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The world of hysteria

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Abstract. – In this work, I will present Freud's great contribution not only to the fields of neuropathology, psychiatry, and medicine in general, but I will demonstrate how his clinical research has opened a new path to understanding psychopathology. I will look at some theories about the genesis of the symptoms of hysteria and describe Freud's scientific journey, which opened up a new perspective and gradually led to the birth of psychoanalysis. An important contribution to this topic is the multiple code theory by V. Bucci, with its three distinct principles of organization of experience. The model is applied to clinical practice and determines treatment, so it is intended to explain and intervene in the world of hysteria. The Bucci model also has critical aspects and obvious repercussions that we will examine in this article. An important contribution is that of N. McWilliams, regarding histrionic personality disorder. The structural symptom takes its rightful place here in the explanation and treatment of psychopathology. In her work there is an important transition: she moves from an explanation of linear mono causality to multi-factorial randomness. Once you have read this article, you will understand that new contributions are needed in order to comprehend psychic processes, and in order to do this we need to re-interpret psychoanalytic theories.

Key words: epistemology; complexity; psychopathology; hysteria; symptom.

Hysterical neurosis

If we throw a crystal on the ground, it breaks, but not arbitrarily, it then breaks according to its cleavage planes into pieces whose delimitation, although invisible, was nevertheless determined in advance by the structure of the crystal. Such cracked and shattered structures are also what the mentally ill are' (Freud, 1932, p. 465).

The term 'hysteria' (Freud, 1888, p. 43; from the Greek word for uterus) dates back to the earliest times of medicine. The hysteria was either dependent on the uterus or was made up, its state was considered the result of sim-

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ulation and exaggeration, unworthy of clinical observation. This disease was associated with problems of the female realm, and if hysterical symptoms were observed in males, new diagnoses such as 'neurasthenia' or 'war shock' were created. The core of the diagnosis today cannot be reduced to simulation; in any case, the healthcare professional must be able to detect hysterical symptoms without stopping at the surface level.

A better understanding of the disease began with studies at the school of Salpètriere (Breuer, Freud, 1892, p. 143; Freud, 1888, p. 69), carried out by Charcot, Janet, Bernheim, Breuer, and other physicians who studied hysteria with hypnotism (Janet, 1882). In Nancy, the school of Lièbeault and Bernheim was in conflict with Charcot's ideas. In the world of psychiatry at the end of the 1800s hypnosis was widespread. Charcot conducted his fundamental research on grand neuroses and focused in particular on hysteria. The hysterical attack, as he described it, consisted of four phases: the epileptoid phase, the phase of contortions and acrobatic postures, the phase of emotional gestures, and the phase of final delirium, as well as a wide variety of physical symptoms, a heterogeneous set of symptoms within a single diagnosis. In this interpretation all the physical symptoms were part of the grand hysterical attack: hysteria served as a cover for the incomprehensible. Stigmata were also part of the clinical picture of hysteria.

Charcot, in his clinical studies, considered hysteria a congenital degeneration of the brain; for him the cause of the grand hysteria attacks was hereditary, and the disease was the result of mercury intoxication. Charcot's ideas were not well received in Vienna. Meanwhile, Freud had applied for a scholarship in order to continue his studies in neuropathology. His wish was granted, and he was sent to Paris on a scholarship to challenge Charcot's theories, but things took a different turn (Freud, 1885-86, p. 5). He immersed himself in the study of hypnotism, learned the hypnotic technique, and initially defended it by finding promising ideas for the future of neurosis therapy. Contrastingly, the authoritative Professor Meynert (Meynert, 1889, p. 686) and other renowned doctors of the time criticized hypnosis, excluding any therapeutic and scientific value: 'being cured does not prove anything, on the contrary, this itself needs to be proven.' (Freud, 1889, p. 97)

For doctors in Vienna, hypnosis remained an ineffective procedure and a dangerous intervention. Freud ended up standing in opposition to the revered master Meynert. He then opened his own professional practice and began to apply the procedure and induce hypnosis in patients with the goal of freeing and healing them from symptoms. The power of suggestion aimed at an immediate effect: 'If hypnotic therapy is aimed only at symptoms, and not pathological processes, it follows the path that all other therapies are obliged to follow' (Freud, 1891, p. 120). Freud spent a few weeks at the school in Nancy in 1889 in order to perfect his hypnotic technique. The theory of suggestion elaborated by Liébeault and his followers

Bernheim, Beaunis, and Liégeois (Freud, 1888) argued that all hypnotic phenomena were psychic effects and ideas aroused in the patient by the hypnotist, while both Charcot and Freud rejected this thesis.

