap, crackle.” His trousers discomfort him, Charlotte gives him the idea of removing the zipper “so that the organs are more comfortable;” but Elise is taken by crazy laughter at the thought of the ripped trousers. Between the two, Jean no longer knows what to do. “I cannot make decisions, I see consequences on either side, I am like the donkey between two boxes of hay: that one I make white, this one I make black, I shall always have my small measurements of phenomena.”

This is a general hesitancy in his thoughts and it leads to hypochondriacal thoughts as well as to thoughts about sexual sins. Thus, he absolutely wants to follow a hydropathic treatment and I recommend that he take showers. Here are some of his thoughts on this subject: “Without doubt, the shower has its advantages, it is a tonic for the nervous system, but it is stimulating, it gives me excitements. After
a shower, I must continuously wiggle my fingers and, so that no one sees it, I move them behind my back, like this... This movement is irritating, it is dangerous, because it could excite my organs... Lukewarm baths, which my old doctor recommended, would be better. Yes, but the bath is flattening; it stupefies me, takes away my energy and any ability to be industrious, it could make fall to me into a torpor... It is true that the shower has a big advantage on this point, it is invigorating and comforting, I shall not take it cold or hot, but lukewarm, at 28°, it will be necessary to take precautions not to aim the spray on the spinal column and to go up each side... Yes, but I have already tried it that way, it is still really stimulating and it could bring back the fluids and temptations... This danger is the biggest on the whole, a lukewarm bath is better, an alkaline bath, I was told that it was comforting; only after baths of this type it is necessary to abandon any activity and me who is already upset to not have a job, no occupation... A shower, of course, would be better to pull me out of there...” If one does not interrupt him, he will go on for several hours.

One understands how much this hesitation will disrupt action. But we will see with the scrupulous many other disruptions of action, that will bring us, little by little, to examine if this disturbance of voluntary action is not the most important fact of the illness.

3. — The manias of the omen or the questioning of fate.

Next to the mania of interrogation, it is necessary to put a phenomenon that for me seems similar, the mania of questioning fate or the mania of omens. The patient cannot come to the solution of the question that is posed if he cannot cut through his hesitation about an action, searching everywhere for reasons that weigh on one side or the other; he defers to some outside affirmation. But he needs an outside affirmation that he cannot discuss, a mysterious and incomprehensible affirmation, as he seeks to obtain the decision of fate. Much like when we hesitate between two actions that seem equal or at least when we do not have sufficient energy to recognize which is best, we play heads or tails.
Here are some examples of this frequent and strange mania: Vy... worries whether she believes in God or if she does not believe and she repeats the following sentence: “If while walking down the street I can avoid crossing through the shade from the trees, then I believe in God; if I do cross through a shadow, then I do not believe.” One finds On..., his forehead heavily pressed on a window-pane. Here is what he thinks: “If the pane does not break when I press, then I am not sacrilegious; if it breaks, I am,” and in fact, he presses not very strongly. “If I do not break this glass that I squeeze,” says Lise, “then I did not devote my children to the devil.” “If I walk right-footed,” says Bor. “then I thought poorly of God.” “If I do my hair in such a manner,” says Vi., “then I will break my son’s leg.” “If the good God,” says Ger..., “sends me ideas to free the dead in the cemeteries, then my granddaughter will be malicious... If I go three consecutive Sundays to mass without intermediate celebrations, then God wants to save me, etc...”

Things get complicated when it is difficult to notice the phenomenon that serve as an omen, because then the doubt begins again and this gives rise to a new examination. So, We ... wondered whether she should, yes or no, become a nun. She concludes, in her wisdom, that if God wills her to be religious, then she will see signs in heaven, that is to say, crosses and figures of saints, and here her nose is in the air to watch the sky and asks herself if she sees crucifixes and images of saints. This problem becomes a whole new delirium with doubts, questionings, perpetual examination of the sky; and what is most unhappy, uncertainty of the memories. Today, she sees no crucifix, no saints in heaven, but she did she see it yesterday? It is necessary to examine how she used the moments of the day and it is there that she is seized by an anxiety. Because deep down she does not want to be religious, she does not see omens and she has a fear of seeing them.

This way of deferring to fate to decide for us is very characteristic and one finds it in many old observations. The English mystic Bunyan interrogates himself while walking along a road and wonders if he has or has not rescued his faith. The tempter suggests to him the idea that he can decide by checking if his prayers, yes or no, can do miracles. So in a prayer, he asks God to change the
puddles of water into dry places and piles of dry dust into mud and then he checks it. The idea comes to him that if he does this check and it is not achieved, then he will believe that he is damned. “If so, I will not test again, I want to wait a little to do it.”

J.-J. Rousseau, who in many ways, was an ill man very similar to those that I study here; he noted in his *Confessions* that he felt compelled to solve intractable questions through a similar process. “The fear of hell still often agitated me, I asked myself: in what state am I? If I died instantly, would I be damned?... Always afraid, and floating in this cruel uncertainty I had, for escape, recourse to the most ridiculous expedients and for which I would gladly confine a man if he sent me to do as much... I decided to make a kind of forecast to calm my anxiety. I said to myself: I will throw this stone against the tree that is near me; if I hit it, a sign of salvation, if I miss, a sign of damnation. While saying so, I throw my stone with a trembling hand and with a horrible beating of the heart, but fortunately it is going to hit right in the middle of the tree; which really was not difficult, because I had taken care to choose one that was very large and very close. Since then, I have no more doubt of my salvation.” Rousseau says he reassured himself on his salvation by the single fortunate experience, it is that he was not ill at this time. Our patients are not so easily satisfied, and we see that for them the search for omens develops into a real mania, as endless as the mania of the questionings, from which it appears to me to derive. Mr. Van Eeden describes an interesting variety of mental manias under the name of the mania of superstition. His patient attaches a prophetic meaning to insignificant facts: a necktie of such a color promises him happiness or misfortune, a post that he does or does not touch with his cane decides his fate. This is not a special and rare disease, as the author seems to think: it is a quite common form of the mania of questioning.

These first phenomena, the mania of doubt, of

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deliberation, of questioning, of omens link themselves together, as one sees, closely. They can form a first group where the characteristic trait is the oscillation of the mind. There is a swaying between two ideas, the yes and the no, and the mind does not come to settle itself once and for all on either the one or on the other. He vigorously searches for the reasons for or against and he does not arrive at satisfying himself despite the questioning of omens.

2. — The manias of the beyond.

The always unsettled mind nevertheless cannot oscillate indefinitely between two opposed terms. It suffices to surpass the given term, to replace it with something else, to simply go beyond. This is the characteristic that I find in a multitude of manias, of which I can only report the principal ones.

1. — The manias of precision.

The patient who cannot arrive at certainty needs to reassure himself by surrounding his actions and his thoughts with all that can specify them, materialize them somehow. Legrand du Saulle has already remarked: “under the influence of compulsive habits of masturbation,” he says, “the patient had a sort of sickly precision, of exaggerated attention, originating from a certain lack of confidence in himself.”

We find this need in many of our patients. Jean is made quite desperate by my writing a prescription for showers, he says that he wants it to indicate the exact temperature, the pressure figures, the number of seconds, the place on the back, where the first jet should strike, the line that the jet should draw on the body making detours to avoid certain points, the place on the back where it must finish, etc.: it must terrify the shower attendant. It is necessary to do everything at his time, and he would have terrible remorse if he read an old newspaper “this is chaos, it is not at this time that it should be read.” Wo... exhausts herself taking meticulous notes on all the books.

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71 Legrand du Saulle, Folie du doute, p. 17.
she reads, to keep a log of all the incidents of the day, to write down everything with precision.

I previously reported about the internal speech of patient F... who had the strange habit of repeating internally the names of the objects that she saw: “it is pavement, it is a tree, it is a pile of garbage.” I did not realize at the time the reason for this need. In reality, she was a scrupulous, who feared hurting people while passing near to them; she went back to see if she had not hit the horses; who questioned herself indefinitely to know whether she had paid, etc. This perpetual naming of objects was with her in connection with a mania of precision.

Others will have the mania of checking, which differs little from the previous one. R.... identical on this point to a patient of Mr. Arnaud, constantly feels her clothing and especially her pockets “to check if everything is in its proper place, if she is neatly dressed, if she has lost any small object.” Ser... constantly touches her ears “to see if she always has her earrings;” one will see that this mania is often the origin of tics. It is pointless to recall the well-known patients who perpetually check if the door is closed, if the gas is off, if the letter is in the box, etc.

The same mania of precision links itself with the mania of the fixity of ideas that was already described in relation to the form of obsessions.

It is necessary to put the manias of order in a neighboring group. One often sees the illness of the scruple starting in children as with Ser..., with Lise’s children, by the mania to fold the dresses exactly in the same creases, to put their clothes in order when going to bed at night, to put order into their armoires in a completely exaggerated and ridiculous manner. Later, the mania becomes serious, Lkb..., a 22 year old woman, can suffer no person, not even her husband, to enter into her room: “I am too much afraid that they will disarrange my affairs, if someone unsettled a hairpin in my home, that would make me terribly sick.” Vk..., a 58-year-old woman, exhausts herself for 20 years to put order in her household, she refuses to eat and to sleep “before she puts in order everything” and she cannot

72 Névroses et Idées fixes, I, p. 23.
achieve that “because she wants perfection and she gets overwhelmed.” Qsa... always feels the need to arrange “his belongings, his papers, it is for him a perpetual need for simplification.”

Claire puts order not only in her objects but also in her ideas. She must think of the same thing at the same hour, at the same place. She must not think more one day than another, it is especially necessary that she recounts events in a determined order. No one will get her to tell right away what she experienced yesterday: it is necessary for her to take things back to the start and to recite in chronological order what she has felt for ten years before arriving to the previous day.

Let us put in comparison the mania of symmetry, of which Mr. Azam gives us an example: “it is always necessary for her to line up objects, half to her right, half to her left... If she steps on a little protruding stone, she feels forced to search the other foot for an analogous sensation. When she has placed a hand on some marble or on any other cold object she is forced to inflict a similar impression to the other symmetrical body part.”

Jean has similar needs: if while looking up he noticed a red object to his right, he then has to look away and look to fix his gaze upon a red object set to the left. Mr. Flournoy, in his book on synesthesia, signals a typographical mania of symmetry: “words and names which are not composed of a uniform number of letters always made an unpleasant impression on me and caused real pains to my eyes. The titles of books, the names of magazines always give me, in this respect, a real job: I count the letters, and if they are not an even number, I cut the words in order to put an isolated letter in the middle of the others; so for the words Japan, alone, I write them in my thoughts this way: Ja-p-an, al-o-ne.”

One often notices the importance of contrast and contradiction with these patients, Mr. Raggi reported the observation

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73 Azam, Les toqués. Revue scientifique, 1891, i, 618.

74 Flournoy, Les synopsies, 1892, p. 221.

75 Raggi, Archivio italiano per la malattie nervose, 1887.
of a young man of twenty years who, at times, could not open his mouth without being forced to make the most absurd reasonings and often even to say the opposite of what he would have wanted. Mr. Séglas, who cites this case, adds several observations of the same type. 76 “What is the most painful,” said his patient, “is that he comes, at times, to contradict himself and at the moment that he wants to express an idea, he says the opposite of what he wants.” Messrs. Pitres and Régis 77 give several examples of this curious phenomenon. “This is,” they say, “the blasphemous mania of Verga.” 76 In the prayer, one sees “cursed” instead of “blessed”, “hell” instead of “heaven,” “Wilde Sau (wild boar)” instead of “Liebe Frau (our Lady)” instead of “I have you at heart” she thinks “I have you at the ass” instead of “my God, I love only you” she thinks “I love that” and she believes she “sees a buttocks.” One easily observes similar facts: Bunyan thinks of worshipping a broom or garbage when he wants to pray to God, Claire, Vy... and many others think about masturbating when they want to prepare a confession and Qi..(113) feels forced to call the people that she respects the most “pigs.”

The authors who remind us of such facts readily attach them to some deep law of the mind. Mr. de Sanctis, in an interesting article, speaks about the association by contrast which he explains thusly: “A certain forced exercise of attention inhibits and moves away the image to which he applied himself and favors the opposition and the victory of the association by contrast.” 78 There is a lot of truth in this remark to which I shall return later, but one should not forget that the phenomena of contrast introduced by the scrupulous are not always primitive, spontaneous phenomena; these are desired phenomena, searched for by the patient, it is very often a mania of precision, of comparison, of extreme opposition that compels him to search for this term that makes for such a great contrast.

It is also in the same manner that I understand the associations of extravagant ideas that some patients present and that seem to play a huge role in the reproduction of the

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76 Séglas, Leçons cliniques sur les maladies nerveuses et mentales. 1895, p. 129.

77 Pitres et Régis, op. cit., p. 45.

obsessions. I have already often cited it in this respect, here is another one: Jean finds obscenity in the length of three-quarters of an hour; a visit of three-quarters would be indecent because he learned that a public figure remained three-quarters of an hour with a woman before dying. These are, in my opinion, mental manias of association and not genuinely ill-considered associations and these manias of association are consequences of the manias of precision.

The mania of cleanliness presents itself frequently, we will rediscover it in many cases, particularly regarding the phobias, but it is also related to this need to do the things with neatness, with precision. Vk... washes her hands endlessly without the specific fear of defilement, simply because “poorly washed hands, this is disorder.”

Micromania deserves attention: it is evident that many of these patients grant more importance to that which is small than to that which is big. Chu..., a woman of 36 years, anxiously searches for the “small crumbs of grease, crumbs of dirt” but does not take care of “big dirtinesses.” Bow... is afraid of “small noises,” not of the big ones. “A canon blow does not do anything to me, but I want to kill the people that chew, who pick their teeth, who cough...” Mr. Stadelmann of Wurzburg\textsuperscript{79} relates a nice observation of a man of 30 years, bothered since puberty by the preoccupation of what various insignificant objects will become in the future, a fly that flies, a lifeless match, the ash of the cigar, the spots of candle fallen to earth, etc. Mr. Farez also relates obsessions and disgust for very small objects, match tips, candle stains.\textsuperscript{80} It is needless to emphasize the importance that patients attach to the “little bugs.” Into this preoccupation with what is small enters, of course, the mania of attention and precision.


\textsuperscript{80} P. Farez, Cas de phobie consciente. Société d’hypnologie et de psychologie, 20 mars 1900.
2. — The arithmetical manias.

The mania of numbers, arithmomania, seems to us to deserve, because of its clinical importance and its frequency, to form a separate group, although it is in reality a variety of the preceding mania of precision: the need of precision makes the patients have passion for ideas that have the reputation of being particularly precise, mathematical ideas or rather the simplest ones of them, the numbers.

One notes first with them a predilection for all that expresses itself in figures. Jean seems to have an extraordinary memory for people’s ages, their date of birth, and the dates of all events of contemporary history and of his own history. He will never forget, as he tells you his history, to say to you the date of his first masturbation and the date of the last one, the date of the day when, for the first time, I forced him to urinate properly. They often cite the cases of the extraordinary memory of individuals who recite the certificates of birth and death of the madmen of the village or who recite the timetable of the railway. They are wrong, in my view, to consider only their memory and to represent them only as hypermnesic. If they pointed out that he is a scrupulous, who had the mania to direct all their attention to this point and that they learn, in reality, nothing else, then they would find this memory less marvelous.

In a second form, the patients attach a great importance to certain specific numbers: Lise gives her preference to the numbers 2, 3, 4, 375, that represent this or that of her obsessive ideas. Jean detests the numbers 6, 14, 20, uttered by Charlotte, 22, the date of the day when the chambermaid left her, 57, Charlotte’s age, 53, the date of her birth, etc.

The need to count has been reported for a long time. Mr. Ginestoux presented to the Bordeaux Society of Anatomy and Physiology, in 1897, a 27-year-old young man who, since age 10, counts all the letters contained in the sentences that he thinks of, that he says, that he writes or that he hears, without this prodigious job being, however, for him, one that discomforts or fatigues him.81

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81 Ginestoux, Revue scientifique, 1897, 1, 473.
the last point will be verified. One knows the famous patient of Legrand du Saule who, when going to the doctor, asked him for permission to count the buttons of his waistcoat first. Jean counts the number of letters in the alphabet that separate the different letters of a word: the word “mère” is for him 7, 12, 12; because between M and E there are 7 letters and 12 between R and E. Zo... feels obliged to count all the pins that are in the house to prove she did not put some in the soup.

Finally, in more complex cases the patients need to count up to specific numbers; Ser.. and E... demand that every question is repeated to them three times before they deign to answer. Mw..., a 28-year-old girl, counts despite herself the number of fingers with which she touches an object: for nothing in the world would she want to touch an object with 7 fingers at the same time, so as to avoid that she takes the resolution to touch everything with a single hand. Nothing works, she touched the object completely with three fingers and slightly with the fourth, this makes 3 and ½ fingers and she thinks out of necessity that if she had placed both hands, it would be 3 ½ x 2, that is to say 7. Jean counts a great number of things, the number of times that he swallows his saliva, the beatings of his heart; he counts by 4 and by multiples of 4, “one, two, three, four, it is necessary that I count them without that I would feel suffocated and I could not stop myself before four; five six, seven, you know that one cannot stop oneself at seven: eight, I was obliged to go even to eight. If the agitation was very strong, another series of four would be needed. Sometimes it is necessary to go until 32, 64.” I note in passing that this account of the beatings of the heart is completely imaginary: I once tried to count his pulse myself as he counted, in his fashion, his heartbeats, our accounts were absolutely discordant. He counts like this all sorts of strange actions that we will find regarding the struggle against the obsessions and regarding the mania of compensation. Another patient Vy... said to me naïvely that she needed to count to grab hold of something. I believe that this patient is right, the arithmomania is not a special obsession, an isolated obsession, it is a mental mania, a sort of pathological need of precision that can apply to all the obsessions, and even to ordinary ideas.
I designate by this word a tendency and a very curious need that seems to me not to have been sufficiently noticed: this is the need to translate sentiments and ideas into images, into delicate depictions. This need establishes itself first in the language of the patients. One is struck by the abuse that they do to the metaphors in order to express their condition. “I am a poor little bird without feathers... I am in the middle of a labyrinth with countless obscure corridors..., I am like a bag lying on the ground and humanity dances on top.” One should write up all their speeches to put this syndrome into evidence.

The symbol is found even more often in the images that the scrupulous present, images that give birth to the pseudo-hallucinations that we studied previously. One must have been astonished by the unique content of these pseudo-hallucinations. The ordinary hallucination reproduces a particularly impressive spectacle that deserves to remain in the memory; an hysterical has hallucinations of the head of his father on his death bed, another of the face of his lover that he kisses. Here we have reported about Voz... the hallucination of the wall at the school, of the four trees that surround him while he walks; about Rp... the hallucination of the silhouette of a man who passes. How have these banal images been able to attract enough attention to reproduce themselves in this way indefinitely? In reality, they are not simple memories, they are images that have a meaning, a signification and that signification is more important than the image itself: in short, they are symbols.

Rp..., who sees the director of the school crossing in front of him at five meters distance with a smiling or a wrathful face, is a scrupulous with the mania of omens. He told himself that his firm would succeed if he saw his director crossing in front of him with a smiling face. He is very soon going to cross-examine himself, as we know, and ask if the face was smiling or not, it doesn’t much matter. The essential thing to notice now is that this imaginary vision of the face of the director became a symbol that summarizes the good and bad omens. Voz..., this young man of 22 years, that has such curious pseudo-hallucinations of the wall, of the trees of the school, of chains that block his way, experiencing
to the supreme degree a very common feeling among the scrupulous and also among the persecuted, a passionate, haunting love of freedom with the impression that he is robbed of it. “I always sense like a limitation that constrains me, that stops me, I am obsessed by the thought of the constraint and of the limits to my action...” We shall have to study the genesis of this very frequent and so curious feeling; for the time being let us point out that it is well represented by the images that the patient sees, the wall of the high school, the trees of the courtyard between which he believes to walk continually, the ropes that bind him. Can one find a more perfect symbolic hallucination?

In other patients, we will find many other less gleaming examples: with Jean, the two images of women symbolize first, the one of Charlotte, temptation, the other, the one of the chambermaid who laughs, the conscience. With Claire, we already stressed the image of the masculine member and Host that symbolize the sacrilegious crime; with the same patient, the precipice represents the disease and its progress. The latter symbol is so natural that other people, in particular Lise, tell me they also have this feeling of descending and have need of making an effort not to imagine a tangible descent into a hole. The holy ones in the sky are, for We..., the symbol of religious life and the face of the child is, for Gisèle, the symbol of the conjugal duties.

Objects and not images can become the symbols. The false collar is for Vy... the symbol of discomfort and constraint, as the newspaper is, for Jean, the symbol of all the political and genital crimes. Hence came many terrors of these objects. This mania of the symbol is also found again in certain actions and in certain movements: to pivot on his heels, is for Lod... the symbol of religion “because one turns aside thusly to greet the altar when one passes in front. To close the fist, is as if one insulted God, to close a drawer abruptly, is to brush off God.” We shall see many examples of it in studying the tics. Let us point out only that the mania of cleanliness, that already was a consequence of the manias of precision, is often linked to the symbol. Rodenbach’s nun with scruples continuously dusts off her wimple to make the dust crumble away, a symbol of small
sins\textsuperscript{82} and Vk... washes her hands with white soap every time that she thought of lying.

This mania of the symbol plays a big role in the impulses and, if one misreads it, one exposes oneself to serious errors. We have seen that these patients have the beginnings of actions, to push his little girl with his finger, to drink a small purgative, to open a button of the fly, I have already cited too many examples to go back over. Others have only the kinesthetic image of a movement that begins. Several authors have seen here the explanation of the impulsive obsession: the feelings of these representations of movement, of these small beginning movements would give the patient the idea that he is compelled to accomplish something. It is sometimes so with the hysterics who have subconscious automatic acts, but it is not so with the scrupulous who also make these small actions, convenient symbols of the crime, to give themselves the illusion of being compelled to the crime and to be able to make themselves lament and guard against it.

This mania of the symbol seems me to play a very big role in the disease and when we discuss the origin of the obsessions themselves, we will see that many do nothing but symbolize a previously felt emotion. As for this mania itself, it seems to me to be related to the preceding phenomena, like arithmomania, it depends on the need to specify, to express with a clarity, in a material way, the feelings and ideas about which the patient never comes to have certainty.

4. — The mania of investigation. — The mania of the past, the mania of the future.

The mental work seems to me to complicate itself when it goes beyond the circumstances surrounding the present action and carries on to all others facts, particularly on past events.

To reply to the problem put by the original question “have they, yes or no, committed a reprehensible action?” the patients are brought to recall exactly the acts previously performed. For example, Ce... has suspicions on this or that action of the day, he stops himself and tries to remember exactly

\textsuperscript{82} Rodenbach, La sœur aux scrupules, p. 86.
the various actions that he made, the various phases through which each action has passed. He passes hours to check in his memory how he passed from one insignificant movement to another equally trivial one. If by misfortune in this review there is a moment the memory of which is not precise, here he is in the depths of despair. What has he done in that moment? It is there that he slips into obsession and he makes the greatest efforts of memory to convince himself that during this second, he did not accomplish some horror. It is the same for Dk...: “at which moment was he able to kill this woman? which method did he use? which is the instant of the day where he was not occupied with something else?” He uses hours in this research.

The indefinite investigation is one of Lise’s major characteristics, because, to her misfortune, she only asks herself these questions about a distant time where the meticulous checking of the timetable is horribly difficult. A year ago, on Friday evening of such and such a date, did she allow herself to devote her children to the devil? To find out, it is necessary to explore, if at that time, she desired something strongly enough to pray to the devil to grant it to her, if she yielded to the temptation to obtain what she desired by the sacrifice of the children, or if she knew to resist while saying the formula of exorcism: “No, no, 4, 3, 2.” Here is a small problem that is not easy to resolve: it is necessary to discover in minute detail the timetable in order to establish a sort of moral alibi. “It does not disappear for a minute from my mind. I feel that I search the whole time and these are hours of immobility in this stupid investigation.” Now, she researches like this all the promises that she made to God or to the devil, all the words that she said, all the signs that she made, to the point of absolutely panicking.

An interesting case of this mania to search for a memory is that of Bre... (141), a woman of 42 years; she lost her husband three years ago under conditions sufficient to cause emotional upset. Since that moment, she has the sentiment that she forgot her husband’s face. We will have to examine up to what point all this forgetfulness is real; for the moment we note that this supposed forgetfulness is the point of departure of a mania of investigation. She must succeed in visually imagining the face of her husband: to achieve this she uses some portraits, descriptions, memories of every sort, she works night and day and does not succeed in getting this portrayal enough to her liking. Then she gets provoked to search in the same
way for the memory of his voice, of his actions, etc. She believes she has forgotten all that concerns him, to have forgotten in the same manner all men’s faces and to no longer even to remember having been married and she exhausts herself to remember precisely all these memories.

It is this mania to search for memories that most often bears a relation to the manias that were described by Charcot and Magnan\(^8^3\) under the name of onomotomanias.\(^{xxviii}\) In the most remarkable case described by these authors, the patient searched all night for the name of a little girl whose story he had read in the newspaper; his state of crisis, caused by this mania of investigation, is dreadful all the way to the morning when he was able to find the name of Georgette in the newspaper.

We could cite several similar examples: Hg... (130), a woman of 50 years, was driven to the mania of investigation in a unique way: she was very annoyed because someone built a wall in front of her kitchen window and all day long she wondered what was happening behind this wall. The mania itself shifts little by little and now she notices a vague likeness about the face of a bystander and it is absolutely necessary that she finds the name of the person who displays this resemblance to the passer-by. Cha... (131), a 76-year-old man, is still at this age tormented by a similar mania. He chatted during the day with a person he knew in passing, he absolutely must remember the name and the address of this person, and he spends days and nights searching for this information in his memory. Also, as soon as he approaches us, he asks us to register our name and our address in an address book that he always has.

It is also to this mania that, in the past, it was necessary to associate all the various forms of the manias of recollection. Mr. Raymond described a curious case: “A man of 40 years, when he travels, always looks attentively at the places that come within his view; when he has traveled a certain area, he tries to recollect the appearance of the landscape he saw. If he cannot do that, he suffers so much that he often retakes the trip so as to fill in the gaps of his memory... Sometimes, he

\(^{8^3}\) Charcot et Magnan, Onomatomanie, Archives de neurologie, septembre 1885.
compromises with himself and sends a servant to verify certain features that remained uncertain in mind.”  

In the case of Mr. Löwenfeld,\(^8\) the mania of the past seems even more independent of the investigating and questioning. Since the age of 13 years, the patient complains “that the mind is invaded by obsessive memories of a photographic exactness...” It results in, says the author, “a remarkable deletion of the present moment, the patient lives more in the past than in the present.” This is a very important point, but it relates to an essential phenomenon that we must study later in isolation. In one of our patients, Cz..., a 33-year-old woman, we again find that mania of recollection without precise searching: “In the past,” she said, “I searched my memory to know if I had to criticize myself for something, to reassure myself about my conduct, but now it is not the same thing. I tell myself all the time what I did a week ago, two weeks ago, I come to see things exactly and I have no interest in seeing them again, it just annoys me, but it returns in spite of myself.”

To this mania of the past one can link certain manias of the conservation of objects, certain manias of collection. Several patients (Nadia, Lod..., etc.), carefully keep drawers full of small papers upon which are written their oaths, their promises or simply summaries of their life, others preserve envelopes, letters (Jean), cardboard boxes (U...), rags (Vk...), and do not want anything destroyed. Mr. S. de Sanctis:\(^9\) has described these manias of collection, but his study focuses on different patients than ours, affected by general paralysis or by various systematic deliria, only some of his examples compare with the cases that I study here.

In all the preceding cases, the mania compels the patients to transcend the present moment by investigating and the considering the past.

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\(^8\) F. Raymond, *Journal de médecine et de chirurgic pratiques*. 1899. p. 566.

\(^9\) Löwenfeld (Munich), *Psychiatrische Wochenschrift*, 10 juin 1899.

The investigation can also concern the future, the patients search for the distant consequences of their actions or simply try to imagine future events. Jean calls it his premonitions, he always imagines all that is going to happen in fifteen days, in a month and he plunges into this contemplation. Bab..., a 28-year-old woman, presents an illness of being curious about the future, obsessive imaginings, completely similar to the obsessive memories of Löwenfeld. In front of the cradle of her small daughter who is 18 months old, she searches for what dress she will put on at the child’s wedding “and this wedding ceremony bothers me enormously, it is necessary that I plan the whole ceremony, all the invitations, I search for how I shall be able to pay for the wedding dress, it is a true fatigue.” Lise always goes ahead of the present moment, repeating to herself what will happen when she finishes this job, when she will be old, when she has died. “I always arrive at the thought of death because it is the last word.” We shall rediscover this thought in the manias of the extreme.

5. — The manias of explanation.

The investigation can go beyond the facts of the past and those of future; one is able to be concerned with all scientific or philosophical problems. It is the search for the sake of the search, without immediate interest.

This form of mania is the most well known, it is often described under the name of the madness of questioning, metaphysical madness, etc. It is the Crübelsücht, the Fragetrieb of the German authors, it is one of the forms of the psychasthénie that was first described by Griesinger. One of his patients could not hear the word “beau” without asking himself, against his will, an inextricable and indeterminate series of questions on the most outlandish problems of aesthetics.

The word “être” threw him into a series of metaphysical discussions. “I ruin my health,” he said, “by thinking continuously of problems that reason will never be able to solve and, despite the most energetic efforts of my will, makes me tired without respite. The flow of these ideas is uninterrupted... This metaphysical reflection is too uninterrupted to be natural..., every time that these ideas return, I try to dispel them and I exhort myself to follow the natural way of
thinking, not to confuse my mind with abstract and insolvable matters and, nevertheless, I cannot escape from the continuous impulsion that hammers my mind.” Since this work by Griesinger, this mental mania has been described very often. The obsession may take the form of a question, said Mr. Saury: “Why are colors unevenly distributed, the green trees, the red pants, mourning in black? Why are men not bigger?” An observation by Mr. Ladame is quite remarkable: it is about a woman who since childhood presented herself with all sorts of unanswerable questions of which she in vain sought the answers in a way that disrupted all of her activities. These are questions relating to the creation (Schöpfungsfragen). “Is it that the world was able to make itself all by itself? Can we divide an object into infinitely small parts? How does the soul go out of the body, etc?”

I was able to observe with many subjects all the degrees of these investigations, from the most unassuming questions on one’s clothing, up to the greatest metaphysical problems. Elg..., a 19-year-old young woman, asks herself about the clothing worn by the person she is looking at: “Why does one wear an apron? Why do they put on a dress? Why don’t men have dresses?” and when she is engrossed in these questions she can neither listen nor answer. A 37-year-old man, Qs..., questions himself about the manufacture of objects, “how can they make a house? a gas street lamp?” He tries to stop himself by murmuring: “Let’s not get carried away, do not think of it,” but he comes back to question: “How can they make gas burn? How can the air set fire to itself and give light?” Rost... limits himself to searching for “the definition of violet.” Za... questions herself about problems of morality: “What is a bad thought? Did I have one with or without my consent? Because everything is there, but what is a consent?” Za..., for three years, remained meditating on the word “to consent” without reaching a solution.

Nem..., after having experienced a sense of astonishment in seeing an individual who seemed odd to him, finds it very amazing and questions himself about everything. “How is it that there is thunder, that there

87 Saury, Folie des dégénérés, p. 63.

88 Ladame, Ann. méd, psych., 1890, II, 384.
are flashes of lightning, that there is a sun, that it becomes day or night? If we had no rivers and no water, what would we do for drinking, washing? And if we did not have eyes, how would we see?"

 Nb... regarding the criticism of the senses and of the intelligence asks herself a lot of philosophical problems: not only, as we have seen, does she ask about the direct or indirect character of sensible perception, but she also tries to understand the nature of understanding, the meaning of speech or writing. “How is it that small black points on paper can contain a thought? How do words come in my mouth at the same time as I think? Is it, therefore, an indication of thought? I get lost in here... How does the word, which is a noise, transport the thought which is not a material thing? Ah, if I could forget all this?... How is it that I understand a person apart from myself? How is it that that I love my daughter who is outside of me?”

It is curious to notice that these speculations present themselves not only with intelligent and cultivated people, they are found again almost identically in common women absolutely without education. Nadia, who is a very educated woman and who reads a lot, wonders “about religion, about future life, about the mysteries of the soul... what will become of my soul, what will become of the soul of the world?” That seems rather natural. But Hm..., a woman of 21 years, a domestic in the countryside, who got used to the hard times of working on a farm, who barely knows how to read and who does not know how to write, is tormented after a delivery of the same ideas. “I am not able to know how it is that there is a world; why does it have trees, beasts, what is it that all this will become later when all will be finished?...” There is a need for speculation, of mental work, that carries itself out regardless of acquired knowledge and the capacities of the subject to discuss the problems that he puts to himself.

6. — *The manias of the precautions.*

The preceding investigations applied especially to the ideas, we will find them again in regard to the actions of the same type of manias that one also can consider as consequences of the
need for precision. One will notice in first place, the mania of precautions, that is to say the need to do many small incidental actions that are intended to make a principal action easier or to prevent an action that one dreads.

Zo..., who has the obsession with pins, looks away from cartons of milk, makes detours in the street in order not to pass in front of food merchants, she eats very slowly, endlessly divides her foods, etc. Dk... gets it into her head to write in a notebook all that she does during the course of the day in order not to forget anything. Cha..., who has the mania to search for the names and addresses of people who speak to him, never approaches you without asking you to immediately write your name and your address in a notebook that he always carries. Nadia takes all sorts of precautions in her diet, I have already spoken about it, she covers her face, orders that her chambermaid have a special demeanor when she passes in front of her, etc. The mania of precautions manifests itself in her letters overcrowded by underlined words and always ending with the expression: “Please, I beg you, have the kindness not to show this letter to anyone and to burn it.” Vob... does not fall asleep without sewing the bottom of her shirt underneath her feet, without attaching the sleeves of her shirt to the sheet with pins, in order to avoid masturbating during sleep.

Jean presents several strange actions related to his precautions: he walks very slowly, with small steps, he takes great precautions at the turns in the streets, for if he allowed himself a slightly abrupt movement, there would be a “psychological rubbing” of his genitals that would provoke masturbation and its terrible consequences. One day, but once only, he went to the point of unstitching his trousers and removing the lining “to clear out the space” he remained there one evening with his undone trousers without, moreover, being any more at ease. He always holds his legs very open when he is sitting, he arranges his shirt and his boxer shorts in a special way. He cannot cut his bread when he is standing, which causes the idea of getting nervous, he changes the place of his bed, etc., he has tricks to blow his nose “without shock”, he cuts down on the act of urinating and spreads out the urinations up to the point of losing the urine by regorgement, etc.

With Claire, it is necessary to note that this need of precautions causes an extraordinary and constant supervision of herself. It is
a constant effort to be on the alert; “I do not give myself a minute of liberty and I absorb all my strength in this supervision of myself.” The same night, she obliges herself to remain perfectly immobile in a specific position and she succeeds at the price of her whole body aching. The limbs are not allowed to go to rest, they are constantly half stiffened. We will discover the same symptom in Lise, in the great periods of self-surveillance, and we will have to study it again as one of the physical demonstrations of the state of anxiety.

To this mania one can relate the mania of slowness, so curious with Vk... This is not a natural slowness related to aboulia, it is a desired slowness, calculated in all the acts that appear to her to have some importance. She must take one-half hour to put on her petticoat and another half an hour to put on a dress, “if I go more quickly I am not sure that this is well done and the sight of hurried people who go quickly irritates me.”

Among the precautions taken by the patients, the simplest and the most banal of all are the precautions of cleanliness. As they are afraid of their hands making an act that they dread and, as we have seen, their fears are about small things; the best means to safeguard their hands is to wash them. As a result, a great number of these patients went through a period where they constantly washed their hands. It is useless to cite names here; we have about twenty patients that washed as continually. Others preoccupy themselves with the cleanliness of their clothing and spend their time brushing them, “for fear that a crumb of the Host did not fall on it,” or they wash the furniture, wiping it continuously for fear of dust, of microbes, of metallic bits.

Sometimes this mania of cleanliness is very far from allying itself with a real cleanliness. U... especially has hypochondriacal ideas and the fear of the phthisis microbe. She continually washes her hands, but she is afraid of touching any object in her room and she cannot tolerate anyone else to touch them. As a result, the room is never cleaned, the bed is never touched and this improbable garbage accumulates into a genuine manure. When I began treating this person,
I made her get a major haircut, change the foul mattress that was impossible to clean otherwise, and this strange result came from a mania of cleanliness.

Of course, the mania for cleanliness complicates previous doubts; having washed themselves, they doubt that they washed themselves and they begin washing themselves again. This mania joins those of the questionings and of the repetitions. “The doubt,” says Legrand du Saulle, “puts itself into the service of the delirium of contact and he wonders if he washed his hands well."89

7. — The manias of repetition and returning back.

Despite these efforts of precision and these precautions, the patients are always little satisfied by their action. They want to try to do things better, to satisfy themselves. In the simplest and the least delusional case, they quite simply start the act again, but they are not satisfied the second time anymore than by the first time and then they endlessly repeat: we come to the manias of repetition that are among the most frequent and the most important.

A young girl, Tr..., who we have already seen hesitating to give final form to a rose petal, comes to not being able to make any movement without starting it again several times: she gets up from her chair and does not leave, but sits down again and begins again to get up; she takes a glass then puts it down again, picks it up again, puts it down again and continues this merry-go-round indefinitely. Ce..., to be sure that the door is closed well, reopens it and closes it about ten times in succession. This symptom of shutting the door several times in succession or the gas lamp several times is completely banal, it begins even in almost healthy individual’s in periods of weakness and distraction. But Ce... goes further, because he starts again and again for eternity, so much that he cannot get to his work. “A man of sound mind and in good health,” said Ball, “is obliged to abandon reading because as soon as he turns a page over, he believes he skipped one and begins again once more without being able to move forward.”90

In certain cases, it is particular acts that the patients


90 Ball, Frontières de la folie, Revue scientifique, 1883, l, p. 3.
eternally start over while they do not hesitate about the others. Vor... (137), when she urinates, feels a discontent that I have already reported, so she immediately goes back to the bathroom, she comes out again “not being sure of having evacuated the last drops.” She goes back to the bathroom like this sixty times before going to bed and she stops only when completely exhausted by fatigue. One of our patients, Rk..., repeats every sentence that he reads, every sentence that he says or he must repeat every sentence that one says in front of him: “My God,” he thinks, “here is another sentence which goes on into eternity and I definitely do not understand it.”

Others, in order not to start over again indefinitely, set themselves a limit, a set number of times. We rediscover here this love for numbers, whose apparent precision delights them and they will begin the act again four times, ten times, hoping thereby to be sure that it will be done well. Nadia wants to do every action six times, Ser... limits himself to three times, Jean to four times or to a multiple of four. Nothing works unfortunately, for they are now no longer sure of having counted well: to be satisfied, it is not necessary for them begin the act again but the series of actions. A poor woman, to reassure herself, wants to recite the rosary ten times, then she begins it again because she believes that it is lacking, also she does it ten times for four hours from morning until noon.

A curious form of this need to begin again, a form that gives rise to many errors, is the need to return back. To start an action again you should not move away from the surroundings where it must be done, you should not leave too quickly from the circumstances under which the act must take place. These patients, therefore, do not want to move. This hatred of change, fundamental among them, in consequence of their abulia is strengthened here by the wish to be in a position to start again their thoughts, feelings, actions under the same conditions where they were already fulfilled. They search, therefore, like Claire, to return back, to repeat the same thought at the same hour, at the same place. They fear that they move in spite of themselves and too fast. As soon as Claire is in Paris, she wants to leave again to the countryside “as it seems to me,” she says, “that I never did what I had done, I also think that I am not at the place that would be necessary, that I should go back to the previous place.”
One understands what terrible unrest is brought by travelling on railroads that rapidly carry one far away from the previous place. It puts this girl in despair, she would like to come back, to her starting point, at least to the previous station.

This idea is very frequent. Mr. Ameline reported at the last congress of psychology on a young person from the service of Mr. Magnan who did not like, on the railroad, to see houses staying behind as the train advanced. “The impression of the soil that runs away under my steps leaves me an emptiness and while I realize that that I must continue my journey, I feel hesitancy to continue toward my goal. When I arrived, it seems to me that I was too fast; I must go back to my departure point. When instead of making a journey on foot, I made it by car, I feel the same emptiness in seeing the houses and fleeing everything on the way and if I was not in a car, it seems to me that I would stop.”

One finds this returning back with Fé..., with Byl..., who always believes that she “leaves a space behind her by passing too quickly.” I think that this mania to go back to the same place and at the same time where the action began sometimes plays a role in the phobia of railways. It is easy to see that it is linked not only to the habit of repetition but also to the mania of the symbol; this returning back is a way of symbolizing the need to begin again, the dissatisfaction with the action.

8. —The manias of procedures and the manias of perfection.

Often the patients do not limit themselves to repeating the act, they seek to perfect it, to make it more complete. They invent things, procedures to make better the action.

L... invented systems for writing. He fastened his quill successively to all the fingers of the hand so well that he had come to stop writing at all and his illness was initially taken to be a writer’s cramp. Rai... had first invented systems for writing well, for holding his

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91 Ameline, Considérations sur la psycho-physiologie des obsessions et des impulsions dégénératives, Comptes rendus du IVᵉ Congrès de psychologie, 1901, p. 572.
quill, for putting the punctuation, for reciting, for sharpening knifes and he came to not be able to write a line, nor to do any job; then he invented systems to smoke well. “In all,” he says, “I aspire to the ideal, I dig into the subject and I dissect it thoroughly.” Finally, what caused his greatest misfortune, he invented systems to swallow and to breathe. He wants to swallow a drop of water between every breath, he grimaces, spits, burps and becomes as repugnant as he is miserable.  

Vor... does not limit herself, as we saw, to repeating urinations fifty times in succession, she investigates, she combines procedures “to urinate well,” she studies the theory of the piston stroke and wrongly meditates upon some vague ideas that she seized upon about the physiology of micturition for men without guessing that they do not apply to women. “Wouldn’t there be some movement, some pucker to be made with the belly to urinate well?” I do not emphasize the mania for perfection in masturbation, which is more common than you might think.

This habit of perfection also plays a large role in certain disorders often designated under the name of onomatomania. This too vague name simply indicates any confusion relating to words, it could be an obsession, a mania of repetition, a mania of investigation, etc. We have just seen Cha... searching throughout the whole night for the name and the address of the persons whom he spoke to during the day. In other cases, it is instead a matter of the mania of perfection. Pn... (139), a 50-year-old man, affected especially by hypochondriacal obsessions, got it into his head to drive away the preoccupations about his health by a cabalistic sentence that he must repeat to stop worrying. He must say: “It is enough, let us be going to dinner, we shall see afterwards.” Unfortunately, this sentence has all its effect only if it is said well. He does not think it is said well enough, he repeats it, it does not suffice for him. He shouted it at the top of his voice or says it in low voice, he looks for how he could say it, he asks his wife to listen, to help him, to repeat it with him: he imagines descending with his wife to the bottom of the cellar, turning off the lights and shouting in unison the phrase in the dark and he goes into despair because he has yet

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to find “a way to say it well.” An interesting observation by Mr. Seglas about a patient who has a word on the tip of the tongue and is not able to repeat it seems to me to relate to similar phenomena.\textsuperscript{93}

The delirium that I found most curious regarding this mania of perfection is that of a 30-year-old woman, Loa... (138). Regarding some masturbations, she has remorse and is frightened by thinking that she did not experience genital contentment in a correct manner. She attributes this incomplete contentment to a numbness that she feels and she goes in search of pleasure. Her husband no longer suffices, she wrongly arranges meetings; she does not always go there, but, however, she sometimes tests if she will have more success with another man, she always comes back disillusioned and desperate. This woman seems to have an erotic delirium, while it is only a mania of perfection in a scrupulous. This peculiar disorder must be frequent, since I find it exactly similar in another woman, Len... “I did not realize what that life was, I was too naïve, it would be necessary to change, to come to be like the other women... I need my nature... I do not come to feel what they must, it seems to me that it is never finished, I shall go on for eternity...” Perhaps there is some truth in her complaints, we shall see later. But it is nevertheless true that she has a strange mania, searching, by all means, to enjoy the perfect pleasure, to dream all the time of this problem as if there was no other purpose in life.

9. — \textit{The manias of the extreme and of the infinite.}

All these manias lead to the same tendency, to push all mental operations to extremes, as far as it is possible to get. We have already seen this mania manifesting itself strongly in the characteristics of the obsessions, it is unnecessary to go back over the extreme character of the sacrileges, the impulsions, the remorses, the shames that these patients imagine.

\textsuperscript{93} Séglas, Deux cas d’onomatomanie. \textit{Bulletin de la Société médicale des hôpitaux}. 12 avril 1887.
Bue..., a 33-year-old woman, who gives an account of this mania, tells me again: “It is ridiculous, my brain works all the time on extraordinary ideas... I wish for terrible things to happen, unprecedented crimes, or else for a fortune, incredible journeys, in short, it must be extravagant.”

We also saw this mania manifest itself regarding the investigations, Lise, for instance, in her conceptions about the future, always comes to think about her death, what will happen after her death, or else if she looks in the past, “she goes right away to the nonexistence which preceded birth.” Bal... cannot emerge from contemplation “of the last beyond,” his mania of explanation relates to the beginning and the end of the world, the destiny of the soul, the world, etc.

It is again necessary to add some new explanations of this mania. We find it again in the mania of generalizations, in the mania of the absolute that often manifests itself. “As soon as I feel a bit weak,” said Claire, “I come to think that everything is impossible, that nobody in the world can do anything, that nobody is religious, that nobody can recover.” Jean presents us some beautiful examples of this mania of endless generalization. A person of his acquaintance has just died in a neighborhood to the east of his small city, “it seems to him that this area is desolate, completely empty; by thinking of it he believes that all of this district has died, that it no longer contains living beings; soon that is how it is for all that is in the east. The entire region of eastern France beyond Vincennes is empty; there is only earth and grass.” The mania of the “all or nothing” is common in these individuals, “they need the perfect love or else it is not worth the difficulty of leaving ignorance...” “I would rather not urinate at all,” Vor... tells us, “than to urinate imperfectly.” In another case, that of Qs..., a 37-year-old man, the extreme takes the numerical appearance. “I am forced to try to multiply tremendously the things of which I think, I try to imagine an immense sea of hundreds, of thousands of ships, then millions and millions of boats and I exhaust myself to multiply them again.”

But the notion of the infinite is found even better in the following observation, interesting from various points of view. A 25-year-old young man, Vil..., in a letter that I asked him to write to me, describes his obsession thusly: “the main idea that torments me
most, it is the idea of eternity: it take me from the domain of reason into that of sensibility and causes me intolerable pain. I sense that time lasts for eternity, space extends itself forever, something like a non-stop crescendo, it seems to me that my being inflates progressively, taking the place of everything, enlarges itself with the universe and with the centuries, then a kind of explosion and everything disappears, leaving me an atrocious pain in the head and in the stomach. This work of the mind chases me and devastates me with a deep discouragement. It is therefore true that eternity exists, I have just seen it, just sensed it too evidently for it to be a simple form from my mind, but then what does it matter the few moments of my life, what does it matter my happiness, misfortune or endless nonexistence? It is eternity that is frightening. Something without end, it is horrible. Always happiness, and afterwards? Again happiness; and afterwards? And afterwards? That is as horrible as always suffering or always being nothing. Eternity exists even when there will be nothing. The most lively entertainment is powerless to chase away these impressions of my brain; all my body is as if impregnated, if I try to reason, I sink even more and I sense quite well that it will be indefinite, never-ending, it is not the result of a syllogism, it is the result of an immediate, obvious perception, even more evident than the awareness of my own self...”

I will resume the remarkable study of this phenomenon about the phenomena of anxiety. For the moment, I note only that he is definitely a scrupulous, shameful of himself, who believes himself to be without personality, who reproaches himself for all that he thinks, who criticizes and analyzes his sentiments to the point of metamorphosizing them into their opposite. “These questions give me so much pleasure or so much suffering, I do not know if it is the one or the other, for my pleasure seems to me at the same time to be pushed too far and yet to remain incomplete and I do not know if this is a type of pain.” He has the mania to push everything to the infinite, to search for what there is after the pleasure that he feels, what would be a greater pleasure, even greater, etc. It is to the ideas of space and of time that this mania is best applied, as he ended up by being obsessed. It is rare to find this mania so explicit, but in reality, it is contained in all the manias of the beyond.

All these manias of the beyond presented, in fact, with the essential characteristic of a restlessness of the mind, unable to stop at
one thought and which was continuously forced to go beyond that to add something, then still one other thing without repose and endlessly. A similar agitation unfailingly leads to the thought of the extreme and of infinity.

3. — The manias of reparation.

Despite all these efforts and these various procedures that all seem to be aimed at perfecting an action or idea, the subject does not come to be satisfied. Also, he devotes himself to another series of exercises that have the goal of repairing, of erasing as many as possible of the defects of the previous action. It is these manias that I bring together under the title of the manias of reparation.

1. — The manias of compensation.

The first one is a simple compensation. After the allegedly defective action, it is necessary to make another that often seems to be chosen in an arbitrary way, which in other cases is compared to the previous one to compensate for it.

When Bunyan had found in the Bible a word, the meaning of which seemed unpleasant and discouraging to him, it was necessary for him to find in the holy books another word, whose meaning was encouraging, to compensate for the first one. An interesting observation by Ladame seems to come close to this group: “When I walk,” says the patient, “and the bad ideas overtake me, I must stop myself to go back one step backwards, to correct the bad thought, it’s as if I corrected an error in an accounts book.”

Nadia resigned herself to eat in order to obey me, but on the condition of taking something right after the meal that would make her lose weight “something to make one thinner, since your cutlets put on weight.” In the past, she took a spoonful of vinegar: I brought her to accept a small cup of an herbal tea that

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95 Ladame, Ann. médic. psych., 1890, II, 382.
I called slimming. She knows now that I deceived her and that her herbal tea is made of tea and chamomile; it doesn’t much matter, she needs to take it still, the symbol suffices to make the compensation.

When the necessities of politeness forced Jean to unwillingly touch a woman’s hand, it is necessary, to compensate, to quickly touch the hand of a man. So when he is alone at night with his mother and she holds out her hand to him before going to bed, he is in a “horrible situation”. He dare not refuse her hand, but he then spends a painful night because he could not touch the hand of a man to compensate. When he entered the Church of the Madeleine (that bears a woman’s name), he must enter at least for a moment another church to erase that impression.

This mania of compensation presents many varieties of which the principal one is the following mania, one of the most important from the clinical point of view.

2. — *The manias of expiation.*

Expiation is only a form of compensation with these two characteristics if not added in, at least stated. The first act, which is the starting point of the mania, seems to be about a shameful and immoral subject, it is especially about the patients being ashamed of themselves or of their body. The second action, which must compensate for the first one, has an unpleasant, painful character, it takes the appearance of a punishment.

“It is always necessary,” says Pn..., “that I do something to relieve my conscience” and he tries to repeat his expression with perfection: “Let us go to diner, you should not think any more of it.” Hil... (71), who is ashamed to go to the commode, goes there only by making bows “to apologize.” Claire who believes she has a Host stuck to her anus, and who, as a result, also dreads to go to the commode, only consents to go there only by kneeling in the bathroom, sometimes for hours before and afterwards. Zei... (142), who has a “craving to say swear words to the good God,” wants to pray for expiation and she kneels all the time. As the prayer does not seem to her to be said properly, she is compelled not to eat and that is her reason for refusing food. Rn... (146) condemns himself to, so as to make expiation for his evil ideas, to give a tap
with his elbow to the furniture that he goes past. One foresees that this phenomenon will play a role in the tics.

Instead of atonement through action actually performed at the time, they want to atone by promising to do a disagreeable action later or by promising to sacrifice a pleasure they promised themselves. L... promises himself to put himself in jail for five minutes to atone for his tactless actions. Mw... (145) imagines a pleasant journey on a bicycle that she hopes will not happen because she does not get dressed quickly enough. This promise of atonement eventually will be repeated for all other acts, even the insignificant. “If I walk, if I touch this chair, if I drink, the bicycle trip will not happen.”

It is the same thing, with a higher degree of complication, which plays the principal role in the Lise’s illness. “To punish myself for having cursed God,” Lise repeats constantly, “I must set for myself an unpleasant thing to do, to give my soul to the devil, for example.” And the same goes for all that she can reproach herself over: about all the acts that preoccupy her, and they are numerous, she must exhaust herself in atonement to reassure herself. If she accuses herself of lying, of indecency, it is necessary to atone and consequently to accept to live somewhere disagreeable for a while, or to accept that one of her children dies, or devote her soul and one of her children to the devil, etc. At first, it was only personal expiations, she wanted to repair only her own faults, but soon the idea of expiation becomes generalized. She must atone for her uncle, for a brother who is not religious; it is necessary to atone for a politician who has just died in a manner not very edifying, it is necessary to atone for the explosion of a tinderbox, etc. “In a word,” she said, “I have cravings to atone for the whole world.” The very word “expiation” eventually fascinates her, she searches for it in all the dictionaries and learns the entry by heart.

What is strange is that I find exactly the same disease in this patient’s sister. She has a lot of scruples, she accuses herself of loving a friend more than her family, for loving to play the piano, for having thoughts of the Eucharist in front of a bakery, etc. And for all these imaginary misdeeds “sorry is not enough, there must be compensation. Always a little something to satisfy God.” These are her tics, play-actings much simpler than Lise’s. She must eat for a while from an empty plate, to undress herself
and then to dress herself again, to open an armoire, to take on a sad air with her parents all morning long to compensate for the afternoon when she will have a good time with a friend. It is more puerile, but it is the same psychological disorder. I do not think that in this case, it is a matter of suggestion or about illness communicated by contagion; it is a matter of the same psychological, deep, hereditary disorder that, by evolving in both sister’s, brings the same manifestations to both.

In these last two patients, one finds a variant of expiation and of the promise. They accept the penalty without reproaching themselves for anything, only as payment for a favor that they requested. Since they hoped for something, they think they must atone to see this wish fulfilled, “I will only have this thing I want, if I make a present to God or the devil... If my little sick nephew recovers, I will give the devil the souls of my children, if I find a lost jewel, I will also give the soul of my uncle.”

These patients who have the mania of expiation come to a small trade with heaven and hell that is quite curious. They are ahead or behind in the payment of their debts, they are frightened and they hasten to atone quickly when they believe they have too much in arrears.

3. — *The manias of pacts.*

Instead of considering the present action and seeking to compensate for it, instead of considering the past action and trying to atone for it, more often the patients think about future actions and they promise beforehand to repair it. They promise to undergo some painful punishments, sometimes if they make, and sometimes if they do not make, a certain action upon which their attention is attracted: these commitments take the form of *solemn vows or pacts.*

Mr. Van Eeden, under the category of mania of superstition, describes a case that we already linked to the mania of omens; this same patient has, in addition, the mania to make vows: “If during the next hour I yield to a single one of my whims, I consent to have an apoplexy within 24 hours.”

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Lanteirès’ thesis,97 there is an often cited case regarding a patient who hates the number 13. “If, tomorrow, I make a single superstitious act, like all the stars of the sky are 13, that God is 13... If, the supervisor, while taking a walk, arrives at such and such a desk, or if by the first ring of the bell I did not arrive at such and such a passage in my work, well, I want to die and go immediately to God...” They often reproduce this case as a curiosity and nevertheless nothing is as banal as this symptom.

“If I do not do 25 signs of the cross without stopping,” says Vr... (48), a woman of 25 years, “then misfortune comes to my whole family,” “if I masturbate only a single time, then all my life is broken,” says Toq... (97), “if I do not touch this piece of furniture before my mother returns,” says Rn... a girl 13 years old, “I will die this week.” “If I cook while looking at my knife, I consent to die tomorrow,” said Vks..., who has criminal impulses to kill his granddaughter with a knife. “If I am cheerful on Friday, I will kill myself on Sunday.” (Ger...) “If I decide not to be religious, I swear that I will get married to the first man who passes by” (We.)...

Nadia is quite remarkable for her mania of vows, “I swear not to touch this piece of furniture (it was one of her tics), otherwise a great misfortune happens to me... I swear I will begin my morning prayer 10, 20 times, 1,000 times, otherwise a misfortune will happen to those I love.” Later came the pacts, as a matter of course, about the shame of the body and the obsession with getting fat that was superimposed, “I swear by all the saints of paradise that I will touch no more than a single crumb of bread, otherwise all sorts of misfortunes will come to my family and to myself.” These vows become more complicated and become more and more terrible by virtue of this disposition to push things to the extreme, as we have already noted. “I swear on the head of my father, of my mother, of my ideal (she refers to a person with whom she had fallen in love),xxx I swear by all the saints of paradise, by the Holy Spirit, by God the father that I will only eat an egg yolk today, and if I break my word, I will never become a great artist, I will never be a

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composer, mom will die soon and my ideal [lover] too.” As she does not keep her vows and cannot succeed in keeping them, she is in despair and racks her imagination to find a way to make them more specific and more terrible with more influence on her poor will. Instead of contenting herself with saying them, she writes them on paper that she carries next to heart; she rereads them while kneeling in front of her mother’s bed upon whom she put a Bible. Nothing worked and she did not keep the vows that only served to preoccupy her more.

With these patients, the pact seems to be a means to repair the defective action or an excitement to make themselves complete a rightly or wrongly desired action. But, little by little, the mania develops and recurs with even the insignificant actions that they do or that they want to do, the expiation or the pact is no more than an obstacle to further action, this mania, then, is comparable to the mania of omens and to the mania of questioning fate. “If I touch this object, my mother will succumb,” Mw... continually tells herself. If she desires a pleasant thing, she believes she is compelled to swear to renounce all other actions. Thus, she prepares for a bicycle ride and at every instant she is forced to swear that “if I do this reading, I swear that I will not go out; if I take my handkerchief, I swear that I will not go riding,... it is very necessary, however, that I blow my nose, she adds with sadness.” Then, when the time comes for the ride, she no longer dares to go out because she vowed so often not to do it. Thus, the vow seems to destroy future actions and also stops the present act.

In this form, the mania of vows and pacts is extremely frequent, although often unrecognized, and plays a very big role in these diseases of the will.

4. — *The manias of conjurations.*

In more severe cases, when the patients are not only dissatisfied with their actions but they also feel compelled to make reprehensible actions, they struggle against the impulse by opposing it with an action they think proper, that they believe is intended to ward off evil temptation. These manias of conjuration are very characteristic of the scrupulous and are very often used to recognize a previously hidden disease.
Almost all these patients, Bor..., Xy..., Claire, Ger..., Lise have been caught making a gesture of the arm or speaking when all alone and repeating for hours words such as: “No, no, ... I do not want... to go there... this is not true.” That is because, inside themselves, another voice blasphemed and wanted to say: “bastard, cow, pig”, in addressing the good God: the patient protested through the exclamation that one had overheard.

It is impossible to enumerate all the formulas of conjuration that one can encounter; they are innumerable. One of the more interesting things to note in these shortened responses, these oppositions to the obsession, is that the responses are abbreviated, signs that have value only in their symbolic meaning. Mr. Paulhan has rightly insisted on this role of symbolic representations in the will.

A first group is constituted by small movements, by simple gestures, raising a finger in the air, wiggling the fingers behind the back or in the pocket, raising the eyes to the ceiling, knocking on a piece of furniture, etc. We will review these phenomena in relation to the tics.

Most often conjuration is made through a sentence or a word. Lise repeats “hush, go away” as though she spoke to the devil, but in reality she repeats this expression to dispel any idea even when it is not about the devil. Vob... exclaims, “no, I shall not do it, back Satan.” Gisèle: “come what may, for the time being finished” and Bu... (85) repeats all day long the following peculiar expression: “Mom, ratan, woman’s hat, bitaquo, I am going to die.”

In many cases, these cabalistic expressions of conjuration are borrowed from mathematics and become numbers, probably because of the abstract and specific character of the number, which makes it loved by the scrupulous, whose mind always vaguely aspires to precision. Or, an arithmetical mania leads the subject to repeat her formula a specific number of times. Lise uses numbers that correspond in her thought to this or that obsession or that summarize a great resistance against it. She sometimes repeats for whole days, to herself, “one, two, four, six.” This is a resistance

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against the ideas designated by these numbers. When she is alone, one can hear her murmur sentences like this one, very incomprehensible to a layman. “The opposite of God, four, three, two, one hundred and seventy-five thousand.” That means that she thought about worshipping the devil and that she launched the expression of resistance. For nothing in the world would she abandon these expressions that protect her from herself; during trials of hypnotic sleep, she repeats at all times “four, three, two,” which does not facilitate the treatment.

To struggle against his genital impulses, Jean must murmur the syllable “té” which is, it seems, an abbreviation of the word “enough;” but it is necessary to say it a specific number of times, four times, eight, sixteen, thirty-two or sixty-four times, by multiples of four according to his arithmetical mania. “I feel a mild erection coming, I feel my attempts to let go, then I stammer my syllables of closure: let’s go no phenomena, té té té té, I must say it by fours, this is not sufficient: té, you know that I cannot stop myself at five, té té té, at eight I can stop myself when the temptation is not too strong; but it would be necessary to go to sixteen when it’s serious.” It is not always words that the patient repeats; they often rely on gestures. When he believes he has the head of woman in his stomach after eating a charlotte or a suspicious bread, then he must tighten his abdominal muscles four, eight or sixteen times; “it is the only way to make it leave.”

Finally, I notice in Jean a most curious form of conjuration, it is a mental act, an effort of the imagination. He imagines that the fluids sent by the women around him are like so many fine threads aimed at his head and, with imaginary scissors, he imagines that he must cut these threads. In other cases, he must visually imagine lines that intersect at acute angles, symmetrically arranged in groups of four. The representation of imaginary figures that this patient was kind enough to draw is, it appears, a supreme remedy to dispel indecent images (figure 2). This mania to imagine lines derives from this patient’s previous mania. He evokes wooden beams that seem to him very high in air, a kilometer above his head, and by an effort of imagination he must make them descend to earth, or he conjures up the image of a man walking in the air and he must, also by an effort of imagination, force the man to set foot on the
ground. It seems that this last operation is very difficult, because he makes great efforts and contorts his whole body in managing to accomplish it.

Similar expressions and actions are also rapidly transformed by these patients and quickly become a mania and an impulsion. The patients want the last word and as many times as the impulsion comes, that many times is it necessary to answer to it. From there a preoccupation with the answer becomes as serious as the obsession itself. Lise does not dare to sleep any more for fear that during sleep an obsession might come and for fear that she would not have the presence of mind to answer. These patients torment themselves about conjurations as much as they do over the impulsions.

4. — *The diffuse mental agitations.*

These various mental manias seem, at first glance, very related; we can list the various varieties in the table below.

Each of the patients usually imagines that he is the only one in the world of his kind and he often succeeds in concealing his convictions from the doctor: from there, all these strange disorders, the malady of superstition, the mania of doubt, the mania of perfection, arithmomania, onomatomania, etc., that are, in my view, only accidental varieties of the scrupulous mania erected into
clinical entities. It is the same problem that we have already encountered regarding obsessive ideas and which must have the same resolution here. Also, we must search for the relationships that these various manias have with each other and the common ground of diffuse mental excitation that can be found in each of them.

1. — Clinical unity of the mental manias.

Some patients, for reasons that are due to the evolution of their disorder, which we will study later, seem to be fond of certain particular manias. Lise makes promises for expiation, Nadia prefers the vows, Jean limits himself to the compensations; Claire searches for procedures to improve, Zo... takes precautions and Zei... is satisfied to repeat her actions. These differences in the variety of the customary mania even gives to certain patients a rather distinct physiognomy. It is certain that Rai..., who looks for procedures to eat well, to breathe better and, to achieve that, spits and burps
continuously, does not externally resemble Lise who, quite motionless, silently questions the promises she made to the devil. But this being said, one must hasten to add that this difference in the appearance of patients is shallow.

In reality, if one carefully follows the history of these patients, one sees that besides the principal mania predominant today, they have a number of other secondary manias about which they do not complain and that relate to all the other forms observed in the other subjects. In addition, it is very easy to note that at other times of their lives they gave the first rank to other manias. Jean, whose compensations are so remarkable, has at the same time the manias of conjuration, of precautions, of omens, etc. We..., who questions fate, also has the manias of conjurations and pacts. Claire has the manias of repetition, of returning back, and of expiations, etc. Lise, next to her promises to the devil, has the mania of questioning, arithmomania, the mania of conjuration, etc. Myl... (98) now has the manias of precision and the micromania began, three years ago, with the manias of investigation and procedures: Zo..., currently tormented by the mania of precaution, had the mania of expiation in the past. Vor... presents now with urinary procedures, ten years ago she was tormented by vows. Gisèle, who nowadays makes conjurations, had questionings, precautions, pacts.

In short, it is very rare that a patient, who presents complaining about one of these manias, does not know all the others from experience. He comes to admit a need to return back, one can, without hesitancy, ask him if he feels reassured by the vows that he has made. One can thus surprise the patient by describing his mental quirks that he has presented and that he believed were completely unknown. The questioning is formulated, one might say, in advance, like that of the hysterical; the questions differ, but the answers are just as well foreseen.

Finally, certain experiments can again put into evidence the relationship that exists, from the clinical point of view, between these various manias. If by various treatments, they succeed in abolishing or in diminishing one of the patient’s manias, one sees the patient fall more or less quickly into another. I prevented Nadia from making vows that begin in the future, she acquired the habit of
limiting herself to conjurations in the present and she remains equally tormented by this new mania. If I were to do away with this one, there will be unending precautions to not run the risk of doing what I have precisely forbidden her. The same is again true, even more clearly, with Jean, he replaces one compensation with another one: he comes, “you do not imagine with what effort,” to go to bed after shaking his mother’s hand without searching for his brother to shake hands with him last, but he washes his right hand eight times in very cold water; and when he comes to tell me this heroic feat, he would like to receive compliments. If I want to abolish all compensations, then there will be interminable deliberations before the action. He is going to remain one hour in the church doorway without deciding to enter or to leave: “if he enters, he knows definitely that he will need to compensate for this shrine with the other one and Mr. Janet absolutely forbid it; but if he does not compensate, he runs the risk of being followed by fluids; which is preferable: the reproaches that he envisages or the fluids?” Clare replaces the returning back with investigations or pacts. That is how it very often is during the course of treatments.

This mixture and this succession of the various manias within the same individual already shows us that, from the clinical point of view, these various manias must be very close to one another and that they all must depend on the same mental disposition that is the starting point for everyone. This disposition is evidently an agitation of the mind, a need of putting thoughts to work that shows itself in a more complete way in the simple mental rumination.

2. — Mental Rumination.

The previous mental manias showed us a mental activity always in the same determined direction; the agitation of the mind was systematized. Very often, these various manias combine themselves, mix themselves more or less vaguely and the character of the systemization becomes less visible. It results in an extremely curious psychological phenomenon whose importance in terms of the interpretation of the mind does not seem to have been sufficiently highlighted. It is an unusual labor by the brain that accumulates the associations of ideas, the questions about the questions, the expiations,
the pacts so as to form an inextricable maze. From time to time, the associations of ideas bring back, as if by accident, one of the questions from the beginning and then the patient restarts all the previous twaddle, he turns in a circle like Lise; or these accidents give rise to a completely different idea that throws thought onto another track and these are “branches of ideas,” as Lod... says. The labor is more or less complicated according to the intelligence and the degree of culture of the subject, but whether he turns in circles or he gets onto branches, he never comes to a conclusion, he never can “take the helm” and exhausts himself in labor as endless as it is useless.

This phenomenon is often described as racing thoughts, flight of ideas, “idéen flucht.” Legrand du Saulle designated it under the name of mental rumination, which we retain. This fact is so remarkable that it is again necessary to review some examples to identify the essential psychological characteristics.

Here is one of Ger...’s ruminations, a poorly educated woman of the common people. One Thursday afternoon, she thinks of preparing dinner and takes a pot to go to the greengrocer to buy something for the broth. She stops on the staircase with the thought that she must reflect for a moment if there is something reprehensible about buying some broth at the greengrocer’s (mania of precision) “in general no, but today is Thursday, it is necessary to pay attention to this detail: what is she going to think about seeing me buy some broth today (mania of questioning)? If the grocer thinks that I am going to make the soup this evening, there is no great harm, but one can assume that the she will believe something else (mania of assumptions); the greengrocer will perhaps think that I want to make a soup for tomorrow, Friday. If she supposes that, she will be scandalized because of me—it is definitely my nature to always give a poor example to others (criminal obsession)—if I make her believe that I committed an act that in itself does not seem very serious, but that is horrible by its meaning; that means that I make fun of the good God (mania of symbol). The whole question turns on whether the greengrocer assumes that I eat my soup tomorrow rather than tonight. Will

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she make such an assumption? Consider what I have in my pantry for tonight’s soup. The last time I saw her, that is to say yesterday morning, I gave her the impression that I had some soup for Thursday evening, what word did I say to her yesterday morning (mania of investigations in the past and branch of ideas).” Here she is now working to recall everything she has said to the greengrocer, unfortunately, the memory does not completely return and she ends up telling herself “that if the greengrocer has at that instant a bad face, then she said something extraordinary to her, but here we are, the grocer at that moment made a bad face. Impossible to know with precision ... no, really, it is best to seek advice from the husband. But her husband will certainly reply: you annoy me with your Friday; and the only result is that she will have given her husband the occasion to speak ill of the good God. Here she indeed scandalizes everyone; what a horrible criminal state is hers. Really, anything would be better than this constant crime and if God granted that she would no longer scandalize everybody, she would indeed promise Him to do anything. But, if God asks her to kill her little daughter (mania of the pacts)? He can ask for it because it is the child of the guilty mother who would be as guilty as she would. Is it better to continue to scandalize everybody or to consent to kill her little daughter with a kitchen knife, etc.? Three hours after the beginning of these beautiful reflections, the husband comes home and finds Ger... standing on the landing of the staircase, her empty pot in hand: she had been unable to decide either to go to the greengrocer or to stay home and give up on making the soup.

The ruminations appear a little more complicated and the reasonings more subtle if one takes a subject from a higher social environment, but this difference is far from being as considerable as one would suppose. Nadia goes out, rather moved by a conversation that she has just had with her father; he tried to make her understand that it is right to eat for the sake of living and that this is a duty for her. Nadia would like nothing better than to accept that this belief would be her solution, her peace of mind; but something opposes it; that is the memory of the countless vows she made. What happens if she fails in such vows (manias of pacts and of questioning)? On the other hand, if it is wrong to renege on her promises, it is also very wrong to refuse to listen to the
pleas of her parents. She also made vows to promise to obey her parents and not to make her mother cry anymore; which of these two vows counts the most? We have told her that she should not take into account vows that are obviously ridiculous, but which are obviously ridiculous and must she break them if she has no evidence that they are such? The direction that we gave her is, as a matter of fact, hypothetical and it is up to her to ultimately decide (mania of oscillation). Fortunately, she took the precaution to write nothing with regard to these vows, what is not written does not count (mania of precision), but is it not possible that she wrote without realizing it: some letter written to a friend can have the meaning of a vow (mania of the symbol), how does she know that did not happen. “If I manage to turn my head five times in succession before my governess turns around, I shall have promised nothing; if I do not manage that, the vow exists (tic and mania of omens)... I succeeded in doing that, but that does not matter, my mother is dead, I had so often sworn on her head, it is for that that she died; if I fail again in my vows, my father will die and my ideal [lover] also. Am I cursed? Etc.” The rumination continues in this direction for several hours without Nadia coming to a solution to the question posed at the beginning: she tried to find out if in fact it was necessary to accept or to deny her father’s assertion that it is her duty to eat to live; she is still at the same point and does not know any more about whether she believes or does not believe what he said to her.

