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Article

The modern coding of hysteria: Rethinking women's systemic conditions and treatment

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Abstract: There is a strikingly disproportionate female-to-male ratio in diagnoses of autoimmune, neurological, and chronic pain disorders. Although biological mechanisms—such as hormonal fluctuations, X-linked genetic factors, immune modulation, and epigenetic vulnerability—are frequently proposed, no single pathway sufficiently accounts for the magnitude of this imbalance. Across diagnostic categories, these conditions share a constellation of symptoms: persistent fatigue, cognitive slowing or "brain fog," diffuse musculoskeletal pain, gastrointestinal disturbance, autonomic irregularities, numbness, breathlessness, and dizziness. Notably, this symptom profile echoes early twentieth-century descriptions of hysteria, a diagnosis historically applied to women whose distress manifested through bodily complaints. This article does not argue for diagnostic equivalence, but rather for conceptual continuity. It considers whether contemporary conditions such as Fibromyalgia, Celiac disease, Ehlers-Danlos syndrome, Premenstrual dysphoric disorder, and Long COVID might, in some cases, represent embodied expressions of unarticulated strain within sociocultural systems that have historically constrained female agency. Drawing on theoretical frameworks and clinical vignettes, the paper explores how trauma, chronic stress physiology, immune dysregulation, and gendered role expectations intersect. It ultimately advocates for an integrative model—medical, psychodynamic, and somatic—that treats women's symptoms as meaningful communications shaped by both biology and lived experience, rather than as evidence of defect or fragility. This perspective seeks to shift the narrative from women's bodies as "broken" to bodies expressing deeper truths that Western medicine has yet to fully understand.

Keywords: hysteria; women; illness; autoimmune disorders; autonomic nervous system disorders; somatic

1. Introduction

Throughout the lifespan, women experience complex and multifaceted physical symptoms, with treatment frequently relying on pharmaceuticals. Western women are more likely to be diagnosed with autoimmune diseases, autonomic nervous system disorders, and central sensitization syndromes (Somers et al., 2009). The disparities between men and women may be attributed to hormonal influences, differences in immune system function, and women's increased likelihood of seeking medical care. Women's pain is often dismissed or downplayed in medical and societal contexts, with conditions like endometriosis and fibromyalgia taking years to diagnose due to misattribution or disbelief. A systematic review (Samulowitz et al., 2018) of 77 chronic pain studies found that women's reports of pain were characterized as hysterical, emotional, and malingering, while men tended to be described as stoic. Childbirth pain and emotional struggles like PMS and postpartum depression have historically been minimized, leading to inadequate treatment. Additionally, racial and gender disparities in pain management have contributed to women receiving substandard care for their pain (Hoffman et al., 2016; Dusenbery, 2018). For instance, female patients with autoimmune diseases see an average of six doctors over five years before receiving an accurate diagnosis in half of all cases; these women are frequently mischaracterized as “hypochondriacs” or “chronic complainers” (Nakazawa, 2008; Dusenbery, 2018).

A January 2025 study estimated that approximately 15 million people in the U.S. have one or more autoimmune diseases, with women representing roughly 80% of cases (Mayo Clinic News Network). As shown in **Figure 1**, women are disproportionately affected by autoimmune conditions, including rheumatoid arthritis, multiple sclerosis, scleroderma, celiac disease, Hashimoto’s thyroiditis, lupus, and Sjögren’s syndrome. Women also comprise the majority of diagnosed cases of central sensitization syndromes such as chronic fatigue syndrome (CFS), fibromyalgia, and irritable bowel syndrome (IBS), conditions that have gained increasing clinical recognition in recent decades. Epidemiological research suggests rising identification of multisystem conditions among women, including antinuclear antibody (ANA) positivity, hypermobile Ehlers-Danlos Syndrome (hEDS), postural orthostatic tachycardia syndrome (POTS), and Long COVID, though prevalence estimates vary by population, diagnostic criteria, and methodology (Murray, 2024; Gracia-Ramos et al., 2021; Conrad et al., 2023). Dysautonomia, a disorder of the autonomic nervous system, is reported in 75–80% women, with POTS as the most commonly diagnosed subtype. Recent data also indicate increased recognition of hEDS and Long COVID in women, both of which share overlapping symptom profiles with the conditions above.

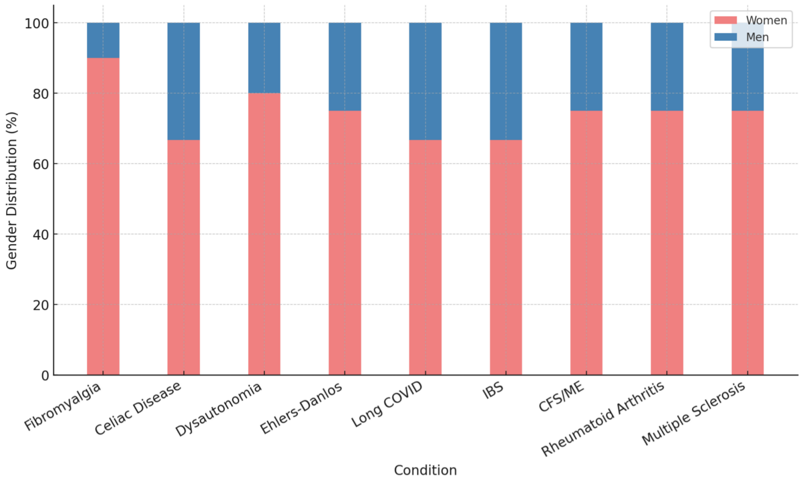

Figure 1. A bar graph showing the gender distribution for various conditions.

Note: The percentages reflect the proportion of individuals affected who are women versus men. All statistics are referenced from the Centers for Disease Control and Prevention and the National Institute of Health.

2. The conditions

Several conditions will be looked at more closely for the purposes of this article: Fibromyalgia, Celiac Disease, Ehlers Danlos, Dysautonomia, and Long COVID. A brief description of each of these conditions follows.

