

Women And Hysteria In The History Of Mental Health

Cecilia Tasca¹, Mariangela. Rapetti^{1,2}, Mauro Giovanni Carta^{2*} and Bianca Fadda¹

¹Dipartimento di Storia, Beni Culturali e Territorio, Università di Cagliari, Italia

²Department of Public Health and Clinical and Molecular Medicine, University of Cagliari, Italy

Abstract: Hysteria is undoubtedly the first mental disorder attributable to women, accurately described in the second millennium BC, and until Freud considered an exclusively female disease. Over 4000 years of history, this disease was considered from two perspectives: scientific and demonological. It was cured with herbs, sex or sexual abstinence, punished and purified with fire for its association with sorcery and finally, clinically studied as a disease and treated with innovative therapies. However, even at the end of 19th century, scientific innovation had still not reached some places, where the only known therapies were those proposed by Galen. During the 20th century several studies postulated the decline of hysteria amongst occidental patients (both women and men) and the escalating of this disorder in non-Western countries. The concept of hysterical neurosis is deleted with the 1980 DSM-III. The evolution of these diseases seems to be a factor linked with social “westernization”, and examining under what conditions the symptoms first became common in different societies became a priority for recent studies over risk factor.

Keywords: History, Hysteria, Mental Health, Psychiatry, West, Woman.

INTRODUCTION

We intend to historically identify the two dominant approaches towards mental disorders, the “magic-demonological” and “scientific” views in relation to women: not only is a woman vulnerable to mental disorders, she is weak and easily influenced (by the “supernatural” or by organic degeneration), and she is somehow “guilty” (of sinning or not procreating). Thus mental disorder, especially in women, so often misunderstood and misinterpreted, generates scientific and / or moral bias, defined as a pseudo-scientific prejudice [1].

19-20th centuries’ studies gradually demonstrate that hysteria is not an exclusively female disease allowing a stricter scientific view to finally prevail. 20th century’s studies have also drawn on the importance of transcultural psychiatry, in order to understand the role of environmental factors in the emotive evolution and behavioral phenomenology and in modifying the psychopathology, producing the hypotheses of a modification to hysteria from the increase of mood disorders.

1. Ancient Egypt

The first mental disorder attributable to women, and for which we find an accurate description since the second millennium BC, is undoubtedly hysteria.

The first description referring to the ancient Egyptians dates to 1900 BC (**Kahun Papyrus**) and identifies the cause of hysterical disorders in spontaneous uterus movement within the female body [2, 3].

In the Eber Papyrus (1600 BC) the oldest medical document containing references to depressive syndromes, traditional symptoms of hysteria were described as tonic-clonic seizures and the sense of suffocation and imminent death (Freud’s globus istericus). We also find indications of the therapeutic measures to be taken depending on the position of the uterus, which must be forced to return to its natural position. If the uterus had moved upwards, this could be done by placing malodorous and acrid substances near the woman’s mouth and nostrils, while scented ones were placed near her vagina; on the contrary, if the uterus had lowered, the document recommends placing the acrid substances near her vagina and the perfumed ones near her mouth and nostrils [2, 3].

2. The Greek world

According to Greek mythology, the experience of hysteria was at the base of the birth of psychiatry.

The Argonaut **Melampus**, a physician, is considered its founder: he placated the revolt of Argo’s virgins who refused to honor the phallus and fled to the mountains, their behavior being taken for madness. Melampus cured these women with hellebore and then urged them to join carnally with young and strong men. They were healed and recovered their wits. Melampus spoke of the women’s madness as derived from their uterus being poisoned by venomous humors, due to a lack of orgasms and “uterine melancholy” [2-4].

Thus arose the idea of a female madness related to the lack of a normal sexual life: **Plato**, in *Timaeus*, argues that the uterus is sad and unfortunate when it does not join with the male and does not give rise to a new birth, and Aristotle and Hippocrates were of the same opinion [2-4].

The Euripidy’s myth says that a collective way of curing (or, if we prefer, preventing) melancholy of the uterus is represented by the Dionysian experience of the Maenads, who reached catharsis through wine and orgies [5]. Women

*Address correspondence to this author at the University of Cagliari, Italy; Tel/Fax: +390706093498; E-mail: mgcarta@tiscali.it

reached catharsis through wine and orgies [5]. Women suffering from hysteria could be released from the anxiety that characterizes this condition by participating in the Maenad experience. Trance status guided and cured by the Satyr, the priest of Dionysus, contributed to solving the conflict related to sexuality, typical of hysteria disease [6].

Hippocrates (5th century BC) is the first to use the term *hysteria*. Indeed he also believes that the cause of this disease lies in the movement of the uterus (“hysteron”) [2-4].

The Greek physician provides a good description of hysteria, which is clearly distinguished from epilepsy. He emphasizes the difference between the compulsive movements of epilepsy, caused by a disorder of the brain, and those of hysteria due to the abnormal movements of the uterus in the body. Then, he resumes the idea of a restless and migratory uterus and identifies the cause of the indisposition as poisonous stagnant humors which, due to an inadequate sexual life, have never been expelled. He asserts that a woman’s body is physiologically cold and wet and hence prone to putrefaction of the humors (as opposed to the dry and warm male body). For this reason, the uterus is prone to get sick, especially if it is deprived of the benefits arising from sex and procreation, which, widening a woman’s canals, promote the cleansing of the body. And he goes further; especially in virgins, widows, single, or sterile women, this “bad” uterus – since it is not satisfied – not only produces toxic fumes but also takes to wandering around the body, causing various kinds of disorders such as anxiety, sense of suffocation, tremors, sometimes even convulsions and paralysis. For this reason, he suggests that even widows and unmarried women should get married and live a satisfactory sexual life within the bounds of marriage [2-4].

However, when the disease is recognized, affected women are advised not only to partake in sexual activity, but also to cure themselves with acrid or fragrant fumigation of the face and genitals, to push the uterus back to its natural place inside the body [2-4].

