British Journal of Psychiatry (1992), **161**, 378–389

Hysterical Conversion
II: A Critique

C. J. MACE

The career of the diagnosis of conversion hysteria is reviewed at a time when it is threatened with expulsion from classifications of psychiatric disorder. Criticism of its face validity has not led to adequate diagnostic alternatives, and has been insensitive to its unusual form as a category as well as the contribution it has made to the stability of the classificatory system around it.

Hysteria as a medical problem

External and internal accounts of hysteria

In recent years, hysteria has stood out among medical concepts for the sheer volume of discussion it has excited among professional historians, philosophers, sociologists, feminists, literature specialists, and others (Micale, 1990). Hysteria has been a vehicle for conjectures concerning social change, deviance, labelling, personality, and sexism, rather than disease. Micale's review points out that this accessory literature on hysteria suffers through speculation and sensationalism, to the point of becoming "hystericised" in its presentation (Micale, 1990). It has certainly tended to emphasise factors that are 'external' to the 'internal' domain of medical thinking when accounting for changes in the perception of hysteria. It has usually also assumed that hysteria has somehow disappeared as a contemporary medical problem: even Trillat's (1985) history of hysteria manages to conclude: "L'hysterie est morte. C'est entendu" (p. 274).

This, of course, remains far from the case, even if hysterical illness is harder to ignore in some clinical settings, such as military or neurological hospitals, than others (Merskey, 1979). Estimates of its prevalence in such settings have varied from 1% to 30%, depending upon whether hysterical illness had to be the primary diagnosis, or whether secondary hysterical symptoms qualified also (Weinstein *et al*, 1969; Trimble, 1981; Marsden, 1986). There are no real grounds for doubting that a significant group of patients will continue to present a range of symptoms that mimic neurological disease, and that their doctors will be asked to assess and treat them.

The pervasive idea that hysterical illness has somehow disappeared may, however, be symptomatic of a lack of communication between disparate groups who pronounce about it, and those clinicians left to confront it. This seems regrettable when successful explanation of hysterical phenomena may require more integration of physiology, medicine, psychology, sociology, anthropology and history than exists at present. Progress, synthesising both 'external' and 'internal' perspectives on hysterical illness, is likely to follow sustained collaboration. This paper attempts to mitigate this dichotomy by considering the immediate descendant of classical hysteria, hysterical conversion, from a viewpoint that is neither 'external' nor 'internal', sociohistorical nor medical–scientific. This perspective, a nosological one, takes the organisation, as opposed to the content, of clinical thought for its focus.

Nosography and nosology

To grasp the state of the art in medicine, one need look no further than the prevailing rules of diagnosis. Faber appreciated this in a classic work:

> "To the physiologist and the worker in the laboratory, morbid categories are subordinate concepts, but to the physician, to the clinician, the reverse is the case; he cannot live, cannot speak, cannot act without them." (Faber, 1923, p. 211)

The elucidation of 'morbid categories' is the work of nosography, with categories evolving continually according to how well they meet two principal demands. These are their ability to order clinical observations, and their capacity to link descriptive groupings to understanding of aetiology and prognosis. Collectively, these provisional categories yield a classification of disease, whose study is the province of nosology. Although 'nosology' has connotations of an idealised Linnean taxonomy which is no longer applicable, it is useful to retain the term to denote the systematic aspects of diagnosis. All attempts to define and revise relationships between groups of disorders, even if these are relatively restricted, are of nosological interest. So long as medicine can get about its business, questions of diagnostic organisation are probably best left alone. However,

https://doi.org/10.1192/bjp.161.3.378 Published online by Cambridge University Press

ever since 'conversion' has superseded 'hysteria' as the nucleus of a morbid category, it has provoked controversy. This paper attempts to indicate why nosological considerations should not be ignored.

'Conversion' becomes a diagnosis

Paper I (this issue, pp. 369–377) traced how the Freudian concept of hysterical conversion emerged out of mainstream 19th-century medical thought. Freud's theoretical innovations were not taken up by the profession at large, and the return of 'conversion' to general medical discussion of hysteria had to wait until 'conversion hysteria' entered its diagnostic vocabulary. The career of hysterical conversion as a diagnosis might be summarised in the permutations it has since undergone in the official nomenclatures of disease, even if these reflect the prescriptions of professional leaders rather than everyday practice:

Standard Classified Nomenclature (American Medical Association, 1935, 1948, 1957, 1970):
- 5th revision – conversion hysteria
- 6th revision – conversion hysteria
- 7th revision – conversion hysteria
- 8th revision – hysteria with localised somatic dysfunction

Diagnostic and Statistical Manual (American Psychiatric Association, 1952, 1968, 1980)
- DSM–I – conversion reaction
- DSM–II – hysterical neurosis, conversion type
- DSM–III – conversion disorder.

Nomenclature of Disease (Royal College of Physicians, 1948)
- 7th edition – conversion hysteria

International Classification of Diseases (World Health Organization, 1948, 1955, 1965, 1975)
- ICD–6 – 311 Hysterical reaction without mention of anxiety reaction (includes 'hysterical conversion')
- ICD–7 – 311 Hysterical reaction without mention of anxiety reaction (includes 'hysterical conversion')
- ICD–8 – 300.1 Hysterical neurosis (includes 'conversion hysteria', 'conversion reaction')
- ICD–9 – 300.1 Hysteria (includes 'conversion hysteria').

American usage in particular has tended to sanction the separation of 'conversion' from 'hysteria' that has also been promoted among post-Freudian psychoanalysts (cf. Paper I). In what follows, only the two most prevalent terms, 'conversion hysteria' and 'conversion disorder', are used to refer to the diagnostic concept of a conversion syndrome.

The transition from 'hysterical conversion' to 'conversion hysteria' and its variants saw two shifts that are pertinent. Firstly, having entered the nosographic listings, 'conversion' referred explicitly to a category, rather than to a process. Although the classificatory framework was relatively pliable when 'conversion hysteria' was first admitted, diagnostic manuals have subsequently proliferated, grown increasingly detailed in their specifications, and developed exclusion as well as inclusion criteria to minimise overlap between categories. While some attempt has been made to offset the Procrustean effects of codification through multi-axial description (e.g. American Psychiatric Association, 1987), the weight placed upon categorisation of a patient's condition has been increasing in the face of external pressures. Rather than remain a convenient shorthand between clinicians, diagnoses have become subject to wider scrutiny, and in several countries a patient's entitlement to care already looks set to depend upon the certification of his/her 'diagnosis-related group'. In such a fastidious atmosphere, it is easy for intolerance to grow towards categories that seem loosely defined, however indispensable they might be at the bedside.

A second change was that 'conversion hysteria', in subsuming the vast bulk of those syndromes that were previously simply 'hysteria', became a mental disorder. This created a peculiar situation in which one medical specialty, psychiatry, assumed responsibility for the definition (and redefinition) of the disorder, yet has been dealing with relatively few of the patients who merit the diagnosis in practice. This contrasts with the needs of practising neurologists to whom such patients present in large numbers, and among whom considerable uncertainty concerning terminology persists (Mace & Trimble, 1991). A real risk has resulted that psychiatrists' proposals for terminology in this area fail to reflect broader clinical needs.