Autoimmune disorders are more commonly diagnosed in women, with prevalence estimates ranging from 70–80% across several conditions; reasons for this sex disparity remain incompletely understood (Nakazawa, 2008). These conditions occur when the immune system mistakenly targets the body's own tissues. Celiac disease, for example, is an autoimmune disorder triggered by gluten exposure that damages the small intestine and produces gastrointestinal and systemic symptoms. The higher prevalence of autoimmune conditions in women is thought to reflect a complex interaction of hormonal, genetic, immunological, and environmental factors, although the precise mechanisms remain incompletely understood (Nakazawa, 2008). While self-reactive immune cells are a normal part of immune functioning and are typically regulated by inhibitory mechanisms, autoimmune disease emerges when these regulatory processes fail (Cohn, 2015; Davidson and Diamond, 2001; Mackay, 2000).

Contemporary models emphasize multifactorial vulnerability, often involving genetic predisposition, immune regulation, and environmental or physiological triggers (Gottfried, 2024). Epidemiological research suggests that diagnoses of autoimmune conditions are increasing, particularly among younger populations (Gracia-Ramos et al., 2021; Conrad et al., 2023). Studies from 2022 and 2023 found that the prevalence of antinuclear antibodies (ANA), a biomarker of autoimmunity, increased from roughly 11.0% in 1988–1991 to about 15.9–16.1% in 2011–2012 overall, with adolescent prevalence rising from approximately 5% to 12–13% over the same period (Dinse et al., 2022; Murray, 2024). Treatment approaches vary by condition and severity, typically involving immunomodulatory therapies and symptom management, with more invasive interventions reserved for severe or refractory disease.

Fibromyalgia, recognized in the 1990s, is a chronic pain disorder characterized by musculoskeletal pain, fatigue, and tenderness, primarily affecting women between 35 and 45. While the exact cause remains unknown, it is believed to involve a combination of genetic, environmental, and psychological factors, with an abnormal pain response in the brain contributing to heightened sensitivity. There is no cure for fibromyalgia, so treatment focuses on managing symptoms through a multidisciplinary approach encompassing pain relievers, antidepressants, therapies, and support groups.

Dysautonomia encompasses a range of conditions that cause dysfunction in the autonomic nervous system and impact bodily functions, including heart rate, blood pressure, digestion, and temperature control. Symptoms vary widely but include difficulty standing still, fatigue, lightheadedness, nausea, brain fog, palpitations, and shortness of breath. Postural orthostatic tachycardia syndrome (POTS), a common type of dysautonomia, presents with an abnormal increase in heart rate upon standing. Treatment focuses on symptom management through lifestyle changes, medications, increased fluid intake, and addressing underlying conditions.

Long COVID, or post-acute sequelae of SARS-CoV-2 infection (PASC), involves persistent symptoms including fatigue, shortness of breath, joint pain, and brain fog, lasting weeks or months after the initial COVID-19 infection. Current estimates suggest that up to 20% of individuals infected with SARS-CoV-2 experience prolonged symptoms consistent with Long COVID, with women disproportionately affected

(Maham et al., 2024). The condition has contributed to a rise in dysautonomia diagnoses, particularly POTS, leading to increased attention and resources for dysautonomia research and treatment.

Ehlers-Danlos Syndrome (EDS) is a connective tissue disorder caused by defects in collagen, with symptoms including joint hypermobility, skin elasticity to joint instability, pain, and digestive issues. While considered a rare genetic disease, EDS disproportionately affects women, without explanation (Song et al., 2020). Reported diagnoses of hypermobile EDS have increased substantially in recent years, possibly reflecting improved recognition rather than true incidence (Demmler et al., 2019).

Across these conditions, a striking convergence of symptoms emerges, including widespread pain, gastrointestinal disturbance, fatigue, syncope, hypermobility, dizziness, joint laxity, affective lability, sensations of suffocation, and dysphoria. This patterned clustering suggests not merely comorbidity, but a shared phenomenological organization of bodily and affective distress.

Figure 2 visually demonstrates where multiple conditions share similar symptoms (Fairweather et al., 2023; Ganesh and Munipalli, 2024). Hysteria exhibits the broadest symptom overlap, encompassing all listed symptoms, highlighting its historical classification as a condition with widespread, varied manifestations. Fatigue and brain fog are the most universally shared symptoms across conditions, reinforcing their role as hallmark features in chronic illnesses such as CFS, Long COVID, and fibromyalgia. Ehlers-Danlos syndrome and dysautonomia share significant overlap, particularly with hyperflexibility and orthostatic intolerance, reflecting their frequent co-occurrence in hypermobility-related disorders.

