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**HYSTERIA – MYSTERIOUS DISEASE AND ITS JOURNEY
THROUGH CENTURIES. FOUR DISCOURSES AND THE HYSTERIC.**

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ABSTRACT

Hysteria has been deeply imbedded in the history of human kind throughout the centuries without having medically explained symptoms. With the development of modern medicine many symptoms have been found to have an organic cause. The same modern medicine has shown through brain scans that there are people who have serious and debilitating symptoms without any organic cause. This leads to the work of Freud and Lacan who dedicated their lives exploring how our inner world- unconscious directly influences our well-being.

Lacan and his followers are courageous to point out that we all are, to a certain extent, a hysteric. Lacan's four discourses are important concepts to better understand how language, the unconscious and other signifiers impact our lives and society as a whole. The Master discourse, The University discourse, The Analytic discourse and The Hysteric discourse shows how language and speech are positioned and how we relate between the Subject and the Other. It can be challenging for the Analyst to work with the Hysteric.

INTRODUCTION

This essay will explore how hysteria has occupied all aspects of humanity and the individual from culturally determined symptom pools to four discourses where the hysteric roots can be found. It will explore modern controversies and uncertainty in diagnostics where the gap between the medically ill and the mentally ill is still a controversial, debatable topic. It will go through the history of the modern era to appreciate the complexity and historical development of the hysteric nature and how deeply it is imbedded in our culture. It will show how the hysteric diagnosis has changed through time but at the same time common ground and connections continue through the centuries and how little has really changed in our progress of the knowledge of the hysteric. Lacan's four discourses will be explored in an attempt to pinpoint the hysteric nature of humankind. This essay will look at the unique relationship between analyst and analysand and what challenges a hysteric client would bring.

BRIEF HISTORY OF HYSTERIA AND ITS CHALLENGES IN THE MODERN WORLD

It is safe to assume that hysteria has been present in people's lives since humankind developed language and the conscious/ unconscious mind formed. It is safe to add that it is here to stay and will always maintain its exclusive and elusive place in modern medicine and with talking therapies. It will maintain its status as controversial and an ever-changing diagnosis. It has existed for 4,000 years (Kinetz, 2006) and it has a lot to offer for centuries to come. The name has changed, its presentation and symptoms still changing, and it is evolving a step ahead of the current discoveries (Gallagher, 1991). There are many who doubt the existence of hysteria (Webster, 2004). Even those who proclaim that hysteria has always been there (Gallagher, 1991) agree that hysteria has always maintained the title of being a great puzzle for everyone.

This title is not surprising, as the symptoms of the hysteric are an attempt by the repressed and unconscious to be acknowledged, but, by the simple logic of our universe, it is an impossibility for the unconscious to be truly acknowledged. This is because of the fact that that which is unconscious cannot be brought to conscious thought, as to do so would strip it of its unconscious nature (Leupin, 2004). Hysteria has always carried a certain aura of mystery and it is impossible to explain it in well-written sentences without contradictions or many more questions arising. Wajcman (2003) names hysteria as a mysterious illness, Gallagher (1991) refers to the monsters in Greek mythology and introduces hysteria as a chimera – a hybrid creature made of multiple animal parts.

Sandler et al (1993) is referring to the development and changes of the concept of hysteria over time. It has evolved from simply being a 'wondering womb' to something bigger and deeper in our society. There are proven scientific roots of the disease. Hysteria is claimed to have an

influence on the historical and cultural aspects through the centuries. It has also been studied as a diagnosis and concept in its metaphorical sense.

Some authors are taking a new approach based on centuries old beliefs and mixing them with modern day feminism. Devereux (2014) is negotiating the return of exclusivity of hysteria as a diagnosis for women.