I will say no more than a third example of these complex ruminations, interesting by the circumstances in which it occurs. Lod... is playing the piano and as she is quite a musician, she begins to take some pleasure; that pleasure will grow and give birth to an artistic enjoyment that she knows and has felt before and that she awaits; but this time a crowd of thoughts begin to emerge in her consciousness. “It is not work that she does here because she takes some pleasure. Does God allow that we can so forget ourselves in pleasures (mania of perfection and of remorse)? It is necessary to erase this selfish pleasure by making some little gifts for the glory of God (mania of the expiation). It is necessary to condemn herself, to make a sad face all day long. Yes, but it is going to annoy her parents; which is best:
not to make anything for God or to annoy her parents (mania of questions)? The ideas are again going to stay in dispute without me being able to take charge and make a decision³xxii and she continues to meditate that way all morning long. One could multiply these examples for eternity, it is very easy to imagine a thousand ways of combining all the various categories of mental manias that we have analyzed so as to form completely endless branches of thoughts or circles of ideas.

3. — The forced daydream.

In the previous ruminations, one can again find the trace of various mental manias; the pathological systematization is incomplete but it still partially exists. I think that it is necessary to move these patients closer to a very interesting group of subjects, whose unhealthy character is not always well understood.

Here is an example that will clarify the phenomenon that I consider. A woman of 44 years, Lib... (117), very intelligent, very reasonable, complains of a mental disorder that for 20 years disturbs her whole existence, prevents her from enjoying life, work and even from sleeping. This disorder is the daydream that imposes itself in an irresistible way; “it seems to me,” she says, “that I am forced to think too much, that I am obliged to tell myself stories, to have discussions with myself, to remember, to reason in a completely exaggerated and useless way.” This woman always stays very calm, very quiet, she has no tics, even fewer emotions or fears, but about any event or about any action, her mind is assailed by endless reveries. Most of the time she can hide her daydreams and she seems to behave, to chat with people or to read a book; but she devotes herself only a little to these activities, the greater part of her mind is occupied elsewhere by the continuous daydreaming. In many cases, when the action becomes difficult or requires more attention, Lib... becomes unable to do so. She cannot follow a conversation between several people; she cannot understand a difficult reading. Most of all, sleep is almost absolutely abolished and replaced with this perpetual imagining.

I shall not now study the disorders of the will and of attention that play a big role in this observation, I
consider now only the reverie itself. The most curious characteristic about this reverie is that it apparently contains none of the pathological symptoms that we have just studied. Lib... certainly has no obsession, moreover she does not at all present with what we have just called a mental mania. No obsessive idea returns regularly, there is no mental process, no interrogation, no investigation, no comparison that plays a predominant role. This daydreaming is very varied, most often it is not unpleasant in itself, and most of all it is not unreasonable. These are reflections, recollections of the past, imaginings of the future, of discussions, of meditations that are only pathological by their exaggeration and irresistibility. “What I regret,” she says, “is to be compelled to think like this of a million absolutely useless things, when I would do better to take care of my work or to sleep. It is uncountable pictures and endless chattering which I may stop only for a moment and with an extreme effort.”

This symptom of forced daydreaming seems to me to be very important, it is found in many of our patients. “It’s not my fault,” said VK..., “if I do nothing, I have ideas in abundance, I am overwhelmed.” “It seems to me,” says Lgh..., “that inside me streams of ideas arise which follow one another with an incredible speed. These are not always crazy ideas, I assure you, nor absurd questionings. All these ideas seem appealing to me: there would be good reasons to stop myself on all of them. But I cannot choose, I am obliged to pass from one to another, in my head it is an improbable chaos of ideas.” Lise feels strongly that at certain moments “all her life concentrates in her head, that the rest of the body is as if put to sleep and that she is forced to think a tremendous amount without being able to stop herself. Her memory becomes extraordinary and develops excessively without being able to aim her attention.” Wo..., who now has very clear mental manias (mania of checking and mania of pacts), recognizes very well that he was not always so. “For many years my daydreams were not like today, always in the same direction, I definitely knew that I thought too much, that my mind became muddled by side issues, that I never stopped thinking of a hundred things instead of only one. For a long time, my thoughts
turned in a vacuum without being able to hang on to anything in particular...” It would be very easy to find this mental state of forced daydreaming at the beginning of many cases of the illness of the obsessions. Even among almost normal individuals, these endless stories that one tells oneself, these easy meditations which take the place of work and of attention are the most frequent.

These forced daydreams were, like the previous rumination, described under the name of flight of ideas because they are closely related phenomena. They also correspond, if I do not make a mistake, to what has been described under the name of mentism “a kind of particular intellectual excitement, in which,” to help myself to the definition from an author who was himself afflicted, Dumont de Monteux, “we see, with a very clear feeling, thoughts that are foreign to us, which we do not know as ours, and having inserted themselves from the outside, proliferate, move with the greatest speed.”

In the study of the obsessions, we are very occupied, and with good reason, with diffuse anxieties, that is to say, with diffuse emotional agitations. It seems to me necessary to draw attention to these forced daydreams that are diffuse mental agitations.

If we get closer to the forced daydreams, and to the mental ruminations of all the mental manias that were previously described, we see that there is in these patients a great mental work that develops in an abnormal way. This work is outwardly rather considerable: it includes most of the intellectual operations, associations of ideas, memory, imagination, judgment, reasoning, all sorts of operations that work especially on images and abstract ideas. This work is not without difficulty nor without effort, it is often tiring and hard. Unfortunately, it presents an obvious character at first glance, it is perfectly useless and sterile: whether it is systematic or diffuse, it never leads to anything real or useful; that is why it justifies the name which we gave it, mental agitation. This agitation is forced, it imposes itself on the subject in a particular way; but this very important characteristic is found exactly the same in the forced movements and in the forced emotions, it will be more usefully studied at the end of this chapter.

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102 Dumont do Monteux, d’après Séglas, _Leçons cliniques sur les maladies mentales et nerveuses_, 1895, p. 69.
SECOND SECTION

THE MOTORIC AGITATIONS

Most of the previous mental disorders were accompanied by some movements, even if it was only in words or writings. But these movements were in reality a minor matter and the main expenditure of strength was made in the phenomena of thought. On the contrary, with the same patients, we observe an especially driving disorder where a kind of agitation seems to exert itself in movement, accompanied by a quite minimal awareness of conscious thoughts.

These movements have, at first glance, the same characteristics already noted in all the unintentional phenomena. They occur without any relationship to external circumstances or to the desires of the subject; however, they are not absolutely unconscious, they do not execute themselves entirely without the participation of consciousness, or even the will of the subject. The patient feels that, at least in part, he carries it out and that it takes place because he indeed wants to carry it out, but he feels compelled to have this useless and absurd will: they are completely, according to a patient’s expression, “forced labor.”

The same as with thoughts, these forced movements can be systematic or diffuse; when they are systematic they constitute the tics, and when diffuse they are the crises of agitation.

1. — The systematized motoric agitations. — The tics.

The study of this phenomenon is relatively recent, it was formerly vaguely confused with convulsions and spasms; but because of the interest attached to the studies of pathological psychology today, the tic has been the object of
many recent works which at least clarified the problem. First, I take from these interesting studies the elements that determine the tic; that is to say, the essential characteristics that constitute the tic. Then I shall briefly describe some important tics presented by my patients with a particular emphasis on the psychological characteristics of these phenomena.

1. — *The characteristics of the tics.*

The first characteristic has been well demonstrated, it is the systematization of the tic, its coincidence with the set of systematized movements that constitutes an act. Trousseau still conceives of the tic in a rather vague way: he characterized it “by fast contractions generally limited to a small number of muscles, usually to the muscles of the face, but being able to affect the other muscles of the neck, the trunk, and the limbs.”\(^{103}\) As a matter of fact, he spoke only about the small size and rapidity of the movement: some tremors of partial epilepsy could be confused with tics. Charcot,\(^ {104}\) Gilles de la Tourette,\(^ {105}\) Guinon\(^ {106}\) tried to differentiate and to group at least some of the very exaggerated and easy to recognize tics. In addition to the previous characteristics, the small size of the movement and its rapidity, they emphasized its regularity and its resemblance to determined actions. “Tics,” said Charcot, “always reappear in the same way in the same patient, and furthermore they reproduce by exaggerating certain complex, automatic, physiological movements applied to a goal, they are in a way, in other words, the caricature of acts of natural movements...”\(^ {107}\)

The author who most contributed to publicizing the tic and to distinguish it clinically from neighbouring convulsive phenomena is Mr. Brissaud. In his lectures at Salpêtrière, he repeatedly returned to the interesting distinction between the spasm and the tic.\(^ {108}\)

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\(^{105}\) Gilles de la Tourette, 1885.

\(^{106}\) Guinon, 1886.


\(^{108}\) Brissaud, *Leçons sur les maladies nerveuses*, 1\(^{st}\) série, 1895, p. 513.
To the abruptness, to the small size, he added a characteristic already pointed out by Charcot but which he highlights much more, systematization. The spasm that results from the irritation of a point in the reflex arc sits either in a single muscle or in the group of muscles innervated by the same nerve. So we observe spasms in the facial area, the tic douloureux of the face is badly named, because it is in reality a spasm: we saw these spasms of the face determined by a small hemorrhagic source on the foot of the second frontal bone, center of the face, by an aneurysm of the cerebral artery in the front of the trunk of the facial nerve, or by fibrolipoma involving this nerve. Contrariwise, in many tics we notice not only the eyelid spasm, movements of the tongue, grimaces of the mouth, but also respiratory disturbances, laryngeal noises, etc.; the complex movement depends on the facial nerve, on the hypoglossal nerve, or the phrenic nerve, there is a coordination that can be understandable only by the operation of the cerebral cortex.

This systematic character, this relation of the tic with the adapted actions finds confirmation in most of the subsequent studies. “The essential character of the tic,” said Mr. Oddo, “is the intentional or better pseudo-intentional character, because the voluntary intention disappeared a long time ago in the tic. It is nevertheless true that the movements of ticqueurs are coordinated for the continual fulfillment of the same act. The tic is an essentially figurative movement, chorea is constituted by an amorphous movement.”

Messrs. Meige and Feindel further stressed this characteristic by making it play a big role in the classification of the tics. “The tics must be classified,” they say, “not according to the muscles that intervene in the movement, but according to the acts of which the tic is the caricature. Thus, we shall distinguish the tics of eyelids, beatings, blinkings similar to acts determined by a foreign body in the eye, by a too bright light, the tics of the eyes, elevations, side movements, similar to acts determined by the presence of foreign bodies, by disorders of vision.

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110 Meige et Feindel, Les causes provocatrices et la pathogénic des tics de la face et du cou. Société de neurologie, 18 avril 1901.
“The tics of the nose, the sniffing, the flapping, the wrinkling of nostrils, correspond to the following acts, the inhalation justified by a temporary congestion of the nasal tract, dilation of nostrils to avoid discomfort or the smarting of a small wound.

“The tics of the mouth, the lips, the tongue, the pouts, the suctions, the nibbles, the pinching, the rictus, the chewings, the gulps, etc. correspond to the movements to remove a film in the cracks of lips, to move a loose tooth, to feel a part of the mouth, etc.

“For the tics of the head, the jerks, the shakings, we find as corresponding acts the shiftings, the adjustments of the hat, the movements to get rid of the discomfort produced by the false collar, by an article of clothing, etc.”

“The respiratory tics,” Mr. Oddo also says, “are abbreviations of more stressed acts, of exclamations, of words of insults.”

In the tics of the neck, in psychogenic torticollis, the corresponding movement is an effort to avoid the pain of a dental swelling, to avoid a muscular pain, to avoid a draft and protect the neck by raising clothing, to hide a sadness, to look in the street, etc.

In the tics of the shoulder, we shall rediscover the gesture of the peddler described by Mr. Grasset, a movement to load a bundle on the shoulder, and many professional actions of the same kind. In the tics of the foot that I described, we shall find limps determined by the pain from a corn, retractions of toes in a too short shoe, etc.

By placing himself in the same point of view, Mr. Meige makes another interesting distinction between the clonic tics which consist of a fast movement and tics of posture, tonic tics in a manner which consist in the retention of a posture: this one always represents an action but a permanent action. He recalls in this matter a case of trismus of the jaws, which I had studied with Mr. Raymond: a brave priest who


112 Grasset, *Nouvelle Iconographie de la Salpêtrière*. 1897.


115 *Névroses et Idées fixes*, II. p. 381.
was afraid of appearing indiscreet and of letting slip the secret of the confessional, had come not be able to loosen his teeth and had to put a cork in his mouth to be able to give a sermon. Mr. Meige also studies in this regard an observation of a completely remarkable ticqueur who, to arrest a movement of the shoulder, takes a permanent posture and holds his arm close to the body, pressed on the epigastrium.

The second characteristic of the tic also highlighted by most of these authors is that the tic is an inappropriate, untimely act. “The tic,” said Charcot, “is only the caricature of an act, a natural gesture, the complex movement of the tic is not absurd in itself, it is absurd, illogical because it takes place irrelevantly, without apparent motive.”116 “The tic,” said Mr. Noir in his interesting study, “is the habitual but untimely reproduction of a gesture”117 and Mr. Guinon also said: “the tic is a convulsive, habitual and conscious movement resulting from the involuntary contraction of one or several muscles of the body and reproducing frequently, but in a inconvenient way some reflex or automatic movement of everyday life.”

I shall add in the same direction that, if the tic is an act, you should not however forget that it is a sterile act that produces nothing. It is evident that it produces nothing useful, but I believe that we can even say in the greatest number of these cases that it is not even capable of doing harm. What harms the subject is the very fact of being a ticqueur, it is the whole of these phenomena, the disorders that accompany the tic. But the act itself that is the tic, the movement of the head, the torticollis, the blinking of eyes, the grimace of the mouth do not make great harm. I described a girl who had the unique tic of abruptly falling to her knees every ten steps in the street as well as in her room,118 and I noticed with astonishment that in these abrupt kneelings she never hurt her knees. This ineffectiveness of the tic is interesting, it has moved closer to the complete uselessness of mental manias and must

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be recalled when we study the disorders of the will that determine these sterile agitations.

This impotence of the tic is connected with another characteristic that you should not forget when we stress the link between the tic and the act. If we leave aside the hysterics whose tics are a little bit idiosyncratic and in whom the reproduction of the act can be more complete, if we consider only the psychasthéniques who are the true ticqueurs, we can say that the tic is not a complete act.

When As... who has the peculiar habit of making herself vomit after every meal by slipping two fingers deep inside her mouth, while she herself thinks that the act is inappropriate, absurd and dangerous, we cannot say that she has a tic. It is an impulsion related to the obsessions of shame of the body and hypochondria. It would be a tic only as the act simplifies itself little by little and when As... does not have more than some spasms, some regurgitations, some belches after every meal. It is necessary to preserve in the notion of the tic, I believe, Trousseau’s earlier idea that the tic is a small incomplete movement, especially since this characteristic of being incomplete is important with the scrupulous. Their micromania, their mania of precision and of the symbol, predisposes them to look for these small incomplete movements. If the tic is thus an incomplete movement, it can reduce itself to a very little thing, become the simplest of movements in which the systematization, always fundamental at the beginning, becomes less and less visible. Ser... constantly raises her hand to touch her earring to check that she did not lose it. Here the movement is very well systematized, but little by little it is reduced and she does not have more than a twitch of the forefinger that rises abruptly. This small movement is still very much a tic because of its origins and on account of the mental state which accompanies it, but if we considered it in isolation, it would be difficult to see a very clear systematization there.

While considering cases of this kind, Mr. Bourdin\textsuperscript{119} comes to dispute the systematization of the tic and to deny that it reproduces acts. The movements of the tic are far too simple and too bizarre, in his opinion. This author goes as far as

\begin{flushright}
\textsuperscript{119} Bourdin, L’impulsion spécialement dans ses rapports avec le crime. Thèse de Paris, 1894, p. 55.
\end{flushright}
connecting the tics, at least the simple tics, to a functional lesion of the spinal cord resulting in motor discharges. A similar error would be impossible if we went back to the origin of the movement and if we noticed that what especially characterizes the tic is the mental disorder that determines it and which, for a very long time if not always, continues to accompany it.

Mr. Brissaud had already observed that the systematization of the tic led to its psychological study. In many cases, he says, the tic would be impossible to diagnose if we examined only the movement itself, if we did not take into account the case history and mental state that prepared the tic and that accompanies it.

Also, most of the recent works on the tics are, as a matter of fact, studies of more or less acknowledged psychology in which we especially try to determine the mental aspect of this phenomenon. Among the most interesting contributions to this study, we must cite the report of Tokarski, the articles of Messrs. Oddo, Dubois de Saujon, Meige, Feindel, Hartenberg. Most of these works especially locate themselves in the therapeutic point of view and must be studied regarding the diverse treatments of the psychasthénique state. We only point out here that they note both aspects of the tic, the systematic movement and the concomitant mental phenomenon.

Indeed, the tic is accompanied by phenomena of consciousness, of will and of thought. First of all, this movement is conscious; I only speak here about the psychasthénique and not about the hysteric. The subject knows perfectly that he closes his eyes, that he turns the head, that he kneels down. He feels it all the more since he has the feeling of making the movement himself and of voluntarily making it. This intervention of the personal will of the subject is so important that he can perfectly make his tic at this moment rather than at another one, that he can suppress it.

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123 H. Meige et F. Feindel, État mental des tiqueurs. Progrès médical, 7 septembre 1901.

124 Hartenberg, Traitement d’un cas de tic sans angoisse. Revue de psychologie clinique et thérapeutique, janvier 1899, p. 17.
for a moment, to postpone it till later and begin it again when he wants it (Guinon, J. Black, Brissaud).

A curious proof of the involvement of the consciousness and the will are the errors that the patient often commits in the execution of the tic. Fous... (101), who has psychogenic torticollis, always holds her head tipped to the left; when she is distracted and worried during an examination of her tic, she makes a mistake and during a part of the lecture holds the head to the right.

Other proofs were especially taken by Mr. Brissaud from the study of the processes that the patients employ to stop their tics for a moment. In most of the psychogenic torticollis described by Mr. Brissaud, the patient can himself stop the tic by some trick, by a light support of the fingers on the head or the head on a wall. Now it is impossible to establish a conflict between our hands and our head, or between our two hands. The definitive attitude that results from this alleged conflict is an accepted attitude, desired by the subject himself and if the patient can stop his tic by pressing his hand on his chin, it is, as a matter of fact, that he indeed chooses to stop his tic. In many cases, moreover, the subject chooses to stop the tic, an action that would be absurd if it was really a question of struggling against it. One of our patients has a tic that flings back her head, she arrests it by touching her forehead with her forefinger, this movement should, in reality, repel her head backward: it is simply, for the patient, an opportunity to want to lower the head forward.

We can also report all the techniques that more or less cure the tics for a long time. It is sometimes enough to explain to the patient what his tic is, how he makes it himself, how he can stop it if he definitely wants to consent to do so, that the tic stops for a more or less long time. In other cases, the patient just has to believe in the effectiveness of a remedy, any ointment applied to the neck or to the arm so that he stops his absurd movement for at least some period of time. All these facts, therefore, show that the tic is not a completely automatic movement but that it is largely a conscious and voluntary act.

But why does the patient want to make this absurd action? Most often we can say that he does not in any way know; he feels compelled

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125 Névroses et Idées fixes, II, p. 375.
to want it without knowing why. If we insist, if we go completely back to the origin of the tic, we almost always find, in a vague way, some demands to specify, to perfect, to check or demands to compensate, to repair something, that make one think of the mental manias which we have just studied. One of the most interesting of Mr. Dubois’ (from Saujon) patients feels compelled to stoop to the ground as if to pick up an object, she feels obliged to do this act with a special perfection, it is necessary that the back of the hand has to touch the ground; she has the mania to count to three, to look three times at an object or at a person, to hit her right elbow against her breast until it injures a small abrasion and then to give a small cry, etc.\textsuperscript{126} We shall see many similar cases among our patients, where a mental mania compels the will to carry out the tic.

Therefore, the tic is, in summary, a set of systematized movements, an action that is reproduced regularly and frequently, but in a completely untimely, useless and incomplete way because the will feels compelled to fulfill it. We rediscover here all the characteristics already observed in all the mental manias; that is why it will be useful in the enumeration of the tics to move them closer to these manias.

2. — *The tics of perfection.*

The first group of the mental manias appeared to us to be constituted by manias of oscillation, by doubts and deliberations. Such manias are almost exclusively mental, they contain operations that are rarely accompanied by physical movements.

If we wanted to look for the attitude that accompanies this kind of mania, it would be necessary to consider *immobilities* as tics, which would be often rather just. Lise stops, very often completely immobile, in the middle of an action. Sometimes, she takes, in advance, a position that can justify her immobility to the audience; for example, she holds a book in her hand. Sometimes, especially if she does not believe she is watched, she remains motionless in a position, standing, the foot raised to

\textsuperscript{126} Dubois de Saujon, *Société de thérapeutique*, 27 mars 1901.
advance and she stops indefinitely. This stop requires another muscular effort, it is definitely a tic of position. It seems to her that she should not move before having found what she looked for, before having passed from her doubt. Claire also forces herself to remain immovable in her bed by remaining in the first position till morning, and she wakes up quite stiff.

The second group of manias, the manias of the beyond, involves numerous movements and very often these movements seem to the subject to be compelled by the underlying mania. When these manias also come along with tics, they are less developed mentally and do not contain all the subtleties that we have just described. They contain simply the vague idea or feeling that it is necessary to perfect the act or the primitive phenomenon, to add something to it, and that the movement of the tic is an urgent addition.

A large number of tics are connected with the manias of precision; checking is among the most frequent. One of Brissaud’s patients shakes his head to put his hat firmly in place. Nadia and Claire, anxious about their personal need to check their state, quickly divert their eyes to look in passing in all the mirrors: it was necessary in Nadia’s apartment to cover all the mirrors. Nadia, furthermore, perpetually touches her body, her legs, her breasts to check quickly that she did not get fat.

Myl... worried at first by his headaches, from time to time shakes his head “to know if it is in its right place.” Fok... worried about the state of his stomach, shakes it with a sudden contraction of the rectus muscles; Ul... makes a grimace with his eyes “to feel if they are in place,” Ser... a 16-year-old, constantly touches her ear and strikes three small blows to the head “to be sure that the earring is securely attached and that it has not fallen.” Many, as we have seen, shake their heads to see if their collar bothers them. Little by little the idea, the definite search that brought about the movements, fades from the mind or is represented merely by a brief feeling of anxiety and the movement is quickly made, in an incomplete and perpetual way. Ul... does not have more than a small movement of rotation of the eyes, which we would consider convulsive, Myl... a small nod of the head.
The mania of symmetry brings about tics of walking as in Azam’s patient who jumps from one stone onto another one to give both feet similar sensations.

The mania of the symbol becomes the starting point for a very large number of tics, because, as we have seen, movements summarize and express ideas. Lod... imagines a religious or atheistic meaning in certain acts, to close the fist is as if we said: I do not believe in God. As she thinks all the time that she does not believe in God and as she needs to quickly formulate this thought so as not to be disturbed too much in the course of life; she is content to quickly give a hint of the gesture of closing the fist. If every instant she turns half around in the street, it is because this gesture represents for her the thought of religion: “it’s like crossing through a church and we turned around in front of the tabernacle.”

Jean has a similar, very bizarre performance: he always imagines himself confronted by genital temptations and he considers it a small satisfaction, like an image of sexual pleasure. Now one day he feels some pleasure by scratching his nose; this pleasure was all the more impressive as it gave him a vivid memory of his former masturbations: he apparently performed it while squeezing his nose against a handkerchief that had belonged to the chambermaid. From there, naturally, a symbolic association of ideas occurs between the act of scratching his nose and the thought of sexual pleasures, the one becomes the symbol of the other one; but as the act of scratching his nose is much simpler and is much less dangerous in his mind than masturbation, the symbol always replaces the genital impulse. These complicated performances came to combine themselves in a dirty habit; he gave it the importance and has contributed to the fixation. The same patient ceaselessly needs a moral support, he symbolizes this need by always holding his right hand half raised over his head and resting on a higher object, “it’s as if I rested on somebody stronger than me at my side.”

The same feeling played a role in the formation of a real spasmodic torticollis, for Brk..., “I always have the need to lean, I would like to have a support, a friend, I do not know how it has brought the need to lean my head sideways on my shoulder.”
For the same reason as above, these movements more or less lost their enactment and Lod... turns around by walking, Jean scratches his nose or plucks the fingernails or raises his arm in the air, Brk... constantly holds her head to one side without quite knowing why, and seemingly despite themselves.

We could relate this need of the symbol to the interesting tic attributed by Rodenbach to the sister with scruples “from time to time she patted her unfolded handkerchief, she dusted, we would have said, as if to scatter the invisible fall of some dust on her, these silent molecules.”

The mania of temptation, the mania of impulsion, which plays a big role in the criminal obsessions, determined the tics of Sau... (13), a 16 year old child, she has the obsession that she wants to kill herself. “Clearly, this idea is serious,” she said, “because, despite myself, all the time my arm starts small movements to hit me, to sting.” We have already seen many similar examples in the obsessions about crime.

It is necessary to make a rather big place for the mania of contrast, which is quite close to the mania of impulsion, Mr. Séglas already noticed that the verbal tics are often in contradiction with the normal expression of the sentiments of the moment. Many psychasthéniques, when making an act with attention, think of the operations that would be completely opposite to their desires and that they dread; for many, this thought remains a simple conscious phenomenon and they ruminate on the thought of these opposite acts. However, for some these thoughts bring an action in contrast with the initial act. Do..., whenever it is a matter of making a delicate movement, feels hampered by the idea to make a mistake, he believes that he is going to throw the glass on the ground, to commit a faux-pas. His thumb, instead of grasping the object, folds strongly into the palm of his hand. Little by little, this tic occurs almost without reflection and Do... cannot carry out delicate actions any longer. As a result, he cannot write any more because of this tic: the thumb puts itself into the palm before it touches the quill. The writers’ cramp is a


syndrome that can have many, diverse origins, but it often occurs through this mechanism.

Gi... (113) presents a remarkable case of coprolalia,\textsuperscript{xxvii} this patient had tics of dancing, she felt compelled to turn, to have beautiful manners,\textsuperscript{129} it was a tic in touch with her preoccupations with the theater where her son went very often. When this tic was cured, she began to scream dreadful shouts and to agonize us with nonsense: “pig, camel, you make me ch....”\textsuperscript{xxxviii} She could very well resist this tic in the street in the presence of strangers. These patients, we know, always stop the impulse when the act could become serious. But “she was compelled to shout these insults” in the hospital, when she saw me. “I would like to be polite,” she says, “I hold on and I am obliged to think of silly remarks that I would not like to make, it seems to me that I am obliged to make them.” This tic is not the expression of the mania of impulsion, it is the mania of contrast.

Renée’s\textsuperscript{130} tics are of the same kind, she loathes cats, dogs, she was frightened by a small, stupid pastry cook who spoke like a child, she would like not to think of all this, she is obliged to think of it, to look for all the circumstances that remind her (mania of associations) of it, to see if she can think of it without danger (mania of the temptations) and here she shouts “meow, wah, wah, Zozo, my nanny, small woman, whore, brothel, etc.”

The previous manias play another role in the tics that imitate diseases. Gauc...\textsuperscript{131} is preoccupied by the thought of tabes,\textsuperscript{xxxix} he is afraid “that there is something in his legs,” especially since he saw an administration of the patellar reflexes examination.\textsuperscript{xl} He looks to see if these reflexes have something peculiar, and despite himself he raises his legs in the air as soon as we touch his knee, he walks with a great shaking of his legs. Renée and Bor... have the tic to hold themselves crosswise, they both have the idea that they are affected by coxalgia\textsuperscript{xli} and the idea that they perform a sham, there is a singular feeling of doubt which adds to the tic of the gait.

\textsuperscript{129} Raymond et P. Janet, Névroses et Idées fixes, II, p. 341.

\textsuperscript{130} Pierre Janet, Accidents mentaux des hystériques, p. 158.

\textsuperscript{131} Névroses et Idées fixes, II, p. 393.
Many cases of spasmodic torticollis such as that of Buq... are linked with an anxiety about drafts, about diseases of the neck, with a need to check the disease, with phenomena of contrast.

Here now are the tics that are connected to the mania of cleanliness, to the mania of precautions: many patients who had the mania to wash their hands even after their apparent cure keep the tic of rubbing their hands, the one against the other one. Zo... who was afraid of swallowing pins has tics of chewing, coughing, crackling. It is necessary to recall Jean’s tics which spread his legs, which stop him for one moment in the corners of streets, which get him up to cut the bread, etc.

The manias to restart actions will also leave, as residues, small incomplete movements or tics; to sit down after two or three steps, to grope about by touching doors, to turn half around as soon as one makes an action, to repeat things two or three times. Here, on this curious matter, is one of Mr. Séglas’ observations. A patient advances in the streets by making circles, “she has to make a tour the other way around on the pavement to make a circle before advancing.”132 It is a tic related to the mania of returning back.

The mania of the procedures determines the growls and the belches of Rai... who wants “to breathe well,” L..., who “wants to write with perfection,” has hand cramps. A 24-year-old young man Vog..., worried and shy is pursued since his childhood by the desire “to speak well in front of the world.” He comes to stutter and to grimace in an abominable way. “The facial tics came gradually,” he said, “as movements to make language easier, to help me, relieve me.” Awkward movements of the tongue that prevent her from swallowing developed at age 39 for Ev... a woman of the same kind. A discomfort in swallowing was the starting point of attentiveness and tics of every kind in the jaws, in the tongue and in the pharynx. Many cases of esophageal cramps fit into this group.

We can also connect to this group the singular tic of a 19-year-old girl, Dey... (105) who tears out her hair, one by

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132 Séglas, Société médico-psychologique, janvier 1888.
one, until making big patches simulating alopecia areata. “It is because she cannot work or pay attention without shaking herself, scratching herself: that incites and encourages her; in this way she developed the habit of pulling out all her hair.”

There are, therefore, a very large number of tics that are not accompanied by ruminations precisely analogous to those that we observed in the mental manias of the beyond, but which seem related to needs, sentiments analogous to those that inspired the manias of beyond.

3. — *The tics of defense.*

In other cases, the mental phenomenon that accompanies the tic is a little bit different, the patient feels compelled to carry out the movement, not to make something better, but to repair, to compensate for something unfortunate, to defend himself against a harmful influence.

Mr. Meige reported a fine example of this kind. His patient, to stop a tic of the left shoulder, feels the need to grab the sick arm with the right hand. Soon, the right hand also presents a tic to squeeze, pull, twist in any manner the recalcitrant arm, and eventually causes lesions. This absurd battle of the two hands was, for the patient, an extreme and obsessing need.133

“The obsessive smile,” about which Bechterew speaks, is instead a tic to smile by one who is shameful of his body. The patient, very shy and very shameful, hit upon the idea to smile when we look at him, it is a formula of conspiracy. This smile presents itself despite himself, or rather he feels compelled to smile as soon as somebody has their eyes on him or simply as soon as he thinks that somebody can see him.134

A patient of Messrs. Pitres and Régis has mental manias of conspiracy, “push this stone with the foot twice and nothing will happen to you” he says to himself ceaselessly. “Actions, in the long run, become automatic,” say the authors, “but for a long time they were preceded by an idea.”135

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Among my patients, there are too many examples to be able to list them all. As..., a 26-year-old man, Ad... (49), a woman of 49 years, Qsa..., a 55-year-old man, are worried about the stomach; they suffer from it slightly and feel swollen. They are ashamed to eat and think that it would be better not to eat, but as they cannot refrain from it completely, they compensate for the meal, some by attempts to vomit and actual vomiting; the others by endless belches and tremors of the stomach. The tics of vomiting have a considerable importance for psychasthéniques. I may only indicate them here in this enumeration of the tics; it will be necessary to return to their pathogenesis and their consequences.

Te..., a 20-year-old, after walking in shoes that were too small, keeps a tic of curling the toes and inflexibility of the whole leg. Qk..., to fight against the fatigue of writing has to write while on his knees, then in more and more bizarre postures.

Xy..., pushes away, with her right hand, an imaginary object which would come over her; Zo... does “ahem, ahem,” not to think any more about pins; Myl... sketches the sign of the cross; Bé..., pursued by the thought that she has a worm-spider in her stomach, dissipates this fear by rubbing her stomach on the right side, this tic is so continuous that it always causes a fray of her dresses in this spot. Lae... (80), a 28-year-old man, obsessed by the thought of rabies, had at first sorts of crises which seemed to him to be related to rabies. In his crises, his bones cracked; he managed to restrict himself to a small, peculiar movement; it suffices for him to crack his joints to be freed of the thought of rabies. The same patient crosses his hands on his trousers because he has the idea that a dog touches him and that by this movement he pushes aside the idea; these two movements eventually establish real tics.

We see that in all these patients the tic is like a reduction of the mental mania, whether the mental mania was formerly fully complete, or whether it was only beginning and still remains embryonic, or whether it does not exist in an intellectual form at all and is completely replaced by this systematized motor agitation. Generally, we can say that a mental mania becomes less developed as the motor tic becomes more complete. But it is similar tendencies that
determine the one or other one of these two phenomena and that is what I wanted to bring to
light by showing that the tics can be grouped in the same way as the mental manias.

2. — The diffuse motor agitations.
   The crises of agitation.

In other patients, the movements become more extensive and at the same time more vague, they
seem to constitute real convulsive crises. I believe that it is necessary to stress the similarity of
the diffuse motor agitations to the diffuse mental agitations. They play a considerable role in the
disease and also play an important role in its interpretation.

1. — The crisis of efforts.

The most curious of these crises can have the name of the crisis of efforts. The patient
dissatisfied with himself, desiring to do better, naturally concludes that he has to do what allows
normal people to be transformed, that is to say, efforts; but these, to his misfortune, turn very
quickly into mania. There is a delicate balancing point, because, as we shall see later by studying
the therapeutic processes, certain efforts are indeed very good for the patient and that he is
transformed by efforts of attention. But these useful efforts must be managed by the doctor and
must have a special nature. It is rare that the patient by himself finds the useful efforts to make
and we do not speak about these now. The efforts that the patient imagines are a series of rather
uniform actions, although less stereotypical than the tics, tiring and painful, that he considers
necessary to accomplish so as to give his action this character of certainty and satisfaction that he
always lacks.

The patients who make efforts of this kind, for whom these efforts turn into a mania and
constitute real crises, are rather numerous. Vy... tries to give herself convulsions to make a
movement that is perfect; she feels the need to
push as if to have a bowel movement. Tr... makes efforts as if to raise a package, before opening a door or praying and contorts himself for hours.

A really extraordinary instance of this kind of mania is found in Claire. Several times a day, this patient has periods of dreadful contortions that were very often taken for crises of hysteria and which, in my opinion, look like them in no way. They are voluntary contortions or nearly voluntary: when she feels or imagines to feel that an action is bad, that a thought is shameful, that she is going to have her obsessive image of the virile member and the Host, then she believes that she has to do something to modify the act or take away the image. This something is what she calls her efforts. Theoretically, her efforts are intellectual; at the beginning, she had her head in her hands, eyes in the air, the glance lost in the distance and she devoted herself to a work of mental rumination. But little by little she convinced herself that the intellectual efforts must be accompanied by corresponding physical efforts and she began to take special attitudes; so it is necessary, when she is sitting down or goes to bed, to stiffen the left leg, to have the mouth open and the head as low as possible, the eyes closed or excessively opened. Then she got used to making uncoordinated movements of her arms and legs to the point of putting herself into an absolute sweat and to feeling pain in all her muscles. She folds at the waist and raises herself in rhythmic movements of greetings; she shakes the thorax with big respiratory movements. She carries her hands in her mouth, she gnaws away at the nails to the point of bleeding, she sucks and bites the fingers: these last manias eventually developed enormous calluses on the joints of her fingers. When she does not eat her hands, she eats her handkerchiefs and her sheets: in winter, she reduced to lint about fifty handkerchiefs. Finally, by surrendering herself to this exercise, she always has horrible grimaces on her face. All these contortions go on continuously over several hours.

The patient imagines that these movements of the body are parallel to the movements of her thoughts: “if I see the idea of everything at the bottom of me, I have to lower the head very low to look for it; if I see it at the top, it seems to me that my will dashes to seize it and that my body does the same... It seems to me that it is my heart that thinks; I have to look for the thought by
movements of the chest and by increasing the beatings of the heart... My being is in the navel, I have to shake the stomach to find it.”

We clearly see here the efforts mixing in with the mania of the symbol and we could apply Mr. Ribot’s remarks about the analogy of the moral effort and the physical effort: “the feeling of effort experienced when we look for our road through a mass of dark and muddled ideas is only a weakened form of the feeling that we have when searching for our road in a thick and dark forest.”

Naturally, all these violent contortions and all these thoughts bring all sorts of visceral disturbances, disorders of exaggerated and anxious breathing, disorders of the heart which beats to break everything. But what is especially provoked following this agitation and following these abdominal movements is a great genital excitement and the efforts end simply in a true masturbation. I call attention to the extreme importance of this substitution of genital excitement for voluntary efforts.

We shall find these facts in the next paragraphs where we shall study the emotional phenomena of anxiety. I want only to point out here that this patient has the external phenomena of anxiety rather than anxiety itself. She complains in no way of suffering during this crisis of efforts. “The movements of her chest and her heart, she says very exactly, are due simply to breathlessness.” The agitation in this case remains motoric much more than emotional.

A very curious example of these crises of efforts is the one of Lrm... (232), a forty-year-old man. His bizarre crises become more complicated by the mania of the symbol and by obsessions of persecution. This poor devil had, as with all the scrupulous, the need for sympathy and he loathed conflict. Following an insignificant quarrel with an individual who was his partner and his best friend, he retains if not an obsessive idea, then at least an obsessive sentiment that he is battling against this individual, X. It seems to him that X attacks him, that it is necessary to respond to him; although it is very painful, it is necessary to defend himself. Without having any hallucination, and knowing well that he is alone, that X is not

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present, he feels compelled to fight against him. The fight is material: he stands up, throws punches and kicks with rage, he struggles like a maniac, he beats himself, bites his own fists and eventually falls on the ground exhausted by such efforts and streaming with sweat. You should not forget that this patient has no delirium, he knows very well “that X is his best friend and that, if X was there, he would take care not to touch him,” but this physical fight is the symbol of a moral fight “that he would make if he had the heart;” it is the result of incredible efforts that he feels compelled to make.

Sometimes the crises of efforts are more precise, even more systematized and come closer to tics. I shall not dwell upon the patients, men or women, who make incredible efforts to arrive at perfection in masturbation. I shall take as an example a crisis of efforts that appears frequently enough and that is very typical. A 55-year-old man, Qsa..., as we have already seen, has painful digestions and often more or less voluntary vomits to unburden his stomach, the vomiting comes closer to tics. From time to time, following premonitory disturbances, about which I shall speak later, he feels that the stomach torments him more and he shakes himself in all sorts of ways, he has mental ruminations about death, about his parents who do not love him enough; then he walks, he cannot stay in one place, then he tries to drink a little, he sucks candies, he begins to shake his stomach by spasms of the abdomen. Then he tries to vomit, but he claims to have gotten there too late, he cannot vomit or at least vomit well enough. He vomits a little, he spits tremendously, but he feels that it is not sufficient, that he would be cured if only he could return a certain mouthful of bile, which does not come. And there are hours of dreadful efforts to vomit this mouthful of bile, contortions of all the limbs and the whole body. He nearly reaches the degree of efforts of Claire, except that from time to time he has a violent movement of vomit. The crisis can last the whole night, he stops either after some small vomiting, or from an exhaustion which eventually puts him to sleep. I find these crises of efforts to vomit in two other patients, in particular with a 12-year-old child who made similar grand crises whenever his parents made him eat anything.
other than the jelly of meat and prunes, the only food that he would digest without crisis.

2. — *The crises of walking and the crises of speech.*

I hesitate to associate the common tics with the more complex phenomena of movement, especially when it is more extended, that we often see in the same patients under the same circumstances. These patients are disturbed about an act or about an idea and, instead of surrendering themselves to mental recriminations, they feel a more or less irresistible need to walk.

Their nervousness calms down only when they have walked for a very long time without engaging in any violence. We saw that Cha... has the manias of investigation and interrogation: he met a person that he had the misfortune of watching carefully, he immediately wondered who this person looks like, what is the name and address of this person who looks like him; he must forever search out these resemblances and addresses. This searching, if it does not succeed at once, is transformed into an agitation that forces him to walk back and forth in his room, he turns like a caged animal for the whole night and peace will return only when he becomes exhausted by fatigue. Car..., a 28-year-old woman, also stops the anxiety caused by an idea of madness by walking without end. Cr... (104), a 44-year-old man, is upset by the slightest emotion and immediately he has to go out and make long journeys.

A patient of Mr. Souques gets closer to these: after crises of dipsomania or instead of these crises, he feels the need to walk for several days and comes back exhausted. The same is true in one of Mr. Magnan’s cases. This subject interrupts their tic by big movements and by long walks.

Ie..., an 18-year-old, presents exactly the same symptoms; he is a scrupulous, shy, dissatisfied with what he does. He puts himself at his work desk with the intention to do a better job than the others; he tries to put in all of his attention. But this


effort annoys him and agitates him, he feels an unconquerable need to walk in order to calm down. So he goes out and begins to roam the streets of Paris, he never looks for companions and satisfies his mania alone as a dipsomaniac; he always takes the same streets, like an old woman and solitary as much as possible, he goes around the same district for five or six hours, then he returns calmed and satisfied.

Here is, if one wants, a type of fugue; but it is a rather distinct variety. It is not the irrational, unconscious, forward march of the true epileptic. It is not a hysterical fugue during a trance followed by amnesia: the patient returns quietly to his home without awakening, without surprise and generally remembers well enough all that took place. Nor is it completely an impulse to escape; nor is it one of the journeys that we observe in the same psychasthéniques that Mr. Régis called dromomania. In those impulses, there is an idea that pushes the patient towards a goal, he thinks of going towards a certain place, of avoiding work as we saw in one of the observations reported in the first chapter of this work. In the crises that I study here, there is no idea that causes the walking, or obsession that pushes one to the journey, it is walking for the sake of walking. It is a forced operation that the patient executes, just like what was employed in his mental ruminations.

In other cases, the walking is replaced by some other equally exaggerated and useless physical exercise. Mr. Tissié described, in this regard, remarkable cases of the mania of canoeing in young psychasthéniques who cannot resist the overpowering need to get excited and to push themselves too hard in sports.

We can connect these crises of walking with the need to speak or even to write that consume patients under the same circumstances. Fy...(34), a 35-year-old woman, a remarkable subject from many points of view, has obsessions of shame, is afraid of becoming crazy, and at this moment feels agitated, “lifted like a feather.” It is necessary that she come and go and especially that she speaks,

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139 P. Denommé, *Les impulsions morbides à la déambulation nu point de vue médicolégal*. Thèse de Lyon, 1890.


140 Tissié (Bordeaux), *Un cas d’impulsion sportive ou ludomanie*. *Journal de médecine de Bordeaux*, 26 janv. 1896, p. 35.
that she speaks forever to anybody, that she tells her troubles, “all that one should not say.” She chats this way all night long and calms down in the morning only by writing about twenty pages in her diary. Jean gives in to a need of the same kind when he comes to me and begs me “simply to listen to him for the relief... He can say nothing about any of this at his home; that would make his parents very unhappy and he has to say it” and for one and a half hours or two hours he speaks, without stopping for one instant, about the crazy laugh of the one-eyed chambermaid; about a two-pence coin that he has in his pocket and that was touched by a woman, which puts fluids in his pants; about the postage stamps that remind him of politics and the personage who died after staying three-quarters of an hour with a lady; about a small dog that, when he was touching it, nearly hit his penis, etc. He feels relieved, “relaxed” when he is finished. It does not matter to him what he said, he simply exhausted in words an agitation that did not arrive, he got enough exercise in a different way.

3. — The crises of agitations.

Finally, the motor agitations can be even more diffuse, even more uncoordinated.

Regarding some powerless effort of the will or of the attention, or regarding a slight emotion, there are those who get up suddenly, who abandon their job by declaring that they are definitively incapable of it or even who interrupt a mental mania, an inquiring rumination, for example, and who surrender themselves to an incoherent agitation. Nadia wants to try to play a piece on the piano for me, she stops at the end of some measures, dissatisfied with herself and begins again; the same stop at the same point, the same resumption; then she gets impatient, surrenders herself to her usual chattering of magic formulae and pacts “if I do not play this whole piece well, then I want to die this evening, if I do not play it well, then it is because of me that my mother died, etc.” Now the agitation, that was mental, becomes physical; the patient gets up, throws her music, and then here she comes and goes about the room, knocking down furniture, throwing pillows, breaking vases. At the strongest moment of her illness, she broke many objects and seemed in a state of maniacal fury,
seemingly dangerous to approach. In reality, she has never hurt anyone, and she broke only insignificant objects; just like Claire in her crises of efforts, she always remained capable of stopping at the point that seemed necessary to her and to stop abruptly if a person entered whom she did not want to show herself to in this state.

These crises of agitation are not rare in the scrupulous and can appear in various forms. For Tf..., a 32-year-old man, they are crises of shaking or “a crazy need to break the crockery.” Ho... (99), a 13-year-old girl, at first has various tics that mix and repeat themselves: she puts fingers in her nose, gnaws at her nails, rubs her stomach, then has contortions of the whole body, then shouts of all kinds that she cannot hold back, she says “it’s as if I had the moral duty to shake myself, to shout.” Mr. Dubois de Saujon also describes, “a ticqueur so agitated that one had believed it to be a very forceful chorea.” Mr. Pitres also describes generalized convulsive tics that, he says, received various names, electrical chorea of Hénoch-Bergeron, électrolepsie of Tordeus, rhythmical convulsive neurosis of Guerlin. Some of the preceding patients could be moved closer to these descriptions, because they look at this moment like extremely agitated choreics.

Others, like Lkb..., a 28-year-old woman, tormented by an obsession of suicide, Sy... a 29-year-old woman, who has obsessions of homicide, Af... (39), Kn... (37), go, come, jump, gesture, shout and break everything; then they eventually rush to their bed, or even fall on the ground and writhe in every direction as if in the grip of great convulsive crisis.

In some cases the resemblance of these agitations to a hysterical crisis becomes so great that, in a simple examination, the diagnosis is impossible. Qes..., obsessed, as we saw, by the idea of killing her mother, claims to resist the obsession by throwing herself on the ground and by making contortions. Before she entered the hospital, this act was obviously her trademark, we saw clearly that she did not lose consciousness, that she laid herself

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141 Dubois de Saujon, *Société de thérapeutique*, 27 mars 1901.

142 Pitres, *Tics convulsifs généralisés*. *Société de médecine et de chirurgie de Bordeaux*, 21 décembre 1900.
down on the ground and that she had voluntary contortions. Since she stayed for a long time in a
room where there were true hysterics and epileptics, she perfected her process and I would give
the challenge to an outside observer to make the diagnosis, by simply seeing her abrupt fall and
her convulsions.

Although I plan to resume, in a special chapter, the discussion of the diagnosis between the
psychasthenique phenomena and the hysteric disorders, I remind here of what distinguishes a
typical hysterical crisis from the psychastheniques’ motor agitations. These patients never lose
consciousness in a complete way; they have no clear amnesia after the crisis; they are always
capable of stopping their crisis at any time, if they understand the necessity; they have no real
automatism; they do not attend to the phenomena, they themselves make them; they are
conscious of making the effort to produce all these movements and they simply feel compelled to
make them. These characteristics are reversed in a typical crisis of hysteria. In the incomplete
cases, the diagnosis can be made only by the study of the antecedent phenomena and the total
evolution of the disease.

In all these movements we easily find the essential characteristics of the agitations. They are
obviously exaggerated and useless movements: this is not the place to demonstrate that these
efforts, these agitations are unsuitable in the given situation and useless, as were the tics. It is
good to recall that these movements are simple, crude, without delicacy and without real
precision. The tics crudely represent an act, but an act executed in a very incorrect manner; the
walking, the contortion crises are simple movements, without delicacy. A small detail was not
pointed out, it... gets much more dirty in these crises of walking than he would in a walk
performed under normal conditions. We notice that the tics and especially the crises of agitation
give rise to symmetric movements: both shoulders go up at the same time; both arms throw
punches at the same time or twist themselves in the same way. The frequent, symmetric
movements of children are found again here in the fatigued subjects; as pointed out by Mr. Féré,
they indicate a decrease in the complexity of the
movement, a kind of motor degeneration. It is very evident that the subjects are capable, under other circumstances, of more precise, more adapted and more delicate movements. We, therefore, find here the third characteristic, already noted in the mental agitations: the *inferior* character of the movements that constitute these motor agitations.

In these last phenomena of great motoric agitation, the efforts of thought, the mental ruminations decreased significantly although there are still traces. We see that a motor agitation was almost completely able to replace the previous mental agitations. Not only can this motor agitation take a systematized form in tics similar to the mental manias, but it can take a diffuse shape similar to mental rumination and to forced musing.

We can therefore postulate the main forms of the motor agitations in the following diagram.

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143 Féré, Revue scientifique, 1890, I, p. 816.
THIRD SECTION

THE EMOTIONAL AGITATIONS

At the same time that the obsessions develop, the countless mental manias and the motor agitations that we have just enumerated, emotional disorders of great importance appear in some of these same patients. The subjects often put them in the foreground because they are very painful and some of the authors who studied the obsessions are inclined to consider this symptom as the starting point of all the others. It is, therefore, necessary to examine it with some care.

These feelings present the general character of the psychasthénique phenomena, they impose upon the subject without a justifiable relationship either with the outside circumstances or with his own thoughts; they are considered by the person who feels them as exaggerated, inconvenient and absurd. But the patient considers it impossible to avoid them; he does not undergo them completely passively as a purely physical phenomenon which strikes him, he gives way to it with a certain accommodation because he believes, because he feels that he cannot do otherwise. These are the characteristics of the forced operations, which are found again in the emotions as in the deliberations and the movements.

These emotions that impose themselves almost always have an unpleasant character, they come closer to pain, to sadness and to fear. Sometimes this fear is precise, systematized, it has clear emotional characteristics and comes along with perceptions and with rather precise ideas: in that case, the emotional agitations are systematized and receive the name of algias (pain) or more often of phobias (fright), sometimes they are diffuse, without relationship to a definite thought and they constitute anxiety. In our study of the phobias, we shall search especially for the precise forms that they take in this or that given case; in our study of anxiety, we shall examine the
general phenomena that constitute these pathological emotions and that already existed, more or less concealed, in all the phobias.

1. — *The systematized emotional agitations. The phobias.*

These forced emotions, which take a shape that is a little bit particularized according to the phenomena around which they develop, appear to be countless. For a while, every author discovered a new phobia and baptized it with a Greek name. We thus invented misophobia, cynophobia, nosophobia, agoraphobia, erythrophobia, microphonophobia, the fear of small noises, amaxophobia or the fear of cars, siderodromophobia, the fear of railroads, dysmorphophobia, fear of deformities, triskaidecaphobia, fear of the number thirteen, etc. I do not claim to be able to enumerate them all; it is enough to indicate certain groups where the main forms line up easily and that serve to accentuate certain psychological characteristics.

1. *The classification of phobias.*

The classification of these phobias seems very difficult because it has been tried many times without yielding a classification that is clearly winning. Mr. Freud, who studied many anxiety neuroses, admits three classes: 1° the traumatic phobias, noticed especially in hysteria; 2° the common phobias, exaggerated fears of things that everybody fears a little: the night, loneliness, death, illness; 3° the phobias of opportunity, agoraphobia and the phobias of other diseases. The first group does not interest us here and, moreover, is connected to very different phenomena; I confess not to see distinctly the differentiation of the two other groups, the agoraphobias, for example, and the phobias of loneliness appear to me to draw closer through so many intermediaries that this distinction has hardly any utility.

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144 Freud, Revue neurologique, 30 janvier 1895.
Mr. Régis in his textbook on mental medicine\textsuperscript{145} recognized a simple classification according to the main groups of objects that give birth to the phobia: 1° phobia of objects (rupophobia, fear of dirty objects); 2° phobia of places, elements, diseases (agoraphobia, astraphobia, bacillophobia); 3° phobia of human beings (zoophobia, anthropophobia, gynophobia). This classification is retained in the report by Messrs. Pitres and Régis on the obsessions.\textsuperscript{146} It is obviously convenient, but it is purely external and teaches us nothing about the psychological characteristics that separate these phobias from one another.

Mr. Marrel, in his thesis on the phobias,\textsuperscript{147} seems to me to have made an interesting attempt by trying to classify them, not according to objects, but according to the mental disorder that is produced on the occasion of the object. He accepts three groups: 1° the phobias relative to a sensory disorder of the general sensibilities, touch, sight, the muscular sense, hearing, taste or the sense of smell; 2° the phobias relative to a disorder of perception or the imagination; 3° the phobias relative to a disorder in thoughts or feelings. The idea seems just to me, but it seems to me that the author does not make a sufficient accommodation for the disorders of actions and for the disorders of emotions.

In trying to combine the classification according to the nature of objects and the classification according to the psychological disorders, I shall propose accepting four groups: 1° algias or phobias of the body which have their starting point in the subject’s body and are especially determined by disorders regarding simple perceptions; 2° the phobias of the objects that have their starting point in the perception of external objects and are especially determined by the disorder of actions; 3° the phobias of situations in which the emotional disorder is not determined by the view of a simple object but by the perception of a body of circumstances that constitutes the subject’s current situation. The disorder exists at the same time in action and in the sentiments; 4° the phobias of the ideas where a thought, even abstracted, is enough to bring about intense and

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\textsuperscript{145} Régis, \textit{Manuel de médecine mentale}, 1892, p. 270.

\textsuperscript{146} Pitres et Régis, \textit{op cit.}, p. 27.

\textsuperscript{147} Marrel, \textit{Les phobies, étude sur la psychologie pathologique de la peur}. Thèse de Paris, 1895.
painful emotions: attention, judgment, belief, are especially in question.

2. — *The algias.*

Many psychasthéniques present, in appearance, like the hysterics; on certain points of the body, there are painful regions where they cannot bear any contact, or any movement. When we touch these parts lightly, or when they have to put these organs to work, the patients seem to feel pains and completely enormous disturbances and, naturally, completely disproportionate to the modification in work; they have disorders of circulation and breathing, they are covered with sweat, they writhe, they back up with gestures of terror and screams of suffering. These disproportionate pains, these inopportune emotions occur in two slightly different circumstances. Sometimes they are almost continuous, regarding a definite part of the body, even when this part remains motionless: they are *the algias,* properly speaking. Sometimes they develop only when the organ naturally has to take up its role, they are *the phobias of the functions.* It is evident, moreover, that in many cases these two disorders come closer to each other and become merged.

First, we consider the phenomenon of *algias.* Leuret\(^{148}\) already reported a girl “who believes she is severely hit and who screams loudly when we touch her only with the fingertip.” Legrand du Saulle reported the observation of a woman who had the obsession of breast cancer and who suffered constantly.\(^{149}\) Observations of this kind soon became quite numerous in the works of Beard, Charcot, Huchard, Bouycret, deVerneuil. I will recall only the interesting article of Mr. Galippe about dental obsessions.\(^{150}\) This author describes all the terrible sufferings that develop in certain persons regarding their absolutely healthy teeth, and also the anxieties of a patient “who feels a weakening of his personality” because they want to make him wear false teeth; he insists on the imaginary cases of cancer of the mouth and the tongue. At the same

\(^{148}\) Leuret, *Fragments psychologique sur la folie,* 1840, p. 86.

\(^{149}\) Legrand du Saulle, *Folie du doute,* p. 28.

time, Mr. Paul Blocq gathers all the phenomena precisely of this kind under the name of *topalgia*. “I propose,” he says,\(^1\) “to designate under the name of topalgia an important variety of monosymptomatic depression in which we notice only a fixed pain, located in a variable region, but not related to a region anatomically or physiologically demarcated... It is the clinical demonstration of the persistence of a fixed sensory image, analogous in the domain of sensibility to what obsession is in the domain of the intelligence.”

We find such algias in all points of the body. The obsession of Her...(61), similar to that reported by Legrand du Saulle, shows us such a pain located in the breast. This 38-year-old woman, always very impressionable, is frightened by her pregnancy; during this pregnancy she feels a small discomfort in the breast, worries about it, looks at it and touches it constantly. She foolishly consults medical books and eventually feels very painful and frightening pains at the slightest contact with this breast. Me...,\(^2\) who has the obsession of phthisis present in two regions of her chest: one in front under the collarbone, the other one on the back, to the right and under the shoulder blade where she suffers a peculiar illness, “if something touches these regions, even slightly, I feel ready to faint and to suffocate.” Fik...(158), a 57-year-old woman, frightened by an absurd diagnosis of angina pectoris, maintains a terrible algia of the chest at the level of the heart.

Ja... (50), who had such aches for a long time in the uterus, now has them “under the skin of the face where there must circulate a corrupt blood that brings stiffness and horrible nagging pain.” Various cutaneous sensations can, indeed, be the starting point of these algias: Mr. Brocq indicated, by the name of *acarophobia*, a cutaneous paresthesia with intense pruritus that he connected with a mental derangement of obsession\(^3\) and Mr. Thibierge combined, under the name of *dermatophobia*, the varied symptoms such as peladophobia, the phobias engendered by genital herpes, syphiliphobia, the acarophobia of Brocq,\(^4\) etc. Sometimes these

\(^1\) Paul Blocq. Sur un syndrome caractérisé par do lu topalgio, neurasthénie monosymptomatique à forme douloureuse. *Gazelle hebd. de méd. et de chir.*, mai 1891.

\(^2\) *Névroses et Idées fixes.* II, p. 284.

\(^3\) Brocq, *Journal de médecine et de chirurgie pratiques*, 1895, p. 90.

\(^4\) Thibierge, *Dermatophobie*. Presse médicale, 9 juillet 1898.
pains are interpreted by the patients who say they feel all sorts of bizarre sensations. A patient of Mr. Hirschberg, while giving her account of her condition and in finding her “sensations inane” cannot refrain from feeling “frogs that walk on her back, tongues of disgusting animals which lick her, worms, rotten intestines that slide along the back.”

The algias of the head form an interesting group, they are naturally connected with the headaches that exist so often in all these patients. But they add to these common headaches an enormous exaggeration of pain and emotional disorders distributed throughout the whole body. Ct...(57), a 28-year-old woman, constantly rubs her vertex to the point that she wore out the hair in this spot and to the point that the summit of the head is revealed: the algia of her head is almost constant. On the contrary, the algia of the head for Box...(58), a 50-year-old woman, appears during crises which last for only a few hours or a few days. At those times, she wears an enormous package of absorbent cotton attached to her head; this is intended to ease the pain and to avoid the lightest touches. In addition, she is constantly holding up her head by leaning back against a wall to support her “without which she would fall with an enormous pain,” here there is both tic and mental torticollis at the same time as algia.

I have already described in the second volume of the neuroses, the case of Bi..., a 35-year-old woman, who banged her elbow and abruptly felt the classic pain in the little finger due to irritation of the ulnar nerve; this pain deeply impressed her and from then on for years she cannot feel a contact to the little finger without feeling an anxiety. The case of Van..., a 72-year-old woman, is similar: 18 months ago, she cut her little finger, and since that moment, she constantly complains about this finger that no longer has a lesion. “If it is warm, this finger has an unbearable temperature; if it is cold, it cools her whole body.” She shouts all night long as if this little finger tortured her, during the day she hides in a corner to cry about


156 Névroses et Idées fixes, II, p. 305.
her little finger. At meals, she takes a knife and pretends to want to cut this little finger; then she goes through the apartment like a lunatic and threatens to throw herself through the window so as to no longer feel her little finger. Another woman of 34 years, disturbed because she learned that a cousin had some swelling in the legs, maintains an alarming pain in the right leg and does not want to walk any more without wrapping this leg in enormous layers of cotton.

We guess that genitalia are going to become the seat of preference for the same alarming pains. I published with Mr. Raymond a remarkable observation on this subject,\(^{157}\) it is about a priest who, after hearing about a surprising adultery, remained obsessed by the thought of genital sex. He constantly had the thought on his mind and even the image of these two lovers in the arms of one another. At the end of one year, the image simplified itself, but became more bizarre and even more embarrassing. He thought about and saw only the feminine genitalia; he could not see a woman, speak to a woman, whatever, without being convinced he could see the genitalia under her clothes. At the end of many years, he noticed a new change in the form of the disease. “By reasoning with the thing, I began to think of my own genital organs and not those of a woman. But this preoccupation brought another inconvenience; it soon produced a physical irritation and developed a very unpleasant hypersensitivity of the penis and of the scrotum.” The same patient, fifteen years after the beginning, came to a final form. He thinks constantly that his genitalia are attached to his body like a foreign object and do not belong to him; he does not know any longer if it is he who is aware of the feelings they make. Nevertheless, he has a horrible fear of the slightest contact.

Algias plays an important role in Jean’s history: he has fluids that circulate in his spine when he turns his back to the direction where Charlotte is located. He has “patches of hyperesthesias” on the regions of the legs that were brushed by a woman’s dress in the trolley car. Most especially, he abominably suffered for six years due to an improbable disease

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\(^{157}\) Névroses et Idées fixes, II, obs. 48, p. 162.
of the glans and testicles. Following masturbations and the terrors that they engendered, he began suffering from the glans, especially when it was uncovered and could rub against his clothes or he had simply “a psychic friction” against a woman’s dress. This organ served as the starting point of dreadful fears: to cure it, he used all the ointments, then he wanted to keep it constantly covered by the foreskin which regrettably stood back; to make the foreskin descend without touching it, which had been dangerous, he imagined making it go down by a tremor of the stomach. This constantly repeated shock irritated the testicles that, in turn, became the starting point of anxieties and the poor boy was horribly unhappy.

For women, these islands of genital algias are even more important than for men, because they give rise, very too often even today, to dangerous surgical operations. Vr...(55), having deceived her husband, has great remorse and intense fears; her anxiety involved the idea of a disease, which she at first used to refuse to run away with her lover; it located the pain in her genitals and ovaries: she remained in her bed for eight months without allowing the slightest movement of her legs or trunk. It is necessary to chloroform her to be able to palpate her stomach and they decided on a surgical operation that simply allowed them to observe perfectly healthy organs.

It is necessary to place next to these genital algias the very frequent algias of the bladder and the urethra especially in men and caused mostly by fears of venereal diseases. Cpt...(56), for example, a 48-year-old man suffered for twenty years due to his urethra, although countless examinations were made and were never able to discover any lesion: he believes to have seminal losses that we were never able to observe. “There is a leak by which all my energy leaves.” Many of the others have “burns and areas of leakage in the canal.” I very often observed, especially for men, terrible algias of the bladder, almost always accompanied by the tic of pollakiuria. “They suffer constantly like damned souls” and are relieved only for one moment by urinating or by trying to urinate every five minutes. They are going be catheterized by all the specialists, “to
find the stone,” and should be very happy when they do not add an infectious cystitis to their algias.

Finally, we are amazed to learn that the algias of the anus always occupy certain minds. Lf...(92), a 46-year-old woman, confesses to us that “for many years her anus played the main role in her life.” Small hemorrhoids are usually the starting point of these preoccupations and these algias. Sometimes they come along with tics as with Bhu...( 54 ), a 43-year-old woman, who for years “agreed to sit down only on a single buttock” and who for the past six months does not want to sit down any more at all.

As I often tried to demonstrate, through the study of hysterical phenomena, the human body divides into psychological regions as well as into anatomical regions; these are regions constituted in the consciousness by functional association of the diverse sensations that originate in this point of the body or that are connected with it, that a certain anatomical unit in a special cortical center corresponds or not to this psychological unit that makes the psychological region; each of these regions, the arm, the heart, genitals, etc., may become the starting point of one of these algias.

3. — The phobias of bodily functions.

The phobias of the functions are closely related phenomena. One type could be the akinesia algera of Mœbius of which Zr...( 60 ), a 47-year-old woman, offers the clearest example. The arm and shoulder are in reality intact and do not present either paralysis or spasm, but she has a terror of movements of the shoulder and does not dare to move her arms anymore because of the anxiety that she feels if the shoulder is put into motion. I have already described a similar fact concerning the movements of the leg and the thigh.158

We can connect these phobias of the movement of the limbs with certain cases of writers’ cramp in which we note less of a tic located in the hand and in the arm and more of a general emotional state, an anxiety with shaking, suffocation and cardiac palpitations as soon as the patient wants to try to write.

We can connect it also to the various basophobias described by

158 Névroses et Idées fixes, II, p. 311.
Séglas and Biswanger. sometimes they develop following more or less real paralyses, as in an observation by Mr. Grasset; mostly they come along with no real disorder of movement. Fou…(72), a 58-year-old man, was frightened of walking because to go to the workshop, he has to follow a trench. He has no fear of the trench or of big areas to be crossed: no, he is afraid of walking anywhere, he moves by quite small steps, with a trembling motion, he moves back a step from time to time, then he falls or rather he sits on the ground, “because walking gives him cold sweats and he has to rest.”

Finally, it seems to me that we can put into this same group the phobias of the functions of the limbs, the singular disease that was recently described by Mr. Haskovec of Prague under the name of akathisia. I shall describe at some length, in the second volume of this work, a remarkable case: Rul...(39), a 40-year-old man who from around ten years old cannot remain seated anymore. When he sits for some minutes, he has to cling to the chair because he feels raised into the air, he has palpitations, breathlessness, he sweats amazingly; the face expresses anxiety in a remarkable way. In my opinion, it is not a hysterical phenomenon, similar to the astasies-abasies, as thought by Mr. Haskovec, but it is an agitation at once motoric and emotional that arises regarding the act of remaining seated, because this position, at least in this case, is associated with the idea of the job that this poor man became unable to do. It is a phenomenon of phobia and of agitation that we can place under the phobias of the functions.

The functions of nutrition give rise to innumerable, very important phobias because of their consequences. I have already indicated, regarding the shame of the body, the patients who refuse to eat because this action seems shameful to them. Others

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refuse to eat and condemn themselves almost to starvation because this action is painful to them and frightens them. Té...(66), an 18-year-old girl, without any phenomena of hysterical anorexia, cannot succeed in eating, although she has the desire. “When I see food, when I try to carry it to my mouth, it tightens me in my chest, it makes me suffocate, it burns me in my heart. It seems to me that I die and especially that I lose my mind.”

In this group, the observation of Gel...(67), a 48-year-old woman, is rather unique. Usually, the patients are afraid of eating and more or less push away their food. This one is afraid of not eating enough, she is afraid of refusing to eat. Near the age of 21, she had a first bout of the common form of food refusal: after weaning her child, she had anxieties, remorse, disorders of digestion. Half because she had remorse, half because she suffered from the stomach, she began to refuse food and to have terror and anxiety when trying to eat. This disease heals by itself, then began again and then disappeared again. The third outburst, which arose during menopause, is completely the opposite of the previous ones. The patient eats perfectly, but she is afraid that her disease reclaims her, that she is prevented from eating by a fear and thus she will starve; as a result she eats out of an anxiety due to fear of being afraid to eat.

One of the most curious, and it seems in practice to be the most important, phobias is linked to functions of nutrition; it is the phobia of swallowing. We shall find several observations detailed in the second volume of this work, I point out in particular the observations of Fok...(69), a 40-year-old woman; of Rib...(68), a 29-year-old woman, of Les...(70), a 40-year-old man, with all of them, the phenomena are exactly the same. These patients are hungry, digest well and want to eat but cannot do that because they have a terror of swallowing the food. They believe that they are going to choke, that they are going to suffocate and to die suddenly; they imagine techniques to swallow in perfection and without danger. For it is necessary to continue breathing while swallowing, to breathe just at the moment that we swallow, etc. In these conditions, it is not surprising that they arrive at nothing: the slightest mouthful of liquid in their mouth causes
unbearable anxiety and brings them cold sweats throughout their whole body. They can feed only by absorbing a liquid drop by drop and Fok... commits a whole day to absorbing two egg yolks diluted with a spoonful of gravy.

Next we observe the *phobias of digestion*. The slightest disorder of digestion, the slightest heaviness of the stomach causes anxiety and these patients have “death in front of their eyes,” when they actually have a little pyrosis. A curious form of this disorder causes pains at the end of digestion, especially at night and the patients awaken with a crisis of terror that arises generally at about one o’clock in the morning. Lyx..., a 28-year-old woman, wakes up at this hour every night: pale, wild eyes, she writhes, claims to have horrible pains that start in the stomach and she awaits her imminent death. In other, more common cases, anxiety develops during the day about all digestions. Qsa...(108), a typical 55-year-old, a scrupulous since his childhood, who has gone through almost all the phases of the disease, for about ten years is especially tormented by the phobia of digestion. Contrary to the previous patients, who have a phobia of food or a phobia of swallowing, he has the desire to eat and “to eat all that we want to give him:” he would even like to continue to eat, because his agonies are going to begin only when he stops eating. At this moment, the stomach stirs, swells, twists itself, “the food mass moves as if in a bag, all the limbs are broken and filled with anxieties, the slightest movement pulls on the stomach as if all the muscles had their point of attachment there, his eyes are drawn back inside his head, all his thoughts are tinged with suffering, etc.” These disturbances are accompanied by this patient’s tics, he has the tic to suck something while he digests, and makes an improbable consumption of pastilles, and finally he introduces the tic of vomiting, which was already described. If we force him to delay vomiting, the anxiety increases with motor agitation and visceral agitation and can bring about serious cases of the crisis that I described under the name of the crisis of the efforts of vomiting. The same phenomena are observed in many of the other patients, because these phobias of digestion are among the most frequent.

Intestinal digestion causes the *phobias of the stomach*, the
sensations “of a worm with spider legs who curls up with cold glidings.”

Finally, Hil..., a 40-year-old woman, shows us the phobia of defecation. “It is going to go away in diarrhea, she is going to lose her food, she suffers so much with this thought that she prefers to die at once than to have a bowel movement.” The whole family must plead with her for her to decide on this sacrifice. The urinary and genital hypochondriacs are countless and almost always their obsessions come along with the phobia of function, it is pointless to stress this.

We can observe even more curious phobias concerning the functions of relation. We know the phobias of language, Bq...(65), a 38-year-old man, for five years he is looked after for alleged lesions of the larynx: he was in several health resorts, he underwent all sorts of treatments. It is because for years words are harder and harder for him; when he tries to speak, he feels a general weakness, his legs feel wobbly, his breathing stops and his body becomes covered with sweat. Therefore, he never tries to speak when he stands, because he would fall. He relates all these disorders to tubercular lesions that he has to have in his throat. The most attentive examination, which Mr. Cartaz was kind enough to repeat, demonstrates that the larynx is absolutely healthy. A little pharyngitis happened years ago and the anxiety caused by his mechanic’s job, “which exposes him to coal dust,” determined the form of this phobia.

Special senses may present the same anxieties and the same dysesthesias. The sense of smell becomes troublesome when the odor combines with one of the manias of the scrupulous. Big...(6), a woman of 49 years, is afraid of smelling a scent especially with the left nostril, because it would give her anxiety. Wy...(164) is afraid of the smells that remind her of the odor of genitals, and Ds...(154), a 21-year-old woman, would have anxiety if she smelled an odor “because to smell it is necessary to inhale by the nose and that brings small animals up into the nose; flies, bedbugs would go up to the brain.” She is obliged to compensate for a smell by blowing her nose ceaselessly.

