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TIME AND MEANING IN THE HISTORY OF PAIN AND HYSTERIA

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THE MEANING OF HYSTERIA THROUGHOUT HISTORY

The meaning of hysteria has changed repeatedly during ages, as well as that of the concepts linked with it. For most, and indeed probably all of that time, pain has been linked with what many or all physicians took to be their concept of hysteria. This concept was not uniform or consistent. It expanded and contracted intermittently. The meaning often fluctuated with social circumstances or the standpoint of the person embracing the idea. In antiquity, it was thought to be related in some way to the uterus (although exactly how is another matter). In the medieval period, it was more often thought to be due to movement of the uterus—when it was not considered to be a consequence of being possessed by evil spirits, a concept still to be found in some cultures including the Inuit.[41]

By the time of Willis[51] and Sydenham,[48] it was understood to be produced by stress. It was then often used as a label for anxiety and depression, and only in the nineteenth century did it somehow begin to be most typically a disorder in which the patient's thoughts played a part *independent of physical events*. This too was frequently disputed, and we are now at a stage in history when the physical events may be thought to be cerebral only, but still physical in origin or mechanism.[30] This article sets out some of the ebb and flow of ideas that have characterized the word *hysteria* through millennia, emphasizing that the meaning of the word has changed repeatedly, even during the medical advances of the last 200 years in which there has been increasing success in anatomical, physiological, and pathological explanations of the causes of disease.

Egypt

One way to understand the relationship between pain and hysteria is to review it historically. Noted historians of medicine[44,49] expatiated upon the idea that ". . .the major organs, the heart, the uterus, the stomach, the vessels, and others had some life of their own. They were able to wander around in the body, had appetites, whims, moods, and had to be satisfied and pacified. . . ."[44] In this explanation, certain pains, among other symptoms, were attributed to hysteria, including headache, eye pain, and back pain. In fact, a systematic examination of the translations in the alleged sources, the Ebers and Kahun Papyri,[32] found no evidence that such explanations were actually offered there. Potions were given to encourage the womb to return to its place. Symptoms that have been called hysteria (paralysis, headache, etc.) were not linked to those remedies. On the contrary, it seems most likely that the treatments offered were simple remedies for the common problem of prolapse of the uterus.[32]

Greece

The Greek view of the conditions that have been taken to be references to "hysteria" identified uterine displacement, whether upwards in pregnancy or downwards in prolapse, but not free mobility.[32] There was no organized concept of hysteria,[23] but rather a tendency to describe certain types of abnormality as feminine. *Hysterike pnix* or hysterical breathing, possibly with pregnancy, is not a well-defined condition with psychological implications. Indeed, King[23] has pointed out that the reification of the notion of hysteria may simply have been due to the fact that the major 19th century translator of the Greek originals into French, Émile Littré, added headings to certain matters and described them as l'Hystérie, using a noun where the Greek text merely uses the adjective hysterical. This fits well incidentally with a modern view that only adjectival descriptions should be used.[46,47]

Seventeenth and Eighteenth Centuries

We need not linger on the early modern view much more than to say that Walker[50] has demonstrated very well how exorcism and belief in possession came to be a field in which rival theologians disputed for the merits of their churches according to who was the more successful at finding and removing spirits that had possessed afflicted persons.

At the end of the early modern period, e.g., Elizabethan times, in the sixteenth century and the early seventeenth century, there was still argument about issues of possession. A 14-year-old girl, Mary Glover, accused an old charwoman, Elizabeth Jackson, of bewitching her and causing her to fall into fits, so fearful that all about her supposed she would die. Mary became speechless and blind, and later her arm and whole side were deprived of feeling and movement. Rather than having pain, she was supposedly insensitive to numerous pins that she claimed to swallow. Jackson was defended by Edward Jorden, a Fellow of the Royal College of Physicians of London, England, who appeared as a witness before Sir Edmund Anderson, the Chief Justice of the Court of Common Pleas. She was convicted but sentenced only to a short period of imprisonment. Sir Edmund declared to the jury, "The land is full of witches; they abound in all places. I have hanged five or six and twenty of them; there is no man here can speak more of them than myself. . . ."[28] At that time, witchcraft was not a capital offense. Jackson had only allegedly injured Mary Glover and was being tried under the lenient 1563 statute; she was sentenced to a year of imprisonment rather than to hanging. However, Elizabeth Jackson was

quickly released from prison and escaped punishment in the pillory to which she had also been sentenced, apparently because of the strength of other influences who did not believe that Mary Glover had been bewitched.[28]

In another case, that of Anne Gunter, there was also no complaint of pain but more of fits and trances. Typically, the young lady swallowed pins, a claim that was later shown to be false.[42]