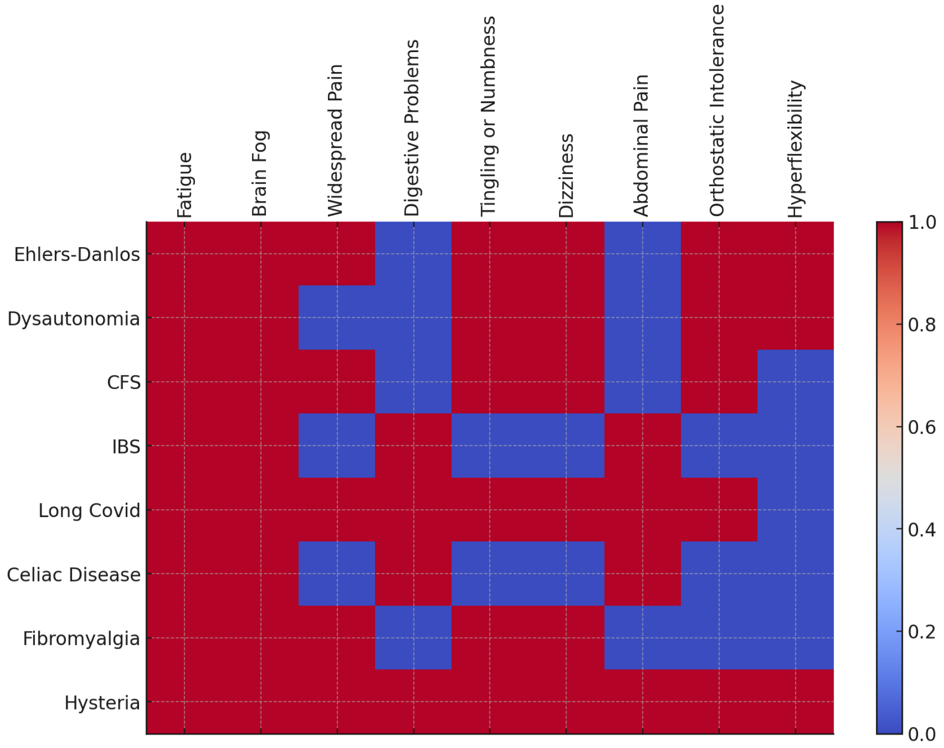

Figure 2. The chart shows the overlap of symptoms across selected conditions.

Note: The colors represent the degree of overlap, with darker shades indicating higher overlap. The conditions are listed along the top, and the symptoms along the side.

To examine this convergence and its predominance in women, the historical construct of hysteria offers a critical interpretive lens for understanding how women's illness has been culturally, symbolically, and clinically produced. This article does not claim diagnostic continuity between hysteria and contemporary autoimmune or multisystem disorders, but proposes a form of conceptual continuity: both can be understood as embodied responses to women's suffering within patriarchal social conditions, articulated through historically specific medical frameworks.

Historically diagnosed almost exclusively in women, hysteria came to be interpreted as the somatic expression of unarticulated conflict and trauma. Its symptom patterns bear notable structural resemblance to contemporary clusters seen in autoimmune, pain, and functional disorders. Situating modern presentations within this historical frame allows for a broader analysis of the psychosocial, embodied, and symbolic processes through which women's distress has been medicalized across time—not to revive hysteria as a diagnosis, but to interrogate its enduring influence on how women's suffering is perceived, interpreted, and treated.

At the same time, this article affirms the physiological reality of autoimmune and multisystem conditions, while also recognizing symptoms as meaningful expressions of distress that may not be otherwise speakable. In a clinical and cultural landscape that has long pathologized women's pain, the central task becomes one of epistemic listening: attending to women's embodied experience without reducing it to biological essentialism or dismissing it through psychologization. This stance opens the possibility for more integrative and effective forms of care.

3. Hysteria

The historical origins of hysteria can be traced to ancient Egypt and Greece, where it was believed that a dissatisfied uterus—the so-called "wandering womb"—could move within a woman's body, producing physical and psychological disturbances such as muteness, paralysis, seizures, and a choking sensation known as globus hystericus (Tasca et al., 2012). In the 19th century, neurologist Jean-Martin Charcot studied women at the Salpêtrière Hospital in Paris and conceptualized hysteria as a neurological disorder with distinct stages, including seizures, "clownism," intense emotional displays, and delirium (Bogousslavsky, 2014). Symptoms were diverse, encompassing non-epileptic seizures, paralysis, gastrointestinal and cardiovascular distress, communication difficulties, and trance states (Bartholomew et al., 2012). Charcot employed photography to document these manifestations and experimented with treatments ranging from sedatives and valerian inhalations to hypnosis, pressure on hysterogenic zones, and electrotherapy—reflecting both the experimental zeal and the gendered assumptions of his era.

Charcot described hysteria as "spasms, nerve aches, and vapors, suffocation of the mother, and uterine neurosis," explaining that when the uterus pressed against organs such as the lungs or throat, it produced experiences of choking, paralysis, and shortness of breath (Scull, 2009, p. 12). Freud (1894), one of Charcot's students, reinterpreted these symptoms psychoanalytically as expressions of unarticulated trauma, often of a sexual nature. Contemporary feminist scholars similarly view hysteria as the physical manifestation of distress in a society that pathologizes female behavior. Early neuroscientist Robert M. Woolsey described hysteria as a "protolanguage," a coded system through which patients communicated messages that could not otherwise be verbalized (Showalter, 1997, p. 286).

Modern psychiatric research often reinterprets historical hysteria diagnoses as manifestations of now-recognized medical conditions. Historical follow-up studies of patients originally diagnosed with "hysteria" indicate that a substantial proportion were later found to have demonstrable organic disease, whereas more recent systematic reviews show that modern diagnostic approaches have greatly reduced such misclassification (Stone et al., 2005). Symptoms historically associated with hysteria—chronic pain, fatigue, fainting, and joint complaints—are now recognized in conditions such as hypermobile Ehlers-Danlos Syndrome (hEDS) and other hypermobility spectrum disorders. Dysautonomia and postural orthostatic tachycardia syndrome (POTS), commonly comorbid with hypermobility, likely explain symptoms such as fainting and weakness, while cyclical emotional lability, heat intolerance, choking sensations, and abdominal pain may reflect fibromyalgia or irritable bowel syndrome (IBS).

Although hysteria as a diagnosis has been discredited, the cluster of symptoms it encompassed—faintness, lethargy, dizziness, hyperflexibility, and dysregulation of body temperature—persists in contemporary conditions that disproportionately affect women. These disorders may be considered part of the clinical "family" of hysteria, representing a modern coding of a historical pattern in which women's distress is expressed somatically.

For the purposes of this examination, hysteria can be understood on three interrelated levels: as a diagnosis, as a discursive construct, and as embodied communication. Diagnostically, hysteria historically described women whose symptoms—ranging from paralysis and non-epileptic seizures to muteness and fainting—defied conventional medical explanation. As a discursive construct, it reflects cultural frameworks that pathologize women's emotional and behavioral responses, often assigning moral or gendered meaning to understandable reactions to stress, trauma, or social constraints. At the level of embodied communication, hysteria functions as a "protolanguage," enabling patients to symbolically express distress or unmet needs when direct verbalization is constrained (Showalter, 1997).

