PSYCHOPATHIC APHONIA, STAMMERING AND CATALEPSY

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S. R. Age 25. Russian Jewess. Married; has four children. Patient was brought to me in a state of helplessness. She could not walk, and was unable to utter a word. When spoken to she replied in gestures. When challenged to walk, she made unsuccessful attempts, the step was awkward, the gait reeling, the body finally collapsing in a heap on the floor. When I shut her eyelids, the eyeballs began to roll upwards, the lids soon became cataleptic, and the patient was unable to open them. When I insisted that she should open the lids, she strained hard,—the muscles of the upper part of the body became painfully tense,—wrinkled her forehead, and contorted violently her face. After long insistence on her replying to my questions, and after long vain efforts to comply with my request, she at last succeeded to reply in a barely audible voice. When whispering she kept on making inco-ordinate movements with jaws and lips, began to shut her eyelids, rolled up the eye-balls, forced the tongue against the teeth, stammered badly on consonants, uttering them with great difficulty after long hesitation, the sound finally coming out with explosive force.

I insisted that she must stand up, she raised herself slowly and with long effort, made a couple of steps, and sat down at once on the chair. During the period of effort there was marked tremor in her left arm. When she sat down, she threw her head backward, rolled up her eyeballs, and began gradually to close her eyelids. She remained in this position for a couple of minutes, and then began spasmodically to open and shut the eyelids. When taken to her room, patient walked up, though with some difficulty, three flights of stairs without the nurse's support.

Patient was greatly emaciated, she lived in extreme poverty. She was married five years, and had given birth to

four children. Patient was suffering from severe headaches which set on soon after the birth of the second child. At first the headaches came at intervals of a few weeks, and lasted about a day, then with the birth of the other children the headaches grew more severe and more frequent, and finally became continuous. From time to time the attacks were specially exacerbated in violence, she then complained of terrible pains in the head, excruciating agony toward the vertex. The face was deadly pale, the hands and feet were ice-cold, the pulse weak and sluggish. During the attack the head had to be raised, since in any other position the pain was unbearable. The pain was originally unilateral, starting on the left side of the head. Of late the pain spread from left to right. The whole head felt sore, like a boil, the scalp was highly sensitive. The intense attacks, sweeping over the patient unawares, were accompanied by twitchings of the eyelids, rolling of the eyeballs, dizziness, sparks before the eyes, pains in the left side of the chest, and by numbness and hypoaesthesia of the face, arms, and legs. The patellar reflex was markedly exaggerated, no clonus was present; the pupils reacted well to light and accommodation. The field of vision, however, was unsually limited:

	Temporal	10		Temporal	15
Right Field:	Nasal	5	Left Field:	Nasal	8
	Upper	5		Upper	12
	Lower	8		Lower	10

The patient was admitted to a local hospital, and was allowed to nurse her one year old baby. Three days after admission, while nursing her baby, she was suddenly seized with a violent attack of headache and pain in the left side. The arms felt numb and "gone." The patient was seized with a panic that the child might fall; hugging the baby to her left breast she screamed for help in agony and terror. Immediately following this seizure the patient lost her voice, speech, and power of walking.

After staying in the hospital for two weeks the patient was put under my care.

Patient was an extremely timid creature. She lived in

Russia in a small town where the religious persecutions of the neighbors were persistent and unremittent. To this was joined the petty annoyances by the village police the representatives of which acted with all the cruel tyranny characteristic of the old Russian regime. The patient's family was in constant terror. In childhood the patient has undergone all the horrors of the *pogromi* with all the terrors of inquisitorial tortures. Fear was the very essence of the patient's life. She was afraid of everything, of her very shadow, of anything strange, more so in the dark, and at night. With this insistent fear which was the basis of the patient's mental life there were also associated a great number of superstitions to which her mind was exposed in early childhood, and in her later life. The patient lived at home in the fear of the most savage superstitions and prejudices characteristic of the poor ignorant classes of Eastern European countries, and outside the house she was in fear of her life. The patient was brought up on fear and nourished on fear. No wonder when she was run down and met with a shock, that the fear instinct seized on her and gave rise to the symptoms of physical and mental paralysis.

