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British Journal of Psychiatry (1986), **149**, 23–28

The Importance of Hysteria

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Hysteria has been a topic of interest throughout the history of medicine; those who have been concerned with it include Galen, Paré, Sydenham, Charcot and Freud. Anyone who chooses to proclaim its importance, therefore, might be asked to provide some reason for gilding the lily. Controversies have

always attended the subject, and different disciplines still disagree over it. The diagnosis, which occurs in the International Classification of Diseases (ICD-9, 1978) has been deprecated on both sides of the Atlantic (Slater, 1965; DSM-III, 1980) and also advocated with varying degrees of fervour (Walshe, 1965; Lewis, 1975; Merskey, 1979). It is a subject of historical study (Veith, 1965; Walker, 1981; Shorter, 1984); there have been at least nine monographs on it since 1977 (Horowitz, 1977; Krohn, 1978; Jakubik, 1979; Merskey, 1979; Roy, 1982; Riley & Roy, 1982; Colligan *et al*, 1982; Weintraub, 1983; Ford, 1983), and there is a steady flow of paper on the topic of hysteria or its major subdivisions (eg, hysterical personality, conversion symptoms) or pseudonyms and partial pseudonyms (eg, somatisation disorders, borderline personality, and operant pain).

Furthermore, the whole field of chronic pain is a prominent theme in which at least some aspects of hysteria require consideration (Merskey, 1980). Nevertheless, it is probably true that the volume of publications on hysteria is less than on other topics, in relation to its supposed importance.

For convenience of definition, I shall follow the ICD-9 classification of hysterical neurosis (300.1) and hysterical personality (300.5). For the subtypes of hysteria, I have suggested the following (Merskey, 1979):

(a) hysteria with one or two symptoms, usually motor or dissociative (as in amnesia), sometimes pain
(b) polysymptomatic hysteria, especially hypochondriasis and Briquet's syndrome as described by Guze and his colleagues (the St Louis group) and now elaborated in DSM-III under the heading of somatisation disorder
(c) hysterical elaboration of organic complaints
(d) symptoms of self-induced illness or self-damage in abnormal personalities ranging from anorexia nervosa to hospital addiction
(e) psychotic or pseudopsychotic disorders (Ganser's syndrome, hysterical psychosis)
(f) hysterical personality
(g) culturally sanctioned endemic or epidemic hysteria.

Since different aspects of this list will occur in many different situations, we have a hint that the theme might be an important one both in medicine and in society. I will start by considering the epidemiology of somatic complaints not due to physical illness and probably not due to psychophysiological causes.

Frequency

If we look only for the florid symptom picture described by the St Louis group, we find that 1–2% of parous women (Farley *et al*, 1968) or women under investigation in a medical ward (Woodruff, 1968) present this pattern of illness. There are similar findings in other surveys (Majerus *et al*, 1960; Murphy *et al*, 1962). About 10% of psychiatric in-patients in university hospitals (Bibb & Guze, 1972) and 5–11% of psychiatric out-patients (Farley *et al*, 1968) are similarly affected. Folks *et al* (1984) found, in 1000 consecutive psychiatric consultations in a general hospital, that the prevalence of conversion disorder was about 5%; one third of these cases had somatisation disorder. Katon *et al* (1984) have reviewed the prevalence of somatisation in primary care and have shown that it is at least relevant, in the majority of general practice cases, whether the patients are seeking treatment for minor somatic complaints because of major psychological problems, or whether it is of psychophysiological origin rather than the result of a conversion process. Many of these symptoms may also be related to depression, but it is impossible to read their survey, or to consider this field in any depth, without reaching the conclusion that an understanding of psychological mechanisms in the production of bodily complaints is fundamental to an understanding of medical practice as a whole.