I question hypnosis and the epistemology behind it. Do the theories formulated meet the criteria of human complexity? The first step of hypnotic treatment is to induce a hypnotic state, and then a suggestion is transmitted to the hypnotized person. The first tool with which we work is suggestion: during the state of hypnosis, hypnotic treatment consists of ordering away the patient's symptoms. Is the trauma buried in the unconscious somehow restored, and to what? In a state of a lack of consciousness – because hypnosis occurs in a trance – if knowledge is somehow restored, it is that of the therapist. Freud was aware that hypnosis met all the requirements of a direct causal therapy, in accordance with the positivist epistemology of the time, and according to a cause-and-effect logic.

After some time, Freud ceased to practice hypnosis in favour of Breuer's cathartic method, which used hypnosis to awaken memories of the past when the symptom first appeared. Breuer was a well-established physician, and together with Freud continued the study of psychic processes during hysteria attacks. Freud came to challenge Charcot's aetiological theory, going beyond the hereditary factor with a momentous turning point. Central to Freud's observation of cause was the fact that it was not found in inheritance, but in sex life anomalies. He arrived at the aetiology of hysteria via the observation of hysterical patients under hypnosis, by analysing the content of the hysterical attack induced by the hypnotic state. He had observed incestuous trauma during the hypnotic process.

Between Freud and Bleuler, both great clinicians, there was clear dissent in conceptualizing hysteria, and their cooperation was far from smooth sailing. In order to better understand the topic, I will describe the normal state of consciousness (without symptoms) and the pathological states (with symptoms) below.

According to Breuer (1893; discussed in Freud, 1893, p. 422), the 'basis and condition' of hysteria was the presence of particular traumatic states of consciousness with limited ability to associate, for which Breuer proposed the name 'hypnoid states'. He endorsed hypnoid hysteria; he did not acknowledge the role of the sexual factor in the aetiology of hysteria. Sexuality as a source of psychic trauma was rejected by Breuer, he instead hypothesized a dissociative psychic mechanism: 'In it a representation would become pathogenic due to the fact that it was excluded from the Ego from the start, accommodated in a specific psychic state' (quote in Freud, 1893, p. 422).

Freud believed in a defensive hysteria: the memory represented the return of the event that had caused the hysterical attack, the return of psychic trauma. It was an unconscious memory, or rather, one belonging to the

second state of consciousness. If the hysterical patient wanted to forget an event, if he/she suppressed or inhibited a representation, these psychic acts ended in the second state of consciousness, while the memory of these returned as a hysterical attack. During the attack the patient was in the second state of consciousness completely or partially, while when he/she was in the normal state of consciousness there was amnesia of the attack; in the first case, the patients were reliving the same event that caused the first attack in a hallucinatory manner. Freud believed that there was a causal relationship between the triggering event and the pathological phenomenon. He noticed that this was not always the case, sometimes the connection was clear, that is, the psychic trauma directly caused hysteria. In other cases, there was only a symbolic relationship between the original event and the pathological phenomenon.

The cause of traumatic neurosis is not a physical injury, but psychological trauma. 'Any experience can act as a trauma and cause the painful affections of terror, anguish, shame and psychic pain' (Freud, 1892, p. 177).

The Freudian view considered that pathology was the result of an active process of the psyche and repression was the central mental process in hysteria. The concept of hysterical conversion was also important for Freud. He spoke of hysterical conversion, meaning an intense emotional state, unacceptable to the conscious Ego, which is repressed because it has failed to find a proper release and flows into somatic innervation (conversion). According to this view, hysteria is generated by repressing an unbearable representation as a defense.

Studies on hysteria resulting from the joint work of Freud and Breuer (1892-95) are a valuable contribution to clinical practice and medicine in general. They include five clinical cases; the first case was written by Breuer and is the famous case of Anna O.

Breuer's experience ended with this case, which was described over twelve years after treatment ended. Breuer concluded that: 'Since then (1882) she enjoys (1895) perfect health'; however, Anna O later had several relapses and was also hospitalized; it was Breuer himself who observed the return of symptoms: the therapeutic effect was therefore temporary. At present, some believe that Anna's case is not so much a clinical picture of hysteria but rather one of dissociative personality disorder.

