ORIGINAL ARTICLES

HYSTERIA: A SYMPTOM OR A SYNDROME

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ABSTRACT

A descriptive follow up study of 100 consecutive cases of hysterical (dissociative/ conversion) disorders was conducted from 1995-1998 at CMH Kharian to describe find out the relative frequency of hysterical disorders and other underlying conditions in the patients presenting with hysterical symptoms and also to see the long term validity of this diagnosis. The findings of this work indicated that in 40% of the cases there was either a physical or psychiatric underlying cause of these symptoms i.e. depression (40%), anxiety state (15%), adjustment disorder (17.5%), personality disorder (5%) and medical illnesses (25%). In 60% 0f the cases of hysterical disorder who responded to the follow up questionnaire, the diagnosis of hysterical disorder was sustained. The prevalence of hysterical disorder was more in women, among young, undereducated and lower socio-economic groups. In majority of the patients, a psychosocial stress was identified. Convulsions, sensory loss, visual symptoms, aphonia, headache, amnesia and possession state dominated the presenting complaints. Further sound methodological studies using the structured instruments are needed to replicate these findings.

Keywords: Hysteria, hysterical disorders, psychosocial stress

INTRODUCTION

Hysteria is an ancient word for a common clinical condition. Medical writtings dealing with the nosology of hysteria have evolved through the successive national and international classifications while in parallel [1] the expression of hysteria has changed with time, cultural evolution and with advancement in medical knowledge. Its uterine connotation, multiple meanings, association with other illnesses especially organic, lack of consistency on follow up studies and of little evidence for genetic basis have all contributed to its recent downfall and exclusion from ICD – 10[2] and DSM – IV [3]where it is now represented by somatization, somatoform, conversion and dissociative disorders. Despite this immediate death knell, it is likely that the term, which has already survived for at least four thousand years, will linger on for a while [4].

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Hysterical symptoms can occur as the major feature of a hysterical disorder or as a feature of another psychiatric or organic disorder. In a study by Ziegler et al [5] 40 out of 134 patients (29.5%) consecutively admitted with conversion symptoms also had depressive symptoms.

In a landmark study by Slater [6] 85 patients with the diagnosis of hysteria were followed up for 9 years. The diagnosis of hysteria from the beginning was coupled with an organic disorder in 24 (26%) patients. After 9 years, further 28 (33%) patients developed an organic disease. The remaining 33 (39%) patients had no significant organic disease but four of them committed suicide, two became schizophrenic and seven developed recurrent depression thus leaving only 20 (23.5%) of the study population with the original diagnosis of hysteria.

Lewis [7] has noted that hysterical patients seen in neurology clinics are more likely to have organic illness than those seen

in psychiatric clinics. Merskey and buhrich [8] examined 89 patients with hysterical symptoms and found that 67% had some organic diagnosis and 48 % had some organic cerebral disorder or systemic illness affecting the brain.

However, a recent study by Trimble and Mace [9] by using much refined method found that only 14% of patients developed some neurological illness at 10 years follow up.

Keeping in view the paucity of research in this area in our country, the present study was designed to describe the relative frequency of hysterical disorder with some other underlying psychiatric/physical disorder in 100 consecutive patients presenting with hysterical symptoms and the consistency of the diagnosis of hysterical disorder over a period of three years.

MATERIAL AND METHODS

The study population comprised of 100 consecutive patients presetting in the psychiatry department CMH Kharian from August 1995 – Feb 1998 with symptoms overtly suggesting hysterical disorder (dissociative/conversion/somatoform). These patients first underwent a detailed physical evaluation followed by the psychiatric assessment with a clinical interview by two psychiatrists independently to categorize the hysterical symptoms into the hysterical syndrome or as a manifestation of another physical or psychiatric disorder. Diagnostic criteria used were that of DSM – IV for conversion/ dissociative/ somatoform disorders. All patients were followed up for 03 year through a postal questionnaire to assess their health.

RESULTS

Out of 100 consecutive patients presenting with hysterical symptoms (Group 'A'), 60 were diagnosed to be suffering from hysterical disorder (Group-A1). In the remaining 40 patient, the hysterical symptoms were thought to represent an underlying physical or psychiatric disorder (Group-A 2). The mean age of total study sample was 23.69 years with range of 11 – 60 years. The male to female ratio was 1:1.6; fifty eight patients were married, 40 unmarried and I widow. The majority of the patients (n = 29) were either illiterate or studied below matric (n = 46), only 16 were matriculate, 5 studied till FA and 6 were graduates.

