

## A CLINICAL STUDY OF 276 PATIENTS DIAGNOSED AS SUFFERING FROM HYSTERIA

DEEPA SUBRAMANIAN<sup>1</sup>

K. SUBRAMANIAM<sup>2</sup>

M. N. DEVAKY<sup>3</sup>

ABRAHAM VERGHESE<sup>4</sup>

### SUMMARY

A clinical study of 276 patients diagnosed as Hysteria in the Department of Psychiatry, Unit-2, Christian Medical College, Vellore, during the period of 1970-1974 is described.

This group of 276 patients formed 10.81% of the total new consultations during this period. 61.2% of these were females. The peak age of onset was 10-20 years. The majority were married. 75% of them had conversion symptoms, 20.3% had dissociative states, and 4.7% had both features. 52.5% showed possible precipitating factors. 66.0% had features of extraversion in their personality make up. 14.1% showed evidence of parental deprivation. There was over-representation of the early born. Somatic symptoms (aches and pains) was the most common mode of presentation. The other common clinical manifestations were fainting attacks, "fits", vomiting, involuntary movements and paralysis of limbs. The immediate follow up showed that 11 patients recovered, 120 improved, 3 were unchanged and 1 patient became worse. Only 93 patients could be contacted for the final follow up. Among these, 28 recovered completely; 50 were improved; 2 became worse and 2 died.

It is emphasized that Hysteria continues to remain a clinical entity.

Hysteria, whose description could be traced to two and a half millennia, has had sentence of death passed upon it (Slater, 1965) and yet it survives. In reviewing the literature, particularly Western, many writers have proposed that Hysteria is not a disease nor even a syndrome (Slater, 1961) and a few have pleaded the cause of its retention (Guze and Perley, 1963, Purtell et al., 1951; Lewis, 1975). The latter group have shown in their patients the uniformity of clinical picture and consistency of course that the other studies (Slater, 1965) have failed to find. In fact Slater, one of the vociferous obitourists says "the diagnosis of Hysteria, is in fact not only a delusion but also a snare." Though Hysteria is infrequent in developed countries it is common in developing countries. Vyas and Bharadwaj (1977) have reported on 304 hysterical patients in a psychiatric clinic in

North India. 10.6% of the new consultations in their clinic were patients with Hysteria.

The aim of this paper is to describe the socio-demographic and clinical details of 276 patients seen during 1970-1974 who were diagnosed as having Hysteria in Unit-2, Department of Psychiatry, Christian Medical College, Vellore, India.

### MATERIAL AND METHOD

Mental Health Centre, which is the Department of Psychiatry of the Christian Medical College, Vellore is situated in a rural set up. The unique feature of this centre is that family participation is actively encouraged. Two close relatives will have to live with the patients during the hospitalization period which is usually 6-8 weeks. Detailed case notes are kept and several clinical studies are carried out in the

<sup>1</sup>Clinical Tutor

<sup>2</sup>Psychiatric Social Worker

<sup>3</sup>Registrar

<sup>4</sup>Professor & Head of Unit

} Department of Psychiatry, Christian Medical College, Vellore-2.

Department. All patients will be discussed in the group consisting of Psychiatrists, Psychologists Social workers, Occupational therapists and nurses and diagnosis and outcome of treatment will be agreed upon. The case notes of these 276 patients were examined. Patients with associated epilepsy, affective disorder or any other psychiatric illness were excluded.

The diagnostic criteria used were:

- (a) A physical symptom in a sensorimotor area or a dissociative reaction without any structural lesion.
- (b) Any 2 of the following:
  - i. Hysterical personality
  - ii. Obvious significant emotional problem
  - iii. La Belle indifference
  - iv. An element of gain
  - v. Previous hysterical episodes.

Data regarding antecedent history, habitat, birth order and family size, educational status, clinical state, treatment and immediate outcome was recorded on a special data sheet from all sources of information in the notes. The immediate follow up was done at the time of termination of treatment which was psychotherapy of an eclectic type lasting for about 8 weeks.

