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Historical overview

The word hysteria . . . has so great and beautiful a history that it would be painful to give it up.
(Janet, 1901, p. 527)

Introduction

Hysteria is as old as the earliest medical texts. Originally it was a concept of the cause of symptoms, found exclusively in women, thought to be due to the wandering womb, which, being frustrated by lack of proper use, leaves its anatomical position and travels around the body causing pressure in anomalous places, and hence symptoms. Although there has been an academic debate about what the Egyptians and subsequently the Greeks were actually referring to when they discussed the wandering womb, early history reflects on two important points. First, symptoms such as are seen today were documented over 2000 years ago, across at least two different cultures, and second, that the postulated mechanism was gender-related.

Examples of the kind of symptoms that are to be described later in this book are noted in these texts, including convulsions and paralyses, and the classical globus hystericus, caused by pressure from the wandering uterus on the throat. Inscriptions from the temple of Aesculapius in Epidaurus record episodes of hysterical aphonia and blindness, and possibly the first recorded case of malingering:

Nikanor, a lame man. While he was sitting wide-awake, a boy snatched his crutch from him and ran away. But Nikanor got up, pursued him, and so was cured (Veith, 1965, p. 19).

The Middle Ages, with its neo-Platonic theological stranglehold on developing scientific thought, and thus on the medical sciences, conflated the manifestations that we would now view as hysteria with those of witchcraft. The latter first became a statutory crime in 1541, a date which heralded 200 years of witch-hunting and persecution. The detection of witches became paramount, and stigmata were identified. In particular, so-called witches, patches – areas of sensory anaesthesia – were

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recorded, but the muscular contortions and convulsions of the afflicted were well noted.

Edward Jorden (1569–1632), a physician of London and Bath, in 1603 wrote a treatise called *A Briefe Discourse of a Disease Called the Suffocation of the Mother*, essentially to counteract the prevailing mood, which was to attribute such symptoms to possession by some supernatural power. His view was that the so-called stigmata of witchcraft were in fact signs of mental illness, thus reclaiming, for the first time since Hippocrates, the essentially medical, somatic nature of the phenomena.

His book was occasioned by a trial in 1602, in which a charwoman, Elizabeth Jackson, was accused of bewitching the 14-year-old Mary Glover. The latter had convulsions, episodes of loss of speech, periodic blindness, paralysis and loss of sensation of the left side of the body, aggressivity and personality changes. The trial was probably the first in recorded history in which a psychiatrist was called to give evidence, but even then, as today, the adversarial nature of the proceedings ensured that there was another psychiatrist present, also giving evidence, who fundamentally disagreed with the formulations of Dr Jorden.

Jorden recognised the polymorphous nature of the symptoms, their link to the female sex and the importance of ‘perturbations of the mind’ in the cause of the disorder.

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Mass hysteria, in which groups of people manifested mainly motor abnormalities, became well described in the Middle Ages, and culminated in the grand chorea epidemics of Europe. Outbreaks of St Vitus’ dance, Tarantism, *convulsionnaires* and the like referred to groups of people, from half a dozen to several hundred, who would display exaggerated movements, dance and convulse until they dropped exhausted (Hecker, 1844). Many episodes were noted in relation to natural disasters, for example after the spread of the great plague, but other outbreaks came in closely knit social groups, often united by some strong religious belief. These outbreaks were similar in form to episodes of contemporary episodic epidemic hysteria, about which more is discussed later. However, these phenomena emphasised the imitative nature of many hysterical afflictions, and the powerful role of social and cultural pressures, and contagion in their pathogenesis.

Concepts of aetiology moved from the supernatural to the natural; the uterus remained popular, but several other shifts of emphasis occurred. The uterine theories slowly gave way to two interpenetrating themes, namely that the main organ involved in hysteria was the brain, and that somehow emotions were highly relevant. The sixteenth-century physician Paracelsus (1493–1541) used the term *chorea lascivia*, a disorder he opined which was provoked by ideas. The English neurologist

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Thomas Willis (1621–75) was one of the first to espouse the central importance of the brain. He reflected that ‘this passion comes not from the vapours rising into the head from the uterus or spleen, nor from a rapid flow of blood into the pulmonary vessels, but has its origin in the brain itself’ (Dewhurst, 1980, p. 87). He was led to this conclusion, not only following postmortem examinations and by his clinical observations of the disorder in prepubertal and senile women, but by the irreconcilable fact that he observed hysteria in men!