An increasing interest in natural explanations rather than theological ones was understandably fostered by the medical profession. Harvey,[19] deeply immersed in studies of reproduction and gynecology, supported the idea that "The uterus is a most important organ, and brings the whole body to sympathize with it. . . . when the uterus either rises up or falls down or is in any way put out of place, or is seized with spasm—how dreadful then, are the mental aberrations, paroxysms of frenzy, as if the affected person were under the demeaning of spells, and all arising from a natural status of the uterus." This post-Renaissance view is best presented in the opening remarks of Sydenham[48] talking about the effects of mental trauma on bodily function:

> When the mind is disturb'd by some grevious [sic] Accident, the animal Spirits run into disorderly motions; the Urine appears sometimes limpid, and in great quantity; the sick persons cast off all hope of recovery; . . . Whatsoever part of the body the Disease doth affect (and it affecteth many) immediately the symptoms that are proper to that Part appear; in the Head, the Apoplexy, which ends in a Palsy of one half of the Body, comes presently after Child-bearing; sometimes they are seiz'd with Convulsions, that very much resemble, the Epilepsy, and are commonly called the Suffocation of the Womb, in which the Belly and Entrails rise upwards towards the Throat; At other times they are miserably tormented with the Hysterical *Clavus* [nail], in which there is a most vehement pain in the Head, which you may cover with your Thumb, the sick person in the mean time vomiting up green Matter like to that sort of Choler that has its name from Leeks.

Sydenham goes on to mention other pains in addition to the hysterical clavus as well as diarrhea, dropsy, tears, and laughter. Thus his treatment of what is hysteria begins with response to mental trauma and proceeds through a variety of physical and psychological changes, some of which we would now recognize as based upon physical illness such as stroke, epilepsy or migraine, dropsy, and also evidence of overt emotional disturbance.

Further, Sydenham regarded hypochondriasis as the male form of hysteria.

Another author who linked pain with mental processes was even more explicit. Blackmore[4] observed:

> Terrible Ideas, formed only in the Imagination, will affect the Brain and the Body with painful Sensations. Thus we find that dreadful Objects presented to the Mind in Dreams; for instance, the empty and unsubstantial Forms of Ghosts and Spectres, will, by their violent Instigation and Impulse on the Spirits, put them into such a Hurry and Confusion, as shall cause great Inquietude and grievous Pains.

All the seventeenth century authors quoted seemed to relate changes in psychological function to brain function. The brain function might be disturbed by external psychological factors, or physical factors. The first to have suggested this appears to have been LePois (also known as Carolus Piso).[38] Piso was perhaps the first to deny a relationship with the uterus and the first to emphasize the cerebral contribution to hysteria, but related his views to the effects of water, possibly edema within the head, as described by Cesbron.[9]

In these developments, pain figures as a small part of an overall attempt to relate emotional factors to physical changes in the brain and to link physical changes in the body with both psychological and cerebrospinal causes. Knowledge of anatomy and physiology was still primitive. In consequence, in the early eighteenth century hysteria remained a broad concept in which it was still thought at times that the womb moved or at least rose somewhat, but that many of the symptoms were nevertheless of the mind.

By the end of the eighteenth century, Louyer-Villermay[27] found it necessary to discuss at length the differences between hysteria, hypochondriasis, and melancholia. He presented ways to demarcate conditions that he thought were often confused. He held that hypochondriasis occurred more in men who led a sedentary life, especially men of letters, while he related hysteria to derangements of sexual function. He argued that post mortem findings showed organic lesions in the abdominal viscera in hypochondriasis while the changes most often occurring in hysteria were in the uterus and adnexa (p. 58). Melancholia showed more signs of depression and suicidal tendencies (pp. 59, 74), yet occurred in individuals who were otherwise organically healthy (pp. 60, 76). Melancholia occurred in famous people from the Greeks onwards. Hysteria was an episodic illness, hypochondria one that could last for a long time but remit; melancholia recurred getting worse with age.

These differences mirror opinions prior to Louyer-Villermay and subsequently. They represent patterns that may still be distinguished. With both hysteria and hypochondriasis, painful conditions would be apparent, but they were attributed to the physical causes that were held to underlie both illnesses. In the nineteenth century, a different attitude began to emerge.

Anatomical and Physiological Progress

This psychogenesis of pain was postulated by Brodie as part of the general notion of hysteria. Hysteria, however, was often thought to be a brain disorder.

