

Hysteria and its metamorphoses

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Objective: *To investigate the historical evolution of hysteria and its possible psychopathological ramifications in today's diagnostic classifications.* **Method:** *Clinical and historical problematization contrasting classical and contemporary references on the subject.* **Conclusion:** *Higher incidence of certain conditions and decline in the use of the construct of hysteria should be seen as different moments in a continuum.*

Key words: Hysteria, somatization, conversion disorder, somatoform disorder

Introduction

Hysteria represents, according to Micale (2000), one of the most intriguing examples of the recognition of psychiatric illnesses throughout history. Frequently diagnosed from Hippocrates' times till the beginning of the XX century, hysteria enigmatically disappeared, as a whole, from the clinical setting and even from the research papers of Psychiatry and other specialties during the XX century, culminating in its elimination from the official disease classification manuals during the 1990s (Micale, 2000; Stone et al., 2008; Merskey, 2004; Ávila, 2002 e 2006; Mai, 1980; Shorter, 2005; Coelho & Ávila, 2007).

The theatrical presentation it frequently exhibited has become rare while, simultaneously, the frequencies of depressive, anxiety and somatization disorders are increasing, suggesting a change in the physical manifestation of the disease (Bathia & Choudhary, 1998; Ford, 1997; Mendoza, 1987; Hudziak et al., 1996; Mai, 2004; Micale, 2000; Vega et al., 1997). Little is known about what caused this transformation in clinical presentation but due to its great plasticity, the remnants of hysteria have taken on new clinical formats. There seems to be an overlapping of old and new diagnostic criteria.

Briquet's syndrome, for instance, evolved from being one form of hysteria to a somatization disorder, thereby possibly explaining frequent comorbidities of borderline personalities with somatization. Classical 'Victorian' hysteria seems to have been re-organized into new categories keeping some resemblance to the original, but showing differences in symptoms. It is as if hysteria has become old fashioned and some of its components are now part of new

fashionable diseases (Hudziak et al., 1996; Kirmayer, 1998; Shorter, 2005; Micale, 2000; Trillat, 1986; Bathia & Choudhary, 1998; Rocca, 1981; Ávila, 2006; Ford, 1997).

Besides historical changes in the conception of this illness, the mild expression and possible substitutes for hysterical symptoms should be carefully considered. To comprehend hysteria is to understand how societies and doctors have and are dealing with it (Micale, 2000; Merskey, 2004; Mendoza, 1987; Wilkinson & Bass, 1994; Ávila, 2002; Ford, 1997; Kirmayer & Young, 1998). Hysterical characteristics exist, to different extents, in everyone. Nevertheless, in some people it appears only under organic or psychosocial pressure, while in others it represents an ordinary pattern of life, without the need of any trigger (Jaspers, 1985; Ey et al., 1969; Trillat, 1986).

For Merskey (2003), there is inevitable confusion in the uses of the diagnosis:

Previous versions of psychiatric classification systems had provided categories of hysteria which were, in general, rather vague and also looked at issues of personality connected to so-called hysterical symptoms. There was much dissatisfaction with the diagnosis of hysteria because, in practice, it frequently appeared to be misleading and was often confused with an organic disorder. (p. 68)

Even so, hysteria is sufficiently prevalent and significant to figure in the differential diagnoses of a wide variety of illnesses. Its symptoms appear as disorders of all organic functions, making it the mask for many objectively identified physical or psychical diseases (Mai, 1982; Fisher, 1999; Merskey, 2004; Dunbar, 1943; Ey et al., 1969; Mace & Trimble, 1991). Besides that, conservative symptoms greatly share comorbidities with anxiety, depression and personality disorders (Black et al., 2004; Engel, 1970; Hudziak et al., 1996), but, as Mayer-Gross pointed out, sometimes symptoms resembling hysteria may be the hallmark of cerebral tumors (Mayer Gross et al., 1971).

Some frequent medical conditions, including incurable headaches, dysphonia, walking coordination disorders, pain and spasms, paresthesia, digestive disturbances, sexual dysfunction, prostatitis, gynecological disorders, among many others, used to be considered important manifestations of hysteria (Rocca, 1981; Ey et al., 1969; Jaspers, 1985). Is it possible that these diseases are mere expressions of somatization? The answer is not straightforward.