3. Rome

Aulus Cornelius Celsus (1st century BC) gives a good and accurate clinical description of hysterical symptoms. In *De re medica* Celsus, he wrote “In females, a violent disease also arises in the womb; and, next to the stomach, this part is most sympathetically affected or most sympathetically affects the rest of the system [7]. Sometimes also, it so completely destroys the senses that on occasions the patient falls, as if in epilepsy. This case, however, differs in that the eyes are not turned, nor does froth issue forth, nor are there any convulsions: there is only a deep sleep”.

Claudius Galen’s theories on hysteria (2nd century AD) are comparable to those of Hippocrates. Furthermore Galen says of hysteria “*Passio hysterica unum nomen est, varia tamen et innumera accidentia sub se comprehendit*” (hysterical passion is the name, but various and several are its symptoms), highlighting the variety of hysterical events [7]. In his work *In Hippocratis librum de humoribus*, Galen criticizes Hippocrates: “Ancient physicians and philosophers have called this disease *hysteria* from the name of the uterus, that organ given by nature to women so that they might conceive [7]. I have examined many hysterical women, some

stuporous, others with anxiety attacks [...]: the disease manifests itself with different symptoms, but always refers to the uterus”. Galen’s treatments for hysteria consisted in purges, administrations of hellebore, mint, laudanum, belladonna extract, valerian and other herbs, and also getting married or repressing stimuli that could excite a young woman [2, 3, 7].

Hysterical cures are only revolutionized by **Soranus** (a Greek physician from the 1st half of 2nd century AD, practicing in Alexandria and Rome), who wrote a treatise on women’s diseases and who is considered the founder of scientific gynecology and obstetrics : women’ disorders arise from the toils of procreation, their recovery is encouraged by sexual abstinence and perpetual virginity is women’ ideal condition. Fumigations, cataplasms and compressions are ineffectual, the hysterical body should be treated with care: hot baths, massages, exercise are the best prevention of such women’ diseases [2, 3, 7].

4. Middle Ages

After the fall of the Roman Empire, Greek-Roman medical culture had its new epicenter in Byzantium, where physicians inherited Galen’s science without making any significant innovations (the most famous was **Paul of Aegina**, 625-690 AD). Sometime before, Bishop **Nestorius** (381-451 approx.), who took refuge in the Middle East in an area between today’s Iraq and Egypt, had brought with him his knowledge of classical science, contributing to the spread of Greek-Roman medicine in these areas.

The political events of the early Middle Ages caused a rupture between Christian Europe, with its *auctoritas* culture – in the hands of just a few scholars – and the Middle East of the Caliphs, where thanks to a climate of tolerance and cultural ferment, the texts of Hippocrates and Galen were translated and commented on in Arabic, becoming widespread and well-known [3].

In this context, two great scientists carry out their work : the Persian **Avicenna** (980-1037) [8, 9] and the Andalusian Jew **Maimonides** (1135-1204) [10]. Thanks to them, the legacy of Hippocrates and Galen is not only maintained, but spreads throughout Europe: the *Reconquista* of Spain (718-1492) and new contacts with the Near East bring important cultural exchanges, Avicenna’s *Canon of Medicine* and Galen’s *Corpus* are diffused along with the Latin translations ascribed to **Gerard of Cremona** (1114-1187), while Maimonides’ texts are disseminated in the Jewish world, along with other basic medical texts, thanks to translations by the Ibn Tibbon family (13-14th centuries). In particular, the medical schools of Salerno and Montpellier were vehicles for the dissemination of these works [11].

This was how Hippocratic concepts of melancholia and hysteria spread in late-medieval Europe, and in informed circles these diseases were treated according to what we shall call the “scientific” vision. In particular, this advocated the use of melissa as a natural remedy nerve comforter (melissa was considered excellent even in cases of insomnia, epilepsy, melancholy, fainting fits, etc.) [3, 12].

Besides the natural remedies, a sort of “psychotherapy” developed, practiced not only by Avicenna, but also for example by **Arnaldus of Villa Nova** (1240-1311). The latter,

considered medieval Europe's greatest physician, will be counted along with Galen and Avicenna in the inventories of physicians' libraries throughout the Modern era [13].

It is also interesting to note that in the many treatises diffused at the time (**Constantine the African's** *Viaticum* and *Pantegni*, but also the *Canon* of Avicenna and Arnaldus of Villa Nova's texts) women were often not described as "patients" to be cured but rather as the "cause" of a particular human disease, defined as *amor heroycus* or the madness of love, unfulfilled sexual desire [8].

But we cannot talk about women's health in the Middle Ages without citing **Trotula de Ruggiero** from Salerno (11th century). While as a woman she could never become a magister, Trotula is considered the first female doctor in Christian Europe: she belonged to the ranks of famous women active in the Salerno School but discredited, among others, by Arnaldus of Villa Nova [14].

Called *sanatrix Salernitana*, Trotula was an expert in women's diseases and disorders. Recognizing women as being more vulnerable than men, she explained how the suffering related to gynecological diseases was "intimate": women often, out of shame, do not reveal their troubles to the doctor. Her best known work, *De passionibus mulierum ante, in et post partum*, deals female problems, including hysteria. Faithful to the teachings of Hippocrates, Trotula was devoted to the study of women's diseases, of which she tried to capture the secrets, without being influenced by the prejudices and morals of her time, also giving advice on how to placate sexual desire: in her work abstinence is seen as a cause of illness and she recommends sedative remedies like musk oil or mint [15].

Trotula works at a time when women are still considered inferior to men because of their physiological and anatomical differences. **Hildegard of Bingen** (1098-1179), German abbess and mystic, was another female doctor. Her work is very important for the attempt to reconcile science with faith, that happens at the expense of science. Hildegard resumes the "humoral theory" of Hippocrates and attributes the origin of black bile to the original sin [16]. In her view, melancholy is a defect of the soul originated from Evil and the doctor must accept the incurability of this disease. Her descriptions are very interesting. Melancholic men are ugly and perverse, women slender and minute, unable to fix a thought, infertile because of a weak and fragile uterus [16]. In the ideology of Hildegard, Adam and Eve share responsibility with respect to original sin, and man and woman - sexually complementary - are equal in front of God and the cosmos [17].