To this life of terror we may add the extreme poverty in which the patient lived in Russia and afterwards in this country. The hard work in a sweat-shop and the impaired or ill nutrition ran down the patient and further predisposed her to disability and disease. Patient lived in constant dread of actual starvation, with fear of having no shelter and with no roof over her head. She was so timid that she was scared by any sudden movement, or by a severe, harsh, threatening voice. She was extremely suggestible, imitative, and credulous. She was like a haunted animal, like a scared bird in the claws of a cat. Fear often threw her into a state of rigidity.

The patient suffered from a fear of fatigue, from fear of exhaustion, from fear of disability, from fear of paralysis, pain, sickness, and death. The fear psychosis, based on an abnormally developed fear instinct which formed the main structure of her symptom complex, had a real foundation in the psycho-physiological condition of her organism.

The patient actually suffered from fatigue due to exhaustion, underfeeding, and overworking.

Married at the age of twenty, she bore four children in succession. This was a drain on the poor woman, and further weakened her feeble constitution. Her husband was a poor tailor working in a sweat-shop, making but a few dollars a week. The family was practically kept in a state of chronic starvation. The wolf was hardly kept away from the door. The family was in constant dread of "slack time" with its loss of employment and consequent privations and suffering.

The husband was a hard worker, did not drink, but the long hours of work, the low wages, the poor nutrition, the vicious air, and the no less vicious environment, cheerless, and monotonous, sometimes gave rise to moods, discontent, anger, and quarrels of which the patient with her timidity stood in utter terror.

The patient's dream life was strongly colored by a general underlying mood of apprehension. The fear instinct formed the soil of the whole emotional tone of the psychosis, waking, subwaking, dreaming, conscious, and subconscious. Again and again did the nurses and attendants report to me that, although the patient was aphonic and it was hard to elicit from her a sound, in her sleep she quite often cried out, sometimes using phrases and words which were hard to comprehend, because they were indistinct, and because they were sometimes in her native language. When awakened immediately, it was sometimes possible to elicit from her shreds of dreams in regard to scares and frights about herself, about her children, about her husband, relatives, and friends. When she came under my care the patient often used to wake up in the morning in a state of depression due to some horrible hallucinatory dreams in which she lived over again in a distorted form, due to inco-ordination of content and to lack of active, guiding attention, dreams in which the dreadful experience of her miserable life kept on recurring under various forms of fragmentary association and vague synthesis, brought about by accidental, external and internal stimulations.

The patient was taken to her room in the evening, and put to bed. During the night she was somewhat restless,

kept on waking up, but on the whole, according to the nurse's account, she slept quite well. In the morning the patient had a hearty breakfast, and felt better than the day before when she was brought to me. The voice improved somewhat in strength and volume. During the day she rested, felt well, and enjoyed her meals. Speech was still in a whisper barely audible, but there was no stammering, no muscular inco-ordination, no twitchings of the face. About four in the afternoon patient sat up in bed, her voice became somewhat stronger, though speech was still in a whisper. This improvement lasted but a few minutes. When her arms were raised, the left hand manifested considerable tremor and weakness as compared with the right arm. (See Tracing I.) After having made a few remarks which apparently cost her considerable effort, she had a relapse, she again lost her voice, and was unable to whisper. I insisted that she should reply to my questions; she had to make a great effort, straining her muscles and bringing them into a state of convulsive inco-ordination before she could bring out a few sounds in reply. A little later, about ten or fifteen minutes after I left the room, the nurse came in and quietly asked her a question, the patient answered in a whisper, with little strain and difficulty. In an hour later the patient regained her speech for a short period of a few minutes. These changes went on during the patient's waking period. Once towards evening the patient regained her voice and speech to such an extent that she could talk with no difficulty and little impediment; the voice was so resonant and strong that it could be heard in the hall adjoining the room. This however lasted but a few moments.

