

and speech therapy may also help. Especially if they are depressed, patients should discuss their problems with a counselor or psychotherapist or with other patients. Hundreds of support groups across the country provide advice, sympathy, and morale-building encouragement to people with Parkinson's disease and the relatives who care for them.

A good source of information is the National Parkinson Foundation, which sponsors research, treatment, and support groups (1501 N.W. 9th Ave., Miami, FL 33136; 800-327-4545, and on the Web: www.parkinson.org).

FOR FURTHER READING

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INSIGHTS

The Decline of Hysteria

by Mark S. Micale

The case of hysteria is one of the most mysterious examples of a pattern that is common in the history of psychiatry — the "rise" and "fall" of psychiatric disorders. A widely used diagnosis from the time of Hippocrates until the beginning of the present century, hysteria began to disappear from medical textbooks 100 years ago. Physicians today regard hysteria in its florid form, with convulsions and paralysis, as a thing of the past, a colorful behavioral artifact of turn-of-the-century Europe. As the French psychoanalyst Jacques Lacan once asked, "Where are the hysterics of earlier times, those magnificent women, the Anna O's and Emmy von N's? What has replaced the former hysterical symptoms today?"

Two answers are generally given. Historians tend to view hysteria as a culture-bound syndrome resulting from Victorian sexual confinement, emotional oppression, and social suffocation. Its decline in the 20th century has attended the passing of these conditions. In short, hysteria has disappeared because of de-Victorianization.

Some medical writers, instead, believe that before the present century people found it easier to somatize their anxieties, that is, to express emotional dis-

tress through physical symptoms, because they had little psychological self-knowledge. Today the concepts of unconscious motivation and psychosomatic illness have become popular. More people understand the psychodynamics of hysterical symptom conversion, and hysterical behavior no longer elicits the desired responses. As a result, according to this reading, people have had to develop subtler and more inner-directed ways of coping with stress. Today hysterical reactions occur mainly in rural and lower-class environments; their decline in the industrial and medically sophisticated West has been accompanied by a rise in depression and narcissistic disorders.

Both these theories have an element of truth, but they do not fully explain the decline of hysteria. A third process, often ignored, has also been at work: conceptual changes in psychiatric diagnosis. Between 1895 and 1915, doctors greatly altered their view of the clinical content of hysteria and its place in the system of medical classification thanks to developments in three fields: neurological advances, a new classification of psychotic symptoms, and the rise of the concept of psychoneurosis.

New diagnostic techniques and new theories about the causes of disease allowed key components of hysteria to be incorporated into neurology. For centuries, epilepsy and hysteria had been hopelessly confused; in French medical literature of the late 1800s, many cases carried the hybrid label

of "hystero-epilepsy." In the years around the turn of the century, physicians came to understand the psychological aftermath of epileptic seizures much better and realized that many cases previously diagnosed as hysteria involved genuine organic pathology. In the late 1920s electroencephalography was introduced, and brain wave recordings could be used to differentiate more finely between hysteria and various forms of epilepsy, including what would eventually come to be known as temporal lobe epilepsy — partial or total loss of awareness, sometimes accompanied by hallucinations and amnesia but not by physical convulsions.

It also became easier to distinguish hysteria from the effects of syphilis. In the 19th-century literature on syphilis, acute paralysis is one of the most common symptoms, and its onset, like hysteria, may be characterized by convulsive seizures, double vision, and loss of pain sensation as well as exaggerated emotional responses. Many of the "hysterical" patients in 19th-century hospitals and asylums may have been suffering from syphilis, which was then known as "the great imitator." In the first decades of the 20th century, the spirochete that causes syphilis was discovered, a blood test for the disease was developed, and the microorganism was isolated from the brain tissue of patients suffering from syphilitic paralysis. Diagnoses could now be corrected because it was technically possible to distinguish advanced neurosyphilis from what had been called hysteria.

While the old fortress of hysteria began to crumble under siege from mainstream organic medicine, it was also being undermined by the psychiatric profession itself. The disappearance of hysteria coincided with the adoption of new diagnostic systems in the mental sciences, including the classification of psychoses developed by Emil Kraepelin. Some diagnoses that became popular were "hebephrenia" (introduced in 1869), "catatonia" (1874), and Kraepelin's terms, "dementia praecox" and "manic-depressive psychosis" (1890s). These categories continually expanded in the late 19th and early 20th centuries. In a famous textbook by Kraepelin, which appeared in eight editions between 1883 and 1916, the scope of dementia praecox and manic-depressive psychosis widened with each edition, eventually coming to include many symptoms that would previously have been regarded as hysterical. In 1911 Eugen Bleuler introduced the term "schizophrenia," which also began to incorporate components of hysteria under new names and in a different theoretical context.

The concept of psychoneurosis appeared along with advances in neurology and the emergence of a new diagnostic system for the psychoses. Aspects

of hysteria not claimed by either organic medicine or institutional psychiatry were taken up by a young generation of physicians eager to develop new theories about the neuroses. In 1901, for example, the French neurologist Joseph Babinski proposed a new and much narrower definition of hysteria, calling it "pithiatism." The Neurological Society of Paris eventually voted to adopt this neologism, and hysteria lost its place in French medical terminology. Babinski celebrated his victory in an essay tellingly subtitled "On the Dismemberment of Hysteria." The physician and psychologist Pierre Janet introduced another concept, "psychasthenia," at about the same time. These terms are unfamiliar today, but they remained influential in France until the 1930s. They illustrate the fluid clinical relationship between "old" hysteria and the "new" psychoneuroses.