The mainstream view of the time is one in which the woman is a physically and theologically inferior being, an idea that has its roots in the Aristotelian concept of male superiority: **St. Thomas Aquinas'** (1225-1274) *Summa Theologica* Aristotle's assertions that "the woman is a failed man" [18]. The inferiority of women is considered a consequence of sin, and the solutions offered by St. Thomas' reflection leave no doubt about what will overturn the relationship between women and Christianity: the concept of "defective creature" is just the beginning. In question 117, article 3, addressing the possibility that the human soul can change the substance, St. Thomas says that "some old women" are evil-

minded; they gaze on children in a poisonous and evil way, and demons, with whom the witches enter into agreements, interacting through their eyes [18]. The idea of a woman-witch, which we shall call the "demonological vision", almost becomes insuperable: preachers disclose the Old Testament's condemnation of wizards and necromancers and the fear of witches spreads in the collective imagination of the European population. The ecclesiastical authorities try to impose celibacy and chastity on the clergy, and St. Thomas' theological descriptions regarding woman's inferiority are, perhaps, the start of a misogynistic crusade in the late Middle Ages.

From the thirteenth century onwards, the struggle with heresy assumes a political connotation: the Church aims at unifying Europe under its banner, so breviaries become manuals of the Inquisition and many manifestations of mental illness are seen as obscene bonds between women and the Devil. "Hysterical" women are subjected to exorcism: the cause of their problem is found in a demonic presence. If in early Christianity, exorcism was considered a cure but not a punishment, in the late Middle Ages it becomes a punishment and hysteria is confused with sorcery [19, 20].

Political and religious status quo in Europe is threatened by the first humanist ideas and the Church responds by intensifying inquisitions: the apogee is reached in 1484 with the *Summa desiderantes affectibus*, Innocent VIII's Bull, which confirms the witch hunt and an obligation to "punish, imprison and correct" heretics [21, 22]. The German Dominicans Heinrich "Institor" Kramer and Jacob Sprenger are accredited with the publication of the famous Hammer of Witches, the *Malleus Meleficarum* (1486) [21, 22]. Although not an official Church manual, it takes on an official tone due to the inclusion of the papal Bull within the text. It is interesting to note that the title itself includes signs of misogyny: "Maleficarum" as witches, not "Maleficorum" as wizards... as if to say "evil is female/ evil origins from women"!

The devil is everywhere in these pages: he makes men sterile, kills children, causes famine and pestilence and all this with the help of witches. The compilers of the manual are familiar with the medicine of the age, and they investigate the relationship between sorcery and human temperaments: their descriptions rival those contained in the best psychopathology manuals [21, 22]. The text is divided into three parts and aims at proving the existence of demons and witches (warning the reader that anyone not convinced is also a victim of the Devil) explaining how to find and punish sorcery.

But what has this to do with women's health? It is quite simple: if a physician cannot identify the cause of a disease, it means that it is procured by the Devil. The inquisitor finds sin in mental illness because, he says, the devil is a great expert of human nature and may interfere more effectively with a person susceptible to melancholy or hysteria. Hysteria is considered a woman's disease, and who more than women are prone to melancholy? This disease is the basis of female delirium: the woman feels persecuted and the devil himself is the cause of this "mal de vivre", which deprives the women of confession and forgiveness, leading them to commit suicide.

Obviously, the women most affected are elderly and single, in most cases they have already been in mourning or victims of violence. Sorcery becomes the scapegoat for every

calamity and etymological explanations are also provided: for Sprenger and Krämer, the Latin word *foemina* is formed from *fe* and *minus*, that is “who has less faith”. This text is the worst condemnation of depressive illness and women to be found throughout the course of Western history: until the eighteenth century, thousands of innocent women were put to death on the basis of “evidence” or “confessions” obtained through torture [21, 22].

5. Renaissance

At the end of the Middleage, journeys along the coasts of the Mediterranean sea contributed to a quick diffusion of Greek Classics, preserved and disseminated by the Arabians.

The humanistic movement (born with Dante, Boccaccio and Petrarch) emphasized a respect for the writings of the Antiquity. During these centuries, a new realistic approach to man as a person was born, which opposed the scholastics and introduced a fresh point of view about nature and man [19].

Italian philosopher **Giovanni Pico della Mirandola** (1463-1494) espoused the principle that each man is free to determinate his own fate, a concept that perhaps more than any other has influenced the developments of the last three centuries: only man is capable of realizing his ideal and this condition can, however, be achieved only through education [23]. Pico's thesis was implemented by the Spanish educator **Juan Luis Vives** (1492-1540). His pragmatic orientation produced occasional flashes of insight; for instance, he thought that emotional experience rather than abstract reason detained the primary role in a man's mental processes: in order to educate a person it is necessary to understand the complex functioning of his mind [19].

Up to this time the medical vision of hysteria, inherited from the Hippocratic-Galenic tradition, continues to dominate [24]. At the end of the 16th century, in European countries affected by the Counter-Reformation, the theological vision tends to overwhelm the medical community. During this period the most intense activity of the Roman Inquisition, in which magic has replaced the fight against heresy, is recorded. Thus in these states, a new generation of physicians emerges, which is destined to be subordinated to inquisitors [24]. It is precisely the physician and theologian **Giovan Battista Codronchi** (1547-1628) who, by criticizing the medical therapy of the time aimed at treating hysteria, give us a detailed description of them.