The emphasis on the emotions was taken up by several writers, including Willis, but considerably advanced by Thomas Sydenham (1624–89). He said that, of all chronic medical conditions in his practice, next to infections hysteria was the commonest, afflicting one-sixth of patients. He recognised the condition of male hysteria, although referred to it as ‘hypochondriasis’, and he noted the polymorphous presentations, stating that ‘few of the maladies of miserable mortality are not imitated by it’ (Sydenham, 1850, p. 85). Not only did Sydenham suggest the chronic nature of the condition, but he also hinted at personality contributions. Patients were prone to irritability and anger outbursts; they were capricious and labile in their moods and affections. He firmly placed the origins of hysteria in the mind, referring to ‘over-ordinate commotions of the mind’, with a ‘faulty disposition of the animal spirits’ (p. 85).

The Italian physician Baglivi (1668–1707), in his classification of diseases, included hysteria under ‘diseases of the mind’, implicating the emotions even more directly than Willis or Sydenham in causing hysteria. He thought that emotional instability was an important factor in the chronicity of symptoms.

Associations with what we may now refer to as depression were noted in Burton’s *The Anatomy of Melancholy* (1621), and the concept that the mind could influence the body, a precursor of twentieth-century psychosomatic concepts, was well accepted. The Scottish physician Sir Robert Whytt (1714–66), discoverer of reflex activity in the nervous system, and one who recognised that the mind could cause actions not appreciated by consciousness, discussed the newly invented term ‘nervous’. Noting how physicians tended to use this term for all disorders they were ignorant of, he gave his own definition thus:

those disorders may, peculiarly, deserve the name of *nervous*, which, on account of an unusual delicacy, or unnatural state of the nerves, are produced by causes, which, in people of a sound constitution, would either have no such effects, or at least in a much less degree (Whytt, 1751, p. 102).

Of those that so suffered, there were three groups: the simply nervous, the hysteric and the hypochondriac. Hypochondriacs were patients who were seldom free of complaints. Passions of the mind acted through the brain to provoke sensory and motor alterations, symptoms which were various and chameleon-like. In a passage which antedated posttraumatic stress disorder (PTSD) by over 200 years he wrote:

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Thus doleful or moving stories, horrible or unexpected sights, great grief, anger, terror and other passions, frequently occasion the most sudden and violent nervous symptoms (p. 206).

Another Scottish physician, George Cheyne (1671–1743), wrote on hysterical and hypochondriacal disorders, referring to them collectively as the English malady. Not surprisingly, the weather was incriminated in aetiology, as were the advances of civilisation. However, he drew distinctions between original and acquired nervous disorders. The former were people born with weak nerves; the latter have their disorder brought on by accidents or by their poor lifestyle, and intemperance. Accidents, for the first time, became clearly noted in this literature on hysteria, but did not necessarily act alone. In one of robust constitution, the debilitating effect of lifestyle, acting through the blood and defrauded juices, was also important. Cheyne outlined a dilemma which is ever-present today:

Nervous distempers especially are under some Kind of Disgrace and Imputation . . . so that often when I am consulted in a case, before I was acquainted with the Character and Temper of the Patient, and found it to be what is commonly call'd Nervous, I have been in the utmost Difficulty, when desir'd to define or name the Distemper, for fear of affronting them, or fixing a reproach on a family or Person. If I said it was the Vapours, Hysteric or Hypochondriacal Disorders, they thought I call'd them Mad or Fantastical: and if they were such as valued themselves, on fearing neither God nor Devil, I was in Hazard of a Drubbing for seeming to impeach their courage: and was thought as rude, as if I had given them the Lye, and even the very best has been, I myself was thought a fool, a weak and ignorant Coxcomb, and perhaps dismiss'd in Scorn (Cheyne, 1733).