Among the four clinical cases described by Freud, the one of Mrs. Emmy Von N. stands out, a typical picture of hysteria. Freud recognizes that it is not easy to decide between a diagnosis of hysteria or other forms of neurosis. This patient lent herself to hypnosis with the greatest ease and reached full suggestibility like that of sleepwalkers. Freud applied Breuer's cathartic method to her: the treatment lasted about seven weeks; a short therapy aimed at eliminating the symptoms. Freud wrote: 'The hysterical attack must perhaps be interpreted as an attempt to carry out a reaction to

the trauma (Freud, 1892 p. 156).' The patient suffered a psychic trauma that was not abreacted. Hypnotic therapy consists in making her relive it, under hypnosis, forcing her this time to complete her reaction. The patient's condition improved quickly, and she ended her hypnotic therapy. Well-being lasted for several months, but she then had other crises. During his work Freud realized that not all patients could be hypnotized, as in the cases of Miss Lucy and Elisabeth von R; this difficulty required him to rethink his therapeutic work and led him to abandon the application of hypnotic psychotherapy in order to get the patient to recall forgotten events. This obstacle led him to consider this difficulty as a fundamental moment of hysteria: 'What saved me from this new difficulty was the memory of having seen Bernheim provide proof that the memories of sleepwalking are only apparently forgotten in waking, and that they can be reawakened by a slight admonishment, given at the same time as pressure from his hand to indicate a different state of consciousness.' (Freud, 1893, p. 266). Bernheim's procedure was Freud's new technical model, and he first applied it with Miss Lucy R. According to the Freudian conception, the patient suffered from trauma or a series of childhood sexual traumas.

Freud's therapeutic goal was to reach certain memories, pathogenic representations that were carried out of consciousness and memory and had fallen into oblivion: these had to come to consciousness, become conscious under the pressure of his hand.

The objective was the same for Freud: to circumvent hypnosis and reach the region of the pathogenic organization that had the origin of the symptom within it. It was about abreacting the trauma, that is, re-traumatizing the patient.

Freud sometimes wavered with respect to his findings, on the one hand he thought he understood the psychic mechanism of hysteria, on the other he wrote: 'but how far we are today from the possibility of such a perfect understanding of hysteria' (Freud, 1892, p. 393). And again: 'new experiences will have to tell us, hopefully soon, if with this tendency to broaden the concept of defense, extending it to all of hysteria, I do not run the risk of falling into unilaterality and error' (Freud, 1893, p. 422).

While he had clinical experience with the technique used by Bernheim, Freud admitted to himself that there was a possibility of failure in the hand pressure procedure, not least because recollection was not always obtained. With regard to healing, he was doubtful that it was the mechanism of remembering the trauma that was working, that is, bringing to consciousness what had happened in reality, but rather the suggestion. Bernheim's technique was therefore replaced.

For these and other reasons, Freud proceeded to find his way to what would be his own specific technique: free association. Compared to hypnosis, this was an innovation in the methods of working at the time, even if it

was not enough: as we shall see, clinical practice gave a devastating blow to the theory.

As he continued his discoveries, he encountered new difficulties in clinical practice: he had to fight against the psychic strength of the patients which was opposed to him, to get to the repressed memories. Freud was certain that he knew the reality of the patient; his interventions were directed to a remote place. He believed that the aim of the psychic strength was to prevent the return of pathogenic representations. At first, he wrote about finding himself in front of this strength as though he were in front of a wall and that penetrating into the patient's world depended on overcoming this strength, the resistance to association: 'the patient resists, he defends himself from my interpretations.' He realized that the symptom 'resisted' words, resisted the cure, and he sensed that there was an almost indestructible link of the subject with his/her symptom.

In Freud, sexuality played a central role, both theoretically and in clinical practice, in the aetiology not only of hysteria but also of psychopathology in general.

He imagined the unconscious as a place where all the thoughts not accepted by consciousness converged by repression and were the source of anguish for the ego. They then resurfaced and the symptoms of conversion were the unconscious expression via the body of the repressed emotions.

Proceeding with the development of his theory, Freud abandoned the theory of real trauma and replaced it with a phantasmatic theory in which reality had no value. He went so far as to say that the basis of hysteria was a twofold fixation: oral and oedipal. According to this hypothesis theorized via the Electra Complex, in early childhood the female child needs constant maternal care; she is disappointed by the mother who cannot make her feel safe, satisfied and appreciated. The male child – due to the rivalry with his father – meets the maternal object, but because of this paternal prohibition replaces it with another object. The female child is initially in the same position as the male: she is the object of maternal care and at the same time the object of the mother's desire; she quickly realizes that her mother desires something that she as a child does not have and that she is not the object capable of fulfilling the maternal desire. She turns to her father as a new object, in early 'competition with her mother', who had been, until that moment, her object. Freud argued that the female child 'receives the phallic gift from her father' and defined the mother-daughter relationship as remarkably complex, so much so that Freud spoke of 'catastrophe'. The development of female [psychism?] proceeded via great separations, involving the separation from the object capable of satisfying the expectations of the child phantasmatically; the object that she had to receive from her father to come out of the 'love prison' of the relationship with her mother. In conclusion, the female child would only be able to sep-

arate herself from her mother by devaluing her and turning her love toward her father.