After having had a good night's sleep patient woke up in good condition; appetite was good. Voice was clear, though low. She was in a state of lassitude and relaxation. I attempted to examine her and kept testing her condition, physical and mental. I was anxious to make a psychognosis of the patient's case. The tests and the questions strained her nervous system by requiring to hold her attention, and by keeping her in a state of nervous and mental agitation. She looked scared, anxious,—the scared, haunted look in her face reappeared. The patient was no more than about

twenty to twenty-five minutes under experimentation when a severe headache of the vertex and of the left side of the head set on. The eyeballs began to roll up, eyelids were half closed; lids and eyeballs were quivering and twitching. The hands were relaxed and looked like paralyzed. When raised they fell down by her side in an almost lifeless condition. There was marked hypoaesthesia to pain and heat sensations. The anaesthesia was more marked on the left than on the right side. The left arm when raised and kept for a few seconds showed marked tremor as compared with the right arm. This is to be explained by the fact that the exacerbations of the headache, of pain, and the general cataleptic seizures set in usually during or after the nursing periods. The infant while nursing was kept by the mother on the left arm, the left side thus bearing the pressure, weight, and strain,—it was with the left side that fear became mainly associated. (See Sidis, The Causation, Ch. Psychopathic Reflexes.)

During the height of the attack the patient was quietened, her fears allayed, and a five-grain tablet of phenacetine was given her with the authoritative remark that the drug was sure to help her. As soon as she swallowed the tablet the patient opened her eyes, and said she felt better. About an hour later, when another attempt at an examination was made, patient had an attack of headache, cried, said she was afraid, but she answered in a whisper when spoken to. She talked slowly, in a sort of staccato way. I insisted that she should talk a little faster and enounce the words distinctly. She made violent attempts to carry out my command, but got scared, began to hesitate, and stammer, her voice and speech rapidly deteriorating with her efforts, ending in complete mutism.

During the day I tried from time to time to keep up the experiment of insisting that the patient should speak, and every time with the same result of bringing about an attack. Patient began to stammer and stutter, becoming more and more frightened the more the nurse and myself insisted that she should make an effort and reply to our questions. Still when the patient's attention became distracted, when she was handled gently, when her fears were

allayed, the speech and sound improved in quality and in loudness, and at times her sentences were quite fluent, her enunciation quite distinct.

This state of instability lasted for several days until the patient became somewhat familiar with the surroundings. In one of her better moments the patient told me that she thought her stammering began with a definite event. One evening when she was fatigued with the labors of the day for her family, a stammerer came in to see her. The stammering made a strong impression on her. She felt the strain of the stammerer in his efforts; she could not control the sympathy and the strain, and involuntarily began to imitate his speech. She began to fear that she might continue to stammer and be unable to enunciate sounds and words. The more she feared the harder it was for her to speak or even to use her voice.

In regard to the limitation of the field of vision, it may be interesting to note the fact, that although the field was narrowed down to 5 and 10, subconsciously it showed to be normal in range. Patient could *guess* objects lying outside the conscious field of vision, narrowed down by her malady. The outlying visual field may be termed the *subconscious field*. Now when tested *the subconscious field was co-extensive with the normal field. At times the subconscious extended beyond the normal.* Patient could guess, although she could not see when directly questioned, all kinds of objects, such as keys, knives, pencils inserted into the subconscious field. Objects inserted on the periphery of the normal field could be guessed by her more often than by a person with a normal field of vision. In fixating the eye I watched her pupil closely, it was found to be steady and immobile. Thus a white strip of paper which the patient could not see unless it was brought within the range of 10 or 5 degrees could be *guessed* by her even when held on the periphery of 85.

A few days later the patient began to improve, she began to adapt herself to her surroundings, and did not get so easily scared. Along with it the field of vision began to improve. Concentration of attention could be prolonged without getting fatigued with consequent headaches and their concomitant manifestations of paralysis, tremor,

aphonia, and muscular and more specially of oculo-motor inco-ordinations. When patient was approached quietly and slowly without arousing any suspicion of danger, thus avoiding the arousal of the fear instinct, the field of vision manifested considerable expansion:

	Temporal	42		Temporal	30
Right Field:	Nasal	25	Left Field:	Nasal	40
	Upper	25		Upper	25
	Lower	25		Lower	30

About eight days after first examination patient woke up one morning in a state of depression; she cried a good deal. She did not sleep well the night before, dreamt and worried on account of her children. She was afraid that something might have happened to them in her absence, perhaps they were sick, perhaps the husband could not take good care of them. She talked in a whisper, her eyes were shut. When I insisted on opening the eyelids, she opened them, but did it with difficulty. I put her into a hypnotic state. In about a minute her eyes rolled up, and lids shut spasmodically. There was present a slight degree of catalepsy. Mutism was strongly marked. Upon sudden and unexpected application of an electric current, the patient opened her eyes, cried out, but soon relapsed into a state of lethargy. Gradually patient was brought out of the lethargic state.