Cullen[14] had introduced the concept of neurosis that was one of a number of other classes of disease. In 1821, Georget[17] called hysterical complaints a brain neurosis, and the same idea was offered by Briquet,[7] meaning a disturbance of nervous function of an organic type producing varied symptoms. Pain was well identified with these symptoms as exemplified in the work of Pomme,[39] where it was part of a crowd of symptoms. This same notion of neurosis for what we would consider to be an organic disorder of cerebral origin was used in the nineteenth century by Charcot[10] when he described paralysis agitans as a "neurosis" because no location had been found for a lesion with it in the brain.

Micale[35] summed up the situation of hysteria as follows: "In the eighteenth century the disorder slid imperceptively into hypochondria, the vapours and the spleen, and in the nineteenth century it often overlapped with neurasthenia, nymphomania, general nervousness and out and out insanity. Many . . . have used the word in reference to any nervous malady with spastic or convulsive complications . . . many physicians have complained vociferously about the vagueness and indefinability of hysteria." With one exception, so far as we can tell, hysteria frequently did not mean what we mean by it today. It meant multiple bodily symptoms often including pain with some sort of relationship to subtle brain dysfunction. The exception is what has now been called somatization disorder.

Despite this, the terms "suffocation of the mother" (i.e., globus in the throat resulting from disturbance of the uterus), hysterical suffocation, and fits of the mother persisted well into the nineteenth century. Dubois d'Amiens[15] wrote about a rounded

foreign body in the throat, or globus hystericus, and Landouzy (reference 24, p. 6) described a ball mounting from the abdomen to the neck, and constriction of the throat. The term *globus hystericus* that they used is still used today—whatever its meaning.

The mid-nineteenth century view still has its echoes. Hysteria, for example, was described by Landouzy,[24] closely following Dubois d'Amiens as a disease usually, or even only, affecting women, almost always young ones. It was characterized by pains in any part of the body and a variety of paralyses and other symptoms including loss of speech, sight and hearing, anesthesias, fits, dyspnea, dysphagia, hiccough, vomiting, meteorism, dysuria, and urinary retention.

Pain Without Lesion

Almost throughout the nineteenth century, the term *neuralgia* was commonly employed in connection with pains for which no very strong physical evidence was available. Some of these illnesses were unquestionably physical in origin (e.g., trigeminal neuralgia), but the provenance of other conditions to which the term was applied was much less certain.[1] Hodgkiss[21] showed how the term neuralgia was employed as a label to solve the problem of pain without lesion, frequently being applied where no physical cause was apparent.

There will be those who wish to say that it is an old-fashioned Cartesian dualistic approach to maintain distinctions between organic and psychological causes with respect to pain. Such an objection is unreasonable if one accepts the notion of multiple etiology and that etiology has to be taken into account in the understanding of disease. It might be relevant, however, to say that the experience of pain is best conceived as unitary, even when the etiology is multiple. What is really most important and has relevance also to the understanding of the nature of pain and hysteria is that while pain may be a disorder of multiple origins, the experience can best be taken to be monistic, i.e., having a single mode (albeit individual patterns may vary).

The dilemma of a lack of proof of some complaints of pain became acute in the nineteenth century and more so in the twentieth century when it was increasingly recognized that medicine could account for a large number of other symptoms (but not all), by means of anatomy, physiology, and more refined methods of investigation. In consequence, in the nineteenth century as knowledge of the nervous system improved, there was a persistent tendency to reject pain as evidence of physical illness when it could not be supported by the more developed methods of investigation. This tendency increased in the twentieth century.

Volition and Repression

The point had been well made by Sir John Russell Reynolds[40] in his paper entitled, "Three Cases of Paralysis Dependent Upon Idea." This paper led to the strengthening of the view that some types of thoughts or ideas could give rise to physical symptoms and was endorsed by Charcot[11] (English translation 1889).

THE DIFFERENCE BETWEEN PAIN AND PARALYSIS AS HYSTERICAL SYMPTOMS

The other way in which pain may be demonstrated as likely to be related to a psychological mechanism that lacks any possibility of physical production (other than through some cerebral process) is the pattern of multiple pains in the absence of anxiety or physical illness, persisting over many years and occurring in association also with other classical hysterical symptoms such as neurological paralysis. In these

cases, it is reasonable to conclude—but cannot be assumed with certainty—that the pain is likely to be due to a thought rather than any other phenomenon. Whether pain itself can be produced by thoughts is also a matter of some doubt. It often helps to make it possible to believe in the potential reality of a conversion disorder like a paralysis if one can produce such a symptom for oneself voluntarily. Thus, it is possible to act a hysterical paralysis. It is then possible to suppose that patients might in certain conditions of conflict lose the use of their legs (without this being due to overwhelming fear) or their sight temporarily, or could persuade themselves of this. It is not easy to persuade oneself that one is feeling a pain where there is none—at least voluntarily. Successful treatment of pain by resolving an emotional conflict (in the absence of anxiety or depression) is rare by any means that will demonstrate that the symptom itself is dependent upon that conflict. The marvels of psychotherapy have not been enough to prove such a claim.