The emphasis on underlying personality structure as important for an understanding of these disorders was further discussed by the German neuropsychiatrist Wilhelm Griesinger (1817–68). He noted the

peculiar hysterical disposition, viz., immoderate sensitiveness, especially to the slightest reproach, a tendency to refer everything to themselves, great irritability, great change of disposition on the least or even from no external motive (humours, caprices), and not the slightest reason can be given for the change; they often exhibit tender sympathy for other female individuals, peculiar eccentricities . . . This general state comprises many peculiarities of character, often of quite another kind, as a tendency to deception and prevarication, to all kinds of misdemeanours, jealousy, malice etc. (Griesinger, 1862, pp. 179–180).

Interestingly, Griesinger also commented on the history of the patients, noting the relevance of past episodes of sensory disturbances, paralyses, globus hystericus and the like.

Themes of either sexual frustration or sexual excess in hysteria, while tending to wane in the eighteenth century, and inherent in names such as the *hysteria libidinosa* (Boissier de Sauvages, 1706–67), or *furor uterinus*, continued to resurface. They were put into a somatic context by Griesinger, who thought that local diseases of the

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generative organs were linked to hysteria, a theme taken up in England by Thomas Laycock (1812–76), teacher of the neurologist Hughlings Jackson (1835–1911). His writings were aimed at trying to understand the reciprocal relationships between the body and mind, developing a biologically oriented scientific psychology. He believed that in hysteria the nervous system was implicated, that it was seen in the majority of cases in females of child-bearing age, and therefore the generative organs were involved in the pathogenesis. The condition often came on following grief, terror, fear or disappointment in love; these emotional events excited deranged actions in the generative system and thence the hysterical phenomena (Laycock, 1840).

Laycock’s investigations took him to speculate into the nature of the mind, and on the role of consciousness in these phenomena. Following on from Whytt’s studies of reflex activity, and Marshall Hall’s (1790–1857) demonstration in animals of the spinal reflex arc, Laycock suggested that the cerebrum (cranial ganglia) was also a reflex centre like the spinal ganglia. From this he developed his law of the unconscious functional activity of the brain. This was several decades before the Freudian elaboration.

The general practitioner, later ophthalmologist, Robert Brudenell Carter (1828–1918) divided hysteria into two main forms – simple, which manifest essentially as hysterical seizures, and complicated. The latter, foreboding the later Briquet’s form, ‘generally involves much moral and intellectual, as well as physical derangement, and when it is fully established, the primary convulsion, the *fons et origo mali* is sometimes suffered to fall into obedience . . . being arrested by the urgency of new maladies’ (Carter, 1853, pp. 28–9). He implicated sexual emotions as causative, and shifted the whole debate away from pathology of the sexual organs to inhibited sexual passions.

This was, according to Veith (1965), the first theory of repression. Emotions led to physical disorders by somatic discharge; affects provoked the wide range of motor and sensory states seen in the condition. Interestingly, Carter also observed the factitious nature of the illness in many patients, and how they used leaches in the mouth to produce bleeding, bandages to cause limb swellings and the like. Although since the time of Sydenham, the chameleon-like nature of hysteria was recognised, and its simulative nature alluded to, this seems to be one of the first texts to raise the question of patients’ motives and actions more directly.

Hysteria in nineteenth-century France

Thus, summarising the history of hysteria to the mid nineteenth century, several statements can be made. The condition hysteria had been recognised for centuries, and had been the source of much speculation regarding aetiology and pathogenesis. Certainly, it is not clear how many patients falling under this diagnosis given perhaps by Sydenham or one of his contemporaries were in reality suffering from

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unrecognised organic disorders, and many diagnostic and nosological confusions existed. However, trends and general statements can be noted. Causation shifted away from the uterus to the brain, and then to the mind. Psychosomatic concepts were readily accepted. Emotions, but especially sexual emotions, discharging through the somatic apparatus provoked the polymorphous, often bizarre symptomatology recognised as hysteria. The potential chronicity of the condition was also recognised, as was its occurrence in males. Certain types of people, that is, certain personality types, seemed more susceptible, and external exciting causes such as accidents could be relevant.