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The sense of hearing is very often involved in the phobias of noises. Ot...(75), a 53-year-old man, withdrawn from business affairs, disgusted by his apartment, his district, feels upset by the noise that he hears there and comes to a terrible dysesthesia of hearing. He must live in a padded room so that no noise reaches him. Bow...(76) adds a particular detail: all noises do not painfully affect the ear, but only small noises: the noise of a whip in the street, the noise of a door that closes, this is microphonophobia. We find here the scrupulous’ attention for the little things that we noted in their manias of precision.

The eye gives birth to a remarkable disorder that seems to be a special disease; it is photophobia or at least one of the varieties of the photophobia. Mv..., (151) a 42-year-old woman attended a concert one evening where a blind musician played, she was not able to refrain from observing him all evening long. The next day, she asks her husband to take her to consult an ophthalmologist; he examined her eyes which were not then in any pain and he does not notice any deterioration. However, Mv... is not reassured, she declares this ophthalmologist is incompetent, and goes to see another one, then a third. She is increasingly agitated; they force her to explain and she eventually admits that she is pursued by the thought of being blind, that she examines her sight constantly, that at night she wakes up with a start to switch on a light and check that she sees clearly. With this, the patient gradually developed a horrible algia of the eyelid and the eyes; it is enough to approach the eyelids with a finger to provoke howls and terrible anxiety. The same identical phenomenon occurs with Mb... (156) and Ria... (62) who are also afraid of being blind.

These dysesthesias of the eyes can bring patients to dread the light and to live in darkness. This is what happens in the remarkable observation of Rs... (63). This woman, a 59-year-old, always had disorders of the will, she was anxious, hypochondriacal, very demanding and very authoritarian, which often happens with those with aboulia, as we shall see in the following chapter. At the age of 56, after menopause, she underwent a dreadful shock: we brought her daughter to her, the young girl married recently, who had just been horribly burned in a fire. Rs... looked after her daughter with
courage for three days without being able to save her. The death of this young woman did not seem to cause her any violent emotion; Rs... was surprised not to have a lot of sorrow, not to be able to cry. Not long afterwards, she began to complain about her eyes, speaking about cataracts, about paralysis, etc. “She could not use her eyes at will, she could not look; when she stared at an object, especially a well-lit object, she felt a discomfort, a painful emotion that choked her.” Soon she developed the habit of holding her eyes half-closed then closed and behaving like a blind person.

Ria... (63), a 16-year-old young woman, constantly covers her eyes with a big blindfold and refuses to see the light “because objects dance in an obnoxious and terrible way.” She has terrible anxiety at the thought that she is going to lose her eyesight. The starting point is more curious. After an abdominal operation performed due to a uterine algia, she had a feeling of oddity, strangeness in her perception of objects; this plays a considerable role with the psychasténiques. She concludes from this that her eyesight was at stake, that she saw poorly, that she was going to lose her eyesight and she gradually developed the symptoms of photophobia.

The observation of Bry... (63), a 16-year-old young man, introduces us to a slightly different crises of photophobia: the mental phenomena are reduced and the organic phenomena are very increased. The edema of eyelids, the congestion of conjunctiva, the watering of the eyes, the nasal hydorrhea that makes him wet fifty handkerchiefs in twenty-four hours are most remarkable. The crises are short and repeat every fifteen or twenty days since his childhood. It is a different form of the disease, which seems to me to come closer to epileptic phenomena and which we shall have to discuss from the clinical point of view in the second volume of this work.

All these algias and phobias of the functions present common characteristics, they develop regarding a sensation determined by the excitation of a part of the body: the skin, the muscles, the pharynx, the ear, the eyes. We could believe that this region is hyperaesthetic and that a local disease causes these painful sensations. This is what so often brings about surgical operations, particularly on the
ovaries. However, an attentive examination allows one to note that the organ is perfectly healthy. Even better, the sensations determined by this organ are not at all disturbed, there is no anesthesia, nor even any real hyperesthesia. Rs..., for whom the photophobia is so remarkable, did not open his eyes for three years, behaves completely like a blind person and was the subject of many examinations by several ophthalmologists: not only is the eye absolutely healthy, but the vision is completely preserved, neither the visual acuteness, nor the sense of colors, nor the field of vision underwent the slightest change; he sees better than most people of his age. Curiously, when he is the subject of a medical examination, he does not move, he keeps his eyes open without any complaining, he accepts that we aim a beam of light into the eye to see the reflexes, whereas he would have horrible anxiety to look at an object.

We could say that the conscious sensation is preserved but that there is a special sense of pain that alone is hyperaesthetic in these regions. I often tried to measure the sensitivity to pain with a needle, the variable pressure of which can be exactly determined; I modified, in this sense, Chéron’s device to measure blood pressure. I first determined the sensitivity to pain in the same region for a normal individual, then I wanted to measure the same sensitivity for the patients who claimed not to be able to touch this region without suffering enormously. We begin by reassuring them, persuading them that the medical examination is useful, to stop their ruminations and their obsessions for a little while, to interest them in this small problem, to teach them to answer exactly at which instant the needle’s contact becomes a painful sting. Many do not allow the experience: Mv... shouted when I wanted to approach the instrument towards her temples or her eyelids and I was not able to obtain a precise figure from her. But others decided to allow the examination: we were quite surprised to notice that they stopped the instrument at the same point as the normal person and that consequently they preserved the same pain sensitivity, neither lesser, nor greater. In some cases, there is rather a certain decrease of sensitivity. These dysesthesias, therefore, are not disorders of the sensations of the region; they are general disorders.
emotions pervading the whole organism and which occur regarding the sensation of the region. We shall find the same law for the other phobias; this is what will allow us to unite all these anxieties in our search for the general characteristics.

4. — The phobias of objects (Delirium of contact).

The same state that resembles a very painful emotion occurs more often following the perception of objects. As this emotion is dreaded by the patient, it results in an anxiety, a fear of an object that exists by chance: this is what characterizes the phobias of objects.

A phobia sometimes develops as soon as the object is perceived no matter by which sense, even when it is perceived by vision or hearing. “Am I crazy or am I not,” said one of Legrand du Saulle’s patients, “will it be necessary then to hold me in a mental hospital, because I tremble at the sight of a dog and because I don’t dare to touch anything at home? But what is the use of my reason?”\(^\text{163}\) It is the same for those who are afraid of seeing stars (astrophobia) or who are afraid of hearing thunderstorms.\(^\text{164}\) Bunyan, after taking a lot of pleasure in ringing bells, made a scruple of this pleasure and since then felt a terrible fear just by seeing or hearing bells.\(^\text{165}\)

Among our patients, Xa..., who has an obsession with homicide, naturally has a phobia of knives, all cutting or sharp instruments; but in addition she cannot, without suffering, see a cut tree branch, a red flower nor even a red paper. If we want to make her walk in the bois de Boulogne, \(^\text{xlii}\) she has an attack of phobia, because one day she encountered a piece of red paper on the path. She is especially afraid that we will make an allusion to one of these terrifying objects; she has phobias about such and such a word which she just only has to hear or regarding a person who formerly pronounced the word and whom she cannot see any more. Myl... (98) has phobias of seeing a red parlor or of seeing the moon. Mii... (183) has the same phenomenon when seeing certain streets in Paris that remind her of


\(^{164}\) Cullere, *Folie héréditaire*, p. 63.

the city of Lyon where a murder was committed and Gisèle of seeing her daughter which reminds her of her marriage and her missed religious vocation. Fi... (83), as with many of the other patients, has these terrors of seeing a dog, or even of seeing his wife because she wears a dress that dragged on the Concorde plaza, their usual meeting place, when rabid dogs appeared, this is lyssophobia,¹ the psychological hydrophobia of Trousseau.¹¹ Jean is frightened of seeing women in streetcars or of eating a meal served by a woman. It is therefore evident that vision or hearing can be the starting point of these phobias.

However, it is contact that causes most of these crises of alarming anxiety; this observation was already made by Esquirol.¹⁶⁶ He describes a 34-year-old woman who constantly rubs her hands, “she is afraid that something of value remains attached to her fingers.” Legrand du Saulle especially stresses this role of touch because he wants, yet he is wrong in my opinion, to make this fear into a special disease or at least a special phase of the disease under the name of “madness of contact;” “A lady,” he says, “is afraid at first of spelling mistakes, then she is afraid of touching everything that is used for writing.”¹⁶⁷ Trélat accepts the same idea, he describes a person who imagines that all his linen is poisoned and that contact would be mortal.¹⁶⁸ Mr. J. Falret explains similar phobias by the fear that objects are of value or are dirty.¹⁶⁹ A patient described by Mr. Tamburini can no longer touch any object in her apartment because she believes them to be “soiled by the rats’ urine.”¹⁷⁰ A woman, Féré relates,¹⁷¹ eventually was able to walk without constantly having the openings of her nostrils and mouth filled by a band of fabric that was intended to prevent the bits of host that could be contained in the atmosphere to penetrate into her body when she was not in a state of grace. Many authors

¹⁶⁶ Esquirol, Maladies mentales, II, p. 63.


¹⁶⁸ Trélat, Folie lucide, p. 23.


¹⁷⁰ Tamburini, Rivista sperimentale di freniatria, VIII, 1884, p. 4.

report similar cases which they designate under the name of delirium of contact, or *mysophobia*, or *rupophobia*, etc.\textsuperscript{172}

We could note these phobias of contact with objects in almost all our patients; we cite only the most interesting. Chy... needs to wash her hands constantly because she is afraid of having touched “crumbs of fat.” U... (79) also has a phobia of germs; Mze... (178), a 46-year-old man, cannot touch sharp knives; as his job obliges him to fabricate knives, he makes them all rounded, too bad for the clientele. The same commonplace phobia of touching sharp knives is seen very often and Sy... eats with her fingers rather than to touch a fork or a knife.

Ger... (214), who imagines that she killed her mother-in-law, cannot touch without horror the clothes of a poor woman and soon has the phobia of contact with every kind of garment. Pr... (210) has a quite complicated idea: she believes she has yielded to an individual and she is pregnant, she dreads now to give in to the temptation to abort by taking a purgative. Therefore, she cannot touch without horror a bottle or glass containing a liquid. We cannot enumerate the objects for which Jean has phobias, women, streetcars, letters, stamps, his room in the countryside, his desk, razors, handkerchiefs, etc., etc. Iu..., a 44-year-old woman, similar from this point to Féré’s patient, is afraid of having dropped bits of the host on her skirt. She hides this skirt and other objects in a suitcase, then she cannot touch the suitcase again which is “at once respectable and dirty” and that becomes a completely taboo object. Vy..., who has genital scruples, has a phobia of clothes that could rub him. Leg..., a 45-year-old, a scrupulous female since the age of 12, is especially afraid of hurting people, of poisoning them by throwing at them specks of dust, the hairs of a cat that she has in her hand, some saliva; she does not dare to speak any more, nor to move; she comes to an immobility that we shall have to study as one of the expressions of the illness.

These examples could be easily multiplied to infinity; contact is the sensation that most directly awakens the thought

of the use of objects, of their role in an action; it is quite natural that for the scrupulous, the phobias quite particularly concern contact. This is well demonstrated to us by certain phobias of contact and upon which I emphasize while ending and that we could call the phobias of vocational contact. Mr. Grasset has cited the doctor’s phobia of the instruments of his trade, Mr. Bérillon\textsuperscript{173} emphasizes the notary’s phobia of his office, and the mechanic’s phobia of his machine. Among our patients, Nem..., a dressmaker, cannot touch her scissors and Pt..., a barber, cannot touch a razor. You should not say that here it is about the phobia of cutting objects because the first one can also not touch a ruler and the second one loathes touching a beard and touching soap. Leh... (78), a 38-year-old man, a telegrapher, after a grave pleurisy, develops a fear of not being able to work and a fear of the telegraphic devices and post offices.

These last examples show us that an action, especially a professional action must play a role in these phobias. This fact is less visible but we find it again in all the other phobias of objects. In many cases, as I tried to show elsewhere, active contact, that is say contact that results from a movement, from an action by the subject, is infinitely more dreaded than a passive contact in which the object is simply approached by the subject.\textsuperscript{174} Iu... “for nothing in the world will she touch her clothing where she imagines that fragments of the host dropped” but, if I myself take the dress and approach her hands, she resigns herself to undergo the contact by saying: “it is you who makes this action and who takes the responsibility...” The object that causes anxiety is especially an object that has a role in an action that he or she must execute; it is a concept that I here indicate in passing and to which we must return when studying the general characteristics and the interpretation of these phobias.

5. — The phobias of places (agoraphobia).

These same phobias can develop in other

\textsuperscript{173} Bérillon, Phobies neurasthéniques envisagées au point de vue professionnel. Revue de l’hypnotisme, 1895, p. 33.

\textsuperscript{174} Névroses et Idées fixes, I, p. 8.
circumstances, regarding more complex perceptions, that no longer bear on a specific object but on a set of facts and the subject’s impressions; that is, on the subject’s physical or mental situation.

In a first group of cases, it is about the perception of a physical situation: this type of these phobias is one that develops when the patient feels isolated, that is when a set of circumstances, a situation that he perceives, creates in him the impression of space around him. Already Leuret in 1834 described a case of this kind by connecting it with hypochondria: “he is sometimes six months without going out; when he does go out, it is by carriage and always accompanied by a person who can help carry him if necessary during the walk. It is very rare that he goes down to the carriage and when it arrives, the person who is accompanying him has to be held very close to him; he would not cross a square or a bridge; barely would he cross a street. In a square, it is as if he is in the middle of a desert, where everything is missing for the one who needs everything.”

Leuret made simply this one statement: a “developed hypochondriac speaks of luxury and idleness” and he rightly notes its relationship to a defect of the will.

Later this symptom is very frequently described as a phobia under the name of *agoraphobia*, which was given to it, I believe, by Westphal in 1872. One of the most complete descriptions is the one by Legrand du Saulle in 1877 and 1878: this author, in fact, makes it a special neurosis, distinct from the mania of doubt and from the delirium of contact, which seems to me to be very inaccurate. “The fear of open spaces,” says Legrand du Saulle, “is a very particular state of neuropathy, characterized by anxiety, an acutely anxious impression or even a real terror, occurring suddenly in the presence of a given space; it is an emotion as if in the presence of a danger, of a space, of an abyss, etc. A patient begins by having stomach pains in the street, with weakness of legs; he worries and in two months he comes to a complete terror of walking...
The thought of being abandoned in that space freezes him with dread and he has the firm belief that there is some sort of assistance that can effortlessly calm him. No fear without the space, no peace without the appearance of some semblance of protection.”

Here are some examples of the phobias of space taken from the observations of our patients. Lise is afraid of solitude, which is, in fact, rather bad for her because it facilitates the development of her reveries and her mania of pacts. Deb... (165), Bor..., etc. are afraid of bridges, of wide places. Por..., a 23-year-old woman, “suffocates with terror in the streets when there is nobody around.” Hnu... (87) cannot walk alone anymore; she is afraid of falling, of being paralyzed, of becoming crazy: “I see emptiness on each side... when I see houses it does not give me the same effect anymore.” Léo... (173) dreads big places or the big cities of the world... she is quieter when she is with a small number of persons whom she trusts. Sc’s... agoraphobia presents some interest because it feigns dizziness; as the patient previously had discharge from the ears, they had diagnosed his state as “Ménière’s vertigo.” In reality, he has none of the symptoms of this dizziness; the fear that he feels in the street is identical to the one that he feels when he touches cards or when he thinks of the number thirteen. Bu... (85), a 40-year-old man, after first having made someone accompany him when outside, cannot make more than a single step by himself in his apartment; a famous patient of Mr. Azam required that his wife accompany him up to the door of bathrooms and to speak to him from a distance, he constantly made her understand that she must stay near him; Bu... cannot be satisfied by this expedient and he requires that his wife always enters with him.

We clearly see from these examples that it is not exactly the big place that provokes the phobia, it is the impression of being alone without physical or moral support in a place that is not familiar to them. As soon as this impression is dissipated, the agoraphobia disappears. Lep... (88), a 49-year-old woman, is agoraphobic since her son left for military service, she feels alone, and then she dreads to go out, cannot cross squares and needs


178 Névroses et Idées fixes, II, p. 83.

“to follow the walls of lanes” but this anxiety disappears as soon as she gives her hand to a child. Oz..., a 31-year-old woman, contents herself at less expense, she just has to carry her arm in a basket, it is for her a habitual point of support “but it has to be heavy, I feel then that I hold something firm, when it is empty I cannot move.” Bo... restricts herself to carrying with her a low bench to sit down on if needed and this prospect reassures her. Another 35-year-old woman, Fie..., needs to lean on her umbrella “with my umbrella I shall go anywhere, without my umbrella I do not have balance anymore, there is only a grocer on the corner to whom I can go without my umbrella.”

All these details are seen more precisely by observing Jean. He constantly needs to have a material support on the left-hand side and always holds his left hand tightly clinging on to some piece of furniture or some object. If this support is missing, in classrooms, for example, he feels a hollowness, an emptiness to the left that can become frightful. He has no fear of some big plaza, but he has terrible phobias when he is in a remote district, far from his house and especially far from his doctor. It is for the same reason that a stay in the countryside makes him horrified: “the doctors of the countryside do not know these ailments, it would take hours and days to explain my disease to them and I could not do it. It is horrible to have the crazy laugh churning up my nerves, the specter of death, the heart in a frenzy far from every competent doctor.” In Paris, Monceau Park has the privilege to cause the same impression because it looks like the countryside. Jean still has the same phobias when he feels turned to such and such direction, when he is in a moving train, when he is in a very small room, in a lecture hall, etc. In open places, he always needs to feel a protection; in closed places, he always has to see an easy exit: he never agrees to move forward in a lecture hall, he always stays very near the door.

I shall add only Dob’s... (85) observation, in which we must return to the matter of anxiety. This 33-year-old young woman has outbursts of anxiety that take her as soon as she is alone in the street; these outbursts began at the age of 12 and
continued to worsen. What she dreads, as a matter of fact, is an outburst of madness “that would make her roam like a lunatic, make her cause a scandal in public.” She is less afraid at night, because we would not see her if she were crazy, we see here the obsession of shame; she prefers the streets where there are shops to be able to take refuge there, this is now the sentiment of the need for protection.

Agoraphobia must be grouped with another phobia, that of closed places, *claustrophobia*, indicated by Beard of New York, by Raggi of Bologna and described by Ball in 1879.\(^\text{180}\) “It is,” says Cullerre, “a constrictive fear comparable to the one that we could feel by crawling through a more and more narrow passage.”\(^\text{181}\) We can connect it to many acts of the same kind, the phobia to be in a theater, the phobia to be in a railroad that we cannot make stop, etc., in a car, the amaxophobia, if we want to hold Ball to his words.\(^\text{182}\)

Rt... (93) “has a terrible fear he will suffocate in the cars that are small closed boxes, in the rail cars which pass through tunnels.” Xo... is not afraid of suffocating on the railroad, but he is afraid of being upset in the car without being able to go out and he can no longer make any journey without terrible fears. Nae... (94) makes dreadful scenes when she must get in a car or in a coach: she wants the door to remain open and she threatens all the time to dash outside. Sometimes the car does not go fast enough, sometimes it goes too fast, or another car approaches much too close; she asks that we hold her so that she does not dash outside and when we hold her, she suffocates and we must make her inhale some ether. The most curious scenes take place when she is in her room and when it is raining hard outside: she looks at the street, is frightened of some water that falls, thinks that she cannot go outside anymore because there is too much water, that the water is going to go up to the first floor then to the fourth where she is, because she will be drowned against the ceiling; she is short of breath, she

\(^{180}\) Ball, Claustrophobie. *Ann. méd. psych.*, novembre 1879.


blushes and goes pale and finally she falls faint. We shall return to these faints; for the moment, we note only the diverse forms taken by these phobias.

The patients of this first group need, as we saw, the support, the help of other people, they dread being alone, separated from people, and in this respect we can say that there is already in these phobias a social feeling. But if they ask to be helped by people, it is because they dread certain physical dangers, it is the physical situation that they dread, the space, the height, the constriction, etc. On the contrary, in the other cases, the alarming emotion is essentially caused by the perception of a moral situation and especially a social situation. We can consider as one type of this second group the fear caused by the blush of the face, the ereuthophobia. This particular localization of the phobia was indicated in 1846 in a report by Casper (Berlin). We have to thank Messrs. Pitres and Régis for having published a translation of this remarkable and difficult to obtain observation. The patient describes very well the disorders of the will and attention, the doubt, the shyness, that prepared the phobia and that, in my opinion, play a big role in its explanation.

Messrs. Piéron and Vaschide have helpfully just communicated to me an observation both rather old and little known about the same phenomenon published by Dr. Duboux in 1874. “Among the causes of the blush,” says this author, “it seems to me that the great naturalist (Darwin) forgot something very interesting: this cause of blushing is the fear of blushing. Suppose that an individual blushes for the first time under one of the influences indicated by Darwin (such as shame or modesty). The sensation that he experiences when feeling his face flush is painful and humiliating: he tries to repress this surge of blood; his efforts are useless and even go directly against their purpose; the blush then becomes only more intense. He dreads to again be exposed to a similar confusion: the fact of its appearance despite his resistance brings a more intense blush than that of shame. He knows

\[183\] Casper, Biographie d’une idée fixe, traduite par le Dr Lalanne, publiée par MM. Pitres et Régis. Arch. de neurol., 1902, I, p. 270.

\[184\] Duhoux, à propos de la rougeur, Bull. de la Soc. méd. de la Suisse Romande, septembre 1874, p. 317.
now that it is enough to be afraid of blushing to blush; he cannot refrain from being afraid and from blushing.

“When he feels exposed to glances, particularly to those from the other sex, the fear of blushing will come to assail him and anticipatory shame will flush his face, any fight is useless: under the influence of the will, the face can present at first a light paleness, soon replaced by the dreaded blush. It may even happen when alone, shielded from any glance, the individual blushes, if he fears, for his brain for example, the effects of congestion. This constant fear, actualized at every moment, becomes for the individual the opposite of Tantalus’ torment;\(^\text{185}\) though one may have the nature to be very bold and very sociable, he will develop a shyness and a ridiculous unsociability; he will avoid all the occasions for it to occur, he will look for solitude; social responsibilities and sometimes the professional duties will become horribly painful for him; his life will literally be broken by a foolishness.

“This kind of neurosis or psychosis, less rare than one might believe, is especially frequent in women. Among the affected individuals, I know a certain number of distinguished figures in the sciences or politics, and among others a celebrated psychologist who, with all his knowledge, is not protected and whose shyness is proverbial.” This interesting observation, especially by its date, already notes the pathological character of the phenomenon, connects it with the neuroses and with the psychoses without, however, clearly indicating the parallel with the other phobias.

Westphal, in 1877, in a report on the obsessions, cites a similar case. Mr. Boucher (of Rouen) published in 1890 an interesting case,\(^\text{185}\) completely accurate about this phobia. The authors who drew the most the attention to the phenomenon and who gave it the name under which it is now known are Messrs. Pitres and Régis.\(^\text{186}\) For the word erythrophobia, which indicates the fear of the color red, they substituted the word ereuthophobia (red from shame). Their work was the occasion for a crowd of studies on this particular phobia and on its interpretation. We shall find the bibliography in the last work of

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\(^{185}\) Boacher (Rouen), Sur une forme particulière d’obsessions chez une héréditaire. Congrès de méd. mentale de Rouen, 1890. *Arch. de neurol.,* 1890, II, p. 280.

\(^{186}\) Pitres et Régis, Obsession de la rougeur (éreutophobie). *Arch. de neurol.,* 1897 I, p. 1.
Messrs. Pitres and Régis and in what was, to my knowledge, Mr. Claparède’s last study. I borrow from the latter author a quick summary of the characteristic aspect of an ereuthophobic patient “he does not dare to show himself any more in public, nor even to go out in the street. If it is a woman, she does not dare to remain in the presence of a man being afraid that her inconvenient blush will be the opportunity for hostile comments about it; if it is about a man, he will avoid women. As, however, the necessities of the life oblige, the ereuthophobic cannot live absolutely isolated; he is going to invent certain stratagems to mask his infirmity. In a restaurant, he will plunge into reading a newspaper so that we do not see his face; in the street, he will hide under his umbrella or parasol or under the wide wings of his hat. He would rather go out in the evening, at nightfall, or, on the contrary, on a day of bright sunlight, so that his scarlet complexion is nothing extraordinary. If he is taken by surprise, he will dry his face with his handkerchief, or will blow his nose, or will pretend to pick up an object under a piece of furniture or will go to look out the window to hide the blush that ensues. Sometimes he resorts to face powder, more often to alcohol; he hopes by this last means to drown his morbid coloring in that of alcoholism. From a similar motive, he begs the doctor or the pharmacist to give him a drug that will dye his face red. He searches for and organizes in his head all the means to remedy his evil. This perpetual fear, this continual uncertainty about the moment that is going to follow, resounds throughout every fiber, embitters him, irritates him. The life of an ereuthophobic is a real living death: at every step, he would like to be finished with his unbearable existence and he goes so far as to curse the being who gave birth to him.”

Some authors, particularly Mr. Thibierge, classified this disease amongst the dermatophobias alongside the syphiliphobias and acarophobias. This does not, I believe, sufficiently accentuate the essential character of ereuthophobia. Indeed, you should not believe that the blush of the face is the essential characteristic of ereuthophobia; as I have already indicated regarding the obsessions,

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many people have emotional blushing of the face without being ereuthophobics and there are ereuthophobics, like Nadia, who are actually incapable of blushing.

It is easy to see that the fact of the face blushing has little importance in this phobia; it simply plays the role of a pretext to justify an anxiety, the origin of which is deeper. To understand this, it is necessary to notice that the obsession of blushing is very often transformed and that other pretexts, usually taken from the appearance of the face, succeed the ereuthophobia, precede it, or alternate with it. As I have already shown in a previous study, Toq..., presently anxious at thought that he has blushing cheeks, previously had anxiety at the thought that his mustaches had grown in too early. Per... (162), a 48-year-old woman, formerly ereuthophobic, now has a phobia of hairs on her face. Ul... (45) was from ages 15 to 20 years old ereuthophobic as such; now, at the age of 33, she is no longer afraid to blush in front of the world, but she is afraid of turning pale, of having convulsions in the face and especially in the eyes that would make her ugly and ridiculous when she asked a person for something.

Besides, it is impossible to separate ereuthophobia from the fears provoked by other changes of posture or of the face in which it is not a question of blushing. Klu..., although he speaks correctly, has a fear of stuttering when he is in front of strangers, he cannot be registered at a school, he cannot ask for directions from a ticket agent, nor to get a rail ticket; he is not frightened by the thought of blushing, but of stuttering in front of these persons. Others, like Pol..., have fears at the thought of a scar that they have on their nose, when they feel that strangers may notice it, it is the disease that Morselli described under the name of *dysmorphobia*. Tk... (145), a 24-year-old young man, has a phobia of his jaw, which he considers to be too big. Bechterew described the patient terrified by the obsessive smile that he constantly has on his lips; and we often meet similar types: a 37-year-old young woman, Wyb...

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190 Morselli, La dysmorphophobie et la taphéphobie. Riforma médica. 1891, n° 158.
is very disturbed since the death of her husband, “she cannot see men without making small
grimaces that look like smiles,” they must find her improper and provocative. This phobia of the
smile was the starting point for a whole series of scrupulous and criminal obsessions. Next to
these cases we could place the observation of Wgn..., a young man of 26 years, anxious because
of the paralysis of his lips “is incapable of ever smiling naturally.” We have already seen,
regarding the obsessions, the case of Wye... (144) whose anxiety is provoked “by the inflexibility
of his face and the mechanical movements of his limbs;” we could enumerate all sorts of
varieties of these phobias all very similar, in my opinion, to ereuthophobia itself.

The essential character which indeed is found in all these phobias is the feeling of being in front
of people, to be in public and having to act in public. Mr. Hartenberg is right to connect the
ereuthophobia with the disorders of shyness.\textsuperscript{191} All these patients have no fear of blushing or
going pale, or grimacing, or smiling or not smiling when they are alone; and the blushing or the
grimacing, if it arose at this moment, would impress them not at all. We could thus call these
phenomena the \textit{social phobias} or the phobias of society.

In this group, the phobias of marriage, which are so frequent, also return (Hnu...(87), De...).\textsuperscript{192}
We can also connect it with phobias related to certain social situations. Bal... (155) is frightened
by the thought of conducting class in front of children. Ku... (42), a 37-year-old woman, has a
peculiar dread at the thought of having domestic servants: her maid intimidates her, she dares not
to order her nor to blame her. She especially has a terror of her concierge and she has anxiety at
the thought that she could be bad to this necessary servant.

All these phobias, which are connected with a type of agoraphobia, claustrophobia, or the social
phobias, appear to me to have a common point. They are not, like the previous ones, only related
to an object awakening the idea of an act, but they are determined by the perception of a situation
and by the feelings given birth by this perception.

\textsuperscript{191} Hartenberg, \textit{Les timides et la timidité}, 1901, p. 201 (Paris, F, Alcan)

\textsuperscript{192} Névroses et Idées fixes.II, p. 87.
The phobias often develop even without having as their starting point either a localized sensation, or a perception of an object, or even a perception of a situation; they arise simply following from an idea that appears in an abstract way in the patient’s mind. It would suffice to repeat here all the obsessive ideas that were studied in the first chapter. Almost all these ideas are accompanied by phobias. Regarding the sacrilegious obsessions, we shall notice the phobia of the devil, of hell, of blasphemy, etc. A patient, such as Ki... (219), feels these alarming emotions regarding any religious or philosophical thoughts. He must avoid thinking of God or religion and, for a while, he loathed the abstract idea of causality because it reminded him of creation and the divinity. The idea of infinity, which caused Vil... such remarkable ruminations, is often accompanied by very characteristic phenomena of anxiety.

It is the same for the criminal ideas. Leg... lives in fear of wanting evil in the world; she is afraid of thinking of making children become deformed. We... (221) has anxiety about the idea of lying, of the idea of “following women to the theater.” Za... (216) had this emotion at the thought that he could cheat during an examination and he has it now merely at the thought of an examination. These patients dread all the circumstances such as conversations or readings that could give rise to these same ideas. And so We... (170) is afraid of newspapers and even is afraid of the printing office because newspapers in their news items awaken thoughts of crimes. They eventually are afraid of the most vague imaginations, of the most abstract thoughts. We... is afraid of trying to imagine a penis and Za... is afraid “to imagine any idea because it could be a bad idea.”

The same observations are made once more for the obsessions of shame. Those who have obsessions about madness, and they are many, have this emotion about the thought of madness. “I suffer,” says Léo, “at the thought that I might become crazy. I see myself locked up, I feel like a silly idiot and it gives me a horrible anxiety.” Byp... ( 180 ), a 28-year-old woman, believes she sees her brother, who is confined at
Saint-Anne, come before her and she hears him say to her: “you will be crazy like me.” At these words, she faints in the middle of the street. De..., a 33-year-old woman, has a complicated obsession that, at the same time, contains shame of oneself and shame of the body. She cannot conceive of the thought of marriage without horror because she considers it completely despicable from the moral point of view and also from the physical point of view. There are feelings of inability to keep up her house, to fulfill her duties, to raise the children and at the same time ideas of deformity of her genitalia, thoughts of not being like all other women. We know all these facts and this case only adds to the earlier ones; but what must be added here is that the thought of engagement renders this woman ill and that clumsy friends, who insist that she marry, caused a crisis of terror and even delirious events similar to mental confusion, to which we must return when we talk about complications of the delirium of the scruple. The regrets of vocation bring to Gisèle... (171) and to Ri... great anxiety as soon as one has ideas about religious life and as soon as the other thinks of a primary school teacher’s job. Also, Nadia has fears when she thinks about getting fat, when she merely imagines that one could find her looking better. All the obsessions of shame of the body, in reality, are accompanied by phobias.

Finally, it suffices to indicate the innumerable phobias bound to hypochondriacal ideas. Morselli reported a curious one, under the name of taphephobia, which is the fear of being buried alive. Ol..., a 37-year-old woman, has anxiety at the thought of the hot season, of typhoid, of suicide, etc. It is needless to recall that Jean has phobias of thinking about meningitis and congestions and that Pn... (139) is taken by panic attacks by the mere thought that we might find her sickly looking, which is just the opposite of Nadia. Among the more banal phobias we must put in the first row the phobia of the idea of death. Ml... (156), a 40-year-old woman, is obsessed at first by the face of her daughter who has just died. We have already discussed what one must think of these hallucinations. Following a small


194 Morselli, La Riforma medica, 1891, n° 185.
operation for an abscess in the neck, she transfers her ideas of death onto herself and she has dreadful anxiety as soon as she thinks of death or even of life.

It is good to point out that these phobias of ideas are intimately involved with all the earlier phobias: very often, as remarked by Legrand du Saulle, the memory of an object or a situation suffices to reproduce the crisis; the mere sight of a drawing that represents the inside of Saint-Pierre-de-Rome leads him to stagger on his legs. For many of our patients it is the same: the mere thought of a woman produces for Jean “a tiring state” and the mere thought of going to a drawing lesson gives a heartache to Dob...

On the other hand, the phobias of objects or a situation often involve complicated ideas. One of Westphall’s patients has claustrophobia in a theater; but it is because he repeats thoughts of this kind: “what will I do if a fire bursts out in the room and if at this moment I have a fit? I cannot save myself.” In all Jean’s phobias, he makes or made similar reasonings.

We see that there are many intellectual operations that can cause these phobias as before with sensations, perceptions, or sentiments.

2. — *The diffuse emotional agitations.*

*The anxieties.*

It is enough to repeat briefly about the phobias what we have already studied regarding the mental manias: neither from the clinical point of view nor from the psychological point of view do these diverse phobias form truly different phenomena from the others. M.J. Falret already very correctly pointed out that all these fears show solidarity with the others: “agoraphobia is often found,” he said, “in the same individual with a fear of a bare sword, a fear of falling out of a window, the fear of carriages or the delirium of touch.”

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196 Id., *ibid.*, p. 8, 18.
supported the same opinion when he suggested encompassing all cases of agoraphobia, claustrophobia, topophobia under the common title of vertiginous phenomena. This conception seems to me much more just than that supported by Legrand du Saulle and by some other authors who wanted to make some of these phobias, in particular agoraphobia, different diseases.

We can easily notice that the same patients are cited regarding the diverse phobias: Jean in particular had almost all of them, and when we cure him of one, he falls again into another one. The difference between agoraphobia and a phobia of contact scarcely exists, only in external circumstances that modified an aspect of the same fundamental psychological disposition. Indeed, all these phobias seem constituted by two groups of phenomena, one is secondary and variable, the other is fundamental and unchanging. The secondary phenomena are the sensations, the perceptions, the feelings that provoke a state of confusion, that mingle with it and give it a particular aspect; the essential phenomenon that one always encounters is a disturbance of the entirety of the individual, physically and intellectually, designated in a general way under the name of anxiety. Just as the mental manias drove us to the phenomenon of rumination, the tics to the phenomenon of motor agitation, all the phobias drive us to the study of anxiety.

1. — *The diffuse anxiety.*

The diverse phobias present the phenomenon of anxiety associated and combined with sensations, perceptions or feelings; this phenomenon can also appear independently of a specific phobia. We often noticed that certain patients are in a constant state of diffuse anxiety: “in addition to all the particular phobias,” said Mr. Ribot, “there are some observations of a vague but permanent state of anxiety or dread that is named panphobia or pantophobia; it is a state where one is afraid of everything and nothing, where the anxiety, instead of always being riveted to the same object, floats like in a dream and settles only for a moment at random

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circumstances, passing from one object to another one.\textsuperscript{198} Morel,\textsuperscript{199} Weir Mitchell Mac Farlane already described these “states of anxiety,” these states of fear. Recently, Mr. Freud\textsuperscript{200} heavily stressed this state, establishing what he calls “the anxiety neurosis.”

Messrs. Pitres and Régis, who make this state of diffuse anxiety the essential phenomenon of the phobias and obsessions, report some remarkable cases from which I shall call to mind this one. A 52-year-old, nervous, impressionable lady felt a great sorrow following the death of her mother, it lasts 12 years; she presents now with a major emotional depression without morbid disorders, strictly speaking. Three years later, following another death, that of a friend, she entered into a state of diffuse morbid emotionalism, with “anxious expectation.” The patient was constantly in a state of vague suffering, in a latent state of fear, which would explode in the form of a paroxysm at the first opportunity. A car passed while she walked on the sidewalk, immediately she fell into crisis, being afraid that a wheel would break loose and come to crush her. With the slightest wind, a tile was going to slide off a roof and split her head. At the table, food was going to suffocate her. Other times, barely having left her home, the anxiety arose, objectifying itself in the idea that someone she knew perhaps had just died suddenly and she was forced to retrace her steps to feel reassured. Every event, every incident, every act of her life became material to discharge her anxiety for a moment, made specific by chance.\textsuperscript{201}

Observations of this kind are among the most commonplace, we can review many of the previous cases and notice that, for certain patients, the phobias multiply themselves. The anxiety does not occur regarding a single object, but regarding a large number. We cannot enumerate the objects which in certain circumstances may create anxiety in Jean, all that relates to sex, everything that relates to the post office, all that relates to politics, to religion, to health, to death, etc. Anxiety ends up being almost


\textsuperscript{199} Morel, \textit{Délire émotif}, p. 395.

\textsuperscript{200} S. Freud. Obsessions et phobies. \textit{Revue de neurologie}, 30 janvier 1895.

\textsuperscript{201} Pitres et Régis, Séméiologie des obsessions et des idées fixes, \textit{Rapport au congrès de médecine de Moscou}, 1897, p. 19.
indeterminate and constantly reproduces itself regarding anything: it can be considered as diffuse.

There are even clearer cases where the fear is almost permanent, or occurs by fits and starts, without the subject attaching any thought to this anxiety, without there being even an apparent, intellectual justification; as we saw Jean constantly doing. A 38-year-old woman, Cs... (41), always an emotional person and impressionable, was very distressed around the age of 31. She had barely recovered from a childbirth when the nurse had the clumsiness to say to her that the child did not breathe and seemed dead; she felt a violent shock in the head, and since then has remained very changed. This first disturbance lasted several months and is almost cured. She had a terrible relapse when a doctor asked her if she had no albumin in her urine. Since then, she remained for more than three years in the following state. About ten times a day, without any sort of reason or pretext, at least seemingly, she starts to fidget, she moves, strikes furniture, she takes a gasping breath, the heart beats quickly, she cries, is upset, complains to be suffering, unhappy, she waits for something she does not know what, she is afraid of something unknown. Never does she have a specific fear, a reason for her despair; from time to time she claims that someone said a word to her that disturbed her, but she does not know why this word disturbed her, and often she cannot come up with any reason. It is a pure panic attack, without intellectual elements, and occurring in a completely diffuse way.

I would like to emphasize a little the observation of Ku... (42) because the details of this case will play a role in the interpretation of the phenomena. She is a 37-year-old woman, always weak and timid; all her life she was tormented by the fear of hurting people; I shall return to this need of a genial environment because it is one of the most curious characteristics of the scrupulous’ mind. Eighteen months ago, a ridiculous incident changed her life; she was called by the police chief as a witness to give her opinion about the behavior of one of her neighbors. This incident was enough to put her in a completely abnormal state that lasted several years. This long disease can be divided into three periods: in the first one, which lasted three months, there was great mental agitation, a perpetual and diffuse ruminating
at which we have already hinted; in the second, which filled about ten months, the agitation was especially motoric, she is one of those patients with hysterical pseudo-crisis that I examined regarding diffuse agitation. Finally, the disease took a third form: “the crises are more painful,” says the patient, “because they became internal.” She means to say that there are much fewer convulsive movements of the limbs, shoutings and gesticulations, but that these outer movements are replaced by visceral movements: particularly strange cramps of the diaphragm and the stomach, a perpetual tremor of the abdomen that replaces breathing, also nausea, vomiting, diarrhea, etc. This anxiety arises all the time in more or less lengthy crises about all the possible incidents, in reality without rhyme or reason. There is an almost perpetual state of anxiety, “a vague anxiety that floats in the air,” said Freud, “and that asks only to attach itself to anything.”

We shall find a large number of similar observations in the second volume of this work. I return in particular to those of Gy... (46), Jo... (43), Hb... (47), Dn... (49). The anxieties of this last patient are particularly remarkable because they occur about ten times during a night’s sleep and happen in the daytime only if the patient tries to fall asleep. We will return to this fact when studying the pathogenic preconditions of the anxieties. These several observations are sufficient to show that anxiety does not always take the systematic form of the phobias, but that very often it is vague, diffuse, without relationship to a definite intellectual phenomenon. This seems so important that certain authors, such as Mr. Freud, wanted to make it a special disease, distinct from obsession and from depression, under the name of anxiety neurosis. It is a clinical interpretation that must be discussed.

2. — *Psychological disorders of anxiety.*

Having noted the various systematized or diffuse forms that anxiety can take on, it is now necessary to consider this phenomenon in itself and to see which elements it is composed of in most of the cases where it appears; it is necessary to look for the
general characteristics of anxiety. These characteristics seem to me to be of two sorts: a large number are physiological characteristics that will be studied first, but it seems to me that there is a second group composed of psychological phenomena, the study of which must not be neglected.

Mr. Freud enumerates thusly the main forms that the panic attack can take, that is, the main phenomena that constitute it and which in this or that case can develop in isolation:

1° cardiac disorders with palpitations, arrhythmia, palpitation, going up to states of the gravest cardiac arrest;
2° respiratory disorders, dyspnoea; nervousness, asthma attack;
3° disorders of the digestive system: fits of raging hunger or bulimia, paroxysmal hunger, often associated with dizziness, paroxysmal thirst, periodic or chronic diarrhea;
4° fits of dizziness or intoxications, they consist of a special feeling of faintness accompanied by the impression that the ground moves, that the legs collapse, they can even bring episodes of deep fainting;
5° paresthesia;
6° night terrors or alarming awakenings;
7° muscular tremors and trembling;
8° profuse sweats often occurring at night;
9° vascular and congestive phenomena similar to those that we observe in the vasomotor form of neurasthenia;
10° tenesmus and the commanding need to urinate.

Other phenomena that Mr. Freud adds: general irritability, the inability to tolerate sensory excitement, worried expectancy, obsession, related somewhat to the psychological disorder.

Mr. Hartenberg adds some interesting symptoms, fits of yawning, the phenomenon of the dead finger, periodic weight losses.

I insist only on the physiological phenomena that appeared most frequently in my patients and I
study here only the phenomena of the panic attack while leaving aside general disorders of health that persist outside of the anxiety attack itself.

I wanted to submit these disorders to a precise analysis and, as much as possible, to take some measurements and some graphs, as I had been able to do for a certain number of hysterical phenomena. I must point out that such studies are much more difficult with this type of patient and I am a bit surprised when I see many authors speaking with so much assurance of the physiological modifications of psychasthéniques, as though they had been able to observe them and accurately measure them. Their panic attacks do not occur at an arranged hour, at the most favorable moment for observation. Very much to the contrary, there is in these patients’ mental states a curious capacity that prevents the crises from occurring in this way. We saw that they can almost always stop or eliminate their crises when there are strangers present and they want to hide them. Claire, who rolls on the ground in her crises of efforts, gets up immediately as soon as somebody enters and she tidies up, with the greatest calm, her messy grooming. In these conditions, will they allow their crisis to occur in the laboratory? Besides we shall see later another interesting characteristic, that they are very easily consoled, reassured by the presence of a person who looks after them or simply studies them. “How is that you want me to have anxiety in front of you,” Jean tells me, “but your place is the only place where I am quiet, I would like to be always with you and I would never have pain.” By definition, even the agoraphobic has his terrors in solitude; he will not have them in a laboratory, when his doctor examines him. That is why, to my great regret, I was not able to gather as many precise documents, graphs as I would have wanted about these disorders. I felt, I admit, a disappointment when I had to note that with two hundred patients observed for years, I quite rarely had the favorable opportunity to observe for myself, under good conditions, these important emotional phenomena about which the patients always speak but which fade very quickly as soon as we wish to analyze them.

However, I was able to do a small number of experiments that I believe must be taken into account in the analysis of these physiological disturbances.
These patients complain a lot about feeling disturbances in the movement of their limbs during anxiety. I do not speak here about the great agitations that can sometimes accompany anxiety. The motor agitations are usually less compatible with anxiety itself, when there is great emotional suffering the external movement is not very considerable, and vice versa. What we often observe is spasms, tremors in Dob... for example, these sorts of spasms never reach contracture for Mb..., and especially the trembling of the arms and legs (Cum..., Bo..., Vim..., Dob..., etc.). For Bue..., this trembling of the legs was even captured during an examination for clonus. When the patient is calm, it is evident that there is no epileptic tremor of the leg and that it is due to the emotional disorder.

Many patients complain to be as if paralyzed, to lose all strength of their limbs, “my legs,” said Fie..., a 35-year-old woman, “are like some wool, I feel like falling on the ground,” “sometimes my legs run away from under me,” says Vim..., “sometimes it is my arms that abandon me. There is no way to hold a quill to write.” “I am going to fall on the ground, the ground beckons me,” says Dob... I wanted to verify this muscular weakness that is not without some importance.

Again and again, I was able to examine these patients who claim to be paralyzed during anxiety: the paralysis or even the paresis is a phenomenon that should be rather easily borne out. Well, I was not able to note anything other than a slight degree of decline of the energy of voluntary movement that disappeared quite quickly when we encouraged the subject. Lkb... claims to have paralyzed arms during anxiety; at first, I took the hand strength in the dynamometer of Chéron-Verdin during his most normal state, then during the crisis, by making him squeeze the instrument ten times and by taking the average. Here is the series of figures obtained in the normal state:

Right hand: 24, 21, 21, 24, 19, 22, 24, 23, 23, 23, average 22.4;
Left hand: 21, 22, 24, 21, 19, 19, 19, 21, 21, average 21.0.

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203 Névroses et Idées fixés, II.
Another experiment also in the normal state:
Right hand: 25, 24, 23, 24, 24, 23, 24, 22, 25, average 23.7;

During an experiment that was able to be made once during the pathological state:
Right hand: 22, 25, 24, 22, 22, 23, 25, 23, 23, 25, average 23.4;
Left hand: 21, 21, 21, 20, 21, 19, 20, 21, 19, 21, average 20.4.

The experiment is regrettably not repeated enough to yield very clear conclusions, we can notice that the strength is weak even in the normal state, and that there are no big variations during ten consecutive pressures, the subject appears to me to make little effort, even at the beginning and to get a little tired, it is connected with his general abulia. But what is striking is the small difference between the series obtained in the normal state and those obtained during anxiety. The paralysis about which this patient complains is not very easy to appraise objectively. I come to the same result in three other patients: the difference between the averages of ten pressures made in the normal state and the averages of ten pressures during anxiety is insignificant.

If we observe true paralysis, we often notice ataxia, the lack of coordination. The movements are disrupted by tremors and spasms and they lack precision. We notice that delicate actions cannot be executed any longer, Nadia stops being able to play the piano and Jean cannot write any more. His writing becomes pitiful every time that he is disturbed, and during panic attacks he is unable to hold a quill. Except for the phobias of speaking that, naturally, render speech impossible, in many anxieties speech becomes jerky, hesitating, muddled. Certain patients have a completely special word during these crises that allows one to recognize their state.

If we pass on to the visceral functions, we must recall that the anxieties of a certain number of patients cause genital arousal. For some like Jean, these
arousals and the erections are related to erotic obsessions and we can say that it is the patient’s musings that brought on the excitement. But for others, Claire and several others in particular, the genital excitement occurs at first as a kind of diversion of anxiety or motor agitation and the erotic obsessions come only later. Hb... (47), a 40-year-old woman, always timorous and scrupulous, remained very quiet all her life from the genital point of view. Following the death of her father, she felt alone and abandoned, she had crises of despair. At this point, she had a previously unknown genital excitement and could not resist the need to masturbate. “Having done it, she feels better, less abandoned and braver.” We can connect with this excitement of the genitalia the curious exaggerations of secretion. Ku, in her anxiety, “loses some water through the vagina like a woman who gives birth.” It is not about a purulent secretion that is connected to some metritis, it is a really very considerable aqueous secretion that occurs only at the time of these excitements and which then disappears.

The gastrointestinal disorders related to obsession and anxiety are important, but they are difficult to study. Indeed, you should not forget that all these patients are extremely neurasthenic and that disorders of the stomach and bowel are fundamental. Almost always their eating, their gastric digestion, their intestinal functions are very defective in a constant way. We shall have to study them by examining the general state of their physical health. But it is very difficult to determine if some of these digestive disorders coincide exactly with the panic attack. For many patients it is not that way, we shall even have to call attention to, for example with Lise and Gisèle, a kind of alternation between the psychological troubles and the gastric disorders. It would now be necessary to notice acute digestive disorders at the time of the anxiety. Legrand du Saulle has already noticed that they are rare and he points out that agoraphobics do not vomit, which distinguishes them from others with vertigo.

Nevertheless, we sometimes notice disorders of
the diet and digestion that coincide with the anxiety. Most of the patients refuse to eat during their anxiety. Ku... went six weeks with almost no food, and it was not about a refusal of food due to an obsession, but about a disgust related to anxiety. Others have crises of bulimia, like Lkb... (100), who at this time would like to glutonize, but I am not sure that this bulimia depends only on the state of the stomach and is not more related to the general feeling of weakness that we find in the emotional disorders.

Among those who continue to eat, a large number like Gr..., Bu..., Bx... (200) complain about painful nausea, only the patient Claire vomited her meal two or three times in the middle of her contortions. Naturally, we set apart those who have tics of vomiting, crises of efforts of vomiting, phobias of digestion. It is more frequent that the patients without tics and without particular phobias relating to digestion nevertheless have a hard time with their digestion, they feel the stomach swell, the stomach tighten, they have cramps of the esophagus, they feel a ball that rises to the throat, they complain to have a dry, pasty and bitter mouth. Bx... constantly has this bad taste in her mouth the whole time that the phobia lasts. For some these disorders become indigestion, when the crisis arises a little while after a meal.

We must also note the singular crises of diarrhea that we observe from time to time. For Xo..., it is a real intestinal flow, repeated and extremely painful. For Gisèle and Lise, it is a lientery state that occurs when they are frightened and food is returned without any digestion. For some, Gs... in particular, an aqueous secretion continues in streams even when the materials are returned by excitement of the bowel glands. There is an intestinal hydrorrhea like uterine and nasal hydrorrhea and these phenomena of exaggerated secretion certainly play a role in the muco-membraneous colitis so frequent among psychasthéniques.

Finally it is necessary to note that some have urinary frequency and more rarely a true polyuria; in a half-day of anxiety, Claire returns three liters of urine. Several others have indicated the same to me without having measured it.
With the functions of circulation, we arrive at disorders that are more distinctly related to anxiety. Many patients complain of suffering in the heart at that moment and they are, as usual, full of imagery and symbolic descriptions. “I feel,” says Al... (15), “something that constricts me and disturbs me to the left and that rises up the throat, it is like a clot that would be in the heart and that would stop the blood;” “I suffer horribly,” says Mm... (5), a 32-year-old woman, “because the heart overflows and because this surplus from the heart spreads all around, the heart bathes in the trouble as if it had been plunged into a vase filled with trouble.” We hardly know the physiological phenomenon that hides under these metaphors.

Several patients, such as Claire, claim to feel that their heart stops. It would be an easy phenomenon to verify but I was never able to observe these stoppages of the heart nor even any real slowing of the pulse; the patients always say that they are going to faint, that they feel faint, but I have never noticed during the anxiety any real cardiac arrests. The losses of consciousness, to which we shall have to return, are of quite another nature.

What we really notice, and it is in accord with what the patients say, are cardiac palpitations: “my heart is disconnected,” says Ky..., “it beats as if we removed the pendulum of a clock.” Brk... speaks about violent shocks of his heart and Jean does not dry up on this subject. According to him, his heart has not only rapid beatings, but enormous beatings that provoke painful shocks on the breast and that we must hear in the distance: this disconnection of the heart, as he also calls it, is what he dreads most at the peak of his anxiety, it is to avoid it that he makes all these operations of mental rumination. He stops its beatings by counting them according to his mania of four by four. I have already pointed out on this matter that this account is purely imaginary. In spite of the exaggerations relative to these cardiac shocks, it is certain upon examination that their heart beats often very strongly and very fast. It is not rare to notice 100, 110 pulsations per minute and more, especially for those who are restless; sometimes, as with Claire, these palpitations go on for a whole day, even after the end of the panic attack.
The blood pressure in the arteries is studied often in the neuropathic states today: Mr. de Fleury believes that modifications of the pressure above or below normal play a big role in depression. I find these measurements of the blood pressure rather difficult to take with men. I used Chéron’s device at the beginning and I noticed that, if I kept silent while the pressure was taken by several persons, then by myself, we arrived at absolutely discordant results and this contradiction discouraged me. Since then, I used Potain’s device and the results seem to me a little more precise; I do not believe that I can, however, grant an extreme precision to these figures.

Many subjects seem to me to keep an almost normal pressure, Jean, who is so anxious, presented mostly 14, 15 or 16; on three subjects, I observed values of 19 and 20, that is above the norm, it is these subjects who fidget; for two others: Lise and Gisèle had values of 9 and 11, these subjects seem rather immovable in their anxiety. A single observation made a rather clear impression upon me: Rk... came to find me one morning because he had been taken at night, at three o’clock in the morning, by one of his obsessions with the mental mania of questioning which had brought, little by little, anxiety. His face was completely broken down, this 40-year-old man, usually sanguine, was pallid, he had cold skin, a heart rate of only 60 pulsations and the pressure measured with the sphygmomanometer of Potain seemed to me clearly very low, 9 or 10 at most. I was able to raise it by a series of processes, which I shall indicate later, to force him to work and to strain and I saw the complexion, little by little, change; the face became colored. The pressure, which I took again, was at least 16. In this case, the anxiety manifestly coincided with the symptoms of cardiac exhaustion.

But I would very much hesitate to generalize upon this observation. Other authors, in particular Messrs. Vaschide and Marchand have

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noticed an increase of two and one-half centimeters of blood pressure on average. The normal pressure of their subject was 18.5 and under the influence of anxiety (it was an ereuthophobic), it amounted to 21 centimeters. I, myself, observed this rise in certain cases, without counting the still more numerous cases where the pressure was normal.

The vasomotor disorders were also presented as essential. Mr. Ribot, along with Wundt and Mosso, believes that a momentary relaxation of the vasomotor innervations causes blushing of the face and comes as a compensation for the acceleration of the heart rate. Messrs. Pitres and Régis make a considerable role for this dilation of the cutaneous vessels that accompanies ereuthophobia. I simply point out here that these vasomotor phenomena are very variable in anxiety: if we notice the blushing of some, we observe in others a pallid paleness that seems to me to be even more frequent. There are sometimes rather fast alternations between blushing and paleness; finally, for many the tint of the integuments remains completely normal.

The experiments that can be done on the state of the vasomotors of the hand must not be generalized too quickly: it is not certain that the circulation in the rest of the body and especially the cerebrum exhibit the same changes. In two cases, I could apply the pletismograph of Messrs. Hallion and Count during anxiety episodes that were obviously made more moderate by the experiment. In one case, the line of the capillary circulation was identical to the one that I had taken during the normal state. In another case, the line of heartbeats was extremely reduced while it was rather strong in the normal state: it would indicate a certain degree of vascular constriction. Messrs. Vaschide and Trader in their studies on a ereuthophobic, note two forms of the radial pulse and of the capillary pulse, depending on whether the emotion and anxiety are weak or become more intense; “the first one corresponds to a fast pulse, with a stressed dicrotism and a sharp summit and in the second a slow pulse, with a diminished heartbeat and a slightly attenuated dicrotism. The capillary pulse presents no clear dicrotism; under the influence of an emotion of the first

206 Ribot, Psychologie des sentiments, p. 477.

207 Vaschide et Marchand, op. cit., les tracés qui ne sont pas publiés dans l’article français se trouvent dans l’édition italienne, Riv. sper d. freniatria, 1900.
Disorders of sudoral\textsuperscript{1} secretion are added to these vasomotor alterations, many of these patients are soaked in sweat. These sweats are natural for Claire, because she devotes herself to a wild gymnastics, but the others, such as Al..., Dv..., Ul..., Lkb..., etc., have their face and the hands covered with sweat although they remain immobile, as the skin cools by vasoconstriction at the same time as the sweat passes through, they frequently seem cold.\textsuperscript{2} An interesting patient, Rul..., a man of 40 years, who cannot remain motionless in a chair and whom we presented as a case of \textit{akathisia}, has his forehead covered with big beads of sweat if we force him to remain seated for more than a few minutes.

The most visible and the most indisputable physiological disturbances are always the disorders of the respiratory movements. All the patients who have anxiety complain of not being able to breathe, of suffocating; Lkb... complains of having tightening in the chest, restricted breathing; “it seems to me,” says Bt....(44), “that I stop breathing.” “I feel that I suffocate,” Fy... says ceaselessly, “I feel that nothing moves in my chest and it seems to me that other persons cannot breathe either; then it had to be the end of the world, everybody died suffocated, and as my breathlessness increased, I dragged myself to the caretaker’s to ask her if she also suffocated.”

These respiratory disorders are not purely subjective: we can easily observe them. Messrs. Vaschide and Marchand, in the work previously cited, note that the mere idea of blushing provokes in their patient an acceleration of respiration

\textsuperscript{1} Disorders of sudoral secretion

\textsuperscript{2} Vaschide et Marchand, \textit{op. cit.}, p. 204.

\textsuperscript{2} Hartenberg, \textit{Les timides et la timidité}, p. 27.
with an increase of amplitude, and that the more intense anxiety brings a slowing down with irregularities and distorted breaths in staccato.\textsuperscript{210}

My observations allowed me to notice similar facts. We observe at first sight that some of these anxious patients breathe too fast. We see, for example, that Ku... is panting; she even has an extremely curious tremor of the stomach and I regretted very much that I could not take a graph of her respiration. These small, continual tremors of the stomach are due to a tremor of the diaphragm; the movements are, at the same time, both very superficial and very quick.

These characteristics become even more visible when we can take graphs; I repeat on this matter how very difficult it is to make a success of this experiment on patients of this kind. Most often, the panic attack dissipates while I lead them to the laboratory and while I arrange the devices. Sometimes, but rarely, the anxiety, on the contrary, persists and worsens at the sight of the devices; but then it is impossible to hold the subject quiet in the armchair; he fidgets a lot and, if we insist, he breaks all these delicate devices, as happened to me with Lkb...

The result was that from such a large group of patients I was able

![Graph](image)

\textit{Fig. 3 — Anxious breathing of Chm... 28 breaths per minute. - These graphs are taken with the pneumograph of Verdin,}\textsuperscript{lxviii} the horizontal and vertical lines serve as landmarks. The horizontal arrow indicates in which direction the graph must be read, the vertical arrow registers the direction of the inspiration. T. Thoracic breath. A. Abdominal breath. S. The time in seconds.

\begin{itemize}
  \item to take only a small number of graphs and that the disorders must be more accentuated in reality than what these figures show us. Figure 3 shows us only a slight
\end{itemize}

\textsuperscript{210} Vaschide et Marchand, \textit{op. cit.}, p. 203.
polypnée \textsuperscript{lxix} for Chm…, 28 breaths per minute, we also note a slight tremor in the movements of the abdomen. It is likely that the disorders were reduced while I arranged the experiment. Ul… (45), in figure 4, already presents us the same phenomena but more accentuated; he has 25 breaths per minute and they are much more irregular; the abdominal respiration

Fig. 4. — Anxious breathing of Ul… when she tries to look at someone in the eyes, in breaths per minute.

is nearly eliminated and replaced by a disorganized tremor.

In figure 5, Lkb…’s polypnea is enormous in all aspects, 55 breaths per minute, with great irregularities. Another type of anxious breathing is the one that we

Fig. 5. — Anxious breathing of Lkb… 88 respirations per minute.

see in figure 6 taken of Sy…; there is no polypnea, he has, on the contrary, a decreased number of breaths, 10 efforts per minute. But the breathing is made by abrupt and deep sighs. Every inspiration is a kind of convulsive movement, especially of the diaphragm. Even when the patient is a little calmer (figure 7) she retains something of this
Fig. 6 — Respirations of Sy… 10 sighs per minute.
abrupt breathing. These two main disorders, the polypnea and the inspiration spasms, usually harmonize and figure 5 taken on Rib... (68) must present the most common disorder:

Fig. 7 — Respirations of Sy... when the anxiety is diminished. 18 respirations per minute.

very irregular respiration, especially in the diaphragm, interrupted by great convulsive sighs.

I was only able to measure in the spirometer of Verdin just one quantity of absorbed air and I found it very inferior to the norm despite polypnea; I was not able to, as I had done

Fig. 8. - Anxious breathing of Rib... 25 breaths per minute, sighs and polypnea, completely irregular abdominal respiration.

with the hysterics, to make an analysis of the gases of the breath. It is likely that we would also see other disorders that could be added to the preceding ones.

These are the briefly summarized, main physiological disorders that we observe in anxiety.
Physiological disturbances exist within anxiety, we observed them: it is even likely, as we said, that these disorders might be more considerable than we were able to observe or, even more so, to record. Under more fortunate circumstances, we might even be able to note more cardiac, vasomotor and respiratory changes. But must it be concluded that these changes exist in all of the anxieties of the scrupulous and that they are only conscious of some of these organic modifications? I think that there are many reservations to be made on this point.

This discussion will be resumed regarding the various theories of the illness. For the moment, it is enough to note that these patients most frequently complain of disorders that they feel in their head and of great disturbances of their mind. Mr. Arnaud pointed out precisely that “the anxiety is especially intellectually cerebral, it is a mental anxiety rather than an organic anxiety,” without perhaps going that far, I shall simply say here that the anxiety is not only visceral, it is also mental and intellectual.

In many cases this second part of the anxiety seems to be the main element and can even exist by itself; in brief, next to the visceral anxiety that could be simply the heart in an asystolic fit and which is nothing special, there exists a mental fear that is peculiar to the scrupulous and which consequently has a lot of importance.

These patients all describe sensations, sufferings that they feel in the head and which we shall have to review in detail. They insist on certain very painful feelings many of which are exclusively of a mental nature. “I feel,” says Dob, “strange feelings in these moments of emotional misery where I desperately try to recover my reason.” They have, indeed, a dominating sentiment that they are losing their minds (Dob..., Jean, Cer...). It is at this moment that they believe that they become mad. “I feel in my head like a humming, at the same time an ecstasy and a torpor, the fear of becoming crazy seized me” (Fy...). “It gives me

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weird ideas suddenly; I have the striking feeling that I go crazy and it is then that I am afraid. I want to shout that I became a lunatic and an idiot” (Sy...).

Another feeling that was very well noted by Claire is death. “I lose not only my reason but life,” she says, “it seems to me that I die, fortunately it is very fast.” They also have the feeling of not perceiving the outside world any more. “You cannot understand the cloud, the black curtain,” Jean continually says, “that falls on your eyes and head at this moment.” “What gives me anxiety,” says Dob…, “is that I have the feeling of not understanding any more where I am, what I am; that I have a coldness and dullness throughout my head.”

Finally, they have the sentiment of losing their freedom, to become as automatons, not to be able to command their actions any longer and this is what gives them grounds to make silly remarks. “At this moment,” writes Dob…, “I undoubtedly have no more than a fragment of will, I am as a wreck beaten by the waves and my head gets lost because I feel that I am no longer my own master.”

These sentiments appear to me to be of the greatest importance in anxiety, they raise a major problem which, if I do not make a mistake, was again well foreseen by Mr. Séglas;212 the problem of the psychological disorders that manifest themselves during the crisis and which perhaps always exist to a lesser degree in the scrupulous.

It is necessary to analyze these impairments of the psychological functions before trying to interpret the mechanism of the obsessions and the irresistible processes. It seems to me to be difficult to separate the study of the psychological disorders during the mental panic attack from those of the psychological disorders that exist more or less constantly in the obsessives, some being only the exaggerations of others. Therefore, we shall study them simultaneously under the name of psychological stigmata of the psychasthéniques in the following chapter.

For the time being, let us content ourselves with summing up in a diagram the main forms of emotional agitations that have just been studied.

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212 Séglas, Leçons cliniques sur les maladies mentales et nerveuses, 1895, 5° leçon, p. 118.
FORCED EMOTIONAL AGITATIONS

Systematic Form

- Phobias of the body
  - The algias
  - Phobias of the functions
    - movements of the arms, of writing, of walking, of eating, of swallowing, of digestion, of defecation, of breathing, of speaking, the sense of smell, of hearing, of seeing
    - of dangerous objects, of dirty objects, of objects of value, of men or women, of animals, of professional instruments

- Phobias of situations
  - Of physical situations
    - agoraphobia, high places, claustrophobia, etc.
  - Of social situations
    - phobias of blushing, dysmorphophobia, phobias of hair, facial features, movements of the face, of servants, of marriage, etc.

- Phobias of objects
  - of the chest, of the breast, of the skin, of the head, of the teeth, of the tongue, of the limbs, of the genital organs, of the bladder, the urethra, of the anus, etc

Diffuse Form

- physiological anxieties
  - digestive, circulatory, breathing

- mental anxieties
  - religious ideas, moral ideas, the idea of death, the idea of illness
FOURTH SECTION

GENERAL CHARACTERISTICS OF THE FORCED AGITATIONS

This long analysis of all the kinds of forced operations that pervade the patients’ minds, aimed not only at describing their very numerous varieties but even more so at establishing between them some order by combining them into classes, by reducing them to a few main types. We thus succeeded in observing three classes or three principal types of these phenomena:

1° intellectual operations that we combined under the title of mental manias and mental ruminations;

2° irresistible movements that we combined under the name of tics and of crises of agitation;

3° visceral fears determined by organic disorders especially of the circulation and breathing.

1 — Clinical unity of the forced agitations.

Generally, clinical education until recently was inclined to separate these three groups of symptoms and to consider them as so many different illnesses. The group of the forced movements constituted the disease of the tics that they placed aside, the mental ruminations formed the madness of doubt and the emotional phenomena lined up under the title of the delirium of contact or phobias.

The first authors who described the obsessions, even when they did not give in to the temptation to set up every mania as an independent disease, were always inclined to formally distinguish
these diverse groups of symptoms. Griesinger, in 1868, set apart the mania of why and how; he made it an obsession with consciousness in the form of interrogation and doubt. He did not make the slightest allusion to the disorders of movement, nor to the disorders of emotion. Moreover, he went so far as to advocate that there was no emotional disorder in the delirium of doubt. When Legrand du Saulle tried to summarize what was known about these bizarre manias, he wrote two small books: one on the intellectual syndrome that he called the delirium of doubt, the other one on the emotional syndrome that he designated under the name of one of his main types, agoraphobia. Later, he was quite obliged to note that there were relationships between these two diseases and he postulated that these two syndromes are two successive phases of the same disease: the subjects had to begin, according to him, with the mania of doubt and then end with a second period where it manifested itself as the fear of touching certain objects.

After him, they still almost always retained the distinction of both syndromes, without accepting his correction and without making two successive phases of the same disease. Mr. Cullerre does not want to accept along with Legrand du Saulle, that the delirium of contact is a second phase of the madness of doubt. “In reality,” he says, “this symptom has an independent existence and deserves to be examined separately.” Mr. Ladame, in his remarkable study on these patients, ends by making two observations that in his opinion demonstrate “the complete independence of the madness of doubt and the delirium of the contact.” He barely acknowledges that these two different maladies sometimes join forces like pleurisy and pneumonia.

However, since that time the inverse opinion develops; Mr. Dubois’ (of Saujon) last works on tics and those of Mr. Meige very often show us the coexistence of the mental manias and the phobias with tics. Mr. Ritti, in his study on the madness of doubt, had already shown in 1870 that a merger of this disease with the delirium of contact would be justifiable. Krafft Ebing, in 1882, Wille, in 1882, Mendel, in 1888, express

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213 Cullerre, Les frontières de la folie, 1888, p. 73.


215 Ritti, Gazette hebdomadaire, n°42, 1877, et article << Folie du doute » du Dictionnaire encyclopédique.
similar opinions. Mr. Magnan, by combining all these facts under the name of “delirium of the mental defectives,” very much strengthened this opinion.

The complete distinctions that were formerly established between these three groups of symptoms at first sight seem rather justified in the clinic. An individual who has a great number of tics, who winks, turns the head, shakes their hands, takes a very special appearance that seems to distinguish him from patients disturbed by another group of symptoms. Entirely through his movements, he barely speaks to us about his mental disorders that bother him much less and that, moreover, are less developed than his tics. Also, a person who has marked, abstract ruminations does not look like the one who has great anxiety.

It is certain, for example, that we cannot completely confuse Lise and Dob..., the one is always completely quiet, shows no disorder, she would rather be completely motionless, her agitations and her sufferings are purely internal, she restricts herself to endless mental ruminations; the other one is an agitated, crying and shouting woman who is overtaken by terror in the middle of the street and who runs like a lunatic to return to her home: the clinical aspect is obviously different. We can even also notice a fact that partially justifies Legrand du Saulle’s conception, as that author already indicated, 216 the phenomena seem to a certain extent to be opposing each other. The more the patients ruminate, they have fewer agitated movements and respiratory anxieties; the more they physically shake, they have less mental agitation. It is therefore just to distinguish these three clinical groups, it is what we did by dividing these symptoms into three different classes: the predominance of one or the other can be made if one wants three varieties of the disease.

It is impossible to go farther: the links that unite ruminations, tics and the anxieties are most narrow. At first, the patients pass very often from one to another. A certain number follow the path indicated by Legrand du Saulle and go from doubt to the phobias: Claire ruminated for a long time upon religion

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before having her crises of agitation, her terrors in front of churches, toilets or bottles, Ul... had scruples, ruminations about good and evil before becoming an agoraphobic. We could just as well enumerate patients who followed the inverse order: De... had genital phobias, then she began wondering about the way she was made, about love, etc., etc., Nem... for a long time had a phobia of knives, forks then she began a mania of interrogation on the way that people are made, on the nature of the world. A large number began by having tics that then evolved towards doubts and phobias, Nu... (112), cured of her tics by a severe treatment, began the manias of interrogation; the reverse path is equally encountered. These diverse evolutions will be discussed from the point of view of prognosis, here it is enough to notice that they exist all.

We must also observe secondarily that these diverse phenomena replace the one for the other with the greatest ease; either spontaneously during the disease, or artificially when, during the treatment, we try to eliminate one of these agitations. All the authors noticed that resistance to the mental mania brings anxiety. If the patient tries hard not to check, not to begin again, not to compensate, not to atone, then he has suffocations and cardiac palpitations: on the contrary, he calms down if we let him give free rein to his needs for rumination. Jean gave his hand to his mother, he has the idea to compensate by touching the hand of a man, if he gives in and if he manages to shake hands with a man, he is doubtlessly dissatisfied because this is an absurdity, but he does not suffer. If this need appears in the evening when he is alone with his mother and if consequently he cannot satisfy his mania, he has anxiety for a while at night and a great motoric agitation. If Pn... does not repeat his sentence: “let us be going to dine, etc.,” he is frightened and his wife prefers “to hear his stupidities rather than to see him gasping for breath.” In several cases, the tics, the motor agitations, the masturbations come instead of the ruminations that they want to eliminate and conversely.

Finally, you should not forget the subjects such as Jean who seem to have had, almost all the time, tics, ruminations and phobias of every kind. In seriously affected patients, we often find these diverse symptoms that evolve
side by side and it is easy to notice that in the previous studies the same patients are cited regarding various forced agitations.

Therefore, I do not believe that, from the clinical point of view, we can accept a complete separation between these diverse groups of symptoms. Their union is still verified by the deep identity of the psychological characteristics that we observe in all of them.

2. — The crises of forced agitation.

After this long analysis, it is necessary to try to clarify the psychological characteristics that occur in a general way in these ruminations, in these motor agitations and in these anxieties. I still do not research their interpretation; I would only like to return to some simple facts regarding this enormous variety of appearances about which we feel so much confusion.