CHANGES ON TERMINOLOGY

The terminology for many diseases and diagnosis has changed over time and it has closely followed scientific progress and political correctness – the word hysteria is no exception. It has been found to be too controversial for many, too sexist for a few and also too ancient and unscientific. It has been amended to suit current scientific and politically correct social norms. It is evident from the literature that naming hysteria has the same difficulty as following its ever-changing symptoms (North, 2015; Shorter, 1992).

Hysteria is the scientifically based diagnosis first introduced by Freud (1895/2001). Origins of his work are influenced by Charcot and Breuer who linked unexplainable medical symptoms to our unconscious trying to be heard and acknowledged. Freud explores the case of Anna O., the first one whose symptoms are linked to the unconscious and the idea of repression, and its correlation with slips or parapraxis is introduced. The case of Dora (Freud, 1905/2001) is an important milestone for acknowledgment of transference which later led to Lacan's theory about discourses (Leupin, 2004).

Hysteria has undergone many changes and corrections mostly to suit medical professionals in their attempt to recognize and classify the illness as such. Classification and evolution of hysteria as a mental disturbance started with DSM's. In DSM-1 which was introduced in 1952, hysteria was put under the category of psychoneurotic disorders where subcategories of dissociative reaction (which was formerly known as conversion hysteria) and conversion reaction were included.

Ten years later – 1968 DSM – 2 was published and hysteria still kept its original roots under the name of 'hysterical neurosis, conversion type'. A separate section was dedicated to 'neurosis' where a separate diagnosis was given to 'hypochondriac neurosis'. It shows a slow turn acknowledging grouping the severity of symptoms.

In 1980 DSM -3 more changes and divisions were introduced, and somatoform disorders were grouped with conversion disorders, and dissociative orders were separated into a different category. North (2015) underlines the significance of grouping somatoform and conversion in this particular order as it has minimized the psychoanalytical theories of their causes.

DSM – 4 in 1987 did not introduce many changes to the diagnostic criteria for disorders with a hysteric origin. It kept somatisation disorder -it was simplified, and somatoform pain disorder was renamed as a pain disorder, to name but one.

In 2013 DSM – 5 introduced significant changes - it has removed somatoform disorder and the new section was called ‘somatic symptoms and related disorders’. DSM -5 kept the conversion disorder but with added description – functional neurological symptom disorder. It is important to note that hypochondria and pain disorder were completely removed from the manual. Both are still a valid diagnosis used in modern medicine and it still refers to the symptoms without medically explainable causes but does not have the official stigma of mental disease attached. Sullivan (2018) explains that most of these cases where patients are diagnosed with psychosomatic (hysteric) symptoms and who are eventually referred to the appropriate professionals are still reluctant to agree to seek psychological treatment.

Many kinds of research were done, and much more will follow to classify psychosomatic, hysteric symptoms. Remarkable is Bowman’s (as cited in North, 2015) observation that all symptoms classified in DSM – somatisation, conversion, dissociation - are interrelated and until last century were all kept under one and only one name – hysteria. All diagnostic and symptom related work done, and hysteria remains the same – a mystery where each who describes hysteria comes with their own explanation without being able to give an answer everyone can agree upon (Wajcman 2003). It also reflects the historical development of

illnesses of humankind, where many diseases were attributed to something mystical or unexplainable happening in our heads and this debate is still valid.

CULTURAL ASPECTS OF HYSTERIA, BIOMEDICAL MODEL AND MEDICALLY UNEXPLAINABLE DISEASES

Some authors, such as Kinetz (2006), are quick to point out that hysteria as such does not exist but has worked as a 'dumping ground for unexplained' by unprofessional and poorly educated doctors or was used before new diseases were discovered with the aid of new medical equipment. No one will argue with the fact that with the development of modern medical science and discoveries and the introduction of new diagnostic equipment, many unexplainable symptoms were discovered to have a link to organic disease (Webster, 2004).