In the psychoanalytic literature, we talk about 'healthy' and 'sick' hysterics. 'Healthy' hysterical patients are defined by a variety of adjectives, such as 'good', 'phallic', and 'authentic'. More definitions have been applied to those falling under the second group of 'oral hysterics', 'good hysterics', 'hysteroids', and 'infantile personalities' (Gabbard, 2015, p. 540).

A central critical point concerns Freudian reductionism: 'When a theory absolutizes a specific characteristic of human nature, as right as it may appear within a given logical coherence, it inevitably falls into reductionism' (Minolli, 2015, p. 34). The exaltation of the libido, assumed to be one of the great limitations of the Freudian approach, is believed to not consider the true essence of a person. There is also a failure in nurturing the environment. It seems to me that without considering the other and the experience with the other one cannot have a theory of psychopathology: everything that is essential to begin to understand human nature and psychopathology would seem to be absent in Freud's theories.

I hope that the psychoanalysts who still today follow the Freudian interpretation of hysteria have the courage to go beyond it. There are many reasons for my objection, but I would like to point out a few weaknesses that I believe require close attention. I believe that in the Freudian interpretation, there is an explanation of the world of the patient that is too simple. The patient's reality must correspond, must fit into the framework of the theory. In the Freudian view, there is a simple idea of psychopathology, which does not correspond to the complex reality of the patient.

To clarify one of the Freudian stumbling blocks, it should be highlighted that the development of female sexuality (and also that of male sexuality) does not follow the path envisaged by Freud. Firstly, I believe that it would be right to start talking about psychophysical development, bearing in mind that pathology and the formation of a human being cannot be explained via sex life alone.

I quote Daniela De Robertis: 'The concept of libido and the economic point of view are two references that Freud inherits from the historical context of his time, an expression of the positivist and physicalist epistemology to which Freud adheres' (De Robertis, 2004, p. 86). Reflecting on the concept of libido I note a contradiction at the heart of the theory of hysteria: Freud argues that the causes of the formation of hysterical symptoms are to be found in the context of psychic life, but at the same time he produces a misunderstanding that will accompany his theory forever, stating that the biological factor and sex life must explain psychic discomfort, psychic life. I believe that trauma and sexual abuse have no power in developing hysterical symptoms and that there is no direct relationship

between the symptom and the repression. Within hypnotic research (which is not psychoanalytic research) Freud noticed the sexual component of hysteria. I will now pose a few questions that I do not think the theory of libido can answer and I will criticize the foundations of psychoanalysis, highlighting its shortcomings from the very beginning. I would like to mention a position on this subject that I share: 'Freudian meta-psychology, due to the very nature of its basic constructs (such as psychic energy, drive, investment and so on) does not appear susceptible to empirical validation' (Solano, 2001, p. 231).

Now, to ask a few questions, which are useful in deconstructing the Freudian approach. How can psychopathology originate from libido? How can psychophysical development depend on libido?

Further support for my assertions about the impossibility of the libidinal factor as an explanation of hysterical symptoms has to do with another 'mistake' made by the father of psychoanalysis, that of transferring the perversions of hysterics, observed during hypnosis, to the world of childhood. The human being can pervert and both hypnotic and clinical research prove it with the discovery of incestuous desires, the Oedipus complex, etc. I believe that the concept of double fixation, both oral and oedipal, is inconsistent in hysteria, and that we cannot talk about oral and phallic hysterics.

I believe that the theory of libido was not well-founded and that it was an improper generalization. I would like to ask another question about the erogenous zones, which in the Freudian concept give rise to several neuroses. How can I determine the fixation time in a given zone from clinical practice? If such zones ever existed, I do not think that anyone could pinpoint the exact moment of fixation by establishing a starting point other than '*a priori*'. Reason leads me to strongly challenge the concept of erogenous zones. As I conclude this section, I want to add some more questions: on what criterion does Freud decide the time span of psychopathology? Where do you start? The next question to ask is: what is real, true, coherent, and concrete in Freudian theory? Based on these questions and arguments, which are fatal to the theory of libido, I think we can assume that psychic reality is very different from what Freud thought and that we need to make new contributions to psychoanalysis.

Multiple code theory and psychosomatics

Before I start examining the emotional schema by Bucci, I will briefly dwell on the construct of alexithymia (we talk about alexithymic functioning) and its direct consequences on health. In this model, a change of perspective is proposed, from a model centered on inhibition, for which the

person suppresses, inhibits, or denies emotions, to one based on the absence of words. At the heart of this approach is a defect in emotional expression as the basis of somatic disorders. According to this view, the alexithymic subject also has difficulty in identifying his/her emotions, is unable to prove them and express them, in short, he/she appears lacking in the cognitive-experiential and interpersonal dimension while somatic disorders are present.