1. — The periods of crisis.

These singular mental phenomena do not at first sight seem, at least for most of the patients, to be continual; they appear to be more or less frequent and more or less long crises. This is an essential characteristic that must be placed in the first rank.

This characteristic is incontestable for the agitations and the phobias with visceral anxieties; it is very evident that Nadia does not jostle the furniture all day long and that Claire does not constantly make exertions and contortions; there are periods of agitations and there are periods of at least relative repose. When we took the graph of Sy’s breathing, we put into contrast his breathing during a period of suffocation and his breathing during a calm period. For these two categories of phenomena, the crises are therefore clearly marked.

This characteristic can seem a little less clear when it is about mental ruminations. For many subjects, the phenomena
go on in an almost indefinite way: this is the case, moreover, for most of the seriously ill patients. Lise claims that she is never free of the ruminations that constantly accompany every action in her life. Alongside the real action, for example, while she tends to her children, or even next to the real thought, while she tries to read and to understand a book, there is always an enormous imaginary job that concerns scruples, hesitations, pacts, preoccupations about her future life, the answers, the formulas of conjuration such as 4, 3, 2, and it almost never stops. During the periods of relatively good health, the rumination goes away and that is that; it seems more distant, “it becomes implicit,” as Jean said. But the patient always has a vague awareness that this work continues to be done in his mind: “even when I am well,” says Gisèle, “there is always a small grumbling in my head.” But it is not like that for all of the seriously ill patients. Many of the scrupulous, especially at the beginning of the disease, have only short ruminations, sometimes for barely ten minutes. In many cases, for Lod..., Nadia, Zei..., Zo..., for example, the ruminations go on in a grave way for one or two hours, then they calm down more or less completely; Wo... feels that although she has crises of counting or of the perfection of her prayers, she is able to delay a crisis, to postpone it till later and to resume it so as to complete it.

Even for the subjects that seem to have continual ruminations, there are apparently momentary exacerbations that force them to remain immobile, their heads drooping towards their laps, then decreases during which the “small grumbling” does not prevent them from attending to their activities. It seems that for them the crises blend with one another, that the first one does not have time to end completely before the second one begins. The tics themselves are only seemingly perpetual. Not only do they disappear during sleep, but for long periods of the day, especially when the subject is alone and when we ask nothing of him, they barely exist.

In short, none of these forced agitations constitutes a stable, permanent state of the subject; they develop out of crises in relation to certain occasions.
2. — The starting point of the crises.

But what are these opportunities that act as the starting point of the crisis: we would not know very much about what to stress here, because it is one of the essential things that must be definitely determined before trying to interpret it. I do not search now for the physical or mental conditions that determine the beginning of the disease or the beginning of a period of escalation during which the crises are more frequent; I seek only for the facts that are the opportunity around which the crises of forced agitation appear to develop.

1° From a first group of cases, the answer is perfectly simple. These crises always begin on the occasion of a voluntary action. It suffices to review all the examples that I cited to see that in a large number it is the beginning of an action, it is the desire to carry out an act that brings about the agitations and anxieties. Nadia’s crisis of agitation begins when she tries to play the piano for me, Claire’s crises of efforts develop when she wants to say her prayers, to sit down to eat or simply to go to the toilet. A whole group of phobias, those that I called phobias of objects, are as a matter of fact only phobias of actions. I believe that the first designation of these phenomena by the name “delirium of contact” was completely unfortunate and that it led observers on a false path. This word seems to indicate that the contact and the object are important here and we thought as much about phobias as we did about objects. The object here is, in my opinion, only an opportunity, as well as the contact, because we do not act without touching objects, but the main part is the action. Legrand du Saulle’s patient who has the phobia of writing implements has her crisis of phobia, in reality, when she wants to write. Mrc... has anxiety when he sharpens or wants to sharpen knives, Ger... when she wants to arrange these clothes, Pr... when she wants to purge herself. Jean has tics, or ruminations or anxieties when he wants to travel, to send a letter, to blow his nose, to shave himself, to wash himself, to cross a square.

There are certain categories of actions that often give birth to phobias; these are the professional actions. We see that, Lch... (78), a telegrapher, is afraid of the telegraph, the post office.
Are we going to say that the phobia develops because he sees or he touches a telegraph? No, it is when he wants to resume his job: the proof is that though we may modify his job, we do not cure him. As the doctor had spoken of a “disease of contact,” they did not make him touch the telegraph any more, they made him write, copy the messages, he acquired a phobia of the messages; they wanted to employ him to be in charge of the ledger, he acquired a phobia of ledgers, post offices, etc. It is the professional action that is the essential starting point.

Another group of important phobias, which I designated by the name of algias, of phobias of the body, gives rise to similar remarks: it is actions of the body, the physical functions, which provoke the anxiety. To move a limb, to move the little finger, to walk especially in many of basophobia and even agoraphobias, food, swallowing as we saw in all those phobic of swallowing, to digest, to urinate, to exercise the genital functions, to go to the toilet, etc., here are the functions and the actions that play the essential role. When it is about dysesthesias of the senses, it is the act of smelling, the act of listening, the act of looking that is the starting point for the crisis.

It is the same for the tics; the obsessive smile arises when it is necessary to enter a parlor, to speak to an unfamiliar person, to quickly carry out a difficult act. The tics with coprolalia arise for Qi... only if she has to get up from her chair and speak to someone; it is when she comes to the hospital to ask me for vouchers to shower that she is forced to shout “Bastard, you make me...” Lod...’s tics, who snaps her fingers, who closes the fist while thinking of God, begin when she has to settle down at the piano. Many ticqueurs make their grimaces, like Ul..., only when they have to address someone, Ul... began her tics when she had to “see ladies search for a place,” she has them now when she has to enter a local train.

We can make the same remark about ruminations, it is the actions that most often provoke them. We have just seen Ger...’s rumination begin when she wanted to go down to look for some broth for dinner. Jean begins to ruminate when he wants to get into a local train, when he wants to sit down at the table, to wash himself, to urinate, etc., Lise, when she wants to write a letter, to dictate an assignment to her children. Fi..., a 48-year-old notary, when
he has to sign a certificate, hesitates and begins ruminating. It is the most general and the simplest case: we cannot stress its importance enough, because it makes us understand that it is a malady of the will and we shall return to that when we shall discuss the very important phenomena of abulia in this disease.

To have this effect, to become the starting point of the crisis, the act has to be voluntary; an automatic, involuntary action, executed through absent-mindedness, does not at all have this effect. This is quite natural, because otherwise the patients could never move; they do move however and they carry out many actions that bring no mental disorder because they do not worry about them. Legrand du Saulle already noted that “if the patient is very worried and if he has a tense mood, he crosses the square without feeling anything whatsoever.”

Lise sits down to eat and eats with a perfect indifference, she gets dressed and pays visits without any disorder; Bu... works at his usual job without having phobias; Jean can have a quiet mind in the middle of the actions most grave to him if he is distracted; when he is going to have dinner in town, he gives his hand to ladies without having ruminations. The essential fact is, therefore, that the action is voluntary, that is it is new to a certain extent and that the subject tries to relate it to his whole personality.

You should not forget that it can involve negative actions as well as positive ones: to take the resolution not to keep silent about an action, to definitively refuse something will be the occasion for the anxiety and the rumination as well as the effort to make the action or to accept the proposition. We remember that many ruminations began upon the occasion of the thought of a criminal or unpleasant act that the subject wanted to push away. Here again, the same remark finds its place; if it is by distraction that the patient moves away from a dangerous situation, there will be no rumination. Claire repeats to me that she can do nothing to look after her own health, that if she wants to avoid putting herself in a draft, she is immediately going to discuss it for eternity; at the same time, I notice that she sat down again and that she refuses to go out because she sees that it rained. It is always the voluntary act, in its positive or negative form, which plays the leading role.

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2° The second phenomenon that plays a preponderant role as a point of departure for these crises is the attention. Indeed, the motor agitations, the ruminations, the anxieties also begin under these other circumstances when it is simply about ideas and not about actions. I note that these provocative ideas demand that there is a certain effort of attention or they were clearly put forward with acceptance or with faith. It is the effort to pay attention and especially the effort to believe or to disclaim, just as much as the effort to act, that seems to be the cause of this unique mental work.

A young girl of 15 years, Ho..., is forced to make her tics “when the class begins at school;” she shakes herself, puts her fingers in her nose, gnaws at her nails, rubs her stomach, thinks of her pubic hairs “because the dictation is difficult.” We can observe the fact in many children as well as for the schoolteacher Lkb... that the rule still holds. She is very quiet during recess; she blinks her eyes and shakes her shoulder when it is necessary to begin class again and especially “when it is necessary to do the major lesson, which requires more attention.” Renée has her tics when she wants to read a book and she is “indomitably compelled to walk endlessly when she puts herself at her desk to write her homework.” This fact is commonplace and very easily borne out.

A whole group of fears can be designated under the name of phobias of ideas. They are borne from an effort of attention to adopt or push away certain beliefs. They try to make an opinion about religion, about God, about the devil, about hell; this is what causes Lise’s, and many others’, fears. Ki... has fears when he tries to pay attention to causality or to any philosophical idea.

Attention to moral ideas about duty, lying, crime, renders all these patients anxious. But it does not have to be a moral idea to remind the scrupulous of their obsessions. Any attention, to a letter, to a newspaper causes phobias and ruminations for Za...; Jean dreads “any application of the mind” that brings about palpitations of the heart. The negative fact has the same value as the positive fact: an effort to deny an absurd story suffices to return all of Lise’s ruminations.

Finally, it is again necessary to make the same remark here as before, it is not about an idea, about any belief
affecting our behavior almost without our knowledge, it is about a voluntary and active belief. Cha... does not ask himself questions when he teaches music. Claire may assert that she can believe in nothing; it is evident, however, that she is convinced of a crowd of things: she believes that it is daylight, that I live in Paris, that she speaks French, etc. All these beliefs are implied in the simple act of writing me a letter, but she does not pay attention to it, and these beliefs do not disturb her. It is, in sum, an act of attention that brings about acceptance or negation that has an influence very similar to that of the will.

3° Another phenomenon can become the starting point of certain ruminations or certain phobias; it is emotion or at least a certain kind of emotion.

Legrand du Saulle\textsuperscript{218} cites this curious fact: “as soon as he made an attempt at sexual intercourse, his thoughts immediately appeared with the greatest intensity and froze all disposition toward penile rigidity.” This interesting observation is completely commonplace: I may not, you understand, relate in detail the singular confessions made to me by a large number of these patients about their genital feelings. But I may raise this main fact: the genital emotion is very often the point of departure for ruminations, tics and anxieties. The patients have the desire, they feel more or less incited, and it is at this moment that their agitations, anxieties or endless mental ruminations begin. It is also the moment when some of them are seized by an indomitable need to urinate, to have a bowel movement, or to begin their tics.

The same is true for pain, physical or mental. Lise has a very peculiar way of feeling her labor pains. It is at this moment when her spirit is invaded to the supreme degree by manias of vows, of pacts, by endless and obnoxious ruminations. The mental pains have the same effect. “Joy or sorrow,” says Mm..., “make me lose equilibrium and make me fall again into my musings.” “Gloomy situations,” says Jean, “give me agitations and fits of crazy laughter.”

Anger, for Lise, is also the starting point for ruminations and she even dreads aesthetic pleasure.

\textsuperscript{218} Legrand du Saulle, \textit{Folie du doute}, 16.
“When I played the piano, I took pleasure there, I gave myself to it, I was carried away, it made me lose balance, made me fall again into all my thoughts; that is why I began to always play with detachment.” It is singular to notice that this detail matches word for word the observation of another patient, Lod... when the artistic emotion is going to reach its height, is going to cause an enjoyment, this activates her absurd reasonings. Similarly, for Cr..., it is the beginning of a small emotion that causes the crises of agitation and the need to walk for several hours. For a large number of patients such as Renée, Qi..., etc., we cause a crisis of tics by abruptly closing a door, which causes them surprise or fear.

I believe that a whole group of phobias returns in that case, those that are determined by the perception of a situation, by a feeling that is a type of agoraphobia. Bridges, big places, main streets create for many persons a small definite emotion, related to the feeling of the size, the space, the isolation and it is this small emotion that sparks the great phenomena of rumination and anxiety. I saw, in this respect, a very curious case of agoraphobia that we could call the admiring agoraphobia. Qs... cannot walk in Trocadéro, [xi] “the view of so many houses incites him, it seems to him that it is beautiful, grand, surprising. He has at the beginning a pleasant feeling of admiration, then it changes. I am forced to wonder how could I make myself build so many houses, how could the men bring so many stones? Then my knees tremble, my chest squeezes up, my heart beats, I suffocate and I runaway in order to go home.” Other phobias begin when the patient is in public in front of people, because then the emotion of timidity develops, which is followed by anxiety, for Ul..., Lkb..., Meu..., for example. Finally, in certain cases, the situation naturally creates fear in all men and it is this fright that is followed by either rumination or anxiety.

There is here a very interesting role of the emotion apparently barely known to us and to which we must return; for the moment we call attention only to the fact that crises of forced agitation begin by way of emotions, actions and attention.
Finally, I describe, with more hesitation and a degree of curiosity, another occasion of these crises that I observed several times in an incomplete way and only once in a completely clear way. Dn... (49), a 30-year-old woman, who was always a scrupulous, had crises of agitation and anxiety about some of the previous causes, especially about actions. Here is how her crises develop. She goes to bed to fall asleep and begins to doze off: as long as the slumber is light, everything is well, she remains quiet in her bed. However, if the sleep is going to become deep, at this moment she suddenly wakes up with an enormous anxiety; she feels she is suffocating and cannot refrain from shouting. The patient loses consciousness not at all, she would like not to shout, not to wake her companions, but her resistance is useless and provokes only a more painful conflict.

She has to yell and contort herself in a thousand ways; it is at the same time both a panic attack and a crisis of motor agitation like that of Nadia. At the end of five or ten minutes, everything calms down and the patient tries to fall asleep again, because she feels a great need; again she stays calm during light slumber then as soon as the sleep becomes a little deeper the crisis begins again. There is no obsession here relative to sleep to explain this awakening by a dream as in the observation of Zy... and it is not question of hysteria. It is a phenomenon similar to all the previous crises, it develops only in singular circumstances regarding the beginning of a sound sleep. This fact gets closer to certain already indicated observations in which the forced agitations began regarding the beginning of a physiological function, regarding swallowing or digestion, for example.

In summary I note that these crises of forced agitations, whether they are tics, agitations, ruminations or anxieties, almost always begin regarding one or the other one these four main phenomena, the voluntary action, the attention, the emotion, the effort to fall deeply asleep. We will, from now on, designate these provocative phenomena under the name of primary phenomena, whereas the forced agitations that come in the aftermath will be considered as secondary phenomena.

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Névroses et Idées fixes, I, p. 355.
3. — *Substitution of the secondary phenomena for the primary ones.*

In the clearest cases, this action, this belief, this emotion that constitutes the primary phenomenon, far from reaching its term, disappears completely, this is, in my opinion, the key fact of rumination, agitation and anxiety. We usually consider these agitations as positive phenomena characterized by the presence of a large number of ideas or feelings which pervade the mind, but you should not forget that these disorders are also and above all negative phenomena, characterized by the abolition of an action, a belief, an emotion which should have occurred. We saw Ger... getting up, her jar in hand to fetch some broth at the greengrocer’s; it is not enough to notice that she had, for two hours on the staircase, beautiful ruminations about meat on a Friday; you should not forget the fact, which is at least as important, that the broth was not searched for and that the soup was not made. It is the same for the beliefs: a problem is presented to the attention, a mental operation begins that should end either in the belief or in the refusal of the idea; in reality, the operation is made only if the subject comes to one or the other. When the ruminations or anxieties happen for several hours, the subject gets up, the crisis ended, in the same state as before, not knowing if he believes or if he does not believe and, in short, the project was not done.

It is very important to notice similar facts regarding the emotions, the fact that I restrict myself to indicating here will confirm itself later. Genital arousal is the starting point of phobias and ruminations, but it is again necessary to add that the secondary phenomena that are added to it seem in no way favorable to the development of the excitement. On the contrary, mostly they bring a complete stop to all the emotions. When Lise had dreadful ruminations at the time of her labor pains, she doubtlessly had mental sufferings, but she no longer had the physical sufferings that she should have had. She does not gain by the exchange, because her mental anxieties
are horrible; but I point out that musing on the damnation of the children, on the eternity of the punishments of hell, the questioning on the problem of knowing if she is crazy, if she is going to live in a madhouse for the rest of her life, all of this is certainly very painful, but it is not the pain that a woman has to feel when giving birth.

The pleasure of playing the piano also disappears, like the admiration of the landscape, when agitations occur regarding these emotions. A more delicate question arises regarding the sentiment of timidity and the sentiment of fear. These sentiments are very often the beginning of the forced phenomena and some of these, in particular certain anxieties, resemble them a lot. That is why they called these phenomena phobias and they often considered them as the development, the exaggeration of fear or intimidation. I do not believe that is completely fair, at least for every case. For many patients the precise, definite fear, which one would have in this circumstance if one felt well, disappears; it is replaced by motoric agitation or rumination that is not the fear, and when the phobia arises, it takes on special characteristics that distinguish it from the fear itself. “I see skeletons in the museum, it would have previously given me a real fear, now I have vague fears with the feeling of going crazy, it is in no way the same thing.” The fear seems to have lost its precision, its relationship with a definite object: it became more vague and more elementary.

In the clearest cases, we thus observe the total abolition of the primary phenomena, that is the action, the attention, the emotion that was the starting point of the crisis. In the less clear cases, these primary phenomena simply decreased and present changes that we shall have to study in the following chapter.

When these primary phenomena, as we have seen, do not come true or come true in a way that does not satisfy the consciousness of the patient, then instead of these phenomena there develops abruptly in the mind quite a different category of operations which we can consider to be secondary. Sometimes they are varied movements, tics, efforts, crises of agitation; sometimes they are visceral disorders,
palpitations, suffocations, anxieties; sometimes they are mental operations, ruminations.

In all the manias of perfection, we see that the subject tries to add something to the first action; in the manias of repair, he wants to erase the first act by some other thought. In the manias of oscillation, he cannot remain on the first phenomenon and he passes continuously to another one. In brief, the essential character of all these manias is that on the occasion of the first insufficient phenomenon or, better said, instead of this first phenomenon, the mind puts another matter: “I may not stay there,” they all say, “it seems to me that, if I stayed at this first point, dreadful things would happen” and they all, very matter of factly, obey this need by substituting a second undertaking for the first one.

It is this second undertaking that essentially constitutes rumination, agitation or anxiety. At first sight, these secondary phenomena seem to be of the same nature as the primary ones: they are always actions to be made, beliefs to be specified, or emotions to be felt. However, these phenomena are far from being identical.

To begin with, it is not about real actions, that is to say operations by a person that bring about a more or less deep and more or less long-lasting change in the outside world. The movements that the patient executes are generally insignificant. They are gesticulations, tremors of the arms, head, or words that are pronounced in a low voice: “not, no, té, té, té, té, 4, 3, 2.” The movements seem more important in the efforts like those of Claire or in the motor agitations such as with Nadia. But these crises have very special characteristics that restrict their importance. The patients do not accomplish any really useful or really reprehensible act: they stir, shout, sometimes threaten their close relatives; but in reality the patients we study here never hurt anybody. When they take it out on objects and threaten to break everything, there is a great deal of exaggeration in their attitude. They break only insignificant objects that they do not like. If one day Nadia knocked down an inkwell, I believe that it was completely by chance and that she was the first victim of this result of her agitations; mostly these absurd acts disappear as soon as they could take on some importance.
The patients allow themselves go there, for example, when they are alone or in front of persons who know them enough to learn nothing more by seeing them; but as soon as strangers enter to whom these grimaces could be revealing, they recover and everything stops, at least for a moment. Claire is remarkable, from this point of view, and agrees “to be a lunatic” only in front of her mother, her domestic or her doctor. Finally, as we have already seen from studying the tics, they are simple, awkward, often symmetric movements, like in childhood; in brief, movements of a very low order.

In other cases, these phenomena seem more complex because there are numerous thoughts. The value of these thoughts is made very clear by the term mental rumination, it is an operation that remains simply mental, intellectual and that does not manage to become real in the form of belief or action. These are faint, incomplete images, words that, above all, express vague ideas that appear instead of the concrete action that the subject does not execute. The subject becomes muddled in the midst of countless, abstract ideas that can be connected in a some way with the primitive thought. “It seems to me,” Gisèle says, “that I intensify the idea of a very simple action that I do not make; I see all the details, even the very distant details that are barely connected with it; it seems like I have entered into the idea, it holds me, encloses me on all sides and I may not exit out of it any more. It’s as if I had within myself a second, deranged person who sees all that can be thought about the slightest action.”

It is very evident that they invent nothing in their ruminations: these hours of very deep meditation never bring out a fragment of an interesting idea; it does not bring out a single belief either. It is easy to see that the patient does not take seriously all the nonsense that he drivels; his threats, his ideas of guilt or dangers remain for him completely superficial because he never makes his actions relate to them.

On the other hand, these ideas in reality demonstrate little intelligence: we can say that rumination is childish and that it is stupid. I wondered a lot, at the beginning of these studies, about the conflict that exists between a person’s ruminations and their intellect. Lise is an educated woman, who read
a certain number of philosophical works, understands them well enough and in her conversations shows a rather broad mind. These ruminations look like the stubborn questions of small children who have the mania of “how” and “why.” On the other hand, the chatterings are filled with the lowest superstitions: they are reasonings about the devil and the good God, small negotiations with heaven and with hell worthy of the religion of a small Negro tribe. The patient knows very well that it is stupid, he realizes that it is quite beneath his usual mental age, it is like that with all of them and we can say that these thoughts seem to show a return to childhood and a return to barbarity.

The rumination also gets closer to the vagueness of a dream, the monotonous repetition and the incoherence that it has. Another characteristic of the dream that is found in these ruminations is the declamation. The dream, as we know, is a ranter, “a flea pricks me,” Descartes said, “and I dream about a blow from a sword.” Also in these ruminations everything is taken tragically; it is only about death, about unnatural crimes, about infanticide, about pacts with demons. There is a ridiculous contrast between the fact and the expression when we hear Nadia exclaim: “if I make a single dissonance in my piece, I swear by the soul of my mother that I shall go to hell this evening and my ideal lover also.” This declamation, which is a major characteristic of the mental illnesses, dominates in the persecution mania where the slightest insult takes on the aspect of an incredible cruelty; it is also at the heart of these ruminations where everything is much more exaggerated in the expression than what the subject thinks of it in reality. The ideas that pervade the mind during the rumination thus represent ideas of another age, ideas of childhood, thoughts from an ancient and lower civilization or a more humble social environment, and ideas similar to a dream. I cannot say, in conclusion, that these ideas are lower than those that the subject should normally have in the circumstances where he finds himself placed.

The anxieties appear to be more important phenomena because they give rise to great suffering. But we can notice that their importance is more apparent than real: these large visceral movements, these palpitations of the heart, these quick respirations are mostly without any danger and bring fewer episodes of syncope, fewer fainting spells, fewer serious
diseases than the less noisy and real emotions. We know many diseases produced by emotions, but it is very rare that we observe them in agoraphobias or ereuthophobias.

These pathological emotions, indeed, are not specific emotions related to a real situation; these emotions are the simplest, the most elementary and the most abstract kind. The anxieties get closer to the fear that is the most basic of emotions, that exists completely at the beginning of the evolution of sentiments. And even, as we have seen, anxiety is not precisely fright, it is an emotion even more elementary than fear. In reality, they are very muddled visceral convulsions, like the movements in the motoric agitations. We can thus consider them to be lower phenomena beneath the feelings that should really develop at this moment.

In short, in the primary phenomena that are not executed or that are executed with a certain disorder are substituted by secondary phenomena that have the essential character of being psychological phenomena that are without doubt exaggerated, but are also elementary, lower, without relationship to external reality and consequently are completely useless.

4. — *The apparent characteristics of the agitations.*

Next to these essential characteristics of the crisis, are certain visible characteristics that play a big role in the classic descriptions of the obsessions: *the preservation of consciousness during the crisis, the irresistibility of these agitations and their consecutive fulfillment until the end of the crisis.* These characteristics that are generally included in a very vague way seem to us much less important than those that have just been studied. It is enough to indicate them quickly here to show that they join, in reality, with a much more vast group of facts, those of the sentiments experienced by the subject during the crises and that they bring us to a new study.

First of all, the insignificant character of the secondary operations is appreciated to a certain extent by the subject himself
who seems to realize well enough the uselessness and absurdity of such operations. This is what we call the *preservation of consciousness* during the crisis.

Is it necessary that the patient understands, as we do, that these movements, these efforts, these processes of perfection, these mental investigations have no sense and that they are childish dreams? Obviously not, because then he would not have an illness; if he clearly and definitively arrived at the negation of a point, he would have ended this first act which is the starting point for all the rest and he would not have any rumination. In reality, he never arrives at this negation, because he always asks us, as he wonders to himself: am I cursed because of my oaths? Don’t I have to try to do better? Is there not a danger? What we call consciousness of the rumination must not be taken in the sense of a negation of the rumination.

Is it necessary to understand by this consciousness of the obsession that the psychological functions remain intact during this period? We shall have to study this problem in detail in the following chapter, but from now on the answer is probably so. Can we consider as intact the mental state of a subject who cannot complete his voluntary actions, beliefs, emotions that he begins and then replaces these actions with useless and absurd operations? It is very likely that consciousness in this sense is not preserved.

The patient’s consciousness of the validity of these secondary phenomena seems to me to consist simply in the fact that he does not completely surrender to these operations, that he is not completely invaded by the agitation, by the questioning, by anxiety. The operation seems incomplete to him and he does not allow himself to go into a real anxiety. He criticizes these operations, he is dissatisfied with it as he was dissatisfied with the primary operations; he applies his manias of doubt to his own ruminations. We find here the same feelings of insufficiency that exist everywhere else but which here do a service to the patient by preventing him from being completely delirious.

Another characteristic, which is almost always presented secondarily, seems to have more importance, it is the *irresistibility* of the pathological mental process. These three secondary operations: the
movements, the ruminations, the anxieties are always represented as being imposed on the subject in an irresistible way. Zwangsvorstellungen, \textsuperscript{lxxii} said Westphal; Zwangsprocessus, \textsuperscript{lxxiii} said Mr. Meschede; uncontrollable psychic diathesis, \textsuperscript{lxxiv} said Mr. Tanzi. \textsuperscript{220} Mr. J. Donath of Budapest\textsuperscript{221} had even proposed to combine all these facts under the strange name of anankasmus.

This characteristic is, however, less clear than they imagine. Do they mean there that these phenomena are determined; that given certain physiological and psychological circumstances that are the [necessary and sufficient] conditions, they will occur? But that is simply the expression of the general law of determinism to which all phenomena without exception are subjected, whether or not they are pathological. Why not, then, say the syllogism that anger, melancholy or insanity are zwangsprocessus?

Do they mean that these operations always, uniformly bring about the result of the execution of an act that the subject thinks about? If we speak about homicides, about suicides, about thefts, about real acts, that is about actions that modify the given reality, can we say that the obsessives present with irresistible impulses? In no way: these patients, who do not manage to execute the simplest things, execute even fewer of the complex and improbable actions, the idea of which they have. We saw that the obsessions of the scrupulous never terminate either in material execution, or in belief, or in hallucination; in this sense, therefore, they are not irresistible at all.

Do they mean that the operations that are executed uniformly and necessarily are the secondary and subordinate operations: the tics, motor agitations, efforts, ruminations, and alarming emotions? That seems a little more fair, because these secondary processes indeed take place frequently and uniformly enough under the conditions that we indicated. Is it a particularly absolute necessity that mental rumination deserves the title of irresistible, which we are not accustomed to applying to a hysterical or epileptic crisis? In no way: these processes can be transformed one into another, if I

\textsuperscript{220} Tanzi, Archivio italiano per le malattie nervose, 1891.

\textsuperscript{221} J. Donath, Archiv. für Psychiatrie, 1896.
oppose myself to Cha... seeking out my address during his grand promenades, it really interrupts his work, but he has a crisis of suffocation, which is not a mental investigation. Moreover, patients themselves can stop everything: Mr. Brissaud insisted strongly on showing that the tics can be momentarily eliminated by the will. We have already verified this very often for all these phenomena, Qi..., who has such remarkable coprolalia at the hospital, stops completely in streets for fear of bad adventures; Claire suspends her contortions as soon as somebody comes to enter; Wo..., plunged into his ruminations about an account, postpones the crisis because “we call him to have dinner and there are a lot of people.” Besides, it is by means of this voluntary cessation, difficult perhaps but always possible, that they manage to curb these psychological disorders. On the other hand, as I noticed from the beginning, these forced operations do not run automatically without the subject knowing, like the subconscious writing of the hysteric. We saw that the patient participates in it and that he even has to make conscious efforts to execute them. Does all this constitute a real irresistibility?

I believe that the term “irresistible” was applied to these actions not by the doctor observing from the outside, but by the patient himself and that it simply expresses a feeling that the subject has with regard to these secondary phenomena. The patients all repeat that they lose their freedom, their will: “I have no more than an atom of will, I am taken by a foreign strength, I do not belong to myself any more, etc.” These sentences are constant in all forms of the disorder. They express a fact that I consider important in their mental pathology and that plays a major role particularly in the mania of persecution: the loss of the sentiment of freedom. This true or false sentiment of freedom, it does not matter which, accompanies each of our voluntary acts and it gets lost under pathological circumstances that would indeed be very important to determine.

This sentiment of the loss of freedom corresponds to two things: first to a sentiment of incapacity and powerlessness that is due to the primary phenomenon, the voluntary action, attention, belief, emotion that the subject desired, that he wanted, that he had even begun but does not produce, does not arrive at the planned end and that there is a disappointment; then to this other fact,
instead of the hoped for phenomenon there occurs another one that is useless, absurd and in certain cases painful. The irresistibility is thus the patient’s sentiment that belongs in the category of all these sentiments of dissatisfaction, which, as we saw, accompanies the cessation of the voluntary actions. To study this more completely we come to an examination of the mental changes of the scrupulous; the necessity of which we have already seen.

Finally, the third characteristic that they usually attribute to these phenomena is the satisfaction that the patient experiences when he obeys the impulse that compels him. This expression, which they always repeat, seems to me to be as extremely vague and debatable as the previous ones.

The patient almost never executes a very precise action; it is not, therefore, in the final execution of an impulse that he experiences some satisfaction. Do they mean then that he is happy to have carried out the tics, the ruminations, to have felt the anxiety? He quite certainly feels a very natural reassurance when this painful crisis is finished, but he is neither proud nor happy to have again given in to a need that he finds ridiculous. I did not see the patients satisfied at the end of their crisis, they are tired and ashamed of themselves. Messrs. Pitres and Régis\textsuperscript{222} make the same remark and say that it is more about a sequential appeasement. They meant to say that there is a state of satisfaction throughout the duration of the forced operation. Mr. Roubinovitch cites a case where the patient is happy to return to his rumination.\textsuperscript{223} That seems to me to be more just, but on the condition of making an indispensable distinction.

Of these three forced operations, there is one that is particularly painful, it is anxiety; whereas the two others are emotionally painful, but do not physically ache. Besides this painful operation, the anxiety can, at least for certain patients, replace the motor agitations or the ruminations, if these are stopped by an effort of the will. If the patient stops his manias, ceases the tics, he will have anxiety; if he gives way again to his manias.

\begin{footnotes}
\item[222] Pitres et Régis, \textit{op. cit.}, 54.
\item[223] Roubinovitch. \textit{État de satisfaction pendant la durée mime de l’obsession continue. Congres des aliénâtes français}, La Rochelle, 1893.
\end{footnotes}
of expiation, to his tics, he will at least be rid of the anxiety.

As the patient has little energy and courage, he prefers to be allowed go through all his nonsense rather than to expose himself to painful oppressions. This satisfaction that they note, the patient who gives in to certain impulses, appears to me to be simply a preference for some of his pathological phenomena rather than for the others, simply because they cause less physical pain. It is a resignation to a lesser evil rather than a satisfaction.

In short, these three characteristics of the preservation of consciousness, the irresistibility of the satisfaction that they always give as the essential characteristics of the crisis of forced agitation are not objective psychological characteristics recognized by the doctor. They are subjective characteristics; that is to say, the feelings of doubt, the absence of freedom, the resignation that the patient himself expresses regarding his crises. To understand these characteristics we are thus brought to study the sentiments experienced by the psychasthéniques in relation to their crises, to examine their mental state during the crisis and outside the crisis.

If we leave aside these subjective feelings and restrict ourselves to summarizing the objective characteristics, the crises of forced agitation appear to us essentially as a set of psychological operations, thoughts, actions, feelings that are useless and of lower order and that develop in an exaggerated way on the occasion of an act, of an attention, of a belief, of an emotion that was not able to be executed or that is executed only in a very incomplete way. To understand this alteration of the primary phenomenon, which is an opportunity for the uncoupling of the phenomena of forced agitation, it is again necessary for us to examine the state of the psychological functions of the subject, the state of his will and his attention. These studies have to join those of the sentiments about which I have just spoken and will allow us to obtain a general idea of these crises.
CHAPTER III

THE PSYCHASTHÉNIQUE STIGMATA

The first authors who described obsessions were especially struck by the fact that the patients were not, strictly speaking, delirious. They never managed to be convinced of their delirious ideas, they fought against them and were themselves the first to declare them false and ridiculous. Due to these declarations, the observers concurred about the lucidity of the patients’ minds and about the integrity of the psychological functions. Legrand du Saulle went so far as to say that the intelligence remained perfect and that moral freedom was intact during the crisis. The preservation of consciousness, and by this word we mean the integrity of the psychological functions as well as the exact appreciation of the value of the ideas, had become one of the classic characteristics of the obsessive crisis, for even stronger reasons no one thought to suspect disorders of these psychological functions during the intervals between crises.

Mr. Séglas is one of the first, I believe, who questioned this famous preservation of the consciousness: “is it very fair to say,” he remarks, “that the preservation of consciousness is always complete for the obsessive, before, during and after the paroxysms?”224 This author does not believe that, especially during the crisis, the obsessives have “the full experience of all the elements constituting their personality at that moment. The secondary synthetic thinking obscures and even erases the primary consciousness.” In addition, they acknowledge that during the crisis there were impairments of various psychological functions, although they were not directly started by the obsession itself.

If we indeed want to ponder about it, psychological disturbances during the obsessional crisis,

224 J. Séglas, Leçons sur les maladies mentales et nerveuses, 1895, p. 118.
and I shall add even outside the crisis, are immensely likely. Is it possible that absurd thoughts, useless and ridiculous manias, unjustified fears come to fill a mind for several hours that is perfectly healthy and capable of resisting them? That is completely against all that we already know about suggestion and about the obsessions of the hysterics. These phenomena are probably not absolutely comparable, but there is a sufficient congruency so that we can assume that for the obsessed, just as for the hysterics, there is a certain incapacity of resistance that allows this parasitic development. Moreover, all these manias are basically bad habits, they had to be born and grow before constituting these crises and consequently even before the crises, even during their remission, the mind that favored such development did not have to be absolutely normal. In short, to better understand the obsessions, it would be very important to know on what grounds they develop and to determine the fundamental impairments of psychological functions that were probably their starting point.

These are modifications in the functioning of the psychological operations, independent of the obsession and of the forced operations, that I designate under the name psychasthénique stigmata, similar to the “psychological stigmata of ticqueurs” about which Charcot previously spoke when he well understood the necessity of their study.225

Regrettably, the study of these psychasthénique stigmata is even more difficult to make than that of the hysterical stigmata. We know what difficulty the suggestibility of the hysterics brings to the study; it is always very difficult, especially if we want to do experiments, to know what a fundamental psychological disorder is and what was added by clumsy suggestions. Here, the subjects’ obsessions and mental manias bring even greater difficulties. Many of these patients are inclined to believe that their faculties are impaired, either by virtue of obsessions of shame, or by virtue of hypochondriacal obsessions; can we believe in their assessments of themselves? For example, is it possible to form an exact idea of Claire’s mental state by questioning her about her own faculties? She has

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225 Charcot, Leçons du mardi, II, 16.
the habit of considering herself completely stupid, to belittle herself about everything; so she is going to make you a fantastical description of her own faculties as though she wanted to be taken for an insane person. On the other hand, if, instead of questioning the subjects, we examine their behavior in specific cases, then we shall see that a large number of acts are stopped, inhibited by mental manias and nevertheless one should not believe in their elimination: if we meet Bu... sitting on the ground alongside a wall and unable to cross the square, we do not need to conclude that he does not know how to walk. These two difficulties can supply perpetual objections against all those who try to describe the stigmata of psychasthéniques, they can always answer me that such a disorder of perception or of the will is produced by some idea, by a mania, a tic or an anxiety that arrested the action at the moment I observed it.

Nevertheless, these stigmata must exist and there are certainly disorders of mental functioning that are logically and chronologically prior to the obsessions and to the manias. That is why, while recognizing these dangers, I consider it necessary to attempt this research while taking the most precautions possible. First, except in rather rare cases, complicated experiments seem to me to be almost impossible, they have the inconvenience of drawing the subject’s attention and of provoking all the ruminations and the forced operations that we dread; it is necessary to make use of the observation of and especially the comparison of the various subjects. There are disorders that are interesting by their great prevalence and that appear in subjects who have obsessions, mental manias or completely different phobias, and in those who have never had the mind directed to these disorders. We also observe disorders that develop before the birth of the mental manias and the obsessions, which we find in simply neurasthenic patients, who do not have any forced operations. Finally, reasoning, to some degree, can confirm the previous remarks, when it shows us that these psychological disorders were the patient’s starting point and not a consequence of the obsessions. In spite of these precautions, I continue to consider the research of these disorders very difficult and the list that I provide, it seems to me, must often be modified.

These psychological disorders did not seem to me to be of a different nature
during the crisis or outside of the crisis; therefore, I shall not establish such divisions; it is enough to remember that the most exaggerated disorders appear during the crisis and that in the seriously ill person they always exist to a lesser degree during the intervals between the crises.

These disorders present themselves to the observer in two ways. First, in a simply subjective way in the form of sentiments that the subject feels and which he expresses more or less well. Consciousness is a more delicate reagent than our devices and it shows disorders that we are not capable of bringing to light in an objective way. However, in the clearest cases we can notice these disorders in the subject’s behavior and in instances determined independently of the sentiments that he expresses. I shall first study the subjective sentiments, then I shall try to bring to light these same disorders in their objective aspect.

Finally, I shall more cursorily indicate, in a third section, the disorders of the physiological functions that are better known, because they are found more or less in all the neuroses.
FIRST SECTION

THE SENTIMENTS OF INCOMPLETENESS

The word “incompleteness” is a barbarism that I ask the reader to excuse; I was not able to better indicate the essential fact about which all the subjects complain, the unfinished, insufficient, incomplete character that they attribute to all their psychological phenomena.

These sentiments that the subject has about his own mental operations are very diverse and change continuously under the slightest influences. I shall differentiate them especially according to the phenomena that give birth to them, as they develop regarding actions, regarding intellectual operations, regarding emotions, and sentiments regarding the consciousness of the personality.

1. — The sentiments of incompleteness of the action.

The crises that are constituted by forced operations, ruminations, agitations, anxieties, very often begin regarding an action. The subject has to make some act, he may even have begun it or partially carried it out, and his mind is invaded by these seemingly irresistible phenomena. It is quite natural to wonder if there is something abnormal about this action, something that can explain the appearance of the crisis. In the simplest cases, as we clearly saw, the action is completely eliminated; but it is not always so, in many cases the observer sees nothing in this action that objectively demonstrates the disorder, the act seems to have been almost normal. So, Wo... has big crises of rumination on the occasion of a prayer or of an addition that she has just made. The husband who observes it notices, however, that the prayer was recited correctly, in a low voice, exactly like the
other evenings, that the addition was made well and that the registered result is right. It is very often like that and, at first sight, we notice in these actions nothing abnormal.

But the subject is not of the same opinion as the outside observer and he has in his mind, regarding this act, a set of very curious phenomena. They are not ideas, that is abstract and general thoughts applying to this act and to others, as he would have in the obsessions; they are sentiments, that is to say a more concrete phenomenon applying to a definite state and to this one only. The sentiment, taken in this sense, is about the awareness of internal facts analogous to the perception of the awareness of external objects. It is an awareness more complex than a simple sensation, an awareness formed by the grouping of several elementary facts, but applicable, however, to a single concrete fact.

Generally, the attention of the psychologists was not sufficiently drawn to the sentiments that accompany the development of the will. They barely analyzed only one of them carefully, the sentiment of effort. Höffding is one of those who best indicated the importance of the other sentiments of the same kind: in a chapter of his textbook, he calls attention to the consciousness of the will, to the sentiment of resolution. The sentiments that accompany the operations of the mind are particularly important, in my opinion, in mental pathology and will one day serve to interpret a large number of deliriums.

For the moment let us notice that, for the scrupulous, voluntary acts are the opportunity for a crowd of abnormal sentiments, which can be briefly summarized: the subject feels that the action is not well made, that it is not completely made, that he misses something. In the first manias of perfection, this sentiment is already very visible. Often it takes a moral shape: the act is not morally good, it is what we see in the mania of efforts. Often it is simply a matter of a practical point of view, the act is not sufficient to achieve its goal, it does not seem capable of producing the desired satisfaction, from there begins all the searches for perfection, all the manias of procedures, ultimately the act or the idea or even the emotion appears to lack distinctness, to have no specific characteristics that belong to him, to be too vague, from there originates the need to act slowly, to begin again and all the manias of precision.
In the second group, that of the manias of reparation, the sentiment that the subject feels about his action or about his idea is even more visible; the act is not only insufficient, it is frankly bad, here again it is not only bad from the moral point of view, it is dangerous to life, to health, it is ridiculous, awkward, unable to arrive at its purpose. “I have the feeling of spoiling all that I do, I do only absurd things,” all these patients continuously say, “what I want is to find my life, I indeed have the right to live like everybody else” and all the manias of reparation and all the tics of defense seem to be connected with this fundamental sentiment.

In the manias of oscillation, this sentiment of dissatisfaction seems to become widespread, it does not concern a single idea that we can repair by thinking of another one, it concerns all possible ideas, the subject tries them successively without being satisfied with any.

These sentiments are found again in the crises of agitation and anxiety. It is because the act seems impossible, because there is agitation, it is because it seems imperfect, because there are efforts and tics. The anxiety get closer to fright and to despair and when these develop, the act appears to be dangerous, terrible or ridiculous.

If we try to analyze this sentiment of dissatisfaction we see that it breaks down into a series of more elementary sentiments relating to the action. These sentiments exist not only at the beginning of the crises; in some cases, they often exist in a continual way regarding all the actions that the subject wants to carry out. It is one of the essential symptoms of the disease that existed well before the ruminations, anxiety and, especially, the obsessions developed.

1. — *The sentiment of difficulty.*

To appreciate the variety of these sentiments it is necessary to follow the voluntary act from its beginning and to see the continuation of the sentiments generated in the patient’s mind. These persons initially have painful feelings at the thought that it will be necessary to act, *they dread the action* most of all. Their dream, as they all say, would be a life where there would be nothing more to do. “I would want,”
said Fa... (169), “a regrettably very difficult thing, I would like to be able to do all the actions at once, once and for all and never again have to do anything... this desire to have finished sometimes gives me courage; I hurry to finish so that they do not speak to me anymore about doing something.”

This horror of the voluntary action is connected with an exaggerated sentiment about the difficulty of the act; the sentiment of the effort and especially the anticipation of the effort that exists in every man’s thought of an act here becomes enormous. “There is no single thing,” Jean repeats with despair, “that does not present enormous difficulties, as soon as it is a question of doing it.” “There are here,” Fz... (59) says to me, “resolutions to adopt, it would be necessary to reply in a letter, it would be necessary to think of the fact that I have to write, to have a conception of the matter. Oh, I am exhausted only thinking of all this, it is going to make the orchestra march in my head, it is better not to think of it for the moment.”

“I wonder,” says Nadia, “how I sometimes can manage to do things like everybody else. It is so difficult, I am beforehand completely discouraged from it. I believe that I in fact have the will, if I do not do what you want, it is that there are dreadful difficulties that deprive me of all my energy.” It is good to notice that these words apply not at all to actions related to the patient’s obsessive ideas and that I did not ask her either to eat or to go out; it was simply a question of beginning a tapestry to have a small occupation.

One of these difficulties that stops the subject is that he imagines his failure beforehand. He feels that he is going to make things very badly, in an immorral and ridiculous way. “I have an apprehension about all that I have to undertake; it seems to me that if I begin, I am going to make atrocities,” it is good to notice that this patient Bu... is simply an agoraphobic and that it is not actions that can awaken his phobias. “I know,” said Nadia, “that if there is just one bad action besides the one that I want to make, I shall do the bad one... you want me to start playing the piano again, but with my rusty fingers I am going to play very badly, I shall annoy everyone by beginning again, I cannot decide to play so badly as that, it would be shameful.”

A neighbouring sentiment is the feeling of the uselessness of action,
especially of its little value in relation to the efforts that it is going to cost. “Nothing is worth the trouble to begin... For what does it serve? Give myself so much difficulty to succeed at what? All the more reason for staying quiet...”

2. — *The sentiment of incapacity*.

A variant of the same sentiment will provide us the sentiment of *incapacity*. When the sentiment of incapacity concerns a definite act it gets a little closer to obsessions: it is like that in the case of De..., “who is frightened of marriage, who has nothing of what is necessary to make a man happy, to raise children, to maintain a household, etc.” But much more often this sentiment of inability is general: “I have no penchant for anything, I have no more strength to do whatever it is” Dd... (18). “Life frightens me,” says Lo..., “I feel that I can do nothing.” A little more and it will be the feeling of paralysis as with Kl... who finds required movement “almost impossible;” she stops at “almost impossible,” notice that these patients never arrive at an idea so clear as that of absolute impossibility.

They have a sentiment of enormous weakness at the thought of making an action, a sentiment that they do not experience when they do not think of acting. I have observed in Lkb..., a 22-year-old woman, a curious phenomenon: she is very quiet in her chair and demands nothing as long as we ask her for no effort; if I encourage her to act, to work a little, she moans about the difficulty of the act “for a person who feels so weak” and here she begins a crisis of bulimia. She demands to eat at once; otherwise, she is going to fall from weakness: “she is going to become crazy, or furious, or to faint, if she does not eat at once.” We can stop this enormous need of food, not by giving it to her to eat, but by reassuring her about the action to be carried out. If we declare that she is too weak to work, that it is better to remain at rest, she calms down and does not ask to eat any more. While examining facts of this kind, I am inclined to believe in a big role for the sentiment of weakness and especially intellectual weakness in the sentiment of hunger. We see here that this sentiment of weakness and incapacity awakens at the thought of carrying out an action.
This sentiment of weakness, of personal impotence appears to me to play a role in a bizarre language that I find with some. They always appeal to a mysterious power that would free them from the action and especially the complexity of the given situation. “It seems to me that I wait for something before acting. I await for a fairy to put all in order by a wave of a wand...” (Vk...) “I count on the magicians,” says Rk..., “they are going to prepare everything and then I can act.” “Ah,” says Qsa..., “if a miracle allowed me to undergo a transformation, freeing me from a heavy past, you would see that I would act very well, but the complexity of things badgers me; it is too hard for me, if heaven does not help me.”

3. — *The sentiment of indecision.*

One of the essential sentiments of the will is the sentiment of resolution, decision. This sentiment, as Höffding says, shows us that a volition really originated, it distinguishes the possible (the wish and the imagination) from reality (the resolution). “One of the particular characteristics of the resolution, the clearest form of the will, is that the mind concentrates there or sharpens itself there by looking at the possible action there as its own. Before actually executing the act, we recognize it, we perceive it as being a part of our self. We adopt it or anticipate it, we consider as a finished act what, seen from the outside, is still only a simple possibility. In opposition to the internal action expressed by the resolution, the multitude of the wishes and the various imaginations are only pure possibilities.”

There is thus in the sentiment of resolution a feeling of unity as if a single trend had persisted, a sentiment of the development of this trend that becomes stronger than before, a feeling of personality because the action is adopted and seems to us to depend on us, a certain sentiment of pleasure that accompanies the end of a conflict and the ecstasy of strength.

None of these sentiments develop naturally for the scrupulous, they never have the whole feeling, that they

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have decided or if they have it, they feel it weakly and incompletely and they are constantly afraid of losing it. Ka…, a 57-year-old man, whom I choose exactly because he has neither real manias nor real obsessions, wants his actions to be done very quickly, he is impatient to see the execution “because he is afraid that his decision will not remain stable, it is so rare that he makes one.” Rt… (89), a 35-year-old woman, never comes to a feeling of decision, imagines that she does not dare to take a stand.

The story of Tr… is amusing on this point, she presents us with a concrete image of the sentiment of indecision. This girl whom I have already cited about the manias of deliberation, has the occupation of modeling porcelain flowers: she is left to her inspiration for the shape and the elegant curve of the petals. The first sign of her disease was that she earned less money during her day, because she makes her rose petals more slowly: in effect she always hesitates between two folds, or two curves to be adopted and she does not feel any more, as she had formerly, that for this given petal, the fold is definitive; she says very clearly that having the petal in hand, even when it should be ended, she continues to imagine two or three possible forms and not only one as before. Her feelings are marked by a kind of small pain instead of the small pleasure that she formerly had in completing a petal and finding it attractive.

Little by little, the same sentiment invades other actions. Having a little savings, she had to use some money to buy to herself a toiletry item: “formerly I would have known how to choose and made the choice, I would have had a pleasure; I feel that I did not choose, that I continue imagining several objects at the same time and even if I take one, I shall have no pleasure.” Qei… herself points out very well that the decisions and the choices do not end in her mind, that nothing is finished and that it is painful. The same sentence is met everywhere: “no ending,” says Gisèle… “I cannot take charge,” says Lod… “I cannot decide, nor take a stand,” says Lise: “if I begin the discussion again, it is because I feel that there are two ideas.” Not only Nadia, but all of her family have this sentiment of always hesitating, to feel upset that they have to decide: “I have a lot of will in theory,” says Nadia, “but I am much too tired to seem to have it;” these girls have the singular habit to take precautions against themselves returning to their
irrevocable decisions. When one of them had made or half-made any small, very insignificant decision, on the color of a ribbon or on the letter to be written, she had to notify each of her sisters or write it on a paper so as not to be able to change it any more. Is there indeed any farther to go for this childish habit of oaths and covenants? As for Jean, with him it is the pain of perpetual indecision: naturally the act is put off until its deadline and as the moment comes when the decision is going to be inevitable, the sufferings increase; but this disorder is already for him completely pathological, it becomes a mania of oscillation more than a disorder of the sentiments. So these patients always wish that another person or even a divinity makes the resolutions for them. “It is the responsibility for my actions that I cannot take,” says Wo... “I ask for a lot of opinions, advice, and even if I have a personal opinion, I always eventually follow these councils, it is less painful than for me to decide according to myself...” “Ah! If I could be always an unskilled laborer,” the artist Qsa... says to me, “to obey somebody who would exempt me from choosing, if somebody always gave me the plan, the place for the figures, the rest would go well; stupid decision, it is atrocious...”

I shall also connect with this sentiment a curious arrangement to imagine an unforeseen change of decisions. “Oh, well yes, it is decided,” said Jean, “but if grave circumstances happen, which I do not know beforehand, that prevent me from doing what I promised you, you should not want me to commit a mistake: you know well that anything can happen.” This observation is noted well in a famous novel. “He thought that, all in all, these commitments were only pure convention, without precise meaning, and that moreover nobody was sure of the next day, or could know if it would not happen that some extraordinary event would carry off life, honor and dishonor. This habitual manner of reasoning often upsets the seemingly most fixed decisions.”

4. — The sentiment of embarrassment from the action.

If the sentiment of cohesion of the decision does not exist, then nor do we

\[227\] Tolstoi, La guerre et la paix, I, p. 33.
see this sentiment of ease, of training that is due to the development of a single persistent tendency: it is replaced by a sentiment of *embarrassment*, of resistance to action. This sentiment can become clearer later and the patients are going to claim that it is this or that habit, this or that phobia, this or that idea that embarrasses them to act, but it is apparent from the beginning that they do not know what embarrasses them or rather that this embarrassment is extremely variable and is produced by whichever of the tendencies that is not definitively eliminated.

This fact is very clear in Byl..., a 21-year-old girl. She ends up making so much nonsense; she is annoyed by this feeling of constant embarrassment of all that she wants to do. Claire, Nadia and all the others describe the same feeling from the beginning of their illness. “Oh, embarrassment, embarrassment, I have felt that all my life as soon as it is necessary to take some action, what torture!” (Meu...) “I cannot live without being bothered!” (Vol...) “All my life the torture of embarrassment, never an action that is made naturally.” (Vk...) “Always something that makes me feel awkward.” (Jean) You should not imagine that this sentiment of embarrassment exists only in the emotion of intimidation, it exists for Rk... when it is a matter of beginning a job on French literature in his office, as well as for Brk... when she has to begin sewing a dress, for Vol... when she does her housework. It is the sentiment of the difficulty of the act, either when they prepare for it through the imagination, or when they carry it out, one does not know how to stress the importance of this sentiment enough.

5. — *The sentiment of automatism.*

In the decision there is, as we pointed out, a sentiment of ownership, personality, because the action seems to us to be adopted by ourselves; we shall not be surprised seeing this sentiment totally missing for the scrupulous; this is what produces the sentiment of automatism, the importance of which is very considerable in the mental illnesses, in my opinion. Ball’s patient describes this impression very well “in this atrocious state it is necessary nevertheless that I act as before without knowing why. Something that does not appear to me to live in me urges me to continue as before and I may not
realize that I really act, everything is mechanical in me and is done unconsciously.”

All our patients have the same language, the words “machines, automatons, mechanics” constantly repeat in their language: “I am only a machine,” Lise says, “and I have to make very painful efforts to remain somebody.” “I always act as if in a dream,” said Nadia, “like a sleepwalker.” “In my outbursts, I am an automaton,” says Dob..., “I see my hands and my feet, I feel them making actions without me wanting them to. Why wouldn’t they do mischief since they act without me? When I am on a railroad in motion, I feel my hands want to open the car door, in the same way as I feel them drawing when I work.” The same thought for Day..., “it is not me who acts, then why couldn’t my hands hurt me, wound me, because I feel for a long time that only they act? Why in the presence of strangers wouldn’t be I allowed do acts of rudeness because I do not control myself.” This sentiment plays a role throughout Claire’s illness, “she exasperates herself by doing things like a machine, she cannot resign herself to it” and she makes comical efforts to try to escape this feeling. When we strongly urge her to carry out an action, when we push aside her hesitation, she has a rather curious way of behaving, she abruptly stops hesitating and does the action at once provided that it is simple. For example, she rolls about on her armchair for half an hour without managing to hand me a letter that she has in her hand, I eventually get angry; then she gets up and gives me the letter at once. But she remains desolate: “it is not me who made the action, my hand worked alone, it is my body, it is not my will; I said it to you from my mouth and not my heart; it is my machine that did it, it is one of my other persons.” We see how much the feeling of automatism gets involved with these patients in all the manias previously described.

6. — The sentiment of domination.

One degree more of this sentiment of the absence of personal action,

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228 Ball, Revue scientifique, 1882, II, 43.
of automatism and the patients will say that there is something outside themselves that influences them, that determines their actions; in brief, they are going to attribute their actions to foreign wills, they do not feel that it depends on their own will any longer. Vau..., a 19-year-old girl, who is completely a scrupulous, complains: “for four months I have outlandish ideas, it seems to me that I am obliged to think of them, to say them; somebody makes me speak, they suggest rude words to me, it is not my fault if my mouth works in spite of me, it has been a long time since it was me who acts.” “An irresistible strength compels me,” says Dob..., “it is like I am hypnotized.” “I cannot hold on any more,” says Claire, “it is like a river that pulls me, it’s as if they deprived me of my freedom, as if they commanded me to have improper thoughts; I would suffer less by making a bad act through my own freedom, than by making even good actions always compelled by somebody else.”

We well understand that in this way the patients are soon going to have the other bizarre sentiments deriving from the first one. The least dangerous is going to be a crazy desire, a passionate love of this freedom that they believe they have lost: I cannot explain it otherwise than as a reaction against the feeling of domination, this singular love of freedom that is demonstrated by so many patients. We are indeed surprised, then, by a contradiction in their sentiments. They need management, they demand a spiritual adviser and a master and yet they boast of remaining free: they are frightened if we command them too openly and they speak ceaselessly about an independence that suits them so little. “What I detest most in the world,” says Nadia, “is to obey somebody, if I make progress I do not want that it comes from others, I want to feel that it comes from me, from my own freedom...” Lise always complains of missing freedom, “there is something that bothers me in all my actions, it is that I am never free; it is that which causes my annoyance.” The most curious is Voz..., a 23-year-old young man, who rants constantly about freedom. “It is a duty to have a wild love of freedom..., we have to love it over everything else... chiefly this word has for me a definite sense, it is the supreme happiness to which I offer all my strengths.”

Other sentiments and other more dangerous ideas can come from the same starting point. Jean constantly has the idea
that he is deceived, that he is deceived by people more skillful than him. “I am always the boy whom they swindle and who realizes it...” He loves, or he believes he loves a girl and he interprets his love very strangely: “it’s as if the stepmother had set a trap for me, I am furious at having allowed myself to be swindled, to get caught.”

Most of them simply have the sentiment that we hold something against them, that we persecute them: Voz... is persecuted by his professors, Rp... by his parents who had to oppress him in his childhood and who again have their paws on him through powerful Jews. The persecution delirium is very related to the delirium of the scruple and I wonder that we so completely separated them one from the other; we shall have to study this connection.

A frequent sentiment is that of an irresistible and mysterious domination that in a very large number of cases is comparable to moral or religious obligation. “It seems to me that it is immoral to act that way, it seems to me that there is some moral obligation, some sacred duty that urges me to act or that prevents me from acting;” this is very frequently said by patients who, once more, do not have, I repeat, sacrilegious obsession or criminal obsession.

But often the idea of a mysterious obligation is even clearer: “when I was small,” said Rp..., “I felt a mysterious power that compelled me, deprived me of my freedom, I believed it was the Blessed Virgin, now I feel the same thing and I wonder if fate is against me.” “It irritates me,” says Nadia, “to always feel something mysterious that holds me back and prevents me from succeeding in my ambitions; it seems to me that there is a fate against me and it will not leave me as long as I shall live, it seems to me that there is a fate that glides over my head and that never leaves me; it is my fate that will bring what I dread most and that will make me get fat so that I am even more tormented; there is a strength that compels me to make stupid oaths, it is the devil who compels me.” “I always have,” says Gisèle, “the feeling of a superior power that grips me, the feeling that I fight against something higher, it is this power that I called a God and that I also want to call the devil.” Lise also says the same thing all the time: “it
seems to me that I desecrate something sacred by fighting against this superior power, it is what constantly gives me the idea of the devil.”

7. — *The sentiment of discontent.*

Several authors stressed the sentiment of satisfaction that accompanies any action, any creation, it is the enjoyment of power, the enjoyment to be the cause. This sentiment of satisfaction, Mr. Lapie observed, exists in the creation of whatever it is, even of ugliness, error, suffering. It is perhaps so for the normal man, but it is absolutely false for the individuals whose will is sick. The scrupulous remain dissatisfied with their action and with themselves “because I cannot manage to make things right from the start,” says Cph... (116); “it is necessary to let me begin again; I suffer too much from this insufficient action.”

“If you had let me make efforts, I would have done the act myself, and now I am sorry to have acted as a machine” (Claire). “It is horrible to see that my action is still unfinished,” Simone says to me, “I don’t have the energy that is necessary to finish... I am an unfinished being. Therefore, give me a push in the right direction, a sacred sign, give me something to continue me.” This feeling of dissatisfaction is, in general, poorly expressed; it seems to apply to the objective perfection of the result of the action and as the result seems sufficient to us, we find that this feeling is delirious. Nadia is never satisfied by an embroidery that she makes, she always wants to undo it, to begin it again; those who examine her embroidery and who find it perfect understand nothing of this need. It is because the patient places herself in quite a different point of view: she complains not to have felt during her work the feelings of unity, personality, freedom that accompany resolutions and common volitions and it is for that reason that she finds that her embroidery is badly made. It is for the same reason that Lise is dissatisfied with the music that she makes, with her readings, all her work.


An interesting variety of this sentiment is their belief about lying, hypocrisy, play-acting, which we find so frequently in psychasthéniques. Many ticqueurs who have psychogenic torticollis or abnormalities of the midsection know the nature of the illness better than their doctor: “my doctor was worried and wondered if I had tubercular coxalgia; I was not as tormented as him, because I strongly felt that it was a hoax, it seemed to me that I played a joke and that I could not do otherwise.” This belief is found even when the patients do not have a tic and in reality deceive no one. “Do not believe what I have just said to you,” says Claire, “I believe that I lied, I always have the impression that I do not say the truth.” “My life is a perpetual sham,” says Gisèle, “it always seems to me that I play a role and that I do not act sincerely.” We will see the importance of this sentiment by comparing it to the sentiments of dreaming and of unreality that we find all the time.

Another variety is the sentiment of humility, of shame that we find in some patients. Toq... thinks he is fit for nothing, he imagines himself beneath everyone else, and Jean ends up thinking he is incapable of whatever it is; he wants to try nothing else, he attempts nothing, convinced of his inferiority. “It is sad, to be a laughing stock for everybody and at my age to be taken for a perfect fool.” The slightest of things worsen this feeling of inferiority. Upon entering a meeting he put his cane in the cloakroom and he notices that some of the assistants kept theirs; from there comes a despair because he feels less than them and he is more embarrassed than ever.

The sense of shame is found in many subjects who have no real obsessions of shame; they feel this sentiment in a temporary way and they themselves find it ridiculous. For stronger reason this feeling is considerable among all the patients for whom we described the obsessions of shame of the self and the obsessions of shame of the body. It is one of the essential sentiments of the scrupulous, but I insisted on showing that it developed following a crowd of sentiments of nonaccomplishment and incompleteness of the action.

Mr. Mourre, in a study on abulia, showed the importance
of the sentiment of the uselessness of efforts. These patients stop making pointless efforts, they even lose their manias that seemed to constitute the main part of their disease, they do not repeat any more, they make no more grimaces, but they are far from being cured. On the contrary, they are much more ill, they do not want to act anymore; they remain absolutely immobile in a state of exhaustion and despair. Through viewing the evolution of the disease, we shall observe these crises in Lise, in Claire, in many others. Claire had, in reality, religious scruples; she very much wanted to make her prayers and for years she had crises of agitation and anxiety about these prayers. We can be surprised, then, to see that now she absolutely gave up all religious exercise: “everything is useless, I arrive at nothing, I am lost and it is all the same to me, I no longer even try to save myself.” Let us notice that after this point, the patient no longer has crises of agitation. All our patients, who at the beginning suffered so much about the confessions and communions, eventually give it up completely and do not approach a church anymore. It is necessary to know this phenomenon of complete depression and the abandonment of an act; certain categories of actions or even all actions are able to bring about this state in a patient.

8. — The sentiments of intimidation.

In the extreme cases, all the feelings that I have just described manifest themselves regarding all actions, whatever they are. But it is evident that in the less grave cases these feelings arise only about certain acts and not about all.

What, therefore, are the actions that have the singular privilege to create them? It is not the insignificant actions that the mania has already made automatic; Claire does not worry about walking, eating, breathing. The actions that arouse this sentiment are exactly the ones that are not usually automatic, these are those that attract attention. The more an act would usually draw attention, the more it is, strictly speaking,

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231 Baron Mourre, l’Aboulie. Revue philosophique, 1900, II, 284.
voluntary, the more it has the chance to awaken all these sentiments of incapacity of the will. We thus understand that these acts are variable according to the subjects; some, and they are many, are especially worried about religious acts and the disorder first comes alive in churches. Right from the beginning, Claire has this sentiment of difficulty, these indecisions, this automatism only when making her prayers and confessing. To others, the grave act is going to be the professional act: sending telegrams or rolling porcelain rose petals, etc.

But there is a category of actions that has the privilege to be difficult and important for all and to demand a certain sum of voluntary attention, these are the actions that must be executed in public in front of our fellow men. I do not see a special phenomenon in shyness, it is for me only an example of all the previous disorders. Therefore, we shall not be amazed that all these patients are shy, that is, they feel the previous disorders to the supreme degree when they have to carry out actions in front of witnesses. Mt..., a 41-year-old woman, is especially embarrassed in her actions when her chambermaid is present, it is at this moment when she feels her action is automatic and ridiculous. “I am embarrassed,” said Fie..., “when there are two persons who look at me.” “I feel a strange effect,” said Ei..., a 42-year-old woman, “when there are a lot of people. It seems to me that I act silly, that I am not free any more to do what I do; I find my freedom when I am alone.” We would find the same sentiments in Dob..., in Jean, and especially in Nadia. This one has, as we saw, such a big need for affection that she would like to prove herself pleasant to the whole world and she pays more attention than ever to her behavior when she is with persons whom she wants to please. “It embarrasses me to say the pleasant things that I would want to say; I am stupid, I am completely disgusted by myself.” I do not discuss here the role of emotional phenomena in the phenomena of intimidation, I note only that the sentiments of insufficiency of the action often show themselves in the same circumstances where this emotion originates.

9. — Sentiments of rebellion.

Finally, you should not forget that the will is not always
active and does not determine only positive acts, there is a negative will, the one that refuses an action and a will that in a passive way accepts the given things and situations such as they are. One needs to make a certain effort to adapt oneself to an event, to reorganize one’s life by taking into account what has just happened. These two forms of the will give birth to exactly the same feelings as the active will. We could find the same embarrassment, the same feelings of difficulty, automatism, fate when it is a question of resisting an impulse or a desire. But I put stress on the last form, which is more curious. These patients have the feeling that they never accept things, that they are incapable of resigning themselves. “I cannot understand,” says Lise, “that a thing is impossible and it always seems to me that I make wishes and even efforts to attain a thing that I should know is unachievable, it is at this moment when I have the idea to call upon a mysterious power that will do what I wish and it reminds me of the devil.” It is more than twelve years since Nadia lost her mother, she always imagines that this misfortune happened yesterday and she can only arrive at this. She has not accepted yet that it is a fact and an irreparable matter. “It has been twenty years since I lost my grandmother,” said Bal..., “and I mourn her like it is the first day; I can, therefore, never take a stand on her death and accept that she died.”

All these diverse sentiments that run alongside the action are connected with each other. They all contain a fundamental sentiment: it is that the action is incomplete. To indicate them, I was obliged to forge a word and I suggest calling them sentiments of incompletion. This word is more just than the term “sentiment of imperfection” that wrongly implies a desire of perfection above the average; it also seems to me more just than the term “sentiment of incapacity,” because it is not about an incapacity, it is about the absence of a definitive and complete ending. The idea expressed by the term ‘complete’ appears to me the most important and this word had to occur in the name of these quite particular feelings. The word “incomplétude” was used by many patients, it seems to fit the picture and I believe that its usage is going to be strongly corroborated
by the study of other sentiments of the same kind that appear regarding the perceptions and the emotions.

2. — *Sentiments of incompleteness in the intellectual operations.*

The previous crises of rumination, agitation or anxiety begin on the occasion of intellectual work, of a perception, of an effort of attention as it did with the occasion of a voluntary act. We find, regarding this intellectual operation, the same sentiments that we noted regarding the voluntary actions.

1. — *Sentiments of the difficulty of intellectual operations.*

These patients claim from the beginning that the mind’s work became almost impossible for them, because of the difficulties that it presents and the sufferings that it causes them. All complain to have pains in the head when they want to apply their mind; we saw, moreover, that attention is very often the starting point for the agitations, the ruminations and the anxieties. Thus, Jean has a great terror of attention, “which is going to give him kicks to the stomach;” exhortations and incredible precautions are needed to obtain a few moments of reading. Lise also complains that reading fatigues her, of difficulties that she has if she tries to make a small calculation. Many subjects, such as Vob..., Ck..., get frightened and angry if we try to fix their attention or to make them accept a regular activity.

This resistance is partially explained by the feeling that they have of the *insufficiency of their attention:* they feel that it does not settle and does not arrive at unity. “When I hold a conversation,” says Jui..., “I would indeed like to be able to think of what I am saying.” Lise always feels a dullness, a vague state, an enormous embarrassment of her thinking; she never has her whole mind at her disposal, she feels that she never gives herself completely to what she does: “what I read, even what I look at, is not very
clear for me, it is that I am always thinking of something else.” Gisèle settles down more readily on ideas than on objects, if it is to be retained, but even when it is about the abstract ideas that she prefers, she can never think about one idea at a time, “I just want to apply my brain so as to embroider.” It is the same in the observation of Vor... (137) “who is never completely in his additions.” “I cannot clarify my ideas, I am as if under a sudden ramollissement, I am not in what you said to me, I am not quite wholly in the place where my body is!..” These are words repeated all the time by many patients.

A variant of the previous sentiment consists in the sentiment of instability; the patient feels that he always abandons the matter that he considered. “I become attached to my ideas for only one minute, barely one second, I may not think in the same way and with the same strength after two seconds.” “Nothing is fixed, nothing is stable in front of me because I may not stop on this point.” Mr. Duprat232 stressed the importance of this sentiment of instability and the role that it plays in the pathogenesis of certain mental disorders.

2. — The sentiment of incomplete perception.

This weakness that the patients claim to feel in their faculty of attention seems to have consequences because they all complain of suffering changes in the perception of external objects. These disorders consist, as usual, of bizarre, abnormal sentiments that they experience regarding these operations.

The most common of these feelings is an impression of poor perception, to perceive incompletely. From there all these expressions are so familiar as we find them in the mouth of all the psychasthéniques. “It’s as if I saw things through a veil, a fog, a cloud, it’s as if I listened through a wall that separates me from reality.” This fact is completely commonplace and the description is already traditional and well known. Billod makes the following remarks about one of his aboulic patients:

232 Duprat, L’instabilité mentale, 1898 (Paris, F. Alcan).
“she asserts that she is in the situation of a person who neither died nor is alive, who lives in a continual sleep, to whom objects appear as enveloped by a cloud, to whom other persons seem to move like shadows and their words to come from a distant world.”

One of Krishaber’s patients explained, in a very fine way, this feeling of incomplete perception: “it acted as an obscure atmosphere around my person, I saw, however, very clearly as if it was broad daylight. The word ‘obscure’ does not convey my thought exactly; it would be necessary to say ‘dumpf’ in German which means heavy, thick, lifeless, faded. This sensation was not only visual, but cutaneous. The ‘dumpf’ atmosphere wrapped me, I saw it, I felt it, it was like a coat, something like a malicious conductor that isolated me from the outside world.”

It is useless to add the other examples that would be absolutely similar: I emphasize this only to remind you that such sentiments are not particular, as Krishaber believed, to a special neurosis, but that they are found all the time in the psychasthéniques in the simple form “of the veil, the cloud” or under other more special forms.

One of these most curious special forms is constituted by the sentiment of the never before seen and of the unusual. In many observations, Krishaber points out that objects seem strange, that they become odd, that they are flat and that a man appears to these patients like a cutout image and without depth.