The difficulty described here is merely the latest example of the problem of determining when pain is an indicator of emotional disturbance—or not—and when the existing physical evidence is sufficient to validate organic cause.

Psychoanalysis and Pain: Hysteria or Somatization?

This final section of this article deals with modern topics and therefore will be brief because the main purpose was to show the historical relationships between ideas of pain and hysteria. There have been numerous difficulties in the diagnosis of those classical conditions of loss of function that were regarded as hysterical. Using Freudian terminology (based on a theory that is now declining), hysteria was considered to be either a conversion disorder or a dissociative disorder, apart from those times when the word had other meanings such as uncontrolled behavior, a personality disorder, etc. A group of workers who nevertheless believed that the notion hysteria had something to commend it and that a diagnosis of hysteria could apply to certain cases described a condition that first of all they called hysteria[47] and later Briquet's syndrome.[18]

The conditions seem rather liberal or questionable under which somatoform pain disorder can be diagnosed because it can be applied in cases where there is a physical disorder but one that does not wholly account for the syndrome, or in cases where there is no physical disorder. In either of these instances, it is sufficient to show that a psychological factor initiates, maintains, exacerbates, or is responsible for the continuation of the pain, at least to some notable extent. In practice, the diagnosis ought not to be used very frequently because it cannot be used where a mood disorder such as anxiety or depression may better account for the patient's mental status (and coincidentally, that mood disorder might be secondary to the patient's pain rather than a primary pattern with it).

The term *somatizing* has also come into popular use, but I suggest it should be abandoned. The reasoning here is that the word has now come to mean something the same as hysteria with the same wide span or implications. These include the following: (a) somatization disorder; (b) conversion symptoms; (c) hypochondriasis; (d) heightened bodily awareness (alerting), resembling hypochondriasis but unlike the latter in responding to reassurance on examination or investigation; (e) psychophysiological events associated with anxiety or depression; (f) certain types of somatic complaints in schizophrenic patients, perhaps with a delusional basis; (g) any of the above combined with organic disease.[29] In clinical practice, the word is also used to imply that the person who has the symptom is somatizing or actively producing physical symptoms, perhaps by tension, even though the intention may be

unconscious. It is thus used somewhat indiscriminately in my observation without the effort to determine the correct psychiatric diagnosis and has come to assume most of the meanings of the old word hysteria that needed to be teased out previously.

CONCLUSIONS

The present situation is evidently unsatisfactory. If change is to be undertaken in the diagnostic systems, it would probably be best to unify cases of pain of psychological origin with the primary categories to which it is related. Thus, "somatization disorder" could be one category of "conversion disorder," i.e., multiple pain complaints and other complaints not medically explained and also with **proof** of production by psychogenesis. Single instances of pain with the same origin would have to be treated likewise—with emphasis that the proof required should be stringent and occasions rare. Other cases would fall under pain associated with schizophrenia, likewise very rare, and pain originating with depression or anxiety, pain modified by depression or anxiety, and pain resulting from depression and anxiety, the latter two also requiring stringent criteria. In the case of conversion disorder, a separate subclass could be useful for multiple somatic complaints. In all the other respects, pain would merge into existing categories with other symptoms. We would then be helped to abandon the very unhelpful and muddled label of "chronic pain syndrome."

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REHABILITATION OF CONVERSION DISORDERS: A PROGRAMMATIC EXPERIENCE

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DEFINING CONVERSION DISORDERS AND HYSTERIA

Historically, the term "hysteria" has most often been used to describe the occurrence of physical symptoms in the absence of organic disease. Hysteria or conversion disorders are thought to originate in an individual's subconscious and are not regarded as being under voluntary or conscious control. Hysteria is now regarded as an unsatisfactory term and in recent years has been dropped from the American Psychiatric Association's taxonomy of mental disorders.[4] It has since been replaced by the term *somatoform disorder*. Like its predecessor, the term somatoform is used to denote the presence of physical symptoms that suggest a medical condition but cannot fully be accounted for by an underlying organic problem. The most recent edition of the American Psychiatric Association's taxonomy of mental disorders[4] includes a variety of diagnoses under the general category of somatoform disorder. There is considerable overlap between these conditions, which can make differential diagnosis problematic and confusing (Tables 1 and 2).

CHARACTERISTICS OF CONVERSION DISORDER PATIENTS IN REHABILITATION

Conversion disorder patients treated in rehabilitation settings generally present with motor disorders. In our experience, the motor disorder most frequently seen involves paralysis or paresis of one or more limbs. Paralysis is typically not