Thirteen patients were serving soldiers, 2 serving officers, 19 entitled families and 64 were non-entitle persons/families. The majority (n=82) belonged to low socioeconomic group, 16 to middle and only 2 to upper class. Ninety three had sib ship above 5, seven had sibship below 5 and 2 had no sibs. Thirty-five had unfavorable environment in the childhood mainly arising from death/ separation of parents. Twenty seven patients had past history of psychiatric illness (all hysterical symptoms) while 20 had positive history of some neuro-psychiatric illness. The comparison of some of these important variables in Group A1 and A2 is given in (Table-1).

Current stresses as precipitating factors were identified in 72 patients. Forty eight in group-A1 and 24 in group-A2. In total, 60 patients had the experience of similar symptoms in the past i.e. 28 had 1st hand and 32 had 2nd hand experience. The commonest symptom was convulsions followed by sensory & motor symptoms. The breakdown of presenting symptoms in various groups is shown in (Table–2). Among 40 patients, hysterical symptom was considered to be a manifestation of an underlying psychiatric or physical disorder. The treatment modalities which were used and their response in the two groups are illustrated in the (Table-3). At three years follow up, 26 patients out of 60 patients with hysterical disorder returned the questionnaire, which had been posted, to them. Twenty-four of them reported no symptoms while one still suffered from convulsions and the one was diagnosed to be suffering from epilepsy.

Table-1: Demographic data – a comparison

Variables		Total (n:100)	Group A1 (n:60)	Group A2 (n:40)
Age (mean)		23.69 years	22.78 years	25.05 years
Sex	(male : female)	1:1.6	1:1.6	1:1.6
Marital Status	(married : unmarried)	1.5:1	1.2:1	1:1.6
Education:	Illiterate	29(29%)	15(25%)	14(35%)
	Below matric	46 (46%)	33(55%)	13(32.5%)
	Matric	16(16%)	6(10%)	10(25%)
	FA	5(5%)	3(5%)	2(5%)
	BA	6(6%)	5(8.3%)	1(2.5%)
Social Class:	Low	82(82%)	44(73.3%)	38(95%)
	Middle	16(16%)	14(23.3%)	2(5%)
	Upper	2(2%)	2(3.3%)	0(0%)
Past h/o psychiatric illness		27(27%)	16(26.6%)	11(27.5%)
Family h/o of psychiatric illness		20(20%)	12(20%)	8(20%)

Table-2: Presenting Symptoms

Symptoms	Group-A (n:100)		Group-A1 (n:60)		Group-A2 (n:40)	
	N	%	N	%	N	%
Convulsions	39	39	23	28.33	16	40.0
Anesthesia & Sensory Loss	25	25	25	41.6	0	0.0
Weakness of Limbs	17	17	13	21.7	4	10.0
Backache	15	15	11	18.3	4	10.0
Amnesia	11	11	6	10.0	3	7.5
Headache	7	7	0	0.0	1	2.5
Loss of vision	1	1	2	3.3	6	15
Chest pain	5	5	2	3.3	3	7.5
Hiccough	3	3	1	1.6	0	0.0
Vomiting	1	1	0	0.0	1	2.5
Possession by Jin	4	4	3	5.0	1	2.5
Torticollis	2	2	2	3.3	0	0.0

Table-3 Different treatment modalities

Treatment Modality	Group-A Responded	Group-A1 Didn't Responded	Group-A2 Responded	Group-A2 Didn't Responded
Simple suggestion & behaviour therapy (n:39)	18(72%)	7(28%)	11(78.5%)	3(21.5%)
Acupuncture (n:40)	22(73.3%)	8(26.7%)	7(70%)	3(30%)
Cerebral stimulation (n:15)	8(80%)	2(20%)	5(100%)	0(0%)
Abreaction (n:3)	2(60.6%)	1(39.4%)	0(0%)	0(0%)
Drugs (n:53)	29(78.8%)	4(21.2%)	19(95%)	1(5%)

Group-A: total study sample (n=1000) ***Group-A1: Hysterical disorder (n=60)***
Group-A2: Underlying physical/psychiatric illness (n=40)

DISCUSSION

The diagnosis of neurological and physical symptoms and signs as hysteria requires caution.

It is doubtful whether it is a unitary disease or only a symptom of diverse conditions grouped together under this term [10].

Kendell [11] described seven syndromes and emphasized that the term hysterical reflects only an unsatisfactory doctor –patient relationship

The present study supports this view since substantial number of patients (40%) on presentation had some underlying physical or psychiatric disorder as cause of their symptoms. This finding is consistent with that reported by Ziegler [5] and Slater [6].