Shorter (1992) explores the hysteria - psychosomatic illness and its development in the modern era and points to the significance of social influence on hysterical symptoms. It does not influence the culture as such but adapts in accordance to the culturally accepted norms. Shorter (1992) is convinced that many symptoms of medically unexplainable diseases are closely shaped by historical developments in newest researches and medical science. He refers to the influence of the medical shaping of the symptoms as 'a symptom pool' (Shorter, 1992, p. 2), where the culture and people around share the common memory and knowledge of what symptoms are culturally acceptable to present with when ill. It is controversial and a provoking thought to accept that the unconscious will choose symptoms which are socially acceptable as no one wants to be laughed at and deemed to be a hysteric. O'Sullivan (as cited in Willis and Malcolm, 2015) agrees and mentions cultural determination of the symptoms today, where certain countries would have the manifestation of certain symptoms more than the others.

Hysteria is difficult to pinpoint. It goes ahead of its time and is sensitive to any changes in perceptions of its symptoms (Gallagher, 1991). A good example is changes in the behavior of hysteric patients who were under Charcot's care. According to Shorter (1992) hysteric fits, which were frequent occurrence for patients under Charcot' care, completely stopped after his

death when, physicians who took the job in Charcot's place, did not accept this behavior, and expressed their disapproval to his former patients when they presented with the hysteric convulsions. Fits stopped, but the door was left wide open for new, socially, and medically accepted symptoms to develop. The unconscious will find the way to express itself through psychosomatic symptoms which will match the symptoms of a real disease, it will refuse to be ignored, or not taken seriously – it will stay, seen and recognized but never fully understood or conquered.

It is evident from literature available that people's attitudes have changed with the times in regard to unexplained physical symptoms. Medical science has always worked hard to come up with new theories, treatments and diagnostics to deal with unexplainable symptoms. Kinetz (2006) is following on how hysteria meaning has changed over the years – it has lost its gender exclusivity and currently is referred to any pathology where no medical explanation is possible. Freud (1985/2001) described hysteria as a neurosis where the repressed unconscious is presenting as a physical symptom. Gallagher (1991), in analyzing both Freud and Lacan, is comparing a concept of the hysteric from the client who is presenting with pathological – psychosomatic illness or symptoms to the concept of hysteria as a discourse where social unhappiness and frustration is presented.

UNCONSCIOUS AND HYSTERIA

Freud's (1895/2001) theories were revolutionary at the time they were first published. In the face of a novelty gone, nothing much has changed today. We are not much closer to understanding and coming up with a united definition or the prospect of successful scientific research in explaining the unexplained (Gallagher, 1991). It was a groundbreaking hypothesis at the time to acknowledge the existence of an unconscious and repression and its major influence on general health. This is the hypothesis which is hard to prove, and it is the one which still has its aura of mystery even today and there are no signs of that mystery disappearing anytime soon (Wajcman 2003) as there are many more medically unexplained symptoms occurring for people who are regulars at GP practices, neurologist offices and psychic wards. Bollas (2000) acknowledges that hysteria is 'the most complex character in psychoanalytic theory' (p. 162) and one can expand that to state that it is complex for all humankind.

Medicine today has moved forward with having modern diagnostics and treatments for symptoms of hysteria. Brain images have proven that the brain of the hysteric has (Kinetz, 2006; O'Sullivan, 2015) a disruption in certain parts which are responsible for motor functions and are activated in the parts which are responsible for emotions and as a result normal bodily function, e.g. movement is prevented without an organic cause. The biomedical model of health comes up with explanations and a description of the new symptom and yet no one has come up with an answer.