The current attack on conversion

The diagnostic concept of conversion hysteria is now an object of official disfavour. The editors of the 10th edition of the *International Classification of Diseases* had proposed not only that the name 'hysteria' be removed from its listing, but that reference to the concept of 'conversion' should disappear too (World Health Organization, 1987). This remained implicit in subsequent revisions (World Health Organization, 1988), in which the term 'conversion' was readmitted as a synonym for 'dissociative', with the latter being preferred for diagnostic use. Several 'dissociative disorders' are proposed that would join an array of rubrics for somatic symptoms of apparently psychological origin

https://doi.org/10.1192/bjp.161.3.378 Published online by Cambridge University Press

that range through 'pain disorder' and 'undifferentiated somatoform disorder' to 'neurasthaenia'.

A comparable form of substitution might be expected from the committee revising DSM–III (American Psychiatric Association, 1980), where 'conversion disorder' appears to occupy an anomalous position. Already, its entry is prefaced by the arresting statement that

> "the definition of this disorder is unique in this classification in that it implies specific mechanisms to account for the disturbance." (p. 244)

Its criteria run counter to the phenomenological spirit of that classification and no symptoms are cited as specific to the disorder:

> "A. The predominant disturbance is a loss or alteration in physical functioning suggesting a physical disorder.
> B. Psychological factors are judged to be etiologically involved in the symptom, as evidenced by one of the following:
> (1) there is a temporal relationship between an environmental stimulus that is apparently related to a psychological conflict or need and the initiation or exacerbation of the symptom.
> (2) the symptom enables the individual to avoid some activity that is noxious to him or her.
> (3) the symptom enables the individual to get support from the environment that otherwise might not be forthcoming.
> C. It has been determined that the symptom is not under voluntary control.
> D. The symptom cannot, after appropriate investigation, be explained by a known physical disorder or pathophysiological mechanism.
> E. The symptom is not limited to pain or to a disturbance in sexual functioning.
> F. Not due to Somatization disorder or Schizophrenia." (American Psychiatric Association, 1980)

Reserve here is understandable, given a wider uncertainty as to what constitutes a conversion symptom. The conservative opinion of Kendell (1983) in the *Handbook of Psychiatry* – that "By convention the term is restricted to disturbances referable to somatic afferent or efferent pathways though, largely for historical reasons, convulsions are also included" (p. 234) – contrasts with the catholic schema of Engel (1970), who lists over 100 candidate conversion symptoms referable to all the major body systems. As a matter of history, Engel is more faithful to Freud's usage (cf. Paper I), while Kendell's narrower concept derives from Alexander (1943):

> "we restrict conversion phenomena to symptoms of the voluntary neuromuscular and the sensory perceptive systems and differentiate them from psychogenic symptoms which occur in vegetative organ systems." (p. 206).

If specific conversion symptoms could not be listed, properties typical of them might have been specified in detail. However, even the apparently symbolic character of conversion symptoms, deemed an essential attribute by post-Freudian analysts (Paper I), was no longer admitted as a criterion in DSM–III. This is consistent with the sceptical conclusion of Lewis *et al* (1965), after an empirical study of the diagnosis of conversion hysteria, that: "for ordinary diagnostic purposes, the criterion of symbolic sense is of little utility" (p. 281).

Instead, the diagnosis of conversion disorder under DSM–III rested heavily upon demonstration of psychogenesis by associations with external events (see above). In DSM–III–R, a curious compromise was achieved in which an introductory paragraph continues to refer to the importance of secondary gain, while the diagnostic criteria that actually embody it (items B (2) and (3) above) have been deleted from the list (American Psychiatric Association, 1987, p. 259). The amendment made proof of psychogenesis harder to achieve, although distrust of the concept of secondary gain is also consistent with Lewis' report that "clearcut manipulation of the environment is by no means an omnipresent feature of cases diagnosed as conversion hysteria" (Lewis *et al*, 1965, p. 280), and with Lazare's (1981) dismissal of it after an attempt to weight different features for their diagnostic validity.

Even the skeleton criteria that currently remain are not necessarily secure. Psychogenesis has effectively been reduced to precipitation by stress (see above), together with a presumed lack of voluntary control (criterion C). However, Ford (1985), in noting that reports of the incidence of a prior stressor ranged from 52% to 93%, recommended that diagnostic weight should be given only to its absence, when he felt organic pathology should be suspected. Moreover, although Ford remains tolerant of the stipulation that voluntary control should be lacking, this too is beginning to attract critical scrutiny. The judgement is based on subjective report, and Miller (1987) has pointed out that experimenters' attempts to demonstrate consistent behavioural differences between people who have a disability through a conversion or dissociative disorder, and people who consciously simulate it, have been unsuccessful. Jonas & Pope (1985) have tried to argue that, although conversion disorder, factitious disorders and malingering are distinguished according to judgements of consciousness and volition, they occupy an epidemiological continuum and might profitably be studied as a single set of 'dissimulating disorders'.

The future seems uncertain for the diagnosis of conversion hysteria. ICD–10 will propose that the

https://doi.org/10.1192/bjp.161.3.378 Published online by Cambridge University Press

cases formerly grouped as 'conversion hysteria' should be reclassified under 'dissociative disorders of movement and sensation', but the admission criteria remain those of psychological precipitation, and are in effect the same as those already discussed here. The nosological entity would remain the same, and indeed represents a category that has changed relatively little despite the fast and furious name changing. Before contemplating change, it will be important to understand just what sort of diagnosis conversion hysteria represents. It has always aroused disquiet since its introduction, and attempts have repeatedly been made to find alternatives. Such attempts have led to concepts having different nosological properties: study of them can highlight the peculiarities of conversion hysteria itself.

The alternatives to the diagnosis of conversion

The resomatisation of hysteria

One way in which the issue of psychogenesis can be minimised is to centre the diagnosis of hysterical illness exclusively around somatic changes. Charcot had insisted that hysteria, being a discrete disease, could be diagnosed on the basis of characteristic physical signs such as tunnel vision, hemi-anaesthesia or ovarian hyperaesthesia. Earlier this century, the neurologist Henry Head had popularised the Charcotian concept of 'positive' physical signs, such as particular constellations of weakness or anaesthesia, that were believed to be specific to hysterical complaints (Head, 1922). However, there is evidence that, when searched for, such anomalous signs can be found also among patients deemed to have bona fide neurological illnesses (Gould *et al*, 1986), making any one sign's usefulness as a discriminator appear doubtful. Similarly, Walters' recommendation that the 'regional' character of symptoms, notably pain (Walters, 1961) but also motor and sensory changes (Walters, 1969), be taken as a specific indicator of their psychogenesis has since been countered by Merskey's argument that regional symptoms can also result from independent physical pathology (Merskey, 1988).

Distrusting the diagnostic significance of any symptom in isolation, the St Louis school proposed an influential equation between hysteria and somatic symptoms: a patient having so-called 'Briquet's syndrome' (previously 'hysteria' (Perley & Guze, 1962) and, more latterly, 'somatisation disorder' (American Psychiatric Association, 1980)) has accumulated symptoms that relate to nearly all the major systems of the body, yet is highly unlikely to proceed to the development of organic pathology sufficient to justify them (Guze, 1970). While this eponym is inexact – referring to multiple complaints, rather than material findings as in Briquet's own practice – it would appear to have predictive validity. Guze has also supported his proposals with evidence that the syndrome carries a genetic loading (Woerner & Guze, 1968; Guze *et al*, 1986). However, only a small, if significant, minority of cases of hysterical illness appear to meet its criteria, a figure of 21% being cited within a small sample of neurological patients having conversion symptoms (Marsden, 1986). Compared with the psychiatric disorders with which it is classified, the syndrome is remarkable for the absence of any characteristic psychological symptoms.