Next, the turn of the century saw the coming of psychoanalysis. In *Studies on Hysteria* and elsewhere, Freud presented some of the best-known clinical descriptions of hysteria, but he also introduced theoretical innovations that eventually contributed to the abandonment of the diagnosis. His terms "psychoneurosis of defense" and "anxiety neurosis" were in effect new labels for patterns of behavior that had often been described as hysterical. Moreover, Freud defined hysterical neurosis by its supposed causes (the mechanism of conversion) rather than by its symptoms, and this eventually led to a reduction in the clinical scope of the diagnosis.

A final step is represented by the work of the American physiologist Walter B. Cannon, who published *Bodily Changes in Pain, Hunger, Fear, and Rage* in 1915. This book showed in detail the powerful influence of certain emotions on vital physical functions, such as breathing, digestion, blood circulation, and the glandular system. Later research established the effects of strong emotional states on the thyroid, pituitary, and other glands, and through these glands, on the sympathetic nervous system and the entire body.

The implications of Cannon's work were immediately apparent. Medical researchers began to explore the long-term effects of these psychophysiological relationships. The ancient principle that mind and body interact was now placed on a scientific foundation, and modern psychosomatic medicine emerged. By the late 1930s, medical scientists were suggesting psychological origins for asthma, rheumatoid arthritis, ulcers, high blood pressure, and certain skin conditions. As a result, many symptoms previously regarded as hysterical were redefined.

Several patterns of change emerge in the history of psychiatric diagnosis. Some categories were described and labeled in ancient times and have retained their consistency and coherence over time. An example is melancholia, today usually called major depression. Other syndromes were first described at a particular historical moment and then translated, roughly, into later diagnostic categories and language. That is the relationship between 18th-century hypochondriasis, 19th-century neurasthenia, and certain 20th-century categories of neurosis. A third pattern is the conversion of a nervous and mental disorder into an organic one; for example, what was once called "chlorosis" is now widely thought to have been a form of severe iron deficiency anemia. In a fourth pattern, a group of symptoms that have been described loosely and sporadically are reconceived as a distinct clinical syndrome — manic-depressive psychosis, the phobias, obsessive-compulsive disorder, and anorexia nervosa. A fifth pattern consists of the sudden appearance of an entirely new syndrome — usually an infection or toxic reaction. Examples are lethargic encephalitis

during and after World War I and, more recently, AIDS-related dementia.

Hysteria has a more complex history. The classical Victorian formulation of the disorder was effectively broken down into its constituent symptoms, which were then assembled in new combinations and distributed to many other medical categories. The illusion that this form of pathology no longer exists is mainly the result of its atomization and constitution in other contexts under other names. One moral of the story is that in accounting for the apparent rise and fall of disorders, psychiatrists and historians should always consider the role of diagnostic drift. Lessons from the history of hysteria as a psychiatric category may apply to changes in the various editions of the American Psychiatric Association's current diagnostic manual.

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IN BRIEF

Persuasion, Catharsis, Aggression

A persistent popular notion is that discharging anger harmlessly on some inanimate object — twisting a towel, hitting a punching bag, breaking glass — is a good way to dissipate aggressive impulses. Suppressing rage supposedly creates tension that is eventually released in violence. Research has consistently shown that this idea is wrong: suppression stills anger and expression stimulates it. But could this effect be reversed by a self-fulfilling prophecy? In a recent experiment, researchers tested the theory that catharsis works at least for people who have been persuaded that it will work.

Three hundred and sixty undergraduates of both sexes were divided into three groups and assigned to read, respectively, a supposedly scientific argument favoring therapeutic catharsis, an argument against it, and a passage unrelated to the subject. Then they were asked to write an essay that they were told (deceptively) would be graded by another participant in the experiment. Half were given a good grade with friendly comments and the other half a bad grade with insulting comments. The students were asked to rank in order of preference 10 activities they might enjoy after writing the essay, including playing solitaire, watching TV, reading,

playing a computer game — and hitting a punching bag. Those who received bad grades were, of course, more likely to be angry, and angry people were more likely to prefer hitting the punching bag. But angry students who had read the argument in favor of catharsis were especially interested in using their fists.

The next step was to find out whether catharsis could be therapeutic in some circumstances. In part II of the experiment, students read the same messages and then hit a punching bag. Afterward they played a game in which (so they were told) they were competing with another person to press a button as soon as possible on hearing a signal. Whoever responded first could inflict a blast of noise on the loser, choosing how long and loud to sound it. Some of the students were told that their opponent was the person who had insulted them with a bad grade; others were told that it was a third person. In reality, there was no competitor.

Students who had read the pro-catharsis message were consistently more aggressive in the noise-making competition. Although they had been led to believe in therapeutic catharsis, they showed no signs of it. The authors suspect that they were still angry after hitting the punching bag and tried to complete the cathartic process by lashing out in the game. An interesting feature of their aggression was