All medical achievements and theories do not change its essence – it is still a diagnosis of the unknown – a diagnosis of physical manifestations of our repressed and unconscious thoughts (Freud, 1985/ 1991). It is important to note that certain diagnoses, accepted by modern medicine are related to hysteria but do not carry the stigma of mental disease. The diagnoses

are taken from manuals and sometimes a certain number (five out of eight for example) are needed to be given a psychiatric diagnosis. Some hysteric symptoms are accepted and in theory everyone can have hysteria and be recognized and function satisfactorily as an adequate member in modern society. Two diagnoses, just taken out of the last DSM are psychosomatic disorder and hypochondria. Hypochondria and psychosomatic disease are currently accepted by medical professionals and despite their inability to find the organic cause of physically unexplained symptoms they are treated with all seriousness by medical professionals. O'Sullivan (2018) acknowledges the prevalence of psychosomatic symptoms in our daily lives. It is evident from her practice, that for every fifth person who arrives with symptoms of epilepsy (fits), there are no detectable changes in their encephalograms- it appears normal and medications prescribed do not make any improvement in their symptoms. O'Sullivan (as cited in Willis and Malcolm, 2015) explains hypochondria as a minor physical symptom with extreme anxiety attached, and psychosomatic illness as having severe physical symptoms without any detectable organic cause. She is not rushing people to go to psychoanalysis or other therapies, instead, she suggests treating certain hysteric individuals and their symptoms with traditional medicine as opposed to therapy. It resembles the stance of Jean Martin Charcot who was once a mentor to a young and enthusiastic medical student, Sigmund Freud who dedicated his life to researching people (predominantly women) with hysterical symptoms. Charcot concluded that symptoms of hysteria – although incurable, can be alleviated with common therapies (Shorter, 1993).

Wajcman (2003) is frank when comparing studies of hysteria to a task akin to that of Sisyphus, the sinner. Sisyphus is condemned to an eternal and literal up-hill struggle by pushing a boulder to the top of the hill, once he is almost up, the stone rolls back down and he has to start the task again. The task is the same and as never-ending as the question presented by hysteria which remains the same but no one has been able to come up with the true answer – only explanations.

A hysteric needs an answer for his/her desire, once he/she comes close to an answer or fulfilment of that desire, it is not needed anymore. What is really needed is the desire to have an unsatisfied desire. And the task starts again.

Freud (1895/2001) was the first one to describe hysteria from the psychoanalytic point of view that hysterics suffered from 'reminiscences' and perhaps they were ill due to 'pathogenic ideas', something for which Charcot had no time but Freud was convinced. His work began in collaboration with Joseph Breuer's who had a patient known as Anna O. and who was subsequently diagnosed with hysteria. Although today there are reasonable doubts to suggest that the suffering of Anna O. had organic nature (Webster, 2004), it was the for the first time 'a talking cure' was announced and further explored. Freud (1895/2001) following research led to the worlds of the unconscious, slips and the repressed, and their place and use with hysteria and the hysteric. While he explored the symptoms of hysteria and obsessional neurosis, which he found to be closely related, Lacan proposed that being engulfed in language and subsequently having the unconscious and repressed meant that almost anyone can be deemed to be hysteric. As no repression has occurred in a psychotic, no unconscious is formed in a way for someone to have a hysteric nature (Fink, 2007).

Language has a symbolic structure (Lacan, as cited in Baily, 2009). Humans have expressed and will continue to express themselves through language. Hysteria expresses its demand through language and demands answers from an analyst or master, who the hysteric assumes must have the knowledge and can fulfill the hysteric's desire with that knowledge (Wajcman, 2003).

Freud (as cited in Fink, 2007) declared in his primary publications that when the thought is detached from its original root and repressed and then transformed into bodily symptoms as it

is with hysteria, it comes from the unconscious, which is only possible if primary repression has occurred.

When does the person with a hysteric discourse become a person who is hysteric? Freud (1895/2001) put it very simple that hysteria presents as a neurosis when the unconscious cannot get out any other way. Lacan (as cited in Baily, 2009) expanded the matter by acknowledging the importance of language in forming the unconscious.

