Indian J. Psychiat. (1982), 24(2), 120—125

A FOLLOW UP STUDY OF HYSTERIA[1]

N. N. WIG[2],
K. MANGALWEDHE[3],
HARMINDER BEDI[3], &
R. SRINIVAS MURTHY[3]

SUMMARY

The present study undertook to examine the outcome of a group of cases who were diagnosed as hysteria, six or more years ago in a general hospital psychiatric unit and correlate various clinical factors with good or bad outcome. Of the 81 cases selected for the study, 57 (67%) could be located and followed up after a gap of 6-8 years. Majority of the cases (74%) had either no symptoms or symptoms less than before at the time of the follow up. In only 3 cases, there was evidence of an underlying organic illness which seemed to have been missed at the initial assessment. A new subclassification of hysteria with glossary of terms used for this study is presented for future research work.

The use of the term hysteria as a diagnostic label seems to have declined considerably in Europe and U.S.A. in recent years. In the out-patient department of Bethlem-Maudsley Hospital, London, the diagnosis of hysteria steadily declined from 223 out of 6229 cases (3.5%) in 1955-57 to only 45 out of 8585 cases (0.5%) in 1967-69 (Triennial Statistical Report). In India, hysteria continues to be a common diagnosis. In various reports from psychiatric clinics it constitutes 6 to 11 per cent of all OPD diagnoses (Dutta Ray and Mathur, 1966 ; Singh, 1968 ; Bagadia *et al.*, 1973 ; Khanna *et al.*, 1974 ; Wig *et al.*, 1978. Subramaniam *et al.*, 1980). The clinical symptomatology of hysteria in India and Europe also seems to be different. The 'grande hysteria' of Charcot's days with dramatic symptoms like hysterical fits, loss of speech, paralysis etc. which have become rare sights in European clinics are still common in India.

A major controversy has been raised in recent years in European and North American medical literature as to whether hysteria is really a separate disease entity and whether there is much point in continuing with this label. Both the proponents (Slater, 1965) and the opponents (Walshe, 1965) have marshalled their arguments very cogently but, one is rewarded by late Sir Aubrey Lewis's comments "Hysteria tends to outlive its obituarists" (Lewis, 1975).

Slater (1965), in his indictment of hysteria has observed that the cases which are commonly diagnosed as hysteria have in common neither etiology nor clinical picture or final outcome. In a follow-up study done after an average duration of nine years on 85 cases diagnosed as hysteria in one of London's major neurological hospitals, 12 were dead, 14 totally disabled, 16 partially disabled and only 43 (50%) remained independent. Only 19 of these patients were actually symptom free at the time of follow-up.

Slater's data are indeed very impressive but one major weakness remains that it dealt with a predominantly neurological sample. Would the same findings be repeated if the sample were selected from a different setting—for example, a general

[1]This study was carried out by a research grant from the Postgraduate Institute of Medical Education & Research Chandigarh.

[2]Professor & Head, Deptt. of Psychiatry, A.I.I.M.S., New Delhi.

[3]Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh.

hospital ? And, would the findings be different if a similar study is done in another culture like India where the diagnosis is still quite common ?

A different view of hysteria has been taken by Perley, Guze and their associates in a series of publications from 1962-75 in U.S.A. (Perley and Guze, 1962; Guze *et al.*, 1971; Guze, 1975). They have mainly tried to isolate a central syndrome of hysteria, which they refer to as Briquet syndrome by rigid criteria of age, sex, onset and recurrent symptoms spread over different body systems. They claim that the diagnosis of hysteria thus defined remains reasonably stable over the years and that it is a chronic disabling disease. Based on such American data, the D. S. M. III has now classified separately, somatization disorder (Briquet syndrome), conversion disorder (Hysterical Neurosis, Conversion type) and Dissociative disorder (Hysterical Neurosis, Dissociative type).

What is the outcome of hysteria in Indian setting ? In spite of the fact that hysteria as a diagnosis is widely used in India, there are unfortunately very few longitudinal studies dealing with the problem. Most of the psychiatric studies on hysteria have confined themselves to the task of correlating diagnosis with simple demographic variables like age, sex, education and socio-economic status. The present study was undertaken mainly to determine the outcome of a group of cases diagnosed as suffering from hystreia in a general hospital psychiatric O.P.D. clinic in India after an interval of about 5 years. The aim was to find out how often such cases would reveal serious organic or psychiatric illness at the time of follow-up and what factors at initial clinical examination are predictive of the subsequent outcome.