The word a-lexi-thymia is derived from the Greek: *alpha*-privative, *lexis*-words, *thymos*-emotion: lack of words for emotions. The person, therefore, has no words for emotions, or rather cannot express them.

'Alexithymia is conceptualized as a disturbance of affective regulation' (Solano, 2001). The different physical and mental disorders (the model of psychopathology) are characterized by poor emotional expression, or by excessive levels of expressed emotion. At its core is an insufficiently elaborated, thought-out, 'digested' emotion that can lead to inhibition of emotional expression, or shortcomings in emotional regulation. According to Luigi Solano, 'while not making explicit reference to the concept of alexithymia, Wilma Bucci proposed a model of construction of emotional patterns that implies the possibility of interrupting or blocking connections within them due to deficiencies in the primary care relationship' (Solano, 2001, p. 212).

Porcelli also makes a similar point: 'For those familiar with psychosomatic literature it will be evident that this model is very close to the alexithymia construct and the concept of 'affective dysregulation' if the term alexithymia can be translated as 'emotions without words', the Bucci somatization model can be described as 'somatic states without symbols' (Porcelli, 1997, p. 152).

At first, Bucci developed an evolutionary model, called 'dual code theory', which was later replaced by 'experience processing theory,' also called 'multiple code theory.' The author extends the solid Freudian basis (primary and secondary thought) to include three (and not two) systems of thought.

In the 'experience processing theory', the activity of the mind is the result of three distinct systems of information storage and organization, that take shape progressively over the course of development. The child, in order to form his/her own emotional patterns depends on the other, whose presence serves as an organizer of his/her symbolic life. According to Bucci, emotional, affective, and sensitive patterns begin to form within non-verbal systems and have the characteristic of always being active, making parallel processing of information possible. The codes for processing the information and categories of experience are: i) Non-symbolic non-verbal system (pre-symbolic): the way in which this system operates differs from the other two systems. The pre-symbolic system is of a continuous, non-categorical nature; ii) symbolic non-verbal system: at this

level of organization and thought functioning, symbols are images and can be organized into schemas. The symbols in this model are discrete entities and can be categorized and combined into an infinite number of meaningful possibilities; iii) symbolic verbal system: the code of language and logic. In the Bucci model, words are symbols that can be combined in an unlimited number of ways. The verbal system stores information and organizes itself according to the rules of language and formal logic. Therefore, words are used to organize and communicate with others and ourselves, to direct and regulate behaviour. The functioning of this system can be considered analogous to that of Freud's secondary process thinking.

Solano makes another point: 'the multiple code theory derives from current cognitive models but goes further in that it emphasizes the role of emotions in human cognition and the complex aspects of the tradition of emotional experiences in verbal forms.' In this paradigm, emotions are seen as image-action patterns and are distinguished from other cognitive patterns as being partially dominated by motor and visceral processing systems. The non-verbal and verbal systems, with their specific organizational principles, are linked to each other via referential connections. The referential process aims to be a measure of the referential cycle, connecting analogue content, in parallel, of non-verbal systems with the 'single-channel' symbolic, sequential format of the verbal code. According to Bucci, normal emotional development depends on integrating somatic, sensory, and motor processes into emotional patterns, and failure to do so causes emotional disturbances. The deepest level of dissociation implies the lack of formation of these connections from the beginning. Bucci speaks of a block of connections within non-verbal patterns or between non-verbal representations and words. 'Bucci (1997b) proposes that the state of alexithymia may imply a dissociation between the analogue global emotional representations present mainly in the right hemisphere and those encoded by images and words present in the left hemisphere' (Solano, 2001, p. 227). She argues that all forms of somatization involve dissociations at different levels of severity between somatic and motor activation patterns and the symbolic representation of objects within emotional patterns. Normal emotional development depends on integrating somatic, sensory, and motor processes into emotional patterns, so it is the failure of this integration that is responsible for emotional disorders. Syndromes such as hypochondria and hysterical conversion involve focusing on particular body organs that are damaged and that a particular bodily area acts as a symbol that organizes the emotional pattern when the primary object of the pattern is dissociated at the service of the defenses. Hysterical symptoms concern a more extensive pre-symbolic activation of traces in visceral, motor and sensory representations. According to Bucci,

somatic symptoms and behaviours may be seen in some cases as adaptive and progressive.

We see the direct application in clinical practice with repercussions in the analysis room. Consider my objections to empirical research: in this case, we have the absolutization of the concept of alexithymia and emotional dysregulation, which tend to extend across to give clinical practice the key to understanding all somatic and mental pathology. It is clear that there is undue generalization. From my experience, I can disconfirm this clinical model. The way in which research is conducted, with simple hypotheses that assume unlimited explanatory powers in relation to psychopathology, leaves me perplexed.