Feminist disability studies, most notably the work of Wendell (1996), warns against reinscribing "hysteria" onto chronic illness as a means of evading the reality of "the rejected body." Wendell argues that by labeling unexplained physical suffering as psychosomatic, the medical establishment employs a "strategy of dismissal" that protects its own authority while shifting the burden of "cure" onto the patient's psychological willpower. Similarly, psychosomatic medicine—most famously in the work of Eliot Slater—warns against reinscribing "hysteria" onto chronic illness, noting that the diagnosis is often a "delusion and a snare" that halts genuine scientific inquiry. By prematurely attributing physical suffering to psychological etiology, both feminist and clinical critics agree that medicine risks replicating the same epistemological violence that characterized the 19th-century clinic, ultimately foreclosing the discovery of complex biological mechanisms.

Elaine Showalter, a prominent scholar on the history of hysteria, suggests that while the label may no longer be as commonly used, its manifestations persist in new forms and are often recast within contemporary diagnostic categories. In her book, *The Female Malady: Women, Madness*, and *English Culture, 1830–1980* (Showalter, 1985), Showalter suggests that even as hysteria was gradually redefined or replaced with modern psychiatric terms like "conversion disorder" or "somatization disorder," its underlying psychological dynamics—stress, anxiety, and societal pressures—remain influential. She argues that the phenomenon has evolved and adapted; though hidden under different terminologies, it continues to shape women's experiences today.

This article examines recurring patterns rather than the persistence of a single disease entity. These patterns include symptom clusters that resist clear biomedical explanation, physicians' skepticism toward women's reports, a clinical emphasis on bodily pathology over lived experience, and moralized interpretations of behavior. Contemporary diagnoses such as Ehlers-Danlos syndrome and fibromyalgia may resemble hysteria in symptom presentation or in how patients are received within clinical settings, yet they arise within distinct medical frameworks and cultural contexts.

Historical comparison can be illuminating. Photographs of patients diagnosed with hysteria in the nineteenth century (see **Figure 3**) contrasted with contemporary images of individuals with Ehlers-Danlos syndrome (see **Figure 4**) reveal visible bodily phenomena—such as hyperextensible skin and joint hypermobility—that can appear strikingly similar across eras. A historical-structural perspective makes it possible to trace hysteria's enduring influence on medical interpretation and patient experience without conflating modern multisystem disorders with the nineteenth-century diagnosis itself.

Figure 3. Photographic iconography of the Salpêtrière (1876–1880): Hysteria by Jean-Martin Charcot, Désiré-Magloire Bourneville, and Paul Regnard, volume I.

Figure 4. Images of EDS sufferers: skin can become extra stretchy and there can be joint hypermobility.

4. Interpretations

There are few pertinent interpretations of the persistent cluster of symptoms that overlaps in several conditions overwhelmingly diagnosed in women. Below, they are categorized as biological, social, and psychological.

4.1. Biological theories

The overlapping symptoms across conditions like CFS, Fibromyalgia, Long COVID, Dysautonomia, EDS, and IBS suggest shared underlying dysfunctions in the autonomic nervous system, immune system, connective tissue, and hormonal regulation. Chronic inflammation, neuroimmune dysfunction, gut-brain axis disruption, and hormonal sensitivity all contribute to symptoms like fatigue, brain fog, widespread pain, dizziness, and digestive issues.

A 2022 review proposed the term “autoimmune autonomic dysfunction syndromes” to encompass conditions like complex regional pain syndrome, fibromyalgia, CFS, silicone breast implant–related symptoms, and post-COVID syndrome. This classification aimed to group these conditions based on their shared characteristics, such as pain without evident tissue damage and dysregulation of the autonomic nervous system (ANS). This proposed categorization reflects a growing understanding of how autoimmune processes and autonomic dysfunction may contribute to a broad spectrum of disorders that were once viewed as isolated or unrelated (Mahroum and Shoenfeld, 2022).

Hormonal fluctuations during puberty, menstruation, pregnancy, and menopause can influence autoimmune autonomic dysfunction syndromes. Estrogen plays a key role by modulating the immune system, increasing the survival of autoreactive B cells that produce autoantibodies, which may attack the body’s own tissues, contributing to conditions like celiac disease and rheumatoid arthritis (Klein and Flanagan, 2016). Estrogen and progesterone also affect gastrointestinal motility, pain sensitivity, and brain-gut communication (Jiang et al., 2019). Changes in estrogen levels can disrupt the autonomic nervous system, causing symptoms such as hot flashes, heart palpitations, blood pressure changes, and digestive issues. This occurs because estrogen regulates neurotransmitters, vagal tone, and thermoregulation, with imbalances linked to disorders like POTS, hypertension, and IBS (Jiang et al., 2019). Historically, female hormones were also implicated in hysteria diagnoses (Showalter, 1985).

Another biological hypothesis for widespread female-dominant diseases points to the X chromosome. As the X chromosome contains genes that regulate immune responses, having two X chromosomes could result in a stronger or more overactive immune system, potentially making women more prone to autoimmune disorders. However, the specific mechanisms are complex and not fully understood.

4.2. Social and environmental factors

There are differences in how men and women perceive and report symptoms, as well as gender differences in healthcare-seeking behavior: Women report symptoms more, seek services more, and perceive pain more readily (Barsky et al., 2001; Bertakis and Azari, 2007; Ballering et al., 2023). Men and women may perceive and report pain symptoms differently due to a mix of biological, psychological, social, and systemic factors. Women tend to have stronger immune responses, lower pain thresholds, and greater emotional awareness, making them more likely to recognize and seek treatment for symptoms, while men may underreport symptoms due to cultural norms.