Models of illness behaviour

A later strategy to avoid the need for diagnoses such as 'conversion hysteria' has taken the 'illness behaviour' of the patient as its focus. This had been defined by Mechanic (1962) as "the ways in which given symptoms may be differentially perceived, evaluated and acted (or not acted) upon by different kinds of persons". Accordingly, conversion hysteria and related syndromes, cast as deviant variants of illness behaviour, became so many subspecies of 'abnormal illness behaviour'. Pilowsky (1969) proposed that:

> "[where] the doctor does not believe that the patient's objective pathology entitles him to be placed in the type of sick role he expects [and] if the patient is uninfluenced by the doctor's explanation of the problem and the way in which it should be managed . . . the doctor may then reasonably conclude that the patient is manifesting abnormal illness behaviour." (p. 349)

Pilowsky's stated aim was to promote "a full and more meaningful understanding" (1969, p. 350) as well as a defusion of conflict between doctor and patient. Although his concept of abnormal illness behaviour deliberately encourages a change of focus from signs and symptoms to the patient's behaviour, it distracts from many instances where a parody is presented not only of the behaviour appropriate to illness (in his terms, inappropriate adoption of a 'sick role'), but of the bodily manifestations of somatic disease. A blind spot, apparent from a misapplication of Pilowsky's term that occurs in clinicians' discussions, can result. 'Abnormal illness behaviour' is frequently adopted as a shorthand for abnormalities perceived in the pattern of a patient's symptoms, rather than in the patient's reaction to explanation as Pilowsky had proposed.

One interesting attempt has been made to operationalise a concept of 'illness behaviour' that seems

https://doi.org/10.1192/bjp.161.3.378 Published online by Cambridge University Press

more in tune with physicianly needs, and which relies upon objectively measurable discrepancies in a patient's signs and symptoms from those typical of organic disease. Waddell *et al* (1984*a*) urged that "the symptoms and signs of illness behaviour must be distinguished from those of physical disease" (p. 741). To this end they developed scales that measure the extent to which a patient's signs and symptoms collectively signify 'illness behaviour' as opposed to organic impairment, and which have proven independent predictors of the patient's disability (Waddell *et al*, 1984*a*) and psychological distress (Waddell *et al*, 1984*b*). As yet, their subtle model has been confined to deviant presentations of one specific problem, low back pain, while its adaptability to other areas of symptoms remains uncertain.

The evasion of diagnosis

Somatic and behavioural reformulations of hysterical illness have contrasting implications for diagnosis. Somatic formulations asserted that 'hysteria' or 'Briquet's syndrome' or 'somatisation disorder' should be a category no different from any other in kind. In this sense, Guze's rigorous definition of Briquet's syndrome was consistent with Briquet's own bid a century earlier to normalise hysteria as a recognised neurological disease (Briquet, 1859; Mai & Merskey, 1980). On the other hand, Pilowsky (1969) proposed that abnormal illness behaviour offered a "flexible framework" that could substitute for a range of labels including 'hysteria' and 'conversion reaction' which he located in a "medical no-man's land" (p. 347). While professing that his interest was not in how "a patient may be placed in a psychiatric or any other category" (p. 347) he is to be found, perhaps inconsistently, offering guidelines on the "diagnosis" of abnormal illness behaviour instead (Pilowsky, 1971, 1978). Waddell's group did not offer diagnostic proposals as such, nor offer any alternative label for occasions when symptoms have to be attributed entirely to 'illness behaviour' rather than disease.

However, the actual effect on practice of either of these proposals – to 'somatise' or to 'behaviourise' hysteria – has been limited at best (Mace & Trimble, 1991). Essentially, the first is inevitably restricted by the small proportion of those cases of hysterical symptoms it would ever account for; the other is so flexible it effectively identifies an independent dimension that may be of enormous significance irrespective of the patient's diagnosis. Indeed, the questions of why 'abnormal illness behaviour' should replace some troublesome diagnoses (such as conversion hysteria or hypochondriasis) but not others elsewhere in the diagnostic system, and of how criteria could be produced that were reliable and that meshed with those of the rest of diagnostics, have not been properly dealt with by its proponents.

A nosological perspective offers a different light on these shortcomings. The proposals to 'somatise' and 'behaviourise' hysteria identify groupings that present complementary issues of boundary, as each promotes categories whose boundary is either excessively restricting or excessively elastic. In turn, this contrast indicates an important feature of the category of 'conversion disorder': its position between extremes of specificity and diffusion. The syndrome of conversion hysteria has retained a boundary that is sufficiently localised for it to fit within the diagnostic system, while being open to a degree that distinguishes it from the boundaries of other diagnostic categories. The controversy that conversion hysteria has excited would reflect in part the precarious nature of the balance it achieves between the opposed demands of specificity and flexibility, such that it can seem to remain barely viable as a diagnostic concept. While interesting, recognition of this anomaly alone cannot indicate whether it has been adaptive rather than accidental. The nosological analysis can be extended further to elicit the character and functions of conversion hysteria as a category, by considering it in relation to its neighbours within the diagnostic system.

Conversion disorders and their nosological context

The secondary status of conversion syndromes

Conversion symptoms have a distinct, derivative quality that is here referred to as 'secondary'. In effect, a symptom is accepted as a conversion symptom because a comparison has been made between the findings a patient presents and those already established as typical of other disorders, and an inconsistency is apparent as a result. At bottom, it is because of what it is not, rather than any simple intrinsic property, that a symptom becomes diagnosed as conversion. (This state of affairs reflects Freud's equation of a hysterical symptom with one that was anatomically inexplicable, before developing the theory of conversion to explain them – see Paper I.)

This quality may explain a tendency for the syndrome of conversion disorder to assume a secondary status within the pool of psychiatric disorders, in the sense that it is likely to be diagnosed only after a process of comparison and exclusion. Not only has an organic diagnosis first to be ruled out (criterion D in DSM–III), but the diagnosis of conversion hysteria seems to stand at the bottom

https://doi.org/10.1192/bjp.161.3.378 Published online by Cambridge University Press

of a diagnostic hierarchy which expects that schizophrenia, affective disorders, or another neurotic disorder would take precedence if they were also present.

The secondary quality by which identification of the symptoms of conversion hysteria must depend upon implicit or explicit comparisons with other disorders has had important implications for its nosological status. However, as it can also fuel the suspicion that conversion hysteria might simply be superfluous as a diagnostic concept, some comments are in order on the topic of its dispensability. Debate on this topic has largely diverted attention from deeper challenges hysteria poses to diagnosis.

The case for disposal

The most trenchant presentation remains that of Slater (1965), who recognised the secondary character of hysteria, but drew inferences that were fiercely reductionist. For instance, in the arresting phrase: "All the signs of 'hysteria' are the signs not of disease but of health" (p. 1396), Slater plainly admits that hysteria begs knowledge of other 'disease', while implying that the absence of particular forms of disease is equivalent to health rather than some other forms of illness. Indeed, the most remarkable thing about Slater's arguments and their influence was his success in exploiting others' reluctance to question what the process of diagnosis actually entails. His repeated comparisons between the chimera of hysteria and 'real' disease ignored the way in which the groupings of diagnosis are often dictated by considerations of internal coherence rather than correspondence with pathological fact – a point made convincingly in Kraupl Taylor's (1979) advocacy of the concept of 'morbus' as the basic unit of nosography.