Codronchi said that midwives, recalling Galenus' and Avicenna's teachings, took care of the hysterical women introducing the fingers in their genital organs in order to stimulate orgasm and semen production [24]. The physician prohibited this treatment at all, an attitude due to the concern typical of that historical phase related to sex and sexual repression. The treatment for him must be practices by the spiritual guides [24]. And if Codronchi is also a proud supporter of the existence of demons, in favour of which he argued by referring to biblical and philosophical sources, the Italian Renaissance had already tried to condemn witch hunts and to give a “scientific” explanation of mental illness: among others, **Girolamo Cardano** (1501-1576) and **Giovanni Battista Della Porta** (1535-1615) were interested in sorcery and marginality, but did not see a demonic cause in them. They identified the origin of certain behaviors in

fumes, in polluted water and in the suggestion (for Cardano) or in the acquisition of certain substances that induce “visions” and “pictures” (according to Della Porta) but both base most of their considerations on physiognomy [25]. Another important physician, the Dutch **Johann Weyer** (1515-1588) intended to prove that witches were mentally ill and had to be treated by physicians rather than interrogated by ecclesiastics [19]. In 1550 he became the private physician of the Duke William of Cleves, who was a chronic depressive. The Duke observed that witches manifested many of the same symptoms as his relatives became insane. So, he sympathizes with Weyer's theory that these women are really suffering from mental illness, but he cannot keep the witch hunter under control because of his transient psychotic episodes cause by an apoplectic stroke [19]. In 1563, Weyer publishes *De prestigiis Daemonum*, which is a step-by-step rebuttal of the *Malleus Maleficarum*. He's been called by his contemporaries “hereticus” or “insanus”, but his pages reveal that he's not rebellious but that he's a religious man [19].

However, for the doctors of that time, the uterus is still the organ that allows to explain vulnerable physiology and psychology of women: the concept of inferiority towards men is still not outdated.

Hysteria still remains the “symbol” of femininity [26].

6. Modern Age

The 16th century is a period of important medical developments, as proved by the writings of **Andreas Vesalius** (*De humani corporis fabrica*, 1543) and French surgeon **Am-broise Paré** (1510-1590).

These authors' findings are the basis of the birth of modern medical science [24], combined with the “philosophical revolution”, in which **René Descartes** (1596-1650) explains how the actions attributed to the soul are actually linked with the organs of the body, and also combined with the studies on the anatomy of the brain by physician **Thomas Willis** (1621-1675). Willis introduces a new etiology of hysteria, no longer attached to the central role of the uterus but rather related to the brain and to the nervous system [24]. In 1680, another English physician, **Thomas Sydenham** (1624-1689), published a treatise on hysteria (*Epistolary Dissertation on the Hysterical Affections*) which refers back to natural history through describing an enormous range of manifestations and recognizing for the first time the fact that hysterical symptoms may simulate almost all forms of organic diseases [19]. However, the author fluctuates between a somatic and a psychological explanation [27]. Sydenham demonstrates that the uterus is not the primary cause of the disease, which he compares to hypochondria: his work is revolutionary as it opposes the prejudices, but it will take several decades for the theory of “uterine fury” to be dismissed [26].

The scientific development does not mark a dramatic shift from a demonological vision of medicine, but progresses hand in hand with evolution of theories on exorcism. The written records tell us of several outbreaks of hysteria, the most famous of which is undoubtedly the one occurred in the village of **Salem** (Massachusetts) in 1692. The texts recall an episode in which a slave originally from Barbados talks about the prediction of fate and some girls creat a circle of initiation. This latter was formed by women younger than

twenty years of age and unmarried. The action of creating a circle of initiation was in itself an open violation of the precepts of the Puritans.

There is no record of the first stages of the disease: the girls result "possessed" since February 1692. The symptoms described were staring and barred eyes, raucous noises and muffled, uncontrolled jumps, sudden movements etc. The local doctor, William Griggs, referred the problem to the priest. The slave and two other women were summoned, and the former admitted witchcraft and pacts with the devil. Gradually they began to accuse each other. Eventually, 19 were hanged as "witches", and over 100 were kept in detention. Only when the girls accused the wife of the Colonial Governor of being part of this circle herself, the latter forbade further arrests and trials for witchcraft [27]. **Marion Starkey**, at the end of World War II, reports the case comparing it with more contemporary events [27]. Her explanation of classical hysteria is that the illness manifested itself in young women repressed by Puritanism, and was aggravated by the intervention of Puritan pastors, this leading to dramatic consequences. The incident proves thus that hysteria could be seen as a consequence of social conflicts [27].

Social conflicts do not occur exclusively in closed societies, such as small communities such as puritanical circles, but they also occur in more open and dynamic societies as big cities. In 1748 **Joseph Raulin** published a work in which he defines hysteria as an *affection vaporeuse* and describes it as a disease caused by foul air of big cities and unruly social life. In theory, the disorder can affect both sexes, but women are more at risk for their being lazy and irritable [26].

Between the 17th and 18th centuries a trend of thought that delegated to the woman a social mission started developing. If from a moral point of view she finds redemption in maternal sacrifice that redeems the soul but it does not rehabilitate the body, from the social point of view, the woman takes a specific role. In 1775 the physician-philosopher **Pierre Roussel** published the treatise *"Système physique et moral de la femme"* greatly influenced by the ideas of **Jean-Jacques Rousseau**. Femininity is for both authors an essential nature, with defined functions, and the disease is explained by the non-fulfillment of natural desire. The excesses of civilization causes disruption in the woman as well as moral and physiological imbalance, the identified by doctors in hysteria [26]. The afflictions, diseases and depravity of women result from the breaking away from the normal natural functions. Following natural determinism, doctors confine the woman within the boundaries of a specific role: she is a mother and guardian of virtue [26]. In this context, the woman-witch appears more and more an artifice to secure the social order of *ancien régime*.

The Enlightenment is a time of growing rebellion against misogyny and sorcery becomes a matter for psychiatrists: in the *Encyclopédie* we read that sorcery is a ridiculous activity, stupidly attributed to the invocation of demons. And further: mental illness starts to be framed within the "scientific view" and hysteria is indeed described in the *Encyclopédie* as one of the most complicated diseases, originally identified by ancient scientists as a problem related to the uterus. Even more interesting is the fact that the causes and symptoms of hysteria and melancholy are linked to the hu-

mor theory. Fortunately, the "demonological vision" of women's mental illness did not prevent previous medical theories from being maintained [28].