The well-established socialization of gender roles often positions women in caregiving roles from a young age, sometimes leading to the early assumption of responsibilities beyond their developmental stage. Emotional parentification—where a child takes on adult caregiving duties—has been identified as a significant risk factor for the later development of psychological and somatoform symptoms in adulthood. This pattern underscores how societal expectations of women as perpetual caretakers can contribute to the accumulation of both emotional and physical strain over the lifespan.

Boys and men are traditionally more geared toward action and expressions of anger, giving them more opportunities to discharge emotional pain and maintain a healthy nervous system. Women, in contrast, are socialized to suppress anger and internalize distress, which can contribute to nervous system dysregulation, collapse, or conditions such as anxiety and depression. Research suggests that women are more likely to engage in "tend-and-befriend" responses to stress (Taylor et al., 2000) rather than externalizing emotions through direct action. This can lead to increased physiological stress, chronic tension, and a higher prevalence of disorders such as fibromyalgia and chronic fatigue syndrome, which are linked to dysregulation of the autonomic nervous system (Chaplin, 2015).

In the case of Mary (all names have been changed and information deidentified for the sake of the article), a woman in her mid-forties, was diagnosed with fibromyalgia in her twenties during a period of significant emotional hardship and lack of support. Her symptoms began with persistent lower back and hip pain, eventually spreading to her elbows, knees, hands, and feet. After years of discomfort, a rheumatologist diagnosed fibromyalgia by exclusion. Muscle relaxers worsened her symptoms, and physical therapy, while helpful, made her feel disabled. Although the diagnosis provided some validation, she wondered whether her symptoms were exacerbated by the diagnosis itself or the heightened attention paid to them. Her symptoms expanded to include redness and burning in her feet, occasional sensations she thought were neuropathy (despite no nerve damage found), and inexplicable deep fatigue. One orthopedic specialist was not convinced Mary had fibromyalgia, and a neurologist later suggested Cognitive Behavioral Therapy, which made her feel dismissed and unheard. She also experienced suspected arthritis, gastrointestinal distress, soreness after mild exertion, and an overall sense of something being “off” in her body that was difficult to articulate. Life transitions—like a recent move—triggered flare-ups, reinforcing her belief that fibromyalgia is linked to a hypersensitive, trauma-affected nervous system.

Mary grew up in a home where she was discouraged from expressing vulnerability and taught to suppress discomfort. Her mother minimized her childhood needs, urging her not to be “a baby” when she struggled with insomnia or needed rest. She learned to push through pain and ignore bodily signals. Her father was disengaged, and her mother, preoccupied with her own health issues, never acknowledged Mary’s diagnosis or symptoms.

Mary now prioritizes self-care, recognizing the restorative value of walking and sunlight, but she also cautions against over-focusing on symptoms, which can create anxious feedback loops. While support groups can offer validation, she warns they may inadvertently reinforce victimhood or symptom perseverance. For Mary, fibromyalgia ultimately reflects the body’s cry for rest, care, and recognition—needs that were long denied.

4.3. Psychological factors and trauma

According to the American Psychological Association (APA, 2020), women are more likely to be diagnosed with anxiety disorders and depression than men, a trend seen globally and across age groups (APA, 2020). These psychological conditions can contribute to the manifestation of physical illness and/or worsen the severity of a disorder when one is anxious or depressed.

One specific form of stress that disproportionately affects women (10:1) is sexual violence. According to the National Sexual Violence Resource Center (NSVRC), approximately 1 in 4 girls in the United States experience sexual abuse before the age of 18, and about 91% of rape victims are female. Among girls who have experienced sexual abuse, 65% reported repeated incidents, 57% identified a family member as the abuser, and 53% stated that the abuse occurred at home (National Intimate Partner and Sexual Violence Survey).

Research has consistently shown a correlation between childhood sexual abuse (CSA) and a range of physical symptoms, including issues with gut health, pain, and shortness of breath. Studies suggest that primary care patients with CSA histories are also more likely to report gastrointestinal symptoms than those without such histories (Irish et al., 2010; Hulme, 2004), with one study involving gastroenterology clinic patients revealing that 53% of those with functional GI disorders (non-organic) have a history of CSA, compared to 37% of those with organic GI disorders (Drossman, 1995). In a 2003 study, Salmon et al. found that sexual abuse in childhood was statistically significantly more common among IBS participants compared with physical-disease participants (Salmon et al., 2003).

Beyond GI symptoms, CSA has been linked to a variety of musculoskeletal pain conditions. Studies have shown that individuals with a history of CSA are at an increased risk for conditions like body and joint pain (Bussières et al., 2023; Walker et al., 1999), muscle aches (Newman et al., 2000), and fibromyalgia (Yamin et al., 2025). However, other studies have not found significant differences in general pain between individuals with and without a CSA history (As-Sanie et al., 2014; Chartier et al., 2009). Some studies suggest that sex may influence these outcomes, with CSA's impact on pain being more pronounced in females than in males (Overstreet et al., 2023; Najman et al., 2007). Research has also pointed to a higher incidence of cardiopulmonary issues among those with a history of CSA. Individuals with such a background are more likely to experience chest pain, shortness of breath, irregular heartbeat, and ischemic heart disease (Dong et al., 2004; Hulme, 2004; Walker et al., 1999). Additionally, these individuals often report poorer overall cardiopulmonary health compared to those without a history of CSA (Golding, 1994; Goodwin and Stein, 2004).

These findings collectively highlight the significant physical health consequences of childhood sexual abuse, particularly in relation to digestive disorders, pain syndromes, and cardiopulmonary health.

4.4. Conversion and somatization

Conversion Disorder—now termed Functional Neurological Disorder (FND) in the DSM-5—refers to neurological symptoms such as limb weakness, tremor, abnormal gait, non-epileptic seizures, speech difficulties, or sensory changes that cannot be explained by structural or biochemical abnormalities of the nervous system (Stone and Edwards, 2011). These symptoms are real and often disabling, arising from abnormal nervous system functioning rather than voluntary fabrication or conscious exaggeration. Historically, this concept originates with Charcot and Freud (1894), who described the "conversion" of psychological conflict or trauma into physical dysfunction. Modern FND diagnosis relies on positive clinical signs (e.g., Hoover's sign for functional leg weakness) rather than solely by exclusion of other neurological disorders. Etiology is considered multifactorial, involving predisposing factors (such as personality traits, trauma, or chronic stress), triggering events (illness, injury, psychological stress), and abnormal brain network functioning, with treatment emphasizing multidisciplinary care including neurology, physiotherapy, psychological support, and patient education (Stone and Edwards, 2011).