Chronic pain has a frequency of 11% in a fairly typical population (Crook *et al*, 1984). When it is a subject for treatment in pain clinics there is always a group in whom anxiety and hysterical mechanisms are believed to play an important role (Merskey, 1980). Ford (1983) provides evidence from various sources to show that physical complaints on the basis of psychological illness (somatisation) affect 50–60% of medical clinic patients; 27% of patients with symptoms had no evidence of disease (Garfield *et al*, 1976). Spear (1967) found that 66% of psychiatric in-patients and day patients had pain. If the complaints are hysterical, even in a minority of these patients, this is a matter for concern in clinical practice.

Diagnostic problems

Hysteria keeps recurring as an issue in difficult diagnostic cases. Whenever we are at the margin of our ability to decide on a diagnosis, hysteria is a diagnostic possibility. If a somatic symptom has a psychological cause, and if benign physical methods of investigation are not enough to rule out organic disease, the patient may be heavily and even dangerously over-investigated. Alternatively, a lack of

adequate technology and a proper unwillingness to undertake hazardous investigations for obscure symptoms may encourage a false attribution of psychological symptoms to a physical illness.

I have emphasised the frequency of somatic symptoms of psychological origin. At the same time, we have to recognise the existence of a group of symptoms for which advances in clinical knowledge have enabled an organic diagnosis where formerly the label 'hysteria' was applied; if such cases are not correctly diagnosed the psychiatrist will be expected to cure a physical disorder with antidepressant drugs or by psychotherapy.

I should like to offer some examples of this dilemma. Firstly, there is a form of paroxysmal hemicrania which is now a well-defined syndrome (Sjaastad & Dale, 1974), but which was earlier diagnosed as headache of psychological origin. Secondly, the thoracic outlet syndrome, particularly if it is relatively mild and accompanied only by modest changes, has often been called 'neurotic'; recently I have seen six such patients whose symptoms were precipitated by a flexion-extension ('whiplash') injury of the cervical region, in whom physiotherapy had failed to provide relief and in whom first rib resection was a satisfactory procedure.

Globus hystericus provides a third example. Sydenham (1697), following earlier writers, spoke of "suffocation of the Womb in which the Belly and Entrails rise upwards towards the Throat". Purcell spoke of the symptom of difficulty in swallowing as if "a hard ball pressed against the outside of their throats; sometimes as if it were a Stick thrust down their Throats...". Traditionally, the symptom was regarded as hysterical. However, it is plausible that anxious patients may swallow air or have trouble with anorexic sensations and have difficulty in swallowing. A disorder of the oesophagus, thought to be a spastic phenomenon, was in fact demonstrated by Jacobson (1924) in an early radiological investigation. Malcolmson (1966, 1968) showed, in a series of 307 patients, that only 21% were completely normal on physical and radiological examination; 30% had a physical lesion (eg, cervical spine osteophytes, overactive cricopharyngeus, hyperplastic tonsils, goitre, postcricoid web or enlarged lymph nodes) which explained the symptom, and 49% had a gastrointestinal disturbance below the pharynx, for example hiatus hernia or duodenal ulcer. More evidence in the same direction has been produced by Delahunty & Ardran (1970), Hunt *et al* (1970), Watson & Sullivan (1974), and Lehtinen & Puhakka (1976). There may still be some patients with globus, now best termed globus pharyngis (Malcolmson, 1966, 1968), whose symptoms are psychological in origin either on the basis of anxiety or a conversion mechanism. However, most cases have a physical basis.

Facial dyskinesias and torticollis provide a fourth example. The diagnosis of psychological disorder has to a considerable extent been superseded by an organic diagnosis. I first learned to think of these as more likely to be of organic rather than psychological origin through the influence of my late colleague Dr R. T. C. Pratt. He observed that neurologists seemed to have more difficulty in making up their minds about organic or psychological causes in relation to torticollis and abnormal movements than on any other topic, and also that the symptoms tended not to respond so well to the usual treatments for anxiety or hysteria compared with other more recognisable somatic anxiety or hysterical symptoms. On one occasion, in 1969, with the knowledge of all participants we showed a patient with abnormal facial movements to six neurologists; three said her symptoms were psychological, and three said that they were physical in origin. All six gave impressive arguments to back up their opinions, but the one whose views seemed to me to be most cogent was Dr M. J. McArdle, who observed a retrocollis and abnormal movements of the soft palate. Since that time neurologists have more readily diagnosed facial dyskinesias as organic, for two reasons: firstly, they may be provoked in Parkinsonism by levodopa, and secondly, phenothiazine drugs used in the treatment of schizophrenia may produce such movements.