In fact, Slater demanded that the diagnosis of hysteria comply with several requirements that other, uncontroversial diagnoses signally fail to. For instance, his proposal (after Brain) that the 'adjectival' use of 'hysterical' might apply to individual symptoms, which he conceded was necessary, but should not lead to talk of a 'substantive' syndrome, is quite inconsistent with practice for other neurotic disorders, whose identity can hang upon the definition of a single, characteristic type of symptom. Conversely, while no automatic assumption applies in the case of symptoms such as obsessions that they may not regularly be seen when a diagnosis other than that of the syndrome of which they are characteristic is appropriate, Slater expected all hysterical symptoms not only to be, but to remain, cases of hysteria.

A further instance of the special pleading Slater pursued was a reluctance to consider the possibility that recognition of more than one hysterical syndrome offered a means of resolving diagnostic difficulties, although other broad diagnoses such as 'depression' or 'schizophrenia' have been repeatedly subject to subdivision. This was curious given that his own data, however unrepresentative, actually revealed two subpopulations separable on the basis of phenomenology and prognosis, namely:

> "seven patients, mostly very young, who had acute psychogenic reactions in the form of a conversion syndrome . . . and 14 patients suffering from a lasting personality disorder who come somewhere near to satisfying the criteria proposed by Guze." (Slater, 1965, p. 1399)

Slater managed to recognise the distinctness of these categories of hysteria while making them grounds for rejection: others have been prepared to make them the basis of a fairly plausible reform of diagnosis that favoured a more differentiated model (cf. Hyler & Spitzer, 1978).

A degree of unreasonableness in these abolitionist claims also manifests in Slater's emotive talk of 'delusion' and 'snare' (1965, p. 1399). The urge to exorcise hysteria evidently taps passions that other syndromes, although candidates for redundancy because of inconsistency or supersession, fail to arouse. It is evidence that hysteria's status is not really a marginal issue, but central to the security of the diagnostic process. Superficially, 'hysteria' can seem to be an obstruction to diagnosticians' efforts to seek and maintain clear distinctions between categories, and therefore appear an unwelcome addition to their ranks, as Slater had complained. However, its presence has enhanced rather than threatened the security of other diagnostic categories: it had come to occupy a pivotal and highly facilitative niche within the wider diagnostic framework.

The evolution of conversion hysteria

The nosological niche occupied by conversion hysteria has evolved directly from its predecessor, hysteria. It has also inherited a tendency of hysteria itself to differ from other disorders insofar as its development depended less on independent nosographic discovery, than on a requirement that it complement those diseases that had already been defined. Hence the ability of hysteria and its antecedents to embrace quite different symptoms (reproductive, gastrointestinal, neural) in the course of its history, as well as its simultaneous but incongruous retention within the ranks of both neurological and gynaecological disorders during the 19th century (Paper I), become more comprehensible.

https://doi.org/10.1192/bjp.161.3.378 Published online by Cambridge University Press

A full historical exploration of the co-evolution of classical hysteria with other disease categories remains to be attempted, the potential importance of diagnostic history here having only recently been recognised (Micale, 1990). However, the episode represented by the recent rise of conversion hysteria presents an important study in itself, indicating how establishment of the category of 'conversion hysteria' has been critical to the cohesion of the diagnostic system, rather than an artefact.

Bridging the rift between neurology and psychiatry

During the last century, hysteria had become progressively more closely identified with the syndromes of neurology and finally exclusively so. The emergence of 'conversion hysteria' was closely linked with the contemporary needs of this department of medicine, where the nosological terrain was different to that familiar to us now, and in a state of considerable flux. Although local differences are found within European and North American medical culture, both in the degree of integration between neurology and psychiatry and in the forces keeping them apart, it would be fair to state that a gap that had been widening between them was nearing its furthest extent at the time 'conversion hysteria' and its variants were being introduced to general diagnostic use (Rogers, 1987).

The organisation of diagnosis reflected this wholesale change, and the corresponding schism within nosology can be traced via the unique record provided by the Royal College of Physicians' *Nomenclature of Disease* in its successive editions between 1869 and 1948. In the earliest editions, 'mental diseases' had been presented as a third subdivision of 'diseases of the nervous system', the others being diseases affecting the nerves, and those of unclear pathology (which had included variants of hysteria) (e.g. Royal College of Physicians, 1906). However, as the perceived incompatibility of psychological and biological perspectives grew, 'mental diseases' were firstly detached from the umbrella of 'diseases of the nervous system' in the 1918 edition, while still following immediately behind in their former place. In 1948 a further break is evident, 'mental disorders' being subsumed under 'diseases of the body as a whole' and removed to a distant section of the classification (Royal College of Physicians, 1948).

Although much reorganisation of the diagnostic net occurs on either side of this divide, only two terms actually transferred from 'diseases of the nervous system' to 'mental diseases'. They were 'hysteria' and 'neurasthenia'. These appear under 'mental diseases' in 1931, with neurasthenia carrying the warning that "this term is used in various senses and should therefore be avoided" (Royal College of Physicians, 1931). By 1948, with neurasthenia dropped, hysteria has finally become 'conversion hysteria'.

That hysteria's transformation into the psychiatric syndrome of conversion hysteria was integral to the distancing of neurology and psychiatry is indicated by concomitant changes. As the schism deepened, local nosology had to respect an increasingly firm barrier between 'psychiatric' and 'neurological' domains, while needing to maintain the integrity of the diagnostic groupings lying on either side of this divide. The availability of an ambiguous category, created to lie just outside neurology, allowed a more homogeneous diagnostic field to be established for those disorders still owned as representative neurological syndromes. As a relatively expendable category, it could be exempt from whatever constraints were being used to level the field of neurological disorder, yet be on hand to accommodate cases that new diagnostic guidelines could no longer place. The choice of a modified concept of hysteria for such a scapegoating role seems inevitable in retrospect. As the paradigm of 'functional' disorders or 'neuroses', hysteria had become uniquely identified with those qualities that were being eschewed by neurological nosography, and ripe for such a displacement.