Clinical presentations, when bizarre or atypical, may be suggestive of hysteria, especially if a patient has had traits of hysterical personality, a medical history of vague diverse physical complaints which were variable in location and in intensity, as well as psychosocial stressors prior to the onset of symptoms (Mai, 1982; Merskey, 2004; Mai, 2004; Ávila, 2002]. Nonetheless, these features

serve only as pointers for clinical assessments, they are not sufficient to establish or to refute a diagnostic hypothesis.

Both organic and psychodynamic approaches to hysteria have developed over the last few years, thus generating new models, behavioral descriptions and a better definition of the hysterical character. Psychoanalysis still has importance in the investigation and treatment of sufferers (Gottlieb, 2003; Nasio, 1998; Ávila, 2006; Bollas, 2000; Verhaeghe, 2007). Experimental psychology, genetics, neurology and cerebral imaging have contributed to a greater knowledge of this complex illness (Mai, 1996; Black et al., 2004; Merskey & Buhrich, 1975; Ludwig, 1972; Vuilleumier et al., 2001; Werring et al., 2004).

The first edition of the *Diagnostic and Statistical Manual for Mental Symptoms* (DSM), produced by the American Psychiatric Association, decided to avoid using the terms *hysteria* and *psychosomatic*. In its second edition, hysteria returned as *Neuroses and hysterical neuroses*, and at that time, included a particular personality disorder, the hysterical personality (Shorter, 2005).

Somatization diseases, originally incorporated in the DSM III, were inserted in the somatoform disorder group, reflecting an effort to include hysterical symptoms in the manual's categories even with the formal exclusion of the term 'hysteria' from the entire text (Merskey, 2004; Shorter, 2005; Mai, 2004; Ávila, 2006; Mayou, 2003). The expression *somatization* was introduced in psychiatry by Stekel, an ex-fellow of Freud. It was coined due to a translation error in 1923 of the German term *Organsprach*, literally meaning *organ language*. But the term *somatization* achieved great popularity as a substitute for *hysteria*, viewed as unsatisfactory and stigmatizing (Mai, 2004; Shorter, 2005; Trillat, 1995).

The authors of the *International Classification of Diseases* excluded the term 'hysteria' due to variations in meaning in respective psychiatric traditions (WHE, 1992; Mai, 2004; Matos et al., 2005). But the exclusion of the term hysteria did not mean the disappearance of its phenomena or diversified symptomatic expressions. Besides, there is no agreement between the international and the American classifications. In spite of the concordance to suppress the name 'hysteria' in both manuals, there are important differences between the APA's DSM and the WHO's ICD classification systems. The former classification manual uses two categories, dissociative and somatoform disorders, with this last one including conversion symptoms, whereas the ICD proposes the title of dissociative or conversion disorders and a different category for somatoform symptoms. Additionally, the items included in these two classifications only partially correspond (WHE, 1992; APA, 2002; Merskey, 2003). Thus, somatization is not the same as hysteria, nor does it match psychosomatization, but the three expressions are applied to the same basic phenomena.

Epidemiology

The onset of hysterical symptoms is rare before the age of five years old but generally occurs during adolescence (Bathia & Choudhary, 1998). Some authors consider a prevalence of only 4.5% among psychiatric out-patients, while others report higher indexes of up to 16% (Mai, 1982). Engel reported conversive symptoms in 20 to 25% of all patients admitted to primary healthcare services (Engel, 1970). In other studies, the prevalence ranged between 6.5 to 10.6% due to differences in diagnostic criteria (Fink & Rosendal, 2008; Merskey, 2004).

Family and genetic factors are, doubtlessly, important in hysteria, since a high prevalence is found in first-degree relatives. Torgensen (Torgensen, 1986) found 29% of concordance between monozygotic and 10% between dizygotic twins, but stressed the fact that similitude of childhood experiences might be the cause of this finding. Briquet (1859), Mai & Merskey (1980) and Arkonac & Guze (1963) observed that male relatives show a higher prevalence of anti-social personalities and alcohol abuse (Mai, 2004). Female relatives of imprisoned men demonstrate a high prevalence of hysterical symptoms, but there is no clear-cut social or genetic evidence for this (Mai, 1996; Hudziak et al., 1996).