A couple of hours later, after she had had a good rest a few more experiments as to her sensori-motor life were attempted. I asked her to raise objects, tested her sensitivity to various stimulations, her concentration of attention, asked her questions about her life, about her family, took again her field of vision. All that was a great effort to her. While I was taking her field of vision the patient's eyes began to close, and it took about twenty seconds before she could open them. She opened them with effort, but shut them again. This time it took her about 45 seconds before she could open the lids. Fatigue set on sooner with each repetition of experiment and test, and lasted a longer time.

For several days patient kept on improving slowly. She then had another relapse. She slept well the night

before, but woke up early about six in the morning, she began to worry about her family, and complained of headache. About half past eight the headache became severe, there was again pain in the left side, the left hand began to tremble, and felt anaesthetic, the eyelids closed, and could not open, aphonia returned, in fact she fell into a state of mutism. About ten o'clock patient opened her eyes, but she was unable to talk. After long insisting on her reply to my question as to how she was, she finally replied in a whisper: "Well," then added "I have a bad headache." She had great difficulty in replying to my questions, moved her jaws impotently before she was able to emit a sound, her muscles were strained, the face was set, tense, and drawn, the brow was corrugated, the eyeballs rolled up, and the eyelids shut tightly. Patient was unable to raise her hands, they lay powerless at her side. When raised the arms were found to be lethargic, fell to her side, only the left hand manifested light, fibrillary twitchings and a gross tremor. When insisted upon that she must raise her arms, she became agitated, scared, began to moan and cry. Claimed severe pain in head, in chest, in heart. "Pain in heart, in head, I am afraid," she moaned in a whisper. There was loss of kinaesthetic sensibility, patient complained that she did not feel her arms, "they are not mine." She had to look at the arm in order to find it. There was also present anaesthesia to other sensations such as pain, touch, heat, and cold. After a couple of hours' rest the sensibility returned. The sensibility was affected more on the left side than on the right, and also returned earlier on the right side.

When the fatigue and the scare subsided the patient was tested again. This time the reactions to sensory stimulations were normal. Patient was touched, pinched, and pricked, she reacted to each stimulus separately, and was able to synthesise them and give a full account of their number. Kinaesthetic sensibility was good,—she was fully able to appreciate the various movements and positions in which her limbs and fingers were put.

Patient was left to rest, quietened, treated carefully, avoiding sudden stimulations, allaying her fears and suspiciousness of danger, lurking in the background of her

mind. After a few hours she sat up, made an attempt to raise herself from bed, got up with some effort, and sat down in an easy rocking chair next to her. Her eyes were wide open. Asked how she was, she replied in a whisper that she felt quite well. The effort however fatigued her, her head began to drop, eyelids began to close, and the eyeballs began to roll up. Twitchings were observed in the eyelids, and tremor in the left arm. She was again put to bed and given a rest of a few hours. She opened her eyes, and told me that she was weak. This statement she herself volunteered. I found that she could move her hands easily, and that the numbness was completely gone.

For a whole week the patient kept on growing in health and in strength, her sensori-motor reactions improved, she walked round the room for a few minutes, talked in a low voice for a quarter of an hour at a time without manifesting her symptoms of fatigue; her appetite and sleep improved accordingly. At the end of the week there was again a relapse,—she did not sleep well the night before, dreamt of being hunted and tortured, woke up depressed, had no appetite for breakfast, complained of headache, pains, worries, and fears. The headaches have abated in their virulence during last week, but now they seemed to have reappeared in their former vigor. When I began to examine her she looked frightened, her eyeballs rolled up, her eyelids closed. The aphonia was severe, patient lost speech and voice. When spoken to she could not answer. Asked if she heard me, she shook her head affirmatively. There were slight twitchings of her left hand and also of the muscles of her face. When attention was attracted to the arm the twitchings increased in violence and rapidity. With the distraction of the attention the twitchings disappeared. When the left hand was put in the patient's field of vision, thus making her attention concentrate on that limb, the tremors increased again, becoming finally convulsive in character.