The last "witch" was sentenced to death in Switzerland in 1782, 10 years after the publication of the latest volumes of the *Encyclopédie*. Her name was **Anna Göldi**, and her memory was rehabilitated only in 2008 [29].

In the 18th century, hysteria starts being gradually associated with the brain rather than the uterus, a trend which opens the way to neurological etiology: if it is connected to the brain, then perhaps hysteria is not a female disease and can affect both sexes. But this is not such a simple shift as it may seem.

The German physician **Franz Anton Mesmer** (1734-1815) found in suggestion a method of treatment for his patients suffering from hysteria, practicing both group and individual treatments. He identified in the body a fluid called "animal magnetism" and his method soon became famous as "mesmerism". Indeed, it was thought that the magnetic action of the hands on diseased parts of the body could treat the patient, interacting with the fluid within the body. Only later we realized that this was a mere suggestion. Mesmerism had subsequent developments in the study of hypnosis [30].

The French physician **Philippe Pinel** (1745-1826) assuming that kindness and sensitivity towards the patient are essential for good care, frees the patients detained in Paris' Salpêtrière sanatorium from their chains. Pinel's theory derives from ideas linked to the French Revolution: "mad" is not substantially different from "healthy", the balance is broken by the illness and treatment must retrieve this balance. Nonetheless, Pinel too considered hysteria a female disorder [19, 31]. Jean Martin Charcot (1825-1893) the French father of neurology, pushed for a systematic study of mental illnesses. In particular, he studied the effectiveness of hypnosis in hysteria, which, from 1870 onwards, is distinguished from other diseases of the spirit. Charcot argues that hysteria derives from a hereditary degeneration of the nervous system, namely a neurological disorder. By drawing graphs of the paroxysm, he eventually shows that this disease is in fact more common amongst men than women [32-36].

During the **Victorian Age** (1837-1901) most women carried a bottle of smelling salts in their handbag: they were inclined to swoon when their emotions were aroused, and it was believed, that, as postulated by Hippocrates, the wandering womb disliked the pungent odor and would return to its place, allowing the woman to recover her consciousness [34]. This is a very important point, as it shows how Hippocrates' theories remained a point of reference for centuries.

7. Contemporary Age

French neuropsychiatrist **Pierre Janet** (1859-1947), with the sponsorship of J. M. Charcot, opened a laboratory in Paris' Salpêtrière. He convinced doctors that hypnosis — based on suggestion and dissociation — was a very powerful model for investigation and therapy. He wrote that hysteria is "the result of the very idea the patient has of his accident": the patient's own idea of pathology is translated into a physical disability [35]. Hysteria is a pathology in which dissociation appears autonomously for neurotic reasons, and in such a way as to adversely disturb the individual's everyday life.

Janet studied five hysteria's symptoms: anaesthesia, amnesia, abulia, motor control diseases and modification of character. The reason of hysteria is in the *idée fixe*, that is the *subconscient* or subconscious. For what concerns eroticism, Janet noted that "the hysterical are, in general, not any more erotic than normal person". Janet's studies are very important for the early theories of Freud, Breuer and Carl Jung (1875-1961) [35, 36].

The father of psychoanalysis **Sigmund Freud** (1865-1939) provides a contribution that leads to the psychological theory of hysteria and the assertion of a "male hysteria". Freud himself wrote in 1897: "After a period of good humor, I now have a crisis of unhappiness. The chief patient I am worried about today is myself. My little hysteria, which was much enhanced by work, took a step forward" [37]. In 1889 he published his *Studies on Hysteria* with **Joseph Breuer** (1842-1925). The key-concepts of his psychoanalytical theory (the influence of childhood sexual fantasies and the different ways of thinking of the unconscious mind) have not yet been formulated, but they are already implicit in this text. Among the cases presented, we find the hysteria of the young Katherina, who suffers from *globus hystericus*. The text does not refer to the famous *Oedipus complex*, which emerges through the study of male hysteria, developed after this treatise [36-38].

We now reach a crucial point: until Freud it was believed that hysteria was the consequence of the lack of conception and motherhood. Freud reverses the paradigm: hysteria is a disorder caused by a lack of libidinal evolution (setting the stage of the Oedipal conflict) and the failure of conception is the result not the cause of the disease [36-38]. This means that a hysterical person is unable to live a mature relationship. Furthermore, another important point under a historical point of view is that Freud emphasizes the concept of "secondary advantage". According to psychoanalysis the hysterical symptom is the expression of the impossibility of the fulfillment of the sexual drive because of reminiscence of the Oedipal conflict [36-38]. The symptom is thus a "primary benefit" and allows the "discharge" of the urge - libidinal energy linked to sexual desire. It also has the "side benefit" of allowing the patient to manipulate the environment to serve his/her needs. However, it is a disease of women: it is a vision of illness linked to the mode (historically determined) to conceive the role of women. The woman has no power but "handling", trying to use the other in subtle ways to achieve hidden objectives. It is still an evolution of the concept of "possessed" woman [37, 38].

During 19th Century, description of hysteria as a variety of bodily symptoms experienced by a single patient is labeled Briquet's syndrome. In 20th Century several studies are based on a particular presentation of hysteria's symptoms: a loss or disturbance of function which does not conform to what is known about the anatomy and physiology of the body, as loss of speech but not of singing. Psychiatrists note that any function of the body can be affected by hysteria [34].

An analysis of the framing of these diagnoses in British medical discourse c. 1910-1914 demonstrates that hysteria and neurasthenia, although undergoing redefinition in these years, were closely connected through the designation of both as hereditary functional diseases. Before the war these

diagnoses were perceived as indicators of national decline. Continuity, as well as change, is evident in medical responses to shell-shock [38].

