Editorial

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Hysteria

Hysteria has a long and complicated record. A narrative which is unlikely to have a basis in a pathological entity unchanging throughout its history. The earliest record is probably an Egyptian medical papyrus dating from around 1900 BC recording peculiar abnormalities produced by movement of the uterus, moving upwards from the pelvis, applying pressure on the diaphragm and giving rise to bizarre physical and mental symptoms. Plato (c. 429–347 BC) continued the descriptive language to evoke what men found particularly irritating or incomprehensible about women ‘The animal within them is desirous of procreating children, and when remaining unfruitful...gets discontented and angry, and wandering in every direction through the body...drives them to extremity, causing all varieties of disease...’. Hippocrates (c. 460–377 BC) described how the female reproductive parts, moving, convulsing or prolapsing caused dizziness, motor paralysis and sensory disturbance. Galen (AD 129–216?) regarded the cause as being due to the retention of excessive menstrual blood.

The onset and expansion of Christian civilisation produced a change towards the supernatural and hysteria was regarded as a sign of possession by the devil. Advances in the understanding of the human nervous system produced a shift from gynaecological and demonological theories. Thomas Willis (1621–1675) thought that an excess of animal spirits was released from the brain and carried by the nerves to eventually enter the blood stream and circulate throughout the body. Robert Whytt (1714–1766), who first described the phenomena of spinal shock, thought that the disorder was caused by a disturbance or weakness of the nerve fibres. Charcot (1825–1893) felt that hysteria was a dysfunction of the central nervous system. Briquet, a nineteenth century French neurologist, has, somewhat dubiously, been credited with the first description of the syndrome of hysteria, and always insisted that it was a neurological disorder. Briquet’s Syndrome is now known as somatisation disorder, although the symptoms that Briquet actually described show a greater resemblance to *conversion disorder*.

The term *historical conversion* was introduced by John Ferriar: ‘In hysterical conversion the body possesses a power of representing the most hazardous disorders ... of counterfeiting the greatest derangement...has in this class of diseases, reconciled

contradictions, and realised improbabilities with a mysterious versatility....’ Freud also used the term *conversion hysteria*: ‘In hysteria, the incompatible idea is rendered innocuous by its sum of excitation being transformed in to something somatic. For this I would like to propose the name of conversion’. Freud invoked, at first, sexual trauma, and then sexual fantasy as the key pathogenic factor with the emphasis, therefore, on psychological mechanisms, ie the repression of remote traumatic memories invariably sexual in content.

Over the last century or so there has been a decline in the recorded incidence of hysteria, partly perhaps due to a sexual liberalisation but also to the fact that many previously described symptoms and syndromes are now reassigned to organic disorders and the psychoses and psychoneuroses. In the past hysteria has not only produced brilliant clinical observation and neuropathological and psychological research, it has also been the vehicle for sensationalism and misogyny.

The obvious problem when confronted with a patient with unexplained neurological or other complaints is making an accurate diagnosis and, in this particular case, to rule out other physical and psychiatric disorders which require treatment. There are modern diagnostic criteria but there remains confusion. The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994, 4th Edition) does not show full agreement with the ICD-10 classification (World Health Organisation, The ICD-10 Classification of Mental and Behavioural Disorders, Clinical Descriptions and Diagnostic Guidelines, 1992). In the DSM-IV, conversion disorder is classified with the somatoform disorders, whereas dissociative symptoms such as hysterical fugue states are classified under dissociative disorders. The ICD-10 classification groups them altogether under neurotic, stress-related, and somatoform disorders. The term *hysteria* has been dropped from both classifications although it is still widely used in practice. DSM-IV criteria for somatisation disorder (Briquet’s Syndrome) includes:

- Four or more unexplained bodily pains
- Two or more unexplained gastrointestinal symptoms
- One or more pseudo-neurological symptom
- One or more sexual or menstrual symptom

Conversion disorder includes one or more symptoms or deficits affecting the motor or sensory function which are not fully explained by general or medical conditions. Wessely (in *Contemporary Approaches to the Study of Hysteria*, Ed. Halligan, Bass and Marshall, OUP, 2001) points out that the formal diagnostic criteria for hysteria are unsatisfactory and includes, amongst others, the following reasons: 'We keep changing them, they were invented by psychiatrists but are used by neurologists, they have too many categories. ...' He suggests that the classic psychoanalytic derived criteria for conversion disorder should be dropped, and that we should classify in clinically relevant ways 'the suggested distinctions that appear to have some empirical and practical validation would be a diagnosis that continues to insist that either symptoms and/or loss of function be inexplicable in conventional biomedical terms, and then distinguish between symptoms and loss of function, and between acute and chronic onset of either'.

Many neurologists see no merit in the separation of dissasociative type of hysteria and a conversion type, based on dubious or unsubstantiated psychodynamic

theory, and feel that the term *conversion* if used at all should refer to symptoms which mimic neurological disease (such as amnesia, paralysis, blindness...).

The usual presentation in clinical neurology is either of a chronic illness with many symptoms, often dramatically or histrionically presented, with no evident cause and this is mainly found in girls and women, or an illness which is mostly found in men, but occasionally in women, where there are physical symptoms or disability with no obvious neurological cause and usually, if not always, associated with compensation or litigation or avoiding military duty.

The study (perhaps meditation is a better word) of hysteria goes far beyond conventional medicine. For example, Descartes felt that mind and matter were not comparable, and the history of hysteria may be seen as an ongoing attempt to solve, or at least theorise, about his dualistic philosophy.

For something like 4000 years the subject of hysteria has reflected attitudes about health, about religion and about relationships between the sexes and the interest raised by this extraordinary condition is likely to continue.

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