Ball’s patient saw an abrupt, strange change occur in the appearance of objects that did not seem the same anymore to him; he found them to no longer have depth, that is to no longer appear natural. These expressions are repeated so often by our patients that it is necessary to restrict ourselves to quote briefly a few examples. “Things do not appear to me any more in the same way as in the past.” (Lap...) “When I am tired, my eyes are affected by the same disorder as my ears, all that I see, the drawings on the wall of my room seem to me as strange as the sound of my words.” (Dob) “The world is drolly made,
peculiar, disgusting.” (Brk...) “It’s as if I saw things for the first time... they have a droll, surprising aspect, as if I had not seen them for a very long time.” (Dod...) “Since I became sick, objects seem to me flat, without depth, dirty, strange.” (Pr...), “it seems to me that everything is false, even the objects that I see.” (Claire) “when I go out, it seems to me that my street is not the same any more, that it is a very long time since I saw it, it is like a city that I did not see for a very long time.” (Qb... 14) “suddenly external things seem to me to be becoming odd, there is something that is not as usual. I lose the notion of the precise, it is as a deformation of reality.” (Gisèle) “all that I see, all that I hear is as unknown, completely strange, it seems to me that I did not understand, it is because of this that I repeat internally the name of all the objects that I see, it is because of this that I need to touch them several times.” (Cht...). Vod... upon seeing one of her friends, looks at her with surprise. She finds it so odd that this friend has two holes in the middle of her face: it is the eyes that give her this strange effect.

Mr. Dugas indicated a peculiar form of this feeling of strangeness. “In M.’s outbursts of anger, his vision seems to be overexcited, it becomes clear, detailed and precise, more exactly it stops being schematic and abstract, the patient notices the shape and the color of every tree leaf... the spine of every book appears to him with its appropriate appearance, its depth and its characteristic tint, the transformation that takes place then in the vision of things is marked by the ascendancy of the detail of the whole group.” In similar cases, a mania of precision often joins the sentiment of incompleteness of perception. At least it seems to me that it is like that in the following, rather similar case. “After dinner,” says Jean, “I am tormented by the colors of the living room; they seem so clear, so precise on all the objects as to be strange and annoying. It obliges me to look for a red color to the right when my eye settled on a red color to the left, it is a fatigue furthermore.”

We can notice regarding the outside perception another neighbouring sentiment, the sentiment of the strange, the sentiment of splitting into two

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that is going to play a more important role in personal perception. Dd..., a 24-year-old woman, after her third pregnancy has the sentiment of not waking up well, of remaining as if in a dream, she finds that everything is strange “it’s as if,” she says, “I saw double of all the objects.” Fya..., a 20-year-old woman, has the same feeling during her panic attacks, “a veil crosses in front of my eyes and it seems to me that I see double.” Gisèle has doubts on what she sees and wonders if she sees double. It is curious to notice that this sentiment of diplopia does not correspond to an objectively appreciable, specific disorder. When we ask them for the place of the second image with regard to the first one, in other words, when we want to specify their diplopia, the patients cannot answer any more and are obliged to admit that in reality they see only a single object, but that it brings them a sentiment of confusion as if they saw two.

To the previous disorders of the external perception, I shall add a small, bizarre sentiment to which my attention was attracted because three or four patients complained about it in exactly the same way, the sentiment of disorientation. Gisèle, in particular, says that when it is very bad, she has a certain difficulty to comport herself not only in the city, but even in her apartment, there is no longer a coordination between the places of the various objects; streets, houses, the doors and the windows of the apartment seem to have lost their relative place and the patient is quite disoriented. Ppi..., speaks to me completely in the same way; since he became sick, he cannot consciously orient himself any more in Paris. He does not lose his way, because he knows the city for a long time, but it is in a subconscious manner that it comes back him: if he tries, before leaving, to imagine the road, the direction of the square of Passy with regard to the Latin Quarter, he cannot manage it at all; he remembers, however, that he did this operation very well before being sick. I do not pretend that this disorientation is a necessary characteristic of the scrupulous. Jean, on the contrary, takes the sense of the direction to extremes because there are certain directions to which he cannot turn his back without receiving fluids; but for the patients who have clearest disorders of perception, this small fact is added to the feelings of haziness and strangeness.

In certain cases, until now rather rare, this sentiment of
disorientation can take a more precise and particular form: it can become *the sentiment of the inversion of orientation*. A 29-year-old woman, Wyx...., whose observation I have just presented to the Society of Psychology,\(^{237}\) was always a psychasthenique, disposed to the sentiments of incompleteness and to the obsessions. She comes to complain now about a strange disorder, it is that she is perpetually upside down; for her, all objects are perpetually upside down. She experienced this sentiment for the first time at the age of 27, some weeks after a childbirth and following painful emotions: upon returning to her home, she claims to have felt suddenly “that her house, its staircase, its door, its rooms, that everything was upside down.” This sentiment persisted continuously for one year: then it disappeared following a trip in the countryside to a region that was unknown her. It began again after an interruption of eighteen months, also following fatigue and emotions. This time the sentiment seems less continuous, it disappears, from time to time, when she walks in places that are unknown to her, where she has no independent representation apart from the current perception. But, when she gets back into known places for a while, it reappears suddenly accompanied with great anxiety like the feeling of déjà vu, and it persists then for a long time, days or weeks.

If we try to analyze this little known pathological sentiment, we see that the sensation, the perception of the objects and of their position is absolutely correct; we notice that the disorder exists only in the representation of the objects. It is this representation of objects and of their place that does not suit the perception and it is this that even determines the disorder of the sentiment of orientation. In this representation the relative place of some objects with regard to the others is not at all modified, the change concerns only the location of all the objects with regard to the subject’s body. It is necessary to be very specific, the disorder exists only with regard to a certain position of his body, to a certain direction of his walking. In brief, objects are reversed only when the subject walks toward

a certain destination, which makes a certain action. Also this feeling of the inversion of the representations with regard to the purpose of the action is not without relationship to the sentiments of incompleteness relative to the act. It is necessary to add, in my opinion, a sentiment of inversion of the lateral position of objects with regard to the right and to the left of the subject when he walks or when he acts: what should be represented to the right is represented to the left and vice versa and it is that which gives the subject the impression that he walks the other way around. This inversion of the lateral position of the representations can also be seen in the imaginary descriptions that he makes of buildings. Although it can seem bizarre, I believe that it is necessary to move this pathological feeling closer toward certain disorders of perception and action that we observe instead of toward hysteria just like allochiria,\textsuperscript{lxxviii} mirror reading and mirror writing. There is here, in my opinion, a kind of allochiria of the representations. Whatever the interpretation is, the sentiment of reversal of orientation happens suddenly for some patients in the same way as the feeling of déjà vu and it goes into the same group of sentiments of incomplete perception.

Finally, these objects that are perceived vaguely, strangely, divided into halves, very often appear \textit{to shrink and to move away}. This feeling of the remoteness of objects is almost always complicated by a sentiment of isolation, because the subject feels himself far from things and separated from them. “For many,” said Krishaber, “objects appear to shrink and to recede into infinity. The patient no longer recognizes the sound of his voice; it seems to him to come from a great distance and to get lost in space without being able to reach the ear of the interlocutors, whose responses are perceived with difficulty...” In his thesis on “the sentiment of déjà vu,” Mr. Bernard-Leroy often notices that the false recognition is accompanied by a sentiment of the smallness and distance of objects.\textsuperscript{238} “Everything goes away from me,” many of our patients repeat, “objects are in the distance and they become small, small...” (Claire, Lise. We-etc.).

In some rare cases, a vision disorder can occur similar to the spasms of accommodation\textsuperscript{lxxix} that are well known in hysteria, but mostly it is nothing. These patients

\textsuperscript{238} E. Bernard-Leroy, \textit{L’illusion de fausse reconnaissance}, 1898 (Paris, F. Alcan).
who claim that objects are far away and small can touch where they are and make correct movements to pick them up as soon as we ask them to do it; they eventually recognize that the objects remained the same, but that the patients give them the impression of being distant and small. Mr. Bernard-Leroy, it seems to me, describes this phenomenon nicely when he says “that it is less about a material distance than of a psychological distance, the visual illusion is dependent upon the impression of estrangement, isolation, flight of the world.”

These subjects no longer recognize the common world, they feel it has disappeared, is remote from them, separated from them by an invisible barrier, by a veil, a wall about which we have already spoken, and they translate this feeling in a symbolic way by speaking about material distance and about smallness.

This feeling can be pushed to the extreme: one of Mr. Bernard-Leroy’s subjects believed “he floated in the interplanetary spaces and thought he was separated from all the universes, in a kind of cosmic isolation.” I saw two patients who had reflections of this kind. Gel... repeats all the time that she left the earth and that she fell on another planet, she would indeed like to return to earth where all her things are. X..., a 30-year-old woman, for six weeks, after a typhoid fever, had the impression that she was “far from the earth and far from the solar system.” The Arc de Triomphe, which she saw from her windows, was a copy of the earth’s Arc de Triomphe “that they had made on another planet.” We see that these delirious interpretations, in which the patient more or less believes, come to complicate the sentiment of the strange and the distant.

3. — The sentiment of imaginary thought.

In a more advanced condition, the patients no longer only have the sentiment that their perceptions are bad, insufficient, bizarre; but they even have the sentiment that their process is no longer a perception of the external object, but another process, a more or less imaginary thought. There is always some difficulty, as I have often pointed out, in distinguishing one from the other: a current perception, a memory or a

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dream. Our patients now make a complete mistake and they perceive the same sentiments regarding the memory as they do about the imagination.

They studied a lot in these last years the phenomenon of false recognition or déjà vu in which the subject has the impression that all the details of his current situation are the reproduction of an identical situation already lived through by him in the past. The earlier descriptions of Wigan in 1844, Jensen in 1868, Sander in 1873, Angel in 1877, are completely classic, “It is,” said one of Wigan’s patients, “a sudden impression that the scene that we have just attended at that instant, (although given the nature of circumstances it was not before seen) already was before our eyes in the past with the same persons, chatting between them seated exactly in the same positions, expressing the same feelings in the same words. The poses, the expressions, the gestures, such a sound of the voice, it seems that we remember everything and that all this draws our attention for the second time.” We shall find many descriptions of this kind in the work of Mr. Arnaud and in Mr. Bernard-Leroy’s thesis.

This feeling of the past is found rather often in our patient’s and I remind you of both of the following cases, Lo... is often surprised seeing that her current life identically reproduces “word for word” a period of her past life. “In certain moments that pass quickly,” says Claire, “it seems to me that I have already lived them... I find the act that I make, the thought which I have, quite as if I relived them again, and it produces a very impressive feeling in me.”

I may not study here the phenomenon of déjà vu in all its details, I only remind you that it does not constitute a disorder of the memory, as they too often say, but a disorder of perception. It is a false evaluation of the character of the current perception that takes more or less the aspect of a reproduced phenomenon instead of having the aspect of a recently received phenomenon. In my courses on memory in 1897, I tried to show that “déjà vu” enters into the sentiments of automatism.

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240 Névroses et Idées fixes, II, p. 168.

241 Wigan, The duality of Mind, 1844, p. 84.


243 E. Bernard-Leroy, L’illusion de fausse reconnaissance, 1898.
The subject who feels his activity decreased no longer finds the sentiment of the small effort of synthesis that accompanies every normal perception, he believes he recites, it is this that gives the appearance of a past phenomenon to the perception. The localization in such or such date becomes a matter of interpretation, when this sentiment gives birth to an obsession. It seems to me necessary now to return the phenomenon "of déjà vu" in a more significant group, that of the sentiments of incompleteness.

When we say that the events of the present perception take, in the subject’s eyes, the appearance of memories, he does not give in completely to an illusion and believe that the appearance is completely from a memory. The patient never, save when there is an added frenzy as in Mr. Arnaud’s patient, completely cedes to the mental illusion; he never asserts that the current event is really a memory of the past, he never behaves as if it was a memory. The sentiment of déjà vu is more a negation of the present character of the phenomenon than an assertion of its past tense character. The subject, unless he himself comes to the interpretation, feels simply that the phenomena do not incite in him the same feeling as present things, that they look like, on this point, past things. There is almost always an important difference between the “déjà vu” and a real memory of the past. The past has the character of being known, to be common, it does not surprise us; contrariwise, the “déjà vu” always preserves a sentiment of vagueness, of strangeness: it always gets closer to the previous sentiments of the veil, to the strangeness of which it is, in reality, only a particular form.244

So it is not surprising that this sentiment has various presentations and that it is not always interpreted as a sentiment of memory. In some rather rare cases, moreover, if I do not make a mistake, the subject always has the feeling that the occurrence is not in the present, and this is the fundamental fact here, he is inclined to place it in the future. “It seemed to me that what I heard was what was going to be said or done.”245 Nadia complains very often not to be in the present, not to realize what exists in the

244 Voir à propos de cette interprétation une étude plus complète de sentiment du « déjà-vu » que j’ai publiée dans le Journal de psychologie normale et pathologique. 1905, p. 289.

245 Bernard Leroy, op. cit., p. 211
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present. “I have,” she says, “some odd impressions, it seems to me that things do not really exist, but that I have presentiments of their existence. Just now, I waited for your visit and I imagined it, and indeed now I want to say that it is the same thing. Are you really there?” It is about sentiments of this kind that some authors spoke about a feeling of presentiment, \(^{246}\) of the sentiment of “promnesia.”\(^{247}\) It is easy to see that it is only a variant of the previous feeling.

Another more natural sentiment will frequently develop instead of the previous ones, it is the sentiment of the imagination, the unreal. “The impression of déjà vu,” states Mr. Paul Bourget,\(^{248}\) “comes along with a sort of sentiment, impossible to analyze, that reality is a dream.” We shall find a crowd of examples of this sentiment of the unreal in Krishaber’s observations. “When I see my friends from the hospital, I say to myself: they are the faces of a dream...” “Even in touching and in seeing, the world appears to me as a gigantic hallucination...” We shall find these same words with Ball’s patient, in the observations of Mr. Dugas, Mr. Bernard-Leroy, etc., it is one of the most frequently observed sentiments. In my opinion, it is much more frequent, more characteristic and more interesting for psychology than the sentiment of “déjà vu,” which was too often studied in an isolated fashion.

For my part, it is the sentiment that I observed most often in psychasthéniques. I will only add that some expressions of this sentiment are in the middle of a crowd of others. “I did not live any more on earth,” says Pot..., “during periods of severe illness, because I see nothing that really exists. I cannot bring myself to the idea that you and the people who surround me actually live, that you are real persons.” This patient is interesting because in all the intervals between the crises, when the disease decreases, she congratulates herself “on finally finding real objects.” Others, such as To... or Mb..., have this sentiment only regarding visual or auditory perceptions, “they need to touch, like Saint Thomas, to realize a little that the object exists.” We remember ourselves the obsession “of the

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\(^{248}\) Bernard Leroy, *op. cit.*., p. 169
truthfulness of the senses, the priority of the touch, the direct sense in the midst of the indirect
senses” that developed for Mb... about this matter.

An expression that the patients very much like to use to indicate this disorder of their perceptions
is that of a dream, although it is, naturally, a simple metaphor as noted by Mr. Dugas, because it
is certain that in no way do we have similar feelings in a real dream. Lo... always repeats: “I
lived in the dream, in the spaces, I do not feel the things of this world.” “I see everything through
a veil, through a fog, I hear as if I was in a dream” (Dd...). “I do not distinguish very well
between what I lived and what I dreamed” (Gisèle). For long periods, Nadia repeats that she feels
funny, that she feels as if in a perpetual dream.

The gravest events do not always bring them out of their dream state. Someone committed the
enormous foolishness of marrying Lo...: she seems to have understood nothing of what took
place; she remains quite surprised that we call her Madam and she cannot succeed in
understanding that all this is not a simple dream.

There are even patients who go even farther in these sentiments of incompleteness of the external
perception and who have the sentiment having completely lost certain perceptions. Btu..., a 56-
year-old woman, whose observation is thoroughly remarkable for the study of Krishaber’s
disease, repeats constantly: “I am locked into a tomb, what a horror is that absolute isolation!
There is nobody, nobody around me. I see only black, the black of ink; even when it is sunny, I
see nothing, only the black.” It is always surprising when examining such patients to notice that
they have absolutely no vision disorder, that they can differentiate the smallest objects and
recognize them without hesitation. Hot..., a 17-year-old girl, arrives and complains she isblind.
“Shall I be able to see clearly again, can I be cured and see clearly?” In reality she reads the
smallest letters of the Wecker eye chart at a distance of 5 meters. Ret... goes to all the doctors
who treat ears and claims to be deaf although we objectively observe no deafness. These are
already obsessions that develop regarding the sentiments of incompleteness of perception.
4. — *The sentiment of the disappearance of time.*

Next to this disorder of the perception of the events in space, it is fair to place a similar fact regarding time.

Studies on the patients’ sentiments about time while the phenomena take place would be, in my opinion, of more interest; they were very rarely made because they are very difficult. We notice, at first sight, the most inconsistent facts among the various patients or within the same subject. It is necessary, in my opinion, to separate the assessments that they hold while they are sick, about their previous state of health or about the phenomena during their period of illness. When the patient thinks of the time when he was in good health, where he had the sentiment of reality, he seems to me to be inclined to enormously push it back in time; to have, on this matter, an exaggerated sentiment of the course of time. Here is how one of Krishaber’s patients expresses himself: “it seemed to me that I was transported extremely far from this world and automatically I pronounced aloud these words: I am very far, very far. I knew very well, however, that I was not taken away; I remembered very distinctly what had happened to me, but between the moment that had preceded and the one that followed my attack, there was an immense interval of duration, a distance like that of the earth from the sun...” If we place ourselves exactly in the same situation and if we question the subject about the time passed from his state of health till the current state of disease, he answers like Krishaber’s patient. “My happy youth is separated from me by centuries,” says Claire. “My crisis, in reality, began only three days ago,” Kl... says to me, “but it is an eternity, it is such a long time that I am amazed to remember what I did before being sick.” It is very much a sentiment of time; it is not the same feeling of distance that urged the subject to put infinite spaces between him and real things. He moves his previous real life apart from now by centuries, just as he now separated his body from the earth to the solar system.

We find sentiments that bear more exactly on time when we take the precaution not to take ourselves out of the period of illness or even out of the period during which the disease has remained the same.
I noted this detail with care in my already published observation of Bei... This girl, afflicted by the sentiment of depersonalization, complained that she had lost the sense of time, she did not understand the meaning of the words: yesterday, today, tomorrow: the day passed by without her understanding how, she believed it is always the same moment, “yesterday, today, tomorrow appear to me the same thing, like a big space,” she could render an account of this bizarre disorder by comparing it to what she formerly felt when she could correctly make the differentiation between the diverse moments of time. Many patients are of the same type, Ver..., P... (20) and at times also Nadia: it is clear that this last one does not realize the distance between the years, she remains always exactly the same and although she is thirty years old, she believes she has completely remained a child.

Lise has made very clear remarks on this point: she is surprised by the way that time passes by when she is sick: “the hours pass completely without me noticing it, I meditate for three hours and when I shake myself I have the feeling that I was only allowed to go barely five minutes. I was very sick all this week and by coming back to see you I had the impression of leaving your place, I cannot imagine that a week has passed... During my periods of illness, the time is always very short... if it exists... or rather I know nothing about it, it seems to me that time is no more when I am very sick...” Mr. Fouillée already said, “even in the [healthy] man, there are unhealthy instances where any notion of time seems missing, where the person acts by mechanical vision of things in space without distinction of past or present.”

We usually explain these facts by saying that the subject is absorbed in the sentiment of the present. Although it is difficult to move forward on this point to something other than hypotheses, I shall be disposed to say that my patients lose the notion of time in a more complete way, because they lose the sentiment of the present. For the duration of their crisis, when perception seems only of the unreal or of the past, they have no sentiment of the

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249 Névroses et Idées fixes, II, p. 63.

250 Fouillée, Introduction à la genèse de l’idée de Temps, par Guyau, 1890 (Paris F. Alcan).
present, this is at least what patients such as Bei... and Lise express “who are in a dream and no longer feel time passing by.”

These modifications of the sentiment of time will later take on a great importance, here we only indicate them and draw attention to them.

5. — Sentiments of intelligence.

The modifications of the attention determine not only the previous feelings about the external perception, they also determine sentiments of the same kind about all the operations of the mind, all the conceptions, all the ideas. The memories and the ideas have the same character of vagueness and unreality as the outside world, “my life passes,” says Claire, “it appears to me to belong to another world, which is not real, it is all so far from me; in fact I cannot explain my ideas, I make efforts to reach a clear idea, for that it would be necessary to open a small door in my head, the clear idea is behind this door but I may not succeed in reaching it.” Dob… wails for eternity about the effort that she has to make to express and to understand her ideas, she despairs of arriving at this precision. Qi... is upset because she can no longer understand her son nor make herself understood to him “one would say that for two years our house is transformed into a Tower of Babel.”

This vagueness of the idea certainly provokes diverse secondary sentiments that we noticed in these patients, first the sentiment of mystery, the idea that they are surrounded by profoundly incomprehensible things, then the need to try, the effort to manage amidst all these things that they do not understand. “The mystical and mysterious things hurt me and attract me, I so strongly feel the mysterious” (Gisèle). For Gat... and for Pot... the progress is very apparent: at the beginning, they have painful feelings of automatism, of unreality, of darkness and that happens only after they begin questioning. “Why are these people who look funny on earth? Why do we live because we have to die?” The taste for metaphysical questions is connected with these diverse tendencies; we see an example of it here.
The patients seem to realize that this darkness is attached to something, a poorly made mental operation; they constantly have, like Jo..., the sentiment that they forgot something, that they lack a mental operation. Ver..., complains that he has lost his personhood, complains to have lost his ideas: in his language without psychological precision he continuously says “that he does not have ideas of things, that he cannot pursue his ideas.” He was in the funeral of one of his uncles and complains that he does not produce the idea that he is dead. “What can you do,” he says in conclusion, “life is to think and I do not think.”

Others more fully realize that they have numerous ideas but that they do not unify them, do not coordinate them: “my attention is always scattered,” says Lise. “I have too many complicated ideas at the same time,” says Nadia. Xyb... realizes that she does not put things in their place. She has doubts and scruples with regard to a domestic, “I am not easy with her, she must have her place in my imagination as a servant, the places of the ideas seem changed to me. Things would have to be balanced anew.” Ppi... always feels weak at his job, he cannot possess an overview, embrace a study, “it is necessary for me to take an eternity over every small part of the question.”

We can connect this sentiment of incoordination to certain needs that the subjects feel. They have, they say, a thirst to learn, they would like us to give them logical proofs, that we read to them so they understand general ideas that are capable of putting order in their mind. This desire is symbolized by the thoughts of Jean who aspires to an incredibly simple and general education. It is impossible to find a book that suits their taste: “how can we have him read the details when he knows nothing of the whole? At 32 years of age, he wants to read only textbooks and very general textbooks; he cannot read a textbook of the history of France before having read a textbook of world history, and before being interested in some scientific notion, he wants to study the ‘general sciences’ that we give to small children.” These tastes correspond to strange feelings relative to the clarity of the deductive method, to the ridiculous need for subordination and coordination that is connected, if I do not make a mistake, to the suffering caused by the previous gap.
We arrive at these patients’ most widely known sentiment, the one that we take very too often as representative of all the others. Even on this point, there are often misunderstandings, so we limit ourselves to say that the patients have the mania of doubt, the mania of interrogation. It is only one of the forms in which doubt can present: in having cited their manias to wonder about a point such as about the existence of God, they have a perpetual doubt that is a simple sentiment concerning more or less all of life’s actions. I had insisted on this distinction in my earlier studies on abulia. Messrs. Raymond and Arnaud also make it with clarity. That is why, having described the manias of investigation, we arrive now at the sentiments of doubt.

At the beginning, the patients doubt the things that are obviously the most obscure and that they comprehend least, that is to say religious things. “When I began to be sick,” says Ball, “I lost the faith of my childhood, I did not know why I did not believe any more and I did all that I could to find my faith, but it was pointless.” Claire began by feeling that the religious law went away, “it was an absence of confidence in God, something in me that went out like a light that goes away.” Her education, her desires, all her ideas connected her with religion; so she was upset with the doubt that invaded her. It is curious to notice that this weakening of faith is not caused by readings, discussions, and does not depend on arguments. Her reason, if we can say that, did not lose the religious law and would be incapable of formulating the slightest objection. It is an old error that to imagine that faith is always determined by reason and doubt by arguments: the faith of this patient gets lost without reasons by virtue of the same mechanism that makes the world appear strange and that brings about the sentiment of depersonalization.

When the disease worsens, the doubt begins to concern things that usually are more easily believed. The patients lose confidence in the people around them. Claire

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no longer believes what we say to her, no longer trusts in the words of her relatives. Lod... similarly believes that only one person, her sister and no one else, can reassure her on anything. “I very well know that they are right,” says Lise, “I know it, but I cannot be convinced.” “I know that what you say to me is true,” Gisèle answers me, “my reason represents it so to me, but my impression persists, it is impossible to be fundamentally convinced.” “I want to believe in you, I repeat that I believe in you but it is not my fault; I do not feel it, I have something, a doubt, a vagueness, an I do not know what” (Claire, Fik…, etc.) To anyone in authority, they match against him the wish for a bigger authority, if the doctor speaks to them, they would want the priest, and if it is the priest, they blame him for not being an archbishop or a pope “and still if the pope spoke to me, I would not believe him, because it would be possible that he poorly understood me and that his infallible answer does not apply to the question” (Claire), similarly they lack confidence for no reason, and reasons are completely unable to bring it back. If this defect of trust in other people inflates and insulates itself, as happened to Simone whom I plan to study in another work on the psychology of the persecuted, the doubt will get closer to persecution.

One degree more and the patients are going to doubt their own future or their own health. The absence of hope, a gloomy future that presents as a black hole is a chief characteristic of these diseases. Am... can believe nothing of what will happen tomorrow and despite all evidence does not know where she will be, if she will have really gone out, if she will know how to walk in the street; Simone even comes to a crazy terror about the future, she does not want to even think of it anymore and does not try to imagine anything beyond the present moment. Others will doubt the past and will feel the need to verify their memories. “Is it definitely me that did this or not?”

Finally, the patients begin doubting the present, and feel that they are not sure of what they see. “For a long time,” said a patient of Legrand of Saulle, “I had taken the habit of speaking to myself, to be sure that I was here or there, to give myself proofs.”252 “I see this clearly,” says Ges..., “but deep

252 Legrand du Saulle, Folie du doute, p. 47.
down I am not any surer of it and I shall return twenty times to this room to see if the object is definitely there, without being any surer of it. However you may assure me of it, I believe that you can make a mistake.” We see here how the manias are grafted onto the sentiments of incompleteness. This doubt of reality leads us to the sentiment of the strange, to the astonishment that certain patients, such as To..., feel in the presence of things and in the sentiment of the unreal that we have already studied. All these sentiments, in fact, closely depend upon one another.

These sentiments of doubt are also connected to the sentiments of discouragement that we saw regarding the will and that can become widespread, “I believe that everything is impossible,” said Claire, “not only for me, but for all the others,” feelings of mistrust, suspicions. These patients are never reassured and take endless precautions so that we do not deceive them, so that we do not betray their secrets. Finally, this doubt is going to give birth to the perpetual need of an outsider’s affirmation that we shall find in their needs of direction.

All these sentiments relative to the intellectual functions are similar to those that were observed regarding the voluntary operations. They are sentiments of incompletion: “You can be at ease,” said Lise, “I shall not attain complete delirium; I am unable to think of something completely, even of a silly thing.” I can, therefore, apply to them the same name as before and make them sentiments of incompleteness also.

3. — *Sentiments of incompleteness in the emotions.*

Very often, the crises of rumination, agitation or anxiety seem to be determined by the emotions: this is an important fact, one that I have previously stressed. Many authors drew from that a very serious conclusion, that the emotion determines the crisis because of its exaggeration and they accepted without debate that the emotions of psychasthéniques were too big, too strong. Without entering this discussion here, I shall point out only that this is not what the patients themselves think and that they have quite other sentiments about their own feelings.
1. — *Sentiments of disinterest.*

A patient, previously cited by Esquirol, expressed himself thusly: “My existence is incomplete, the functions, the acts of common life stayed in me, but each of them misses something, *namely the sensation that is appropriate to them and the enjoyment that follows from them.* Each of my senses, every part of myself is separated, so to speak, from me and can no longer give me any sentiment.”

The patients very often feel, in fact, a very curious dissatisfaction about their emotions and especially about the emotions that seem to determine the crises of forced agitations: that is to act on the genital emotion or on the emotion of anger, it seems to them that the emotion stops before becoming complete and that it is transformed into another mental operation, ruminations, tics and anxieties. “I cannot,” Lise says, “arrive at the end of an emotion or of a feeling, it is this that gives me scruples.” This appreciation of the emotions and the sentiments is very general and as the phenomenon has its importance, it is necessary to report some examples.

“It seems to me,” says Pot..., “that I shall not see my children again, everything leaves me indifferent and cold, I would like to be able to despair, shout out in pain, I know that I should be unhappy, but I do not arrive at that, I do not have more pleasure than trouble, I know that a meal is good, but I swallow it because one has needs, without finding the pleasure there that I would have formerly had. The pleasures ran away, the pains also, I go to my grandfather’s funeral and I do not even have a crisis of grief... There is an enormous thickness that prevents me from feeling the moral impressions, which prevents me from even feeling pain.” We find here regarding the emotions the same expressions “of the wall, the thickness” that were already used by many patients to characterize the disorder of external perception.

Nem... is no longer the same, she no longer takes care of either her husband or her child. “I would very much like to try to think of my little girl, but I cannot, the thought of my child barely crosses my mind, it crosses and leaves me no sentiment.” “It seems to me,” says Brk..., “that for one year I love no one anymore.” “My children embarrass me,” Xyb... says, “I am not for them what I was..."
before, I do not exist anymore from the maternal point of view, I would definitely like to be interested in it, but I do not have desire.” “In the past, I was fearful,” said Gay... “and you would not have been able to make me come into this room full of skeletons (the museum of Salpêtrière); now it does absolutely nothing to me, I do not even feel frightened; everything is the same to me.” “I do not love people anymore,” says Gisèle, “it does not seem to me that I love as others do, as I loved before; I have the impression that they would prefer that I love them. I lived folded up on myself like a selfish woman who nevertheless would hate herself. I no longer get angry at anything. I am afraid of nothing. I am interested in nothing, and everything slides on me as on an oilskin, everything is dulled.”

Here are Claire’s remarks on her own emotions: “the emotions stop, do not develop, they get lost and do not reach me, a thing that would have frightened me leaves me calm, I do not have fear, I have too much peace; I experience all the same enjoyments and pains, but weakened. It is very rare that I can laugh, I smile but I cannot laugh heartily, a joy or a pain stays in the distance, it stays in the air and it is that which saddens me most, not to have a heart anymore... It sometimes wakes up then it wanes again... You do not want to believe that I have no heart, I have only the air of loving my mother. Deep down, everything is equal to me, I do not want to recover, I am carefree, I would so much like to be able to have lots of sorrow, I would like to be deeply moved, to suffer a lot: to be so quiet, so quiet, it frightens me.”

We find the same sentiment of incompleteness of the emotions in the very complex phenomenon of shyness. “There are hearts,” Mr. Dugas said eloquently, “who do not know how to adapt their sentiments to the circumstances... We can take Amiel as a case when he complains to have become unable to feel: ‘my heart never dares to speak seriously,’ he says, ‘I banter always with the moment that passed and I only have retrospective emotion.’”

We also find this sentiment of insufficient emotion in the perpetual feeling of boredom, so commonplace with all the psychasthéniques that it is useless to bring to mind their inexhaustible groans. To many the boredom is obviously connected with the abulia and the aprosexia;... they get bored because they

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do nothing. But I was amazed to see a profound feeling of boredom in the patients who, however, continue to sufficiently occupy themselves. It is because the action and the work did not give them 'the sensation that is appropriate for them and the enjoyment that follows them.’ It is because they always remained indifferent and that, as one of them said very nicely, ‘we get annoyed not to suffer, as well as not to enjoy.’

To these sentiments of incompleteness of emotions, I shall also link a sentiment of a little different nature, a sentiment that these subjects have about their sleep.

If sleep can also be, as we saw, the starting point of the crises of anxiety and agitation, we shall not be surprised to notice that in certain cases it gives birth to the same sentiments of incompleteness. Claire, like many of these patients, does not manage to have a complete sleep, she is only half-asleep, and it always seems to her ‘that there is a person who continues to think as clearly as if she was awake... I have only one person who sleeps, the others stay up and dream and they do not dream about quite the same thing;’ she also continues to feel the same anxiety during sleep as during the day.

Lise has the sentiment that she half sleeps, that she continues to ruminate as she does during the day; upon awakening, she has the feeling of having slept in a very incomplete way. When she gets better, she awakes with a start, amazed at sleeping so profoundly, in a way that contrasts with her usually incomplete sleep.

2. — *The sentiment of anxiety.*

Next to this sentiment of incompleteness, it is necessary to describe a completely essential state of mind in the obsessives, it is the sentiment of anxiety. “A characteristic trait that unites all these so seemingly diverse states, it is the intellectual anxiety, that we can compare with the anxious lypemania that corresponds to an emotional anxiety.” In my opinion, all these patients almost always have an anxiety that is at once intellectual and emotional.

“I am anxious,” this is the word that all the patients perpetually have

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In their mouth. “Perpetual anxiety,” says Brk..., “such is my life, it is anxiety that leads to bewilderment.” “I always have an anxious, tormented mind as if there was going to come to me some great, unknown misfortune.” ( KI...). “My disease,” says Nadia, “is to have an anxious mind, I would be cured if I could have a little security.” “Anxiety, constant torment,” repeats Claire, “it is my great impairment.” “In sum, I am sick from anxiety,” Gisèle says to us very clearly, “sick from fear from doubt, I have no confidence in myself, nor in God, nor in anything; I have no peace; I make superhuman efforts to have some peace and my soul is always wrapped up in anxiety. I am afraid of my sentiments, of my actions, I am afraid of my ideas, fear of my brain that I do not feel like the ruler of any more, I am afraid to struggle, fear of everything in a word and of I know not what, and at heart I do not even know if I am afraid. It is an anxiety pushed to an enormous degree as though one always waited for somebody very dear exposed perhaps to a very great danger, one does not know which.”

This anxiety, in fact, looks a lot like fear and we see that the patients often use this word, I do not believe, however, that the phenomenon is completely identical. Fear is a more precise, more definite state that creates in us positive sensations and that awakens ideas of a precisely known danger. Anxiety is much more vague; neither the state one is in, nor the cause of this state, nor the actions to be made to express it or to get out of it are well ascertained. Moreover, we notice the difference in the patients themselves. When we ask them to pay attention, they recognize that they are not really afraid; “it would be better to have the real fear,” says Gisèle, “it would be less painful.” We observe certain subjects for whom the emotions are very decreased or even abolished and, since their illness, became unable to be afraid. The patient Gay..., who complained of not being afraid to look at skeletons any longer, adds: “I have no more fear, I see that it only negates action, nothing more... however, I always remain so worried.” For these reasons, I, therefore, believe that anxiety, especially that of the scrupulous, is not fear, no more, for that matter, than it is any other precise emotion.

Anxiety appears to me to be a complex phenomenon; in the first place, it contains an excitation that is bound to exaggerated, useless, inferior action,
to the agitation: the anxious person feels that he must do something to get out of this state, he does not know precisely what and he cannot remain still for five minutes. In the second place, anxiety contains a suffering, a painful state of consciousness. But the bulk of it is caused by the sentiment that one’s state is not stable, definitive, complete. There is an anxiety due to the action when they feel that the action is not ended, that there is something to do, that the decision is not taken. There is an intellectual anxiety when they feel that their attention is not fixed, that their perception is not precise, that the world has a strange and unreal aspect. There is an emotional anxiety, when they do not really reach a state of clear pleasure, clear suffering, or real fear. A clear-cut misfortune does not yield anxiety, no more than a real danger. But these diverse states are exactly the ones that I have just described under the name of the sentiments of incompleteness, in the actions, perceptions and emotions. The anxiety is thus essentially constituted by the sentiments of incompleteness to which are added a feeling of malaise and an agitation to make an effort to get out of it.

Observation of the patients demonstrates this interpretation: the anxiety began for Claire with the first religious doubts around the age of 18 years, that is to say with the first sentiments of incompleteness, it is at this moment when she had anxieties for her faith, for her confessions, anxieties about “the light that went away.” Lobd..., a 35-year-old woman, says to us very clearly: “when I am worried, it’s as if I had not finished anything, as if there continued to be, about everything, something pressing to carry out.” “I need to complete something,” says Gisèle, “I always search for what I should do, what I should keep an eye on, for what I should look for, my mind has never seemed to occupy me enough, sufficiently excited, it always looks for what it should have to do, to feel more.”

A sentiment of this type can obviously be the consequence of certain obsessions. But it is necessary to notice that it exists for all these patients, whatever obsessions they have. It does not seem certain to me that the anxiety is really determined by the motive that the subject calls upon to explain it. If we remove this motive, he at once takes another one, the motives eternally change and the anxiety remains the same. When the patients
get better and when they really have no more clear obsessions, they remain worried for some
time due to habit, they say. They continue to search for what could definitely torment them. “It is
essentially habit,” says Lise, “that still prevents me from sleeping soundly.” For many patients,
these anxieties existed for a long time before the disease itself, Mus..., Mb..., Lise recognize that
they were this way since childhood. Jean was worried in high school because of the homework,
the lessons, the extra assignments; he became ill when there was an oral presentation to be
prepared; today he is tormented by women, the fluids, the local trains and the letters to be
mailed. Anxiety, therefore, seems to me to be a fundamental sentiment prior to the obsessions
and on whose account the patient often tries to justify the obsessions; it is the complex form
taken by some of these sentiments of incompleteness.

3. — The need for arousal. The ambition.

To get out of this worried suffering the patients instinctively look for something that pushes their
insufficient feelings farther away, that excites them. It is this need that we have already seen
boorishly manifesting itself in the need of the stimulating poisons, in dipsomania, in
morphinomania, in the search for the perfect genital excitement in certain erotomaniacs, in the
impulses to walk, in the desire for suffering. We even see it in “the need to make absurdities to
rouse themselves” in “the need to establish new sensations.” We shall even see it again in many
varied forms, particularly regarding the needs of direction and affection.

Anxiety also contains an active part, it incites one to make efforts. This remark is verified by the
existence of an unexpected sentiment in our scrupulous, ambition. They are first of all
conscientious, they try hard to do things precisely right up to its conclusion because it seems to
them to always be insufficient. Jean was a model pupil in his mediocrity, he would rather have
gotten sick than not to carry out a duty up to the end, he took all possible precautions to never
annoys a teacher. Even now, Vor..., at 50 year old, recognizes that she has a ridiculous
conscience:
in her housework, she forces herself to do all the painful things; when she begins a book she believes she is obliged to read it through to the end without skipping a line, even if the book annoys her. Meu... works all day long without allowing herself any rest, “it seems to me that if I stopped working for a moment I would no longer have the right to eat.” This worried activity overshoots the present: “it is always necessary,” says Lise, “that I think of later, that I search for what I shall do after that, that I be ahead of this work, I go beyond.” This need is going to become a mania and we have just studied it under the name of the mania of the beyond, but the subjects have this need before being sick, they have it all their life and I believe that at the beginning it is a character trait in connection with their perpetual anxiety.

One degree more in the same direction and we understand how it develops into a kind of insatiable ambition. Nadia is never satisfied by the way she plays the piano, she wants to be “a totally big artist,… me, I am the earthworm,” she says, “and my ideal boyfriend, he is a star and I would like to become more deserving of him. It seems to me that I always want to become the equal of the most marvelous men, although I know well that I was never good at much... Even if I had been able to manage to be a big musician I would never have been satisfied, I would always have wanted to climb higher still... My ambition has no limits.”

Whatever the situation is that they achieve, the scrupulous are always dissatisfied with it, they always dream of better, always something else. It is very likely that these strange feelings are sometimes the principle of a useful activity and that they inspired generous ambitions; but it is true as well that they can be more often the starting point of unhealthy jealousies and of a kind of delusion of grandeur. “I have the ambition of everything,” says Fa..., “it makes me jealous of everything, oh! if I was like the people who are in this carriage, like this beautiful lady..., I would like to arrive at the height of fortune and glory and I would perhaps not be satisfied yet.”

All these sentiments of incompleteness that the subjects experience regarding their emotions are very similar to those that were noticed regarding action and regarding intelligence and they well deserve the same name.
4. — Sentiments of incompleteness in personal perception.

Mr. Séglas, in describing the crisis of obsession, indicated some very interesting phenomena that he considered as indicative of a disorder of consciousness during the crisis. “One of them, an agoraphobic, expresses himself thusly: at the end of some steps, it seems to me that I am divided into halves, I lose consciousness of my body that seems to me to be in front of me, I am quite conscious that I have to walk; but I am not conscious of my own identity, that it is definitely me that walks. I make efforts to prove to myself that it is definitely me and often I must call out to a passer-by, to enter a store, to speak, to ask for something to give to me a new proof that I am really, definitely me.” Another patient, a 12-year-old boy, tormented by obsessions, manias of doubt and contact remains behind for one moment with his private tutor; he runs up frightened, exclaiming that we had left him behind, that it was necessary to return to look for him, that he was lost. The same patient, on seeing a patrol wagon pass by, is taken hold of by a big fear, being afraid of having been taken by the guard who would have looked at him in passing. These two observations seemed to bring to light a remarkable disorder of personal consciousness.

Similar facts have been actually observed for a very long time. The observations of Krishaber known by the name of “cerebro-cardiac neurosis” were made famous by Taine. “From the first moment, immediately after my attacks,” said one of these patients, “it seemed to me that I was no longer of this world, that I did not exist anymore, that I did not exist. I had no sentiment of being someone else, no, it seemed to me that I did not exist at all. I felt my head, my limbs, I felt them. Nevertheless, I needed a great concentration of the mind and will to believe in the reality of what I touched...” “I had,”

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255 Séglas, Leçons cliniques sur les maladies mentales, 1895, p. 131.
256 Séglas, ibid., p. 139.
257 Krishaber, De la névropathie cérébro-cardiaque, 1873, observation 38.
says another patient, “a burning desire to see my former world again, to become my former self again. It is this desire that prevented me from killing myself... I was the other one and I hated, despised this other one; he was absolutely obnoxious to me, it is certain that it was the other who had taken on my shape and taken up my offices” and Taine added: “the subject does not recognize himself any more, he finds all his sensations changed and he says “I am not,” later he will say, “I am the other one.” He seems to be in the world for the first time (sentiments of strangeness), he believes that his actions escape him, that he establishes his actions as a spectator.”

Later these observations multiplied, I call to mind Ball’s patient who is remarkable: “In June of 1874,” writes his patient, “I more or less suddenly felt without any pain or exhilaration a change in the way of seeing things, everything seemed to me to be odd, strange, although keeping the same forms and the same colors (sentiment of strangeness of perception). In December, 1880 more than five years later, I felt myself to be diminishing, disappearing: there was not any more of me than the empty body. Since that time, my personality has disappeared in a complete way, and no matter what I do to recapture myself, it escapes me, I cannot be that. Everything became more and more strange around me and now not only do I not know what I am, but I cannot render an account of what they call existence, reality.”

These cases in their typical form are so strange that they have continued to draw attention. In an article published by the Philosophic Review, Mr. Dugas suggests indicating the phenomenon under the name of the sentiment of depersonalization, he observes that this sentiment is connected with another curious phenomenon, “déjà vu;” that is, the sentiment of depersonalization often combines with false recognition. “Often the subject afflicted by false recognition was conscious of becoming some one other, he felt like the same person becoming two. I listened to a voice, says a patient, like that of a stranger, but at the same time I recognized it as mine, this me who spoke gave me the effect of losing myself, very old and

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259 Ball, Revue scientifique, 1888, II, p. 43.
This impression the patient has not only regards his speech, but he also has it about his movements, about his actions and he arrives at the alienation of his person, at depersonalization.  

I had the opportunity to report two observations absolutely remarkable in the same way, that of Bei... and that of Ver... Both patients are identical in their chief traits: following emotions they lose consciousness of themselves, they continue, however, to execute all the psychological operations in a correct way, they feel everything, remember everything, speak, act, in a nearly normal way; but they always repeat: it is not me who feels, it’s as if it was not me who speaks, who eats, as if it was not me who suffers, as if it was not me who sleeps. “Bei... saw clearly, heard well, felt correctly, could move without any trouble, but she searched for herself having the impression that she was not there anymore, that she had disappeared, that the present things had no relationship with her person. From this moment, she continually repeats the same thing: but where am I? What did I become? It is not me who eats, it is not me who works, I do not see myself doing this or that, there is something that misses me.”

Recently, Mr. Bernard-Leroy, who had already published, regarding these facts, a discussion to which I shall return, presented to the Congress of Psychology a new remarkable case, completely identical to the previous ones. It is a 41-year-old woman who fell ill gradually following lively and prolonged emotions. She stirs constantly and is engaged in the execution of bizarre and complicated movements, she feels her hands, arms, walks with her hands on her head and neck. She even unfastens her blouse to feel her breast, she slams her jaws, pulls her hair, pulls her ear... she says that she no longer feels anything or at least no longer feels as she did in the past and that from then on it is stronger than her. (It is the phenomenon of the manias of checking, tics, motoric agitations that we know with these patients.)

“She has to feel. She is unfeeling to all this, she says while

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261 Id., *ibid.*, 502.

palpating the ear. When I comb myself I do not feel my hair, nor my hands when I wash myself, nor my lips when I kiss. It is unfortunate to be alive and not to be able to see one’s own when they are there. The way I see is nothing like before, I do not listen as before, it seems to me that I do not hear the sound of my steps, it embarrasses me to walk, I remember nothing of myself any more, I know nothing any more, I have no more emotion...” In reality, we notice no significant decrease of any sensibility, she seems to have precise memories when we question her and she appears to feel the normal emotions.263

Messrs. Pitres and Régis, in reporting Mr. Séglas’ observations, point out that in these cases consciousness is not disturbed in a complete way. “If we think of the word consciousness from the clinical point of view as exact perception of the experienced psychological phenomena, it is evident that, save for very rare exceptions, consciousness is preserved in the obsession; if the patients notice this splitting into two, if they analyze it so correctly and so finely, it is because they are aware.”264 These authors here only remind us of the important fact that the intellectual appreciation of the obsessions is preserved, that the delirium of the obsessed is incomplete and does not determine either firm belief or complete impulsiveness. But the preservation of the intelligence itself, as the faculty of criticism and judgment does not at all prevent the impairment of the other psychological phenomena that enter into personal consciousness. If Mr. Séglas’ observations and all the other similar ones, because I consider them very numerous, do not exhibit to us a disorder of the critical judgment but simply a disorder of personal consciousness, then they are nonetheless very important for the interpretation of the obsessions themselves.

Messrs. Pitres and Régis point out that these observations on the sentiment of dual personality do not relate to our current study of the very homogeneous group of psychasthéniques, on the malady of the obsessions. “These facts,” they say, “form a special category belonging to psychic automatism

263 Bernard-Leroy, Dépersonnalisation. Comptes rendus du congrès de psychologie de 1900, p. 482.

264 Pitres et Régis, op. cit., p. 40.
at least as much as to obsession, the patients who split in two so as to imagine themselves in front of themselves or to look for oneself somewhere else have something other than a simple obsession, they feel a phenomenon similar to certain effects of hysterical duality."\(^{265}\) I cannot share this opinion, the hysterical splitting in two can remarkably give birth to quite similar expressions, but as a general rule it does not appear under this aspect. In hysteria, true, subconscious, psychological phenomena form two independent groups that ignore each other, but each of these groups preserves his personality. Here there is no real splitting in two; we notice neither anesthesia nor amnesia, we can bring to light no lacuna in the main group of the phenomena, but there is a general sentiment that concerns all these facts and that represents them to the consciousness as changed, as insufficiently connected with the personality, this is a different case than hysteria itself.

Mr. Bernard-Leroy in searching for the diagnosis of these disorders said “that he successively eliminated the diagnoses of the mania of doubt, the syndrome of the negations, melancholy, mental confusion, hypochondria, and that he puts these cases under Krishaber’s cerebral-cardiac neuropathy.”\(^{266}\) That it is about Krishaber’s disease is indisputable, because this disease is clearly established only by this unique symptom of depersonalization. The real diagnosis consists in looking for which of the morbid groups currently recognized go into this neurosis of Krishaber. It is also easy to eliminate the syndrome of the negations, melancholy, mental confusion. But I do not share the author’s opinion when he eliminates the mania of doubt, hypochondria and probably also the obsessions about which he does not speak. The patient whom he describes has doubts, she even has mental manias of perpetual checking, her ceaseless touches are nothing other than tics related to manias of checking. All the patients previously described, those of Krishaber, those of Ball, those of Mr. Séglas, those of Mr. Dugas, have at the same time doubts, manias and obsessions. It is interesting to call upon, regarding this matter,

\(^{265}\) Pitres et Régis, op. cit., p. 40.

\(^{266}\) Bernard-Leroy, Comptes rendus du congrès de psychologie de 1900, p. 487.
the continuation of Bei’s... observation, which I published in 1898. After 18 months of pure depersonalization, during which the patient was preoccupied only about the loss of her self, Bei... became a little quieter about her person, she partially forgot the sentiment that she felt; but she began presenting crises of interrogation regarding memories: she must look for what she did the day before, if she was there at the dance eight days ago or if she was not there, etc. They are genuine crises of rumination characteristic of the mania of doubting, that is to say, one of the forms of the psychasthénique state. In my new observations of the sentiment of depersonalization, to which I am now just going to make an allusion, numerous observations bear upon all the obsessives. In short, in most of the obsessed, the maniacs, the phobics that I have just studied in the previous chapters we find at least the germ of this feeling of depersonalization. I am thus inclined to believe that the sentiment of depersonalization is one of the symptoms of the psychasthénique state and that it is necessary to assimilate it into all the previously studied phenomena.

We are then in the presence of another problem. Which group of phenomena do we put these cases of depersonalization into? I believe that very often it is a matter of genuine obsessive ideas. Some of these patients eventually conceived a more or less general idea regarding the disturbances of their personality. They are obsessed by the thought that they lost their self, as the others are by the thought that they lost their morality; it is an obsession that goes into the category of the obsessions of shame of oneself, and I have already signaled that in this respect.

Other cases of this kind develop the mental manias of interrogation and of checking, as we have just seen. But in a very large number of cases, I think that, especially at the beginning, when the disease is simple, it is about a sentiment that the patient experiences regarding all his phenomena of consciousness. All these patients have, like Claire, a mania to demean themselves; how is it that they would have come across an idea so absolutely strange and outside of common thought. This idea appears abruptly for Bei..., for Ver..., for Pl... before any mental mania, which for Bei... only begins two years later. Finally, in a very important discussion we shall have to compare this fact with a sentiment that is
undoubtedly very frequent among the epileptics, and it is evident that it is not a matter of obsessive ideas. I therefore believe that this personality disorder is often a primitive psychological change in the scrupulous and that it reveals an insufficiency of personal perception.

Thus, we agree that the sentiments of personality disturbances are very frequent in our patients and present in diverse degrees.

1. — *The sentiment of the strangeness of the self.*

D...., at the beginning of a crisis of dipsomania feels a confusion in her person “it seems to me that I collapse, that my whole being becomes confused and strange, it is an unbearable state and I feel the need to do something crazy to get out of it.” Vof...., a 38-year-old woman, who was bitten by a dog, the first day of her menstrual cycle, of which she keeps a vivid impression; she is not tormented right away by the obsession of the rabid dog, it will only come later. For several months she remains tormented by a sentiment that she expresses in the following way: “it seems to me that I am mortified to have been bitten, it’s as if it had withered me, I am not as I was before, I am no longer the same, *I am an odd person, inferior, lower than I was.*”

Kl...., during the periods of self-abasement that precede the crisis of forced agitation, experiences something like an aura, feels odd, “I feel as if enveloped by something that is not me, that is how I recognize that I am going to have a crisis and that I am going to wonder about the birth of my child.”

Tr... ceaselessly repeats that “she is not herself in the ordinary way, that she does not want to be a separate being and that she will make efforts (motoric agitations) to find her natural person.”

2. — *The sentiment of splitting into two.*

Another, more profound, disorder of the sentiment of the personality is the sentiment of division, splitting into two: we encounter it very commonly. Moreau (of Tours) already noticed that it is frequent in the monomanias.\(^{267}\) Krishaber reports it

\(^{267}\) Moreau (de Tours), *Psychologie morbide*, 1859, p. 208.
repeatedly: “A very strange idea that imposes itself upon my mind in spite of me,” said one of his patients, “is to believe myself doubled. I experience a self who thinks and a self who acts.” 268

“I have the impression of being double, I feel like two thoughts that fight,” Mr. Séglas’ patient also says, 269 “the one which is very mine, who tries to argue but is unsuccessful, the other which would be imposed on me in a way and to which I always submit.”

I observed a feeling of splitting into two, more or less accentuated, in all my patients and I could present one hundred examples of it here. I report only some varieties of this phenomenon. “We discuss me inside, it is as if there were two persons in me.” (Pr... 210) “I contain two people, the reasonable and the unreasonable who fight constantly, the one against the other.” (Za... 216) “I am as though divided into halves, I give myself as entertainment to myself.” (Nah...) “Because that doubles me...” (Ver...) “Since the end of my pregnancy, everything seemed to me new and strange and it seemed to me that I became double...” (Dd... 18) “It is as if there was in me two selves, one thinks a heap of things about life that I never thought, the other one repeats: why do all these stupidities.” (Pot... 19)

Dob... gives a material expression to this splitting in two which if it was general would lead us to make use of a role for the duality of hemispheres. “I experience a sentiment that makes me horrified, I walk as in a dream, my head seems to me sharply divided into two parts, one part is entirely plunged into the deepest inertia, into a kind of dream, so much that the eye on that side seems immobilized to me, the other part remains lucid and belongs to me alone; it is unbearable.”

Lise always feels her mind is split into several persons and they, inside her, always experience several thoughts that take place simultaneously and independently. “There is always,” she says, “a part of my brain that is free and that does what she wants. I never speak without having another idea in mind. I always need to think of thirty six things at once, one is not enough for me.” It goes without saying that she never sleeps

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268 Krishaber, _La névropathie cérébro-cardiaque_, observ. 6.

269 Séglas, _Leçons cliniques sur les maladies mentales_, 1895, p. 125.
well at night. “When I sleep, everything does not sleep. There is a side that does not sleep, which
does not know what to think about and that gets bored. As a result, both sides of the head quarrel.
If I think of cursing God, a part of the mind accepts it and the other part does not and I do not
know any more which is right.” When she gets better, she is quite amazed to no longer have two
ideas at the same time and it bothers her. It is so true and so curious, she wakes with a start at
night, as we have already seen, feeling that there is something abnormal because she sleeps quite
well.

If Lise always only speaks of two persons, it is not the same with Claire. For her the person from
before has absolutely disappeared, she left, it was for the best. “It seems to me that she does not
exist in me anymore, that she cries next to me, that she is delirious, my real person no longer
manages to appreciate things. To replace this real person there arose another, less good one,
which gave way to the third, to the fourth. She formed at least six persons, good and bad, which
appear simultaneously or successively, which manifest themselves through voices, which treat
each other like Judases.” Three of these persons seem to her rather precise, the others are vague,
we do not know what they think. Generally, they quarrel and never all think of the same thing.
To accept an action or an idea completely, it would be necessary for her to make it acceptable to
six persons and she repeats an idea as many times as there are persons, but this work is endless.
She never comes to an end because there are musings that interject themselves. “It is because of
that,” she says, “that an idea is never accepted completely, it always seems to me that there are
persons who did not understand it.” As for Lise, this strange halving also exists during sleep. “In
sleep, there are fewer persons, there were never more than four, but all four dream together.
There is one whose dream is so far away and so empty that we do not know any more what it is,
another one’s dreams are vague but perceptible, the next one: it is the worst.”

When she gets better, it seems to her that she does so by eliminating the persons most recently
formed, it is what she calls “to pass over persons.” They can “physically pass over” when she
finds the state of organic sensibility that appears to her to belong to a previous person; but it is
much
more difficult for them “to pass over psychologically,” that is to unify their ideas: there always remain some who quarrel. On the contrary, when it goes badly, when she gets down, she revives persons. “At the beginning I had in me two persons who thought of two things at a time, now there are six or eight.”

In this last very complex observation we notice a bizarre expression “my real person cries beside me.” If we insist, Claire immediately recounts a multitude of circumstances like this where she sees her real person outside herself. Often she sees herself beside her “attractive, kind, lively, good, as she was formerly, it is a face so different from what I am today,” mostly she sees herself sad: her real person sheds tears upon herself. These bizarre hallucinations which consist in seeing oneself outside oneself are frequently cited regarding the feeling of the depersonalization under the name of autoscopy.\textsuperscript{lxxvi} The ill agoraphobic quoted by Mr. Séglas saw himself a few meters away in front of his body. Mr. Bernard-Leroy cites a patient “who saw herself appearing three or four meters in front of her at the same time that she had the impression of being transported outside her real body, it seemed to her that she attended as a simple witness to the progress of her own states of consciousness as if they were those of a foreign person.”\textsuperscript{270} I have already said regarding the obsessions what I thought of the hallucinations of the scrupulous, they are incomplete and lack reality. The subject “believes himself to see himself crying outside, he is not sure of it; it seems to him that he should be on the outside to cry on himself.” These images are more or less precise, more or less vividly colored symbols which the subject, by virtue of his manias of precision and symbol, tries hard to conceive of how to express this feeling of splitting in two: the sentiment itself remains the essential phenomenon.

5. — The sentiment of complete depersonalization.

Already in many of the previous cases, in the feelings of strangeness of the self, of the splitting in two of the person, they are combined with a feeling of more or less complete depersonalization. Claire says to us very clearly that her actual person is divided, divided into halves, but

\textsuperscript{270} Bernard-Leroy, Revue philosophique, 1898, ii, p. 161.
that it is an already artificial and added person, the real person, from the old days, is completely
gone, she is outside, nearby, she cries. It is a case completely identical to those about which
Taine spoke: at the beginning, the person died, then she becomes some other.

In less complex cases we shall find simply the disappearance, the death of the normal person. To
both of the cases that I have already studied, those of Ver... and Bei.... I add, in summary,
some new cases. PI..., a 28-year-old woman, the depersonalization begins following a pregnancy,
she feels that she is not natural, that she does not live as she lived before, she searches to find
herself by looking in the mirror and she does not recognize herself “it is bizarre that she still feels
the suffering because she is nothing anymore; her arms and legs work alone, because she does
not exist anymore... I reason like everybody and I assure you that it is no longer me, I clearly
sense that I eat yet however it is not me who eats, it is so funny that I cannot divert my mind
from this illness.” This woman at the same time cannot act any longer because something holds
her and forces her to repeat the beginning of an act for eternity. She infinitely repeats the efforts
which are tics and small convulsive movements “because she is afraid of dying completely if she
does not make them.” She thus has, besides the feeling of depersonalization, two characteristic
mental manias, that of repetition and that of the efforts.

Ck, a 41-year-old woman (amorous obsessions, the need of direction, obsession of remorse,
mania of the search, the mania of the expiation), asks only for a single thing “that is to find my
poor and weak personality; I can never find this poor self who for three months seems to me to
have disappeared, this afternoon it seems to me that it is me who suffers, this afternoon I need to
see myself in front of the mirror to know that I am still myself, I am obliged to make efforts not
to believe that I died.”

Léo..., a 36-year-old woman (phobia of thunderstorms, pins, death, mania of expiations): “I do
not know where I am, I do not know where I come from, I lose the idea of myself, I am so odd as
I believe myself half dead and half alive, I am

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271 Névroses et Idées fixes, II, p. 61 et sq.
always occupied with wondering if I still exist.” To... (typical mania of doubt with mania of the search) wonders with fear if she is still herself “or if she is a piece of furniture, an animal, a pig whom we bleed.” Dob..., during a crisis of agoraphobia, is frightened by her own voice “my voice has a strange tone, which hurts me, I am convinced that it is not me who speaks, I do not recognize my limbs anymore, I need to think and to hold myself back in order not to go and try to look for myself, because it seems to me that I stayed behind,” we see that this one speaks completely like Mr. Séglas’ patient. Gisèle, whose obsessions of vocation and all the mental manias I have already very often cited, has terrible fears “because suddenly,” she says, “it seems to me that I am not me anymore, that I have just died, and it gives me a sentiment of madness.”

Finally I shall call upon the observation of Pot... which is very complete, this 32-year-old, always scrupulous woman, who fell ill after her third pregnancy, here is what she writes me: “I do not understand life any more, or the world, or myself, I lost all consciousness of my being. It seems to me that I do not live corporeally anymore, that my soul is separated from my body... I come to wonder if I exist at all... I imagine not being on earth anymore, if I have some life, it is in another world... I cannot put it into my head anymore that I and ourselves are alive... I am tired of this uniform life that lasts for eternity without my being able to realize for how long, I do not understand it anymore. When these feelings take me, I experience the need to caress myself so as to persuade myself that I am all right compared to them and I reproach them for not giving me the feeling that I did not die.” All the disorders of the perception of things, the perception of the self, the notion of time, the need to be loved meet in this observation.

Without trying here to interpret these sentiments of depersonalization, I would only like to raise their relationship to the previous phenomena. Mr. Dugas already showed that this feeling of depersonalization got closer to the sentiment of false recognition of “déjà vu,” he spoke so very precisely on this matter about the sentiment of apathy, about moral atonia. A patient of Krishaber,
whom he quotes, said that he acts on an impulse foreign to himself, automatically. \(^{272}\) “I act like a mechanical device that runs after they withdrew the key that is used to wind it up.” In brief, Mr Dugas proved to be inclined to unite into one group the sentiments of depersonalization, déjà vu, apathy, domination. Mr. Bernard-Leroy also wants to move the sentiment of depersonalization into a larger group, that of the sentiments of strangeness. These sentiments of strangeness can, he says, appear in four forms: 1° the subject has the unanalyzable sentiment that reality is a dream; 2° he has the impression of estrangement, flight from the outside world; 3° it is the subject’s own actions that appear to him with this color of strangeness, of unexpectedness: he then translates his impression by saying that it seems to him that these are the actions of someone else; 4° finally what arises is what we can call the complete shape of the impression of depersonalization when the subject experiences as foreign all his perceptions, actions, memories, taken as a group. \(^{273}\)

These mergers are very interesting and in my opinion indispensable, for a long time I have supported that it is fair to make them bigger still, as I have just said about the sentiments of the strangeness of perception and of déjà vu. In my courses of 1897 and 1898 on the intellectual sentiments that accompany the functioning of the will and memory I tried to show that the sentiment of déjà vu, the sentiments of strangeness, the sentiments of depersonalization come closer to the sentiments of the loss of freedom, mechanical action, domination and merge into the group of the sentiments of automatism. I continue to conceive of this group in the same way, but when it is about the scrupulous it seems to me more fair to merge this whole group of phenomena into the sentiments of incompleteness, the many forms of which we have already seen.

What characterizes the sentiment of depersonalization such as the preceding sentiments is that the subject feels the perception of his incomplete, unfinished person. “I cannot arrive at the unity of my person,” they all repeat, “I cannot attain myself...” In fact, they all know well that they


are not really divided into halves and that they did not die, and in spite of their often exaggerated expressions they do not have a meaningful sentiment of multiplicity and death. It would be too easy to show that a positive sentiment of this kind is a contradictory and impracticable conception. What they have in reality is the negative sentiment of not being enough, not being alive enough, not being real enough. They should say, and we can very easily make them say as soon as we insist a little: “I do not feel the reality of my person enough.” This is what they translate into their symbolic language by the words “I feel that my person died” without realizing the nonsense of these terms. The fundamental sentiment that exists underneath this language is therefore the same that we met regarding action, regarding intelligence, and the emotions, the perpetual sentiment of incompleteness: it is the explanation of this that we must search for.
If most of these pathological sentiments are primitive phenomena and not obsessive ideas, it is necessary to wonder what their significance is. Do they correspond to disorders in mental functioning that we can assess other than as the subject’s conscious sentiments? As our procedures of investigation, whether psychological or physiological, are still rudimentary, this problem is very difficult to resolve and it quite often requires us to limit ourselves to the hints that the observation gives us.

1. — The symptoms of contraction of the field of consciousness.

When we examine these patients who complain to have lost their personality, to not see things anymore as they are, to not be able to act anymore, nor to feel as before, the first idea that comes to mind is that we are easily going to notice in them abolitions of known psychological functions and we immediately think of the disorders that were often described for the hysterical subjects. Do we observe in the scrupulous the disappearance of the sensations, memories, movements as in the hysteric?

This is the first question that we have to resolve.

1. — The anesthesias.

The existence of anesthesias, in particular, would have here a very large importance: it seems that it would explain well enough certain sentiments of privation, incompleteness that we meet
everywhere with these patients. I was, therefore, very preoccupied with the study of the sensibility of the scrupulous, without having reached, I have to confess it, very clear results.

First, it is indisputable that we never observe the grand anesthesias of the hysteric. Never have I found in these patients a vast region of the body, of the internal organs where conscious sensibility seems completely abolished and where we can show the persistence of a certain sensation only by particular procedures. Never do we observe these losses of the muscular sense, which come along with complete paralysis or with Lasègue’s syndrome (movement with the eyes opened, paralysis and catalepsy when eyes are closed, etc.): this first point is completely clear even during the biggest crises of rumination or anxiety. Pinch one of these subjects during the most violent crisis or raise his arm in the air, he will always turn around and will not maintain his arm in the air.

On the other hand, for most of the subjects who are not very sick and especially who are not ill for a very long time, either during the almost normal state, or during the crisis we can with our current means of investigation notice no clear impairment of sensibility. As this point is significant, here are some observations and some figures. With Bei... and Ver..., these two subjects who so drolly maintain that they lost their person and who repeat ceaselessly: “it is no longer me who talks, who walks, who feels, who lives, who sleeps.” The state of their sensibility was especially studied. We were willing to think, as I said on this matter, that these subjects do not have to have the same sensations of their bodies and their internal organs as before. But while trying to record these a priori postulated disorders of sensibility, we experienced a surprise. For Bei..., there is no anesthesia: the esthesiometer generates 2 to 5 millimeters on the palmar face of the fingers, 20 millimeters to the right and 25 to the left on the inferior face of the wrist. These sensations are clear, without errors, unaccompanied by any pain, with no tickle, they are localized in the back of the hand, for example, with a precision of 2 to 3 millimeters, they appear completely like that of a normal person.

To assess and measure, at least in a unrefined way, the said sensations “of the muscular or kinesthetic sense” that appeared to us to have some importance, we also
used the method of the weights. We make the subject feel the weight of small cylinders, from rifle cartridges, as previously done by Galton. These cartridges all appear absolutely similar, but they are filled with lead so as to introduce specifically determined and uneven weights, and the subject’s assignment is to tell, by taking these cartridges, by moving them, by feeling the weight of them, to estimate the difference in weight, which of the cartridges we present to him is the heaviest or the lightest. To make these experiences comparable, it is necessary to choose a weight, always the same for all the subjects, which serves as the starting point. We adopted the 10-gram weight and we express the answers of the subject and the result of this small experiment through a fraction. The denominator indicates the weight taken as the starting point, that is to say 10 grams; the numerator is the necessary additional weight so that the patient acknowledges a difference. By accepting this representation, the muscular sensitivity for the weights for Bei... will be one-tenth for the right hand and two-tenths for the left hand. These are almost the figures that we obtain in a normal individual who is not particularly educated for this kind of research.

The sense of hearing was examined by Mr. Gellé, who was not able to ascertain any modification. The visual sense is not altered at all,

the acuteness is perfect for the right eye and of 9 tenths for the left eye, the field of vision is completely wide (fig. 9). The visceral sensibilities are obviously difficult to measure and we
claim to assert nothing: but, after all, this girl is hungry and thirsty at mealtimes, eats with a very
good appetite, digests perfectly, feels the need to urinate and to have bowel movements; she feels
choked if we close her nostrils, in short she behaves in no way like a hysterical anorexic with
visceral anesthesias. However, in spite of this apparent preservation of all the sensibilities, she
continues to say: “I do not see, I do not hear, it is funny, I feel nothing, it is very odd to be like
this.”

The same study was done again on Ver...; here is the conclusion: “there is no stigma of
anesthesia for this boy. He distinguishes the points of the esthesiometer at 20 millimeters on the

inferior face of the right wrist; he distinguishes very light weights; he suffers as soon as we prick
him: taste, hearing, the sense of smell, sight are not distorted; the field of vision is 90° in each
eye (fig. 10). Is it about disorders of visceral sensibility? They are even more likely than the
preceding, because this sensibility plays a big role in the personality. But where are these
disorders? He has hunger, thirst, the need to urinate, etc., he feels what he swallows,
differentiates tastes as before. We cannot, however, describe visceral anesthesias of which we
observe no indication. To postulate, by virtue of philosophic theories, a link between the
sentiment of the personality and these sensibilities would be to forget the elementary rules of the
clinical observation.”
Since these studies, Mr. Bernard-Leroy had the opportunity to redo the same research on a very similar case. He arrives at exactly the same result, that we are not able to experimentally observe any type of disorder of sensibility. “I first observe,” he says, “that the patient does not present any tactile anesthesia, no significant decrease of sensibility; the localization of sensations is made with normal accuracy. The sensibility to pain does not seem to me to be decreased nor to thermal sensibility either. Vision also seems to have lost none of its acuteness; the field of vision is of normal dimensions.”

If we pass on to the other patients who have obsessions, manias, various anxieties, here are some statistics that we collected: Bu..., a great agoraphobic examined in the middle of a crisis, distinguishes the points of the esthesiometer at the end of fingers when they are separated by 2 or 3 millimeters; on the inferior face of the right wrist he distinguishes them when they are separated by 35 millimeters, on the inferior face of the left wrist he distinguishes them at 30 millimeters; the field of vision of each eye extends 90°. Ger..., examined near the end of an intense crisis of mental rumination, has normal tactile sensibility everywhere: the esthesiometer yields 3 millimeters at the fingertips, 25 on the inferior face of the wrist, 30 on the forearm; the muscular sense examined by the weights results in 1/10. Qei..., who complains to no longer feel pleasure or pain, has a normal tactile sensibility everywhere, I measure the sense of pain with a spring algesimeter (Chéron’s device for measuring blood pressure modified by the addition of a point and by a different scale) and I find 25 on the back of the hand, which is normal. The same observations are made on Red..., Vod..., Bor..., Lod... (esthesiometer on the wrist: 35; algesimeter on the back of the hand: 20; the field of vision: 90°). If we want to observe sensibility at the height of a panic attack, which is difficult, as we saw because the observation stops the crisis, we can be in the presence of subjects who do not want to be touched, who become afraid of the instrument and we can go to a lot of trouble to obtain an answer. When we obtain it,

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it is normal; at most, it indicates a little decrease in relation to the state of the subject’s lapse in concentration.

We can encounter a special difficulty when we experiment on the great doubters who hesitate to answer because they are never sure of anything. I try to apply the esthesiometer to Vi... in the middle of a crisis of rumination and hesitation; she claims to be never sure if there is one point or two points and I have to demand an answer, even if she has to feel unsure of her accuracy. The average of these experiments made in these conditions on the inferior face of the right wrist yields 40: this figure seems to indicate a slight decrease. However, given the countless chances of error, I had formerly accepted that a result of at least 60 was necessary to concede that a case was a clinically interesting hysterical hypoesthesia: the figure observed for Vi... is still far away from that. It is likely, moreover, that this is a slightly elevated figure in relation to the subject’s need for certainty; Mr. Binet clearly showed that the figure given by the esthesiometer is considerably modified by the degree of interpretation that the subject makes of his tactile sensations and it is very likely that it is raised by the need for precision, by the desire to consider as duplicates what are actually very different sensations. We can therefore say that for most of these psychasthénique patients the current methods of measurement do not bring to light any significant anesthesia.