There is a positivist epistemology that dominates the research: even the Bucci model does not depart from it. Ours is a time of complexity and a cause-and-effect type of explanation is not without consequences for psychotherapy.

Consistent with this model of healthy and psychopathological development, the psychotherapist assumes the function of a new primary object for the patient. Following this model, therapy then consists of repairing emotional dissociation and reconstructing dissociated emotional patterns. In this approach, the somatic symptom is attached to emotional meanings (in truth there is no development of emotional meaning, but rather a cognitive one of cognitive patterns, as the symptom is not under the control of consciousness, without meaning per se). The bodily symptom of the adult patient in the 'here and now' is taken back to 'there and then'; the therapist must repair the childhood deficiency, and to do so he/she goes to focus the treatment intervention in the 'there and then' of the patient's trauma, but in this way, psychophysical health is not restored. The Bucci model cannot be followed as a general psychopathology model.

After much thought, I will explain my thinking on psychophysical discomfort (not physical and mental discomfort): it must be inserted into an evolutionary process; there is not only a physical development (weight, height, that is, the body) but most importantly a psychophysical development. An identity-building process is being formed. Every formation of the being requires a very long period, which is why a single or cumulative trauma, a defect in emotional expression as the basis of somatic disorders, cannot explain psychopathology. A minor pathology can become a major one.

In my conceptualization, content has a role that should not be overlooked in clinical practice, it outlines identity as a whole. I will use a metaphor, that of a tree. The branches of the tree are the behaviours that are most easily seen, in which also the physical symptoms are present; the branches are attached solidly to the trunk which becomes an integral part of our Ego, which in turn is rooted underground, the deepest part. But there is only one tree.

Hysteria in the DSM-5

I think it would be useful to begin dealing with this section by referring to some of the criticisms of the DSM-5.

'The DSM is a diagnostic manual, and in medicine, diagnosis means identification of a disease and possibly its causes. In psychiatry, since the causes of mental disorders are not known, the concept of diagnosis refers only to the first part of the definition of a disease' (Porcelli, 2014, p. 432).

'The forms of discomfort that psychiatry has always sought to determine and describe continue to undergo redefinitions and relocations in the nosography framework and this is true for hysteria too. In the DSM-5 the choice was made not to use the term in the classification of disorders, and this is consistent with the intention of making the manual an exclusively descriptive tool, with objective criteria, detached from any theoretical conception' (Fontana, 2015, p. 85).

'However, it tries to be as 'atheoretical' as possible, it is clear that the need to maintain the diagnosis at the lowest level of theoretical interference in explicit terms of observable disorders is not ideologically neutral since it presupposes a dichotomy between what is medical (*i.e.*, organic) and what is not (*i.e.*, psychological) falling once again into the old mind-body dualism' (Porcelli, 2014, p. 436).

According to Migone (2013), the 'atheoretical' approach of adhering to the descriptive criterion alone is a key aspect of the DSM-III, DSM-IV, and also DSM-5. The atheoretical approach of the DSM is to put aside aetiopathogenic theories by entrusting the diagnosis of psychopathological disorders exclusively to the symptoms observed by the clinician. For this reason, the DSM-III, among other things, had to eliminate the terms hysteria and neurosis, because they were too connected to theoretical hypotheses, for example, psychoanalytic ones. The 'atheoretical' approach has also been maintained for somatization disorders.

According to Fontana, the turning point occurred in the transition from the DSM-II to the DSM-III, because the former still contemplated hysterical conversion neurosis, dissociative neurosis and hysterical personality. Charcot, Janet, Bernheim, and Freud made a huge contribution to the world of hysteria. I believe it is one of Freud's great merits that he took these patients seriously with the intent to understand their discomfort.

Many physical symptoms belonging to dissociative personality disorder, obsessive-compulsive disorder, hypochondria, borderline disorder and other disorders were included in the grand hysterical attack, leading to diagnostic confusion which included epileptic seizures within these hysterical symptoms.

Gabbard states: 'In modern psychiatry there is a broad consensus that hysterical conversion symptoms and hysterical personality disorder are

not related clinically nor psychodynamically. Although conversion symptoms may be found in patients with hysterical personality disorder, they may also be present in several other character diagnoses.' (Gabbard, 2015, p. 540).

Gabbard also states that many physical symptoms are common to several mental disorders, but others are typical of a form of psychopathology.

In hysteria, psychic suffering is manifested in a specific way via somatization. We are in the presence of a body that expresses psychic discomfort in the 'here and now' via somatization.

Freud wrote: 'In the patients I analysed there was mental health until their Ego had been presented with an experience, a representation, a feeling that had such a painful affection, that the subject had decided to forget, convinced that he/she did not have the necessary strength to resolve it, with mental effort, the existing contrast between this incompatible representation and the Ego' (Freud, 1894, p. 123).