Now, if we consider the epidemiology of somatization as defined by the DSM and ICD we find a similar picture. Somatization is as frequent as schizophrenia in the general population and is responsible for 20% of all new consultations; thus the severity and cost to society are comparable (Mai, 2004; Rocca, 1981; WHE, 1992; Bass et al., 2001; Petrie et al., 2001; Hillee et al., 2003). A high correlation was found linking somatization with lower economic classes, lower educational levels, women and certain ethnic groups (Mai, 2004; Kiemayer & Young, 1998).

Epidemiological studies have shown a prevalence of somatization disorders during the lifetime of between 0.2 and 2.0% for women and below 0.2% for men, but the reason for this difference remains unclear (Mai, 2004). A retrospective study of 13,314 patients, in a consultation-liaison psychiatric service found that somatization disorders caused incapacity and job losses at a higher rate than any other mental disorder. A reduction of 53% in healthcare costs has already been demonstrated when adequate medical care was given to somatization patients (Mai, 2004; Thomassen et al., 2003).

The metamorphosed hysteria

Organic illnesses, in particular those affecting several body functions, such as multiple sclerosis, systemic lupus erythematosus and certain endocrinopathies,

are frequently confounded with symptoms imitated in hysteria and thus by extrapolation, with somatization disorders. Evidently, these diseases must be carefully investigated, as the possibility of associated somatization disorders can not be excluded (Mai, 2004).

The considerable overlapping between somatization disorders and other specific diseases, such as fibromyalgia, chronic fatigue syndrome and irritable bowel syndrome, is remarkable. These conditions commonly occur conjointly and recent evidence questions whether they are disconnected events or merely parts of the same pathophysiological *continuum* (Mai, 2004; Nimnuan, 2001; Wilkinson & Bass, 1994), including convergence with mood disorders, especially in the case of fibromyalgia.

Seventy percent of fibromyalgia patients and 30% of those suffering from 'multiple chemical sensitivities' fill the criteria of chronic fatigue syndrome, and are regular attendees of healthcare clinics (Ford, 1997). Dependence, passivity, idealization of personal and family relationships, traits of obsessive-compulsive personality, bad-adaptive responses to losses and work addiction have been described in patients suffering from fibromyalgia (Gildea, 1949; Black et al., 2004).

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Myofascial pains and temporo-mandibular dysfunctions have been intimately implied in fibromyalgia syndrome throughout history, receiving different denominations: fibromyosite, neuropsychastenia, myalgic encephalitis, and chronic infection by the Epstein-Barr virus, reflecting the manner in which the condition was understood. It is well known that there is no clear etiologic definition for fibromyalgia, even if its symptoms are severer than other rheumatologic conditions, such as rheumatoid arthritis.

Some authors believe fibromyalgia is the result of an overall reduction in pain thresholds, but these variations in muscular pain are frequently accompanied by unspecific symptoms, such as insomnia, headaches and gastrointestinal complaints (Ford, 1997), well-known manifestations of hysteria. Fibromyalgic patients have many more unexplained physical symptoms, a history of surgical interventions and many more consultations with specialists, all characteristics of somatization disorders.

Correlatively, the symptoms attributed to the borderline personality disorder are compatible to the clinical symptoms of the syndrome investigated by and named after Briquet. Borderline personality disorder is associated with many clinical disturbances, in particular mood (around 87%) and anxiety disorders and a combination of somatization, substance abuse and anti-social personality disorder (called *the Briquet cluster*). It is possible that this apparent comorbidity is a consequence of the use of criteria common to many nosological entities (Hudziak et al., 1996) – similar to what happens with hysteria.

It can be speculated that if pure cases of borderline personality disorder did not exist, the majority of patients would simply be considered as suffering from hysteria. Between 1801 and 1994, borderline personality disorder received at least 16 different denominations, including 'mania without delusion', 'moral insanity', 'borderline states' and 'virtual structures'. The same happened with what is currently called fibromyalgia. Besides, we can see that the expression 'histrionic personality disorder', which has a difficult and scarcely evident differentiation in relation to borderline personality disorder, as adopted by DSM III and IV, is basically a substitution of the deeply rooted term hysterical personality (Stone, 2005). That is to say, it is probably a common ancestor in the evolution of the terminology.

