Papers and Originals

Diagnosis of Hysteria

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"The diagnosis of 'hysteria' is a disguise for ignorance and a fertile source of clinical error. It is in fact not only a delusion but also a snare" (Eliot Slater, 1965).

"Il vaut mieux ne plus discuter sur les mots, mais vous enquerir de la vérité des choses." (*Collected Works of Galen*, Ch. 1, Daremberg's translation.)

Dr. Eliot Slater ends his Shorvon Lecture on this subject* with the Cromwellian gesture cited above, telling neurologists to "take away that bauble" hysteria. When the Lord Protector of the Realm thus dismissed the Long Parliament's mace, it did indeed go into a brief recess, soon to return with its significance and prestige undimmed to our own day.

I think it likely that the concept of hysteria will repeat history in this respect, but even if, to hide the term's etymology, we replaced it by another the idea symbolized by the new name would still keep what of reality the old embodied.

Names and Words

As for Galen, alas! in this matter Dr. Slater and I are at odds about things as well as about words, but the things might appear less discrepant if we could achieve greater precision in our use of names. So about names and words we must have some preliminary discussion.

That the name here in question is based upon an old myth is not a discovery that had to await the 1960s or even the twentieth century.

Yet even though the disputed word is based upon a myth we may not assume that what we refer to when we use it is mythical. Indeed, to few in medicine can it be more perilous than to a psychiatrist to become an etymological purist, for within the lives of many of us the Greek myths have been freely borrowed from to lend a classic dignity to the content and terminology of his discipline. Also his incursions into Latin have not been without the possibility of misunderstanding. For example, the words "obsessive" and "obsession" are common coin in his writings, yet the original reference of the words was to sitting down before and besieging a fortress.

Because the "obsessive" patients he now endeavours to relieve are not thus engaged, must we conclude that these words are a delusion and a snare and a disguise for an ignorance of more than Latin? If we are to satisfy Slater, we must do so. Admittedly the nomenclature of neurology is not without blemish, but knowledge is not enriched when the pot calls the kettle black.

Nevertheless, there is an important basic idea in Slater's thesis, and this may stand out more clearly when we have pruned the semantic jungle within which it hides. Three words stand out for some measure of clarification. They are "functional," "hysterical," and "hysteria."

However far from being ideal, to-day the word "functional" as used in relation to psychologically engendered illness gives rise to no genuine misunderstanding, but in Bastian's day the word was so indiscriminately used that it had no defining meaning whatever. This is plain when we turn to his textbook of 1886, which is one of Slater's main sources.

Bastian's Classification

For example, in this work Bastian classifies acute spinal paralyses under nine headings. Of these the "so-called functional spinal paralyses" are five in number. They include (a) *toxic spinal paralyses* attributed severally to poisoning by lead, arsenic, possibly alcohol, aconite, ergot, prussic acid, and veratrine.

Nothing is said of the pathology of any of these, and they make up a heterogeneous collection that at that date had no known morbid anatomy. (b) *Intermittent paraplegia*: this is mentioned, but its underlying pathology is not. (c) *Hysterical paraplegia*: this is described in a way that reveals the very imperfect knowledge of organic nervous disease in Bastian's day. It constitutes, he says, a "special class" of functional paralysis, difficult accurately to differentiate, and then only by a dangerous process of exclusion of organic disease. While hysterical paralysis is functional, not all functional paralyses, he says, are hysterical.

The next item is (d) *paraplegia dependent on idea*. How Bastian differentiates this from hysterical paraplegia is not clear, for he says that it is characterized by "the absence of any positive indications of structural defect in the spinal cord," that "it occurs in persons of delicate or neurotic constitution" and is probably due to "imagination continuously excited in one direction" and "with a tendency to pervert spinal cord activity in that region."

This gem of the collection seems strangely to have escaped Slater's notice, but what can it be except hysterical paraplegia, which, by endowing it with a new name, Bastian thought to have made "an honest woman"?

Finally, we have (e) *reflex paralysis*. This is a heterogeneous assembly of clinical states with no known pathology, but due, Bastian surmises, to irritations arising in various parts of the body, particularly in the urinary tract and the female genitals.

It is not easy to see what enlightenment as to the being or not-being of an entity to be known as hysteria is to be obtained from this source. The only unequivocal term in the list is that of "paraplegia dependent on idea," and this can scarcely be a basis for the denial of hysteria.