It is necessary to set apart a last and extremely interesting group in which we can find rather distinctly significant decreases of sensibility, especially during crises. Messrs. Buccola and Séglass observed cases where the sensibility was decreased. I also observed one.

Some patients at first use expressions that we are used to finding in the mouths of anesthetics. “During the crisis,” says Bal..., “my hands seem hard and cold to me;” “it seems to me,” says Buq..., “that I have numb skin and that I feel as if ants are there, one would say tiny creatures that roam my body.” Mio... (186) complains of feeling that her neck

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276 Séglass, Leçons cliniques sur les maladies mentales, 1895, p. 75.
and throat are full of buttons. I was not able to examine these two patients except during their crises and I must note that, despite what they say, their sensibility was normal.

For others, the checks yield some results, Qb... complains of feeling more confused on the right-hand side, this side seems to him more numb and bigger than the other one, this is the language of hysteric: I obtained by the esthesiometer a small but distinctly significant difference: 50 on the right wrist and 30 on the left.

Tr... complains that she lost her sense of taste, sense of smell and that all of her face becomes numb, I find the sensibility of the face normal, but the sense of taste is indeed decreased and the sense of smell has almost disappeared. It is true that it is necessary here to take into account this dryness of the mucous membranes that often exists in these patients.

The two patients who seemed to me the most interesting from the point of view of disturbances of sensibility are Lise and Claire. Lise noted many details that show her great numbness. During a crisis of rumination she cut her hand without noticing it; she becomes especially indifferent to temperature, it came to her, while getting dressed, to be absorbed by her ideas and to remain standing for half an hour, half naked in a very cold room without being bothered; she tells me that one day when giving her child a bath while letting herself get lost in a daydream she burned him and she burned her hands without feeling that the bath was too warm. She claims that when the idea is strong, she sees less and she barely hears.

The experiments on checking are very difficult as usual and when their attention is attracted we no longer observe such substantial anesthesias. The sense of touch, strictly speaking, measured by the esthesiometer is only a little decreased, vision and hearing are barely changed, but I was struck by finding a rather serious decrease of the sense of pain. A hypodermic injection that is painful in the normal state becomes completely insensible during the periods of rumination. The measurements of painful feelings with the algesimeter yield rather clear differences so that we can summarize them in a diagram. We notice during the crises of rumination a general hypoalgesia especially distinctive to the right side of the chest and on the shoulder. The figures are 50 and even 85 and 105, whereas when the patient is well, in particular following sessions about which we shall speak, she
does not allow the needle to push in any more than 20 or 25 (fig. 11 and fig. 12).

With Claire, the disorders of sensibility are even clearer. When she complains that her body died, that there is something like a hole under her right breast where her personality falls out, there is something objectively significant. There are a series of regions of the body, in the larynx, in both breasts, in the epigastrium, the lower part of the abdomen where the dullness is considerable, especially to the right side.

![Figure 11. — State of Lise’s sensibility during a period of rumination measured with the spring algésimètre. — Analgesia more accentuated to the right.](image)

The pain of an injection in these regions is appreciated only at 105 whereas in the wrist it is felt at 30. The contact of a hair, following the method of Bloch,\textsuperscript{xcii} is distinctly perceived in the surrounding area and stops being perceived when it reaches these regions. I was even able, which is completely exceptional for these patients, to establish a kind of schema of the sensibility as we did for the hysteric (fig. 13). You should not forget that the shaded parts of this figure do not correspond to the true anesthesia, but at the most to a decrease of sensibility,
especially the sensibility to pain. While considering this figure we shall see that it completely resembles the one that we have already published regarding hysterics with genital obsessions.\textsuperscript{277}

We know that the sensations and the images coming from certain parts of the body have a definite function and, consequently, have a certain common quality, and form a group, associate with certain feelings so as to establish psychological regions. The sensibility of the genitals, pubis,

breasts and sometimes the navel forms a system that is connected to all the genital emotions or ideas: it is interesting to notice that for a scrupulous, who has had genital obsessions for a dozen years, the sensibility of all these regions is disturbed as it is in hysteria. I have already reported the observation of a man who, after twenty years of meditation on obsessions of this kind, also ends up with a hypoesthesia.

\textsuperscript{277} Névroses et Idées fixes, II, p. 434.
of the genitals: the difference with hysteria is always the same, the insensitivity is very incomplete and distinctly suffers only pain.

In summary, we found significant disorders of sensibility only in a small number of cases and still these disorders concern almost exclusively the sensibility to pain and they depend strictly on the degree of attention. In the immense majority of the cases, there was no definite disorder of the tactile sensations and the special sensibilities, finally in no case were we able to note great and profound anesthesias.

I do not insist on amnesia or on paralysis, because really I observed nothing in my patients suggestive, even from afar, of what we observe with the hysterics; there is little more than subjective symptoms. “Bei... maintains that she has no memory, that since her accident, she remembers nothing. It would not be necessary, we said, to take her at her word and imagine that she presents with

Fig. 13. — Schema of the distribution of hypoesthesia for Claire X Localisation of the cephalalgia.

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278 Névroses et Idées fixes, II, p. 65, p. 72.
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real and vast amnesias; question her, if you like, we put to you the challenge to find a real forgetfulness.” “Ver... conceived of saying that he has lost his memory and that he even wants to get exempted from military service under the pretext of amnesia: ‘I remember nothing,’ he says, ‘I cannot hold a conversation, because I cannot follow an idea’ this what he describes, the same trouble as right now, if you search for what type of amnesia he presents, you can find nothing. Question him about it all that you want, he will answer you with endless details: and he continues to say I have no memory, whereas his utterances reveal all conceivable memories.”

Claire also claims to have lost her memory, to no longer remember the past and not to be able to learn in the present. In reality, she recounts everything and when I tried to make her learn 10 syllables by pronouncing them in front of her, she correctly acquired it after 13 trials. This does not indicate a great power of attention, but it is not from amnesia.

Gisèle complains to have complete paralyses at times, I have never observed it: this difficulty that the patient experiences when she has to walk in certain circumstances is connected to the types of crises of fatigue that arise frequently for these subjects; they are not at all real paralyses.

2. — The subconscious movements.

Another phenomenon that we are quite inclined to look for in the scrupulous is involuntary and subconscious movement, the ideal type of which is the automatic writing of mediums. The patients speak as if they constantly observed phenomena of this kind in themselves “I act without thinking about what I do,” says Ver..., “my hands are in charge, it is not me who occupies me,” these patients certainly speak about automatism much more than the psychics themselves. But experimental verification corresponds in no way to this pretense, I tried with a large number of these psychasthénique subjects to reproduce the classic experiments that consist of divining the number that one is thinking of by the movement of the fingers, the experiments of the pendulum myograph, xcv or automatic writing xcv by the tablet method, etc.: in the great
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In majority of the cases, the results are absolutely null and void. As an exception, I obtain some gestures suggested to Lise in her waking state, but she does not forget the hand, she feels it moving and writing, she can always stop it when she wants and there is a lot of readiness to oblige in her compliance. Claire always says that she acts without realizing it; but it certainly does not happen when I want to verify it. She somewhat complies with the suggested movements; she presents at this moment some seemingly involuntary movements of the finger, but like Lise she can always monitor herself, pull herself together, stop them if she wishes it: never is it a matter of genuinely subconscious movements. Moreover, this question must be generalized by looking for what develops, in these patients, from the phenomena of hypnotism and suggestion.

3. — *The hypnotic sleep.*

I had the opportunity to study this question of hypnotism in the obsessives with some care, because most of the patients specifically asked for hypnotic suggestion as the remedy of their obsessions and they lent themselves to it with the best faith in the world with the deepest desire to allow themselves to be put to sleep; for some of them I was able to extend the experiments for three and even five years, in a manner of speaking, without interruption.

Do they attain hypnotic sleep? Here it is necessary to pay attention to the precise words, the scrupulous are individuals for whom everything consists in nuances and in restraint. If we seek a true and complete hypnotic sleep, a typical somnambulism, it is necessary to obtain two things: 1° during the state of sleep a sufficient intellectual process so that the subject can speak or at least understand speech and act in accordance with the suggestion without waking up; 2° a complete forgetfulness upon awakening.

We never obtain these characteristics in the scrupulous. Lise achieves one of the most complete states of hypnoses. The sessions were repeated every week for five years, later we shall see why. Even today, she has not achieved the second characteristic phenomenon, the forgetfulness of somnambulism. This forgetting exists a little, the memories are vague. But on the condition that she makes no effort to look for them.
If she searches for them, the memories become clearer and reappear very well. And still this slight forgetting with which she contents herself began to appear only in the 53rd session.

As for this hypnosis itself, it consists simply of a numbness in which the subject has difficulty moving, opening the eyes. This state resembles what Lise spontaneously feels when she falls once more into an obsession, into a rumination of thinking of the devil. But what is characteristic is that she can triumph over this numbness; if she likes, she can make a voluntary effort and succeed in opening her eyes; she can also with an effort move and speak. But then these movements, and especially speaking, awaken her; so that she complains to be disturbed if I want to make her speak while she sleeps. Add that the mind remains lucid, that she never loses consciousness and continues to monitor herself during the hypnosis.

In that case, however, there are some interesting phenomena of hypnosis obtained by an extraordinary elongation of the experiments: there is a considerable numbness, not only of movements but, which is more curious, of ideas. The patient has difficulty in finding her obsessions and in describing them, there are things that she cannot manage to express in this state and that she expresses well when awake, she maintains, even a few hours after the session, a certain numbness and slight urge to sleep. Finally, this state became rather routine for her to reproduce upon a signal, for example, when I put her hand on her forehead.

In the other patients, I do not even obtain this incomplete result. Lod... barely has a little bit of trembling eyelids, nothing more, no numbness nor movements, nor ideas, naturally no difficulty with memory. For We... a small beginning of numbness after about twenty sessions, no forgetfulness after the session. For On..., and Tr..., nothing else. Mb... falls asleep a little more, but does not present forgetfulness. Kl... arrives at a very incomplete drowsiness, persevering memory.

With Claire, the experiments are difficult, she takes so long to make any action, as she goes on endlessly before accepting that we try to put her to sleep; she would like to speak to me beforehand, to say what burdens her consciousness by beginning from the start. This narrative, supposing that she could make it, would be endless; then she is afraid of what she will say during her sleep, of her
misgivings about the hypnosis, which postpone the experiment. Finally, by dint of patience, I succeeded in seriously trying at least 30 times, which would be more than sufficient to hypnotize completely a person who was even a bit predisposed. The results are insignificant: heavy head, some shivers of the eyelids, a little settling of the limbs, it all stops as soon as she wants to shake herself, even without my order.

Is this truly considerable failure in hypnotizing the scrupulous only due to the way I managed the experiments? I do not believe it, when I put in opposition to these patients the very considerable number of hysterics in whom I was able to induce all possible degrees of somnambulism. The first fact is that the same author proceeding in the same way, achieves the hypnotism as he wants it in the hysteries in several sessions, very often in only one, and that he achieves nothing with the scrupulous even despite one hundred sessions as in the exceptional case of Lise. But there is more to say, fate has made it that many of my patients, either before or after having been studied by me, passed into the hands of some of my colleagues who made the same attempts. A few tried to delude themselves by calling hypnotism any numbness, but all the times where I was able to get precise reports, I noted that none of them had obtained anything more than me.

To cite only one example, Jean was been looked after for a long time by Mr. Dumontpallier who with a great confidence has made every effort to hypnotize him; after very numerous trials, Mr. Dumontpallier was obliged to say to the patient “that his mind wandered too much to achieve the induced sleep.” I also noticed that the authors who have a large practice of hypnotism, like Mr. Bernheim, demonstrate themselves to be adroit and infer purely by the appearance and the narrative of these patients that they are not hypnotizable. In four of my observations, Mr. Bernheim skillfully refused to try a treatment through hypnotism: I do not say that he was right from the therapeutic point of view, these trials of hypnotization can have, as we shall see later, useful results; but from the scientific point of view I find that he was completely right by considering these patients as rebels to hypnotic sleep.

My researches on this point, I am happy to observe,
completely agree with the conclusions that Messrs. Pitres and Régis reached. “In a general way, the obsessives present this curious peculiarity that, very sensitive to the effect of the common suggestion, to the moral comfort of the doctor, they are rebellious to the hypnotic suggestion which did not often take hold of them. In that regard they again resemble the neurasthenics who are for a moment relieved and even cured of their troubles by a simple visit from the doctor and who are not usually hypnotizable.”

It is true that some authors, a very small number, published observations of hypnoptic sleep induced in agoraphobics or obsessives. Mr. Bérillon has reported several, Mr. Auguste Voisin in particular described a very large number at the Congress of Psychology held in Munich in 1896: “phobias and multiple manias, habits of religiosity, improvement by hypnotic suggestion. — manias and multiple phobias, fear of breaking promises, absolute sleep in 2nd session, cured in 4th session. — agoraphobia, claustrophobia, fear of railroads and cars, hypnotic sleep in one session, a cure in 3 sessions, etc....” I admit that I remained very amazed by hearing these communications.

These conflicting opinions appear to me to be able to be explained in two fashions. Either the authors, only worried about the therapeutic point of view, did not bother to specify the diagnosis of the state that they called hypnotic sleep, or they were concerned only about the contents of the obsession and not about the diagnosis of the underlying neurosis and they were dealing with the fixed ideas of the hysteric. I remain inclined to believe that one of the chief characteristics of psychasthéniques is not to be able to present the state of natural or provoked somnambulism that, on the contrary, characterizes the hysteric.

4. — *The suggestion.*

During these completely insufficient and poorly

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280 Bérillon, *Société de médecine et de chirurgie pratiques*, 8 juin 1903.

induced hypnotic states I, however, tried to push the experiments of suggestion as far as possible.

It is again with Lise that I obtained the most interesting results. I tried to induce the most simple phenomena of suggestion, attitudes and movements by suggestion and I suggested to her that her fist closed up very forcefully and that she could not open it any more. Only in the 13th session did this suggestion have a result that seemed rather clear, the fist closed and appeared contracted. Since then, the suggestions of movement seemed to have some success. We can now induce some movements of the arm, the leg raising in the air, or following my hand as if she were enticed by it. Since the 28th session some suggestions can even be executed after the sleep. The patient takes a paper and tears it as I had commanded it during the sleep; she claims not to make a voluntary effort to carry out this act; it even seems that the suggested acts are better fulfilled if Lise does not pay attention to it.

In spite of these seemingly positive results, there are two comments to be made on these acts: 1° There has never been forgetting of the suggestion after its execution. 2° The impulse was never strong enough to overcome the patient’s will, the movements are fulfilled in a seemingly automatic way without voluntary efforts, but provided that Lise allows it, lets it happen while thinking of some other matter: as soon as she wants to oppose to it, she always abolishes them in a definitive way. These remarks are particularly clear regarding contractures. These now seem very developed in Lise and pervade all the limbs: during sleep we can stiffen her completely. But the patient always has to lend herself to it, if she seeks to try to undo these contractures or if I ask her to seek to undo them, she almost at once took back the free disposition of her movements, sometimes after a kind of conflict.

It is also necessary to notice that the suggestions were never able to be developed beyond this quite elementary shape, never was I able to obtain more complex actions through suggestion, I especially was never able to create dreams or hallucinations. Lise indeed thinks of a rose when I tell her to think of it, for a while she has a certain fixed idea and an a little bit of a
rudimentary image. In the most favorable circumstances, she believes she dreams about it, but there is no illusion and she never sees the rose outside of herself. It is equally impossible, even in 56th session, to induce real anesthesia: she claims to feel the injection a little less, but she feels it all the same and does not let us push the pin more deeply.

The same results of suggestion are found in some other subjects with the difference that the phenomena of suggestion are for them generally much less accentuated, some automatic movements suggested to Ger..., to We..., to Claire and that is all. Other obsessed patients, ticqueurs, phobics, when they are completely psychasthéniques and not hysterics, are in no way suggestible.

It was interesting to bring to light through numerous, sufficiently prolonged experiments the smallness of importance of the subconscious movements, of the hypnotic sleep, of the suggestions to psychasthéniques. This characteristic, although simply negative, seems to me to have a certain importance in the interpretation of their mental state.

2. — The disorders of the will.

If we do not observe in the scrupulous the precise and rather special disorders that characterize the hysteric, we should not conclude that all their sentiments of incompleteness are erroneous and that they do not have previous, fundamental disorders in their own sentiments and especially in their obsessions. These disorders are especially in the voluntary activity that is profoundly disturbed in these patients well before we observe their disease and in many cases, if I do not make a mistake, since childhood. The detailed description of these disorders of the will would be endless, I have already done it so often in my other works that I believe I can restrict myself here to a quick enumeration of the main symptoms in order of increasing gravity.

1. — Indolence.

Almost all these persons present, sometimes since
their early childhood, a very recognizable character: they are listless, indolent, sluggards. With variable words, families and patients themselves always describe the same characteristic “what a sluggish child,” as it was said about Tr..., “it is necessary to beat her to make her play as well as to make her work.” Claire was always, doubtlessly, a good child, she claims that she was more active in the past and that now actions are eliminated by the unhealthy ideas; but that is not completely precise, she was always lazy, she always had a reluctance to work “she remembers that when she was young, she already needed to rouse herself to work by threats or promises that she made to herself.” Let us note that this is the girl who has never had the mania of pacts and, however, that work was done by her only through stimulations of the same kind.

As you will be amazed to learn, Jean was always “sleepy, apathetic, indolent, without energy.” Although endowed with a rather superior intelligence, he never succeeded at anything, even in his secondary school. This laziness is therefore fundamental, much earlier than the manias and the obsessions, we find it in all the patients, if not for their whole life, like the previous cases, at least during all the periods of illness.

2. — Indecisiveness.

This general languor can decompose into a certain number of particular disorders of action, the most prominent comes before the action, it is the perpetual indecision that exists in fact, in my opinion, well before that the patient has the sentiment or when he speaks about it, well before he has crises of doubt and deliberation. All the authors who spoke about the obsessives and doubters clearly described this indecision. The examples we could cite of this indecision, we could choose, I repeat, anything except the crises of pathological excitement, Tod..., her whole childhood, spent endless hours to tidy up her drawer because she “could never decide if an object had to be to the right or to the left.” Bsn..., a woman who is at present 51 years old, while laughing tells of incidents of her

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youth: “she was very unhappy when they wanted to force her to tidy up her room by herself, because she hesitated for eternity over the placement of a trinket.” Qei... was always unhappy when she had to choose a dress, a hat or an entertainment. Min... never knows what he wants to do, he needs days and days to know if he wants to take advantage of a vacation day to take a walk: “what I always liked best,” he says, “is when a companion decided for me, his opinion gives me a kind of boost.” Also, he never went out alone even at the age of 20, he did not leave his mother’s petticoats. Naturally, these hesitations are going to become curious when the decisions to be made are more serious; it is interesting to see that these persons hesitate between completely opposite actions, actions so far apart from each other that at first glance the comparison seems impossible. All these women for example, such as Fya..., hesitate to decide whom to marry between several young men, but Renée does better, she spends years hesitating between the religious life and an actress’ life in a small theater. This last livelihood, moreover, she imagines it very clearly as a life of disorder. But, as she said in her innocent language, she spent years wondering if “she wanted to have a wedding or be a saint.” If a decision seems to be made, she changes and disappears at the slightest obstacle: these persons like pretexts and give up on what they had decided due to a cloud, a sunbeam or a more or less real migraine.

This characteristic is in the highest degree in two of my main patients. Claire, since her childhood, and for better reason during her illness, decides on nothing in a firm way, she ceaselessly changes occupation, she leaves a matter, resumes it, leaves it again: she wanted to be religious, then she gave up it, the idea returns from time to time then disappears; she does not know if she wants or does not want to get married. She fluctuates about everything, and this is apart, I repeat, from any frenzy; here is one example among one thousand: she wrote a letter to give to me; she needed a great effort to write it. She comes home and hides her letter, no longer wanting me to see it; then a quarter of an hour later she says to me that she wrote it and shows me, then she puts it back in her pocket, then she gives it to me and here she throws herself on me to remove it from my hands; the same scene because she wants and does not want us try to hypnotize her, etc.
Lise always lived the same way, she had hesitations about religious life, about marriage, about almost all actions. Today, when she goes out into the street, she no longer knows where she wants to go and it comes to her to return after a few steps rather than to choose between the miscellaneous errands that she could make.

3. — The slowness of actions.

Even if the action is decided, it is very slowly made and before it there are manias or ruminations to stop it. The slowness of these persons to get up from bed is classic: they need hours to know if they are or are not awake. Their slowness to make their toilette, to take their meals, to write a letter, in general to make any action is fully observed in early childhood. Claire became demanding on this point, she wanted that we allow her hours to write a short note, to get ready to go out, to sit down to eat. As we noticed before with the hysterics, as Messrs. Raymond and Arnaud described it in an aboulie, these patients divide the action, they use the first day to look for some writing paper, the second to take an envelope and perhaps in a week they will manage to write a letter.

4. — The delays.

This behavior brings an inevitable consequence, they never arrive at anything at the same time as other persons, at the time when it would be needed. When they are intelligent, they moan like Ka... about this character trait that damaged them throughout their career, they are never ready in time to seize any opportunity, “I always allow the moment to pass and I succeed at nothing.” They always delay the effort to the last possible moment: Claire will only speak to me a little at the end of her session when I obviously cannot keep her any longer; she will make some efforts to be cured at the end of her stay in Paris, when she sees that it is necessary for her to return.

A curious characteristic that results from this is the total absence of the notion of an hour. There is nothing more terrible than to have appointments with a scrupulous: a delay of one hour or two,
when they have no obsession on this point, appears to them to be such a little thing and so insignificant that they believe that by arriving they deserve compliments. They point out to me this characteristic of never being on time, which is so clear in Xyb... (209), Vk..., etc., is a true family trait, which is found in the patient’s parents, brothers and sisters.

5. — The weakness of the efforts.

It is very evident that these patients will have a great moral weakness, we saw that they abandon an action at the slightest pretext. It seems to me that they have another certain physical weakness at least in the instantaneous effort: I made many dynamometric measurements, hoping, as I said, to find proof of a certain paralysis during the states of anxiety. As we saw in the previous chapter, the experiments on this point have nothing decisive: but they gave me another impression. I am amazed at the weakness of the figures that we find as the average, So Bu..., a strong man of 42 years, has as an average over 10 experiments on the right hand, 31. Jean, a muscularly well developed male of 32 years, has as the average for the right hand 28.5 and the left hand is 23. Qes..., a strong 25-year-old young woman, an average for the right hand, 22.3, for the left hand 20.7. Claire, the average for the right hand is 25.5, the left hand is 16.9. Lise, an average of 10 pressures, in a first experiment on the right hand 25.4, the left hand, 23.9 in a second experiment an average for the right hand of 23.4, the left hand is 21.7. These figures obviously do not signify a paralysis, but they are weak and indicate very little effort.

The patients, however, imagine that they ceaselessly make enormous physical and moral efforts. Lise has at the slightest job a feeling of effort, stiffening of the limbs as if she carried out extraordinary works, it is the same for Claire.

6. — The fatigue.

As soon as they make the slightest physical or moral effort, the psychasthéniques are exhausted and feel a horrible feeling of fatigue. “It is a topcoat of fatigue that falls on me,”
says Lf..., a 46-year-old woman and this feeling comes along with pains in the joints and muscles, with feelings of the legs giving way, of letting go of the whole body. Jean often allows himself to fall stretched out across his bed and cannot move any more.

Psychologically, we also observe that they cannot follow an idea any more, that their attention no longer settles down at all. Wo... tries to do a mathematical addition: “I have a sentiment of horrible soreness, I spent a big effort that has exhausted my attention, my mind does not settle any more, everything flickers in front of me.” Jean exhausts himself by a reading of some lines; very quickly he no longer understands anything and does not even see anything. It is necessary to carefully make allowance for this rapid fatigue in the treatment.

This rapid fatigue occurs, in fact, in the sensations as it does in the perceptions, the intelligence and the movements. If we continue for some time a contact or an injection to the same point of the body, the impression very quickly stops being felt or it is necessary to press much more strongly to produce a conscious sensation again. If we make these patients listen to the sound of a watch, it is necessary after few moments to move the watch closer to the ear, because they quickly stop hearing it at the same distance as at the beginning. We observe the same fact if we experiment with a tuning fork, in the second or in the third experiment, they no longer hear the vibration as long as in the first one.

We can, I believe, connect the same phenomenon of rapid fatigue with a curious experiment that I presented in 1904 to the Society of Psychology. A device that I had built allowed me to revolve a cardboard disk, bearing colored sectors, at all the speeds from one revolution up to 10,000 revolutions per minute. A special meter allowed me to know the rotation speed at all times. I wanted to see if the perception of the various appearances of the rotating disk and especially if the fusion of colors would occur in the same way and at the same rotation speed for normal individuals and for the patients. For some of the psychasthéniques that we know, I noticed this rather curious fact: the fusion of colors is made much earlier and at much lower speeds than for normal individuals. That seems to show that the elementary visual phenomena of psychasthéniques

cannot be so numerous in the same unit of time and that they arrive faster at confusion and at the fusion. There is also, if I do not make a mistake, a kind of rapid fatigue that prevents the discrimination of sensory phenomena when they become rapid.

7. — The disorder of actions.

This characteristic will seem curious in those persons who have the mania of precision and order, it is however indisputable. We know that there is no chamber dirtier than that of a woman who has the mania of cleanliness: U..., who has a phobia of germs, had succeeded in making a true manure of her room. In addition, there is nothing more muddled than the room and the table of a person affected by the mania of order: these persons tidy up two or three objects with a meticulous circumspection and do not manage to put the rest in order. This characteristic of disorder in actions sometimes manifests

Fig. 14
itself in writing: this fragment of a letter of one of these patients, who authorized me to reproduce it (fig. 14), is completely characteristic. His writing is as confused as his thoughts and he is just as unable to convey it clearly as he is to put a little follow through into his actions. We can also notice about this subject that his writing becomes more and more muddled and illegible as we move towards the end of his note because of the rapid fatigue.

It is necessary to move this disorder closer to an awkwardness of movements that seems very interesting to me. Many of these patients cannot touch an object without breaking it, they cannot learn any undertaking because of their manual incapacity. I wanted to have Jean do some small jobs, to learn to stitch books, to glue papers: you cannot imagine how he shreds and makes a mess without ending up with anything. For others, this characteristic is not constant and exists only during the periods of illness. Simone, who wants to glue together a cardboard building, is upset to have become so dirty and so awkward, whereas when she was younger she did this small job with a wonderful precision.

8. — Incompletion.

In the same way as when we consider the characteristics that appear as a slight disorder of the will prior to the manias and obsessions, it is necessary to stress a detail often observed by the family itself. These persons sometimes begin actions but never finish them: for Ka..., this characteristic exists without him knowing, in a completely curious way. He has not the slightest obsession on this point, he does not even know that his wife constantly observed this feature of his behavior: that he sits down at a task or that he begins to rake a path in his garden to amuse himself, he never finishes what he began, he gets a little disgusted before the end. He also does the same when eating and never finishes what he put on his plate, there is a quite particular instability that makes him disgusted with things when they approach their end.

This characteristic is found in all the other patients and contributes to their characteristic instability. This incompletion of actions corresponds to their doubt and to the oscillation of ideas, as we noted before with Debs in his “Tableau de l’activité volontaire,”
so remarkable for that era.\textsuperscript{284} “the vague desire that is in the voluntary actions corresponds in the intelligence to guess-work, the doubtful judgments to which the mind attaches only an incipient support and that it abandons effortlessly a moment later. Just as there are all degrees of belief, there are between the vague desire and the perfect resolution an infinite number of differently forceful volitions.”

9. — The absence of resistance.

They often use their resistance to the impulse as proof of the strength of will preserved by the obsessions. “It is not absolutely true to say, as they generally believe, that the obsessive’s will is very diminished. Many may give proofs of an uncommon energy and it is very much a reality that they fight their obsession...”\textsuperscript{285} I am not certain that this claimed resistance to the impulse is a proof of an uncommon energy. They have obsessions describe themselves, believe themselves, show themselves in the grip of temptations and they have obsessions fight desperately against an impulse that they invent. What would be a proof of energy would be to stop this grotesque fight and to think of something else and it is this that they cannot do.

As we often pointed out, the weakness exists not only in the active will, but also in the will that is limited to resisting passively. These patients who do not do anything themselves are unable to stand up to those who want to do something. They do not know how to either fight or defend themselves against those who rob them and torment them. I was very struck by this characteristic trait in the childhood of all the patients. They are very unfortunate in boarding schools, they become the victims, the scapegoats of all their companions. Dk... (215) was always tormented in middle school. Jean especially had a pitiful youth in this regard: at 12 or 13 years he was the victim of all the pupils of the school. It was not pranks that they tried to do to him, they made him bear the consequence of all his companions’ wickedness

\textsuperscript{284} A. Debs, \textit{Tableau de l’activité volontaire pour servir à la science de l’éducation}, 1844, p. 25.

\textsuperscript{285} Pitres et Régis, \textit{op. cit.}, p. 36.
and they constantly ridiculed his qualities, his honesty and his kindness: “I definitely knew,” he says, “that I should have defended myself, I knew well that I was even stronger than many of those who tormented me most, but I could not bear the thought of fighting: at the time of defending myself, I became tremulous, paralyzed, I always was a wretched man without defense.” They shall certainly say here that emotion paralyzed the will, we shall see later what must be thought of this theory. For the time being, let us simply notice the fact that they get upset instead of defending themselves and that, in fact, they do not defend themselves.

One of the peculiar consequences of this absence of conflict is that to have peace, they obey everybody. When we speak about these patients, we always say that they allow themselves to be lead, that we make them do and say all that we want and that they obey the first to come along. Bei... Claire give in to the last one who speaks to them and we can get them to go back on a decision after an interval of a few moments. They draw from this the conclusion that they are very suggestible individuals. This conclusion would be contradictory to the experiences that I have just related about hypnotism and about suggestion, also I do not consider it true. Their obedience is in no way due to suggestion, like that of the hysterical.

A suggestible hysteric adopts the act, allows herself to be pervaded by the thought that is sowed in her, and takes it to the extreme, she believes to have decided on the action herself and, although we insist, she even invents the motives for her resolution, in brief she considers herself free and devotes herself quite entirely to the act. The scrupulous is only obeying, he does it unwillingly, feeling humiliated, considering it thoroughly and finding the act stupid he does not adopt it, he does not take this act to the extreme; he only does the least possible without putting into it any faith, enthusiasm, or feeling of freedom. Why does he do it then? For two reasons, first because it would be necessary to fight to resist those who command and second because it would be necessary to make the resolution to do something else: two things that he cannot do. That is why his obedience is in no way the same as that of the suggestible individual.

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286 Névroses et Idées fixes, II, p. 63.
The previous characteristics were, all in all, rather mild, we arrive at more and more grave characteristics that appear when the disease advances and that usually accompany the manias and obsessions, although in my opinion they do not depend on it.

Until now, actions were poorly done, with hesitation, slowness, weakness, but they ended up being done all the same. Now certain actions terminate themselves, that is to say the subject does not manage to do certain actions right from the beginning, without knowing why. We see at first the disappearance of new actions, all those that require an adaptation to new circumstances. Previously, I heavily stressed this characteristic fact of abulia and it suffices to recall that. “All that is new frightens me,” says Nadia while not realizing that she gives the definition of the misoneism. All these scrupulous are creatures of habit who will, for eternity, begin again with boredom and sadness the same monotonous existence and who are incapable of any effort to change it.

To the previous characteristic, it is naturally necessary to connect it to the impossibility of ceasing habits once they are acquired; these persons have an enormous difficulty getting used to a new situation, it is among them that we observe those curious individuals who “cannot get used to his wife” when they get married (Ka...) and who once they become accustomed to it after many years, cannot do without it any more. It is among them that we find all the “manias,” in the vulgar sense of the word before there were real mental manias: going to bed in the same way, having the same place at the table, the same quill and the same blotting paper, etc. “Changes in my habits always upsets me,” says Lise. We shall see, by studying the evolution of the disease, how the big changes, a change of apartments like a change of jobs and especially the big change of marriage, provoke grave relapses.

11. — The social abulias, timidity.

After the new actions there is a category of actions that are
very frequently abolished, it is the social actions, those that must be carried out in front of other persons or that in their conception imply the representation of some other person.

This powerlessness to act in front of people, this social abulia appears to me to constitute the bulk of timidity. Many authors have already stressed these disorders of the will and action in timidity; “shyness,” says Mr. Dugas, “disturbs voluntary movements, paralyzes the will. It most often affects commanded movements while abiding instinctive movements and looks like abulia.”287 “This limited abulia that we call shyness,” stated Mr. Lapie.288 Mr. Hartenberg, in his interesting study on timidity, especially insists on the emotional aspect of the phenomenon of shyness, but he indeed notes, however, this abolition of actions that he calls an abstention. “He avoids the occasions to show himself, this is the precaution of the timid; as these occasions consist of social contacts, there results from it a tendency to seek isolation... for him there is an inhibition that momentarily paralyzes the will, which restrains the word upon lips, which also prevents the timid from refusing or accepting, which prevents him even from expressing feelings of gratitude or tenderness.”289

This inhibition or better this disappearance of the voluntary act in the presence of people, because we shall have to see if it is definitely an inhibition, plays an enormous role in almost all the psychasthénique patients. There are very few, who for a moment of their life and sometimes for all their life, who have not been rendered powerless by shyness.

Here is a beautiful example of this shyness: “apart from the members of my family,” says a patient, “there was a very restricted number of the persons by whom I was not bothered. In front of most, I was absolutely paralyzed, I could not make a simple addition in front of somebody. I was obliged to be fake to mask this powerlessness, to look for pretexts, to break my pencil, to fetch a pocket knife, I kept silent about my addition,

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furtively. I had the feeling that if I admitted this powerlessness, I would be finished, I would be lost, I would no longer succeed at anything.”

Not able to play the piano in front of witnesses, no longer able to work if they watch you, no longer able to even walk into a drawing room and especially no longer able to speak in front of somebody, having a hoarse, high-pitched voice or remaining voiceless, no longer finding a single thought to be expressed when you previously knew so well what was necessary to say, this is the common fate of all these persons, it is the commonplace story that they all tell. “When I want to play a piano piece in front of somebody,” says Nadia, “and even in front of you whom I know well, it seems to me that the act is difficult, that there is embarrassment in the action and, if I want to surmount it, it is an extraordinary effort, I am hot in the head, I feel lost and I want the earth to open and gulp me down.” Cat..., a 30-year-old man, runs away as soon as he hears someone enter, he has difficulty in teaching his class in front of his pupils “I would really do well in my class if only I did it alone without pupils and especially without a headmaster.” “I would like to speak to you,” says Dob… or Claire, “and I cannot, it stops in my throat, I take one hour to ask for something insignificant. I really speak to you well only if I am alone, if you are not there.” Lev... does his accounts well in the basement of the store, but cannot write any more than a figure, because he is taken by a writers’ cramp, when he is put in front of the public. All repeat like Simone: “I would be completed, I would do everything, if I could be completely alone, like a savage on a desert island; society is made to prevent people from acting, I have the will for everything, but I have this will only if I am alone.”

We usually admit that these disorders of timidity are emotional phenomena. That there are emotional disorders, anxieties in the timid, I am convinced of it; this is also true of motoric agitation, tics and even mental rumination, about which we do not speak enough. But you should not forget that this is also true in voluntary powerlessness. Mr. Hartenberg, who explains everything by the emotions, notices it himself regarding Amiel “the simple lack of faith, the indecision through distrust of myself, almost always questioning everything that concerns my personal life. I am afraid of the objective life
and shrink back from any surprise, request or promise that befalls me; I have a terror of action and feel comfortable only in the impersonal, selfless, subjective life of thought. Why so? Because of shyness,” and Mr. Hartenberg adds: “does he mean that at the time of carrying out an act, he is abruptly stopped by a poignant emotion that paralyzes him? No, what he indicates by shyness is the instinctive fear of acting, it is also the fear to make a decision with useful consequences or the misfortune that it includes. It is an illness of the will, as a matter of fact, that he calls shyness.”

Why do we hesitate to apply this apt remark to the other cases of shyness? We are struck by the fact that the timid are incapable of making an action in public, but make it perfectly when they are alone. Nadia plays the piano very well and easily when she thinks she is alone, and Cat... would teach his class very well if there were no pupils, we conclude that from this that they are not powerless to do the action and that it is necessary to appeal to a disorder outside the act itself to explain its loss in public.

Here is a misunderstanding, the act of teaching an imaginary class without pupils and the act of teaching a real class in front of in the flesh pupils is not the same act. The second is much more complex than the first one, it contains, other than the utterance of the same ideas, perceptions and complex attentions to unstable and variable objects, countless adaptations to new and unexpected situations, which completely transform the action. Why can an aboulie individual do the first act but he cannot do the second? I answer simply, because the second is more difficult than the first one. It is like that in all the social acts, because there is nothing more complex for people than relationships with people. That emotions, motor agitations, writer’s cramps, tics come to be added, or better yet to substitute themselves for this action that is not fulfilled is a major secondary phenomenon that must be taken into account; but the essential fact is the incapacity to carry out the complex action and in particular social actions.

This is verified by the examination of the diverse forms of


291 Hartenberg, Les timides et la timidité, p, 106.
this shyness. The shyness brings great misfortune to these persons, they have a sentiment that urges them to want affection, to be supervised, to confide their torments and they do not manage to be able to show themselves to be pleasant, to even be able to speak. Nadia repeats ceaselessly: “I believe that I would not have become so daft, if I had had the courage to confide my agonies to somebody, but in spite of myself I was always very uncommunicative.” They are all “uncommunicative” who feel so much, but who do not manage to express and especially who do not manage to express in front of their fellow men, because expression is an action and social expression is a complex action and because complex acts for them become impossible.

This results in another contradiction, these persons are pursued by the need to love and to be loved, they think only of making friends, on the other hand they deserve the tenderness; should not extremely honest persons with a terrible fear of offending anybody, not wanting any fights and inclined to give in on all the points, very easily obtain the friendship that they seek? Well, in reality they are without friends: they are isolated and find sympathy nowhere and who suffer cruelly from their isolation. How to understand this contradiction? It is because to make friends it is necessary to act, to speak, and to do so relevantly. To draw people’s attention and make oneself understood by them, it is necessary to seize the moment when they are listening to you, to say and do at that moment the best that we can do. Now our scrupulous are incapable of seizing an opportunity; like J.-J. Rousseau, they find on the staircase the word that it was necessary to say in the parlor. They have the idea, they do not decide to express it and if they do decide to like this poor man Jean, they definitely want to speak about it to everyone only when no one is there, but they cannot speak any more as soon as someone is there. So that if somebody is interested in them, they have to conjecture about them, they must make every effort to put them at ease, to facilitate their expression. Then they will hang on to him with passion and will embrace reckless affections, about which we shall have to speak. Such a happiness rarely comes to them and almost always they pay a very high price for it. All these characteristics of their shyness and their social relationships hinge upon, at the core, their fundamental abulia; the reduction or disappearance of social actions that occurs in shyness is one of essential phenomena of the psychasthéniques’ abulia.
12. — *The vocational aboulias.*

After the social abulias, abulias for the acts of one’s vocation appear very often. We have already studied the professional phobias, almost always they began with an “enormous disgust of the job that seemed more wearisome than any other, ridiculous, shameful...” (An... 110) Mr. Bérillon and Mr. Bramwell cite a priest who cannot mount the pulpit, a doctor who cannot make a prescription.\(^{292}\) I find this feeling in all the occupations, for the cleric, the professor, the primary school teacher, the violinist in the orchestra, the blacksmith, the mason. It is because the job is still the most considerable of all the actions of the people who do little. It is there that the abulia begins to be felt.

It is interesting to notice that one of the first described abulias, those of Billod’s notary, is a professional abulia; it is the official documents of his work that the patient is no longer able to sign;\(^{293}\) it is only later that the abulia extends to the other acts.

13. — *Abulia and inhibition.*

We arrive at the gravest disorders that most often appear in a clearly defined circumstance, at the beginning of these crises of “forced phenomena,” of the ruminations, motor agitations or anxieties that we studied in the previous chapter.

Ordinarily, we consider these crises only from a single point of view: from the point of view of the abnormal development that takes hold in the crisis of the secondary phenomena: thoughts, movements or emotions. If we want to pay close attention there is in these crises another negative phenomenon that is even more important than the first one. It is the arrest, the complete eradication of the voluntary act that the subjects were carrying out when the crisis began.

We indeed saw that very often these crises began


\(^{293}\) Billod, *Maladies de la volonté*, p. 177.
regarding actions. Ger... went down to look for some broth, Nadia wanted to play me a piano piece, Jean wanted to mail a letter. Now not only did these subjects begin being delirious, having incoherent movements and fears, but again the initiated action stopped and was not carried out.

We often divide the obsessions into two groups distinguished by Mr. Régis and accepted by Mr. Séglas. On one side, we place the impulsive obsessions in which the subject is urged to carry out, in spite of himself, useless or absurd acts: break everything, make endless cogitations or letting themselves get emotional. On the other side, we put the inhibitive obsessions that stop an action, stop a phenomenon from being fulfilled. This distinction can be useful in practice: for some patients the inhibition can be more remarkable and for others the impulse to the pathological act can be considered as more distressing and be put in first place. But these are only differences in points of view. In my opinion, these crises simultaneously present inhibition or even cessation and the impulse.

There is a phenomenon of abolishing and another that occupies an enormous development in its place. Here is an example that will show well, I believe, how much this distinction between the obsessional inhibition and the obsessional impulse is in reality a small matter and depends on an accident in the evaluation of the patients. Fate made it that I had two patients who had exactly the same accidental event, but, as a result of the environment where they were located, each connoted it in a different way. These two patients, Xyb... (209) and Vk..., are both unable to maintain their household; one act in particular became impossible and provokes great crises of rumination, it is the act that consists of paying the expenditures made by the maid: neither of them can decide to settle these accounts. When they begin to make this calculation, the hesitations arise, the doubts around the bill, the searches, the fears of the maid stealing, anxieties, etc., and the crisis of rumination or harsh anxiety for several hours. This last fact constitutes, if we want, a major impulsive phenomenon, but what you should not forget it is that there is another phenomenon nearby that consists of the fact that the maid was not paid, a phenomenon that we can call an inhibition. One of these patients is home alone with her with children who are too young to maintain the housekeeping in her stead, which makes us
especially notice the negative phenomenon. The patient and her family complain especially about a powerlessness, about a hindrance that Xyb... fails to pay her maid and we make of this disease an obsessional inhibition. Vk..., on the contrary, is surrounded by girls old enough to have completely taken over the management of the household in place of their mother, we reconcile ourselves, therefore, to the fact that this one does not pay the maid; but what seems important is that she suffers from ruminations and we come to say that Vk... has impulses to count, to question, to speak when she is all alone. In brief, the disease appears more for one under its inhibitory aspect, for the other one under its impulsive aspect, although it is at root exactly the same in both cases.

This fact of the more or less complete arrest of certain acts or even all actions is one of the most essential phenomena of the mental state of the obsessed. They may well say that he preserved an intact consciousness, but there is always a considerable lacuna. This is because he is absolutely unable to carry out certain actions regarding which he began the crisis. During her crisis of agitation, Nadia is unable to play her piano piece or to leave her chamber, or to turn her face to the light, or to eat her lunch, etc. The abolished act varies according to the action that the subject was carrying out as the crisis began, but there is always one that is abolished. It is the same for Lise: “as soon as this sentence is formed in my mind,” she says, “if I do this action, then I give my children to the devil, I am not there anymore, my will is stopped...” Jean wants to begin to urinate, when the thought pops into his mind that he is not far from a funeral home and that he almost had to deal with these sad houses because of his masturbations, he has a great crisis of ruminations and phobias; but at the same time it is finished, he can no longer open his trousers and he cannot urinate anymore. Claire is also stopped in her prayers, in her meals, in her walks, in the act of going to the toilet, etc. “It makes me embarrassed to act, sometimes because of one action, sometimes because of another one.”

It seems, as Mr. Sautarel stated, in a thesis on genital inhibition, “that the subject vainly tries to transform an idea into an action, that his will is no longer sufficient to activate his motor system; the efforts that he attempts in this regard succeed only to increase his agitation and his
This is one of the great disturbances of the disease: when it appears in seriously ill persons, it joins with the other fears, ruminations and anxiety, and it is an important problem to know if we must consider it as the consequence of these agitations or if we should regard it as a primal disorder. For the moment, I am content with indicating its frequency and its importance among the disorders of the will that these patients present.

14. — The insurmountable fatigues.

This abulia can extend and abolish an even larger number of acts without inciting, at the same time, these crises of agitation. It regards a very curious and still little known phenomenon that often presents in these patients. These are crises of exhaustion accompanied by a completely incredible feeling of fatigue.

Apart from the constant feeling of fatigue, there are real crises of fatigue. These crises arise for Fz... following sexual intercourse, for Gisèlè following much work for a ceremony, for Jean following the efforts of attention, for most of the patients, Nadia, Lise, Brk... (24) following the efforts that they made to triumph over their obsessive ideas: it is one of accidental properties that we expose during the course of the treatment of these diseases. The subject feels completely exhausted: “it is,” says Jean, “a horrible fatigue, to believe that one is going to fall faint, that one is going to lie down on the ground.” “It is a fatigue like fainting,” says Brk..., “there is such a weight on my limbs and on my eyes and on my stomach that I become unable to do anything.” The fact is that in these cases, the patients become unable to do anything; they remain in bed or drag themselves to armchairs for hours and days. For several days, Nadia, Gisèlè almost do not move and feel that their senses are numb, “all the sensations are in some cotton.” (Gisèlè)

The others, like Lise and Brk..., drag themselves around with difficulty and do not have even enough strength to think of their obsessions, they think of nothing.

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It is for Brk... even a kind of happiness, this absence of ideas, “after so much agitation of the mind, there is a great comfort in thinking of nothing.” Ic... not only thinks of nothing but he finds some pleasure in not making the smallest of movements. “If he is in his bed in a bad position or the contact of an object is painful to him, he prefers to bear this discomfort for eternity rather than to make the slightest movement to push it aside.”

In general, these crises are related to a previous effort and the fatigue does not last long and the patient does not delay resuming more activity and at the same time, regrettably, he rediscovers his physical and moral agitation.

15. — The inertias.

Finally, in the last term, the abulia extends further, the patients do not wait until the action is made impossible by an inhibition, a crisis or a fatigue, they remember the difficulty that they felt to act, and they exaggerate it by their imagination and manage to do nothing more at all. We notice very quickly that all these patients no longer know how to do anything, they remain for whole days without any activity: “I no longer have a taste for anything, I hold objects in my hand without doing anything, I have no occupation any more” Ce... (124), Cht..., Mio... (208 ), Vob... (194).

Those who had a job eventually stop it; Sy... cannot sew any more, nor even to occupy herself by reading. Ver... completely stops working and takes no more work. Cat... who was a primary school teacher wishes to stay in bed without doing anything; if we do not force him to get up, he stays in bed without moving. This desire to remain in bed is found very often, it characterizes Chy..., Za... (216), Xyb... (209), etc. Almost all remain immovable for hours and spend their life sitting in a corner.

The active will proved to be disturbed from the beginning of life: we noted at first the indolence, the indecision, the listlessness, the delays, the weakness of the efforts, the disorder, the clumsiness, the incompletion,
the absence of resistance, then we saw certain acts disappearing, at first the social actions due to
timidity, the professional actions, any acts that are embarrassing, then cancelled and abolished.
The subjects have crises of exhaustion, then finally a general and constant inertia. This group of
disorders of the will forms an important stigma of the psychasthénique state and it is essential to
take it into account and to look for the connections that it introduces with the other accidents.

3. — Disorders of the intelligence.

The disorders of the intelligence as such are much less evident, much more difficult to observe
than those of voluntary activity. It is a point that had already struck the first observers when they
called this disease a madness with consciousness, with preservation of judgment and critical
thinking. Far from seeming unintelligent, the scrupulous very often seem to have a superior
intelligence, to be capable of everything in the realm of the mind, if we do not ask them for
action. It is what Amiel already notes very well about himself: “to love, to dream, feel, learn, to
understand, I am able to do everything if we exempt me from wanting, it is my inclination, my
instinct, my defect, my sin. I have a sort of primitive horror for ambition, for conflict, for hatred,
for all that dissipates the soul by making it depend on things and on external goals.” Amiel
intellectual development is not always clearly apparent: I was often struck by the genuine
intellectual superiority of many of these patients.

In reading the previous pages one has to take note that among the numerous words of the
subjects that I quoted there is a host of picturesque expressions, ingenious comparisons,
metaphors happily cropping up. Their conversation is enameled, there are some for whom we
would like to write everything down and to preserve it all: Gisèle in particular has an
extraordinary and genuinely altogether alluring language. Under this dazzle of words, there are
many fine and fair observations: the scrupulous are very often remarkable

psychologists. Gisèle makes an analysis of love as good as the ‘pays du tendre,’xcvi Jean is celebrated for his appreciation of character and people, he astonishingly dissects the motives of behavior and he is stupid only when he speaks about his illness.

We find in them all sorts of talents and knowledge, they are often very artistic: Claire draws very well, many, like Nadia, are outstanding musicians. We find among them refined litterateurs, we would not be surprised to see among the patients whom I cited some known writers. Rk... translates Greek texts into elegant verse and so made an entire anthology of Greek poets. The ideas that they manage to conceive are often surprising given their environment: we saw the reflections of Vil... on the infinity of happiness and misfortune, the analyses of Mb... on perception. A patient in the hospital, absolutely unschooled in any study of psychology, expressed to me the result of her reflections on the laws of the associations of ideas; a poor woman of the countryside affected by the doubt of her perceptions managed to discover with astonishment the homology of the limbs between fishes, birds, mammals, and man. The most striking case of this intellectual superiority is Nadia. This girl speaks and writes five languages fluently: English, French, German, Italian, Russian. I had the opportunity to put her in contact with a Russian girl who assured me that she spoke Russian completely correctly, as with the other languages. She reads enormously, and knows by heart the literature of these five languages about which she can speak with a surprising memory. She is above all a very good artist; not only does she have a remarkable virtuosity on the piano and on the violin, but she composes music with a very sufficient knowledge of harmony, which I was able to verify by giving her pieces to competent persons to read. She has a very pure taste in all matters of art, and can invent, draw and execute all sorts of decorations. She would be certainly, from the point of view of taste, a superior woman. Reflections of this kind could be made, to various degrees naturally, for most of these patients and, having associated with a lot of them, I have the impression that their group is superior to the average intellect of normal people taken at random.

However, it is evident that their intelligence is not complete
and that there must be lacunae that allow for the development of all the disorders which they present. It is necessary to look for them by examining the faculties that seem able to be disturbed.

1. — The amnesias.

As I have just said, it is evident that the disorders will be encountered infrequently among the abstract intellectual phenomena; the reasonings, the judgments, the generalization are completely correct especially when these operations run in an unintentional way without the patients having to fix their attention voluntarily.

The memory very often seems to be rather exaggerated, Wo... has accuracy in memories, she can, probably as a result of a long habit of this exercise, remember all the sensations that she experienced from one moment to the next, all the words that were said during a visit. Lise preserves for eternity the memory of all the smallest incidents of her life, she complains not to know how to forget; the memory of Jean, we have already seen it, touches the improbable. These memories are so clear that many of these patients, as Lowenfeld said, live more in the past than in the present.

In spite of this general character of the psychasthéniques’ memory, several authors noticed changes of the memories in certain particular circumstances. Mr. Séglas points out that the evocation of the memories is sometimes full of uncertainty, especially when it is a question of finding the memory of a crisis. The patients also believe they have a very bad memory and complain about it very often. In the cases of depersonalization, they maintain that they have lost their memories as well as their sensations. Very often the crises of questioning are caused by the inability of the subjects to remember a memory. Bre... (141) is a remarkable example: since she lost her husband, she is tormented by the sorrow of having forgotten his physiognomy, the features of his face; she cannot evoke in her imagination this image that she loved. So she spends her days searching for the face of her husband, photos seem insufficient to her, she does not recognize him

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sufficiently, she must search better; due to repetitive searching, she feels that more and more she forgets all that has a relationship to her husband’s face. So she can evoke, in her imagination, flowers, monuments, the Arc de Triomphe, women’s faces, but not men’s faces, and especially not men’s faces wearing mustaches. She forgets her husband’s voice, his words, his job and even their marriage. This patient resembles the famous case presented by Charcot with a loss of visual representation; she has the logical conception that “her husband had dark eyes, a big nose and a dark mustache, but she cannot imagine him in front of her eyes.” It is likely that Charcot’s patient, who could “define the ogive and not visualize it,” was a scrupulous of the same kind.

What must we think of these at least apparent amnesias? Mr. Séglas points out precisely that they are paroxysmal, they present through a crisis with a violent impulse to search, which we do not find in the other amnesias. 297

Even in these moments of crisis, are these amnesias always real and profound? We easily notice, especially in the cases of depersonalization, that the subjects really do not have this forgetfulness. As soon as they definitely want to let themselves go, they tell us all that we ask them. It is not necessary to evoke subconscious memories as with the hysteric, it suffices that the evocation is not voluntary. That which makes them ill, in effect, is the voluntary evocation; they have, as it were, cramps of attention on a point and cannot move past it to evoke neighbouring facts: as soon as they do not watch themselves any longer, they easily express all the memories.

This obstinacy of the memories is found, in my opinion, almost always and I am not completely in agreement with Mr. Séglas when he accepts a certain degree of amnesia in the periods of crisis. This amnesia would be important because it would move these crises closer to somnambulism: that does not seem very clear to me. Most of my subjects told me of their crises of rumination and anxiety with an incredible luxury of details. Jean could tell how many times his heart went “plop, plop” and how much “he had to lift the beams in repeated number,” he in no way has an amnesia and I believe that it is like that in almost all the

297 Séglas, Troubles du langage chez les aliénés, p. 100.
others. The misunderstandings on this point depend, I believe, on two things. First, the patient should not make too many voluntary efforts to find the memory of the crisis, it is necessary to wait so that the narrative occurs spontaneously to him; second, it is necessary to avoid looking for this narrative too soon after the crisis itself.

These patients remember much better a matter that is much older, they seemed to me to have a certain degree of “delayed memory.” This agrees, moreover, with the previous remark, we know that the voluntary evocation of memories is all the more difficult when the memory is more recently acquired, all the easier when it is older: it is quite natural that when the power of attention and the voluntary evocation are weak that the memory is delayed.

I believe, however, that we can observe in certain cases after the crises a certain forgetfulness when we question the patients not about their own ideas and their own feelings, but on the events that took place outside them during this period. Claire knows well that she stayed on her knees in toilets because it seemed to her that she had a host stuck on her anus and that she made efforts “to get past this idea;” she knows how the idea took place, the movements that she made. But it is apparent that she does not know if it was her mother or her maid who came to look for her and forced her to stop her contortions. Other patients, Gb... or Sy..., who were sick all day, do not know any longer where they were, if they ate or not, if we spoke to them. There is a certain degree of continuous amnesia for the external events clearly in relation to a state of absentmindedness.

Moreover, generally speaking, the clearest disorders of the memory that psychasthéniques present are connected with a type of continuous amnesia. The patient seems obviously absent-minded, he often repeats the same thing, he babbles, he forgets that he has just told us all this and when one points it out to him, he claims that he did not make these questions and that we did not answer him. “It is impossible for me to retain a word,” a patient of Baillarger has already said, “having read and read again a letter, nothing stays in me as I read, I forget. It’s the same in writing.

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I forget what I have just written.” In some patients whom I have already described in my previous study on “the continuous amnesia,” in particular in the case of Sch... (observation IV), who is completely linked with our group of psychasténiques, we find an amnesia of recent events that develops in a continuous way as life takes place: “she can do no errand, no shopping, because immediately in the street she loses the memory of the addresses and the memory of what she has to do. Or, to the contrary, she does things several times, quite amazed for example to find her bed already made or surprised to notice that her soup is not edible because she salted it ten times. It is only while thinking about her usual activities that she can rather vaguely assume what she did yesterday or this morning. This forgetfulness is not always so intense and so rapid, it increases on the anniversaries of the disaster, it decreases in the meanwhile.” Other observations in this study of continuous amnesia chiefly have a relationship with hysteria in which, moreover, the symptom is more accentuated. But it would be easy to add here many cases just as clear in psychasténiques. We find continuous amnesia in ticqueurs such as Myl... or As... or Lrm..., with phobics like Ku... or Dob... “who does not know any more how she has made use of her days,” for obsessives like Bei..., “unable to remember at the end of two minutes what she herself has just now done,” for Claire “who forgets every bit.”

In spite of the banality of this symptom, which we shall find in almost all the patients, I believe, however, that you should not expect to find it as perfectly clear in the psychasténiques as in some hysterics or as in Korsakoff’s polynéritic psychosis. Very often the memories reappear more or less completely after a while when the subject no longer tries to evoke them voluntarily. There is especially a delayed memory and a disruption of the attention in the fixedness and evocation of the memories.

299 Baillarger, Recherches sur les maladies mentales, 1890, I, 568.

300 Névroses et Idées fixes, I, p. 115.
These disorders manifest themselves, moreover, in many ways. The subjects obviously did not take advantage of the education that they received, as would have been done by normal individuals. Lo... (213), who attended all possible classes, in reality does not know much, she is behind the young women of her age placed in the same conditions. This fact is even more obvious with Jean: he pursued all the classes of secondary school, he was helped and supervised as much as possible, I continue to think he is intelligent based on his speech and his psychological and moral analyses; however, he reached the elementary examinations with great difficulty, he was not able to continue the study of law and as a matter of fact he knows almost nothing of what they tried to teach him. I have already indicated the bizarre sentiment that compels him to develop general ideas, but this sentiment corresponds to something legitimate. He has an extraordinary memory for dates, raw facts, but he has no general education. Red...’s illness began later, at about 18 years, her progress stopped at this time and the scientific studies that she previously pursued perfectly became too difficult for her.

These lacunae manifest themselves especially in the exercises that require precision and composition. We could believe that the arithmomaniacs, who always want to count and who search for a very great precision, are going to have a disposition for mathematics. It would be a large error: they loathe mathematics itself and are unable to understand the slightest geometrical reasoning or to solve a small problem. I tried very often to perform a logical argument of this kind in front of them, nobody even let me get to the end, and it is evident that they understood nothing there. An exercise that most do not manage to do anymore is writing a composition on some subject. They especially dread the descriptive subjects where it is a matter of real objects; they prefer ideas, especially abstract ideas. Gisèle points out that she understands ideas better than concrete things. Vye... definitely wants to occupy herself with psychology but not physiology, this is an important fact to which we shall return. But they cannot put their ideas in order, they want to be able to talk.
about it profusely, wildly; they cannot coordinate a written composition. It is one of reasons that they have so much trouble writing to you and sometimes speaking to you. We find here a curious characteristic that we indicated from the beginning of this study while describing the attitude of the patients. Their embarrassment, their difficulty expressing their disorders depends not only on their ideas, on their feelings of embarrassment, but also on the impotence of their mind to coordinate and to be expressive.

3. — The unintelligence of the perceptions.

It is not easy to bring this intellectual incapacity to light by a quick experiment. Almost always the patients are still capable of fixing the mind for a moment when we incite them: they do not behave like certain hysterics who read some lines aloud, who even recite them and yet understand absolutely nothing of what they read. It is necessary to make them read pieces that are longer and a little more serious; it is especially good to let them read for only a few moments and to question them then about what they read. I often did this experiment with Tr..., Lo... and with Claire and I often noticed that these subjects had grasped their reading very poorly. They always asked me to let them begin again and read the same piece again several times in succession. It was not all due to a mania of repetition and a false feeling of dissatisfaction: the understanding of the piece was really quite insufficient.

We can sometimes even notice and see that the patients not only have conscious obsessions, as we call them, whose falseness they definitely recognize. They also have false ideas about their situation and about the persons who surround them. They do not take into account the opinion that they inspire, they believe that their situation is not grave in the most hopeless cases, they continue to believe a crowd of impracticable things are possible. Lo... got married, left her parents, lived for two months with her husband without taking this situation seriously and without understanding it; she suddenly leaves her husband and returns to her parents; the husband asks for a divorce, etc. None of this interrupts her dreams, this young woman
repeats, while smiling, that she is quite surprised at being called Madam; she does not take into account having really been married. It is certain that this poor woman does not at all feel the gravity of her situation. Xyb... dismissed a domestic then she took her back a short time later. Apart from her hesitations and her obsessions, she has made a completely wrong evaluation of this action. She believes she owes extraordinary compensation to this domestic, she believes that the “common relations of master to domestic no longer exist between them, this maid no longer has a place in her imagination as a domestic, she feels bound towards her maid by something, etc.” I insist on this point, the patients not only have conscious obsessions, they have inaccurate ideas which can easily become delirious ideas.

This defect of intelligence does not usually manifest itself in simple conversation, we observed a disorder of auditory perception only in two cases, first when the patients are in the middle of a crisis of rumination or a very strong anxiety, often they understand nothing of what we say to them, but this disorder generally lasts only a brief time. We also observe it when they try to listen to a conference or a sermon for a long time. Claire was upset at the beginning because she could no longer understand sermons, she blamed her religious sentiments; in reality, she could follow the clergyman’s words for only a short time. Jean puts in a lot of diligence to follow literary conferences but he scarcely takes advantage of it, because he can listen to the professor for no more than a few minutes, his mind leaves and thinks of other things.

4. — Disorders of attention.

These changes in the result of mental work reveal rather grave disorders of attention. It is, indeed, a fact of common observation that the obsessed are in a state of perpetual distraction. Baillarger already noted “the lesion of attention in monomania.”301 Buccola and Tamburini stressed the exaggeration of

spontaneous attention and the decline of voluntary attention. We can say that the main disorder consists not in an abolition of the intellectual faculties, but in a difficulty fixing the attention. They always have the mind distracted by some vague preoccupation and never give themselves completely to the object which we offer them. It results from this division of the mind that he only gives a little strength to the main operation. They have difficulty in performing mental operations as soon as they become a little bit difficult, they understand poorly, do not have overviews, become muddled extremely quickly as soon as the object of study is a little complicated: Xyb... admits that she loses her head as soon as she has several operations to be done at the same time. If somebody enters while we speak to her, she does not understand anymore. She would want, more than anything else, to be at the greatest peace to read a sentence or answer a question. “As soon as I receive a visit,” says Lib... (117), “I can no longer fix my attention on a simple embroidery, I have my head full of things, I have to be absolutely alone to settle a little on something.” “It became very difficult for me to be present,” said Wo..., “all the time people shake me and say to me: of what do you think? I feel this difficulty especially when I try to play the music for four hands, I, nevertheless, may not say to the person who plays with me: I am not there, wait for me. I need an enormous effort to continue down-the-line and not leave on some search.”

Even when the attention settles a little, it always has another defect, it is its extreme brevity. You should not maintain the same operation for a long time, the patient quickly stops being interested in it: Jean can follow a study only for a few minutes, even without his manias on this subject, at the end of three or four minutes he begins making you repeat and does not understand anymore; it is the same for Mm... who cannot prolong a conversation for more than a quarter of an hour. Claire ceaselessly changes activity, she leaves a thing and begins it again, it annoys her not to be able to fix her attention and she falls into her manias. Lise complains of not being able to go to the end of an addition. For Simone, the fact becomes unrefined: I manage to tear her away from her obsessions by interesting her in the botanical analysis of a flower. Everything goes very well at the beginning, by attentively listening to her, she becomes pleasant,
she asks about what she does not understand and no longer manifests delirium. These nice dispositions lasted no more than four or five minutes; then I definitely see that her face changes, she stumbles and does not understand anymore, she rubs her forehead as though she suffered there; if I continue, she is going to get angry and fall into a crisis of deranged agitation.

We observe the inverse fact when it is about an association
of ideas that returns mechanically. The subject ceaselessly returns there, he cannot speak any more about the other thing. “I noticed,” says Trélat, “that when his ideas concerned a subject, he thought only of it and no longer spoke about any other matter.”

I would have deeply wished to make obvious this brevity of the attention through measures and graphs and to verify Mr. Buccola’s observation on the increase of response times. The difficulties are very great: seriously ill persons do not lend themselves to the experiments, the others are momentarily changed by the device, finally the techniques of measuring the attention are

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302 Trélat, Folie lucide, p. 57.
Fig. 20 - Curve of the time of simple reaction to tactile stimuli for Qes...
still insufficient. I, however, tried to obtain for some patients the graph of response times following a method that was discussed in a previous work. The graphs of attention via the curve of response times, taken with Bei..., are not very characteristic. When it is about the simple response time to tactile stimuli made on the back of the left hand or the right hand, the curve is barely above normal, and it rises just a little under the influence of fatigue, as we see in figures 15 and 16 borrowed from our books on the neuroses and which represent an experiment of a quarter of an hour in duration. In figures 17 and 18, which represent reaction times to auditory stimuli and to visual stimuli, one notes a significantly greater elevation than the curves that better demonstrate the reduction of attention. The two curves (Figures 19 and 20) obtained by the same methods on Qes ... are interesting: the curve of responses to

Fig. 21 - Curve of the simple reaction time to visual stimuli for Gei ...

303 *Névroses et Idées fixes*, I, chapitre 2, La mesure de l’attention et le graphique des temps de réaction, p. 69.

304 *Névroses et Idées fixes*, II, p. 69.
tactile stimuli and the responses to visual stimuli are both far too high. This elevation is a little less great in figure 21 that shows the curve of Gei...”s reactions to visual stimuli. I have already pointed out all the criticisms to which this mode of measuring attention is liable. These researches add little to our previous observations on the weakness of attention, they only confirm them.

5. — The reverie.

This disappearance of attention results in their thoughts very much resembling a state of daydreaming, a perpetual reverie. Every action provokes associations of ideas that go absolutely adrift without the patient being able to manage them. “My ideas,” says Lise, “are essentially never clear, I am unable to manage there. They come suddenly, occupy the mind for one-half of a day and then go away. I have a paralysis in the head that prevents me from shaking them off.” We... (170) dreams all day long, she herself notices that her ideas appear at night in a dream in the same way as during the day. There is for her no great difference between waking and sleeping.

With Claire, the musing is very well described. “I always dream about so many things that I do not even know the half of it.” They are not always ideas having a relationship to her delirium, they are things that she saw, which come, she does not know where from, which merge confusedly and she cannot fix one of her ideas without a crowd of others coming around. “When I look back, I do not know how I lived, I find endless musings on everything. All my thoughts turn into a dream; when one speaks to me, when one touches me, it makes me jump as if I was not there anymore, as if I was always in another world.”

Gisèle pointed out that she is never completely in what she does because there are always three lives in her: the outside life is in touch with things from the outside, it is the least developed; the internal life of the reflections, the most interesting and the most developed; and the third life that she poorly understands and that she feels at the core of herself as though something dreamed
in her even more profoundly. These divisions of thought that occur when the effort of attention decreases would justify Mr. Espinas’ very accurate phrase that “a weakened consciousness is a scattered consciousness.” We shall not be any more amazed at the musings of Lib..., which I described as an accident, a diffuse mental agitation: it is only the exaggeration of a stigma that we find in an attenuated form in all the other patients.

In these conditions, it seems very difficult for these minds to arrive at a clear conclusion on a fact or on a reasoning. Krafft-Ebing said precisely that what strikes us at once is the impossibility to bring these patients to a conclusion.305 This sentiment of doubt that we noticed in the sentiment of incompleteness is the expression in the consciousness of this insufficient work of the attention. “It is,” said Mr. Ribot, “a state of constant hesitation for the most useless reasons with an impotence to arrive at a definitive result.”306

6. — Mental eclipses.

I would like to point out, regarding these disorders of attention, a very curious phenomenon, the full importance of which we shall see before long. Simone comes to complain of often feeling a peculiar standstill in her thinking. Suddenly, she stops in the middle of a conversation and remains for a brief moment without speaking, then she recovers; sometimes she continues her conversation as if nothing had happened and her parents alone notice the small interruption; often she remains a little disturbed and needs some efforts to know where she was.5 This fact seems to me all the more curious as for this girl it preceded by a few months and announced the arrival of great obsessions of shame of the body, which took a long time to develop. The same fact appears for Gisèle, a grand scrupulous. According to her expression, “she loses her ideas,” but it appears, she claims, that it is a frequent phenomenon in her family and that her brothers are also used to losing their ideas from time to time.


The diminution of attention can therefore take some of them up to the point of eclipses of thought as the diminution of the will arrives at complete inertia.

4. — Disorders of the emotions and of the sentiments.

The study of the emotions and the sentiments of these patients would be particularly fruitful, I believe, because it would explain many of the other facts, but we always find the same difficulty; the disorders that appear and that are indisputable are they the results of the patient’s absurd ideas, are they created by his frenzy or do they come prior to this frenzy and do they form the natural core of the disease? Very often the patients themselves connect the disorder of their emotions to a kind of restraint that they suppose is almost voluntary, it is what often makes them timid: “there is in me,” stated Amiel, 307 “a secret inflexibility to let a true emotion appear, to say what I please, to abandon myself to the present moment, a foolish restraint that I always observed with sorrow... my heart never dares to speak seriously, I always banter with the moment which passes and I have retrospective emotion. It feels abhorrent to my refractory nature to recognize the solemnity of the hour where I am, an ironic instinct that results from my timidity always makes me skim lightly over what I want under the pretext of something else and from another moment... Fear from training and the mistrust of myself chase after me into the emotion.” Is this arrest of the sentiments really a restraint due to fear from training, or on the contrary is this alleged deduction not invented to explain it?

The same problem arises regarding the ideas of scruple that seem to be the reason for this arrest of the emotions. Lod... complains about a matter that irritates her intensely, it is that she cannot have fun anymore, be delighted, take good-hearted pleasure in something. When the pleasant excitement arrives and when the pleasure is going to arise, she is stopped, she can no longer surrender to the sentiment whatever it

is, she has to think of something else and her ordinary ideas. Her problems appear: she has to resolve them first, before continuing the enjoyment. A hat pleases her, immediately there appears the idea that it is a selfish satisfaction. She wants to pass by, she has remorse as if “she had the idea of sending religion for a walk.” She listens to a comedy in the theater, it is necessary for her “to put straight her ideas on God” before being interested in the play. She cannot take pleasure in the music that she plays, it would first be necessary to get rid of the idea that she thinks badly of God. She has a friend whom she likes very much and cannot allow herself to come to the pleasure of affection, to the simple pleasure of kissing him, because she has the idea that she would have been quite able to kiss him on the lips and that this would be contrary to chasteness.

In listening to this language, we are brought to think that she is especially delirious, that it is she who abolishes her pleasures because of the scruples that persecute her, and we have tried to say to her: “Do not think anymore of the good God and morality and you will have fun.”

The question is more delicate, because this arrest of pleasure is found in many patients who do not exactly have either obsessions or phobias on this subject and whose emotions stop, however, in the same manner without there being either a definite idea or a fear that can act as a pretext for this stoppage. For many, ideas appear and proliferate after this stoppage but without having any relationship with the antecedent emotion, for the others the arrest of the emotion is followed by no particular disorder. It thus seems that for these patients there is a fundamental disorder of the emotions and sentiments, independent of the other phenomena that we have just studied.

On the other hand, we see developing in many of these patients a large number of special sentiments that we do not find, at least to the same degree, in normal individuals. For some of them, these needs or these strange love affairs are accompanied by intellectual phenomena, obsessions of the same kind, but for many it is not like that and the abnormal sentiments develop outside of the subject’s contemplation, almost without him knowing. These sentiments are adjacent to the sentiments of incompleteness that have just been studied, but they are not identical to these phenomena: rather, they are alterations of natural sentiments that exist in all men. These remarks lead us to study, in the following paragraphs,
these primitive modifications of the emotions and the sentiments.