I insisted she should try to open her mouth, and say something,—she made fruitless efforts, moving inco-ordinately the muscles of the face and of the forehead, but she could not utter a sound. She could not move her arms on com-

mand, could hardly wriggle the fingers of her hand. She appeared like a little bird paralyzed by fear. When the arm was raised passively it fell down slowly being in a cataleptic state.

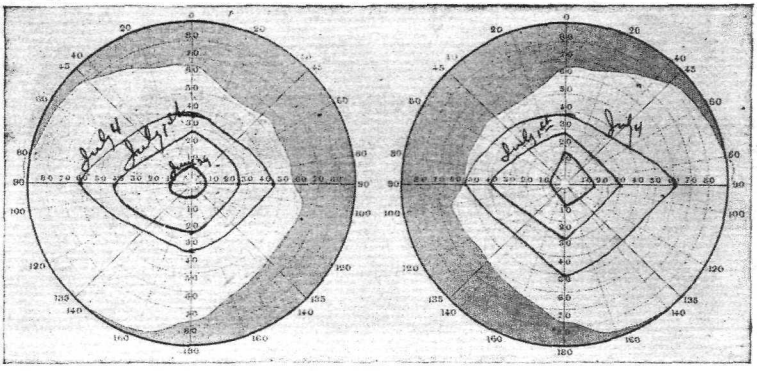
I allayed the patient's fear. I strongly impressed her with the groundlessness of her fears, and also with the fact that everything was well with the children, and that her husband will be good and gentle with her. The patient was permitted to see her family. The husband was made to realize that he must treat her with more consideration. He came often to visit her, and learned to treat her well. He soon found a better position, was advised to remove to a healthy locality and to more cheerful surroundings. The children were well cared for. The patient found deep satisfaction in the midst of this family happiness. The fear state abated,—the patient became more confidential, more hopeful for the future, and began to improve. The infant was weaned so that the strain of nursing was removed. The patient's appetite began to increase; she gained several pounds in a few days. Long periods of examination and investigation of her nervous and mental state no longer exhausted or terrified her. Her concentration of attention could be kept up from a quarter to half an hour at a stretch without giving rise to fatigue, headache, or to a seizure with its consequent psychomotor effects. The haunted look of fear disappeared, and along with it were also gone the fatigue and dread of physical and mental exercise or work. She could work and walk with ease the whole length of the room and of the hall. She began to take more and more interest in her appearance and in dress. For many minutes at a time she looked out on the street taking an interest in all that was done and what was going on. The field of vision taken at this stage of the patient's condition was markedly increased, almost approaching the normal:

Right Field:	Temporal	50–80	Left Field:	Temporal	60–88
	Nasal	45–60		Nasal	55–62
	Upper	35–40		Upper	38–45
	Lower	40–62		Lower	54–60

(See Chart II.)

In a couple of weeks the patient no longer complained of headaches and pains; she felt strong and well; her voice, speech, movements, reactions became normal. Sudden stimulations no longer scared her, nor did they bring about any attacks of tremors, trembling, anaesthesia, aphonia, mutism, and catalepsy. (See Tracings I, II.) The patient was sent home, and stayed well.

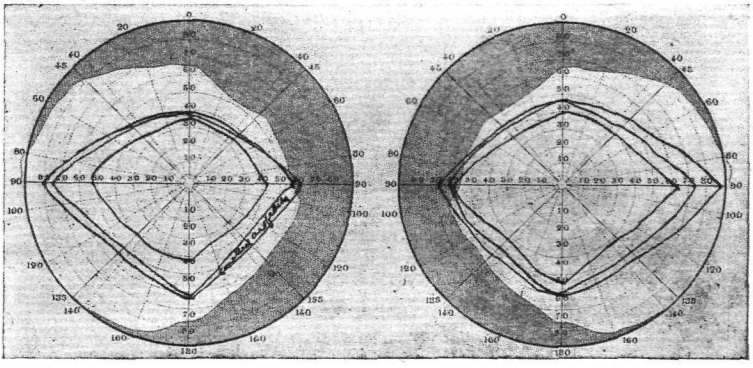
Charts and Tracings



O. D. V= O. G. V=

CHART I.