As the nineteenth century progressed, there was an explosion of interest in hysteria; the main writings came not from England, but from France. Not only did the sexual theme become revived, but also the concept of posttraumatic hysteria was crystallised.

Some of the early nineteenth century French physicians, such as Pinel (1745–1826), Landouzy (1818–64) and Dubois d’Amiens (1797–1873), reverted to uterine theories, challenging the concept of male hysteria. The relationship with hypochondriasis was again raked over. Hypochondriasis, as noted above, was used by Sydenham to refer to a form of male hysteria. Writing shortly after Willis, Sir Richard Blackmore (1653–1729), in his book *A Treatise of the Spleen and Vapours; or, Hypochondriacal and Hysterical Affections* (1725), regarded hypochondriasis and hysteria to be the same malady, differing only in degree of severity, and he hinted at underlying personality factors: ‘fluctuation of judgement . . . reversing of opinions and resolutions, inconstancy, timidity, absence of mind, want of self-determining power, inattention, incogitancy, diffidence, suspicion, and an aptness to take well-meant things amiss’ were cardinal features (Hunter and Mcalpine, 1963, p. 321).

Jean Pierre Falret (1794–1870) seems to have been the first to use hypochondriasis in this way in France, but the nervous, cerebral origins of hysteria found increasing support through Brachet (1909–88), Georget (1795–1828) and Pierre Briquet (1796–1881). Briquet was chief physician to the Paris Charité, and he readily admitted that he undertook to study hysteria as a matter of duty, on account of the frequency of cases that he reluctantly had to examine.

His book *Traité Clinique et Thérapeutique de l’Hystérie* (1859) reported on the results of personal examinations of nearly 450 patients, and stands as the nineteenth-century landmark in hysteria studies, having a considerable influence on Charcot and his school.

Briquet firmly rejected uterine theories, and described a series of cases in males. He outlined the multifarious symptoms, including the spasms, anaesthesias, convulsions, paralyses and contractures which by now had become familiar in descriptions of patients diagnosed as having hysteria. In one table he refers to the length of

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time that the symptoms lasted. Of 418 patients, 179 had the condition for between 6 months and 4 years, 81 between 5 and 10 years, and the rest lasted a longer time: in 59 patients the condition lasted longer than 20 years, while in 5 patients it spanned 55 years. These patients were polysymptomatic, ‘des troubles permanents qui portent sur presque tous les organes’ (Briquet, 1859, p. 519). Clearly forerunners of the later-christened Briquet’s hysteria!

As to pathogenesis, he was clear that it was a condition of that portion of the brain which received sensations and affective impressions, and he described hysteria as a nervousness (neurosis) of the encephalon. However, he recognised many interacting factors. These included heredity, and emotional predisposition, impressionability and emotional lability. He cited several antecedents, including the excitement of accidents, and physical abuse. Incidentally, Briquet was critical of the term ‘hysteria’, but felt it should not be given up because it had been in use so long and everyone understood its meaning.

Charcot and his school

The hysteria mantle than fell to Charcot (1825–93), the doyen of mid to late nineteenth-century French neurology, and his school of successors, many of whom also wrote on the subject of hysteria. Working at the Salpêtrière, where he became chief of neurology in 1882, he observed in detail the clinical phenomenology of cases of hysteria. It was his view that hysteria should be viewed as any other neurological condition, and by sufficient and detailed observations it should be possible to define its cause and course, the former being sought in the brain. Hysteria major (*la grande hystérie*) was hysteria with convulsions (Charcot, 1889).

He documented the physical stigmata of hysteria in considerable detail. These included anaesthetic patches, often involving the whole of one side of the body, contraction of the visual fields, and, interestingly, ovarian tenderness – a reversion to the genital region! Hysteria in his clinic was rarely monosymptomatic, and often chronic.

