HYSTERIA—A RE-EVALUATION*

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IT is interesting to reflect that it is 70 years since Charcot delivered his lectures on Hysteria at the Salpêtriére, 60 years since Freud and Breuer published their *Studies in Hysteria* and 50 years almost to the day that Pierre Janet was invited to lecture on the same subject at Harvard University. In that period—from Charcot to Janet—almost everything was said that could be said of this disease. So much so that we have entered into a sort of post-Galenic period in which all subsequent authors repeat—more briefly and less accurately—all that was said with such brilliance by this eminent triumvirate. What may be said that is new, really fresh? What researches of importance have been carried out in recent years that must today be reported, what up-to-date views on aetiology and treatment? It is humbling to admit that there are precious few. True there have been many contributions to other branches of psychiatry but it seems to me that the situation of the hysterical patient today is very much as it was when his grandparents and great-grandparents submitted themselves to the awesome scrutiny of a full neuro-psychiatric investigation.

I am conscious that descriptions of this state have been given for over 2,000 years, that Plato essayed an aetiological explanation, that Ambroise Paré, Fernel, Sydenham and other giants of the past concerned themselves with its various manifestations, making little more sense of it all than their predecessors. Furthermore, having acquainted myself with recent and current literature on the subject, I find that much confusion abounds: confusion that must in turn be communicated widely among students, physicians and young psychiatrists alike.

This confusion remains despite a number of notable advances that might well have had the effect of simplifying the problem. I will name a few of these advances:

(i) *Advances in Brain Physiology*

Studies on consciousness, cerebral integration, localization and differentiation of function with special reference to the visceral brain and the reticular activating systems (MacLean, Magoun, etc.).

(ii) *Advances in Brain Pathology*

The work of Penfield on temporal lobe epilepsy, followed up by Smith, who has reviewed 600 cases at least half of whom had shown functional symptoms that could have been diagnosed in the past as hysteria. All the information coming from studies of brain-injured and leucotomized patients indicating psychological and physical sequelae. Further knowledge regarding the correlation between hysteria and various organic diseases such as disseminated sclerosis and encephalitis. The discovery of new metabolic and endocrine

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syndromes such as spontaneous hypoglycaemia and phaeochromocytoma, the symptoms of which are often taken to be hysterical in the early stages.

(iii) *Advances in Psychology*

Particularly those concerned with learning theory (Hull, Guthrie, Mowrer, Dollard and Miller), and those by Eysenck and his co-workers in this country. There is also the brilliant work of Jean Piaget, much neglected by psychiatrists, which will surely have applications to abnormal processes in so far as they describe so comprehensively the development of mental processes in the child. There is greater understanding of the nature of suggestion, and of course, from psychoanalysis, an immense hinterland of data behind the simple term, coined by Janet, "the fixed idea". Indeed, one might truly say that the whole of psychoanalytic theory is ranged behind the hysteric.

(iv) *Clinical Studies*

These have not been without their value. For instance the follow-up and re-examination by Reichard of the five patients described by Freud and Breuer in their original paper, in which it was found that two were in fact schizophrenics.

Despite all this we are still told in modern textbooks and monographs much that should have been discarded many years ago. One may even yet discern the Inquisitorial scorn of many writers when describing hysteria in terms similar to those which, in the days of the Malleus, would have immediately led to a burning at the stake! There are the witch-like qualities of personality, the cunning self-interest, the feignings and deceptions, the despicable weirdness of such symptoms as somnambulisms and fits and trances, the inexcusable dramatization and the diabolical tyrannizing by the hysteric of her relatives and friends, and so forth. Always there is the implication that the hysteric does this on purpose (Curran and Partridge), perhaps to avoid some unpleasantness (Harrowes), to create an effect and gain attention (Dicks), or simply to stir up trouble for everyone including the unfortunate doctor whose doubtful privilege it is to treat her—trouble that at times can be put down to plain malingering (Mayer-Gross, Slater and Roth). Some writers have explained hysteria on the basis of a single process. Gordon, for instance, regarded all hysterical phenomena as due to suggestion, as Charcot and Babinski had done before, but taking no account of Janet's detailed criticisms of this viewpoint. More recently Cobb has put forward the view that the basic process is that of "Playing 'possum' " as other mammals do in conditions of danger. Janet's own words are here relevant—"It will be later a matter of astonishment that physicians should have attributed to the caprice of the subject all the psychological and physiological laws that will be discerned in these various 'accidents'." Janet goes on to urge a much more precise definition of hysteria and the essential processes of hysteria. He saw a *peculiarily direct* connection between the hysterical idea and somatic function, a suggestion of a more primitive process than the normal relation between idea and function. He went on to elaborate his views on restriction of the field of consciousness and the presence of dissociation as explanatory concepts. "*It is a malady of personal synthesis*", he says, and in this respect he is in accord with Freud's earlier writings in which he gave prominence to dissociation and the hypnoid state. Here is Janet's own definition. "*Hysteria is a form of mental depression*