In short, in Bastian's day the term "functional" had no defining meaning whatever, and all the semantic jests about it, heavy with pedantic humour, from Bastian's day to Kinnier Wilson's, are irrelevant to the problem of hysteria. Yet before we leave this word, it is well to remember that the term

* See *Brit. med. J.*, 29 May, 1965, p. 1395.

"functional" implies that *there are functions* that may be disordered. The adjective would not and could not exist without the substantive of which it is the offspring.

Surely this must be true of the adjective "hysterical" also, for, if there is no state to which we may apply the term "hysteria," then the adjective becomes one defining nonentity and has neither meaning nor place in our terminology. One cannot accept hysteria adjectivally and deny it substantively.

Even Wilson, who denied all distinction between the ideas expressed by the words "functional" and "organic," uses the term "hysterical." Thus, in his well-known textbook (Wilson, 1940) he writes: "genuine [*sic*] hysterical symptoms are grafted on the disease" (disseminated sclerosis). What can this mean, except that there is a state or malady known as hysteria that exists in its own right, and, in Descartes' words in another connexion, "requiring nothing but itself in order to exist," though it may become parasitic on an organic malady?

Thus the two reeds upon which Slater so greatly depends to support his thesis that hysteria is a figment of the neurologist's mind and has no existence in *rebus naturae* appear to be broken reeds indeed.

Babinski, though reluctant to do so, thought it might be appropriate to replace the word "hysteria" by one expressive of his view of the illness so named, and he coined another Greek neologism—namely, "pithiatism"—derived from the Greek roots *πειθω* and *λατρός* meaning respectively "suggestion" and "curable." The new term did not establish itself and is nowhere used to-day.

The name it sought to replace misleads no one, and Slater has made what is, we may hope, the last joke about it, which it will outlive.

Objections to Hysteria as a Nosological Entity

The modern neurological literature on hysteria may be said to date from the Charcot period, though it is, of course, not exclusively from his pen. It reaches its peak of clinical and theoretical development in the writings of Babinski (1901–28). In this country writings on the subject have been essentially clinical and pragmatic, and thus incomplete in that they neglect the psychopathology of hysteria.

In the latter respect, perhaps, they justify Slater's criticism, but not his following in their footsteps as he does.

Babinski (1909) dismembered the overlaid picture of hysteria left by Charcot, removing from it elements not belonging to it, including the secondary consequences physical in their nature, and, finally, the role of fraud ("supercherie")—that is, of self-inflicted injuries and pathological lying. Possibly, in respect of the last of these, the separation was not fully justified, for it has long been acknowledged that the hysteric is a master, or a mistress, of this upon occasion, and it may be an integral element in what is essentially a psychical illness. Lhermitte has said that "hysteria is the mother of deceit and trickery."

In short, fifty years ago Babinski enumerated and discussed all the diagnostic difficulties surrounding hysteria that Slater has exhumed, provided a definition of it, and placed it firmly in the category of psychologically engendered illnesses, with no necessary underlying disorder on the physiological or morphological levels. What stands out in Slater's lecture is the absence of any discussion of the psychopathology of hysteria, or any mention of the many psychiatric contributions to it. He seems not to be discussing principles but details of diagnosis and prognosis and the stressing of human failures in making statements about both. He writes like a frustrated neurologist who had found himself defeated by the clinical difficulties of diagnosis and treatment rather than as a psychiatrist taking a holist view of the subject.

There are, therefore, two aspects under which hysteria must be considered; first, the nosographical isolation and descrip-

tion of what is to be included under this name, and, secondly, the psychopathology of hysteria. Of the latter probably no better summary is easily available to us than that written by two distinguished psychiatrists, both in their times directors of the Maudsley Hospital—namely, Edward Mapother and Aubrey Lewis—for Price's *Textbook of the Practice of Medicine* (fifth edition, 1937). This, it seems to me, must command the assent of the neurologist no less than that of the psychiatrist, and Slater's critique does not impair its cogency.