A fifth condition which I have seen diagnosed as hysterical, but know to be organic, is that of painful legs and moving toes (Spillane *et al*, 1971). Nathan (1978) has now shown that this is a characteristic syndrome with a specific organic basis in damage of either the dorsal nerve roots or the spinal cord.

The final example is the whiplash syndrome. It is well established that people who undergo rear-end collisions in motor vehicles typically show a pattern of development of cervical pain, headache and muscle tenderness. Animal experimentation has shown that there are recognisable and distinct soft tissue lesions, some of them severe, like retro-oesophageal haematoma, which can even be demonstrated in accident victims if the patient complains of difficulty in swallowing and an X-ray is taken at the right time (McNab, 1973). Evidence (Merskey, 1984) supports an organic aetiology in most of these cases. Moreover, patients who have had such injuries may not recover merely because litigation issues are settled (Mendelson, 1982; Merskey, 1984). What used to be called hysterical or compensation

neurosis is now better considered to be a symptom based on physical disability. It may carry in its wake some secondary depression and secondary psychological manifestations, but when a condition is poorly understood and the patient is referred from one medical department to another, it is understandable that psychological symptoms should develop; these will include anger, frustration, irritability, and some criticism of the medical profession. In such conditions hysteria should not be diagnosed in the absence of positive grounds for the diagnosis.

Social consequences

The figures quoted above for the frequency of somatic symptoms in medical practice give some indication of the importance of the production of bodily symptoms. The numerous social implications of 'illness behavior' or 'abnormal illness behavior' (Pilowsky & Spence, 1975) cannot be considered here in detail. Some of the many cases of attempted suicide, some disability claims and financial settlements, and perhaps many changes in family relationships will be influenced by hysterical symptoms. In military practice, particularly when the danger is great and the opportunity for a 'respectable' hysterical illness exists, the numbers increase considerably. By April 1918, according to Hurst (1940), there were over 20 000 cases of 'war neurosis', who received invalid pensions. It is not known what proportion of these patients suffered from hysteria and what proportion from anxiety states or depression, but the frequency of hysteria in that era is well attested to by the numerous books and other publications on the topic of 'shell shock' and 'war neurosis' (Merskey, 1979). Since the First World War such cases have been less frequent; during the Second World War the organisation of the Allied military psychiatric services was such that the development of hysterical symptoms was discouraged. However, hysterical manifestations have always been found in men under stress. Likewise, epidemics of hysteria occur, most often in girls' schools (Sirois, 1974).

It has been suggested that one of the important theoretical consequences of the recognition of combat neurosis and hysteria in the First World War was the strength it gave to the argument that, since so many men who often seemed otherwise normal were affected, hysterical symptoms were not necessarily sexual in origin.

Symptoms from thoughts

The single most important aspect of hysteria is its contribution to our understanding of the mind. To place this in context it is worthwhile considering the 17th century concept of hysteria, about which I have written in more detail elsewhere (Merskey, 1983). Sydenham (1697) included two major ideas under the rubric of hysteria. Firstly, he indicated that emotional stress disturbs the function of the nervous system; even before the time of Galen others had recognised an influence of the mind upon the body (Veith, 1965, and Hunter & McAlpine, 1963, give several illustrations from writers such as Bartholomeus Anglicus, Elyot, Langton and Paré).