Freud (1905/2001) emphasized the lack as the absence of an imaginary phallus, Lacan extended this proposal by emphasizing the symbolic and not the imaginary constitution of the phallus. And subsequently, desire for the mother follows to the more symbolic – lack of love. Which Lacan sees as a universal desire – we all need love and being loved (Hewitson, 2016). And as we see our ego as our own mirror image, we need to fulfill our desire through the eyes of the Other. Lacan (as cited in Baily, 2009) has brought the concept of discourses as an interchange between subject and the Other.

FOUR DISCOURSES AND HYSTERIA

Lacan's theory of four discourses was introduced in his seminars from 1969 to 1970 (Leupin, 2004) where he attempted to systemize the way people communicate to each other with or without language and speech. His work produced a theory of four discourses where according to Lacan (as cited in Baily, 2009), the communication between different people is structured through social structure and hierarchy which is often expressed without people consciously being aware of it. These discourses can be seen in action and present everywhere and almost every aspect of our lives can be described using Lacan's theory. The four discourses have a symbolic structure and are based on our basic nature of the unconscious and the symbolic. The concept of discourse emerged in close relation to Lacan's proposal that the 'unconscious is structured as a language' (as cited in Leupin, 2004). The four discourses and Lacan are open to the possibility of more (e.g. scientific discourse) and are as follows: the Master, the University, the Analyst, and the Hysteric. Lacan's (as cited in Leupin, 2004) description of discourses in his Seminar 17 summarises its superficial simplicity and deep complex nature: 'The discourses in question are the signifying articulation, the apparatus, whose sole presence and existing status dominates and governs everything that can emerge as speech' (p. 68).

Discourses are activated through language – simply talking. Where this superficial simplicity is undermined is by the notion that we are not fully aware what we are saying and, through this articulation, the Other has to be present and put in a position where through this speech he/she is pressured to construct knowledge (Leupin, 2004). In the linguistic structure of unconscious each word has a meaning which is unique to the individual and when it's expressed it is not fully known what has been said and intended by the agent, it is the Other who produces the meaning and understanding through reflecting it.

Four discourses have the same basic formula, with set positions where there is the Agent, who produces the speech, The Other to whom this speech is delivered – this presents our daily conscious communications. This interaction produces a Product which can fit in to our daily sense of communications, one is asking, other is listening and there is the result of this communication – end product, which might not always be the desired outcome, but it does produce something of the values to the agent. The fourth position is the one we are not fully aware of and might never be fully aware of and it carries the truth. It does bear the resemblance of the notion of free association where the meaning of the said word is not always acknowledged by the agent.

The Masters and University discourses do not acknowledge unconscious nevertheless it is there as unfulfilled wish and desire.

The Masters discourse can be seen abundantly in daily tasks between employers and employees. People in power (the Master) request their desire to be fulfilled and workers (the Other) will need to perform in an attempt to satisfy this need. However, that fulfilment according to Leupin (2004) is logically impossible as if done so, the unconscious would become conscious. Baily (2009) explains this fulfilment of desire as an impossibility as the Other needs to give up goods to satisfy the Master's desire and the Master cannot execute that desire fully as he needs constantly to reinstate the desire again. It does resemble the psychoanalytic notion of the hysteric as unfulfilled desire. In the Master's Discourse the truth and the repressed are foreclosed and adapted through a position of power.

The discourse of the University is referring to institutions and their interactions with the Other – one's who desire this knowledge or a place of being in the position to be able to reproduce the knowledge set by establishment. Institutions as such possess the master signifiers and the production of truth is non-existent, it is only reproduced, no master signifiers are made or the

existence of the unconscious is acknowledged. It is important to note that the agent – in this case the one who has the knowledge can eventually adapt hysteric identification by identifying master signifiers of the establishment to themselves (Leupin, 2004). Psychoanalysis can fall victim to the desire to be incorporated in this discourse where conceptual structure of the knowledge can be ignored and dogmatic attitude towards texts can be adapted. In this discourse the truth is repressed and is adapted in the position of knowledge.