MATERIAL AND METHOD

The study was conducted in the Department of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh during the year 1977-78. The sample studied consisted of adult patients who were diagnosed as suffering from 'hysteria' (ICD-9-300.1) and were seen for the first time in the psychiatric outpatient facility PGIMER, Chandigarh during the period 1971-72. Only those patients were included whose residences were within 30 km of Chandigarh. The records of all the patients were scrutinized and the information transferred onto a specially prepared proforma. The following clinical criteria were used for the diangosis of hysteria :

(*a*) Absence of a demonstrable physical illness which could explain patient's symptoms.
(*b*) Presence of a 'suspect' neurological symptom (e.g. aphonia, blindness, paresis)
(*c*) Psychogenic precipitating factor.
(*d*) Hysterical or histrionic behaviour.
(*e*) Element of secondary gain.
(*f*) Evidence of dissociation.
(*g*) La Belle Indifference.

The case records were divided into 'likely' and 'doubtful' cases. Only those cases were included where diagnosis seemed likely on the basis of presence of two or more of the above criteria. However, absence of physical disease which could explain patient's symptoms was considered an essential criterion. Socio-demographic data, clinical history and examination, family history and details regarding admission, in case of admitted patients were recorded in a separate section of the proforma.

Based on this analysis, the cases were allotted to the following clinical subcategories :

A. Monosymptomatic conversion reaction

This category was applicable in the presence of definite and clear cut physical symptoms of the central nervous system

like paralysis, aphonia, anaesthesia. It also included all other single somatic symptoms judged to be hysterical manifestation because of the lack of related organic pathology and presence of additional features as noted above.

B. Multiple somatic symptoms

The clinical presentation was characteriezd by the presence of multiple symptoms referring to different parts of the body. The commonest systems affected were the gastro-intestinal, musculoskeletal and cardiovascular. The complaints were often vague and changing over a period of time.

C. Hysterical fits

This category referred to the presence of a predominant complaint of episodic "loss of consciousness" or "fainting", with or without associated movements of the body. These attacks were distinguishable from epilepsy by the absence of bodily injury or of tongue-biting, of tonic-clonic contraction of the muscles and voiding of urine during fits. Episodic attacks of hyperventilation, and falling down were also included.

D. Psychological dissociative reaction

This refers to the conditions in which there was an altered state of consciousness manifesting as amnesia, fugue, trance state, double personality without any associated oragnic features. Epidosic possession states and cases of so called hysterical "psychosis" were also included in this group.

E. hysterical personality.

This group included those cases where personality disorder was considered to be the central problem, though occasional neurotic symptoms could be present. As defined in I.C.D.-9 a hysterical personality disorder was considered by the presence of shallow, labile affect, dependence on others, craving for appreciation and attention, suggestibility and dramatization. There could be associated sexual immaturity.

In case of overlap of categories, the most important symptoms were used for classification.

For the purpose of follow up, all patients were sent a letter requesting them to come to the O.P.D. clinic alongwith a family member. A special follow up clinic was set up on a particular day of the week, where these patients were seen. Those who did not respond to the first letter, were sent a second letter, after fifteen days. Those patients who did not respond even after the second letter, were visited at home by a psychiatrist and a social worker. Special efforts were made to trace the patient who had left their previous residence, by enquiries from the neighbours, office etc. A specially constructed proforma was filled in every case contacted after interviewing the patient and/or the relative in the clinic or at home.

The major aspects studied at the time of follow up were (i) clinical status of the patients at follow up, (ii) course of the original symptoms, (iii) present social adjustment, (iv) development of any organic or psychotic illness during follow up period.

RESULTS

In all, 81 patients fulfilled the criteria for inclusion in the study. 67 (83%) of these were females. Of the total group of patients, 73% were in the age range of 15—29 years. There was an equal distribution of single and married patients. One patient was widowed. 49% of the patients were housewives, 35% were students and 16% were employed. Their educational distribution showed that 63% of the patients had less than 8 years of schooling. In 53% of the cases, the household composition was nuclear ; 35% of the patients came from joint extended families

and the family composition was not clearly known in 12% of the cases. The details of the follow up are shown in Table 1-5.