The decline of the 'functional' disorder

In consolidating its schema, neurological classification increasingly emphasised anatomy as a common point of reference, in preference to inferences of physiological change. The vicissitudes of the important subclass of 'functional disease' in the English literature, and those of 'neurosis' on the Continent, reflect this directly. The concept of 'functional disorder' had exercised neurologists considerably in the late 19th century. The first edition of the College of Physicians' classification assigns 'functional diseases of the nervous system' a separate section, after conditions which could be attributed to diseases of the brain, its membranes, the spinal cord or the nerves. The functional disorders therefore included tetanus, hydrophobia, epilepsy and other convulsive disorders, as well as hysteria (Royal College of Physicians, 1869). However, in the second edition, of 1884, this section was headed "the names of symptoms and groups of symptoms related with such pathological conditions, or with other conditions not accurately known", a practice that continued with slight variations throughout subsequent editions (Royal College of Physicians, 1884). The demise of a subgroup of 'functional' diseases was consistent

https://doi.org/10.1192/bjp.161.3.378 Published online by Cambridge University Press

with the criticisms of Gowers (1886), who had sought to minimise the 'functional' sector of disorders in his *Manual of Diseases of the Nervous System*. Instead, Gowers had discussed a continuum of disease, ranging through the 'organic' (where the lesion could be extraneous, as in haemorrhage or tumours); the 'structural' (having evident neural pathology, these accounting for most forms of neurological illness); and the 'nutritional' (where there is no evident lesion, only "a disturbance of function", whose effects are nevertheless lasting, as in chorea or paralysis agitans). 'Functional' disease became a residuum, in which symptoms had to be transient in addition to being lesionless, and to which Gowers wished to admit only hysteria, neuralgia, and some forms of epilepsy (Gowers, 1887). It was hysteria that typified 'functional' illness, and as the concept of functional disease became increasingly anomalous within neurological nosology, the simplest solution by which an internal division between structural and functional diseases could be obliterated was to have hysteria, as the purest representative of the latter, removed from the ranks of neurological disorder. Its transplantation to the growing domain of the mental disorders has sanctioned a largely implicit identification of 'functional' with 'psychological' rather than 'physiological' disorder. The ambiguity by which 'functional' may be used in either of these senses, deprecated by commentators such as Rogers (1988) and Trimble (1982), has been an unfortunate but lasting consequence.

In the UK, the concept of 'functional' diseases had effectively displaced that of 'neurosis' in nosological discussion from the middle of the century (Lopez-Pinero, 1983). On the Continent, 'neurosis' survived to embrace conditions whose symptoms referred to the nervous system, but for which physiological rather than anatomical explanations were sought. Its own fate shows many parallels with that of 'functional' neurological disease. Its range was to become increasingly restricted, until by 1890 hysteria was seen as the quintessential neurosis (Charcot, 1889), while many 'intermediate' neuroses unrelated to frank pathology became subsumed under a single bridgehead, 'neurasthenia' (Lopez-Pinero, 1983). The subclass of neurosis was then largely banished from the ranks of neurological disorder as it became psychologised, via the inception of the 'psychoneuroses', with neurotic disorder becoming the province of psychiatry. This transition, requiring the archetypal neurosis of hysteria to become the psychoneurosis of conversion hysteria, was also to permit neurologists to reorganise classification more assertively on the basis of structural pathology or its plainly acknowledged absence.

The irrelevance of conversion to 'conversion hysteria'

This analysis, demonstrating that 'conversion hysteria' came to label a niche that had been shaped in order to fit wider nosological demands, suggests that the specific features of Freud's theory of conversion may have been largely contingent on the success of conversion hysteria as a diagnosis. It supplied a means by which hysteria could be constructed as an essentially psychogenic condition, that had appeared at a particularly favourable moment. Indeed, some previous formulations of hysteria had been even more exclusively psychological in their explanations (e.g. Carter, 1853), and their surprising neglect by contemporary medicine may have owed much to a greater incompatibility with contemporary nosology. Conversely, it is less of a surprise that Russell Reynolds, when setting out ideas on the psychogenesis of hysteria in 1869 that were ultimately to be highly influential (cf. Merskey, 1983), took pains to differentiate his "paralysis and other disorders of motion and sensation, dependent on idea" from the condition being diagnosed as 'hysteria' at that time (Reynolds, 1869, p. 484).

As the precedent of using 'conversion hysteria' to indicate a syndrome, set by Freud, was more widely followed, the 'psychiatrised' concept of hysteria became tied to the theory of conversion. It is interesting that the refinements it has since undergone showed that psychoanalytic ideas concerning the interpretability of symptoms have enjoyed progressively less influence on the criteria by which it has been diagnosed, in keeping with the thesis that they were contingent to acceptance of the syndrome in the first place. Nevertheless, conversion hysteria's psychoanalytic heritage survives in the general supposition that symptom formation is a reflection of unconscious processes. This residual emphasis upon the aetiological implications of 'conversion' continues to distract attention from those features, evident from its nosological situation, that make it most remarkable.

Among these, conversion disorder has retained the singular distinction of being a psychological disorder whose symptoms are identified with the peripheral nervous system. The persistence of such a concept, seemingly indispensable to practising neurologists (Mace & Trimble, 1991), indicates that many of the conditions prevailing when it was introduced may not have changed greatly. The concept is certainly an untidy one, although this impression may be enhanced because it signals deeper faults in the

https://doi.org/10.1192/bjp.161.3.378 Published online by Cambridge University Press

diagnostic structure. Nevertheless, with the mood for reform looking set to prevail, conversion hysteria's future may be viewed from a nosological standpoint.

Conclusion: the future of conversion hysteria

Appreciation of the particular qualities of the category of conversion hysteria, and of its functions within the diagnostic system, carry a number of implications for the success of further diagnostic changes.

Firstly, an understanding of the functions and character of the category of conversion hysteria suggests that reform that merely substitutes labels, for instance letting 'dissociation' operate where 'conversion' used to be, can solve little. It would further obscure, rather than positively exploit, the category's nosological idiosyncracy. In any case, a cosmetically acceptable substitute, remaining just as permeable in its boundary and reactive in its content, can be expected to be the object of renewed criticism once its predecessor's Freudian associations are discovered not to have been the source of all the problems it had posed.

Secondly, as 'conversion hysteria' has been the inheritor of a niche created through larger changes in diagnostic practice, significant reform is unlikely to be possible without adjustment to the terrain around it. So-called 'functional' nervous disorder posed a conundrum because of a psycho–physical dualism that was increasingly mirrored within nosology. The emergence of conversion hysteria as a unique category, by which anomalous cases could be flipped between zones of neurological and psychological disorder, complemented other nosological revisions which had consolidated this polarisation. Although that division has since been somewhat attenuated, an abrupt discontinuity in nosology between neurological and psychological disorder persists. It might be mitigated were a more differentiated map to be used at the neuropsychiatric borderlands, in which psychological as well as somatic features would each have weight in the diagnosis of a broader range of non-structural syndromes than is the case now. Such a potentially sweeping (and in some senses retrograde) change would not come about simply through fiat. It is more likely that significant reorganisation would be deferred until it was forced by independent developments that challenge the agreed basis of diagnosis. For instance, greater continuity at the neuropsychiatric interface is a likely result were pressure to restructure the diagnostic scheme to grow once again within neurology. Signs of this may already be detected. The increasing refinement of investigative techniques poses serious problems for the localisation paradigm upon which attempts to link symptoms to specific structural defects have rested. These developments permit changes in function to be mapped *in situ* that are complex and dynamic, yet associated with anatomical alteration at remote sites (which they may also precede). They therefore contradict the simple topographic correspondence between structure and function that the idea of the focal lesion begs (Reynolds, 1989). The assumption that a clear judgement can be made as to how 'structural' a given disease is has depended upon a reliable distinction between structural and functional change that is looking increasingly hard to apply. These judgements had underpinned the nosological rearrangement in which the category of conversion hysteria emerged. A future reorganisation of nosology that respected patterns of physiological as well as structural change would forcibly shift the ground on which conversion hysteria has stood, if not displace it altogether.

Thirdly, even if attempts to resolve some of the deeper problems in the present nosological structure do follow, this will not in itself guarantee substantial change. The present paper has been necessarily selective in looking to official classifications for observations about nosology, and these inevitably misrepresent day-to-day practice (Mace & Trimble, 1991). Although it is probable that sanctioned diagnoses and actual practice are more closely aligned than formerly, diagnosis has traditionally been shaped by the working needs of practitioners who, as Faber (1923) well appreciated, are thoroughly dependent upon the diagnostic matrix to structure their clinical thinking and behaviour.