Historically, somatization described the physical expression of psychological distress, though this framework was often criticized for neglecting physiological mechanisms. Contemporary research increasingly highlights how unresolved trauma, chronic stress, or emotional suppression can manifest physically through mind-body interactions. Chronic stress can dysregulate the hypothalamic-pituitary-adrenal (HPA) axis, leading to prolonged cortisol elevation, systemic inflammation, and increased risk for conditions such as autoimmune disease, irritable bowel syndrome (IBS), cardiovascular disease, chronic fatigue syndrome (CFS), and pain syndromes (Slavich and Irwin, 2014). Neuroscientist Lisa Feldman Barrett's concept of the "body budget" explains how chronic stress and unresolved emotional distress deplete the body's energy resources, resulting in fatigue, illness, and emotional dysregulation (Barrett, 2017). Maté (2011) and van der Kolk (2014) similarly emphasize that unprocessed psychological trauma can produce persistent physiological effects, including increased susceptibility to autoimmune disease and chronic pain. Polyvagal Theory further elucidates how unresolved trauma can dysregulate the autonomic nervous system, producing chronic hyperarousal or hypoarousal states that contribute to conditions such as fibromyalgia, chronic pain syndromes, and postural orthostatic tachycardia syndrome (POTS), which often co-occur with trauma histories (van der Kolk, 2014; Porges, 2011).

In this framework, both conversion symptoms and somatic manifestations can be understood as the nervous system's adaptive—but ultimately maladaptive—response to chronic psychological stress and trauma, highlighting the inseparable interplay between mind and body in health and disease.

In the case of Kay who was diagnosed with Ehlers-Danlos Syndrome (EDS) in her early 30s, but her symptoms began in childhood. As a young girl, she developed a benign tumor on the palm of her left hand. Despite the visible lump, both of her parents, including her physician father, dismissed it as insignificant. By age 10, Kay noticed her left hand was smaller than her right, a result of the tumor impairing its growth. Only then did her parents seek care from a specialist abroad. During surgery, doctors discovered the tumor was entangled beneath a nerve and would require a second procedure. In the interim, they closed her hand crudely, leaving her with a grotesque open wound from her palm down her forearm. In the second surgery, they removed part of the tumor and attempted a nerve graft from her legs to her arm. The graft ultimately failed, and a lump remained in her palm. Her legs and arms bore large, poorly healing scars—classic atrophic scars later linked to her EDS diagnosis. Kay's father, a doctor, incorrectly identified the scars as keloids, failing to recognize the poor healing and atrophic scarring typical of EDS. Even during a scar revision surgery in her teens, no medical provider noticed that her scars indicated a broader connective tissue disorder.

Years later, at 33, a pilates instructor commented on Kay's unusual flexibility, prompting her to seek a physical therapy assessment. A Doctor of Physical Therapy noted multiple EDS indicators: hyperextension in her joints, disproportionate fat deposits, soft and stretchy skin, atrophic scars, a high palate, papules on her feet, and a narrow mouth. Her high Beighton Score, used to assess joint hypermobility, strongly suggested hypermobile EDS. Kay began to see the threads connecting her lifelong symptoms.

She had long struggled with digestive problems—bloating, gas, and constipation—and frequent fainting episodes in varied settings: after donating blood, stepping off a plane, dining out, or visiting friends. She experienced chronic pain in her lower back, sciatic nerve, and sacrum, making sitting uncomfortable. She also endured heat intolerance, abnormal sweating, and flushed face, hands, and feet. These symptoms, which she had dismissed as sensitivity or weakness, were now seen in the context of a systemic condition.

Following her EDS diagnosis, additional testing revealed that Kay also had Mast Cell Activation Syndrome (MCAS) and Postural Orthostatic Tachycardia Syndrome (POTS). She learned that her fainting was due to blood pooling, a hallmark of POTS.

Looking back, she recognized intuitive habits she had adopted to self-manage her symptoms: craving salt to balance electrolytes, using compression socks and weighted blankets to aid circulation, taking baths to regulate body temperature, and practicing pilates, which supported her joints. Today, physical therapy has eased her pain, and supportive relationships have helped her cope.

5. Hysteria as collective distress: The female body in conflict

Interpreting these conditions through the historical lens of hysteria offers insight into how women's bodies and pain are experienced and understood in Western society. Conditions such as fibromyalgia, Long COVID, and Ehlers–Danlos syndrome (EDS) are recognized as distinct medical entities; however, when examined through a structural and statistical lens, their shared characteristics and disproportionate prevalence in women suggest a broader pattern of embodied distress. Rather than implying diagnostic equivalence, this perspective highlights how collective symptom patterns may function as a form of social and somatic communication.

Research on mass psychogenic illness demonstrates that individuals often report physical symptoms such as fainting, pain, nausea, tingling, dizziness, chest discomfort, headaches, and fatigue—symptoms frequently classified as somatic and closely resembling those seen in female-predominant multisystem conditions. These symptom clusters tend to emerge within shared social contexts and are often associated with heightened stress, perceived threat, or collective anxiety, spreading through relational and cultural networks rather than biological contagion (O'Sullivan, 2021).

In contemporary society, women are exposed to persistent structural stressors, including economic inequity, workplace harassment, limited maternal support policies, high rates of physical and sexual violence, and pervasive misogyny within cultural and political systems. Such chronic and systemic pressures may generate psychological distress that becomes embodied, particularly when direct social expression or institutional recognition is limited.