The identification of hysterical fit, according to Pierre Janet's theories, was for a long time considered impossible: an example of this diagnostic dilemma is provided by the **Royal Free Disease**, an epidemic of neurological, psychiatric and other miscellaneous symptoms which swept through the staff of the Royal Free Hospital in London between July and November 1955 and which affected a total of 292 members of staff. In the Medical Staff Report it was concluded that an infective agent was responsible [34]. In 1970 **McEvedy** and **Beard** put forward an alternative suggestion that Royal Free Disease was an epidemic of hysteria (for example the sensory loss affected a whole limb or part of a limb but the pattern rarely followed the distribution of nerves to the skin) and also pointed out that the spread of the symptoms, predominantly affecting young female resident staff, is characteristic of epidemics of hysteria, which usually occur in populations of segregated females such as girl schools, convents and factories. They wrote also that hysteria had a pejorative meaning in their society, but that should not prevent doctors from weighing the evidence dispassionately [34].

Besides defining the nature of hysteria, 20th Century psychiatrists also considered its history and geography. During **World Wars** hysteria attracted the attention of military doctors, and several authors have recorded their impressions on the frequency of hysteria in this period. Under battle conditions, the way in which hysterical symptoms provide a solution for emotional conflicts is particularly clear. A soldier torn between fear of facing death and shame at being thought a coward may develop a hysterical paralysis of his arm, sickness being a legitimate way out of the conflict [34]. For instance, in 1919 **Hurst** wrote that "many cases of gross hysterical symptoms occurred in soldiers who had no family or personal history of neuroses, and who were perfectly fit". In particular, in 1942 **Hadfield** commented that the most striking change in war neurosis from World War I to World War II was "the far greater proportion of anxiety states in this war, as against conversion hysteria in the last war" [34]. But World War II not only allowed for a comparison with World War I in terms of patterns of neurotic symptoms, but also became an opportunity for cross-cultural comparisons between troops from widely differing **cultural backgrounds** [34].

Abse's studies (1950) on hysteria in India during World War II demonstrate that, 57% of the 644 patients admitted to the Indian Military Hospital in Delhi during the year 1944, were diagnosed as suffering from hysteria and 12% were diagnosed as suffering from anxiety states. Abse also collected data from a British Military Hospital in Chester (June to October 1943) and he demonstrated the existence of a majority of anxiety states (50%) than hysteria cases (24%) [34].

Others studies confirm these data. In particular, in 1950 **Williams** demonstrated that Indian hysterics were often of high morale and were of all grades of intelligence, whereas among the British, gross hysterical reactions were the breakdowns of men with low stability and morale and usually of low intelligence [34]. Moreover, these studies demonstrate that from World War I to World War II there was a small relative decline of hysteria among British soldiers which was

paralleled by a relative rise in anxiety states and by contrast, hysteria was still the most common form of neurosis among Indian soldiers in World War II. The contrasting patterns shown by soldiers suggest that hysteria and anxiety neurosis bear a reciprocal relationship, so that the decline of the former is compensated for by a rise in the latter [34].

But this also seems to demonstrate a different progress of hysterical disease in Western and non-Western societies. In the second half of the 20th century, we witness a “decrease” of hysteria (as response to stress, which represents the patient concept’s of bodily dysfunction) in western societies. Data of annual admissions for hysteria to psychiatric hospitals in England and Wales from 1949 to 1978 show that they are diminished by nearly two-thirds, with a marked decline in the proportion from 1971 onwards, and a similar decrease is recorded in a study conducted in Athens as well [34]. Hysteria was in fact a major form of neurotic illness in Western societies during the 19th Century and remained so up to World War II. Since then there appears to have been a rapid decline in its frequency and it has been replaced by the now common conditions of depressive and anxiety neuroses.

But the studies focused on Indian patients as well as on others non-Western countries as Sudan, Egypt and Lebanon [34] demonstrate that during the second half of 20th Century hysteria, as one of the somatic ways of expressing emotional distress, remained a prominent condition among psychiatric patients, although anxiety and depressive neuroses may have gained a little ground. Hence, psychiatrists supposed that it was an unstable transitional phase and predicted the disappearance of hysteria by the end of 20th Century [34].

There seems to be an inverse relationship between decreasing of hysteria and increasing of depression in Western society. The idea that depression was more likely to manifest itself in those born after the Second World War has been suggested in 1989 by **Klerman** [39]. More recently it has been documented by studies repeated over time in America and Australia, although there are exceptions in specific areas in relation to specific socio-environmental conditions and migration [40-44].

A systematic review of misdiagnosis of conversion symptoms and hysteria, based on studies published since 1965 on the diagnostic outcome of adults with motor and sensory symptoms unexplained by disease, demonstrate that a high rate of misdiagnosis of conversion symptoms was reported in early studies but this rate has been only 4% on average in studies of this diagnosis since 1970 [45]. This decline is probably due to improvements in study quality rather than improved diagnostic accuracy arising from the introduction of computed tomography of the brain [40].

We know that the concept of hysterical neurosis is deleted with the **1980 DSM-III**: hysterical symptoms are in fact now considered as manifestation of dissociative disorders.

The evolution of this disease seems to be a factor of the social “westernization”. Several studies on mental diseases seem to validate this hypothesis. In 1978 **Henry B. Murphy** (1915-1987) [46] individuated the main causes of melancholy in social change and consequent socio-economic changes. A picture characterized by self-blame feelings, low

self-esteem and helplessness. These features were described as being due to a rapid social change in two different social theatres: in those areas of England interested in turning the feudal economy into an industrial one at the centre of one at the end of the 17th century, and more recently in some areas of Africa affected by rapid economic development. In both cases the onset of psychopathological symptoms has been related to two main factors: on the one hand, the disruption of an enlarged family and the loss of a close emotional support for the individual, and on the other hand by a marked striving towards economic individualism. In this new psychological and external contest destiny and future will no longer be determined by fate, but men build their own destiny, an unknown and hard responsibility towards life [47]. In 1978 Murphy wrote that in Asia and in Africa these symptoms are rare, except among the Westernized persons, and that it could be useful to examine under what conditions these symptoms first became common in different societies [46].