It may be argued that the concept of conversion has been unusual too in underpinning a characteristic form of clinical behaviour, which might be termed 'conversive'. A patient may be said to have provoked conversive behaviour when the doctor painstakingly pursues investigations to detect minute structural or physiological abnormalities to a point at which an abrupt switch occurs. Then all investigation stops, attitudes to the patient may alter, and the symptoms are interpreted as psychological manifestations without the patient necessarily having changed in any way. Instead, the doctor's perception of the patient's problem has undergone a form of conversion. The reframing that occurs here is often radical, and reflects the diagnostician's dependence on a schema in which neurological and psychological frameworks remain mutually exclusive. Rogers (1988) has aptly used the simile of Necker's cube to illustrate the sort of switch that can be entailed.

Although conversive behaviour can be seen as an expression of nosological limitations, and to illustrate

https://doi.org/10.1192/bjp.161.3.378 Published online by Cambridge University Press

the relevance of the perspective that has been pursued here, its real value is that it offers an important opportunity for empirical study. Conversive behaviour is relatively common, yet it remains unclear what relative contributions are made by a range of variables to its precipitation and the form it takes. These include the symptoms patients present with, other aspects of their behaviour, as well as the training of doctors and their diagnostic and attitudinal set. Research that took conversive behaviour as a focus of study would offer a practical exercise by which the perspectives of social and medical science might be pooled, and a reconciliation between the 'internal' and 'external' perspectives on hysteria, outlined at the outset of this paper, realised.

Lastly, while conversion hysteria has now featured in psychiatric classification for half a century, the recent attack it has faced indicates the presence of powerful pressure for change. A category that remains essentially 'fuzzy' in its boundary, elastic in scope, and (though less essentially) aetiological in implication, is bound to seem untidy in a scheme concerned with phenomenological purity. However, this seems a curious development given the traditional concern of nosography with aetiological as well as descriptive classification, and the likelihood that psychiatric nosology will face an enormous challenge once understanding of the biological underpinnings of individual symptoms prompts regroupings founded on a revised pathology (Trimble, 1989). The current growth in formalism within psychiatric diagnosis is curiously reminiscent of the situation in medicine two centuries ago, when nosologists' emphasis on the comprehensiveness, clarity, and cohesion of a scheme took precedence over the incomplete insights afforded by biology and pathology. That of course was the prelude to a revolution within medicine, one that was to render Ferriar's (1795) original concept of hysterical conversion obsolete. A reform of psychiatric nosography, leaving it free to devise groupings based on a fresh understanding of the neurological pathology accompanying psychological symptoms, would ultimately dispense with the current concept just as surely. However, even then, provided diagnosis had remained the clinician's most essential tool, one should expect a further incarnation of hysteria to emerge elsewhere within medical nosology.

Acknowledgements

The author is grateful to Dr Mark Micale, Professor Harold Merskey, and Dr Michael Trimble for comments received on earlier versions of the manuscripts, and to the Raymond Way Foundation for financial support.

References

ABRAHAM, K. (1921*a*) Contribution to a discussion on tic. In *Selected Papers of Karl Abraham*, pp. 323–325. London: Hogarth Press (1927).

—— (1921*b*) Psycho-analysis and the war neuroses. In *Clinical Papers and Essays on Psychoanalysis* (ed. H. C. Abraham), pp. 59–67. London: Hogarth Press (1955).

—— (1926) A short study of the development of the libido. In *Selected Papers*. London: Hogarth Press (1927).

ALEXANDER, F. (1943) Fundamental concepts of psychosomatic research. *Psychosomatic Medicine*, **5**, 206–210.

AMERICAN MEDICAL ASSOCIATION (1935) *A Standard Classified Nomenclature of Disease* (5th revision). New York: Commonwealth Fund.

—— (1948) *A Standard Classified Nomenclature of Disease* (6th revision). New York: Commonwealth Fund.

—— (1957) *A Standard Classified Nomenclature of Disease* (7th revision). New York: Commonwealth Fund.

—— (1970) *A Standard Classified Nomenclature of Disease* (8th revision). New York: Commonwealth Fund.

AMERICAN PSYCHIATRIC ASSOCIATION (1952) *Diagnostic and Statistical Manual of Mental Disorders* (1st edn). Washington, DC: APA.

—— (1968) *Diagnostic and Statistical Manual of Mental Disorders* (2nd edn) (DSM-II). Washington, DC: APA.

—— (1980) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn) (DSM-III). Washington, DC: APA.

—— (1987) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn, revised) (DSM-III-R). Washington, DC: APA.

BENEDIKT, M. (1868) *Elektrotherapie*. Vienna: Tendler.

BREUER, J. & FREUD, S. (1893) Preliminary communication. In *Studies on Hysteria, The Complete Psychological Works*, Vol. II (standard edn, ed. J. Strachey), pp. 3–17. London: Hogarth Press (1955).

—— & —— (1895) *Studies on Hysteria, The Complete Psychological Works, Vol. III* (standard edn, ed. J. Strachey), pp. 19–305. London: Hogarth Press (1955).

BRIQUET, P. (1859) *Traite de l'Hysterie*. Paris: Baillière.

BRODIE, B. C. (1837) *Lectures Illustrative of Certain Nervous Affections*. London: Longman.

CARTER, K. C. (1980) Germ theory, hysteria, and Freud's early work in psychopathology. *Medical History*, **24**, 259–274.

CARTER, R. B. (1853) *On the Pathology and Treatment of Hysteria*. London: Churchill.

CHARCOT, J-M. (1877) *Clinical Lectures on the Diseases of the Nervous System, Vol. I*. London: New Sydenham Society.

—— (1889) *Clinical Lectures on the Diseases of the Nervous System, Vol. III*. London: New Sydenham Society.

—— & MARIE, P. (1892) Hysteria mainly hystero-epilepsy. In *A Dictionary of Psychological Medicine* (ed. H. Tuke). London: J. & A. Churchill.

CULLEN, W. (1791) *First Lines of the Practice of Physic* (4th edn), vol. 4. Edinburgh: Bell & Bradfute.

—— (1797) *Clinical Lectures, Delivered in the Years 1765 and 1766*. London: Lee & Hunt.

—— (1827) *A Methodical System of Nosology* (trans. E. Lewis). London: Jackson.

DAVID-MENARD, M. (1989) *Hysteria from Freud to Lacan*. New York: Cornell University Press.

DEUTSCH, F. (1959*a*) On the formation of the conversion symptom. In *On the Mysterious Leap from the Mind to the Body* (ed. F. Deutsch), pp. 59–72. New York: International Universities Press.

—— (1959*b*) Symbolisation as a formative state of the conversion process. In *On the Mysterious Leap from the Mind to the Body* (ed. F. Deutsch), pp. 75–97. New York: International Universities Press.

ENGEL, G. (1970) Conversion symptoms. In *Signs and Symptoms* (eds C. M. Macbryde & R. S. Blacklow), pp. 650–668. London: Pitman.

https://doi.org/10.1192/bjp.161.3.378 Published online by Cambridge University Press

FABER, K. (1923) *Nosography in Modern Internal Medicine*. New York: Hoeber.