Moreover, digital platforms such as Instagram, TikTok, and online forums have further transformed how illness is experienced and shared, creating spaces where women exchange health narratives, seek validation, and form support communities around conditions such as IBS, fibromyalgia, and dysautonomia/POTS. These networks often provide meaning, recognition, and belonging, reflecting a collective dimension of suffering that parallels historical patterns of shared illness narratives.

As Showalter observes, hysteria is not best understood as weakness or deception, but as "a cultural symptom of anxiety and stress," raising the question of what unmet needs women seek to address through "therapeutic investments, sickness lifestyles, and emotional histories" (Showalter, 1997, p. 65).

In a patriarchal and productivity-driven society, "hysteria" can be understood as the challenging and often painful adaptation process women undergo. From the onset of puberty, with its emotionally intense bodily changes, young women find themselves ill-prepared for a capitalist world that values relentless output and linear progress. Society signals to women that they are non-conforming to capitalistic rhythms. These signals, often subtle but pervasive, pressure women to reject their natural feminine rhythms that prioritize rest, cyclical patterns, and pacing. This forced rejection leads to overexertion and, ultimately, a range of physical and emotional illnesses. This pattern reflects a broader cultural suppression of the feminine, where qualities like softness, receptivity, rest, and intuitive knowing are dismissed in favor of constant productivity, logic, and visible achievement. To adapt, women are conditioned from a young age to disregard their bodies' needs, prioritize the demands of others, and suppress emotions like anger, sadness, or vulnerability. This results in chronic stress and nervous system dysregulation, leaving them in a state of constant "fight or flight."

The cyclical nature of the feminine, with its inherent need for surrender, introspection, and periods of rest, is often perceived as weakness or inefficiency in this performance-oriented culture. This misperception causes feelings of guilt and internal conflict when women attempt to honor their bodies' natural needs. Consequently, the body's manifestation of extreme fatigue, chronic pain, or other debilitating symptoms can be interpreted as a forced rebellion, a desperate cry for self-care and a return to balance when the conscious mind, driven by societal pressures, resists it. The female body resists the demand to keep producing and reproducing under patriarchy. It stops digesting (celiac). It stops circulating blood (dysautonomia, EDs, POTS). It produces chronic fatigue and pain as a form of refusal (fibromyalgia).

Ruth is a 69-year-old woman who developed Long COVID following a severe COVID-19 infection, despite being fully vaccinated prior to illness. A self-described workaholic, she worked as a psychotherapist for over four decades, often seeing up to seven clients per day, and had long-standing back and hip pain and arthritis associated with prolonged sitting and occupational strain. Her acute infection was marked by high fever and persistent cough, followed by an incomplete recovery, with symptoms transitioning directly into a chronic post-viral condition. Early in the course of Long COVID, she developed prominent neurological and vestibular symptoms, while other organ systems remained largely unaffected.

Ruth's most disruptive symptoms included persistent brain fog, dizziness, vertigo, and lightheadedness. These severely impaired her cognitive functions: she was unable to read from a screen, complete forms, or fully process written language. Her vertigo never resolved, and exhaustion became constant and debilitating. She required daily naps to function; her sleep schedule shifted, needing more nighttime rest to get through the day.

After researching Long COVID on her own, Ruth sought care at the neurology department at Northwestern, where physicians confirmed a diagnosis of Long COVID, though they could not offer a prognosis. She was prescribed vestibular physical therapy to address her dizziness and balance issues. The exercises, which included walking in a straight line while turning her head, were a form of desensitization therapy designed to rebuild tolerance. However, they often triggered intense reactions; during one session, she became so overwhelmed that she had to run to the bathroom.

For five months, Ruth suffered from severe eye strain, ongoing achiness, and crushing cognitive fatigue. She sometimes lost focus while driving and twice found herself unable to concentrate at work. Gaps in her memory emerged, particularly around the period of her illness. She often felt as though something had gone fundamentally wrong with her brain. Although people around her were kind and supportive, she struggled with the sense that few truly grasped the depth of her suffering. Ruth's professional workload was ultimately substantially reduced.

6. Therapeutic approaches: Moving beyond symptom management to the mind-body framework

Recognizing a core cluster of symptoms—fatigue, pain, cognitive dysfunction, and mood disturbances—across female-dominant conditions like Fibromyalgia, EDS, and POTS reveals underlying mechanisms, including nervous system dysregulation or unresolved emotional trauma. This insight underscores the importance of addressing root causes to achieve lasting relief. For example, prescribing pain medication for Fibromyalgia without acknowledging nervous system dysfunction or trauma may offer only temporary benefit. The case vignettes support the need for a multifaceted, personalized approach that treats the whole person. Integrative care that combines medical treatment with evidence-based psychological interventions, such as somatic processing and psychodynamic therapy, can more effectively address the systemic nature of these conditions. These mind-body approaches support emotional healing alongside physical recovery, offering a more comprehensive and sustainable path forward for women suffering from complex, chronic illnesses rooted in both biology and lived experience.

The mind-body connection underscores the well-established interplay between mental and physical health, where each continuously influences the other. Based on this understanding, theorists and clinicians have developed mind-body interventions—such as mindfulness, cognitive reappraisal, and body awareness therapies—that foster emotional regulation and physiological balance.

Mindfulness practice, which involves staying present and fully engaging with the current moment, has been shown to reduce stress and improve emotional regulation. For individuals with chronic physical conditions, mindfulness promotes a nonjudgmental acceptance of bodily sensations and emotions. By training individuals to observe their experiences without reactive distress, mindfulness can ease discomfort and enhance resilience. Even highly distressing symptoms, such as fatigue or migraines, may become more manageable when approached with mindfulness, reducing the intensity and duration of discomfort.