Hysteria commonly presents itself to our observation as a mimesis or as a caricature of disturbances on the physiological and morphological levels, and thus the psychiatrist is apt to encounter it only after a first clinical study has indicated that the presenting phenomena do not require an explanation on these levels, and also, what is not less characteristic, that they are not congruous with what is possible and known to occur on these levels. Thus the psychiatrist must often have to take on trust a differential diagnosis that was not his own and one that may have required experience within almost any field of medicine. It would be unrealistic to believe that this can endear the treatment of hysteria to him, as clearly it has not done to Slater.

Thus, in view of the polymorphic manifestations of hysteria, diagnosis and psychological study present peculiar difficulties. These are not unknown. They include the possible co-existence in the patient of psychological and somatic illness, the difficulty when both are present in apportioning the measure of disability between them, and finally the difficulty arising from the long-known experience of the proneness of the subject to exaggeration, to invention, and even to pathological lying.

Slater points out that the diagnosis turns out in practice not seldom to be incorrect. This point, of course, is not one involving a principle but one having reference to human fallibility, though he would perhaps prefer to say that error arises because we seek to identify a non-existent entity. I cannot think that any experienced physician or neurologist would accept this argument.

It may be added that in this country major syndromes of hysteria are far less common than they used to be forty or more years ago, at least under peacetime conditions, and current experience in any one observer's life is scantier to-day than once was the case. This situation may be a factor in the errors Slater emphasizes.

Let us agree, then, that difficulties may beset diagnosis, but this does not separate hysteria qualitatively from other modes of illness, and the measure of accuracy in diagnosis is a measure of the experience of the observer, and upon his having the courage of his convictions when he does diagnose hysteria, for the diagnosis is never popular.

Nevertheless, Slater's nihilism in regard to hysteria is a challenge to neurologists once again to justify the concept of hysteria as a nosological entity in its own right.

Diagnosis by Exclusion

His objections to this view are two. First, great play is made of the weakness of *diagnosis by exclusion*. Yet in all fields of medicine exclusion is but one aspect of discrimination. Trained observation is a matter of discrimination and selection, as I have on a former occasion sought to show (Walshe, 1948). If this were not so we should be no more than collectors of information, significant and without significance, from which we did not seek, or refused to seek, patterns of relevance to science. The whole process of differential diagnosis is one of exclusion and inclusion, selection and rejection. Thus we transform the presenting data of our experience into ordered knowledge.

So it is with hysteria, and this state or illness emerges from the process of discrimination as showing (1) an absence of

signs that require or tolerate the postulation of primary disorder on the physiological and morphological levels, and (2) the presence of signs that positively transgress those modes of disorder and are not congruous with them, and are (3) patterns of disorder that plainly arise from mental dispositions, "dependent on idea," as Bastian in his one lucid utterance on the subject postulated. These patterns which are not congruous with nature's "laws" as observed in the physical and biological sciences reflect the subject's notions about his bodily arrangements and functioning.

Thus, while dissenting from Slater's verdict on the concept of hysteria, I am bound to agree that the English neurological contribution to the subject has been conceptually inadequate, and primarily pragmatic, concerning itself with differential diagnosis, which, however, is a fundamental element in our consideration of hysteria, but descriptively rather than generalizing.

Unhappily, instead of remedying this defect, for which a golden opportunity lay before him, Slater has chosen to be a demolitionist only and has left an empty building-site when he might have endeavoured, what it was within his power to do—namely, to develop the subject on the same level of theoretical ability that Babinski displayed, and so to have given us a true picture of hysteria.

Is it credible that the younger neurologist of to-day, armed with his diploma in psychological medicine, can really believe that hysteria consists of no more than random aggregates of symptoms and disabilities which collateral knowledge of the present time does not allow to be accounted for in terms of somatic disease, and that the word symbolizes only a confused negative idea with no positive features, and a state to be recognized timorously only by a process of exclusion? This is what Slater proposes. I cannot believe this.

I use the term "random aggregates" in preference to Slater's expression "random selection" because these two latter words are antithetical, referring to chance and order respectively, and are thus inappropriate in discussing a concept to which order or pattern is denied by him.

Idea of Health

Secondly, Slater maintains that the manifestations of hysteria are in fact signs of normal health, and we have to ask how he defines "health." He does not define it, but over two hundred years ago Laurence Sterne, anticipating what in another grandiose neologism we now call psychosomatics, wrote in his book *The Life and Opinions of Tristram Shandy, Gentleman*, "A man's body and his mind are exactly like a jerkin and a jerkin's lining: rumple the one, you rumple the other."