The Psychoanalyst's discourse is the one which recognizes the existence of the unconscious and operates in accordance with that awareness. It is the only discourse which does not seek the knowledge and does not look for answers as it is aware of the logical impossibility to be able to find the direct answer which comes from the unconscious (Leupin, 2004). The analyst takes the position of the agent which creates the desire for the analysand to want to know and is acting as a mirror which reflects the analysand's unconscious and eventually create the transference situation which allows the analysand to discover the knowledge of its own desire which is veiled through a master signifier. This work can be achieved through the assumption by the analyst that the analysand is barred from the master signifier, and subsequently he/she adapts the role of the agent to reflect analysand's unconscious knowledge (Baily, 2009). It is achieved through transference and displacement. This discourse is unique and can be referred as being elusive as it is working with an individual and is aware of the fact that each case is different and one meaning cannot be applied to all.

Lacan (as cited in Leupin, 2004) pinpoints that in the face of scientific roots of discourses and psychoanalysis as such, it is important for the analyst to see the uniqueness of each analysand's case. It is not sufficient for the analyst to know the theory only. Lacan is brave enough to submit that to know the scientific part might not be essential at all. In order to be a good practitioner, the analyst has to undergo psychoanalysis him/herself. In other words, he or she must experience the hysteric discourse to be able to exercise his role as analyst fully. It is

important for the analyst to undergo his/her own analysis not only to understand specifics of being the analysand but also be able to maintain the neutrality and non-involvement in the psychoanalytic setting.

Gallagher (1991), speaking of the hysteric, emphasizes the fact that a human world is 'linguistically determined' (p. 113) and the psychoanalyst has to hear the patient's unconscious desire which the analysand was not able to express and therefore the unconscious has forced itself to be acknowledged in the way of a symptom – either physical or mental. Discourse of the Analyst is the one which induces speech from the analysand and which in return incites the analysand to believe that the analyst has the knowledge which the hysteric wants to acquire and will place a demand on the analyst to give the hysteric the answers and the knowledge - this is the analysand's unconsciousness, which is impossible to control and impossible to obtain. The analyst then has to be able to listen to the words and hear that hidden knowledge of the barred subject.

Lacan (as cited in Baily, 2009) in explaining discourse of the hysteric proposes that everybody is hysteric in some way; it is a way we learn and attempt to acquire the new knowledge and fulfill our unsatisfied desire. Only absence or presence of the physical symptoms sets the hysteric apart from his/ her ability to function within society within its accepted norms. Anyone is in the possession of the question about the unknown which is hidden in the unconscious. Not the question itself is unknown, it is the hysteric him/herself who cannot be sure he/she is able to tolerate the answer or not. The discourse of the hysteric does lead to knowledge which can be accessed through the discourse where the master acts as the object of transference and displacement too. In a clinical setting it is usually the psychoanalyst, in ordinary life, it can be any person of power.

In psychoanalysis the hysteric is given an opportunity to be heard in the manner which allows for free association to emerge which will aid the analysand to vocalize and recognize the repressed and help them to manage difficulties which they encounter in the world based on language and structures emerging from it. The analyst's role is to help communicate their unconscious desire which has had a major impact on their lives as a physical or mental symptom (Gallagher, 1991). The analyst has an important task - to be able to listen in a manner which allows him to hear that hidden and unconscious content emerging (Fink, 2007). Most likely the reason for avoiding the answer, as it might be too traumatic or hurtful to be acknowledged, as it also might expose a vulnerable side which the hysteric's frame feels is more than enough to deal with. It is simple and complicated at the same time as Gallagher (1991) exploring the nature of the hysteric asserts that the hysteric presents himself/herself in a form of a riddle where two existential questions are present. Those are about a person's place in the world with the fundamental 'who I am' in the universe and our universal need for love. Hence, exploring our sexuality and how it relates with people of a different sex around us. It is safe to deem that these are universal and fundamental topics of human kind and will always come in the form of a question for an individual and society.