characterized by a retraction of the field of consciousness and a tendency to the dissociation and emancipation of the systems of ideas and functions that constitute personality".

It would be interesting to speculate on what changes Janet himself would make if he were as familiar with modern trends as we are. He would no doubt be fascinated with psychoanalytic efforts to answer one question he repeatedly asked: "What is the reason for the particular symptom, the specific localization?" Although he himself was well aware of Freud's views on repression and the effect of psychic traumata, which he was inclined to repudiate, he might well by now have been won over by the mass of clinical evidence to support Freud's views. He would have been delighted with the discoveries of the learning theorists who have shown that "reactive inhibition" of the cerebral cortex is a fact and that it may well correspond to his "form of mental depression restricting the field of consciousness". Eysenck's recent studies of hysterics, in which he claims a significant correlation between this tendency to "reactive inhibition", extraversion and hysteria would have given him great satisfaction. He would have been influenced by some of Penfield's findings, and those of his countryman Gastaut, concerning the presence of hysterical symptoms in the epilepsies, and this would confirm him in the view that the condition of hysteria was a disorder of the central nervous system, no doubt to be formally distinguished from the epilepsies, but closely related to them.

I very much doubt if he would find anything of interest in a current textbook. Indeed he might be amused to see that the fashion among medical men to find yet another definition of hysteria continues. He would poke fun now as he did then "Though Lasègue said that hysteria should never be defined . . . since that declaration everybody has tried to define it." But he goes on more charitably, "But . . . do not forget that we are speaking of medicine, and that this is rather a special domain, less calm and serene than high mathematics. You should not ask too much of the virtue of the physician, or hope that he will confine himself to repeating the definition of a predecessor, even if he does not cite his name. What would be left for him?"

Thus, with some encouragement from Janet and the other immortals I feel I may express my own views on this topic. You will readily observe that they are not in any way original, but rather an up-to-date review of established findings. My principal aim is to simplify these findings in such a way as to bring a little more order into this very confused topic. It is, if you like, a "narrowing of the field of hysteria".

The Conditions for a Satisfactory Definition of Hysteria

If we are to have a clear and simple notion of hysteria, certain conditions must be fulfilled:

(*i*) The data to be described must conform to accepted scientific standards of reliable and consistent observation and to accurate, agreed definition. The various paralyses, dysfunctions, fugues, fits, anaesthesias and so forth must be accorded exact significance.

(*ii*) The definition must be sufficiently distinctive to exclude similar conditions known to be caused by organic disease and other factors. We must not talk of hystero-epilepsy, nor of "hysterical overlay" of a cerebral organic disorder such as encephalitis, disseminated sclerosis and cerebral tumour, although these may later come to throw some light on the hysterical process.

(*iii*) We must accept the general finding that the *onset* of hysteria is *rapid*, and invariably related in time to some *impressive event*. This impressive event may be of almost any character: Here are some examples from Freud—A girl watching "with harrowing anxiety" at the bedside of a sick person when her arm goes to sleep. A man assisting at the reduction of his brother's ankylosed hip. Dora's seduction by Herr K.; a clerk assaulted by his boss. Then there are the war neuroses and the traumatic neuroses linked to definite events of a threatening character. The list could be multiplied indefinitely. It is, however, not always clear whether an impressive event is, of itself, sufficient to precipitate an attack. Psychoanalytical theory now requires some *prior event*—a psychic trauma—occurring at the time of the Oedipus complex and repressed. But for simplicity we may then take this *prior event* as fulfilling the requirements for an *impressive event*.