Freud senses that symptoms do not occur spontaneously and that they depend on pathogenic psychic formations, representations that are considered as a foreign body to Consciousness. Somatic physical symptoms play a valuable role, they indicate, with certainty, the presence of psychopathology, of mental discomfort.

There is a persistent state of anxiety. These are patients who sleep little, they suffer a lot, there is chronic fatigue at the end of each day. They often ask for help for their somatic symptoms, such as pain and paralysis of a limb. They have concerns, disabling fears. One of my very distressed patients exclaimed: 'my greatest fear is to go crazy'.

At this point in my work, I would like to focus on the theory of hysterical conversion.

In the Freudian view, the conversion mechanism indicates a linear cause-and-effect process, that is, the sum of excitement, which is a biological force, can be deflected, transformed into something somatic, but not eliminated. I notice that there is no process, there is a pathological representation that is fixed in the past, in itself, that returns after years producing a symptom.

I argue that it is not enough for the DSM-5 to state that all diseases are multifactorial, or to deny the psychological factor as an explanation of psychopathology in favour of the biomedical factor.

In the paradigm of psychiatry, which is referenced in the DSM-5, the physical symptom is considered the 'identification of a disease'. In medicine it is sufficient to give weight only to the physical symptom, without the need for a total understanding of the disease/psychopathology; this scientific position has at least two effects on psychiatry: it is not immune from diagnostic errors, and it cannot think of healing the various symptoms only with a drug. Medications only relieve symptoms, but they cannot cure psy-

chopathology. Definitive cessation of symptoms is not achieved with pharmacological therapy.

Since the psychopathological reality is the same, regardless of the different theoretical settings, I argue that there is a need for collaboration between psychoanalysis and psychiatry, and I would say also with similar disciplines such as neurology, neurobiology, neuropsychiatry, *etc*., with the aim of improving theoretical understanding and knowledge of psychopathology with positive implications on clinical work.

The psychoanalytic diagnosis, histrionic personality disorder

In this last part of my work, I will devote myself to the contribution of N. McWilliams (an unsurpassed psychoanalyst in many ways). She describes the hysterical personality disorder. Hysterics are sociable, hypersensitive, their sensitivity appears superficial and exaggerated. When expressing emotions, they often give words a dramatic, inauthentic character, and their feelings can change rapidly (hysterical emotional lability). These patients have a high degree of anguish, and their feelings can change rapidly. However, they may be affectionate people who are interested in others. They are frequently seductive and manipulative, suggestible, easily influenced by the opinions of others. They are prone to performing, albeit unconsciously they may be ashamed of their own body, they tend to be the centre of attention while feeling subjectively inferior to others. In hysterical people, acting out is generally counterphobic: they approach what they unconsciously fear, such as enacting seductive behaviour when they fear sex. People with hysterical structure, given their intense temperament, which is strongly exposed to overstimulation, are easily overwhelmed. The Psychodynamic Diagnostic Manual (PDM) 1 (2006) also goes in the same direction: patients with hysterical personality disorder are concerned about gender, sexuality and power issues. They consider themselves fragile, flawed because of their sexual gender, placing little value on people of the same sex, while people of the other sex are powerful and exciting. They use sexuality, the only power they think they have, not expressively but defensively; women fear men and their abuse of power, it is not easy to enjoy sexual intimacy with them, and it is possible that they suffer from vaginism and the absence of orgasm. Hysterics are not apathetic and indifferent, they are able to fascinate others and they fear intrusion, exploitation and rejection.

According to my clinical research, a central dynamic of hysteria is as follows. The hysteric patient, on a deep level, has a fragile, weak, needy self-image, and a strong, powerful, destructive image of the other sex, which creates a difficulty in maintaining deep, lasting and satisfying relationships. In my opinion, behind the ‘theatricality’ of the hysterical patient,

behind his/her omnipotence, on a deeper level (the unconscious identity) there is an insatiable need for attention and affection (receiving love, continuous requests to be wanted, to be received), a constant and exasperated search for the satisfaction of these absolute and exasperated needs that moves the whole being as if it were asking the other 'look at me and let me exist.' This is not under conscious control. It is important to understand that behind the acting and the impressionistic style, there is an extreme and totalizing loneliness to fight. We know from research that hysterics devalue people of their own sex and idolize the other sex.