1. — *Indifference.*

It is necessary to put in the front row of primitive modifications a very important and unexpected modification of emotions. We are always inclined to believe that these patients are emotional persons and we imagine that they feel all the emotions and all the sentiments to a supreme degree. There is perhaps some truth in this opinion, if we consider the emotional shocks that quickly upset the equilibrium of thought; but this opinion is certainly very exaggerated if we study the emotions and sentiments that must extend themselves for a certain time and that consist of more or less developed tendencies in consciousness.

Indeed, it is essential to notice that most of the patients complain of becoming completely indifferent. Al..., a 27-year-old woman, became a patient after an absurd marriage to a semi-insane and sexually perverted individual, and after a scandalous trial of more than two years in duration, notices very clearly the change that was made in her character. At the beginning of her adventures, she was incited, angry, very desolate about her marriage, her trial, in brief, her misfortunes that she deeply felt. Very often she allowed herself to go into crises of despair, she cried and lamented. Now everything is changed, she does not cry anymore, is no longer upset, she became indifferent to everything, she thinks of her husband without it doing anything to her: “I have no desire,” she says, “no regrets, no ambition, nothing is bad, nothing embarrasses me, nothing opposes me, nothing has pleasure for me.” Nadia complains of not to being able to get upset and not being able to mourn her mother. Kl... and Wks..., who were formerly very lively and very angry became calm and no longer have their fits of anger. Vil... is indifferent to reality and is interested only in his dreams. What is especially affected by this indifference are the affectionate sentiments for family and friends, and this coolness contrasts with the love that they had before for those whom they chose as spiritual advisers.

According to the confidences of some patients, we can comment on an emotion that usually is intense, the genital emotion. It is curious to notice that persons formerly
very excitable on this point became almost completely cold and feel a real genital numbness, this remark was made by a dozen subjects. For some, this numbness even causes an exaggerated and bizarre search for sexual excitement that can be transformed into a real frenzy, as we see in the observations of Loa... and Len... Some allow themselves to masturbate with a kind of frenzy “to get to the end” of the emotion, it is that which they became incapable of doing.

In many patients, men and women, this arrest of the genital emotion is accompanied by none of the manias nor by any other obsession. Their intellectual disorders or their phobias bear on quite different matters; they have no disposition to reproach themselves for the genital act completed in normal and justifiable conditions, they do not want to change it or to improve it. They note only that they previously felt a violent emotion that grew to its upper limit, then abruptly stopped while leaving a feeling of satisfaction and reassurance and that now things have changed, that this emotion begins and develops imperfectly, and that it never gets to its upper limit followed by reassurance. Even more, some had paid no attention to this fact and are quite surprised when we point it out to them. There is, therefore, next to the feeling of genital incompleteness that we indicated and that could be more or less accurate, a real numbness that does not seem to depend on the subject’s evaluation.

One would not need to conclude that all these sentiments have completely disappeared and that we are in the presence of the moral anesthesia that we observe in some hysterics. The patients have the emotion or at least they begin having it, but these beginning emotions quickly stop, cease developing or are transformed into ruminations or into anxiety. The patient realizes that his sentiment is not complete, is not finished and on the other hand he dreads these painful transformations. He himself comes to dread his insufficient sentiments, which, if he tries to extend them farther, give birth to painful crises and he eventually makes this stoppage a voluntary restriction that, at first, naturally arose. Since he has scruples, On... is afraid of anger, of emotions, he is afraid of sexual excitement,
he fears surprise, “he fears letting himself get carried away by whatever it is.” He obviously makes himself more indifferent than he would spontaneously be.

As the fact seems to me extremely important, I once more report about the observation of Lise that confirms all the previous remarks. This person seems to be inaccessible to any emotion. “It has been a long time since she gave up taking pleasure in something and she does not even think of complaining about it.” The indifference is noted not by the patient, but by the family who observes it and tells me these details. Lise has no intimate friend, no desires, no whims, no serious fears even when the children are sick, no impatience towards a completely unbearable husband: she is admirable in her peace and reason. If we knew her to be reasonable, we could admire this peace, but as we know the disorder of her spirit, we can wonder if this good behavior is not a pathological symptom.

When we search for the origin of this indifference, we are at first glance inclined to consider it voluntary. We notice that she has been very affectionate, that she sometimes even has a great sensitivity of sentiments; she claims that she is capable of getting angry like any other person and of feeling pain and indignation. But all this only potentially exists and no longer develops itself; because it seems to her that she stops herself: “if the emotions developed to a certain extent,” she says, “my ideas, my terrible ideas on the devil, the doomed children, etc., would appear and would dominate me in an irresistible way. If I let myself go to the excitement or to the anger for one minute, I am not the chief of my ideas any more, they appear with strength and are going to persist for a long time.” As a result, she has a hideous fear of allowing herself go to an emotion, she watches herself constantly, is never allowed to get to a complete emotional state; even in the middle of the violent scenes that she is present at, she keeps her composure, there is always a part of herself which does not take part in it. She is also afraid of being allowed to get to an emotion by attending the theater or by listening to some music; in brief, she works to maintain in her a state of indifference, so she figures that it is she herself who stops the feelings.

I believe that her will and her caution contribute a little to decrease the phenomena: but according to her confession and according to the observation
of the other patients, her emotions would stop themselves alone, perhaps at a slightly higher intensity, and would be transformed against her will into ruminations and into anxiety. These are obviously phenomena of a different nature than the emotions of joy, affection, artistic pleasure which had begun to develop. We can note on this matter a small, rather demonstrative detail. Lise endured for ten years, without getting angry and without complaining, the bizarreness of her husband’s character. When she begins to be cured, she can no longer keep the same peace. Although she again wishes to stop the emotions and especially the manifestations of the emotions, she does not succeed at that anymore and in spite of her will she gets angry and she suffers from this marriage. It was, therefore, definitely an unhealthy state that prevented her from suffering from it.

These observations are completely concordant, they are easy to verify and show that these patients have much fewer sentiments and normal emotions than we are inclined to believe.

2. — Melancholy sentiments.

The sentiments that remain with a certain acuteness are the sentiments of sadness similar to those that we meet in the melancholic. The abolition of any lively emotion joined with the depression of any activity gives birth to a perpetual feeling of ennui. Mr. Tissié points out very clearly the role of the sentiment of boredom in all fatigue. “The sentiment of ennui dominates all the psychoses and we always find it at given moments in intensive excercise in all the most cheerful and best balanced subjects...” It is not surprising that we find this sentiment in all our perpetually tired psychasténiques.

Ku..., Dk..., Dd..., etc., all, moreover, repeat that they cannot take part in the joys of life any more than in its sufferings for that matter and that they get incurably bored. Lise claims that she was this way from her early childhood, that she never had fun completely and that she was never able to allow herself to go to a pleasure or to some emotion because of a burden of incurable boredom.

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They have no great sorrows but they have a vague sadness that consists rather in the absence of any enjoyment than in a real feeling of sorrow, it is a nuance of ennui. Qsa... (108) is always morose: “he does not like seeing cheerful people who irritate him, he feels that he could be capable of gaiety if his disease did not separate him from all things.” Claire complains of saddening herself constantly: “I do not like myself... because I detest myself..., I bore myself and am saddened by not seeing myself.”

Gisèle, Jean, Nadia wail about this lifeless existence to which they are condemned “I was always very sad even in the happiest moments of my life, it is a bad existence.” “I cannot even take a pure pleasure in the music that I like so much; I blend sadness into everything, I have a mind magnificently organized to be unhappy.”

This sentiment of sadness gives its nuance to all perceptions and to all ideas. Claire spreads this ennui and this sadness across the universe “it seems to me that everybody must be unhappy and all the places that pleased me in the past seem sad to me as if the whole world which is not very real was always about to die, to collapse.” Jean, as usual, exaggerates these melancholic inclinations: on many occasions, regarding certain persons and certain places, he is pervaded by “the feeling of the end of the world.” When he leaves a place that he liked, when he learns of the death of a relative who lived in such region, when he has a sad, depressing emotion in a place, he is invaded by a sentiment of deep sadness, by a sentiment of death that applies only to this place. We have already seen these sentiments of dying in the moral anxieties, but what is special in Jean’s observation is that the feeling combines with the thought of a region “in this province everything died, it is the end of the world for this province.” Soon the mania of generalization is going to seize the sentiment and all the surrounding regions, all of western France is going to have died. It is easy to see the connection of such sentiments with melancholic frenzies: with our patients, they remain in a state of vague sentiments without being transformed into a clear idea or especially into an idea accepted and believed by the subject.
3. — Emotionalism.

We meet patients, however, who appear to behave otherwise and it is from them that this common opinion that the obsessives are extremely emotional persons is formed.

First, there are the timid, almost all our scrupulous were shy, now “to be shy,” said Mr. Hartenberg, “it is necessary at first to be inclined to feel a certain emotion in certain circumstances... it is a spontaneous, blind, irresistible emotional reaction that arises due to the mere fact of appearing in public, as dizziness occurs at the sight of an abyss.”309 They are followed by the ticqueurs “who are all emotional persons, affected by a muddled affectivity.”310 Then all the phobic whose disease consists in an irresistible tendency to disproportionate emotions.

So it is not surprising that many of our patients complain about their excessive emotionalism: for example, Vr.... Brk... observe that for them the slightest feeling takes enormous proportions, surprise, word sent abruptly, the sight of an accident in the street gives them hot flushes to the head, heart palpitations, suffocations, breathing in sighs for more than ten minutes, “the slightest of aggravations,” says Za..., “becomes for me, after a while, the cause of nervous trembling, jerks in all the limbs and completely absurd crying fits.” Wo... begins melting into tears at the slightest of things. These exaggerated feelings appear especially when it is a question of presenting oneself, of doing an action in public: when Ul... is in front of someone, she feels squeezed in the throat, she feels a big weight that crushes her chest, she chokes, she feels as though all the muscles in her face and eyes were in convulsions. This description is commonplace, we could find it repeated by hundreds of patients.

Does this complete emotion and disposition contradict the previous one? In a sense, yes, it is a certain form of emotion, it is in reality more or less completely a panic attack that appears; and does not it seem that having constant panic attacks is to be an emotional person?

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It seems to me, however, that there are many reservations to be made about this emotionalism. This emotion presents at first a very curious character that deserves to draw our attention: it is delayed, “retrospective,” as Amiel said. These patients often stay perfectly calm in the face of the event that should upset them, they behave as if they were completely indifferent. The cardiac and vasomotor reflexes that, following the theory of Lange and James, should immediately accompany the event, prior to any clearly intellectual work occurring in any way. However, everything is not finished: at the end of a few hours or at the end of a few days a job was done in the brain about this event and the patients have palpitations, endless tremors as if they were violently moved by this event that, in its present reality, had seemed to pass unnoticed. Claire finds a man who injured himself by trying to commit suicide, she has a peacefulness incomprehensible for a young girl, she remains indifferent all day long; but she is sick with emotion the next day. The same observation in a crowd of circumstances for Nadia, for Jean, for Gisèle, Dob..., KL..., etc. This fact of the delayed emotion seems to me very interesting, it must be moved closer to the delayed action that characterizes aboulics, to this delayed memory that I have just stressed. In brief, for certain patients, an event to which there is no reaction, only creates the seemingly appropriate psychological phenomenon after some time goes by.

Another character of this emotionalism of psychasthéniques is that it remains a vague, indeterminate emotion, an anxiety, that is to say the lowest of emotions and that it is little adapted to the event that shapes it.

The patients themselves notice that this emotion has a bizarre character, it is that it is always the same, it happens also regarding events that should create fear, or those that should create some anger or those that should create joy. We can verify it very well with Ul... who has the same phenomena of suffocation, convulsions of the face and the eyes from receiving a letter for which she waits or from entering a local train. The panic attacks of Cs... seem to be connected with her hypochondriacal frenzy and to begin when we speak about disease in front of her
or when she sees a phial from the chemist’s shop, but they arise, exactly identical, when she
meets a friend in the street or when she receives a page of “sticks” made by her little boy who
is four years old. Lac... expresses this commonality of his emotion in a bizarre way. He was or
believed he was bitten by a rabid dog at the age of 15; since then, he perpetually experiences a
quite special anxiety that he himself nicknamed “the emotion of the rabid dog,” it consists of
special headaches, whirling in the stomach, tremors of the left leg and the need to look at, to
touch this leg to see “if a dog does not lick it,” to push aside this dog. Ah well, he can no longer
have any other emotion than that one, “it is too strong, I can no longer be in love, if I kiss a
woman, it gives me only my emotion of the rabid dog and despite myself I divert my head to see
if a dog does not touch my leg or does not lick my thumb.”

A curious detail is that these panic attacks can appear in subjects like Jean and Nadia who come
to us repeatedly and show us they cannot have emotion. They have crises that we call phobias
that vaguely resemble fear and they protest that they are no longer susceptible to experiencing
fear; they have motoric agitations that vaguely look like, as I said, anger and they complain to no
longer be able to get indignant or angry; it is because these crises are not the normal emotions of
fear or anger and because they are substitutes for these normal feelings at the moment where
their development stops. In brief, when we notice that these patients have some emotionalism, it
does not mean that they are more likely than other persons to have normal and complete
emotions, but that they are more disposed under the influence of the slightest shock to begin
crises of motoric agitation or anxiety.

4. — *Sublime emotions.*

To be complete in this chapter and to indicate briefly the sentiments and the emotions that appear
in the scrupulous, I have to indicate a very singular emotion that is very difficult for me to
explain completely and that I consider necessary to return to later after having acquired some
general notions
on the psychology of these patients. I observed these emotions in about ten persons with rather similar symptoms so that they not do not appear to me to be accidental phenomena.

We saw that usually and for most of their lives these patients are depressed, sad, unable to elevate themselves to action, to attention, to normal emotion: from time to time, for some of them, there occurs an extraordinary ecstasy that lifts them over the usual level and gives them, for a moment, feelings of ineffable happiness, feelings of superhuman activity, wholly complete intelligence. Mr. Lanteirès, in his thesis on the psychopathic disorders with lucidity has already indicated, a little bit vaguely, that certain patients feel suddenly “a kind of ecstasy, a kind of nervous erethism with sensual tremors.”

Here are some examples of this singular fact, Gs... while contemplating houses from the top of the Trocadéro, he is fired by enthusiasm, he has wonderful feelings of admiration and he forgets for a moment all his miseries: “it seems to me that it is too beautiful, too grand, that I am lifted over myself; for the moment it causes me an enormous pleasure, but it exhausts me, makes my legs tremble and it seems to me that I am going to fall faint, unable to bear this happiness.”

Fy..., while walking in the countryside, feels intoxicated from the open air “everything seems delicious to me, it seems to me that I am going to burst from happiness, never had I felt it, the day passes like a dream, the time moves fifty times as fast as it does in Paris. I feel better and it seems to me that there are no nasty people as in the other provinces, all the faces are nice and it seems to me that I am in the golden age. Expressions come to me more easily, me who cannot open my mouth when there is one person, I could speak in front of an assembly.” Nadia also experienced this at times, but incompletely, those sentiments at the time of her wild love for a great musician. Nah..., a 21-year-old man, feels for a moment “a sacred bewilderment that causes an infinite happiness.” Gv..., a 26-year-old man, “feels taken away above his condition, he believes he walks

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311 Lanteirès, Essai descriptif sur les troubles psychopathiques avec lucidité d’esprit, Thèse, 1885, p. 44.
on another earth where we are better and stronger.” One of the most curious on this point is Jean who called this phenomenon by a name that I partially retain: “the sublime and solemn sensations.” From time to time, but rarely, he is taken by this sensation when he dreams about an intelligent and high occupation that would please him, but which is in complete contradiction to his character, for example, when he dreams that he is delegated to the Chamber and that in front of the very full grandstands he delivers a major political speech. He then feels a small shiver everywhere on his body but which has none of the painful fluids, he feels his heart quiet and slow, his muscles are at once strong and relaxed, instead of his humble walking with small steps, the lowered head, he recovers and strides with an important air; he has some intellectual excitement, he indeed understands things and feels the thirst to educate himself, finally and especially he has a feeling of happiness that he has never felt. “They are divine impressions that prove to me the existence of the soul in the body.”

These sublime emotions usually did not last long, the patients almost always pay dearly for them. Gs... fall very quickly into a painful rumination on the infinite number of houses, and begins the questions again: “How were we able to build them? How were we able to count them?” There is again a horrible sentiment of depression. Fy... (34), ends her idyll in the countryside with a small crisis, with loss of consciousness and emission of urine the nature of which we shall have to discuss, and the poor man Jean again falls pathetically from the forum: the excitement spreads in the genitalia, returning the thought of masturbation and all his anxieties are bigger than before.

I find these emotions excessively curious, they form a contrast with the ordinary sentiments of decline that characterizes the scrupulous. Besides, they establish a very interesting connection with the other patients with whom I do not concern myself here. But whom I hope I shall study one day, the ecstasies. I arrived, not without some astonishment, at this conclusion that the ecstasies are not hysterics as I originally believed, but that they are much more connected with the group of the scrupulous. In studying them it will be necessary to show that the ecstasies have crises of rumination, anxiety and decline like the scrupulous; it is interesting to show here that the scrupulous have crises of ecstasy at least in germinal form.
5. — The need of direction.

Next to the fundamental disorder of the emotions, next to the sentiment of incompleteness, and probably because of it, our scrupulous develop quite particular sentiments related to special tendencies that do not exist to the same degree in normal individuals, one of the most important is the need of direction.

I have already had the opportunity to insist on this sentiment, especially regarding its pathological exaggerations. Before giving birth to morbid disorders, this sentiment exists in the normal state of certain persons and contributes to establishing their character. This attains the highest degree in the scrupulous. I leave aside here those who have amorous obsessions and those who are in despair because they lost a person who supervised them, I take patients who have quite other obsessions or quite other manias and I notice that this sentiment exists in them, so to speak, without their knowledge. These persons experience a certain pleasure to obey, to receive very formulated judgments that they must have, the decisions that they must make. Instinctively, they put themselves under the command of somebody and, their submission once made, they never make the effort to check or to discuss the orders that this person gives them, the judgments that they follow, the examples that she shows them, they want to do nothing without this person’s opinion.

This character is described by all the observers. Legrand du Saulle notes “the need to be reassured which leads the patient to the doctor at the most unusual hours.” He describes a 30-year-old lady who is managed by a 8-year-old little boy “It is enough,” she says, “so that I avoid a crisis.” Baillarger notices in the doubters “this enormous need of outside affirmation.” “They can act only at the instigation of the others,” said Messrs. Raymond and Arnaud about their patients.

312 Legrand du Saulle, Folie du doute, p. 35.
313 Legrand du Saulle, ibid., p. 38.
315 Raymond et Arnaud, Ann. méd. psych., 1892, II, 199.
To the numerous cases which I already have described, I add only some examples.

Ps..., a 23-year-old girl, abandons herself into the hands of a nun whom she chose and forces her to decide about everything in her life. Bu... (85) calls for his wife all the time and does not raise his little finger without asking her for permission. Dua... (135), a 27-year-old woman, can no longer take a step without the order of her doctor, she feels the need to tell him everything, to make her entire confession under any pretext. She asks advice on everything even about the least medical things and obeys thoroughly. Mbo... obeys her sister and Vi... is managed by her child who is barely 10 years old. Kl... behaves exactly the same: without knowing me, she confides completely in me and begins to think only through me. Lise clearly realizes that she feels this need in a ridiculous way, she tried repeatedly to satisfy it with friends, with priests and she has to resist to not let herself go too much. Despite herself, she feels worried when she is far from me, “To feel that I am free for several months, it is like something terrible; I am going to be very bad at first, then I shall get better at the end by the thought that the end of my freedom approaches.”

Claire has completely the same character, she is happy when she is understood, that is to say when somebody takes account of her thoughts, her needs, and decides for her. At the end of some visits she just desperately hangs on to me, does not want to leave me anymore, and claims that she cannot live any more if I do not dictate to her “literally all that she has to do and think during the day.” Za..., Rk..., write me pleading letters all the time asking me “to answer at once what they must believe.” Xo... demands me to leave orders and affirmations in writing and Jean “lives only through the prospect of coming to see me.”

When these patients do not have a spiritual adviser who suits them at their disposal, they make no efforts to find one. “I put myself voluntarily,” says Gisèle, “under a moral dependance, I sought to substitute another thought for the one that haunts me, a will of my own,”

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I feel so much that it is necessary for me to obey at all costs. She had tried to confide in a priest; but she was very quickly frightened by seeing that her sentiment of dependency was complicated by her profane sentiments.

Conversely, when they lose this very necessary direction, these patients fall into the most complete disorder. Gri... (82), a 28-year-old young woman, since the age of 15 years had all sorts of disorders of the will, crises of excitement, phobias, etc.; she eventually finds a lover who imposes on her a proper deportment, she obtains a regular job and a sufficient attention. Under this influence, the patient forgets all her disorders and carries on perfectly for five years. Since this lover left her, she falls again into the most complete disorder, she is tormented by obsessions and especially, naturally by obsessive love for this lost director. The observation of Ck..., which I have already cited, is the most amusing. This poor 41-year-old woman, having had all the obsessions and phobias, met, towards the age of 30 years another poor woman tormented by manias of cleanliness which brought about a big mess in practice. These two persons with disabled wills consoled, supported and reformed each other; for ten years they formed an admirable, perfectly reasonable couple, like the blind person and the paralytic. A pitiful adventure separated them: a dismissed domestic has maintained, it seems, a comment that tended to question the morality of the mutual affection of the two old ladies. They are then disturbed by a scruple about their friendship and believe they have to part. We shall see, regarding the treatment, that the obsessed takes scruples like that with regard to the one who treats him and manages him and that these scruples are a serious sign of relapse. In this case, both patients began again a true frenzy with obsessions of every kind, obsessions of crime, remorse, hypochondria until I managed to unite them again.

By studying cases of this kind, I have shown that this sentiment depends principally on the need to have the other one do the act of will that has become difficult. “The patient,” I said on this matter, “has in reality no resolution, no idea in a given circumstance, the director himself has to make the

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317 Névroses et Idées fixes, I, p. 470.
synthesis that his subject cannot make and imposes on him the already made resolution. It is very often this that the doubters come to ask of their doctor when they tell him of their life and their uncertainties. “Is it necessary to lose my temper with this person who gave me a funny look? — Is it necessary to do my housework? — Is it necessary for me to marry? — Is it necessary to buy a dress? — Is it necessary to accept my lover? etc.” These are among the thousand questions that the patients put to me, the questions which we cannot declare insignificant when we see them causing such sufferings and such frenzies. The answer does not matter to them; if it is clear and decisive, they are relieved at once... We understand now the role of the director and how he must in reality will for the patients.”

6. — The need for excitation.

The need of direction does not always appear under this simple shape that I have just brought to mind. In many cases, it is evident that the subjects know what they have to do and do not ask for instructions on this matter. What they ask for is simply an excitation capable of enriching the resolution of a cortege of emotions that she lacks so that she has the strength to accomplish it. “In simpler cases,” I said previously on this matter, “the director is simply going to strengthen the resolution that the patient had already formulated. It strengthens her by enriching her, by supplying to her the facts of the circumstances in which she is placed, the details and emotions that were missing for her. The confessional, the consultation, the priestly or medical title, and especially the famous medical prescription, so many mockeries of which were not able to affect its tremendous authority, already renders great services. But the director often has to add even more, he avails himself of threats, irony, the caress, prayer, to address all the feelings that he knows still exist in the subject’s heart and that he awakens them one after the other to force them to make a procession towards the unsteady idea. — You will miss commitments that are already posted, you will be ridiculous in the eyes of Mr. so and so, you will sadden a person whom you love, etc. — Many times I had to make use of all these resorts to rhetoric to get
a patient to drink a glass of water or change his shirt, as if it was a question of arriving at the gravest resolutions.”

To the patients whom I cited in the previous work, we can easily add many others, I remind only that Claire demands not only a director, but “somebody who incites her, who raises her spirits, he has to shake me to have me do what I well know must be done.” The poor man Bu... needs his wife to give him slaps on his behind, “it humbles me to see me treated like a child and it gives me some energy.”

For many, the role of excitement is even more considerable. It is no longer only about a particular excitement that is added to a piece of advice, to grow into the execution of an action; it is some excitement capable of pushing the subject up to an emotion. These patients experience the complete emotions with great difficulty and, as we shall see, they are much better when they succeed in experiencing them. So they look for all the possible means to obtain these emotions and they experience a pressing, often almost irresistible need, to find the cause of this excitement. From there is the origin of the taste for alcohol, for morphine, for all sorts of poisons. From there comes this curious and very characteristic need “to do nonsense, eccentricities, anything strange that takes us out of our numbness.”

It often happens that the cause of the thrilling excitement is a specific person who manages to physically and morally incite these numbed patients. There results from this a particular passion for this person that gets closer to previous love affairs inspired by the need of direction, but which develops by a slightly different mechanism. So the wild, obsessing passion of Sim... (185) for a lover can hardly explain itself by the need of direction, because this lover manages her in no way; but she explains very well through her observation of the difference between a husband and a lover. “My husband does not make my head work enough, he knows nothing, teaches me nothing, does not surprise me. I need that they give me new ideas, new impressions, different feelings. He does not know how to make me

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318 *Névroses et Idées fixes*, I, p. 470.
suffer a little and I cannot love somebody who does not know how to make me suffer, because I need it from time to time... The other one amazes me by his coolness, by his cruelty, by his absence of any feeling... A little remorse, fear, finally made it a spicier thing than with the husband and it is that which did good for me.” The equally unhealthy passion of Nadia for the musician X... would be inexplicable if we looked only for the need of direction there, because X... has never spoken to her and could not at all direct her mind. But here is the fragment of a letter that explains this passion very well: “the concerts of X... were for me a revelation, they so enthused me that I never recovered from this emotion: I may not explain the effect that it had on me. When I went out of the room after the first one of these concerts, my legs and all my body trembled so much that I could not walk anymore and I spent the night crying... But I did not suffer; on the contrary, it seemed to me that I came out of a dream that previously filled my life, that I saw things more as they are, that I was in a true sky of happiness. (In brief, she experiences in these concerts one of the sentiments of excitement that Jean called a sublime sentiment, she finds relief from her usual apathy.) My only hope for years was to hear him again and to experience the same sentiments. I believe, indeed, as we both reproached me for it, that I had a passion for him, but my passion is not the same kind of passion as that for other persons, of this I am sure. It seemed to me to have a supernatural influence on me and it alone was able to pull me from my perpetual dream.” I find this letter very interesting for the explanation of certain platonic love affairs that often distinguish the obsessed, it is here an artistic excitement that the patient longs to find.

The excitement does not have to be produced by a real person to have the same result. “I very often need,” says Gisèle, “to go to see the statue of Notre-Dame of Victoire; and it would seem like an obsession for me: it is because this statue has a special impression of strength, it cheers me up to look at it.” I call attention to the position of this singular need of excitement with these few examples, we shall have to discuss it again regarding the interpretations of the disease and its treatments.
The same feelings easily become neighbors of love. Some patients avoid it, they content themselves with a cold direction or with a paternal love, but we clearly understand that many of these persons are going to transform these sentiments into loving sentiments, of course by understanding love in a certain way. Gisèle feels it such that she perpetually meditates on love, she imagines very clearly the various sorts of love: “the love that gives, it is the one that manages, which protects and the love which gives itself, it is the need to be embodied in the other, to give oneself, to abandon oneself, to strengthen an impression of weakness that looks for a strength, it is a sacrifice of her person to live in something higher.” Now she very much admits that she has the second love and not the first one, because, according to a pretty expression which she likes, she always had “the need to snuggle up.”

We notice in her, to a supreme degree, this excessive need of confession that makes her unnecessarily hand her whole life over. Repeatedly, she tried to put herself under the moral direction and under the reliance on someone else, the husband, as usual, seemed to her to be insufficient for this role: “he does not understand me.” Her dream “to meet a true and firm will which we can enjoy without evil” seemed satisfied for a moment when she was managed by a priest; regrettably, she very quickly combined her docility with the other sentiments and it had to stop. It is the misfortune of these women who search for a moral direction and who find that it becomes confused too quickly with physical love. I have already cited many cases of these persons who obviously abandon themselves only to obtain a master. Sim...’s history is more typical on this point, she liked so much to feel under this dependency, she so needed a master capable of thrilling her that she did everything to please him, without him asking much, very simply because she hoped to retain him longer.

It is curious to notice that these patients are sometimes very intellectually superior to the master than they allow; they feel good that he is an imbecile, but they find it so sweet to obey that they do not want to make the effort.
to judge. We find the same need of direction mixed with love in New..., in Bs..., in Lod.. who has such a bizarre passion for a young girl, it existed for Nadia. She herself had taken a passion for a great musician who had become her ideal, her god, who represented for her all that there is to have of beauty, nobility, greatness on this earth; she did everything while thinking of him, she even agreed to eat. She would have sacrificed everything to be able to follow him, to have him to herself and to be his slave: “life is nothing for me if I do not have somebody to admire, to love, to listen to; it seems to me that the one that I love is like a good rock to which I am attached in the middle of a stormy sea.”

Rk..., confesses while wailing “that at 40 years old he still looks for the perfect friend, who manages and who consoles, the one that you love more than anything, a younger brother who has more brains than me.” Wye... was for a long time a lover of college,\(^\text{319}\) he had a wild love for some of his classmates whom he wanted to make “his beloved masters;” even at the age of 40 years, he thinks only of love and of finding love. Always he is worried to know if he has pleased, if he is liked; he only wants to work, to make an effort to succeed at love.

This need to love seems complex to me, on one side it is connected, as we clearly saw, to the need of direction, but the on other side it treasures the need of excitement. The loved object has to “amuse them, take them out of their sad environment, and pick them up by a kind word.” But the devotion that he requires must also be a cause of excitation. We often encounter these bizarre individuals who without necessity, without understandable reason dedicate themselves completely to the care of a patient, to the education of an idiot, to the consolation of an aggrieved. These persons exaggerate their aid, they are demanding and require an enormous gratitude, they are jealous if somebody approaches their patient. These persons have an excessive need to devote themselves because they need the thought of a purpose that incites their activity and their emotion, because they need to cheer themselves up by continuously proving to themselves that they are good, generous, useful.

\(^{319}\) On the love affairs of college, see Marro, Puberty, translation, p. 66. This author, who takes full account of the physical side of these love affairs, does not appear to me to stress enough the moral needs that I signal here.
8. — *The need to be loved.*

It seems to me, however, that all the disorders of these patients do not solely explain this need to take direction or excitement from others. When Ku... experiences an intense need to be loved by her caretaker, when she thinks with terror of a possible quarrel with her neighbors or a misunderstanding with her maid, it does not seem to me that she wants, like the previous ones, to ask for direction or for an excitement from her caretaker, from her neighbors or from her maid. Many of these patients such as Kl..., Bal..., Voz..., Qsa..., speak ceaselessly about their need “of affable manners around them, of a sympathetic environment,” they have mortal anxieties at the thought that they could indeed be indifferent or unpleasant to some persons in their circle of acquaintances and then they take incredible precautions “to hurt no one, not to displease anybody, to be forgive what they may experience as displeasing.” Wye... wonders with anxiety what his effect was on the persons in the living room, if everybody finds him pleasant; he would have to despair, I do not say if he hurt somebody, but if he displeased somebody. “A dissatisfied face puts me in agony and deprives me of all my strengths.” Lrm... (232) confesses “that he was never able to bear the thought that somebody was irritated with him, he would like to be convinced of the sympathy of all, to live in an atmosphere of sympathy.”

This feeling is not obviously identical to the previous one, the patients ask for nothing from the persons who surround them, but I believe that they are afraid of something. They are afraid of a hostility, of a fight that would require effort on their part. “In this need of universal sympathy,” Voz..., a 22-year-old young man, said to me very clearly, “there is simply a fear of having to fight, it is not horrible to feel that we are in competition with somebody.”

This feeling often manifests itself in the relationships of masters with domestics. A very large number of these patients developed the habit of never speaking directly to their domestics: Qsa... always sets his wife as an intermediary to ask them the slightest of things. It is obviously
the fear of meeting resistance, at having to order, to struggle that intervenes in these cases.

Naturally, this fear of conflict can get involved with all the previous sentiments and establish certain, more or less complex, “needs to be loved.” Here is the touching expression of one of these sentiments: “my dream,” says Qi..., a 35-year-old woman, “would be to be a phthisical young girl. To be phthisical, that would be delightful! They give phthisicals all that they want, they spoil them, they never make demands, with nasty looks, of them. I would so much like to be loved as well, and especially that they say it to me all the time, that they make me feel it, that they force me to believe that it is very true.”

9. — The fear of isolation.

Another aspect of these same sentiments will be the fear of isolation. I add only some examples to the cases that I have already indicated in another work. Dob... (86) thusly explains her disease: “my sufferings come from a lack of contentment of the heart... all actions become easy with somebody close to oneself and impossible when one is alone.”

Pou... is so unhappy when she is alone that she stops eating and eats only with company. We could enumerate a whole series of these women: Lkb..., Fy..., VI..., Mm..., etc., who moan of their isolation. “Her husband does not speak to her enough, he is sombre, he does not talk enough, he does not understand: if I was a little afraid of him, it would be somewhat better: one cannot, nevertheless, live alone.” “When I am alone,” said Qi..., “I walk in vagueness, it seems to me that I do not have ideas anymore, that everything becomes odd and I am afraid of all and everything.”

What these persons dread when they are afraid of being alone is to be without direction, without excitement and without protection.

10. — The return to childhood.

One degree more and these sentiments exaggerate themselves, up to the point of giving to their character a very singular aspect: these persons play a kind of comedy, they make themselves small, naive, affectionate, they play completely ignorant and like to pass “for a little bit childish.”
It is because they want to be managed even more strictly than the others, it is that they also wish a sweet-tempered direction that brings them to all the actions, to all the pleasures by smoothing the way. They want that we not only indicate to them the actions to be done, but that we amuse them, that we distract them, that we make them play as well as work; in brief, they want that we treat them as small children and they try to deserve this treatment.

Min..., at 20 years old, does not leave the underskirts of his mother and “he wants that she scolds him like her baby.” Ger..., at 35 years old, demands “a children’s pension,” that would be best for her.” Gisèle, at 27 years old, likes “to be a child with people, it is a habit that she takes on very easily.” Gr..., a 40-year-old woman, herself admits that she needs to imagine herself as 16 years old, she always needs her parents nearby, like being close to a small, young girl. C..., a 25-year-old woman, would like us to be constantly in charge of her, like a small child; it does not seem to her that she grows. We have already seen this characteristic in Nadia regarding the shame of the body: if she is afraid of developing, of seeing her breasts enlarging, it is not, as we would believe it to be, due to modesty, it is that she is afraid of appearing older, of no longer being treated like every small girl, of not being loved any more like a child; although she is thirty years old, she cannot believe that she is more than 15 years old and we obtain everything from her by treating her like a small child. In fact, it is the same need that exists in Jean, he wants not only that we direct him, but he wants that we dictate everything to him: “it seems to him that he would be so happy if he were as a child on the knees of a grown-up.”

The most remarkable observation is that of Qi... (188), a 35-year-old woman, who is pursued by the desire to jump rope, to cut her hair short, letting it fly in the back and who dreams of being called “Nénette.” Obviously there is there an obsession, but it developed upon the earlier character: “we love a child for his naughtinesses,” she says ceaselessly, “for his good, small heart, for his kindnesses, and that it is asked of him in return, to love you, nothing more. This is what is good, but I may not say it to my husband, he would not understand me. To be held, I would so much like to still be small, to have a father or a mother who would hold me on their knees, who would caress my hair but, no. I am MADAM, mother of a family,
it is necessary to hold me inside, to be serious, to think all alone, oh what a life!”

11. — The love of honesty.

Other feelings derive from these. I do not stress the mystical sentiments in this work, because I plan to resume their study in a work on the ecstasies. We understand that the need of direction and the search for excitement from the other, the mysterious leads to religious sentiments, brings one to lovingly abandon oneself to the divinity. We often find the germ of the same sentiments in the scrupulous, very far from the ecstatic state; we saw Gisèle search for energy in the contemplation of a statue of the Virgin. Bal..., Fy... please themselves in thoughts of death and the other life “where the good God collects the small souls.” These sentiments, in their development, give the disease a bit of a special character.

In this work, I especially distinguish the sentiments of honesty because they have a more narrow relationship to the criminal obsessions that are the object of this study. We are struck by the observation of the extraordinarily developed moral feelings in the individuals of this group. They tremendously want to be very sincere; Rk., Nadia loathe the lie and protest with indignation as soon as they can suspect one of a small hypocrisy. It is evident that Nadia does not understand the social accommodations that often disguise the truth: she gets excessively indignant at it. We are struck by the honesty of Toq… of Brk… “I have no merit in being honest,” said this one, “if something in my behavior displeased my scrupulous consciousness, I would be very unhappy, life would be too painful to me.” Kl..., Bal... would for nothing have the sentiment of violated justice. Voz... cannot resign herself to be accepted in an examination while one of her other companions is refused, because to her it does not seem absolutely fair. On this point, the state of mind of the scrupulous justifies their name.

What is it necessary to think of these beautiful sentiments of justice? Could we not speculate that justice is especially useful to the weak and that honesty is especially necessary for those who want to have commotions with nobody? Does it belittle these
beautiful sentiments to notice their close relationship with the need to be protected and the fear of conflict?

12. — *The need of authority.*

A more curious feeling that seems at first sight to be in contradiction with the preceding is the excessive need of authority and command. This sentiment and this tendency characterize what we call “authoritarian.” These seem to us to have been little analyzed and to be generally very poorly understood by the psychologists.

Let us notice at first that it exists very frequently in neuropathic individuals, who are more or less obsessed and have absolutely all sorts of disorders of attention and of the will. Nadia had become completely unbearable to her family: since her childhood, she boasted of obeying no one and to make everyone obey. “Nobody in the world will succeed in having any influence on me; I was born with a very dominating character.” Since the death of her mother who still managed her a little, she horribly tormented her father and her sisters, she demanded from them a constant obedience to her ridiculous whims; she obviously tended to impose on them the same absurd life as she had adopted for herself. She did not allow her sisters to receive a visit, to get dressed to go out: a little more and she would have imposed on them the same diet as she had chosen. When they resisted her a little, she accused everybody of injustice, of cruelty to her and she engaged in scenes of violence. Gisèle and Sim... both have the same peculiar claim, it is to absolutely dominate her husband, to make him do all that she wants, to adjust the whole house according to her whims: they are convinced, however very wrongly, that the husband has no will, no energy and that he is perfectly unable to resist to her. Moreover, they show in the organization of the house a voracious activity, running everywhere, taking care of everything, dictating to each their actions, their attitude, even their ideas. “She cannot tolerate,” the husband of one of them said to me, “from me, from her children, from no person who approaches her, a word, a gesture that she did not dictate.” I find the same character in Fy... (34) and in many of the others. I was astonished to
find it alternately in the patients themselves and at least in the parents, especially in the patient’s mother to such a point that I was inclined to say: “authoritarian mother, scrupulous girl.” The mother of Ku..., Zo..., Sim, seem to have the same merciless egoism that commands even the smallest details and which at the same time inspires a tireless ardor to attend to all these small details that they demand.

Moreover, these authoritarians will form two groups the distinction of which offers little interest here: the violent authoritarian who wants to impose their thoughts and whims through force and the meek authoritarian who demands by wailing in the name of the respect, of the affection that we owe him, who declares every other minute that we make him die from grief if we show the slightest independence.

Next to this need to command, there is very often a need to torment others, to humble them, to make them suffer. Many of these women cannot refrain from endlessly saying unpleasant things to their husband or to their daughter, especially when there are witnesses and when they can successfully injure their victims. They only stop when they have upset them and they are delighted if they see them crying: “oh! If you knew how I like to make my husband suffer... when I need his love, I torment him as long and so much that he eventually falls into the trap and as he cries, then I repent, I kiss him, I love him and it is charming.”

These characteristics drew my attention a great deal, and at the beginning they seemed to me very inexplicable, in contradiction with what I knew about the weak will of these patients, with these countless needs of direction, needs to be liked that characterized the same scrupulous. The strangest, indeed, is that these two seemingly contradictory needs coincide very often in the same person. In Sim... and in Gisèle we see this madness to command, but, at the same time, we observe an extravagant need also to be loved by everybody, and a despair when the persons tormented by them do not show in return a great affection. Sim...’s mother beat her children if they had some independence in a tiny detail and the next moment began crying because her children do not appear to love her enough. When these patients adopted a victim for them to especially torment, it is not difficult to see that this victim is exactly the person
whom they love most and by whom they wish to be most deeply loved.

Much better, these same patients have already introduced us to the folly of obedience. Nadia, when she had known me some time, one day gave me a compliment which flattered me a lot: “you are an even more stubborn person than me, I would not have believed that it could be possible.” She is delighted to have found this person, not only does she obey him but she wants to obey him even more as a child, whereas she remains extremely demanding towards her father and towards her sisters. Sim... gives herself to a lover to have a master and she is enchanted with his incredible hardness. We saw Gisèle looking for master by confiding in a priest. We shall find simultaneously with these persons a wild authoritarianism toward a part of their family and a ridiculous submission towards a son or towards a stranger.

These characteristics show us that it is not about a real power of the will. The great self-willed persons are leaders, and are not authoritarian: everybody comprehends the difference. They command the substantial things, by inspiring a general direction of behavior and especially by commanding in a manner favorable to their subordinates; the authoritarian commands in little things more than in the major ones, gives no general direction and too often lets them see that the command always has his own interest as its aim and not that of the subjects.

One of the reasons for this command appears to me to be exactly the same as the reason for their obedience, it is the difficulty of their adaptation to the real world. They are people of weak mental activity, for whom any new effort of adaptation, organization is painful and who, however, feel an extreme need for an adapted and orderly life. They want others to do their job or at least to make the task easier for them. Instead of modeling oneself on the surrounding environment as done by one who adapts himself, they want the surrounding environment to model itself on them, so that they do not have to adapt themselves. We saw that the environment most embarrassing for the scrupulous is the social environment; the variations of the social environment cause his shyness and all his panic attacks. It is this social environment that he wants to model upon himself and
from which he demands perfect conformity with his own ways of being.

Here are exaggerated examples that will make my thoughts understood. Bow... (76) is in his office and tries to fix his attention on a reading; here he is who enters a crisis of fury because he hears a domestic who sweeps a nearby room. The noise of the broom distracts him and his reading and because of his weakness of attention, it evokes in his mind the images of another action than prevents him from reading. He wants to promulgate that everybody in the house has to read at the same time as him. Vk... can no longer manage to wash her hands, because in her room she hears the cook who pours some water in the kitchen sink: “what can she make from this water? Something dirty, undoubtedly. It gives me ideas of dishwater, bits of burnt fat and you indeed understand that it prevents me from accepting the idea that my hands are clean. I would want if it was possible, if everybody in the whole house, from top to bottom, did clean things, when I try to wash my hands.” These two cases please me very much, because they seem to me to explain the mechanism of authoritarianism. These feeble-minded persons cannot do a thing, believe in a thing, enjoy a thing, if the other people do something else at the same time, believe in some other thing, if the other people have another enjoyment. Hence this need to impose uniformity; from there also is this strange blend of the need to be managed, be loved, associated with the need to command. These two methods overlap and do not contradict themselves to reach a vital adaptation. Through authoritarianism, they try to produce a homogeneous environment and through obedience, they try be adapted to the variations that the environment preserved.

Mr. Murisier, in his excellent small book on the pathology of religious sentiment,\(^\text{320}\) explains very well in a similar way the formation of religious zealotry. Weak minds do not feel reassured in their own faith; they feel shaken in their alleged convictions when they see people next to them who believe otherwise. They need to remove them either by converting them, or by destroying them to be able to believe everything at their ease. It was not religious faith that lit the stakes of the Middle Ages, the true believer indifferently attends

\[^{320}\text{E. Murisier, Les Maladies du sentiment religieux (Paris, F. Alcan), 1901.}\]
to the denials of others: it is religious doubt, or rather it is terror of religious doubt, that inspired the fanatics. I am happy to find that adjacent phenomenon of authoritarianism in the actual patients this time reached an obvious delirium of doubt to complete this interpretation.

Other reasons still intervene in the need to command and to be obeyed, in the need to torment and to make suffering. These attacks against much loved persons deserve the name of *teasings* and I am surprised that the psychologists and the moralists are not more attracted to the analysis of this very remarkable phenomenon of teasing. These patients always dissatisfied with themselves, doubting their strength and the affection that others have for them, feel the perpetual need to experiment to verify both. They ceaselessly demand to have the satisfaction of being obeyed and to feel powerful; they seek to humble those whom they consider far above them to lift themselves up; they are happy to make suffer those whom they love most so they notice that they are not indifferent to them, that they can hurt them and that they are loved all the same. These singular sentiments play an enormous role in persecution mania; you should not forget that they also have their place in the mental state of the scrupulous and that they explain seemingly incomprehensible behaviors and characteristics.

All these disorders of sentiments are connected one to another; this group comes to complete the picture of the disorders that the will and the intelligence had already introduced to us in a more objective way.
Many of the psychasthéniques worried about their obsessions, about their mental manias or about their phobias complain only of psychological symptoms and the observer could be at first sight inclined to believe simply in a disease of the mind. Certain patients, at least for a while, justify this illusion. Rk... is a 40-year-old, big, strong man, a fresh complexion, without visible physiological troubles, he has only scruples and manias of searching which are enough to torture him. But he is a very rare exception and it maybe more apparent than real; most often, an attentive examination will reveal a crowd of physiological troubles which make the psychasthénique state a disease of the whole body.

We would not know how to stress this essential point enough: the obsessed through their gossip, through the endless description of their extraordinary thoughts divert the doctor from the organic examination that should never be neglected. Their physical appearance is almost always characteristic: they are very often emaciated, they are pale and have drawn traits, the dry skin has a poor appearance, their tongue is furred, their breath is bad and almost always this physical appearance changes completely at the same time that they find peace of mind. In brief, whatever interpretation we give to their mental state, you should not forget that they are especially and above all patients.

1. — *Disorders of the nervous functions.*

Without doubt, all the disorders previously studied, obsessions, agitations, psychological incapacities were in relation to
disorders, to intellectual functions, but they especially constituted psychological disorders. It is
necessary to place some nervous system disorders next to the disorders of the physiological
functions, these disorders are still little known but they will doubtlessly later serve to interpret
the first ones.

1. — *The headaches and back pains.*

A first fact, of the most importance, shows us that these disorders of the mind are in touch with
an abnormal functioning, a pathological change of the brain. It is the pain that most of the
patients feel in the head.

They always locate these pains in the head, but there stops their agreement: there is a surprising
variety in the description of the forms or the modalities of this pain and in the place to which
they ascribe it. It is very likely that in these colorful descriptions there are many insignificant
things. We shall realize it later, when we shall know the real reason for these pains, we are now
still in the empirical period of former doctors who noted exactly the characteristics of the
caprizant\(\textsuperscript{viii}\) pulse and of the somewhat hard pulse,\(\textsuperscript{cix}\) we are obliged to collect such expressions
of the patients.

If we concern ourselves first of all with the form, the modalities of the pain, we have at first
those who do not have enough imagination and who say simply that they have a headache, that
they feel a discomfort, a more or less serious pain in the head. We shall then have those who
speak about numbness: “I have paralyzed brains” (Bsn... 10). “I have a numb head” (Claire).
“There is a corner of my head that is numbed and that wants to sleep” (Vod... 203),” I experience
a kind of torpor” (Dob... 86).

A certain number of patients complain about a phenomena of movement in the head “it is like
there are foreign bodies that roam under the skin of the skull, and inside are bizarre effects, the
contractions, the twistings, spaces which pushed to a certain point are completely alarming”
(Gisèle). Jean feels “as if he had objects which turn in the brain without being able to stop them,
wheels, pulleys, windmills; he sees nothing, he hears nothing, he has a feeling that there is a
small pulley that turns.”

Other sensations can be compared with itches:
“it seems to me,” says Mt... (12), “that they tear away mucus on the top of the head or I feel like ants on the head.” Ck... feels twinges over the skull “as if an invisible thread slithered.”

We arrive at the very numerous patients who translate their impressions by sound sensations and who have noises, crackles in the head (Lap..., Qb... 14), crackling (Gisèle). The most interesting observation from this point of view would be that of Fz... (59) to whom I return: he always has noises in the head, sometimes very strong when he is subjected to any fatigue, railroad whistles, pistol shots, bells, or when he is rested, weaker noises, a cascade of water, a train that goes by, boiling water, the singing of cicada: for four years these noises have never stopped. You should not confuse these noises with the buzzing or the hisses that result from real diseases of the ear and especially from sclerosis of the middle ear, because these persons have none of the signs of a lesion of the ear. I wanted to examine with great care the last patient, Fz..., on account of Mr. Gellé who assured me that the ear was intact. Moreover, these noises are not situated in the ears but in the head; it is still, if I do not make a mistake, an interpretation similar to the previous ones of the same cerebral phenomena.

I also call attention to the impressions of cold (Gisèle) which lasts for hours or those more frequent of abnormal heat. “They dry out my brain by warming it” (Dob...).

Among the more frequent impressions again it is necessary to note a heaviness: “it is a heavy helm on the head, a headband, a lead crown, a contusion from a weight, a heavy brick (Gisèle, Dob..., etc.), a heavy brick in the middle of the head (Lag..., Qb...).” It is, in brief, the classic helmet of neurasthenics.

The most interesting of the expressions, the one that we find in nearly half of the patients, alone or superimposed on to the others is the one of emptiness. “My head is emptied” (Al...15, Day..., Lobd...22). “My head is empty,” said Ver..., “it’s as if I don’t have a head or rather nothing in the head.” Lise claims that she has “a need to fill this space with her ideas” and Claire asserts that “the head is empty and filled at the same time by a heavy pebble, it is the bad ideas which form this..."
pebble in the middle of the emptiness,” we note the analogy between these two patients.

After the form of this pain, it is very interesting to go over its localization. Let us notice at first that it is very rarely lateral; I noted only a small number of patients claiming to suffer more on one side than the other: Vod... (203), Claire, Lise, sometimes say that they suffer, that they are numbed, that they have burns especially on the right. Gisèle feels a liquid that they inject on the right, Fz... has more noises on the right, the head seems for Lise to grow fat on the right. Two of these patients: Claire and Lise, already had some slight disturbances of cutaneous sensation situated also to the right, consequently we cannot bring into play the crossing of pyramids here.

Sometimes the pain is general in all the head, often it is rather superficial. Lise notices that it is not very deep, it seems to her that it goes down as she is sicker. But most of the localizations in the immense majority of the cases are made on the median line. To start with, we have a first group of patients who place this pain on the forehead, Ball’s patient already said that he had a discomfort on the forehead, between the eyes, at the top of the nose, Fie... has a compression in the middle of the forehead, Brk... (24), Vod... has a weight between her eyes on the stem of the nose, like a brake which one compresses, Car... (176) a burn in front, over the eyebrows, she also believes there is a predominance on the right side.

A much more frequent localization is that of the vertex, the pain is similar to the famous nail of the hysterical. Lobd... (22) wonders if her mother did not give her blows to this place when she was small, she noticed herself that it was the place of the fontanel in children. Vod..., Claire have “the head quite peeled in this place,” Lise feels like there is a thickness there, etc. We could obviously name, regarding the pain of the vertex, a good third of the patients.

We arrive at the most frequent localization for many: the occipital location. Sometimes, it is vague, “I suffer at the back of the head” (Brk...), “I have a lead skullcap in the back” (Vi...) “my bad region is the back of the head where there is a claw, a weight and where all my noises make themselves heard” (Fr...). Mt..., Jean, Cs..., Gisèle localize their bizarre phenomena
in the back, in the occiput. Sometimes the occipital localization presents with a little more precision; many patients as Gisèle, Voz... (122), Rai... indicate with the finger a point situated on the median line some centimeters above the occipital bump and which appears to me to correspond to the anatomists’ lambda point, to the meeting place of the occipito-parietal sutures. Fy... claims that for a long time she had like small buttons at this point and Bei... claims that this point hollows itself out under the hammer blows that she perpetually feels there. This localization appears to me even more frequent in the scrupulous than the previous ones and I believe that it exists in nearly half of the cases.

We can hardly claim to be able to explain at present the mechanism of these bizarre pains, it is not likely that the patients directly appreciate through the sensations the state of their cerebral substance, they appreciate it only indirectly through the consciousness of their mental operations, which creates all the abnormal feelings that we described. I do not believe that we can explain the sensation of emptiness by the loss of certain sensations normally produced by the brain itself. In Ver... who presented this impression extremely, I was able to notice no disorder of the sensations usually furnished by the head: there is no anesthesia of the integuments of the skull and he does not seem to have disorders of the sensations of the weight of the head. The patient feels very well a weight that I put on his head; with his eyes closed he discerns the inclinations that I give to the head. As much as one can tell, it seems to me that he has preserved a certain internal sensibility: I tried to place him head down for some time, he feels, like everybody else, the influx of blood, the warmth and heaviness of the head. To further verify the sensibility of the cerebral surface it would be necessary to open to his head, but these observations are enough so that we can consider as completely hypothetical the interpretation that attributes a special cerebral anesthesia to these instances of a feeling of emptiness: you should not resolve the problems by unverifiable and imaginary anesthesias.

A patient, Ll... ( 226 ), suggested to me his own explanation, which seemed interesting to me: “when we say that the head is empty, it is not that we feel something particular inside, it is that we feel in a painful way the envelopes
of the brain, the skull and the skin, this abnormal sensation of the skull draws the attention to the periphery and points out to us the emptiness inside. When I no longer feel my skull, I no longer have the idea of emptiness.” This patient’s explanation is worth at least as much as most of those that have been proposed.

It seems today likely that intracranial sensibility exists only in meninges, in the periosteum and in the bones of the skull; as a result most of the headaches are due to modifications that affect the meninges and, in particular, as the fine studies of Mr. Sicard have recently shown, in modifications in the pressure of the cerebrospinal fluid. It is, therefore, necessary to suppose that, due to secretory disorders or due to vasomotor disorders, the cerebrospinal fluid is in exaggerated or insufficient quantity; this supposition is not absurd if we think of all the secretory and vasomotor disorders that we have come to observe of the skin, the mucous membranes and especially the stomach. Why would not the small glands recently discovered and that secrete the cerebrospinal fluid also be disturbed?

This modification of the pressure of the cerebrospinal liquid is also probably related to circulatory disorders. Angel, in 1884, reported that vertigo in neurasthenia has its origin in vasomotor congestions321 and he demonstrated distension of blood in the brain through the study of a vasomotor disorder observed in the periphery, to which we shall return regarding circulation. The decline of arterial tonus would bring frequent dilations of the cerebral vessels. This explained the how the menstrual flow, and the sleep that causes anemia can often bring a decrease of these headaches, rest acts in the same sense by producing a diversion and by raising the arterial tonus. Mental labor increases the headache by causing an increase of the congestion.

Mr. Auguste Voisin,322 then more recently Mr. Lubetzki,323 have


sought to specify these actions by studies of cerebral thermometry. By the employment of a thermometer with a very sensitive surface, they tried to establish the following points: 1° that the temperature of the walls of the skull of neurasthenics with headache is appreciably more elevated than the one that we observe in healthy individuals, this elevation could reach more than 2 degrees; 2° that for neurasthenics without headache, the elevation of the temperature is not very considerable; 3° that generally the thermometer indicates in the same individuals a higher temperature when there is a maximal headache. 4° That when the headache decreases, the temperature also decreases.\textsuperscript{324} Regrettably, these measurements are very debatable. Mr. François-Franck already pointed out a few years ago that an enormous increase of the cerebral temperature was needed to cause, on the outside of the skull, a significant modification to the thermometer.

If these still isolated observations were confirmed, they would justify our general interpretation that the headaches are due to modifications of the cerebrospinal fluid pressure, itself dependent on secretory and circulatory disorders. The headaches would doubtlessly remain a consequence of the functional numbness of nerve centers, but a very indirect consequence and not an immediate sensation of this numbness.

As for the various forms that the patient attributes to his cerebral pains, we are not capable of explaining them completely, they depend on the degree of these modifications of the intracerebral pressure and on a crowd of concomitant sensations. Muscular contractions of all the muscles that are inserted on the skull and that cause pains located in their tendons, disorders of the eye or the motor muscles of the eye, the disorders of hearing and in addition the various sentiments of incompleteness, strangeness, isolation, come to join in the subject’s mind in the main sensation of pain and determine these various nuances of headache that he likes expressing through metaphors and symbols.

As for the localization, I have already had the opportunity to express

\textsuperscript{324} Lubetzki. Thèse, 1899, p. 33.
my opinion on this subject, I may not believe that a man is aware of the place in his diverse convolutions and that he feels a pain in the place of the convolution that works least well. It is about a much less important localization: the patient feels a vague pain that has its main starting point in the meninges and he localizes it vaguely towards the skull that is most in touch with them and that preserved the greatest sensibility. I had the opportunity to redo on Ll... (226), who had a beautiful bald skull, an experiment that I have already described, which consists in looking for, centimeter by centimeter, the sensibility of the skin on the skull to pain. By employing my spring algesimeter, I noticed that the skull is generally a little sensitive, the instrument has to tally from 25 to 30 so that the patient acknowledges a sting. Now, there are two rather small regions that stand out very distinctly in the group due to their sensibility; it is precisely the vertex and the lambda point where the needle marks no more than 10 or 15. These two regions are the fontanels: is it impossible that the absence of bone tissue for several years of childhood, the small movement that fontanels have during the child’s breathing, the long-term, incomplete suture and the presence of the periosteum preserve this exaggerated sensibility in these places. It could be due to this feeling that the patient would so localize a pain experienced in a vague way.

Naturally, it is necessary to take into account a crowd of secondary circumstances which, by drawing the attention, determine the localization to one point rather than to another one. E..., a 15-year-old boy (tics and mental manias), has a scar at the top of the forehead, to the left, the result of a small wound caused by a fall in early childhood; figure 22 represents a schema that I often used to note the place attributed by the patients of their headaches, the cross indicates the place of this small scar, moreover, slight and not adhering to the bone. The patient has taken the habit of localizing at this point all his abnormal headaches. A dryness of the nostrils,

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a discomfort of breathing, cramps of the frontal muscle or the occipital muscle and the muscles of the nape of the neck cause the localization of the other illnesses in the front or in the rear.

To these cerebral pains, it is necessary to join the pains in lumbar vertebrae, rachialgia. This symptom did not seem to me to have a great interest, but I was amazed to see that some authors gave it a certain importance to diagnose the neurasthenia of what they called anxiety neurosis.

I shall study this question of diagnosis later, for the moment, I note only that rachialgia is frequent in the patients whom I observed, whatever is the form of their psychasténique disorder. Wo..., who has manias of searching and the sacrilegious or criminal obsessions present like Dob... Jean, etc., who have anxieties, like Es... who has tics. Rachialgia is maybe a little less frequent than cephalalgia, but it exists in a rather considerable number of cases so that we cannot, in my opinion, make this symptom a distinctive characteristic of neurasthenics without mental disorders.

Mr. de Fleury points out precisely that rachialgia is often in relation to fatigue or cramps of muscles of the lumbar vertebrae; I am convinced of it, but I do not consider it impossible that this phenomenon of the circulatory disorders of the marrow and the modifications of the intraspinal pressure cannot play a role as in cephalalgia.

2. — Sleep disorders.

The importance of sleep is so great in the neuroses, its relationship with the will and attention is so likely as it is necessary to place here a quick note on the modifications of sleep in our patients.

In a first group, sleep seems little disturbed, on the contrary, the subjects are rather big sleepers. Lo... (213) since his childhood sleeps rather too much. At 20 years old, he still needs 12 hours of sleep a day and still he sometimes falls asleep again

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326 Hartenberg, La névrose d’angoisse, 1902 (Paris, F. Alcan).
during the day. This case is rather frequent and a good many of these patients have a heavy and prolonged sleep. In these cases, it is necessary to note that sleep is not disturbed by the ideas that tormented the day before. As we often noticed, the dreams of a sound sleep do not reproduce the emotions of the day.

In some subjects this heavy sleep at times becomes completely excessive and pathological: it happens rather often that Bu... (85) sleeps 24 hours in succession; once he remained sleeping two days and one night. Lo... sleeps despite herself in the middle of the day, it is the same for Vod... With Je... this exaggerated sleep takes place over periods of time: for a fortnight she is going to be numbed, very frequently she is going to be taken hold of by sleep that persists for several hours. During this period she does not have obsessions anymore and is no longer tormented by her questioning and her continual searches. I believe that this exaggerated sleep must be moved closer to those enormous periods of fatigue that we studied regarding the disorders of activity, they are phenomena of the same kind.

In another group of patients perhaps more numerous than the first one, sleep is disturbed: it became lighter, it remains incomplete and it is traversed by painful dreams. Claire is tormented at night as in the daytime although to a slightly lesser degree. It seems to her that she does not sleep quite entirely “there are always two or three of my persons who do not sleep, however I have fewer persons during sleep, there are some who sleep a little. These persons have dreams and these dreams are not the same: I feel that there are some who dream about other things.” Claire’s dreams are almost all of a well known kind, she pursues something that she never succeeds in reaching, she gets lost in endless corridors, she opens thousands of doors and she has the feeling that she will never arrive at the end. This dream “of the labyrinth” appears to me to be the continuation, under a more colorful form, of the searches, the endless and fruitless efforts that this person constantly made the day before, it is the same state of mind that continues in both states contrary to what took place in the sound sleeps.

Many of the other patients Bei..., Tr..., etc., complain of
not being able to sleep completely. Lise wakes up at the slightest noise and in the morning, she has the sentiment that she did not sleep, that she stayed at the beginning of the sleep, “that she can no more finish sleep than she can end an act or some sentiment.” She sleeps rather better when she is very sick and when she exhausted herself all day long in her ruminations. When she is in the process of improving, she is amazed at the change of her sleep: “I was used to sleeping in a bizarre way by continuing my discussions, now I sometimes awaken with a start, amazed at this new way to sleep soundly; it tires me to sleep in this way.” In brief, there is a change of sleep when she gets better, and this change disturbs her at the beginning.

It is often fair to bring into play in these sleeping disorders the physiological phenomena similar to those that appeared to us to play a role in cephalalgias. Vasomotor disorders, phenomena of congestion are called in to explain them by Angel, by Lubetzki and by several authors. Mr. de Fleury connects insomnia with modifications of blood pressure: normal sleep would require an average pressure from 9 to 12 centimeters of mercury measured at the radial artery; over this figure we would observe insomnias due to high blood pressure, below that insomnias due to low blood pressure.327

There is some truth in these remarks, but I believe I must observe, as I previously demonstrated,328 that sleep is a mixed phenomenon, it depends not only on extra-cerebral physiological phenomena, so to speak, circulation, cerebrospinal pressure, but also still on psycho-physiological facts that take place in the privacy of the brain. On one side, sleep is an act, it demands a certain energy be dedicated at the appropriate moment and to be correctly achieved. The bad habits, the tics, the mental manias intervene in sleep: we have already seen the observation of Dn... (49), in which the agitations and the anxieties appear upon the occasion of the beginning of sleep just like at the beginning of actions. In many ways, the insomnia of psychasthéniques gets closer to their abulia.

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328 *Stigmates mentaux des hystériques*, 1892, p. 127.
3. — *The modifications of the reflexes.*

To all the nervous disorders already indicated, it is necessary to add some modifications of the reflexes. We must note that these modifications are rare and not very clear; the psychasthénique state bears, of course, more on the higher functions of the nervous system and only slightly disturbs the elementary functions and the reflexes. However, in about ten persons I notice that the reflexes of lower limbs are exaggerated. I am not convinced that this is only about an exaggeration of quasi-voluntary movement and related to the motor agitations or the tics. I believe that we sometimes observe in the neurasthenics a real exaggeration of the reflexes of the lower limbs that seems to accompany the cerebral numbness. I, moreover, have to add that I distinctly observed neither the clonus of the foot, nor the phenomenon of Babinski, even when examining patients who have phobias of walking, the dérobements of the legs or crises of fatigue especially concerning the lower limbs. It is an important observation, very useful for the often very difficult diagnosis of these symptoms which sometimes feign diseases of the spinal cord.

I especially stress a remarkable dilation of the pupils that we notice in Claire, Qes..., and for several others; there is not a complete suppression but it actually is a laziness and decrease of the light reflex. This dilation decreases when the patients are a little better and can serve as a sign to follow their improvement.

2. — *Disorders of the digestive functions.*

The disorders of the functions of nutrition are much clearer, more independent of the patients’ mental state. Their general appearance is almost always poor: they are thin, have a bad complexion and change countenance and appearance in a very fast and very frequent way, Jean and Gisèle suddenly take extremely miserable appearances and we would believe them under the blow of a grave disease.
1. — *The gastric disorders.*

The main physiological disorder that exists in the great majority of these persons is constituted by disorders of stomach digestion. We can say that nine times out of ten we have to deal with subjects who digest badly, an extraordinary exception is Jean who seems to have a rather good stomach: all the others almost without exception have gastric disorders.

A small number of these patients presents an exaggeration of appetite and a perpetual need of food. Mr. J. Roux, in an interesting study on hunger, reports the interesting observation of a woman affected after a childbirth by a continual hunger.\(^{329}\) She perpetually feels a state of weakness and regains a little energy only having taken in a little food. I have observed several subjects of this kind: Nol..., a 25-year-old, obsessed, phobic girl, and especially aboulic, asks constantly to eat and, if we let her, she devours all day long. “She needs to revive and, for that, to eat constantly... it is as if she has died from hunger..., she would eat constantly without stopping and if they had not always prevented her from eating, her malady would be already finished for a long time.” I have already indicated the case of Lkb... (100) who demands to eat as soon as we want to obtain from her the smallest effort. Pi... has in his pocket a piece of bread and a slice of ham and he “eats them on the stairs before entering someone’s home to give himself some assurance.” They are phenomena similar to the needs of excitement by alcohol or morphine related to feelings of physical and mental weakness. We notice it very clearly in the observation of Lkb... who forgets her bulimia when we leave her sluggish, plunged into her musing and who demands to eat when the difficulty of an effort reminds her of her feeling of weakness.

These exaggerations of the appetite are therefore completely accidental; generally, the great majority of psychasthéniques barely eat. These patients have no appetite and they are rather disgusted by all alimentation.

---

The pains almost always begin as soon as the patients eat, Brk..., Nadia, Za..., Mrc..., etc., begin to suffer immediately and complain about cramps and about burns. Some (Claire, Qs...) have vomiting, but this phenomenon is not very frequent. What is constant is that the stomach is inflated and heavy; the patients suffocate, have yawns, are forced to loosen their garments. In the examination, we often observe some epigastric swelling and we notice especially a splashing noise caused by any jolt. This noise is heard more or less low as the stomach is more or less distended, very often it descends to the navel and sometimes further below. The digestion is slow, the malaise continues until the following meal and the patients have the sentiment that the first meal is not digested when they take the second. They have heartburn, pyrosis, they have a furry tongue, they experience a vile taste in the mouth and very often atrocious migraines without delay following these bad digestions (Bal..., Claire, Gisèle, etc.).

This picture can present some varieties, Lise differs a little from the general description in the fact that mostly she feels nothing during the digestion and complains about nothing; but I am inclined to believe that she is absorbed far too much by her ideas to take account of what she experiences. She eats in a mechanical way, very quickly without knowing what she swallows, her stomach splashes enormously, she often has indigestions followed by vomiting or by diarrhea immediately after the meal in which she returns the food almost intact. However, she does not suffer from the stomach and only complains of feeling an enormous fatigue during the digestive period.

Gisèle also has some remarkable peculiarities of gastric disorder. This girl always digests with difficulty, with swelling and even some discomfort of the heart by backflow, but from time to time she begins great, quite special gastric disorders. The beginning is rather abrupt: she feels an irritation of the throat, the esophagus and the stomach burns, the tongue abruptly becomes white and is going to remain furry for a rather long period, the digestion is deleted, so to speak, food becomes diarrhea almost immediately after having been absorbed. Like the preceding patient,
and much more so than her, Gisèle’s head feels the repercussion of her digestive disorders. As soon as she eats, she feels a violent pain in the back of her head and this pain is such that she dreads it and refuses food. As a result, during these singular crises of the stomach, sometimes for several months, the patient seems to have another obsession, instead of being preoccupied by her remorse of vocation, she has the obsession to refuse food or to absorb minimal quantities of food.

The alternation that appears here is one of the most singular phenomenon that present in the disorders of the stomach for psychastheniques. In about twenty patients, with much regularity, I observed an alternation between the psychological disorders and gastric disorders: it is evident that Gisèle is less scrupulous, less obsessed by her remorse of vocation when she is sick to her stomach. It is the same for Lise, when she is very obsessed, she eats well and does not speak about the stomach; when her state of mind is better, she complains about strong stomach cramps, indigestions, abdominal paralysis. It is the same for Lod..., for Bal..., and for a very large number of the other patients.

To explain these singular alternations between the mental disorders and the gastric disorders, I had supposed at first that the gastric disturbance was somewhat permanent and that during periods of mental disorder the patients stopped noticing it because of the excess of their moral preoccupations. This explanation seems insufficient to me now, at least for certain subjects. During the period of gastric pain, Lise has diarrhea immediately after the meal and she does not have them during the period of obsession; in the first period she loses weight, whereas she gets fat in the second. It is likely that the alternation must be deeper: things take place as if the nervous disorder sometimes concerned the centers of the psychic functions, sometimes the visceral centers.

It is indeed evident that these gastric disorders have their starting point in a nervous disorder. I am not able, here, to resume the study of this special disease of the neurasthenic stomach that was very well analyzed in many works. 330 Most of

these disorders are connected with three main phenomena: 1° there is a motor paralysis of the stomach that becomes flaccid, falls, is allowed to distend due to food, liquids and gases; 2° we notice a defect of secretion from the gastric glands, a poverty of the liquid secreted as hydrochloric acid and pepsin: most of the analyses of gastric fluid that were made in these conditions show a state of hypochlorhydria; 3° finally, the badly digested, stagnant foods in the dilated stomach undergo abnormal fermentations, give birth to acids and to toxic products that modify the state of the blood and are going to have an effect on the central nervous system and to play a role in migraines.

In some rare cases, it is a matter unlike gastric hypersthenia, according to Mr. Robin, behind the cramps and hypersecretion of hydrochloric acid. It is the disease of Reissmann, this disease can indirectly weaken the central nervous system and cause psychasthénique disorders. It is necessary to take it into account in the treatment. But it is, in my opinion, an exception in the true and primitive psychasthénie. The gastric hypersecretions that sometimes appear at the beginning of eating are a flash in the pan, as Mr. de Fleury said, and the fundamental state remains mostly a motor and secretory pareses. These gastric disorders of psychasténiques are not, as can happen sometimes in the hysterical, directly in touch with an idea. Mr. Dubois of Bern\textsuperscript{331} seems to me to exaggerate when he says that any nervous dyspepsia is answerable to suggestion. Many of these patients have no obsession relative to their digestion. It is only indirectly, through the weakness of the intellectual functions, that thought has an influence here on the stomach.

By studying the circumstances that make the disease alter in various directions, we shall see how a happy excitement, albeit simply emotional, transforms the digestion and how this gastric adynamia is in touch with a reduction in all nervous functions.

\textsuperscript{331} Dubois (de Berne), Troubles gastro-intestinaux du nervosisme, Revue de médecine, 10 juillet 1900.
Abdominal and intestinal modifications almost always accompany these gastric disorders. We are mostly struck by the flaccidity of the abdomen, so well described by Mr. Glénard.\textsuperscript{332} We note in Lise, in Ger, etc., the decrease of tension, the languor of the wall that offers no resistance, the visceral rolling, the stomach in numbness, pouch. Sometimes I observed that both relaxed rectus muscles deviate from each other in a completely abnormal way, that can accidentally give rise to pinching the internal organs as described by Gibert (Havre).