Mindfulness-based stress reduction (MBSR) is a well-researched intervention shown to alleviate chronic pain, reduce pain-related depressive symptoms, and improve quality of life (Taub et al., 2024; Panahi and Faramarzi, 2016). Techniques such as meditation, yoga, and stress-reduction practices have been integrated into MBSR programs with significant success. A prospective cohort study found that individuals with chronic pain who participated in MBSR experienced reduced pain intensity, fewer medical symptoms, and improved coping ability (Kabat-Zinn et al., 1985). Likewise, research has highlighted the effectiveness of mindfulness in treating conditions like fibromyalgia (Taub et al., 2024), showing its role in reducing pain, emotional distress, and nervous system dysregulation. Additionally, body awareness practices—including deep breathing, progressive muscle relaxation, guided imagery, and yoga—help individuals develop a more attuned and compassionate relationship with their bodies. These techniques counteract tendencies toward hypervigilance, dissociation, and self-pathologization, fostering a sense of safety and control over one's physical and emotional experience.

6.1. Somatic therapy

Somatic therapies are a category of healing approaches within the broader spectrum of mind-body therapies, specifically emphasizing a bottom-up approach to healing (Kuhfuß et al., 2021; Payne et al., 2015). These therapies focus on the lived experience of being embodied, recognizing bodily awareness as fundamental to how individuals relate to and navigate the world (Kuhfuß et al., 2021). They work with the body's innate wisdom and internal resources, enabling individuals to access, process, and shift their emotions, thoughts, and behaviors through bodily experience (Kuhfuß et al., 2021; Levine and Frederick, 1997).

Somatic therapies can be particularly beneficial for individuals with conditions such as fibromyalgia, Ehlers-Danlos syndrome (EDS), and celiac disease—conditions that often leave individuals, especially women, feeling as though they lack control over their bodies or that their bodies are unsafe. According to van der Kolk (2014), somatic therapies can help restore a sense of safety in the body, particularly after trauma and chronic stress disrupt nervous system regulation. These therapies can also help reduce hypersensitivity to pain, regulate emotional responses, and improve overall well-being.

Moreover, research in somatic psychology has demonstrated that somatic therapies can effectively regulate the autonomic nervous system, helping to modulate pain perception and reduce chronic distress in individuals with fibromyalgia, EDS, and celiac disease (Payne et al., 2015; Levine and Phillips, 2012). These conditions frequently involve multisystemic symptoms, including chronic pain, inflammation, nervous system dysregulation, and emotional distress. By addressing these interconnected factors, somatic approaches offer a holistic means of symptom management, helping individuals cultivate a greater sense of bodily awareness, agency, and resilience.

6.2. Psychodynamic therapy

Psychodynamic therapy emphasizes the exploration of unconscious processes, early experiences, and the effect of past relationships on present behaviors and emotional patterns. Rooted in psychoanalytic theory, its goal is to bring unconscious conflicts into awareness, enabling insight and emotional healing. When multisystem conditions common in women, such as chronic pain, muscle tension, autoimmune disorders, digestive issues, and fatigue, are understood as possible somatic expressions of unconscious conflict or unresolved trauma (van der Kolk, 2014), psychodynamic therapy can serve as a meaningful and complementary approach to medical care. A central focus of psychodynamic therapy is uncovering psychological conflict. Therapists working with patients who experience chronic physical symptoms, particularly those with unclear origins, can help them explore the unconscious meanings behind their symptoms. For example, a patient who experiences severe stomach pain when reunited with an abusive family member may be unable to express their emotions verbally, instead manifesting distress through digestive issues. The therapist helps the patient recognize this connection and then works with them to tolerate and process difficult emotions rather than expressing them through physical symptoms. In this way, psychodynamic therapy helps process trauma, allowing the body to release stored distress or trauma, reducing its physical toll on the body.

Certain analytic Techniques central to this approach include free association, where patients speak without censorship, allowing hidden thoughts and emotions to emerge. Dream analysis further aids in surfacing repressed material through symbolic content. Creative expression—such as drawing, movement, or music—can also be therapeutic, offering nonverbal channels for processing trauma. These methods help individuals access, integrate, and release difficult emotional experiences, reducing psychological and physical distress. By addressing the psychological roots of suffering, psychodynamic therapy offers a holistic approach to healing conditions that often elude strictly biomedical solutions.

7. Limitations and Implications

This article is theoretical and interpretive, drawing on clinical vignettes rather than empirical data, and therefore cannot establish causal relationships or generalizable conclusions. Its effort to identify common patterns across diverse conditions risks overgeneralization and may underrepresent important biological differences and complexities. Additionally, while emphasizing sociocultural and psychodynamic meaning, the framework could be misapplied if not carefully integrated with rigorous medical evaluation and attention to individual and cultural variation.

Despite these limitations, the article offers a novel integrative framework that brings together biological, psychodynamic, and sociocultural perspectives to better understand the disproportionate burden of chronic illness in women. By reframing symptoms as potentially meaningful expressions shaped by lived experience, it expands the clinical lens beyond pathology and invites more nuanced, patient-centered care. This approach may support clinicians in conducting more comprehensive assessments that include relational and developmental histories, while also encouraging interdisciplinary dialogue between medicine and the psychological sciences. In doing so, the paper contributes to a growing effort to move beyond reductive models and toward a more holistic understanding of women’s health.

8. Conclusion

The narratives of women living with conditions like fibromyalgia, chronic fatigue syndrome, and autoimmune disorders reveal not just patterns of physical suffering, but a deeper, gendered experience of illness. These conditions, often dismissed or misunderstood within the medical model, echo the historical diagnosis of hysteria—a pathologization of the female body rooted in patriarchal control. Rather than viewing these conditions as mere dysfunction, it becomes clear that they are embodied expressions of unspoken distress, both personal and collective. Women's bodies, in this sense, are communicating what has long been suppressed: the emotional and psychological toll of living within a system that devalues and silences them. These physical conditions may represent a collective, embodied response by women to societal trauma, specifically, the suppression and marginalization of women under patriarchy. By understanding these conditions as a form of somatic resistance, we can begin to move beyond mere symptom management and toward true healing that acknowledges the complex interplay between trauma, gender, and the body.

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