Hysteria Revisited

G. Gayle Stephens

Despite the attrition of psychoanalytic explanations for clinical conditions and the disappearance of "hysteria" from diagnostic lexicons, the phenomena first addressed in an orderly manner by Charcot and Freud continue to reassert themselves, as is apparent in the article by Vorhees in this issue of the *JABFP*.[1]

An elderly woman began to have spells of falling, paralysis, paresthesia, and uncontrollable movements of an extremity—from which she recovered completely until the next spell. She was taken to the local emergency facility by her children, where she had the good fortune to encounter a physician who could cure her symptoms by listening, talking, and physical examination. How easy; but how truly extraordinary!

The therapeutic movements of the physician are instructive. He was available at the moment of need and performed the routine tasks of clinical evaluation. He listened to the patient's exact words, touched her in the process of physical examination, paid attention to family members who accompanied her, and was verbally active in offering them his emerging understanding of her condition. He reviewed her previous medical record and did not feel compelled to repeat tests. He responded to the family's request for a consultation but did not thereby lose interest in the patient. He engaged the patient in an interpretation of his understanding, even before she saw the neurologist, and broke through the mystery by imaginatively connecting her symptoms to her current life circumstance in a meaningful way that the patient and family members could accept. Ten days later, the patient had recovered her equanimity and her health, and the family living problem was resolved.

Things do not always turn out so well. Pierre Janet, in his lectures on hysteria to Harvard Medical School faculty (1906), warned of the dangers:[2]

> You must be able quickly to recognize this disease, to foresee its evolution, to provide against its dangers, and immediately to begin a rational treatment. This early diagnosis. . . will keep you, let me tell you plainly, from making blunders. . . what is always very serious is to mistake a hysterical accident for another one, and to treat it for what it is not. You cannot imagine the medical blunders, and too often, the medical crimes, committed in this way. . .
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> . . . the physician. . . frightens the family, agitates the patient to the utmost, and prescribes extraordinary diets, perturbing the life and exhausting the strength of the sick person. Finally, the surgeon is called in. Do not try to count the numbers of arms cut off, of muscles of the neck incised for cricks, of bones broken for mere cramps, of bellies cut open for phantom tumors. . . Humanity ought indeed to do homage to Charcot for having prevented a greater depopulation.[2]

Things do not always turn out well for patients who have mysterious symptoms nowadays. Our capacities for repeated workups, endless rounds of referrals, polypharmacy, and invasive procedures hide the low-tech flaws in our practices. Although it is true that our medical payment systems do not reward low-tech skills such as talking, touching, thinking, explaining, interpreting, and nurturing enduring relationships, that does not change the fact that many clinical problems do not yield to anything else.

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References

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2. Janet P. The major symptoms of hysteria. New York: Hafner Publishing; 1965. p. 11–12.