It is known that Charcot’s later theories of causation moved towards a more psychological approach. This was partly due to his work with hypnotism, but also because of his observations of traumatic hysteria. He tended to move away from the use of the term ‘hysteria’, and preferred the expression ‘neurosis’.

With regards to hypnotism, he started to use this after experimenting with magnetism and electricity, as a way of influencing hysterical symptoms. By hypnotising patients he was able to demonstrate that the symptoms of hysteria could be produced, or resolved, but importantly, that in posttraumatic cases, identical symptoms to the posttraumatic symptoms could be reproduced. He therefore did not accept

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any fundamental difference between hysteria of traumatic and non-traumatic origin.

Charcot quoted with approval the work of the English surgeon Sir Benjamin Brodie (1783–1862), who had observed the disuse atrophy of the limbs of patients diagnosed with motor forms of hysteria, and that hysterical conditions could come on after only minor local insults (Brodie, 1837). He also readily quoted Russell Reynolds (1828–96), who had introduced the concept of psychical paralysis, in which states the paralysis is invoked by an idea (Reynolds, 1869). Through hypnosis one could call into existence an idea or group of ideas which may be connected with previous associations, but that remained free from the control of personal ideas or the ego, and which could become fixed. To quote Charcot directly:

A man predisposed to hysteria has received a blow to the shoulder. This slight traumatism or local shock has sufficed to produce in this nervous individual a sense of numbness extending over the whole of the limb, and a slight indication of paralysis. In consequence of this sensation the idea comes to the patient’s mind that he might become paralysed; in one word through autosuggestion, the rudimentary paralysis becomes real (Charcot and Marie, 1892, p. 630).

Although it is often contended that Charcot never moved away from his neurological approach to understanding the symptoms of hysteria, the above comments are clearly a herald to the later-developed Freudian theories. They are also a reaffirmation of the importance he placed on suggestion in the evolving symptomatology.

By the time he was writing, Charcot was quite familiar with the concepts of nervous shock and traumatic hysteria, as had developed from the discussions about railway spine, discussed below, and which had appeared in the English medical literature a decade or two before. Similar cases, of posttraumatic hysteria, had been reported in France and Germany, and following many types of accidents, not just from the railways. Charcot reported many cases of hysteria provoked by an accident, and opined that the severity of the accident was less important than the patient’s constitution. Further, he quoted cases in which fright or emotional shock, with no physical injury, also precipitated hysterical symptoms.

Of course, for Charcot and his school, it remained the nervous system which was abnormal in such cases, and his invocation of hereditary factors was related to the predominant place of degenerative theories of causation in nineteenth-century neurology. Thus, not all people would succumb to hysteria, or could be hypnotised; only those with certain nervous constitutions, which reflected hereditary and sometimes sinister moral degeneration.

Janet and dissociation

For many years the seminal contributions of Pierre Janet (1859–1947) to the hysteria debate were overridden by those of Freud, but in recent times, with a renewed

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interest in the phenomenon of dissociation, a revival of interest in Janet’s views has occurred.

Janet initially studied philosophy, but started experimenting with hypnosis at Le Havre, and then studied medicine in Paris, spending time at the Salpêtrière, where he examined Charcot’s patients. Charcot encouraged him to study experimental psychology, and patients with hysteria and neurasthenia became his main interest.

By careful analysis of the patients’ symptoms and the content of their mental states, he developed a scheme that related to subconscious mental ideas, which themselves were related to traumatic events, and which could become replaced by symptoms. The mechanism was through a narrowing of the patients’ consciousness, related to a weakening of psychological synthesis. Subconscious fixed ideas could be clarified through hypnosis (or by examining dreams), and their exposure provided a therapeutic avenue. Incidentally, Janet always claimed that psychoanalysis was an extension of his ideas, and that he discovered the method of cathartic cure.