Discussion

The organicistic approach to hysteria, which dismisses any emotional content, can seriously harm patients and may prejudice healthcare systems channeling economic and professional resources to treat badly-diagnosed patients (Hutto, 2003; Ford, 1997). It is an urgent task to discriminate potentially severe organic pathologies from unsustainable beliefs, with consequences for both patients and the professionals responsible for them (Wilkinson & Bass, 1994; Merskey, 2004; Mai, 1982).

As Stone et. al. (2008) pointed out, when neurological investigations of hysteria were separated from psychiatric studies at the beginning of the XX century, hysteria moved into a 'no man's land' between both specialties. The lack of interest of neurologists in hysterical conditions, the medical anxiety in relation to this diagnosis, the involvement of excessive psychologization and the patient's 'preference' to have a neurological disease, instead of a psychiatric one, are all important factors in the creation of the gray zone of hysteria.

Other studies are needed to better evaluate possible organic etiologies with better methodological control of the variables involved, considering that, maybe, hysteria is a condition with an as yet unidentified organic etiology. It has, nonetheless, its own clear psychodynamics. Patients suffering from hysteria and/or psychosomatic symptoms do not submissively render to the expectations of the medical order. They are not exclusively medical or psychological, but both. So, it is not surprising that patients frequently do not respond to simple prescriptions of anti-depressant or anxiolytic medications (Ford, 1997).

Manifested on different fronts, hysteria frequently appears in the consulting rooms of different specialties. Nevertheless, it is unknown whether professionals who are not familiar with the treatment of psychiatric patients are prepared to deal

with the subtle psychological characteristics of this condition. Patients that, in the past, were formally acknowledged as suffering from hysteria may currently be complying with badly-specified criteria including fibromyalgia, borderline personality disorders, irritable bowel syndrome, chronic fatigue syndrome, multiple chemical sensitivities, etc. The adoption of labels such as fibromyalgia or other putative organic pathologies, gives legitimacy to the complaints of the patient, avoiding stigmatization by society and permitting patients to assume the role of sick people, as their problems are not considered as imaginary by healthcare professionals (Coelho & Ávila, 2007; Ford, 1997).

The analyses of the current epidemiologic data on hysteria may contribute, in a more objective way, when it is examined the hypothesis that the hysterical phenomenon is transformed throughout time and societies, leading to the diminution of the prevalence of certain conditions besides to the increase in the frequency of others. Thus, when no organic pathology is identified, 50% of all primary healthcare consultations are considered somatization, thus this condition is very prevalent in the general population (Mai, 2004; Coelho & Ávila, 2007; Wilkinson & Bass, 1994; Kirmayer & Robbins, 1991; Escobar et al., 1987; Thomassen et al., 2003). But somatization disorders, strictly speaking, affect only 0.3% of the population according to epidemiological studies (Bass et al., 2001; Escobar et al., 1987; Hillee et al., 2003; Jackson & Kroenke, 2008). In this gross variation, of less than 1% to half of the patients, a large number of questionable diagnoses emerge: 'neurovegetative disorders', 'burnout syndrome', 'multiple chemical sensitivities', 'chronic fatigue syndrome', 'psychosomatic illness', among others. Probably this extremely confused terminology is the legacy of the exclusion of hysteria from medical diagnostic classifications (Trillat, 1986; Micale, 2000; Ávila, 2006). A recent denomination is 'unexplainable medical symptoms', common in papers originating from Anglo-Saxon countries and unsatisfactory as the authors themselves admit (Wessely, 2003; Reid et al., 2001; Kessler, 1985; Aiarzaguena et al., 2008; Jackson & Kroenke, 2008; Rief & Broadbent, 2007).

Hysteria, somatization and psychosomatics: what is the practical meaning of different denominations for a phenomenon that has common symptoms? It is our contention that a great change in the field of hysteria with the use of diverse historical substitutes magnified the diagnostic ambiguity due to the fragmentation of its concept. In the same way as what is seen in other chapters of modern Psychiatry, a unified theory of the several fragments occupying the place of hysteria would represent a strategy to better impact on the health of many patients. This would solve clinical difficulties both in the diagnosis and the handling of these patients.