(*iv*) Almost all writers describe a particular *state of mind* as a necessary condition at the time of breakdown. This is variously described as a hypnoid state (Freud) and as restriction in the field of consciousness (Janet) and of exaggerated suggestibility (Babinski, Charcot, Gordon). "In an atmosphere of emotion or in one of bodily discomfort" (Purves Stewart quoted by Barbour).

(*v*) In one form or another *Dissociation* is observed by all: a splitting-off, conversion, displacement, belle indifférence and, from a different viewpoint, repression, all contain this same factor. To quote Henderson and Gillespie: "An independence of function as well as isolation of it from other functions . . . The dissociation of the ideational content while affect remains."

(*vi*) There must be some account of the essential immaturity of the hysteric, physical and emotional; an excessive demand for security. This feature is held to be constitutional in nature, though some might argue that it arises during the early months and years of life under conditions of rejection and other forms of insecurity. This latter view would equate the hysterical illness with the hysterical personality, and this point must be examined more closely later.

(*vii*) The definition must take account of medically induced artefacts.

(*a*) Direct and indirect suggestions by doctor.

(*b*) Surgical and medical treatment distorting the process.

(*c*) "Observer error" (counter-transference) in the doctor.

These artefacts abound in the medical literature on this subject, and creep into countless case records that may later be employed in researches into this condition.

(*viii*) In so far as the condition affects bodily functioning it must follow that hysteria is a disorder of the central nervous system. There remain some who still hold to peripheral theory—that the particular organ itself is affected. This is a relic of the theory of the wandering womb first put forward lightheartedly by Plato. Likewise there are some who hold to an exclusively psychological theory. But this too is nonsensical, for we are manifestly concerned with the physical and the tangible.

Keeping these points in mind we must now attempt a definition. Hysteria is a condition of the central nervous system characterized by a particular form

of immaturity whereby the integrating functions are impaired. It is a constitutionally determined *un-integration* (rather than a dissociation) of the several autonomous systems normally operating in the central nervous system.

I must make clear what I mean by this definition and in particular what I mean by integration. Recent studies of the structure and function of the C.N.S. suggest the need for a revision of the classical views of Hughlings Jackson and his innumerable followers. Jackson's view was that the organization of the C.N.S. followed a roughly phylogenetic principle: the evolutionally earlier and simpler structures come under the control of the later, more complex structures; with the cerebral cortex, the most complex and last of all responsible for the so-called "higher" functions. It now seems likely that there is no such rigid hierarchy, but that there is a number of more or less independent systems, composed of both early and recent structures, and that there are, for instance in the rhinencephalon, old structures that have continued to develop in the course of evolution every bit as much as the cerebral cortex. In other words, vestigial structures have acquired new functions. A particular example of this is the hippocampus, which in primates appears to be less associated with the differentiation of olfactory stimuli than with the elaboration of emotional feeling. The exact function of these various systems cannot as yet be defined, but enough is known to assign to them roles for which at one time we thought only the cerebral cortex was responsible. However, these systems are interdependent, the one on the other, and are subject to established laws relating to neuronal development and organization. Recent research on the reticular formation, for example, has begun to classify this notion of interdependence. It therefore does not seem necessary to think of mental processes as strictly hierarchical. In some respects anarchy reigns—or at any rate a crude democracy. The capacity for integration and organization resides, not in the cerebral cortex alone, but throughout the whole central nervous system. This organizational capacity is perhaps closely related, in the mental sphere, with what we call the ego. We must therefore imagine, not a Jacksonian pyramid, but a matrix or lattice. Indeed we could not at this stage do much better than take for our model the actual physical characteristics of the human brain and nervous system. This has been done with great brilliance by Hebb. Cybernetics has also contributed its share to this revision.