TABLE I—*Distribution of Sample*

Total No. of patients	81	
No. of patients followed up ..	54	(67)*
Follow up information obtained at :		
—O.P.D. clinic in response to letter	20	(37.0)
—Home/Office visits	34	(63.0)
Information obtained from :		
—Patients & Relatives ..	37	(68.5)
—Only Relatives	17	(31.5)

*Percentages given in parentheses.

TABLE 2—*Diagnostic Categories at Initial Contact*

Diagnostic Categories	Male	Female	Total
Mono symptomatic conversion Reaction ..	4	13	17
Multiple Somatic Symptom	..	6	6
Hysterical Fits ..	2	20	22
Psychological dissociative Reaction	..	1	1
Hysterical personality ..	..	7	7

TABLE 3—*Clinical Status at Follow up*

Clinical status	Male	Female	Total
1. Completely *Asymptomatic*	5	24	29
2. Symptoms present but less than before ..	..	10	10
3. Symptoms about the same	1	9	10
4. Symptoms definitely worse	..	4*	4
5. Deaths	..	1**	1
Total ..	6	48	54

*Three out of four turned out to be having organic illness.

**Patient died of myocardial infarction at the age of 48 years. Cause of death not related to original illness.

TABLE 4—*Course of the Original Symptoms*

Course of the original symptoms	Male	Female	Total
Symptoms lasted less than six months ..	4	19	23
Lasted 6-12 months ..	..	1	1
Lasted 1-3 years ..	1	4	5
Symptoms still persisting	1	23	24
Total ..	6	47	53

TABLE 5—*Original Diagnosis and Condition at Follow-up*

Original Diagnostic Categories	Present Outcome				Total
	Asymptomatic		Symptomatic		
	Male	Female	Male	Female	
1. Mono-symptomatic Conversion Reaction ..	4	10	..	3	17
2. Dissociative Reaction ..	..	..	..	1	1
3. Hysterical Fits	1	10	1	10	22
4. Multiple Somatic Symptoms ..	..	2	..	4	6
5. Hysterical personality ..	..	2	..	5	7
Total ..	5	24	1	23	53

Chi-Square test was carried out with the following categories :

a. Categories 1, (2 & 3)*, 4 & 5 $X^2=16.73$, d.f.=3, $p<0.001$

b. Categories 1 and (2 & 3) $X^2=14.95$ d.f.=1, $p<0.01$

c. Categories 1 and 4 $X^2= 5.00$, d.f.=1, $p<0.05$

d. Categories 1 and 5 $X^2= 6.46$, d.f.=1, $p<0.02$

e. Categories (2 & 3) and 4 $X^2= 0.41$, d.f.=1, N.S.

f. Categories (2 & 3) and 5 $X^2= 0.80$, d.f.=1, N.S.

*Categories 2 and 3 were pooled together for statistical analysis.

DISCUSSION

As shown in Table 3, at the time of follow-up only three out of 53 cases gave evidence of an underlying organic pathology which seemed to have been missed at the initial assessment. One additional case subsequently developed a psychotic illness, though it was difficult to determine whether it was a schizophreinc or a reactive psychosis. Majority of the cases at follow-up (74%) had either fully recovered or had symptoms which were less than before. This finding is quite in contrast to the findings of Slater (1965). As already pointed out, Slater's sample was a highly selective one from a neurological hospital, There are still very few follow up studies on hysteria reported from India or other developing countries. However, in one recent study done at Vellore in South India, in which fairly similar criteria for diagnoiss as in the present study were used (Subrahmaniam *et al.*, 1979). the authors have reported a 4-8 year follow-up of hysteria done by a postal questionnaire method. Only 93 patients out of 276 (33%) replied. 78 out of 93 who replied the questionnaire reported that they have recovered or improved in their symptoms. It can, thus be, argued that in the context of an Indian setting, majority of those who are diagnosed as hysteria, remain reasonably well at the end of a long follow-up and do not change to an organic brain or functional psychotic illness.

A comparison of those who had recovered from their symptoms at follow-up with those who were still having symptoms reveals interesting differences in terms of initial clinical picture (Table 5). Those who had initially mono-symptomatic conversion symptoms showed maximum recovery, while larger number of cases in 'multiple somatic symptoms' and 'hysterical personality' groups continued to have symptoms at follow-up. The so-called 'hysterical fits' cases were equally divided into two groups of good and bad outcome, thus suggesting that it was not a very pure group. It was chosen as a separate group because such cases occur in large numbers in Indian clinics. Subrahmaniam *et al.*, in their study referred to above, report 27 per cent cases having fainting attacks and fits. The hysterical "fits', as they occur in India seem to have both the features of "dissociation" & "conversion". Obviously, more clinical studies are necessary to establish the nature of such symptoms.