What wonder, then, if we meet bodily and also psychological disturbance in the same human person. Is not one as real as the other? Is the human person merely physical?

What then is the "health" of which Slater speaks? It is no more than physical health, and it is evident that the flaccid and immobile legs of an hysterical paraplegia are not signs of "health" if we use the word in a holist sense as meaning the health of the whole human person, body and mind. All he is really asserting is that he does not accept hysteria as an illness primarily and essentially on the physiological and morphological levels. Here his thesis falls apart, for neither does the neurologist. More surprising, however, is the unescapable implication that if hysteria be not a physically engendered disorder it can have no mode of being whatever.

Perhaps our debt to Laurence Sterne is not yet exhausted, for his aphorism reminds us that hysterical and somatic disorder may be commingled, and thus the presence of signs of disease on the psychological level, as well as on the physiological and morphological, does not invalidate the concept of hysteria.

Babinski on Hysteria

Babinski relates how he was *chef de clinique* to Charcot and how, while admiring his chief's contributions to the subject now under discussion, felt that he could not accept without qualification the whole body of opinion Charcot left behind him.

Particularly he could not accept that "suggestion" could be made responsible for the "stigmata" of hysteria—that is, the cutaneous lesions, the blue oedema, and other structural changes noted in some hysterical subjects. These he regarded as secondary consequences, or as artifacts self-inflicted by the patient either consciously or "subconsciously."

The signs of hysteria, he concluded, were such as could be produced by "suggestion" in abnormally suggestible persons, and could be removed by "persuasion." The suggestion might be imposed or be an auto-suggestion; the latter accounting for the ordinary occurrence of hysteria.

However, Babinski, like a good French speaker aware of the precision with which tradition dating from the foundation of the Academy by Richelieu in 1635 watches over the references of words, defined "suggestion" precisely (quoting Littré's dictionary) as "insinuation mauvaise." It expresses the action by which one seeks to make another accept an idea that is manifestly unreasonable ("déraisonnable"). The other operative word which appears in his definition is "persuasion." Using this in relation to the curing the hysteric of his paraplegia, Babinski refers to something that is "eminently sensible" or reasonable.

These are two operative words in his definition of hysteria, which is as follows:

"Hysteria is a special psychical state which reveals itself principally by disorders that are primary, and accessorially by secondary disorders. The primary disorders can be produced in certain persons by suggestion with a rigorous exactitude, and made to disappear by persuasion alone. The secondary features are subordinate and arise from the primary."

Babinski claimed to be able to evoke in suitable subjects—that is, highly "suggestible" persons, particularly in hypnotizable persons—all the characteristic forms of paralysis, anaesthesia, contractures, and seizures, and to remove them by persuasion.

What could not be produced, or if present abolished, in this way were the secondary consequences—for example, muscular wasting after prolonged immobility of hysterical origin, erythemas, cutaneous haemorrhages, blisters, ulcerations of the skin, and the local cyanosis and oedema that may accompany persistent muscle spasm ("contracture") of hysterical origin.

He also pointed out that certain physiological and morphological patterns of disorder cannot be produced by suggestion—for example, a Bell's palsy, or a weakness of flexion at the elbow in which (as after a radial-nerve lesion) biceps act but brachioradialis does not. Similarly, anaesthesia in peripheral nerve or segmental sensory territories cannot be produced in this way. Dissociations of this order are not within the ideational content of the hysteric, and if they were he cannot produce them.

During his lifetime Babinski was able to demonstrate to his colleagues the validity of his claim to produce by suggestion, as defined by him, the motor and sensory disorders of hysteria and his ability by persuasion to abolish them. He also showed his inability to produce by suggestion what Charcot had called the "stigmata" of hysteria, and which I have enumerated above.

Some of these were secondary physical consequences of the hysteric syndrome—for example, muscular wasting after prolonged immobility of a limb, or oedema and cyanosis ("oedème bleu") of a part of a limb long in spasm.

In raising the problem of self-inflicted cutaneous lesions, among which he included the phenomena of stigmatization in which, in girls or young women in Catholic countries, the wounds of Christ crucified are mimicked by appropriately situated superficial lesions, Babinski stresses that fictitious phenomena were now most commonly encountered in what he called "hystéro-traumatisme" in association with legal actions. It may be doubted, however, whether the syndromes in all such cases in this last category are really entitled to be given the title of hysteria or psychoneurosis, for their motives do not always dwell in the subconscious but are often only too apparent both to subject and to doctor.