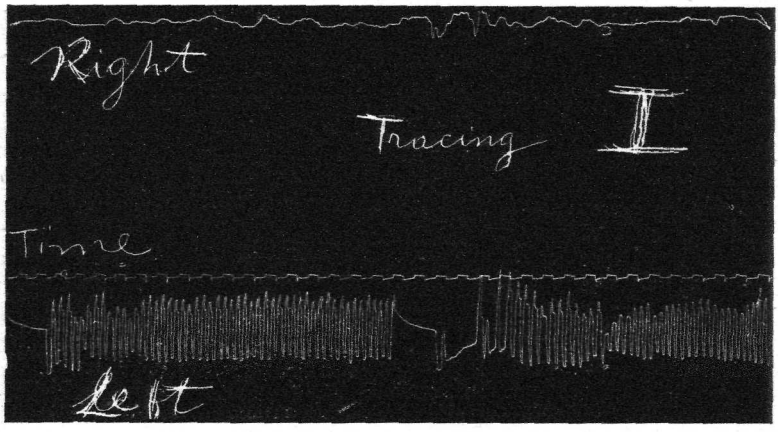
Chart I gives field of vision taken the first few days of treatment. The chart shows gradual enlargement of field.



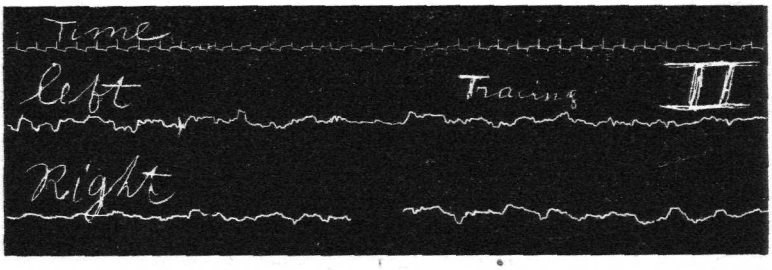
O. D. V= O. G. V=

CHART II.

Chart II gives field of vision taken the last few days before the patient went home. The chart shows an almost normal field. The field of vision became enlarged under the influence of stimulations which the patient regarded as beneficial to her health.



Tracing I shows the tremor of her right and left arm respectively. The upper vibrations are of the right arm, the lower vibrations are of the left arm. The tracing above the lower vibrations is the time line.



Tracing II gives the tremors of right and left arms. The tracing was taken the day before the patient left. Both arms give the same reactions and show no difference in their vibrations and tremors. The upper tracing is the time line.

The case is essentially one of functional psychosis of the Psychosomatic variety (See Sidis, *Symptomatology*). Like all such cases the symptoms manifested are due to Associated Psychopathic Reflexes and instinctive Fear reactions (See Sidis, *Causation*).

I am glad to find that psychologists, such as J. B. Watson, as well as medical men are coming round to my teachings of *Functional Psychosis as constituting at bottom psychobiological, psychopathic Associated Reflexes and Fear Reactions of early life experience.* I devoted to this work years of psychopathological research and clinical labor. It is but just to ask that the results of my long scientific activity and arduous labors in the domain of Psychopathology should not be piled on that heap of Austro-Germanic Pseudoanalysis which is akin to Astrology, Alchemy, Cheiromancy, Oneiromancy, and generally to Mediaeval symbolism, occult exegesis, Oriental mystical interpretation, scholastic allegorical subtleties, and generally to the pseudo-philosophical, pseudo-scientific savage and barbaric speculations and practices of Sympathetic and Imitative Magic. It is but right to ask of the psychologist and psychopathologist as well as of all fair minded medical men that my scientific results in the domain of Psychopathology, such as the Associated Psychopathic Reflexes and FearReactions of Functional Psychosis should be referred to my work to which I had devoted a life time of unremitting research and arduous labor.