The separation of the sample into a good and bad outcome hysteria seems to suggest interesting possibilities. In our opinion though hysteria may manifest as a 'hysterical' overlay of symptoms in an existing neurotic (or even psychotic or organic) condition in many situations, it also appears as a 'core' hysterical illness which remains steady over the years in some cases. Looked at this way, hysteria resembles other psychiatric groups like anxiety, depression, obsession or depersonalization, where symptoms may be secondary in many psychiatric conditions but can also be recognised as separate psychiatric entities. Clinically, it would be important if these two types of hysteria could be separated. Our classification of hysteria into five sub-groups suggests interesting possibilities, but more clinical studies especially prospective types are required to confirm this. Guze and his associates in their various publications (Guze, 1975; Guze *et al.*, 1972) have also emphasized the need for separation of a bad outcome group of hysteria which they prefer to call Briquet syndrome. Unfortunately, the criteria, though very helpful for research purposes, are not very practical for routine clinical work. However, with the available knowledge, separation of hysteria into an 'hysterical reaction' group and a 'core hysterical illness' seems justified. The later being recognizable by the presence of multiple somatic symptoms over a span of

time, hysterical personality traits, and prolonged course.

REFERENCES

BAGADIA, V. N., SHASTRI, P. C. AND SHAH, L. P. (1973). A prospective study of demographic factors of 192 cases of hysteria. Indian J. Psychiat., 15, 179.

DUTTA RAY, S. AND MATHUR, S. B. (1966). Pattern of Hysteria observed at Psychiatric clinic, Irwin Hospital, Delhi. Indian J. Psychiat., 8, 32.

GUZE, S. B., WOODRUFF, R. A., AND CLAYTON, P. J. (1971). Hysteria and Antisocial Behaviour : Further evidence of an association. Amer. J. Psychiat., 127, 7, 957.

GUZE, S. B., WOODRUFF, R. A. AND CLAYTON, P. J. (1972). Sex, age and diagnosis of hysteria. Amer. J. Psychiat., 129, 6, 745.

GUZE, S. B. (1975). The validity and significance of Clinical diagnosis of hysteria (Briquet's syndrome). Am. J. Psychiat., 132, 2, 138.

KHANNA, B. C., WIG, N. N. AND VARMA, V. K. (1974). General Hospital psychiatric clinic. An epidemiological study. Indian J. Psychiat., 16, 211.

LEWIS, A. (1975). The Survival of Hysteria. Psychol. Med., 5, 9.

PERLEY, M. J. AND GUZE, S. B. (1962). The stability and usefulness of clinical criteria, of Hysteria. New England J. Med., 266, 421.

SINGH, G. (1968). A clinical psychological study of Hysteria. Indian J. Psychiat., 10, 84.

SLATER, E. (1965). Diagnosis of hysteria. Brit. Med. J., 5447, 1395.

SUBRAMANIAM, D., DEVAKY, M. N. AND VERGHESE, A. (1980). A clinical study of 276 patients diagnosised as suffering from hysteria. Indian J. Psychiat., 22(1), 63.

TRIENIAL STATISTICAL REPORT (1967-1969). The Mandal & Royal Bethlem Hospitals. (Ed.) E. Hare, London : H. M. S. Press.

WALSHE, F. (1965). Diagnosis of hysteria. British Med. J., 2, 145.

WIG, N. N. VARMA, V. K. AND KHANNA, B. C. (1978). Diagnostic characteristics of a general hospital psychiatric adult outpatient clinic. Indian J. Psychiat., 20, 262.

BOWDEN HOUSE CLINIC

Harrow-on-the-Hill, Middlesex

Tel. : 01-864 0221

Only 20-25 Mins from London via Westway Extension

Founded in 1911 by Dr. H. Crichton-Miller

A non-profit making Charity outside the National Health Service

A private clinic (all patients having single rooms) for the treatment of patients suffering from neuroses, early psychoses, psychosomatic disorders, drug addiction and alcoholism.

Treatment is supervised by experienced psychiatrists whose services are inclusive in the patient's fees.

A full physical examination and pathological investigations are made in the first week.

Facilities are also available to Consultants wishing to treat their own patients independently.

Apply for details :

ADMINISTRATIVE SECRETARY

Applications for admission to the Matron