Then we notice the prolapse, the reduction in the intestinal mass, and in some cases the visceral prolapses such as the floating kidney (nephroptosis), the wandering liver (hepatoptosis), the mobile spleen (splenoptosis), etc. Other signs are described by Mr. Glénard, a narrowing of the colon, a cecal stenosis, a sigmoid cord, a transverse colon cord,\textsuperscript{cxxi} a beating epigastrium are rarer.

Disorders of intestinal digestion always accompany these changes in a motionless abdomen. Except the diarrheas that sometimes come after a complete indigestion, we note, in the immense majority of the cases, an obstinate constipation with mucoid stool, from time to time accompanied with dried out mucus and sometimes with a little blood. Ron..., Ab... (7), Ce... (148), are remarkable types of this coincidence between the frenzy of the scruple and the muco-membranous colitis. In the last patient, the muco-membranous strands played a role in the formation of the hypochondriacal obsession of the “worm spider.”

The most remarkable example is that of Nadia: we can say that to look after this patient it is necessary to be perpetually worried about her constipation. It is about serious things here, as we shall see by speaking about complications; she can make prolonged retentions

of the fecal matter which cause the most dangerous states and in which it is necessary to practice a real curettage\textsuperscript{cxiii} of the rectal pit. These retentions produce more or less grave phenomena of autoinfection in the various patients; in Nadia they were accompanied by states of mental confusion for three months and even by the peripheral neuritis, but to all other subjects they bring at least a worsening of the mental state.

Such disorders are not only mechanical, according to Mr. Glénard’s theory, nor only chemical, according to Mr. Bouchard’s theory, they are obviously connected with the nervous breakdown which already manifested itself by so many other signs. Mr. Brocchi (of Plombières)\textsuperscript{333} indicated two observations of mucomembranous enterocolitis, occurring following emotion. We shall have to discuss many similar facts.

3. — The disorders of nutrition.

These disorders of digestion re-echo in the general nutrition. Except for rather rare cases of obesity, the patients are thin. Jean, for years, presented a terrifying thinness; in spite of a more than sufficient alimentation and an almost always passable digestion, he remains strangely thin and maintains a rather bad complexion. Lise, always very thin, still loses weight in a remarkable way, when she passes through a bad mental period. She passed from 54 kilograms to 46 in 3 months, under the influence of repeated crises of ruminations on the devil. When one manages to calm her mind, she quickly regains weight and increases at about 500 grams a week. Io..., in a crisis of hypochondria that lasted 10 months, had all the preceding digestive disorders and lost 20 kilograms.

Gisèle for her extreme height (1m, 82), has a very small weight of 57 kilograms. During certain periods, she loses even more weight, exhausts herself and seems in a desperate state. Like the previous patient, the weight quickly increases as soon as the mind calms down. I followed about such twenty patients by taking their

\textsuperscript{333} A. Brocchi (de Plombières), A propos de la pathogénie de l’entéro-colite muco-membraneuse. \textit{Presse médicale}, 28 août 1901.
weight every week; it is useless to reproduce these columns of figures, the general result is a
curious concordance between mental improvement and the increase of weight.

It is not surprising that the same disorders of nutrition favor all the infections and that in some of
these cases there are tubercular lesions. But most often we mainly observe the symptoms of the
arthritism. The warping chronic rheumatism is frequent especially in the old patients: Germ..., already at 26 years, has entangled and deformed fingers, Xa... (204) at 65 years has
hypertrophied knees, all the joints of the fingers swollen and deformed, the same is true in thirtee
of these patients.

These remarks suffice to show that the psychasthénique state is not only a psychological
disorder, but also a disorder of the organism’s nutrition.

4. — Urinary Disorders.

The psychasthéniques rarely present the characteristic disorders of urinary functions that we
often see in the hysterics: we do not observe the complete retentions or the incontinences that it
is necessary to discuss and to interpret in the other neuroses.

However, in two patients, Brk... in particular, I have clearly observed crises of polyuria: once,
the emitted urine was three liters per day. This polyuria precedes their periods of insuperable
fatigue.

With other patients, what disturbs the urinary functions is not limited to these functions, they are
tics of repetition sometimes causing polyuria or the search for urinary perfection, as we saw in
the observation of Vor...

The analysis of urines would be particularly interesting if it could be precise enough to give
particular indications of the disease. Regrettably, the data from this analysis is still very vague
and is found in the diverse forms of arthritism.

The total analyses that I have made, a small number it is true, about approximately twenty, gave
me nothing of interest: I observe generally a decrease of urea, a certain increase
of uric acid and phosphoric acid. I observe an increase of indican and skatole, these products are related to the intestinal fermentations, which was already indicated by Mr. de Fleury,\footnote{De Fleury, \textit{op. cit.}, 178.} but I am not struck as he is by the increase of sodium chloride in those who have gastric disorders. I most often notice over 24 hours: 10.20gr (Lise), 9.50gr (Lise), 13.650gr (Bal)..., 11 grams (Dob...), these are normal values, the average being from 10 to 12.\footnote{Yvon. \textit{Analyse des urines}, 1901, p. 163.}

That which has particularly been the object of my studies was urinary acidity. Struck by the importance of Mr. Joulie’s works on this point, I had tried to verify them, from this standpoint, by examining urines of the neuropaths. I owe all my thanks to Mr. Lacroix, physician in the pharmacy at Salpêtrière who, with a very large accommodation, was kind enough to make a considerable number of these analyses for me, following Mr. Joulie’s method.

I leave aside here the very numerous analyses made on hysterics and I give only the results obtained on psychasthéniques. The analysis is done on the first urine of the morning with a solution of saccharate of lime, the titer of which is very frequently verified.\footnote{The measured acidity value, reported as equivalent bisulfate, $\text{HSO}_4^-$ concentration is divided by the excess density of the urine examined compared to that of water, both values normalized to 15 C. I report also the [measured] quantity of phosphoric acid per liter, and the ratio of that value to the excess density calculated in the same manner. Most of these patients were subjected to the treatment proposed by Mr. Joulie, by the phosphoric acid. I shall later give you more about the treatment of urine analysis modified by this drug. I indicate here only the urine analyses prior to any treatment.}

To appreciate these figures, it is necessary to remember the figures given by Mr. Joulie as normal.

Density corrected to 15°...........................1 017°,8
Total acidity in $\text{SO}_3^3\text{HO}$.................................0 ,849
Phosphoric acid in $\text{PhO}_3^3$..............................2 ,083
Relationship of the acidity to the excess of density..................4 ,55
Relationship of the phosphoric acid to the excess of density....... 11 ,17
Analyses made by Mr. Lacroix.

<table>
<thead>
<tr>
<th>Patients' Names and number of analyses</th>
<th>Density corrected to 15°</th>
<th>PhO³ Per Liter</th>
<th>Relationship of acidity to the excess of density</th>
<th>Relationship of PhO³ to the excess of density</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jr.</td>
<td>1.013</td>
<td>2 kg, 10</td>
<td>5,86</td>
<td>15,17</td>
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<td>Ls.</td>
<td>1.028, 5</td>
<td>4,84</td>
<td>3,34</td>
<td>16,8</td>
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<td>2.</td>
<td>1.027, 5</td>
<td>4,43</td>
<td>3,83</td>
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<td>Bro.</td>
<td>1.017</td>
<td>1,32</td>
<td>0,39</td>
<td>7,4</td>
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<td>2,01</td>
<td>4,70</td>
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<tr>
<td>Dn.</td>
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<td>3,78</td>
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</tr>
<tr>
<td>2.</td>
<td>1.012</td>
<td>1,41</td>
<td>4</td>
<td>6,71</td>
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<tr>
<td>3.</td>
<td>1.033</td>
<td></td>
<td>3,9</td>
<td></td>
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<tr>
<td>4.</td>
<td>1.031</td>
<td></td>
<td>3,83</td>
<td></td>
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<td>Fr.</td>
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<td>2,86</td>
<td>2,163</td>
<td>9,37</td>
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<td>Ger.</td>
<td>1.015</td>
<td></td>
<td>4,03</td>
<td></td>
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<td>1.022</td>
<td>1,42</td>
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<td>7,85</td>
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<td>4.</td>
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<td></td>
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<td>Qes.</td>
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<td>3,48</td>
<td></td>
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<td>2.</td>
<td>1.014</td>
<td>1,911</td>
<td>3,98</td>
<td>7,1</td>
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<td>Sim.</td>
<td>1.012, 76</td>
<td>1,58</td>
<td>4,55</td>
<td>12,39</td>
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<td>Mad.</td>
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<td>2,49</td>
<td></td>
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<td>4.</td>
<td>1.019, 34</td>
<td>1,59</td>
<td>2,22</td>
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<td>6.</td>
<td>1.015, 25</td>
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<td>4,16</td>
<td>13,81</td>
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</table>
Analyses of urines made by Mr. Terrial, same method.

<table>
<thead>
<tr>
<th>Patients’ Names and number of analyses</th>
<th>Density corrected to 15°</th>
<th>ACIDITY TOTAL IN SO₃HO</th>
<th>ACID PHOSPHORIC In PhO₃</th>
<th>RELATIONSHIP Of the acidity to the excess of density</th>
<th>RELATIONSHIP Of PhO₃ to the excess of density</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rt.</td>
<td>1015,6</td>
<td>0,529</td>
<td>1,157</td>
<td>3,77</td>
<td>8,20</td>
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<td>X.</td>
<td>1019,5</td>
<td>0,502</td>
<td>1,363</td>
<td>2,56</td>
<td>9,67</td>
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<tr>
<td>S.</td>
<td>1033,3</td>
<td>0,477</td>
<td>5,838</td>
<td>1,42</td>
<td>17,48</td>
</tr>
<tr>
<td>Jean.</td>
<td>1023,8</td>
<td>0,379</td>
<td>3,366</td>
<td>1,40</td>
<td>13,51</td>
</tr>
</tbody>
</table>

Analyses made by Mr. Yvon, same method

| Vic.                                  | 1033,3                  | 1,17                   | 3,27                    | 3,50                                          | 13,73                                         |
| Nadia.                                | 1016                    | 0,98                   | 1,71                    | 6,1                                           | 10,7                                          |

We notice in these analyses some common characteristics, interesting by their frequency. The density offers nothing remarkable, it is twelve times below normal, fifteen times above, this characteristic varies according to the regimen of beverages, which it is important to regulate in these dyspeptics.

But what is striking is the weakness of the relationship of the acidity to the excess of density, it is only 3 times more than normal and it is 31 times less. If we refer to these analyses, psychasténiques, like most of the neuropaths, would be hypo-acidics.

The relationship of phosphoric acid to the excess of density is 8 times above normal and 13 times below.

We can take these observations into account, particularly the indications relative to the very frequent hypoacidity, according to this treatment. Regrettably, this chemical method of analysis and the exclusive choice of the morning urine are today still very controversial and we cannot consider these results, especially those relative to the acidity, as definitive. Other authors, such as Mr. Vigoureux, mostly found urines of the neurasthéniques to be hyper-acidic.

It is, therefore, necessary to content ourselves to registering these urine tests as documents of expectation, without drawing from them more general conclusions about the state of these patients’ nutrition.
I shall not dwell on respiration: in the panic attacks, mechanical disorders appear that I have already indicated through studying some graphs. But except for these crises, respiration remains about normal.

We can simply remark that it is generally weak, rather shallow and a little bit fast. Other disorders of respiration, the coughs, the laryngeal murmurs, are connected with tics and with anxieties and were already described in the previous chapters. I did not have the opportunity to analyze the gases of the breath in these patients as in the hysterics; it is likely that we would observe some decrease of carbon dioxide in relation to the slowing down of nutritive activity.

The most striking disorders of circulation occur at the time of the anxieties where we noted palpitations, modifications of the blood pressure, and vasomotor disorders. It is interesting to wonder if some of these disorders do not persist outside the periods of anxiety.

The number of heartbeats seemed to me almost always normal or at least to present only insignificant variations, in relation to the emotions of the moment.

1. — The modifications of blood pressure.

Several authors, Angel in Germany, Webber in America, accepted a decline of the arterial tonus in the neurasthénique state. Mr. Chéron in France, and Mr. de Fleury, gave a very great importance to this symptom. Mr. de Fleury accepts a small number of neurasthéniques with hypertension of the pulse, and connects their disease with autointoxications and a great majority of neurasthéniques with arterial low blood pressure.


338 Webber, Boston méd. Journal, 3 mai 1888.

This decline of the blood pressure would result from a weakness of the propulsion from the heart and from the weakness of the tonus of the walls of the arteries, it would cause an impoverishment of hemoglobin in the blood, and a closely related decrease of the number of blood cells due to an increase of the liquid part of the blood, whereas in high blood pressure, there would be flushing in the peripheral tissues by a contraction of the arterial network and a closely related increase in the number of red blood corpuscles. These observations are interesting and probably right in many cases.

I am always disposed to admit that there is a frequent arterial hypotension related to the muscular weakness, the diverse visceral prolapses and mental depression. I only note that a precise, experimental check of this fact is not always easy.

I took many measurements of blood pressure with the sphygmomanometer of Chéron and I was brought, as I said regarding anxiety, to consider these figures as doubtful and unusable. Since I got the sphygmomanometer of Potain, it seems to me that it is easier to use and gives me more concordant results. However, I cannot refrain from remaining amazed at the precision of figures given by some authors, when, in my opinion, the clinical measure of the blood pressure in a man is still very imperfect and subject to many errors.

Be that as it may, here are the figures that seemed to me the most certain for some of the previous patients:

<table>
<thead>
<tr>
<th>Name</th>
<th>Measurement</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lpx...</td>
<td>not in a crisis of scruples</td>
<td>12</td>
</tr>
<tr>
<td>Ul...</td>
<td>not in a crisis of anxiety</td>
<td>14</td>
</tr>
<tr>
<td>Ul...</td>
<td>other measurement</td>
<td>13</td>
</tr>
<tr>
<td>Meu...</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Lise</td>
<td></td>
<td>15</td>
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<tr>
<td>Kl...</td>
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<td>15</td>
</tr>
<tr>
<td>—</td>
<td>other measurement</td>
<td>15</td>
</tr>
<tr>
<td>—</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Pot...</td>
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<td>15</td>
</tr>
<tr>
<td>Chx...</td>
<td>other measurement</td>
<td>18</td>
</tr>
<tr>
<td>—</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>Lais...</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Claire</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>—</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>—</td>
<td></td>
<td>13</td>
</tr>
</tbody>
</table>
If we remember that normal is 16, it is evident that most of these observations show a certain degree of low blood pressure.

In one case, that of Meu..., I was able to notice a pressure from 17 to 18 during a period of good improvement in contrast with the previous figures of 10. But generally the relationship of arterial hypotension to mental depression is far from being very clear.

2. — The vasomotor and secretory disorders.

Angel in 1884 and Mr. Bouveret in 1891 described a particular disorder of vasomotor reactions in neurasthéniques: in a healthy man who makes an intellectual effort, the cerebral vessels dilate, and they observe at the same time that the vessels of the arm tighten. In the neurasthénique, according to the observations of these authors, this vasomotor reaction of the arm no longer exists. The arm does not change volume, at the very most there is observed on the arm some slight vasomotor oscillations. Angel explained these facts by supposing that the vessels of the arm were already contracted beforehand and the vessels of the brain dilated. The persistent oscillations would be due to the overdistension of the vessels of the brain during the intellectual effort, a new influx of blood would cause the return of a part of the blood to the periphery.³⁴⁰

These experiments often give interesting results about the psychasthénique patients if we can at least replicate it on them with some precision. Indeed, it is easy to observe that they often present a large number of phenomena related to vasomotor disorders.

Gisèle has numbness of the fingers that goes up to the phenomenon of the dead finger. Many patients often have hands and feet that are red or bluish and cold; they present with red patches on their ears and nose, red scars on both sides of the nose below the eyes as if they wore a much too tight lorgnette.³⁴⁵ These persons, especially in their youth, very often had congestions of the pharynx, swellings of the tonsils, pharyngitises on the

³⁴⁰ Lubetzki, op. cit., p. 15.
slightest pretext. I note in Claire a curious tendency to the edemas that occur mostly in eyelids, lips and sometimes in the vulva. In some patients, these edemas can be reproduced in an experimental manner, it suffices to exercise a pressure on the skin to see them appearing. It is a phenomenon of dermographia\textsuperscript{cxxxvi} that I observed five times in obsessives or phobics and in a particularly remarkable way in Du... (49); in Qi... (188), who has this curious obsession to want to be a child, there are outbreaks of hives. For this last patient, Qi..., when she carries a package under her arm, when a hard object presses on a part of the skin, there quickly appears in this place a patch of hard, whitish edema. If she sews, there is an edema on the fingertips, if she rubs her eyelids they remain swollen for a whole day, if she leans on the edge of a window, then her arm remains swollen, her thighs swell if she remains seated for a while, etc. I stress these vasomotor disorders because they played a role in the emotional theory of the obsessions. But you should not believe that all the psychasthéniques presents these abnormal reactions. Many have no trace of dermographia and their vessels seem to react to the various agitations in a most normal way.

To the previous phenomena, we can connect certain cutaneous diseases in which the nervous disorders certainly play a role; I was struck by the frequency of eczema in these patients; I found it in about twenty cases, eczema of the face is particularly persistent for Lise. A perineal eczema was the starting point of urinary mania for Vor... (137).

Finally, it is necessary to indicate the secretory disorders, dryness of the skin is a commonplace phenomenon that worsens during the bad periods of the mental illness. A dryness of the nose, an absence of tears is observed frequently. Many agoraphobics, like R..., complain “that their nose is dry, like it is hardened inside” either on a single side or both.

In contrast, there are crises of exaggerated secretions, in the photophobia of Bry..., there is edema of the eyelids, improbable watering of the eyes “to soak forty handkerchiefs” in
one morning. After the crisis, we note an outbreak of herpes on the eyelids, on the nose and mouth.

Numerous psychasténiques present these crises of rhinorrhea so well studied recently by Mr. Nattier in the journal La Parole.\textsuperscript{341} For Mrs..., a 41-year-old woman, “the nose begins suddenly flowing, like a fountain, for several hours.” For Gay... (26), a 20-year-old girl, rhinorrhea happens the day after an emotion or after a big crisis of scruples. She wakes up with the feeling that her nose is swollen and painful like at the beginning of a head cold. At the beginning, the secretion is a little bit thick and mucoidal, then little by little it takes on the character of the hydorrhea; it is a continuous aqueous flow. She tried to collect for me, rather exactly, the liquid that passed through her nose for a determined time. The quantity was about 30 cubic centimeters in one hour. Mr. Lacroix was kind enough to make the analysis that follows:

Neutral reaction.
Chlorides 9.3 grams per liter.
Phosphoric acid (alkaline phosphates) traces.
No sulfates.
Sodium (chloride and phosphate) traces.
No potassium, nor calcium hydrate, nor magnesia.
Traces of albumin.
No cholesterin.

It is, all in all, the fluid of edema, and the rhinorrhea gets closer to previous disorders of edema. In the second volume of this work, regarding the observation of Gay... (26), we shall study the interpretations of this phenomenon, we shall see that it is almost impossible to explain the nasal hydorrhea of this girl by a flow of the cerebrospinal fluid and that it is probably from a disorder of the secretory glands that hide in the frontal sinuses.

I observed a case of vaginal hydrorrhea: “the water flowed by the glassful, like a woman who delivers.” The serous diarrheas, “the intestinal rain” of Lasègue, obviously gets closer to these phenomena.

\textsuperscript{341} M. Nattier, La rhinorrhée exclusivement symptomatique de neurasthénie. La Parole, juillet 1905 et sq.
I have already spoken about the disorder of the sexual functions regarding the emotions, because the disorder is rather more psychological than physical. The sensibility is dulled, the emotion seems incomplete, unfinished, and the excitement, especially for a woman goes on for eternity without succeeding. This incomplete act is followed by fatigue, by regret, by dissatisfaction. Sometimes there is, for the woman especially, an intense need to reach this sensation that seems to break out into a mania of perfection in a completely singular matter.

But next to these psychological disorders some physical disorders take place. Insufficient erection, premature ejaculation, insufficient secretion, are observed very frequently.

I tried to gather some information on the menstrual functions in these scrupulous women and I was not able to arrive at very clear conclusions because the disorders are very variable. Almost always, the establishment of menses is late and is made only at 15 or 17 years of age; as we shall see by studying the evolution of the disease, this late establishment of puberty is, for many, the date of the beginning of the mental accidents. I observed a curious and rather rare fact in Gr..., a 30-year-old, it is that this woman was never regular; I have just remade the same observation on another patient.

Mw... (145), a 28-year-old, had, around the ages from 15 to 17 years old, periodic nosebleeds for a few months; since the age of 20 years she has faintness and gets tired, which arises every month, but she has never had her menses. She is a typical scrupulous with the mania of oaths, etc. Most curious is that she has two sisters who are similar in the fact that they were never regular either, but who are simply nervous without having the same mental illness.

In many of the others we note delays, irregularities, vaginal discharge and sometimes bleedings. Very often we observe the abolition of menstruation for a more or less long period,

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342 De Fleury, op. cit., 305.
when the great mental accidents develop. In a curious case this arrest of menstruation happened at 23 years of age for Mx... and was permanent. The patient is now 40 years old and menstruation has never reappeared. In the patients who preserved their menstruation, the menstrual period is usually characterized by a redoubling of all the disorders. It is what we observe with Claire, Ger..., Vi..., and Lod..., etc. Some patients such as Lise are not at all impressed by their menstrual period. By exception, some subjects are better at this moment, like during pregnancy. These last phenomena will be studied with more interest as we examine the evolution of the disease and the phenomena that influence its course.
I would like to become acquainted with and to clarify the general characteristics, from the previous chapters, of these diverse psychological and physiological disorders, the group of which establishes the *psychasthénique* state. I still do not try to interpret them but simply to summarize them.

1 — *Psychological incompleteness.*

The psychological disorders present for the most part in the form of sentiments that the patients experience and that they describe with a grand luxury of comparisons and metaphors.

These sentiments can be summarized by the following chart:

**THE SENTIMENTS OF INCOMPLETENESS**

- Sentiment of difficulty
- Sentiment of uselessness of the action
- Sentiment of incapability
- Sentiment of indecision
- Sentiment of embarrassment
- Sentiment of automatism
- Sentiment of domination
- Sentiment of humility, shame
- Sentiment of rebellion
If we try to find and to express what there is common in all the sentiments, we arrive first at this notion of incompleteness, the incompleteness that the patients express in one thousand ways about all these various sentiments: “the worst of everything,” said Lise, “is that I arrive in the end to essentially nothing, it is a kind of vertigo as soon as I must get to the end of something.”

I indicated this remarkable fact by the words sentiments of incompleteness. Psychasthéniques are characterized by sentiments of psychological incompleteness that are more or less general, more or less deep, more or less permanent.

It was, therefore, very important to realize the value, the importance of this sentiment. The first question was: is this sentiment of incompleteness wrong or is it fair? Is it a wrong idea, an obsession, a mental mania, or does it correspond to the real characteristics of the psychological operations themselves? The problem seems very simple, but it is extremely difficult in reality. The intelligent patients, like Lise, pose this question to themselves and do not manage to answer in any clear way.
Of course, there are numerous cases where this sentiment has become exaggerated and ridiculous. When Vor... goes back fifty times in succession to the restroom because she has the sentiment of having urinated insufficiently, it is clear that it is absurd. An act like that one seems to us to consist simply in emptying the bladder and requires nothing else, and she emptied it enough the first time when she urinated a half a liter, as a result we think that she is delirious due to having a feeling that the act of urinating is incomplete.

In other cases, it is clear that if the act is imperfect, it is the patient who made it that way, precisely by improving it. Certainly Rai... breathes in a poor way, by spitting and belching on all sides; such breathing is very faulty. But it became irregular because of techniques used by the patient and these techniques happened only because the patient considered it already imperfect. It is, therefore, probable that this breathing was not poor at the beginning, in any case it was much less so than today.

But these exaggerated cases do not resolve the problem. From the fact that the patient obviously makes a mistake now, it does not follow that he is always wrong. Could it be possible that he generalizes indiscriminately, that he applies to an insignificant act a sentiment determined by a real psychological imperfection? I confess that, despite the difficulty, it is towards this opinion that I am inclined and that for me the problem of the scrupulous consists in finding what is this psychological imperfection that, like a thorn, perpetually torments them, which causes their exaggerations and their ravings. What inclines me towards this opinion is that I found sentiments of incompleteness in many subjects without obsessions of humility or self-accusation, who took note of these sentiments in a very moderate manner without attaching any importance to it, without transforming them into manias or into obsessions.

The second reason for this opinion is that we can observe in these patients a certain number of real psychological disturbances, independent of their own evaluation. All the authors found in the obsessed and the phobics arrests or delays in the development of various faculties and especially an unequal development, a lack of harmony and equilibrium between these faculties. “These people,” said Mr. Séglas, “are psychologically partial, incomplete, unbalanced beings, they
can have a prodigious memory, but they cannot succeed in fixing their attention. Mobile and
absent-minded, their mental instability is sometimes extreme. They are aboulics, apathetic, yet
at the same time, they have fits of great excitement and inexplicable enthusiasm: they are
original, eccentric, dreamers, having inordinate imagination with romantic tendencies. Finally,
they are emotional, timid, sensitive to excess, impressionable and susceptible, selfish and
bumptious.  

I tried to specify these very often made comments and to enumerate, in addition
to the agitation described in the previous chapter, the psychological insufficiencies that the
psychastheniques most consistently present.

These insufficiencies are summarized in the following table:

THE PSYCHOLOGICAL INSUFFICIENCIES

Symptoms of the constriction of the field of conscience, anaesthesias, subconscious movements, suggestions in a
rudimentary state

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Séglas, Leçons sur les maladies mentales, p. 68.
All these fears have a certain importance, more or less significant depending on the case, they seem very independent of the obsessions and of the manias.

As a result we can already present a first general characteristic that summarizes a considerable part of psychasthéniques’ stigmata. The patients have the sentiment that their mental activity is incomplete and, on the other hand, this activity indeed presents a certain number of gaps which, to a certain extent, justify this sentiment of incompleteness.

2. — *The loss of the reality function.*

By placing ourselves at another point of view, we shall find in all these psychological disorders another general characteristic so curious and so important that it is essential to highlight it. Among the most remarkable sentiments that the subject experiences regarding actions, regarding the perceptions of external objects and regarding the perception of himself, there is a whole group composed by the sentiments of oddness, strangeness, of never having seen, of dreaming, that we can, if I do not make a mistake, reduce to one common characteristic.

When the subject repeats that he cannot succeed in doing an action, that this act became impossible, we can notice that he no longer feels that this action exists or can exist, that he lost the *sentiment of the reality* of this action. When others tell us that they act in a dream like sleepwalkers, that they play a comedy, it is still the reality of the action, as opposed to the simulation of
an action in a dream or a comedy, that they became unable to appreciate.

This fact when it occurs in the external and internal perceptions is so curious that I desire to give one more example to add to all the previous ones. A 58-year-old woman, Gou..., admitted to Salpêtrière has just been sent to the infirmary because for two months she is affected by an extraordinary frenzy. She no longer wants to do any more work nor to occupy herself with anything, no matter what it is, she stays constantly on her chair to moan and to complain: “it is useless to do anything,” she repeats, “because everything is dead... they put me in a grave where there is nothing, where I am absolutely alone in a hideous darkness... Everything is black around me, the black of ink... everything is empty, nobody exists any longer, no living being around me, it’s as if I had died also, etc...” As always, the usual examination of the senses and behavior causes us the same astonishment, we cannot observe any disorder even the slightest of any sensibility, the patient sees objects and colors very well and behaves very correctly. At the same moment when she declares that everything is black and that everything died, she is very well going to ask the supervisor for her herbal tea.

The main sentiments observed in that case, as in the prior ones, are the sentiments of: the absence of relief, darkness, blackness, oddness, strangeness, disgust, never having seen, the inauthentic, simulation, dreaming, estrangement, isolation, death. What is the sentiment to which all the others are connected? They have said that it was once again the sentiment of strangeness; I believe instead that it is the sentiment of non-reality, the sentiment of the absence of reality. It is the sentiment of the absence of psychological reality in external beings that makes them say that animals and persons placed in front of them are dead. It is the same sentiment concerning the disappearance of the common reality that is in the sentiment of dreaming, of simulation, of never having seen and of strangeness. In short, the patients continue to have the sensation and perception of the outside world, but they lost the sentiment of reality that usually is inseparable from these perceptions.

It is the same for personal perception: when the patients feel that they lost their self, that they are half-alive, that they died, that they live no more than materially, that their soul is separated from their body, that they are strange, odd, as if they had a life in another world,
it is still, in my opinion, that they feel unreal. They preserved all the psychological functions, but they lost the sentiment that we always have, rightly or wrongly, of being real, being a part of the reality of the world.

Does this very remarkable phenomenon of the loss of the real exist only in the patients’ subjective sentiments? Can we not find through external observation of their actions and the demonstrations of their thought, proof that there is a particular disorder in their mind? This disorder would concern the psychological functions in their relationship with the given reality, the special function that we can call *the reality function*. cxvii

It appears necessary to me, indeed, to summarize the previous observations, so as to distinguish an operation, or if one prefers a part of the psychological operations, that classical descriptions do not set apart, but that the disease seems to have analyzed. A mental operation, a memory, an attention or a reasoning seems to remain of the same nature no matter what its object is, whether this one is constituted by completely imaginary representations or if its object is formed by completely real events, belonging to the world into which we are plunged. The association of the ideas, as it is often said, is the same in a dream as it is in the experience of life. Is this universally accepted assertion wholly legitimate? The observation of our patients introduces, indeed, a singular fact; it is that their mental operations are not disturbed when it is only about the imagination and that they present some disorder only when it is a question of applying them to reality.

All the disorders of reasoning, attention, the evaluation of situations do not exist in ruminations nor in daydreams, the patient constructs in his imagination very coherent and very logical short stories: it is when it is about reality that he is no longer capable of paying attention nor of understanding. Some of these patients have some literary or musical talent; when they invent stories or pieces of music, their mind works perfectly well, they have neither hesitation nor doubt. Hesitation is going to come if the work of the imagination has to be transformed into real work and be given to the bookseller or the merchant. “I lived in outer space,” says Lo..., “and I lived there very well, but I cannot enjoy things of this world, I do not
see reality and my life is imaginary and fictitious...” “If it was only about my taste I would very well know how to end my rose leaves,” says Tr..., “but when it is a question of providing a finished rose leaf so that it can be sold, I hesitate for eternity.”

Also, the functions are correct in the field of the imagination, they remain perfect when it is about the future and the past. There are some subjects who have curious experiences that bring this characteristic to light. Wo... has dreadful crises of scruples about the accounts of the household and especially the back bills from the suppliers, it seems that her attention is tired as soon as she does a sum of some figures and that she can no longer attain certainty. If we ask her to do a sum on imaginary figures without connection to her real life, the work is very easily done, for as long as we want it, without fatigue and without hesitation. Much more, the patient noticed herself that one of her domestic accounts can be done without any trouble on the condition that it is old, on condition that it is related to business from the previous quarter. She spontaneously gets used to letting the accounts wait to verify them, “the more they are old, the more easily they are reckoned.” It is apparent that the past, like the imagination, is an element at ease, it is the reality and the present that disturb the action.

Indeed, all the disorders that we observed come down to the present and to reality, the emotions are vague without adaptation to the present and real circumstances. “The present gives me the impression of an intruder,” said a patient of Mr. Dugas.\textsuperscript{344} “There is for me a deformation of reality,” says Gisèle, “and I cannot be interested in the world such as it is, nor to work myself up for what exists,” “in fact,” says Lise, “all my agonies come from the fact that I have a bad appraisal of reality.”

The most accentuated disorders are encountered in the voluntary act, in the attentive perception of the present objects, in the perception of the real personality, because they are the operations most strictly in touch with the apprehension of what is real. Their indecision, their defect of certainty, their so characteristic doubt are only different aspects of the same fundamental phenomenon.

The patients indeed act on a condition, it is that their action

is insignificant, this is what makes their agitations, their impulses so little dangerous: they can walk, chat, moan in front of close friends; but as soon as the action becomes important and consequently real, they stop being able to act, they abandon the job little by little, the struggle against the others, the social relationships, etc. Some connect this defect of real action with timidity. “Me, whose whole being,” said Amiel, “mind and heart thirsts to be absorbed in reality, in my fellow man, in nature and in God, me, whom solitude wastes and destroys, I lock myself into solitude and I seem to please myself only with myself. The pride and the modesty of the soul, the timidity of the heart made me violate all my instincts, absolutely invert my whole life.”

It would be necessary to discuss whether, as Amiel thinks, this estrangement from reality depends on timidity or if it is not, as I believe, the timidity that results from this inability to confront reality. But for the moment, I notice only how much this estrangement from reality exists at the bottom of all the disorders noted in the scrupulous. Other patients do not give Amiel’s interpretation, “it is not the action itself which is difficult for me,” said Claire, “it is to take a real action, to make an action for the real world, this is what makes me shy.”

Jean, since childhood, has a special existence: not doing either good or evil, perfectly insignificant from all the points of view, worrying not at all about the given world, he lives, as his teachers in school already said, “foreign to things, foreign to everything.” He was never able to be interested in whatever is of reality, he acquired no handicraft “he does not know what to do with his ten fingers.” It is in vain that we wanted to teach him to play music, to draw, to bind books, to work the earth a little in the countryside, he was able to understand nothing of these various practical jobs. And, indeed, when we try to understand this strange young man, we recognize that it is the practice of life that he lacks in a improbable way. Although he was always affluent, he knows nothing of the value of money, of wealth; he lived in an agricultural region and he ignores everything about farming. This 30-year-old, very intelligent young man, I repeat, is in despair when he must find his dinner in the streets of Paris. To choose a restaurant, to enter it, to order

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345 Amiel, Journal intime, I, 159.
his dinner appears to him an incredible operation: it is not about shyness or about obsession here, it is the practical act of which he does not have the slightest notion. It is the same to different degrees for all our subjects. It is necessary to pose questions about this point, not to the patients, but to their families and I heard a lot of groans coming from mothers, husbands or the wives of the patients. They always repeat that the patient was never practical, that he spent money wildly, that he did not realize his fortune, his real situation, that he knew how to organize nothing, to make a success of nothing. The patients’ circles of acquaintances also insist on this absence of handicraft which is often at home a sign of their defect of practical sense.

The patients retain more of a calling for things that are more removed from material reality, they are more easily psychologists, Jean, who sees nothing of material things, makes psychological comments on people and these remarks are often fine. They enjoy literature, like Gisèle, and turn little by little into literary women, they especially enjoy philosophy like Qsa... and become fantastic metaphysicians: when we had seen many scrupulous, we came to wonder with sadness if philosophic speculation is not a disease of the human mind. These few remarks and studies of several patients are still able to confirm the general character of their mind, which is always estranged from concrete reality.

A very remarkable and a somewhat unexpected consequence of this estrangement from reality is asceticism. Jean is interested in nothing, admires nothing, likes nothing; he has only one concern outside of his obsessions and that is to make the least efforts possible in life. As his efforts bring about deliberations, endless scruples, he does not like reality enough to brave these mishaps: so he comes, little by little, to do without everything, to renounce everything. He has a life of a regularity, one of sobriety, an improbable simplicity for the situation in which he finds himself: “there is no merit in it,” he answers me when I make that remark to him, “the things that you like do not interest me and entail no pleasure; I am separated from your life by a chasm.” It is to this asceticism that all the scrupulous arrive: Nadia, in spite of her brilliant qualities, withdrew little by little from the world, she lives for five years in a small apartment, which she almost never leaves. Outside of her doctor and except for some family members whom she receives from time to
time, she sees absolutely nobody and lives so withdrawn from the world it is as if she was in a convent. All come, little by little, to simplify their life like this, not only due to the progress of the disease, as a result of the manias and the phobias, but because they are fundamentally disinterested in real life.

I would, once again, like to connect this estrangement from reality with the disorders that we noted previously of the sense of time. Bain says that “to understand the behavior of man, it is always necessary to take full account of the absorbing potency of the present.”346 This remark is not precise for our patients, because the present is not absorbent for them. It seems evident to me that they do not make the same distinction that we do between the present and the past.

They grant a disproportionate importance to the past and to the future, but especially to the past. Löwenfeld, as we saw, reported on a patient absorbed by his past;347 but we showed that this characteristic, to varying degrees, is absolutely across the board: “they do not live in the present, their close relations always repeat; they are always keen to recount to themselves and to settle in their imagination some old facts.” They are convinced, as Xyb... said, “that the present can never erase the past.” It is because of the little interest accorded to the present that the scrupulous have no notion of an hour and that they are always late. It is also due to this that they have the singular sentiment that Ver... and Bei... described to us, these patients affected by depersonalization, the sentiment of no longer distinguishing between yesterday, today and tomorrow. Today distinguishes itself for us by a higher coefficient of reality and action, it is because they are detached from reality that they have no sense of the present.

Finally, a last remark must be added to the previous observations, it is that we find a similar disturbance in the pathological phenomena of psychasthéniques, in their hallucinations and in their impulses. As I tried to demonstrate, they only have pseudo-hallucinations that have all the characteristics of hallucinations except the feeling of reality; they have impulses that have all the characteristics of psychological compulsion

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347 Löwenfeld, Psychiatrische Wochenschrift, 10 juin 1899.
except the power to determine real actions. This remark is interesting, because it here appears to me to escape the objection that until now we always made. If the emotions, the sentiments, the actions of these patients are incomplete and remote from reality, as we said, it is perhaps because they have an obsession of imperfection that stops them. Well, these patients do not call into question whether the hallucination would be, from our point of view, a perfect phenomenon. They do not even realize the character of a true hallucination and when they describe their so imperfect hallucinations, they cannot bring any humility to it.

They also have no idea of the result of the practices of hypnotism. They desire more the sleep that they consider useful for their cure. However, the hypnotic experiments, carried on for a long time and earnestly continued, showed me that as long as the scrupulous are very sick, they are neither hypnotizable nor suggestible. All these phenomena of impulsion, suggestion and hallucination consist especially in giving the illusion of reality to the subject; it is curious to see that the scrupulous miss out on these like the previous ones. Not only do they no longer have the apprehension of true reality, but they also cannot attain the illusion of reality. This fact would suffice to prove, if it was needed, that the disorder does not consist in an insufficient action of reality on the subject, but in an insufficiency of the mental operations that lead either to the perception of reality or to the illusion of this perception.

We could, therefore, combine a rather large number of their psychological disorders by supposing, contrary to common opinion, that the present reality requires a special complexity of the psychological operation and that there is consequently a special function that we can call the reality function. It is a disorder of the apprehension of reality through perception and through action that summarizes the disorders presented by our patients except for their manias and except for their obsessions.

The study of the physiological disorders is simpler and it is easier to summarize them. We observed: pains in the head probably in connection with an inability to regularize the intracranial pressure and with vasomotor disorders; digestive disorders in touch with gastro-
intestinal atonia; urinary hypoacidity; cardiac weakness and vascular hypotension; the secretory disorders and disorders of the genital functions.

In a general way, these are the symptoms of depression. We shall have to discuss, regarding the diagnosis, if need be, separating the obsessions and the anxieties from depression itself. For the moment it is enough to remark that we note in the entire body the signs of a nervous exhaustion which is parallel to the decrease of psychical activity.

In brief, the general characteristics of psychasthéniques stigmas can now be summarized by these three simpler notions: 1° the sentiment of nonachievement, incompleteness of the psychological operations; 2° the decrease or the loss of the reality function; 3° the physiological symptoms of nervous exhaustion.

3. — The psychasthénique periods.

These psychological and physiological phenomena which I called psychasthénique stigmas are not continual throughout the all of the patient’s life, they do not exist continuously, even in the gravest cases, from birth till death. I believe that this notion is central and that it did not sufficiently strike the minds of those who consider this disease as a simple mental degeneration. Reasoning alone could foresee this characteristic: most of the abnormal feelings expressed by the patients are understandable only if we assume a comparison in their minds between the current state of disease and a previous state of health. The subjects say to you ceaselessly that they decline, that they lost their strength, their intelligence, their person: it is, therefore, necessary to admit that they were higher, that they had at some point another strength, another intelligence, another person.

The sentiment of reality, the mechanism of which we ignore almost completely, has to be a relative phenomenon and depend on a certain degree of average activity to which the individual is accustomed. An idiot who had a weak mental activity all his life arrives, however, at a certain sense of reality which is enough for him. It is
very likely that if our patients had always had the same weakness of thought, they would not notice it now and would not complain of not seizing reality, of finding that everything is far off, or that everything died. This reasoning, which can apply to almost all the symptoms, clearly shows that psychasthénique stigmata pertain to an accidental state and are of transitory nature, like an authentic disease.

Moreover, the observation on this point is very demonstrative: without entering the study of the evolution of the disease to which I shall dedicate a special chapter, I may point out here that for all the patients without exception, these stigmata constituting the psychasthénique state appeared from time to time. It is true that only in grave cases can these periods last for a very long time.

In certain, particularly typical cases, the periods are very precise and may last only a few days. In these cases, we can indeed note the appearance of these disorders, their evolution and their disappearance. The authors who described dipsomania, such as Mr. Magnan, definitely noticed the melancholic disturbances, the confusion that often precedes the impulse itself by several days.  

Mr. Séglas is one of those who best noted in the obsessives the appearance of these periods that “actualize,” he says, “as an attenuated form of mental confusion... There is for two or three days an exaggeration of some neurasthénique symptoms... The patients do not recognize themselves any more, are no longer as they were before. The attention is very defective, difficult to fix, easily fatigued; the memory is lazy and unreliable, the will is affected in its motoric form and abulia is rendered by an invincible apathy.”

In many of our patients we can observe these periods of psychasthénie which prepare for the crises of obsession: things take place this way for Got..., for Pot... I shall especially take as an example the observation of Kl... This woman formerly had long unhealthy periods for years; at present, the periods are short, they last only a few days and they stop in a rather clear way. The disorder generally arises a few days after the end of

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348 Magnan, La dipsomanie, p 98.

349 Séglas, op. cit., p. 70.
her menstrual period, it was prepared for by various emotions, the importance of which we shall study, it is announced almost always by a modification of sleep, the patient sleeps less well and in a bizarre way. It seems to her that she sleeps too deeply and at the same time that she does not rest. Those who studied the sleep of epileptics are accustomed to this description. At the same time, Kl... feels that her sleep is painful, that she has while sleeping a pain that forms over her head; it is what she calls “to have the fever in the head.” When she wakes up in the morning and remembers that she had the fever in her head during her sleep, she is sure that she is again going to be sick. Indeed, on this first day she feels very ill at ease, she is tired, her head hurts, she has no appetite; the digestions are long, painful, accompanied with heaviness and with swelling of the epigastric region, the tongue at once becomes completely furred, and the constipation is obstinate. We see that, at least in this patient, it is the physical symptoms that seem to be the first ones to appear.

The next night is even worse and the “head fever” stronger. When the patient wakes up, she is psychologically flustered: “I feel that I am not there anymore, I have completely lost my will, they can make of me what they want, because I became a machine... I cannot read any more nor understand... people seem odd to me and I want to get angry at them because they have odd heads... I become strange, incomprehensible to myself and I wonder about a crowd of things.”

Here it is, then, that our psychasthénique symptoms arise and that very clearly form for this person a period of illness. When these symptoms go on by taking a turn for the worse, the slightest opportunity, an effort to recover the absent will, an effort of attention, or a small emotion, is going to determine the beginning of the other phenomena which we know well; the patient is going to have a crisis of mental rumination and to wonder for eternity about the birth of her child. “The small birthmark that he carries on his behind is the proof that he is from her husband, we can conceive children without having had many lovers, etc.” Or if the patient wants to get rid of these obsessing questions, she will have motoric agitations and enter into real crises of agitation. If the period goes on, the obsessing ideas...
are going to become clearer and Kl... is going to take the blame of having deceived her husband with everybody, is going to have remorse of, shames of herself, etc....

In the past, the periods so begun went on for months. Today, the crisis of rumination or agitation only arises powerfully two or three times for a few hours, the patient is exposed to it only for two or three days. The sixth or the seventh day of the illness, especially if she took some care, is already less serious; there are no more true crises of forced agitation. Everything is restricted to the symptoms of the still very serious psychasthénique state, abulia, the sentiment of strangeness and a certain degree of depersonalization. These symptoms diminish the next day and when Kl... slept well for one night without a “head fever,” everything is finished.

This remarkable case is very instructive: it shows us that the psychasthénique period is longer than the crisis of forced agitation. The crisis of forced agitation and especially the crisis of obsession add to the psychasthénique period, these crises begin not long after the beginning of the morbid period, and generally they disappear some time before it. We can, therefore, in the very clear cases like this one, say that stigmata are preliminary to the crisis of obsession, that they establish a kind of aura similar to the respiratory disorders and to the hysterical’s lump [in the throat]. But you should not forget that things are not as clear as in hysteria: the stigmata that play the role of aura do not disappear when the crisis has begun, they persist all the time in a rather deteriorated condition; besides this aura does not precede a single crisis, but rather a state of illness during which the crises are numerous apropos the circumstances that I indicated and between which the psychasthénique state persists.

It is very evident that for the other patients things are not as clear, the psychasthénique state does not disappear completely at the end of a few days; it constantly persists, more or less attenuated, and we observe only an increase of these stigmata that precede and announce the crises. We shall see again, with more precision, these various groupings of symptoms when studying the evolution of the disease. This picture presented by the typical cases was only intended to summarize and to present, in their aggregate, the various phenomena that we have just reviewed in this especially descriptive and clinical study.
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Endnotes

See footnote 67 on page 113 for Janet’s explanation of the use of this term. Also, consider the terms dipsomania and trichotilomania, then the meaning of “mania,” in its usage here, will be more clear.


There is further elaboration on the meaning of “the beams” on page 152 of this text.

m... is most likely “merde” abbreviated for the sake of etiquette. Merde means “shit.”

Nadia’s case presentation is truly remarkable in many ways. The following are just a few highlights. Janet is said to be one of the earliest writers on eating disorders. On this point, see, for example, Pope HG, Hudson JI, Mialet JP. (1985). Bulimia in the late nineteenth century: the observations of Pierre Janet. Psychological Medicine, 15(4). pp. 739-43. It is primarily a detailed effort at illuminating the illness of psychasthenia. And it is one of the finest descriptions of a failed Electra Complex that I have ever read (here and as developed throughout this text), made all the more noteworthy because Janet was not using the case as an example of retreat from and horror of that developmental phase. Incidentally, I am unable to find Nadia’s case referenced in any analytic articles on the Electra Complex, which seems a shame.

The Garden of Plants is a park and zoo in Paris and is, according to en.wikipedia.org, the “main botanical garden in France.” The webpage “Jardin des Plantes - Wikipedia, the free encyclopedia” was retrieved December 28, 2012 from http://en.wikipedia.org/wiki/Jardin_des_Plantes. The webpage “Jardin des Plantes. Histoire Jardin du Roy Paris” retrieved December 28, 2012 from http://www.paris-pittoresque.com/jardins/1-1.htm has illustrations corresponding to about the time of Janet’s writing. It is unclear to me whether the reference to the bear is to the statue Le Dénicheur d’ours by Emmanuel Frémiet, which can be seen at the webpage “Sculptures à Paris : Jardin des plantes” retrieved December 28, 2012 from http://www.nella-buscot.com/jardins_paris_5_plantes.php or to one of the bears in the zoo; most likely the latter.


See page 141 of this text for elaboration on the connection between urination and a piston for this patient.

A symptom of conversion hysteria wherein the patient can no longer stand or walk normally, according to medical-dictionary.thefreedictionary.com’s webpage “astasia-abasia - definition of astasia-abasia in the Medical

xiii According to T. E. C. Jr., MD (December 1, 1980). Charles Dickens on the Medical Use of Tar-Water, Pediatrics Vol. 66 No. 6, p. 839, Bishop Berkeley recommended this as a cure for virtually all known diseases. This can be viewed at “CHARLES DICKENS ON THE MEDICAL USE OF TAR-WATER” retrieved December 28, 2012 from http://pediatrics.aappublications.org/content/66/6/839.abstract.


xvi Hair loss due to autoimmune disease, see the niams.nih.gov webpage “Questions and Answers About Alopecia Areata” retrieved December 28, 2012 from http://www.niams.nih.gov/Health_Info/Alopecia_Areata/.

xvii See Sully, J. (1888). Teacher’s Handbook of Psychology, New York: D. Appleton And Company, page 145, for a further discussion of this concept wherein, for example, a black object may bring to mind the color white by contrast. This was retrieved December 28, 2012 from http://books.google.com/books?id=9LsKAAAIAIAJ&pg=PA144&lpg=PA145&ots=Fs4kL6WmsB&dq=%22association+by+contrast%22&v=onepage&q=%22association%20by%20contrast%22&f=false.


xix This is a diminished will or motivation or a difficulty in making decisions. Janet will discuss this disorder at some length later in this work. See, for instance, pages 358-363.

xx Psychiatrist.

xxi They believe that logic should be the wellspring for opinions. For more on this philosophic movement, see en.Wikipedia.org’s entry retrieved December 28, 2012 from https://en.wikipedia.org/wiki/Freethought.

xxi.1 An acute infection of the intestine bringing about diarrhea. For more on this topic, see the cdc.gov webpage “CDC - Cholera - General Information,” retrieved December 28, 2012 from http://www.cdc.gov/cholera/general/.

xxiii For a brief video of this disorder, now known as Sydenham's chorea, you can see St. Vidas’ dance in a young girl on YouTube by sarahking11 (Feb 26, 2009). Sydenham's Chorea (aka St Vitus Dance) - Learning to Walk Again. Retrieved file last on December 28, 2012 at http://www.youtube.com/watch?v=RnxqqW_nH0k.

xxiv See page 162 of this book for a definition.
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xxiv The experience when real sensory input is accompanied by an experience in a different sensory system. See the web.mit.edu webpage, “The Synesthetic Experience” at http://web.mit.edu/synesthesia/www/, retrieved December 28, 2012, for more on this phenomena.

xxv For a further discussion of this mania, see Shrady, G. F., Stedman, T. L., Medical Record, Volume 62, July 5, 1902-December 27, 1902, New York: William Wood And Company, p. 304. This can be seen at http://books.google.com/books?id=PhcCAAAAYAAJ&pg=PA304&dq=blasphemous+mania+verga&hl=en&ei=gk0gTcv7fiQglAe04cy6BQ&sa=X&oi=book_result&ct=result&resnum=2&ved=0CCcQ6AEwAQ#v=onepage&q=blasphemous%20mania%20verga&f=false, last retrieved December 28, 2012.

xxvi A cloth covering a woman’s head as well as the neck and chin. See the Wikipedia.org entry on the webpage “Wimple - Wikipedia, the free encyclopedia” located at http://en.wikipedia.org/wiki/Wimple, last retrieved December 28, 2012, for a further description.


xxviii Tuberculosis.

xxix See also page 398 of this text for clarification on why the term “ideal” is used here.

xxx In Catholicism, Canons 1250 through 1253 required abstention from meat as well as soups or gravies made from meat on Fridays. This is considered an act of repentance. A more complete discussion of this topic can be found at catholic.org’s page “Fasting and Abstinence - Easter / Lent - Catholic Online” which is located at http://www.catholic.org/clife/lent/abfast.php, last retrieved December 28, 2012. Thus, Ger… is concerned that the grocer would perhaps think that she was making a meat-based meal for her family on a day that the church forbid.

xxxi The original text has the phrase “tirer la barre.” Literally, this would be “pull the bar” or “pull the helm.” After a discussion on the forum at wordreference.com, I decided to loosely translate it as “take charge” or “take charge and make a decision.” See the webpage “tirer la barre - WordReference Forums” located at http://forum.wordreference.com/showthread.php?t=2546322&p=12830798#post12830798, last retrieved December 28, 2012.


xxiv Fibrous, fatty tissue. Wikipedia.org’s entry on this matter can be found at the webpage “Neural fibrolipoma - Wikipedia, the free encyclopedia” located at http://en.wikipedia.org/wiki/Neural_fibrolipoma, last retrieved December 28, 2012.

xxv Contraction of the neck muscles on one side, according to lexic.us on the webpage “Torticollis: Definition with Torticollis Pictures and Photos.” The entry was last retrieved December 28, 2012 from http://www.lexic.us/definition-of/torticollis.

xxvi Inability to open the mouth, according to lexic.us on the webpage “Trismus: Definition with Trismus Pictures and Photos.” This definition was last retrieved December 28, 2012 from http://www.lexic.us/definition-of/trismus.

xxxviii “ch...” is probably a shortened form of “chier” which means “to shit.”


xli Hip-joint disease, according to lexic.us, last retrieved December 28, 2012 from the webpage “Coxalgia: Definition with Coxalgia Pictures and Photos” at http://www.lexic.us/definition-of/coxalgia.


xliii Pain, usually psychogenic in origin, that leads to immobility, according to drugs.com on the webpage “Akinesia algera definition | Drugs.com,” last retrieved December 28, 2012 from http://www.drugs.com/dict/akinesia-algera.html.

xlv Fear of standing upright or walking, for further discussion of this term please see the en.Wikipedia.org webpage “Astasia-abasia - Wikipedia, the free encyclopedia” last retrieved December 28, 2012 from https://en.wikipedia.org/wiki/Astasia-abasia.

xlvi Heartburn.


xlviii Abnormal sensitivity to stimuli of the senses. For further discussion of this term please see the Wikipedia.org webpage “Hyperesthesia - Wikipedia, the free encyclopedia” at http://en.wikipedia.org/wiki/Hyperesthesia, last retrieved December 28, 2012.

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liv For betraying the gods, Tantalus was condemned to stand in a pool of water where a fruit tree’s branch hung over him. Every time he that he reached for a fruit, the branch withdrew. Every time he stooped for a drink from the pool, the water receded. Read more on the story on Wikipedia.org’s “Tantalus - Wikipedia, the free encyclopedia” at http://en.wikipedia.org/wiki/Tantalus, last retrieved December 28, 2012.


lvii Shortness of breath.

lviii According to en.Wikipedia.org’s webpage “Paresthesia - Wikipedia, the free encyclopedia” at http://en.wikipedia.org/wiki/Paresthesia, last retrieved December 28, 2012, this is the sensation of “pins and needles.”

lix This is now known as Raynaud’s phenomenon or disease. For more on this topic, see the Canadian Centre for Occupational Health and Safety’s webpage “Raynaud’s Phenomenon : OSH Answers” at http://www.ccohs.ca/oshanswers/diseases/raynaud.html, last retrieved December 28, 2012.

lx Involuntary muscle contractions. For further information, see the webpage “clonus - multiple sclerosis encyclopaedia” at http://www.multiple-sclerosis.org/clonus.html, last retrieved December 28, 2012.

lxii An image of this device can be seen at phisick.com’s “Antique Dynamometer by Verdin Paris - Phisick | Medical Antiques:” at http://www.phisick.com/a8dynamom.htm, last retrieved December 28, 2012.

lxii Undigested food passing through with diarrhea.
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lxiv Skin.


lxvii Of or pertaining to sweat, according to definitions.net on its webpage “What does sudoral mean?” located at http://www.definitions.net/definition/sudoral, last retrieved December 28, 2012.


lxix Rapid breathing.

lxx Built for the 1878 World’s Fair and then demolished for the Exposition Internationale of 1937 when another building was erected there. You can see images of the original building at the the webpage “L’ancien Palais du Trocadéro de Paris,” located at http://paris1900.lartnouveau.com/cartes_postales_anciennes/le_trocadero.htm, which was last retrieved December 28, 2012.

lxxi The German to English dictionary, dictionary.reverso.net, on the webpage “Zwangsvorstellung translation English | German dictionary | Reverso Collins” translates this as an obsessive idea. Last retrieved from http://dictionary.reverso.net/german-english/Zwangsvorstellung on December 28, 2012.

lxxii The German to English dictionary, dictionary.reverso.net, on the webpage “Zwangsvorstellung translation English | German dictionary | Reverso Collins” translates this as an obsessive idea. Last retrieved from http://dictionary.reverso.net/german-english/Zwangsvorstellung on December 28, 2012.

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lxxiv A predisposition, susceptibility or tendency to a disease, illness, or abnormal state.

lxxv Stigmata is used here in the sense of a mental or physical mark that is characteristic of a defect or disease, as defined by dictionary.reference.com at its webpage “Stigma | Define Stigma at Dictionary.com” found at http://dictionary.reference.com/browse/stigma, last retrieved December 28, 2012.

lxxvi An abnormal softening of a bodily organ. Here, the reference seems to be a softening of the brain as in a stroke. See Rudy Schmicty’s webpage “Archaic Medical Terms English List R,” at http://www.antiquusmorbus.com/English/EnglishR.htm, last updated 4/10/2012 and it was last retrieved December 28, 2012. This would be in line with the definition provided by mediadico.com at the webpage “ramollissement définition et synonyme” located at http://www.mediadico.com/dictionnaire/definition/ramollissement/1, last retrieved December 28, 2012.

lxxvii This is a distance of roughly 4 miles, see the mapquest.com map at http://mapq.st/hu9MY6, last retrieved December 28, 2012.


lxxix See Putnam-Jacobi, Mary M.D. (1886) Some Considerations on Hysteria, The Medical Record, October 9, 1886, page 400, for a more complete discussion of the spasms of accommodation. A copy was last retrieved December 28, 2012 from http://books.google.com/books?id=80JAAAAMAAJ&pg=PA400&dq=hysteria+spasms+of+accommodation&hl=en&ei=4XAtTfaxCI24sQPL843sCw&sa=X&oi=book_result&ct=result&resnum=1&ved=0CCwQ6AEwAA#v=onepage&q=hysteria%20spasms%20of%20accommodation&f=false.


lxxxiii Krishaber first named this illness as “cerebro-cardiac neurosis (neuropathy)” and the illness later took on Krishaber’s own name, Krishaber’s disease. For a further discussion of this topic, please refer to page 1476 of Dieulafoy, Georges, A Text-Book of Medicine, Volume 2, trans. Collins, V. E. and Liebmann, J. A. 1911. This can be viewed at http://books.google.com/books?id=r0kSAAAAAYAAJ&pg=PA1476&ots=FNUKC-8o5&dq=Krishaber%20disease&pg=PA1476#v=onepage&q=Krishabers%20disease&f=false, last retrieved December 28, 2012.
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lxxxiv A French critic and historian who was influential in a number of areas. See the Wikipedia.org entry on the webpage “Hippolyte Taine - Wikipedia, the free encyclopedia” located at http://en.wikipedia.org/wiki/Hippolyte_Taine, last retrieved December 28, 2012.

lxxxv This phrase puzzled me for quite a while. In the end, I translated it as it was after help from the Wordreference forum. One’s own, I initially took as a reference to one’s own body or perceptions. However, it is clear to me now that it refers to friends or family who visited, etc. See this link to the webpage “voir les siens - WordReference Forums” for the discussion on wordreference.com, which was last retrieved December 28, 2012, http://forum.wordreference.com/showthread.php?t=2542400&p=12811463&posted=1#post12811463.


lxxxvii Atonia means languor, weakness, feebleness.

lxxxviii For a further description of this syndrome, see the webpage “Whonamedit - Lasègue’s syndrome II” on whonamedit.com at http://www.whonamedit.com/synd.cfm/2470.html, last retrieved December 28, 2012.


xci This decreased sensitivity especially to touch is called Disturbance of Skin Sensation in the ICD-9-CM. A description of this disorder can be found at the webpage “2012 ICD-9-CM Diagnosis Code 782.0 : Disturbance of skin sensation” found at http://www.icd9data.com/2012/Volume1/780-799/780-789/782/782.0.htm, last retrieved December 28, 2012.


xciii Headache.


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xcvi A 17\textsuperscript{th} century literary and intellectual movement in France. More about this movement can be found at the derrierelescartes.over-blog.com webpage “Le Pays du Tendre : une cartographie de l'Amour précieux - Derrière les cartes” last retrieved on December 28, 2012 at http://derrierelescartes.over-blog.com/article-16870390.html and the relevant Wikipedia.org entry on the webpage “Map of Tendre - Wikipedia, the free encyclopedia,” which was last retrieved on December 28, 2012, and is found at http://en.wikipedia.org/wiki/Map_of_Tendre.

xcvii According to en.Wikipedia.org’s webpage “Ogive - Wikipedia, the free encyclopedia,” an ogive is a “roundly tapered end of a two-dimensional or three-dimensional object.” The entry is found here: http://en.wikipedia.org/wiki/Ogive and was last retrieved on December 28, 2012.

xcviii “Let themselves go” is used here in the sense of relinquishing control or going with the flow. See the translation of “se laisser aller” at Wordreference.com’s webpage “laisser aller - traduction - Dictionnaire Français-Anglais WordReference.com” for at http://www.wordreference.com/fren/%20laisser%20aller, last retrieved on December 28, 2012. Janet will develop this idea later in the text, for example, see page 383.

xcix For a further, contemporary description of this disorder, see pages 294-296 of Jacoby, G. W. (1918). The Unsound Mind and the Law, New York: Funk & Wagnalls. This was last retrieved on December 29, 2012 at http://books.google.com/books?id=yAgxAAAAIAAJ&pg=PA294&ots=1PQUNyBKo3&dq=Korsakoff%E2%80%99s%20polyneuritic%20psychosis&pg=PA294#v=onepage&q=Korsakoff%E2%80%99s%20polyneuritic%20psychosis&f=false.

This is a description of the phenomenon also called thought blocking. As such, it is one of the early descriptions of this formal thought disorder. However, I am unable to find any references giving Janet at least partial credit for the discovery. Instead, Kraepelin and Bleuler are often noted. Janet is perhaps overlooked because thought blocking was linked to schizophrenia. For instance: “Tangentiality, derailment, loose associations, and thought blocking are typically considered pathognomonic of schizophrenia.” Lake, C. R. (2008). Disorders of Thought Are Severe Mood Disorders: the Selective Attention Defect in Mania Challenges the Kraepelinian Dichotomy—A Review. Schizophr Bulletin 34 (1), 109-117. First published online: May 21, 2007, at http://schizophreniabulletin.oxfordjournals.org/content/34/1/109.full, and was last retrieved on December 28, 2012. Yet, there is importance in Janet’s finding as the thought blocking occurs outside of schizophrenia. However, “… Bleuler believed that he and Janet, with their respective concepts of Schizophrenia and Psychasthenia, were covering the same ground.” Moskowitz, A., Heim, G. (2011). Eugen Bleuler’s Dementia Praecox or the Group of Schizophrenias (1911): A Centenary Appreciation and Reconsideration, Schizophrenia Bulletin 37 (3): 471-479. Published online by Oxford University Press on the webpage “Eugen Bleuler’s Dementia Praecox or the Group of Schizophrenias (1911): A Centenary Appreciation and Reconsideration” which is located at http://schizophreniabulletin.oxfordjournals.org/content/37/3/471.full and was last retrieved on December 29, 2012.

ci Please see the brief interchange on Wordreference.com, the webpage “entraînement intensif - WordReference Forums” about translating this phrase at http://forum.wordreference.com/showthread.php?t=2548777&p=12844457&posted=1#post12844457, last retrieved on December 28, 2012.

cii In short, the theory that emotions are results of physiological responses to experiences in the world; the emotions are effects of and not causes of these physiological responses. See the Wikipedia.org entry for more at http://en.wikipedia.org/wiki/James%E2%80%93Lange_theory, last retrieved on December 28, 2012.
According to the description provided by OLN, senior member at WordReference Forums, which was last retrieved on December 28, 2012 and can be seen at the webpage “faire des bâtons - WordReference Forums” located at http://forum.wordreference.com/showthread.php?t=1550749, this is one of a child’s first lessons in learning how to write by making vertical lines and, if possible, to make them parallel to each other.

Giselle is saying that she voluntarily places herself under another’s will to replace the distress that the idea of having her own will gives to her and that she will do anything dictated to her to avoid that distress.


According to the entry at education.yahoo.com on the webpage “phthisical - Thesaurus Synonyms and Word Suggestions - Yahoo! Education,” this is a reference to someone with tuberculosis and the term is now obsolete. See http://education.yahoo.com/reference/thesaurus/entry/phthisical, last retrieved on December 28, 2012.

The modern equivalent of this would appear to be Social Security payments to a child who has lost one or both of their parents or one of them has become disabled.

The definition of caprizant, according to drugs.com on the webpage “Caprizant definition | Drugs.com,” is a “bounding, leaping... form of pulse beat.” See the entry at http://www.drugs.com/dict/caprizant.html, last retrieved on December 28, 2012.

The original word Janet used is “duriuscule.” The translation was a bit difficult to track down. Both fr.wiktionary.org’s webpage “duriuscule – Wiktionaire” at http://fr.wiktionary.org/wiki/duriuscule and littre.reverso.net’s webpage “duriuscule: définition de duriuscule, citations, exemples et usage pour duriuscule dans le dictionnaire de français Littré adapté du grand dictionnaire de la langue française d'Emile Littré” found at http://littre.reverso.net/dictionnaire-francais/definition/duriuscule, each last retrieved on December 28, 2012, have it as “un peu dur” or a little bit hard.


The upper surface of the head, Wikipedia.org provides the webpage “Vertex (anatomy) - Wikipedia, the free encyclopedia” that gives the definition for vertex at http://en.wikipedia.org/wiki/Vertex_%28anatomy%29, last retrieved on December 28, 2012.

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cxiii The lower region of the back of the skull.


cxv There was believed to be a correlation between sleep and anemia of the brain. For example, see page 146 of, Clevenger, S. V. (March, 1894). Sleep, Sleeplessness And Hypnotics. Notes on New Remedies, Volume 6, NY:Lehn & Fink. This can be viewed at http://books.google.com/books?id=IFQCAAAAYAAJ&dq=anemia%20and%20sleep&pg=PA146#v=onepage&q=anemia%20and%20sleep&f=false and was last retrieved on December 28, 2012. Or the following comes from H.S. (1898) Sleep. The Literary World, Volume 57, London: James Clarke & Co., pp. 102-103 in a review of Sleep: Its Physiology, Pathology, Hygiene and Psychology, 1897: “Coming next to consider the pathology of sleep, we are led to note the chief causes of insomnia which can be most easily understood if we bear in mind the generally acknowledged condition of sleep-anemia of the brain…” See: http://books.google.com/books?id=oTsZAAAAYAAJ&printsec=frontcover&source=gbs_ge_summary_r&cad=0#v=onepage&q&f=false, last retrieved on December 28, 2012.

cxvi Webber’s Online Dictionary defines rachialgia as “A painful affection of the spine; especially, Pott’s disease; also, formerly, lead colic.” See the webpage “Dictionary - Definition of Rachialgia” at http://www.websters-online-dictionary.org/definitions/Rachialgia, last retrieved on December 28, 2012.

cxvii Cephalalgias are pains in the head due to “dilation of cerebral arteries or muscle contractions or a reaction to drugs,” according to websters-online-dictionary.org’s webpage “Dictionary - Definition of Cephalalgia” at http://www.websters-online-dictionary.org/definition/Cephalalgia, last retrieved on December 28, 2012.

cxviii Medline Plus tells us that “Babinski’s reflex occurs when the big toe moves toward the top of the foot and the other toes fan out after the sole of the foot has been firmly stroked. This reflex, or sign, is normal in younger children, but abnormal after the age of 2.” Please see the webpage “Babinski’s reflex: MedlinePlus Medical Encyclopedia,” located at http://www.nlm.nih.gov/medlineplus/ency/article/003294.htm, last retrieved on December 28, 2012.

cxix According to Dr. J. E. Perraudin’s website, “dérobement is characterized by the sensation of a knee which yields, floats, gives way, which is weak.” This definition can be found at the webpage “Dérobements du genou” located at http://www.docteurperraudin.com/derobements.htm, last retrieved on December 28, 2012.

cxx The site mdguidelines.com informs us that “Hypochlorhydria and achlorhydria refer to decreased or nonexistent hydrochloric acid secretion in the stomach, respectively. Either condition may occur spontaneously as a result of a clinical disorder or from drug administration.” See the entry at the webpage “Achlorhydria And Hypochlorhydria - Medical Disability Guidelines” located at http://www.mdguidelines.com/achlorhydria-and-hypochlorhydria, last retrieved on December 28, 2012.

cxxi I am unable to find any satisfactory descriptions or definitions of “Reissmann’s disease.”

cxxii Einhorn, M. (1896) Diseases of the Stomach, New York: William Wood And Company, p. 369, describes the transverse colon cord and its significance to “nervous dyspeptics” in this way: “By the term ‘corde colique transverse’ Glenard means the resistance which is found lying over the aorta 3 to 5 cm. above the navel running horizontally 6 to 10 cm. on each side of the median line. This gives the impression of a
ribbon 1 cm. in width and was supposed by Glenard to be the displaced colon transversum, for pressure on the right iliac region at the beginning of the colon ascendens produced rumbling sounds in the ‘corde transverse.’ He consequently concluded that all the symptoms in these patients were caused by this abnormal position of the intestine. He named this condition ‘enteroptosis.’ This can be found at http://books.google.com/books?id=jmAQAAAAYAAJ&lpg=PA369&ots=Zpc_jS3By1&dq=la%20corde%20colique%20transverse&pg=PA369#v=onepage&q=la%20corde%20colique%20transverse&f=false, last retrieved on December 28, 2012.

cxxiii Removal by scrapping with a curette.

cxxiv This passage is terse. Janet is referring to a method of urinalysis developed by Mr. H. Joulie. The procedure is much more complex than Janet’s description would imply. And he would truly have owed all his thanks to Mr. Lacroix. The translation of this section was discussed in a WordReference forum, see the webpage “l’excès de densité - WordReference Forums” located at http://forum.wordreference.com/showthread.php?t=2016531. If the reader has further interest in the details of Joulie’s technique, please see Prunier, M. (1898). Dosage de l’acidité des urines, Journal de pharmacie et de chimie, Sixth Series, p. 116; this can be found at http://books.google.com/books?id=0R44AAAAMAAJ&printsec=frontcover&source=gbs_ge_summary_r&cad=0#v=onepage&q=joulie&f=false, last retrieved on December 28, 2012.

These are spectacles that have a handle instead of earpieces. See the Wikipedia.org entry on the webpage “Lorgnette - Wikipedia, the free encyclopedia” located at http://en.wikipedia.org/wiki/Lorgnette, last retrieved on December 28, 2012, for more description, as well as images, of the lorgnette.

cxxvi Dermograhia is a condition in which the skin rises after contact. For further information, see the Wikipedia.org webpage “Dermatographic urticaria - Wikipedia, the free encyclopedia” at https://en.wikipedia.org/wiki/Dermatographic_urticaria, last retrieved on December 28, 2012.

cxxvii Reality function is more commonly referred to now as “reality testing.” The latter is a term coined by Freud. See Roussillon, R. “reality testing: Definition from Answers.com” webpage for more elaboration on the meaning of this term at http://www.answers.com/topic/reality-testing, last retrieved on December 28, 2012. This degree to which the reality function is performing can also be seen as a distinguishing factor between schizophrenia and psychasthenia, but this is not explicitly discussed in this text.

cxxviii Janet uses the term “bas bleu” here. For more of the significance of that term, which is rather interesting, please refer to the webpage “Bas Bleu - What's A Bluestocking?” at http://www.basbleu.com/info/bluestocking.hzml, last retrieved on December 28, 2012.

cxxix This is a reference to the hysterical conversion symptom of globus hystericus, the feeling of having a lump or some object stuck in the throat, but there is no physiological basis for this feeling. For more on this topic, see the Wikipedia.org webpage “Globus pharyngis - Wikipedia, the free encyclopedia” at http://en.wikipedia.org/wiki/Globus_pharyngis, last retrieved on December 28, 2012.