Figure 1 is a diagrammatic representation of personality structure based upon this modified scheme of organization. There is no departure from any previously established principle except that of simple hierarchy. The systems are drawn in clusters in white, grey and black. The black have become integrated by reason of their connections with other systems. Some of these are small, not yet clustered; others have acquired considerable cohesion with contiguous systems and as they cohere they enlarge. The white represent unintegrated systems having no external connections. The grey represent systems of intermediate degrees of integration. This diagram might represent either an immature or an abnormal (hysterical) personality structure because of the presence of unintegrated systems. The mature, fully developed personality would be expected to have achieved a more extensive and efficient organization than this. "Ego strength" would perhaps be determined partly by the degree of integration and partly by the degree of awareness (insight) of the nature and limitations of the integrated systems.

Now the principle of generalization is not particularly affected by this new scheme. It merely suggests that generalization is more a matter of "horizontal" spread than of vertical, i.e. to ever higher degrees of abstraction and ever more

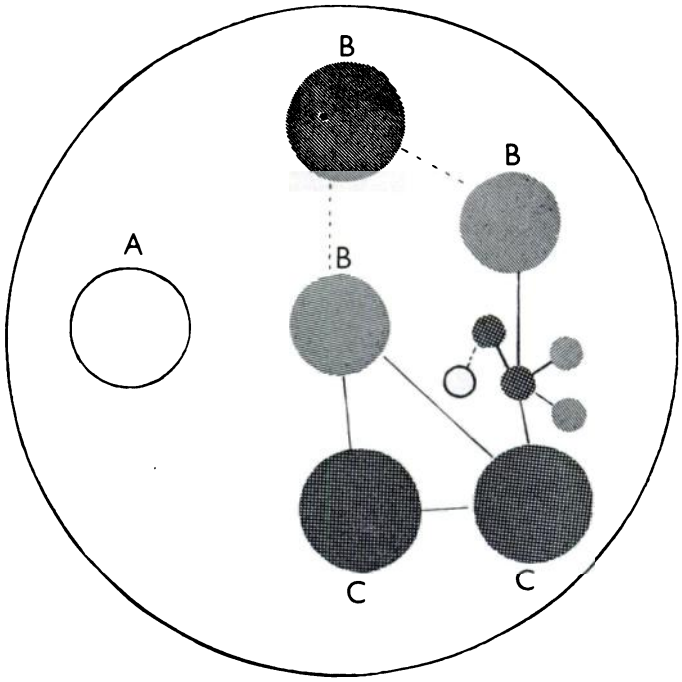

FIG. 1.—Diagrammatic representation of hysterical personality structure.
Note: A. Ego system unintegrated with other systems.
B. Ego systems partially integrated with other systems.
C. Ego systems fully integrated with other systems.
Ego boundary indicated by surrounding circle.

general sets of principles *for the whole C.N.S.* (There is considerable agreement here with Eysenck's "six points" regarding personality organization, although he has not himself abandoned the traditional usage of the term "hierarchical").

We must particularly bear in mind that every "system" being autonomous must possess its affector, central and effector components. (I personally incline to the view that in some (for instance the reticular formation) the central component is the most important and may well be responsible for spontaneous, creative experience, irrupting into the outside world with no previous history either in that world or in the inner world of personal experience. But this is a digression.)

We now have, I submit, a simple and understandable basis for the hysterical state. The basis is un-integration of autonomous systems. These systems possess an arbitrary character and may give trouble or distress at any time. However, since we know that in some manner hysteria is related to "impressive events", we must assume that these events have a specifically evocative character for some particular independent sub-system (not related to the main personality). This evocation will be expected to produce symptoms relevant to the system, and to some extent relevant to the event. This is therefore not dissociation but un-integration. How much this corresponds to Janet's "emancipation of the systems of ideas" you may judge for yourselves, but to me it is a striking tribute to his clinical acuity.