FAIRBAIRN, W. R. D. (1954) Observations on the nature of hysterical states. *British Journal of Medical Psychology*, **27**, 105–125.

FENICHEL, O. (1945) *The Psychoanalytic Theory of Neurosis*. London: Routledge.

FERENCZI, S. (1919) The phenomena of hysterical materialization. In *Further Contributions to the Theory and Technique of Psychoanalysis*, pp. 89–104. New York: Brunner/Mazel (1950).

FERRIAR, J. (1795) *Medical Histories and Reflections*, vol. II. London: Cadell and Davies.

FORD, C. V. (1985) Conversion disorders: an overview. *Psychosomatics*, **26**, 371–383.

FORRESTER, J. (1980) *Language and the Origins of Psychoanalysis*. London: Macmillan.

FOUCAULT, M. (1973) *The Birth of the Clinic* (trans. A. M. Sheridan). London: Tavistock.

FRENCH, R. K. (1969) *Robert Whytt, the Soul and Medicine*. London: Wellcome Institute.

FREUD, A. (1936) *The Ego and the Mechanisms of Defence*. New York: International Universities Press.

FREUD, S. (1888) Hysteria. In *The Complete Psychological Works, Vol. I* (standard edn, ed. J. Strachey), pp. 39–59. London: Hogarth Press (1966).

—— (1893) *Some Points for a Comparative Study of Organic and Motor Paralyses, Vol. I* (standard edn, ed. J. Strachey), pp. 160–172. London: Hogarth Press (1966).

—— (1894) The neuro-psychoses of defence. In *The Complete Psychological Works, Vol. III* (standard edn, ed. J. Strachey), pp. 45–61. London: Hogarth Press (1962).

—— (1895*a*) On the grounds for detaching a particular syndrome from neurasthenia under the description 'anxiety neurosis'. In *The Complete Psychological Works, Vol. III* (standard edn, ed. J. Strachey), pp. 90–117. London: Hogarth Press (1962).

—— (1895*b*) Project for a scientific psychology. In *The Complete Psychological Works, Vol. I* (standard edn, ed. J. Strachey), pp. 283–397. London: Hogarth Press (1966).

—— (1896) Further remarks on the neuro-psychoses of defence. In *The Complete Psychological Works, Vol. III* (standard edn, ed. J. Strachey), pp. 162–185. London: Hogarth Press (1962).

—— (1897) *Infantile Cerebral Paralysis* (trans. L. A. Russin). Coral Gables: University of Miami Press (1968).

—— (1906) My views on the part played by sexuality in the aetiology of the neuroses. In *The Complete Psychological works, Vol. VII* (standard edn, ed. J. Strachey), pp. 271–282. London: Hogarth Press (1953).

—— (1907) Three essays on the theory of sexuality. In *The Complete Psychological Works, Vol. VII* (standard edn, ed. J. Strachey), pp. 231–245. London: Hogarth Press (1953).

—— (1908) Hysterical phantasies and their relation to bisexuality. In *The Complete Psychological Works, Vol. IX* (standard edn, ed. J. Strachey), pp. 159–166. London: Hogarth Press (1959).

—— (1909*a*) Some general remarks on hysterical attacks. In *The Complete Psychological Works, Vol. IX* (standard edn, ed. J. Strachey), pp. 229–234. London: Hogarth Press (1959).

—— (1909*b*) Analysis of a phobia in a five-year-old boy. In *The Complete Psychological Works, Vol. X* (standard edn, ed. J. Strachey), pp. 1–145. London: Hogarth Press (1955).

—— (1917*a*) Psychoanalysis and psychiatry. In *The Complete Psychological Works, Vol. XVI* (standard edn, ed. J. Strachey), pp. 243–256. London: Hogarth Press (1963).

—— (1917*b*) The sense of symptoms. In *The Complete Psychological Works, Vol. XVI* (standard edn, ed. J. Strachey), pp. 257–272. London: Hogarth Press (1963).

—— (1923) The ego and the id. In *The Complete Psychological Works, Vol. XIX* (standard edn, ed. J. Strachey), pp. 3–67. London: Hogarth Press (1961).

—— (1924) Neurosis and psychosis. In *The Complete Psychological Works, Vol. XIX* (standard edn, ed. J. Strachey), pp. 147–153. London: Hogarth Press (1961).

GOULD, R., MILLER, B. L., GOLDBERG, M. A., *et al* (1986) The validity of hysterical signs and symptoms. *Journal of Nervous and Mental Disease*, **174**, 593–597.

GOWERS, W. R. (1886) *Manual of the Diseases of the Nervous System*. London: J. & A. Churchill.

—— (1887) *Lectures on the Diagnosis of Diseases of the Brain*. London: J. & A. Churchill.

GRIESINGER, W. (1867) *Mental Pathology and Therapeutics* (trans. C. Lockhart Robertson & J. Rutherford). London: New Sydenham Society.

GUZE, S. B. (1970) The role of follow-up studies: their contribution to diagnostic classification as applied to hysteria. *Seminars in Psychiatry*, **2**, 392–402.

——, CLONINGER, C. R., MARTIN, R. L., *et al* (1986) A follow-up and family study of Briquet's syndrome. *British Journal of Psychiatry*, **149**, 17–23.

HEAD, H. (1922) The diagnosis of hysteria. *British Medical Journal*, *i*, 827–829.

HOLLENDER, M. H. (1972) Conversion hysteria: a post-Freudian re-interpretation of 19th century psychosocial data. *Archives of General Psychiatry*, **26**, 311–314.

HUNTER, R. & MACALPINE, I. (1963) *Three Hundred Years of Psychiatry*. London: Oxford University Press.

HYLER, S. E. & SPITZER, R. L. (1978) Hysteria split asunder. *American Journal of Psychiatry*, **85**, 1500–1504.

JACQUART, D. & THOMASSET, C. (1988) *Sexuality and Medicine in the Middle Ages* (trans. M. Adamson). London: Polity Press.

JONAS, J. M. & POPE, H. G. (1985) The dissimulating disorders: a single diagnostic entity? *Comprehensive Psychiatry*, **26**, 58–62.

KENDELL, R. (1983) Hysteria. In *Handbook of Psychiatry*, vol. 4 (eds G. Russell & L. Herzov), pp. 232–246. Cambridge: Cambridge University Press.

KNIGHT, I. (1984) Freud's "project": a theory for studies on hysteria. *Journal of the Behavioural Sciences*, **20**, 340–358.

KRAUPL TAYLOR, F. (1979) *The Concepts of Illness, Disease, and Morbus*. Cambridge: Cambridge University Press.

LACAN, J. (1966) *Écrits*. Paris: Editions du Seuil.

LAIN-ENTRALGO, P. (1961) *La Historia Clinica* (2nd edn). Barcelona: Salvat.

LAZARE, A. (1981) Conversion symptoms. *New England Journal of Medicine*, **305**, 745–748.

LEE, R. (1871) *A Treatise on Hysteria*. London: Churchill.

LEWIS, W. C., BERMAN, M. & MADISON, W. I. S. (1965) Studies of conversion hysteria: I. Operational study of diagnosis. *Archives of General Psychiatry*, **13**, 275–282.

LOPEZ-PINERO, J. M. (1983) *Historical Origins of the Concept of Neurosis*. Cambridge: Cambridge University Press.