Secondly, Sydenham provided a catalogue of bodily changes presumed to result from this disturbance. Some of these are clearly organic: apoplexy with hemiplegia, epilepsy, vomiting bile, and swollen legs, for example; others, such as excessive laughter, tears and labile emotions, reflect general emotional disturbance, or more specifically hysteria. Some, such as diarrhoea, may be psychosomatic in the strict sense of being related to peripheral somatic changes induced by psychological causes. Sydenham did not elucidate these matters. The critical point is that hysteria was considered to be a mixture of symptoms that we would now call organic, psychosomatic or perhaps hysterical; at the time, they were all thought to result from emotional causes. Gradually, the organic symptoms have been clarified (as the examples given earlier indicate), but it was still not really possible for the distinction between a hysterical symptom representing an idea and a physiological symptom presenting an autonomic disturbance to be made before the days of modern physiology and anatomy. Only with Sir Benjamin Brodie (1837) did some of these possibilities begin to emerge, although precursors existed. These were reviewed by Wright (1980), who remarked upon the fact that Descartes explained strange aversions by past experience. For instance, a cat might have jumped into a baby's cradle, thus causing a dislike of cats without the adult retaining any memory of it afterwards. Descartes also discovered that he was attracted to cross-eyed women, and attributed this to his love, as a young child, for a girl who looked after him and who had this defect. It is noteworthy that the recollection and analysis of the memory cured him of that particular fixation. We see here some recognition that thoughts might cause symptoms, although the symptoms which are caused are also psychological ones.

Others saw physical symptoms being transmitted by example. Robert Boyle is cited by Wright as noting that it is common for one hysterical woman, when she observes another in a fit, to be "infected with the like strange discomposure" and Blackmore (1725) wrote: "Terrible ideas, formed only in the

https://doi.org/10.1192/bjp.149.1.23 Published online by Cambridge University Press

imagination, will affect the brain and the body with painful sensations...". These authors recognised the way in which ideas could produce physical symptoms, but until the age of modern neurology and neurophysiology it was probably impossible for a consistent distinction to be established in respect of the topic, except perhaps for epidemic hysterical complaints, which were well reviewed by Hecker (1844).

The new conception really began with Sir John Russell Reynolds, who was Professor of Medicine at University College Hospital. At a meeting of the British Medical Association Reynolds described "three cases of paralysis dependent upon idea". The report was published the same year (Reynolds, 1869) and seems to have been the first systematic discussion of the theme. Certainly Charcot (1889), who said that the idea was long known, gave Reynolds full credit for his comments. Charcot was then inspired to produce symptoms in patients by the implantation of an idea under hypnosis, and this constituted the second step in the recognition of the special characteristics of the hysterical symptom. The third step we owe to Freud (Breuer & Freud, 1893–5) and his explanation of the origin of the symptom in conflict or in repression. This is so well known that I will not dwell upon it; nor upon the fact that it was the foundation of psychoanalysis, although I also take that to be an important contribution of hysteria to mankind.

The significance of hysteria and its interest lie above all in this reflection of the way in which the mind may transform a person's concept of himself or a part of his body. It has become an avenue to the discussion of personality types, a theme for evaluation in social relationships, a key to motives, and a highway to the unconscious. It is difficult to ask more of a single condition.

The demand on the doctor

However, this condition (whether single or multiple) gives us yet another theme to tackle, and one which is personally demanding for all doctors. Hysteria imposes a test on our professional skills. We can, if we wish, dismiss it as counterfeiting, none of our business, and something with which physicians need not be concerned once they have established the true situation. For reasons which deserve longer discussion elsewhere, I think that this would be an inappropriate professional response. The physician should be as committed to understanding and treating patients with hysteria as those with any other psychological or physical disorder. In order to provide that understanding and treatment, he needs an extensive background in traditional organic medicine and, equally, a tolerant and flexible approach based on psychiatric skills. That combination offers a challenge to the personal qualities of every doctor who aims to treat patients.

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British Journal of Psychiatry (1986), **149**, 28–37

Epilepsy and Hysteria

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Charcot's term 'hysteroepilepsy' implies brain mechanisms in common between epilepsy and hysteria. No such direct link between these two conditions exists. Nevertheless, there are a number of