I have often wondered, when a patient under psychotherapy recalls some past traumatic event, whether the unique factor in the whole complex was not

the particular manner in which the patient handled the experience. This point has of course been made repeatedly since Freud described the hypnoid state. But somehow later writers, including Freud himself who abandoned the notion of hypnoid state for the more dynamic one of repression, have focused their attention on this uniqueness in terms of past experience, rather than upon an enduring characteristic of the individual nervous system. I think we might profit again by a re-examination of the hypnoid state and ask whether it may not *always have been present*, i.e. that it was an enduring feature of the personality structure. One reason why this old and rather static idea may have been abandoned was that under the influence of the Jacksonian hierarchy, it could not be imagined that *at one and the same time* an hysterical personality could exhibit purposeful, integrated behaviour *and* unintegrated (dissociated) behaviour. If only one unitary system were operating then hysterical behaviour could only be accounted for by some such notion as "dissociation" or "repression". Now we see that it is altogether possible for the hysterical person to display incongruities of behaviour and thinking without the need for these notions. (This, of course is not to suggest that repression does not exist, but rather that it does not seem to occupy so central a position in the psychopathology of hysteria as had been formerly attributed to it.)

It is known, for instance, that sensory information can be picked up and stored without the subject being consciously aware of it—as many psychological experiments have shown.

We have then a truly "split mind", in the hysteric, a situation for long appreciated by most psychotherapists. (Fairbairn in particular, has stressed this process in the language of object relations.) However, it should again be stressed that we are here dealing with a split mind that has always been split, and not with one that has come to be split under the stresses of early life. Loewald comes nearer to this view in his reappraisal of Freud's account of the hypnoid state. He puts forward the view that "traumatic events" in early life are merely laid down as unconscious memory traces, i.e. that they do not establish associative connections. Repression perpetuates this "non-arrival in consciousness", which in the hysteric is due to the immature state of the ego. He elaborates this more fully in keeping with the classical view of the repetition compulsion but this seems to me to be unnecessarily cumbersome as an explanation, when we may more simply explain the "non-arrival in consciousness as 'un-integration'". An amusing example of this unintegrated state is told by Siegman, when discussing "Emotionality as a Character Defence". "A new widower disappears on the occasion of his wife's funeral. He is finally found, to the horror of everyone, having intercourse with the maid. To their cry, 'What are you doing?' he responds, 'How do I know? I'm out of my mind with grief'."

We come now to a brief discussion of the term "Impressive event". I use "*event*" as Whitehead has defined it. Space and time do not permit me to give an extensive definition. "Impressive" is employed in a somewhat neutral sense, i.e. any event that is transmitted from the external world by whatever route. It need not be a painful event, nor one that carries with it the implication of conflict. Any relatively novel circumstance in the life of the individual is an "impressive event". The point to note is that it arrived "out of the blue" and is not recognized in terms of past experience. It may contain many of the elements of familiarity, e.g. the appearance of a parent, but there are novel elements that transform the whole event, e.g. the inclusion in the parental event of explosive temper or an exposed genital. In the normal person there will

be an attempt to recognize, to evaluate, discriminate, criticize and then to accept, modify or reject such an event. The wealth of associations from other systems is mobilized and the individual comes to terms with the event. In the hysteric on the other hand, there is a failure of recognition, an absence of criticism, a limited incorporation of the event, almost unchanged, with little or no associative reverberations with other systems. The event has been impressive but it has no significance. At least it has no significance in relation to the rest of the personality, though it may occupy an important—at times disrupting—position within it. Later editions of similar events transmitted to the individual may reinforce or modify the process which takes in the character of arbitrariness. Thus we may find any and every kind of symptom occurring, relevant to the particular system involved with the impressive event. The variety is further ensured by the phenomenon of identification and mimicry commonly found in this condition. It will be apparent why, in accordance with this thesis, identifications are so readily established in this condition. There would seem at all times to be a readiness on the part of one system or another to become impressed with a novelty, impressed in an uncritical unintegrated manner.

It follows that the more elaborate consequences of a highly organized individual experience do not occur in the hysteric. Events retain something of their pristine and primitive character. A scolding mother will remain the provider of bad and poisoned milk. A threatening father will retain much of his crudely biological character. Reactions to these events will likewise persist on a more infantile level. It is not that the hysteric has learned more "control" over his visceral functions than the normal (as a fakir might) but that he has never learned anything else. He persists in operating at a non-verbal level. The immature hysteric does not perceive events as does the mature person—as events overlaid in their immediacy by the reverberations of past organized experiences, modifying the present and in turn being modified by it. He perceives events as isolated experiences.