Indeed, the traumatic neurosis so-called is not appropriate material for any profound conclusions upon the origin or the phenomena of hysteria. It is too often dominated by consciously entertained aims—namely, as T. A. Ross (1937) expressed it, by the exploitation of injury for gain.

Slater asserts that no one has claimed that there is any "distinctive feature in which 'hysterical' individuals differ from normal ones." This cannot be accepted. Babinski taught that the hysteric was a hypersuggestible person and one who could be hypnotized. No one would claim that this is an exhaustive account, but so far as it goes I believe that any neurologist with due experience of such patients would say they are a recognizable type in a majority of instances. Lewis and Mapother (1937) go into the question more deeply, remarking what few would dispute, that "the combination of heredity and environment may result long before actual illness occurs, in a *hysterical personality*," and the entire section on the aetiology of hysteria which these authorities provide is a cogent case against Slater's nihilist attitude, and deals with the role of deceit very aptly, noting the "more or less sincere ignorance or ambiguity of purpose" the hysteric shows. The qualifying words "more or less" are vitally necessary here, for the nature of his (or her) state is not always *wholly* below the level of his (or her) conscious thought.

Perhaps the French view on this—namely, that exaggeration and lying are but one expression of the hysterical personality—is nearer the mark.

I trust it is not cynical to say that men are not born truthful. If they become so it is by example and education within the home, where not everyone is given the opportunity to learn it. A moral question cannot be wholly ignored in our consideration of hysteria, as Babinski noted. The assessment of its role is part of the diagnostic responsibility upon us, and we do not escape it by the glib conclusion that hysteria is no more than a euphemism for malingering.

History presents to our notice some remarkable women of high achievement in whose lives periods of hysteria are discernible: Teresa of Avila, Florence Nightingale, and Elizabeth Barrett are examples, and for them the diagnosis of malingering would be too grotesque even for Slater's scepticism as to the reality of hysteria as a psychical illness in its own right with its own characteristics.

Finally, we cannot ignore the epidemics of mass hysteria that are on record. We can hardly dismiss these as organically determined or as a conspiratorial mass-malingering.

Centuries ago these were attributed to witchcraft or to demoniacal possession, but, armed—perhaps "hampered"

would be the better word—with all the modern science of our time, it is likely to-day that we should declare them to be due to some unknown and undiscoverable virus and call the condition encephalitis. This could very well happen and, indeed, may have happened already.

Conclusion

I do not propose to enter upon a psychopathological exegesis of hysteria, for there are psychologists and psychiatrists who can do this better than I, but I must regret Slater's retreat from this responsibility in favour of a criticism based upon the alleged shortcomings of the thought and diagnostic capacity of clinicians. No one in any branch of medicine grows into infallibility, and hysteria does present its own peculiar difficulties in diagnosis and treatment.

Also something may be said about the unity of hysteria. Whatever the kaleidoscope of its manifestations, I submit that its essential difference from somatic disease is that it constitutes a *behaviour disorder*, a human act, on the psychological level. An hysterical paraplegia is exactly this, but a compression paraplegia is not this at all.

Apart from the mimeses of somatic disease hysteria may present, the dramatizations, the exaggerations, and the pathological lying are also behavioural disorders, part of the total expression of the abnormal psychical state which is hysteria. A diversity of symptoms from case to case and, in any single case from time to time, no more destroy the unitary quality of the malady than the same diversities destroy that of disseminated sclerosis or of neurosyphilis.

As for treatment, whoever may have seen and heard Babinski will recall his attractive, impressive, and dynamic personality and will appreciate how successful his persuasive powers must have been in the treatment of patients with hysteria. Alas! we are not all cast in his mould, and, liable to frustration in the handling of the subject of hysteria as we are, it is only too easy to resent our dilemma: so that when presented with an essentially curable clinical state that we still cannot banish we suggest to ourselves that there is no such illness.

This is what Babinski would call "une insinuation mauvaise," that we need all our self-persuasive powers to escape from when, with Slater, we are tempted to take refuge in it.

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