Janet, like Charcot, also emphasised patients’ predispositions, an elaboration of the degeneracy ideas. For him these abnormal tendencies were not only preponderant in hysteria, but were related to fundamental properties of the brain. Merskey comments as follows:

Janet was associated also with a tendency of the Parisian group to identify increasing numbers of traits which characterised the hysterical personality. Briquet (1859) only mentioned seven such traits, but Axenfeld (1864) identified 12, including affective features, with which he also mentioned sensitivity, vivid imagination, simulation and egocentricity or selfishness. Successive workers with Charcot identified 15 (Du Saulle, 1883), or 17 (Richer, 1885), and ultimately the numbers rise to Janet’s 23 in 1907 (Merskey, 1995, p. 33).

Janet developed further the concept of symptoms being dependent on ideas, noting that suggestibility is important, but that there also existed ‘a number of mental states anterior to suggestibility’ (Janet, 1901, p. 227). Suggestion, in which there is ‘complete and automatic development of an idea’, takes place ‘outside the will and personal perception of the subject’ (Merskey, 1995, p. 251). These are subconscious acts. In the same way that ideas can become associated, so they can be dissociated, and dissociated ideas can have their own independent existence. There is a dissociation of mental unity, and ‘at the moment of suggestion there is a shock, an emotion which destroys the feeble personal synthesis of the subject. The suggested idea remains isolated, more or less completely separated from the other ideas; it can then develop and suppress all else, or even foreign thoughts . . . a tendency to suggestion and subconscious acts is the sign of mental disease, but it is above all, the sign of hysteria’ (Merskey, 1995, pp. 275–6). These fixed ideas grow, and install themselves in the mind, in a phrase of Charcot’s, quoted by Janet, ‘like parasites’. The links with the later-developed Freudian idea of repression is clear.

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Some of Charcot’s antagonists and successors took the concept of suggestion to a more extreme degree, insisting that hysteria was nothing but suggestion, and that, even worse, the great master himself actually suggested to patients the symptoms they should have. Everyone was more or less suggestible, more or less hysterical; there was no entity of hysteria at all.

The freudian approach

The story of how the Viennese neurologist Sigmund Freud (1856–1939) went to Paris for 5 months in 1885–6 to study with Charcot is well known. Although he still busied himself with neuropathology, he swiftly fell under Charcot’s spell, and his interest in psychology crystallised. He returned to Vienna, and presented to the local society of physicians a case of traumatic hysteria in a male whom he had seen with Charcot. This was not well received. Although hysteria in males was by that time accepted, to equate male hysteria with traumatic neurosis was unacceptable. Freud then felt obliged to present a case of his own, which he did a month later:

A 29 year old man was knocked down in the street, and over the next two years had convulsions. He then developed hemi-anaesthesia and other stigmata of hysteria. The diagnosis was post-traumatic hysteria.

The reception of this presentation was also lukewarm! Withstanding this rejection, as Freud saw it, from the Austrian medical establishment, he then pursued his interest in hypnosis with Joseph Breuer (1842–1925). The story which led on to the development of psychoanalysis and his psychological elaborations of the structure of the human psyche is well known. Hysterical symptoms related to traumatic ideas, absent from consciousness, which could be uncovered by the analytic method. The unconscious mind, riven with conflicts, converted energies into physical symptoms, the latter resolving the psychic tension. To quote in full:

Our experiences have shown us, however, that the most various symptoms, which are ostensibly spontaneous and, as one might say, idiopathic products of hysteria, are just as strictly related to the precipitating trauma as the phenomena to which we have just alluded and which exhibit the connection quite clearly. The symptoms which we have been able to trace back to precipitating factors of this sort include neuralgias and anaesthesias of various kinds, many of which had persisted for years, contractures and paralyses, hysterical attacks and epileptoid convulsions, which every observer regards as true epilepsy, petit mal and disorders in the nature of tic, chronic vomiting and anorexia, carried to the pitch of rejection of all nourishment, various forms of disturbance of vision, constantly recurring visual hallucinations etc. The disproportion between the many years duration of the hysterical symptom and the single occurrence which provoked it is what we are accustomed invariably to find in traumatic neuroses. Quite frequently it is some event in childhood that sets up a more or less severe symptom which persists during the years that follow (Breuer and Freud, 1893, p. 88).