We see then, that the hysteric can with great facility manifest almost any symptom that could be produced by the activation of any of the systems of the C.N.S. And we have seen that descriptions and definitions of hysteria have varied over the years for this reason, like a Sears, Roebuck Catalogue, requiring a mammoth new edition each year. We have noted the various mechanisms associated with hysteria: identification, dissociation, displacement, conversion, dramatization. We see also that they overlap or are more or less synonymous. Each may be re-evaluated in the light of the present thesis. Dissociation we have already discussed at length. Conversion we may now see as immature, somatized activity that has not yet reached a more symbolic level of organization: it is asymbolic rather than dissymbolic. Displacement is likewise immature somatization. Identification may be understood as I have already indicated: as an impression of events upon an over receptive, uncritical limited system. Dramatization is also to be regarded as a part reaction by a limited system, usually on the basis of identification. A professional actor would take serious exception to the dramatic performance of the hysteric. He might describe it as "hamming" of the worst order. (In this connection, however, we should also consider the role played by the mechanism of "spectating" in the dramatic performance of the hysteric. If we assume the existence of several autonomous systems and not one hierarchical system then there is room for this notion of "spectating" of some systems upon others. This is a common finding in psychotherapy.)

What of treatment? It follows from what has gone before that therapy in the hysteric is essentially synthetic and educative. Insight therapy with or

without abreactive procedures is unsound. It is interesting to note that psychoanalytic views are exactly in keeping in that they stress the need for the "working through" of unconscious conflicts in the hysteric. If we assume that Eysenck is right, and that one important factor in this immaturity of the hysteric is "reactive inhibition" this will explain why it is that sedative and tranquillizing therapies are ineffective or even harmful. Social therapy, carefully planned to meet the special needs of the hysteric, should be more fully developed. There is a fundamental contrast here between the obsessional process and the hysteric. For this reason it is mistaken to apply similar methods of treatment. This tendency to blanket our neurotic patients with uniform treatment procedures must result in a paradox: some will improve, some will remain unchanged and some may actually deteriorate. Among those that improve there will be some making a spontaneous recovery. There is a need, therefore, for a more rational approach to therapy in general and this examination of the essential nature of hysteria represents, in a very limited way, the kind of approach I think we should make.

Hysteria will always fascinate some and annoy others. It might be interesting to speculate on this: for instance do the extraverts or the introverts bristle more when faced with a "gross hysteric". One could think of many points of debate on their side but we will not pursue the matter here.

Let me end with a fanciful description of the hysteric:

The hysteric is a young woman who believes:

That God is a daemon
That her father is God
That her husband is her father
And that her son is her husband.

References

BARBOUR, R. F., "Hysteria" in *Modern Practice in Psychological Medicine* (Rees, J. R., Ed.), 1949. London: Butterworth. p. 187.

CHARCOT, J. M., *Diseases of the Nervous System*, 1889. London: New Sydenham Society.

COBB, S., *Foundations of Neuropsychiatry*, 1948. New York: Williams & Wilkins.

CURRAN, D., and PARTRIDGE, M., *Psychological Medicine*, 1955. Edinburgh, Livingstone.

DICKS, H. V., *Clinical Studies in Psychopathology*, 1939. London: Arnold.

FENICHEL, O., *Psychoanalytic Theory of Neurosis*, 1946. London: Kegan Paul.

GORDON, R. G., *The Neurotic Personality*, 1927. London: Kegan Paul.

HARROWES, W., *Human Personality and its Minor Disorders*, 1949. Edinburgh: Livingstone. p. 234.

JANET, J., *Major Symptoms of Hysteria*, 1907. London: Macmillan.

MALAMUD, W., "Psychoneuroses", in *Personality and Behaviour Disorders* (Hunt, Ronald, Ed.). Vol. II. 1944. New York.

MAYER-GROSS, W., SLATER, ELIOT and ROTH, MARTIN, *Clinical Psychiatry*, 1954. London: Cassell.

PIAGET, J., *The Construction of Reality in the Child*, 1954. New York: Basic Books.

REICHARD, S., "Re-examination of *Studies in Hysteria*", *Psychoanal. Quart.*, 1956, **25**, No. 2, 155.

SIEGMAN, A. J., "Emotionability", A Character Defence, *ibid.*, 1954, **23**, No. 3, 339.