Wajcman (2003) acknowledges that essence of the hysteric lies in the contradictory statements, which paradoxically work in the way to produce knowledge. The hysteric will ask the questions – it can be verbal demands expressed through physical symptoms, either way it will demand an answer but at the same time, once or if the answer is given, he/she will come back with a new question or symptom. The hysteric sees the analyst as the Master and places the demand to answer her/his desires upon them, and when this analytical engagement is progressing, she/he will want to master the analyst by bringing a new riddle for the Master to master. Verhaeghe (1995) has an interesting viewpoint about the desire which we seek and avoid, it is based on the works of Freud and Lacan, where he stated that the desire we are after is the

jouissance and our inability to have it is a basic survival of ourselves as a functioning human being. Lacan (as cited in Baily, 2009) spoke about *jouissance* which he based on Freud's work about infantile sexuality in explaining infants' inner world, full of innate joy and which was repressed soon after language and the symbolic structure of the subject developed. It is desire which has to be left unfulfilled to maintain existence of the subject.

The biggest challenge for the analyst in their work with the hysteric is to maintain non-involvement and not to succumb to the demands of the analysand. If this neutral approach is lost, the analyst most often becomes either too emphatic or feels irritated by the hysteric's constant demands. To avoid that, an analyst must be able to maintain mental fitness and take care of his own psychic state by regular therapy and supervision.

Hysteric discourse allows us to have a glimpse on how the hysteric's desire for the knowledge which is inaccessible to him/her progresses in therapy. The analyst is here to aid the hysteric in accessing his/her unconscious with its symbolic structure and through psychoanalysis rearrange it to the real and come close to the truth about the barred subject (Leupin, 2004). This task is not simple – the unconscious guards that knowledge and repression is there to protect ourselves.

Hysteric discourse can be applied to the hysteric in order to alleviate symptoms. With the same effect it can work as a scientific discourse - where the question presents and we are looking for the true knowledge and learning. Leupin (2004) stated that if the mystery is removed from the hysteric discourse, we are left with theory which will lead to the scientific discourse.

At the end, it has merit to mention the new theory of the nocebo (Stromberg, 2012)–which is opposite of placebo and makes people feel sick without any medical reason, just based on their own assumptions and beliefs. New nocebo effect is characterized as the presentation of

symptoms, without the organic cause, yes, medically unexplained somatic presentation— it is new, but we have heard that before.

CONCLUSION

Hysteria, with its constantly transforming name and appearance has never changed its exclusive and elusive place in the human mind and society. It has been renamed, condemned, disproved, acknowledged reluctantly and triumphantly, but never fully understood or explained. Many have made attempts with varying degrees of success to disprove or prove their understanding about the nature of the hysteric. It is evident from materials to assume that these attempts have been progressing in a circular manner – all debates have led to similar conclusions and even treatments through centuries but have not undergone drastic changes. The four discourses shed light on the unconscious nature of the social bond formed through communication where it is led by unfulfilled desire. Desire which is tempting but too precarious to fulfil as it carries the danger of eradicating the symbolic structure of our mind and can undermine our existence as a subject.

Hysteria is not only a diagnosis where the physical symptoms can have debilitating effect on our life without medically explainable symptoms, it is also a part of the exquisite nature of humans, the ones who are not psychotic.

One can be bold and assume that the hysteric nature is either pathogenic or is not humanity's best kept shared secret and through the centuries we have been looking for the master who can help us find an answer - either through Google or the Sphinx, as long as we can persuade the master to reveal the knowledge. But there is the catch - we want the door to the sacred knowledge to be opened, but once its ajar, desire is potentially lost and without the desire to enter, there is no need to go through and we are looking for another door which revokes that desire to knock and demand an entrance.

It does not stop – the chimera is still showing its multiple faces with the emerging theory of nocebo which has proven through researches that often symptoms are as strong as the person's trust in them.

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