From the expression of discomfort "hysteria" to the expression of discomfort "melancholy" the different conception of the self is essential. The world of hysterical manifestation is a world of "dissociation": something dark (trauma, external influences) affects a symptom not directly interpretable. From here the development in the West of hypnotic therapies (up by Mesmer to Freud and Janet) [36] and, in the West more than in non-Westernized world, it is the implementation of exorcism and purificatory rituals that mark the meeting with the groups: **Tarantism** and **Argia** in South Italy [47], **Narval-Wotal** practices of West African immigrants [48-52]. A world linked to a vision of women as a means unaware of evil forces, "out of control" from reasonableness or (in European Positivism) be an "immature" with manipulative behavior that seeks to achieve an improper position of power. Also the world of Melancholy is female, predominantly female since women suffer from depression at a ratio of 2.5 to 1 compared to men [48, 43]. But it is a reality in which, indeed, the patient (and therefore the patient woman) is aware of the conviction-conquest of being the master of its own destiny (and therefore to blame for their failures). We can see this passage in 1980s Africa.

Modern Africa is characterized by a variety of different economic and social situations which are not easy to compare, but in which urbanization and the progressive loss of tribal links is a common trend. In recent years several research projects concerning the transformation of psychopathology, based on African populations and African Immigrants in Sardinia, Italy, confirmed Murphy’s hypotheses on the role of social change and its socio-economic consequences in the genesis of a depressive symptomatology [48]. Studies involved populations in which traditional social structure still survives and which have just marginally been affected by social changes; populations undergoing a rapid change towards economic individualism, although these have now become a rarity in modern-day Africa; populations whose traditional social structures and underlying human relationships have been able to compromise and face the processes of partial change by actively adapting to the new realities [48]. The starting point is the distinction between the **character of African psychopathology**, the prevalent form of which is characterized by ideas of reference, persecutory delusions and psychosomatic symptoms, and the “western” depression,

which involves self-guilt, unworthiness and suicidal conduct. The "Westernization" of the pathology is expressed through the changing of symptoms, from African to West models. A detailed analysis of the African community surveys revealed in the Bantu area the existence of populations characterized by a psychopathological risk similar to the one highlighted in westernized settings such as among the women in Harare who presented a yearly prevalence rate for anxiety and depressive disorders. A psychosocial key - confirmed by several studies - may suggest that maintaining close links with the group of origin can play a protective role against mood-related disorders [48].

Several studies identify the existence of two counterposed means of expressing depression which are most likely "culturally determined" from a "different level of westernization" [42]. Researchers in transcultural psychiatry suggest that social factors may influence the modification of the melancholic phenomenology and modulate the risk of depression [53-55].

A survey on the **Dagon Plateau** conducted amongst farmers and nomadic Fulani herdsmen in **Mali**, reveals a very low frequency of depression and depressive cadres that are exclusively linked to secondary reactions of serious somatic disease in illiterate individuals [50]. In addition, the psychopathology over the Plateau is manifested with two opposing syndromic lines, first the constellation of symptoms of persecution, psychosomatic and psychastenia, loss of interest in things, syndrome guilt, sadness, suicidal ideas. This is typical of educated individuals [51].

A study carried out in the Namwera area in **Malawi** on the Mozambique border, during a deep **micro and macro-social transformation** which led to the establishment of a multiparty form of democracy following popular referendum, demonstrates that an emotional earthquake was caused by the conflict in having to choose between innovation and tradition. This situation in fact flew into a full-blown epidemic of hysteria among young women [48]. In the above context, in 1988, a dress factory, financed through an Italian co-operation, had been established in a village populated by the Yao and Chicewa groups, characterized by an agricultural economy. The project was articulated in order to allow women to redeem the equipment following a training period and set up independent activity [48].

In view of the particular condition of women in these cultures, this sudden passage from a traditional female role to a more independent activity seemed to be particularly suited for a study of the relationship between personal transformation and psychopathological changes. The study was carried out using three samples of age-matched women: dressmakers, farmers/housewives (traditional role), and a group of nurses and obstetricians [48]. The history of their development, including the presence of stressful events and other risk factors, together with the degree of satisfaction with their jobs and married life and other socio-anagraphic variables, was investigated by means of a specifically validated interview [51].

The choice of an innovative occupation (dressmaker/nurse) could be read as an adaptive answer in order to survive. Innovative occupations were source of satisfaction as job in itself, but they were causes of serious interpersonal and couple con-

flicts, linked to the new woman role and job. Housewives and dressmakers were more dissatisfied with their situation than nurses and they presented an increased number of psychopathological symptoms and the number of depressed subjects diagnosed according to DSM-III-R was higher [48, 51].

Housewives also experienced an increased frequency of psychosomatic symptoms, such as headache, excessive fatigue, feelings of worthlessness, and often reported suffering from the conviction that people did not recognize the importance of their role, and that someone could affect their health which is interpretable as an external localization of the source of their distress, in according to the character of African psychopathology. [48, 51] On the other hand, dressmakers showed a high frequency of depressive symptoms, problems about self-esteem, belief of social uselessness and suicidal thoughts [48, 51].

In a characteristic manner the suffering women also differed in the attribution of the causes of their discomfort. The "entrepreneurs" believed that the cause of their suffering had to be sought in their mistakes, the traditional women attributed to "evil spell" their ailments [51].

Among the three groups, nurses showed the highest frequency of psychological well-being and emotional stability. This should be interpreted as the result of good integration into a new identity due to a job related to a women's traditional role and to satisfaction about financial stability. Without drastically breaking with tradition, according to several psychosocial lines, a cultural institution such as an innovative job is perceived by both society and the individual as being an integral part of the evolving self, and it creates conditions for cultural transmission to go on. This interpretation explains why nurses did not suffer from conflicts between tradition and innovation, while dressmakers, whose new individualistic role broke with women's traditional one, did not feel accepted by their group and were consequently more vulnerable to mood disorders and particularly to depression, a "western" depression [48].