Now I will look at the causes of the development of hysteria according to the McWilliams approach. The author, using the stories of patients as a starting point, focuses on certain causes that increase the likelihood of developing a hysterical personality. Common hysterogenous situations are families where the female child is aware of the preference that one or both parents have for her brother or perceives that her parents would have wanted a son. The child may also become aware that the father and other males in the family have much more power than the mother, herself and her sisters. As the child grows up, she notices that her father is distancing himself from her and seems to feel uncomfortable with the development of her sexuality. As a result, she feels rejected because of her sex but also perceives that femininity has power over men.

It has also been observed that the fathers of many hysterical women were both threatening and seductive. An affectionate father who at the same time intimidates his daughter is an exciting object, but frightening at the same time and this creates a kind of approach-avoidance conflict. The child will learn that people of the same sex as her have less value. An additional external cause contributing to the formation of the internal hysterical structure, and increasing the greater spread of hysteria in women, is attributed to two factors: 1) in all cultures, men have more power than women. 2) in all cultures, men are less involved in the primary care of their children and their absence makes them more exciting, more idealizable compared to women.

The different predictive risk factors, which I have just summarized, are what in McWilliams' conception determines hysterical personality disorder. Indeed, all family and cultural circumstances proposed by McWilliams are generally conducive to the onset of psychopathology. Among the factors that promote the development of a hysterical personality, the cultural factor is the most decisive. In my view, this logic is based on linear, external and one-directional randomness, while I believe that the specific causes always make the outcome uncertain and that the precise effects cannot be predicted: by this, I mean that the form of psychopathology depends on the subject above all else. In my conceptualization, there is a free and active subject, not a passive one. Psychopathology should never be sought in

trauma, no matter how traumatic and devastating the experience has been. My hypothesis is that in living conditions there is nothing from the outside that determines the form of psychopathology, but this can determine the initiation of psychopathological processes. I infer that in the family conditions proposed by McWilliams, we may have a hysterical functioning (personality disorder) in the future, but it may not develop. Based on clinical research, the effect cannot be hypothetically established, that is, the prediction of the result is hypothetical. I think the laws of probability cannot explain psychopathology with certainty, not least because the relationship can never be random, direct and unilateral. I argue that hereditary disposition, the cultural factor, and the sexual factor, must be relativized and placed in the background.

It seems that McWilliams gives more importance to female hysteria. Today, as has always been the case, I believe, you can find this form of malaise even in men. Partly because anthropologically and culturally the distinctions between male and female are diminishing.

Conclusions

The theories are based on epistemic assumptions, that is, the way in which our knowledge is formed. Positivism believes that reality is the repository of truth. The Maestro Freud wanted to achieve rational detachment of knowledge, which in my opinion explains the neutrality in the analysis room in relation to the patient. The stakes are high: it is the method of knowledge itself.

We know how Freud defended his theory of libido: those who thought differently from him were expelled from the psychoanalytic association. I would just like to mention, for example, one of Freud's famous counterparts, Jung, who criticized these theories by suggesting that we should not absolutize libido. I also quote Daniela De Robertis: 'For Freud, who focuses everything on libido as a quantitative measure relevant to the energy of the drives, all the investments through which the individual relates and participates in the world come from unloaded, repressed or sublimated pulsional drives' (De Robertis, 2004). The theory of libido had to be all-encompassing, thus also explaining psychosis, but in truth Freud never worked with this type of patient. Knowing how to keep in mind which theory guides us when we work with the patient, what the underlying epistemology is, and the author's 'Weltanschauung' [worldview], allows us to avoid absolutizing theories and to be critical of their conclusive ideas. Partly because as Minolli writes: 'Theory is like a lighthouse in the night, it helps keep the course and guides us in the sea during a storm' (Minolli, 2009, p. 68).

I believe that Freudian meta-psychology by its very nature (organizing

principle: libido) has never been adequate in explaining health and psychopathology.

Another consideration relates to empirical research, in particular research that is limited to geometric and mechanical measurements of scientific knowledge, in accordance with Cartesian metaphysical methodology. The first step that research needs to take is to get out of the cause-and-effect logic. This type of causal research does not answer the complex laws of development.

The above observations lead me to believe that the old positivist paradigm is strongly present in empirical research (including psychoanalytic research) in general and that it continues to reduce reality through its manipulative measurements, which consequently give us a false, illusory result of the experiment; it is untrue because the patients who undergo the experiment behave differently compared to real life. In this type of research that breaks down variables, human complexity is not taken into account and the data results will always be invalidated. It is a matter of concretely counteracting the old method of research, and this is convenient for research, since positivism and simple determinism do no clinician any good because they are reductive. Psychopathology cannot be dismissed with a linear explanation.

Edgar Morin (1982) famously cites human complexity and invites us to broaden our knowledge horizons. Morin and others who refer to human complexity, urge the various disciplines to revise their knowledge. According to this author, each discipline should question its own dogmas, and this represents an open challenge for the scientific community within psychoanalysis.

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