The great lack of definition between the areas of psychosomatics and hysteria highlights the need for great care when approaching psychological and psychiatric factors involved in the geneses of these conditions.

Conclusion

Although extensively studied, this issue must be discussed, as the clinical and social management of hysteria unfortunately continues to be inadequate. The exclusion of the terms *hysteria* and *psychosomatics* from the ICD and DSM does not provide the solution and this exclusion may be seen as resignation to the inability to psychodynamically comprehend these conditions. Biological and psychodynamic studies are still necessary to better understand this entity that probably has an organic etiology, but which has its own psychodynamics.

Hysteria has not disappeared; it has just adopted new presentations, in order to deceive the rules of the medical game. Hysteria is still alive in its tenuous frontiers with other human conditions, camouflaged as fashionable diseases, generating costs and defying science, as was always the case. We are living through a historical moment when sharply psychodynamic and existential questions are frequently placed in diagnostic categories, based only on the clinical criteria of diagnostic inclusion, thereby depriving man, and especially hysterical individuals (obviously we are not considering the pejorative connotation that is traditionally connected to this term) of his most immanent condition: his human singularity.

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Abstract

(A histeria e as suas metamorfoses)

Objetivo: Promover um pensamento investigativo acerca da evolução histórica da histeria e de suas eventuais ramificações psicopatológicas nas classificações diagnósticas atuais. Método: Problematização histórica e clínica a partir do contraponto entre referências clássicas e contemporâneas sobre o assunto. Conclusão: O aumento da incidência de certas condições e o declínio no uso do constructo histeria deveriam ser observados como momentos distintos de um mesmo continuum.

Palavras-chave: Histeria, somatização, transtorno de conversão, transtorno somatoforme

(L'hystérie et ses métamorphoses)

Objectif: Promouvoir une réflexion sur l'évolution historique de l'hystérie et ses ramifications psychopathologiques possibles dans les classifications diagnostiques actuelles. Méthode: Problématisation historique et clinique opposant les références classiques et contemporaines concernant ce sujet. Conclusion: L'incidence accrue de certai-

nes conditions et la diminution de l'utilisation du construit "hystérie" devrait être considéré comme des moments distincts d'un même continuum.

Mots clés: Hystérie, somatisation, trouble de conversion, troubles somatoformes

(La histeria y sus metamorfosis)

Objetivo: Promover un pensamiento investigador sobre la evolución histórica de la histeria y sus posibles ramificaciones psicopatológicas en las clasificaciones diagnósticas de la actualidad. Método: Problematización clínica e histórica contrastando referencias clásicas y contemporáneas sobre el tema. Conclusión: El aumento en la incidencia de ciertas condiciones y la declinación en el uso del constructo de la histeria deberían ser observadas como momentos distintos del mismo continuum.

Palabras clave: Histeria, somatización, trastorno de conversión, trastorno somatoforme

(Hysterie und ihre Metamorphosen)

Ziel: Entwicklung des Forschungsdenkens über die Evolution der Hysteriegeschichte und der eventuellen psychopathologischen Verzweigungen im Rahmen der heutigen diagnostischen Kategorien. Methode: Historische und klinische Problemstellung, ausgehend vom Kontrapunkt zwischen den klassischen und den gegenwärtigen Beiträgen zum Thema. Schlussfolgerung: Zunehmende Vorkommnisse bestimmter Bedingungen und der Zerfall des Hysteriekonstrukts müssten als unterschiedliche Momente eines selben Kontinuums beobachtet werden.

Schlüsselwörter: Hysterie, Somatisierung, Konversionsstörung, somatoforme Störung

Citação/Citation: ÁVILA, A.L.; TERRA, J.R. Hysteria and its metamorphoses. *Revista Latino-americana de Psicopatologia Fundamental*, São Paulo, v. 15, n. 1, p. 27-41, mar.2012.

Editor do artigo/Editor: Prof. Dr. Manoel Tosta Berlinck

Recebido/Received: 27.1.2011 / 1.27.2011 **Aceito/Accepted:** 15.6.2011 / 6.15.2011

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Financiamento/Funding: Os autores declaram não ter sido financiados ou apoiados/The authors have no support or funding to report.

Conflito de interesses/Conflict of interest: Os autores declaram que não há conflito de interesses/The authors declares that has no conflict of interest.

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