However, at 3 year follow up, only 26 patients returned the questionnaire, 24 of them were reportedly symptom- free while 2 were still symptomatic with one having been diagnosed to be suffering from epilepsy Low rate of response and relatively short duration of follow up makes it difficult to compare these findings with other follow up studies. Among the 60 patients with hysterical disorder, the commonest diagnosis was conversion disorder (n=44) followed by dissociative disorder (n=10) and somatoform disorder (n=6). The commonest diagnosis in 40 patients with symptomatic hysteria, was depression (n=17) followed by adjustment disorder (n=7), anxiety state (n=6), personality disorder (n=2), fever NYD (n=7) and epilepsy (n=1) and the prevalence of hysterical disorder is reported to be more in women in rural areas, among the undereducated and lower socioeconomic groups [12,13,14], this study confirms these findings. Large sib ship was related to hysterical disorder most probably due to poverty, family conflicts and poor parenting.

In our study there were more married women than unmarried ones apparently contradicting the traditional view in our culture that hysteria occurs primarily in young unmarried girls. This finding may be a paradox as husbands of many married women were away mostly in foreign countries which may have triggered the classical Freudian sexual conflicts in these ladies.

Hysterical disorders seldom appear for the first time after the age of 40, presumably because most predisposed patients have already encountered problems severe enough to provoke reaction at an earlier age. If no stressor can be found the diagnosis is in serious doubt. The present study supports these observations as 96% of the patients were below the age of 40 and 72% had some identifiable current stress.

Although hysterical symptoms are not produced deliberately, they represent the patient's ideas about illness. Sometimes the symptoms imitated are those of a relative or a friend who has been ill while sometimes they originate from patient's own experience. In this work, 60 patients had either first hand or 2nd hand experience thereby emphasizing the role of learning in the pathogenesis of hysterical symptoms

The various treatment modalities employed showed almost equal efficacy (about 70%) in alleviating the hysterical symptoms in both Group-A1 and Group-A 2.

CONCLUSION

This study confirms that a substantial proportion of patients presenting with hysterical symptoms suffer from some other underlying psychiatric or physical disorder. Therefore, a considerable caution is required before labeling a symptom as hysterical disorder. Same has been emphasized in William A Frosch's article on 'Freud's Couch' [15]. Failing this, a serious physical or psychiatric disorder may be missed with important therapeutic, medico-legal and economic implications. Further studies using standardized instruments and with reasonable follow up period are needed to replicate the findings of this work and to determine future course/prognosis of hysterical syndrome/ symptoms in our culture.

REFERENCES

1. Mai, FM Hysteria in clinical neurology. **Can-J-Neurol-Sci., 1995; 22(2): 101-10**

2. World Health Organization. The ICD- 10 Classification of Mental and Behavioral disorder, **Geneva: 1992; WHO.**

3. American Psychiatric Association, Diagnostic and Statical Manual of Mental Disorder (4th ed) (DSM IV), **1992; Washington,-DC: APA.**

4. Consoli, SM. The Borders of hysteria. Rex Prat (French) **1995; 45 (20): 2556-62.**

5. Ziegler, F.J. Imbordn, J.B. and Meyer, E. et al contemporary conversion symptomatology. **Am J Psychiatry 1960; 116: 901 – 10.**

6. Slater and Guithro. E. A follow up of patients diagnosed as suffering from hysteria. **J Psychosomatic Research 1965; 9: 9 – 13.**

7. Lewis, A. The survival of hysteria. **Psychol Med 1975; 5, 9-12.**

8. Merskey, H. and Buhrich, N.A. Hysteria and organic brain disease. **Br J Med Psychol 1975; 48, 359.**

9. Trimble and Mace. Ten year prognosis of conversion disorder. **Br J Psychiatry 1996; 282 – 288.**

10. Cleghorn, R.A. Hysteria – multiple manifestations of somatic confusion. **Can Psychiat Ass J 1969; 14,539.**

11. Kendell, R.E. A new look at hysteria. Medicine, 1st Ser. No. 30, 1780-1783 Ziegler, FJ. Slater, E. (1965) Diagnosis of 'Hysteria'. **Br Med J 1974;i, 1395.**

12. Ashraf, M. Conversion hysteria a study **Pak Armed Forces Med J 1982; 1: 1-6.**

13. Nandi, DN. Aimang, S. Ganguli, H. Psychiatric disorder in a rural community in West Bengal - an epidemiological study. **Indian J Psychiatry 1975; 17: 87-89.**

14. Nandi, D.N Mukherjee, S.P Boral, G.C. Socioeconomic status and mental morbidity in certain tribles and cases in India-Cross-cultural study. **Br J Psychiatry 1980; 136: 73 – 85.**

15. William, A Frosch,. Seven new interpretations of Freud's case histories. **Am J Psychiatry 1998; 155(1): 1296-97.**