MACE, C. J. & TRIMBLE, M. R. (1991) "Hysteria", "functional" or "psychogenic"? *Journal of the Royal Society of Medicine*, **84**, 471–475.

MAI, F. M. & MERSKEY, H. (1980) Briquet's treatise on hysteria. *Archives of General Psychiatry*, **37**, 1401–1405.

MARSDEN, C. D. (1986) Hysteria – a neurologist's view. *Psychological Medicine*, **16**, 277–288.

MECHANIC, D. (1962) The concept of illness behaviour. *Journal of Chronic Diseases*, **15**, 189–194.

MERSKEY, H. (1979) *The Analysis of Hysteria*. London: Baillière Tindall.

—— (1983) Hysteria: the history of an idea. *Canadian Journal of Psychiatry*, **28**, 428–433.

—— (1988) Regional pain is rarely hysterical. *Archives of Neurology*, **45**, 915–919.

—— & POTTER, P. (1989) The womb lay still in ancient Egypt. *British Journal of Psychiatry*, **154**, 751–753.

https://doi.org/10.1192/bjp.161.3.378 Published online by Cambridge University Press

MICALE, M. (1990) Hysteria and its historiography: the future perspective. *History of Psychiatry*, **1**, 33–124.
MILLER, E. (1987) Hysteria: its nature and explanation. *British Journal of Clinical Psychology*, **26**, 163–173.
MILLER, N. S. & KATZ, J. L. (1989) The neurological legacy of psychoanalysis: Freud as a neurologist. *Comprehensive Psychiatry*, **30**, 128–134.
MOEBIUS, P. (1894) *Neurologische Beitrage, Vol. I*. Leipzig: Meiner.
NEMIAH, J. (1967) Conversion reaction. In *Comprehensive Textbook of Psychiatry* (2nd edn) (eds H. Kaplan, A. M. Freedman & B. J. Sadock), pp. 870–885. Baltimore: Williams & Wilkins.
PERLEY, M. & GUZE, S. B. (1962) Hysteria – the stability and usefulness of clinical criteria. *New England Journal of Medicine*, **266**, 421–426.
PILOWSKY, I. (1969) Abnormal illness behaviour. *British Journal of Medical Psychology*, **42**, 347–351.
—— (1971) The diagnosis of abnormal illness behaviour. *Australia and New Zealand Journal of Psychiatry*, **5**, 136–138.
—— (1978) A general classification of abnormal illness behaviours. *British Journal of Medical Psychology*, **51**, 131–137.
PINEL, P. (1806) *A Treatise on Insanity* (trans. D. D. Davis). London: Cadell & Davis.
RANGELL, L. (1959) The nature of conversion. *Journal of the American Psychoanalytic Association*, **7**, 632–662.
REYNOLDS, E. H. (1989) Structure and function in neurology and psychiatry. In *The Bridge between Neurology and Psychiatry* (eds E. H. Reynolds & M. R. Trimble), pp. 38–55. London: Churchill Livingstone.
REYNOLDS, J. R. (1869) Paralysis, and other disorders of motion and sensation, dependent on idea. *British Medical Journal*, 483–485.
RISSE, G. B. (1988) Hysteria at the Edinburgh Infirmary: the construction and treatment of a disease, 1770–1800. *Medical History*, **32**, 1–22.
ROGERS, D. (1987) Neuropsychiatry. *British Journal of Psychiatry*, **150**, 425–427.
—— (1988) Psychiatry and the Necker cube. Neurological and psychological conceptions of psychiatric disorder. *Behavioural Neurology*, **1**, 3–10.
ROYAL COLLEGE OF PHYSICIANS (1869) *Nomenclature of Disease* (1st edn). London: Royal College of Physicians.
—— (1884) *Nomenclature of Disease* (2nd edn). London: Royal College of Physicians.
—— (1906) *Nomenclature of Disease* (4th edn). London: Royal College of Physicians.
—— (1918) *Nomenclature of Disease* (5th edn). London: Royal College of Physicians.
—— (1931) *Nomenclature of Disease* (6th edn). London: Royal College of Physicians.
—— (1948) *Nomenclature of Disease* (7th edn). London: Royal College of Physicians.
RYCROFT, C. (1966) Introduction: causes and meaning. In *Psychoanalysis Observed* (ed. C. Rycroft), pp. 7–22. London: Constable.
SLATER, E. (1965) The diagnosis of 'hysteria'. *British Medical Journal*, *i*, 1395–1399.
SPERLING, M. (1973) Conversion hysteria and conversion symptoms: a revision of classification and concepts. *American Psychoanalytic Association Journal*, **21**, 745–771.
SULLOWAY, F. (1979) *Freud, Biologist of the Mind*. London: Burnett.
SYDENHAM, T. (1848) Epistolary dissertation. In *The Works of Thomas Sydenham, M.D.* (trans. R. G. Latham). London: Sydenham Society.
SZASZ, T. (1972) *The Myth of Mental Illness*. London: Paladin.
TRILLAT, E. (1986) *Histoire de l'Hysterie*. Paris: Seghers.
TRIMBLE, M. R. (1981) *Neuropsychiatry*. Chichester: Wiley.
—— (1982) Functional diseases. *British Medical Journal*, **285**, 1768–1770.
—— (1989) *Biological Psychiatry*. Chichester: Wiley.
VEITH, I. (1965) *Hysteria: The History of a Disease*. Chicago: University of Chicago Press.
WADDELL, G., BIRCHER, M., FINLAYSON, D., *et al* (1984*a*) Symptoms and signs: physical disease or illness behaviour? *British Medical Journal*, **289**, 739–741.
——, MAIN, C. J., MORRIS, E. W., *et al* (1984*b*) Chronic low-back pain, psychological distress, and illness behaviour. *Spine*, **9**, 209–213.
WALTERS, A. (1961) Psychogenic regional pain alias hysterical pain. *Brain*, **84**, 1–18.
—— (1969) Psychogenic regional sensory and motor disorders alias hysteria. *Canadian Psychiatric Association Journal*, **14**, 573–590.
WEINSTEIN, E. A., ECK, R. A. & LYERLY, O. G. (1969) Conversion hysteria in Appalachia. *Psychiatry*, **32**, 334–341.
WOERNER, P. I. & GUZE, S. (1968) A family and marital study of hysteria. *British Journal of Psychiatry*, **114**, 161–168.
WORLD HEALTH ORGANIZATION (1948) *Manual of International Classification of Diseases, Injuries and Causes of Death* (6th revision). Geneva: WHO.
—— (1955) *Manual of International Classification of Diseases, Injuries and Causes of Death* (7th revision). Geneva: WHO.
—— (1965) *Manual of International Classification of Diseases, Injuries and Causes of Death* (8th revision). Geneva: WHO.
—— (1975) *Manual of International Classification of Diseases, Injuries and Causes of Death* (9th revision). Geneva: WHO.
—— (1987) *Tenth Revision of the International Classification of Diseases, Chapter V* (provisional proposals). Geneva: WHO.
—— (1988) *Tenth Revision of the International Classification of Diseases, Chapter V* (revised provisional proposals). Geneva: WHO.

Christopher J. Mace, BSc, MRCPsych, *Senior Registrar in Psychiatry, St George's Hospital, London SW17, and Honorary Lecturer in Neuropsychiatry, Institute of Neurology, London WC1*

https://doi.org/10.1192/bjp.161.3.378 Published online by Cambridge University Press