Instead, in populations which were far removed from the processes of westernization depressive disorders were relatively rare and nearly always secondary to severe somatic disorders, while they manifested themselves as primary disorders only in better educated subjects [48]. Several studies demonstrated that the threshold of onset of depression is situated on a higher level compared to western cultures and tend to support the hypothesis of a means of expression characterized by syndromic aggregations halfway between "western" style or "guilty" and "traditional" or "dislocation from the group". Environmental factors seem to affect the evolution of depressive symptoms and risk of depression, through modifications in the social organization that elicit an attitude of "compulsive self-responsabilization" which would otherwise have been destined for extinction [48].

8. Focus on Sardinian Modern Cases

We should like to conclude by discussing some Sardinian cases which seem to contradict what has been said above: in modern times, they apparently document the continued use of Hippocrates' and Galen's ancient medical theories in relation to hysteria.

THE MANAGU HOSPITAL IN SIDDI, SARDINIA, ITALY

This small rural hospital, which was open from 1860 to 1890 in the small village of Siddi (in the heart of the Marmilla area, Sardinia) admitted 463 patients, the subject of our recent research. 122 were women (mainly peasants, maids and housewives), and of these, 10 were suffering from hysteria (sometimes the diagnosis was simple hysteria, on other occasions they were suffering from convulsions, constipation, intermittent fever...) [56]. In analyzing the simplest cases, where the hysteria was not combined with other diseases, we found the constant use of antispasmodics, sedatives and refreshing concoctions in the form of decoctions, infusions, creams, ointments and poultices. First of all, a decoction of tamarind and barley, extract of belladonna, valerian and liquid laudanum. Following this, infusions of fennel, mint and orange flowers, chamomile flowers and lime, cassia pulp and elder-tree ointment [57]. Only in one case (1868) was additional treatment prescribed in the form of polenta poultices, sulphates of potassium iodide, leeches, rubbery emulsions with iron carbonate and gentian extracts, and in another (1871) morphine acetate, infusions of senna leaves, citric acid and ammonium acetate ethers [57].

Treatment varied when the hysteria was associated with other symptoms such as, for example, epileptic convulsions: in the first phase the patient was administered zinc oxide, valerian extract, enemas with an emulsion of asafoetida and an egg yolk (to be repeated every 4 days) and then baking soda, water, fennel, turpentine and rosewater for rubs. Finally electuaries and polenta poultices [57].

The case of a young female patient at Managu is similar to the previous ones. Hospitalized for less than 54 days, the young woman was subjected to treatment based on emulsions of chloral hydrate, Burgundy pitch plasters, lemonade, water mint and lemon balm [57].

VILLA CLARA, CAGLIARI'S PSYCHIATRIC HOSPITAL, SARDINIA, ITALY

We are at the beginning of the twentieth century: the psychiatric hospital Villa Clara in Cagliari is an institution which ensures the implementation of the most advanced "psychiatric therapy". In actual fact, this advanced therapy consisted in the "application of leeches, drastic purges, cold baths and in procuring groups of blisters, usually on the neck" [58]. Villa Clara's story is contained in 16,000 archival files, still being sorted, but if there were any need of corroboration, its history is screamed out in the words of Giovanna M., Villa Clara's Register 1. Giovanna M. was admitted to Genoa hospital when she was 10 years old, diagnosed with madness: she had a terrible headache, but preferred to say she had a "cranky head" and three years later in 1836, she was moved to the basement of Cagliari's Sant'Antonio Hospital [58]. She describes this "as dark as a tomb, the only place on the island where the mad... or the insane... or the maniacs... or the idiots - as we were called- were locked up. We were 50 people in chains, in the smell of our own excrement, with rats gnawing at our ulcers..." [58]

In the early years of the new century, after a long break at Cagliari's new San Giovanni di Dio Hospital, Giovanna M., now old and blind, was transferred to the Villa Clara psychi-

atric hospital, where Professor Sanna Salaris formulated a diagnosis of "consecutive dementia" and hysteria. But despite being constantly subjected to careful clinical observation, she was only treated here with "tonics ... two eggs and milk ... balneotherapy, rhubarb tinctures, potassium iodide, lemonade and laudanum, insulin and laxatives, a lot of purgatives: always, for everything". Giovanna M. died in the mental hospital in 1913 due to "ageing of organs" and "senile marasmus", as confirmed in the necrological report. Anna Castellino and Paola Loi know all there is to know about Giovanna M. and end their work *Oltre il cancello* with Giovanna's words: "And you'd better believe it: I was 90 years old. Fate, which takes away healthy, free, young people, never pardoned me once. It has let me live all this time, quite lucid, but closed up in here ... since I was ten years old ... eighty years in psychiatric hospital for a headache" [58].

CONCLUSIONS

Lengthy the history, social changes seem to offer a fertile substrate for the evolution of complex innovative systems of interpreting reality, of attributing the causes and controlling events, of living emotions. A critical study of the historical development and the interpretations of mental diseases may contribute to providing an explanation for the means of psychopathological expression. Moreover, it may provoke a re-discussion of the threshold and vulnerability concept in cases where it could be hypothesized that the new cognitive systems, although adaptive to new social requirements, might represent a factor of vulnerability ("culturally specific") to specific mental disorders.

We have seen that both the symptomatic expression of women' malaise and the culturally specific interpretation of the same malaise witness the changing role of women. From incomprehensible Being (and therefore mean of the Evil) to frail creatures that try, however, to manipulate the environment to their own ends (in Freud's view) to creature arbiter of his fate (in the modern transformation from hysteria to melancholia), where the woman seems to have traded power with the loneliness and guilt.

CONFLICT OF INTEREST

The authors confirm that this article content has no conflicts of interest.

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