#### RESULTS COMMENTS

This group of 276 patients, diagnosed as Hysteria forms 10.18% of the total number of consultations, which shows a striking similarity to the figure of 10.6% reported by Vyas and Bharadwaj (1977) in a group of patients from North India. Table 1 shows the age and sex distribution. 61.2% of the patients were females. The peak age of onset was 10-20 years. This age and sex distribution is in agreement with other studies (Guze and Perley, 1963; Robbins *et al.*, 1952; Purtell *et al.*, 1951; Vyas and Bharadwaj, 1977; Bagadia *et al.*, 1973; Venketaramiah and Embar, 1969; Ziegler *et al.*, 1960).

Table 2 shows the marital status and sex distribution. 54.3% were married and 45.7% single when both males and females

TABLE 1—Age & sex distribution

Age	Male		Female		Total	
	No.	%	No.	%	No.	%
10—20	44	41.1	65	38.5	109	39.5
21—30	37	34.6	52	30.8	89	32.2
31—40	18	16.8	41	24.3	59	21.4
41—50	6	5.6	8	4.7	14	5.1
51—60	2	1.9	3	1.7	5	1.8
Total	107	100.0	169	100.0	276	100.0

TABLE 2—Marital status

Marital Status	Male		Female		Total	
	No.	%	No.	%	No.	%
Single	71	66.4	55	32.5	126	45.7
Married	36	33.6	114	67.5	150	54.3
	107	100.0	169	100.0	276	100.0

were taken together. Single males (66.4%) were more than married males and married females (67.5%) were commoner than single females. It is reported in other Indian studies that Hysteria is common among the married (Mathur, 1975; Vyas and Bharadwaj, 1977; Bagadia *et al.*, 1973). Epidemiological community surveys in India also show that psychiatric disturbance is more in the married group. (Verghese and Beig, 1974; Sethi *et al.*, 1967). This is in contrast to studies in the West. The difference may be due to cultural factors. In India marriage is often arranged between families and there is a belief that marriage can cure mental illness. The mentally ill are therefore encouraged to marry, more so among females.

Table 3 shows the educational status of the patients. The majority had reached only secondary and only 13.5% had gone to College. Hysteria is known to be commoner in people who have had only minimum education. (Purtell *et al.*, 1951; Guze *et al.*, 1971; Mathur, 1975). Our study also

TABLE 3—*Educational status*

Education		Number of Patients	%
Illiterate .. ..	..	32	11.7
Primary School .. ..	..	67	24.2
Secondary School .. ..	..	133	48.2
College .. ..	..	37	13.5
Not Recorded .. ..	..	7	2.4
Total .. ..	..	276	100.0

shows a similar association. Other Indian studies also have reported similar findings. (Vyas & Bharadwaj, 1977; Bagadia et al., 1973).

Table 4 shows the birth order of the patients which suggests that there is an over

TABLE 4—*Birth order—Green wood-Yule method (Schooler, 1964)*

Ordinal Position		(E)	(O)	(O-E) <sup>2</sup>
		Expected Frequency	Observed Frequency	E
Eldest ..	..	59.3	70.0	2.06
Youngest ..	..	59.3	47.0	2.44
Intermediate ..	..	144.4	146.0	0.04
		263.0	263.0	4.54

representation of the early born. Association between birth order and psychiatric disturbance is widely reported. Studies in India have reported that schizophrenia is associated with early birth order (Rao, 1964; Sunder Raj & Rao, 1966) while studies in the West have reported an association between Schizophrenia and later birth order (Granville-Grossman, 1966; Hare and Price, 1970), from our Department we have reported that both schizophrenia and neurotic reactions are commoner in the early born (Subramaniam and Verghese, 1977; Abraham et al., 1973). It is a matter of conjecture that the burden of responsibility in the early born may be one of the

factors which make them more susceptible to get psychiatric disturbance.

Table 5 shows that parental lack (death or continuous absence from home of either

TABLE 5—*Parental Lack*

Parental Lack		No. of Patients	%
Present .. ..	..	39	14.1
Absent .. ..	..	209	75.4
Not recorded .. ..	..	28	10.5

parent for more than one year before the patient was 16 years old) was seen only in 14.1% of the patients. Several studies show that parental lack is positively related to the tendency to get psychiatric disturbance especially in neurotic reactions (Wig et al., 1969; Kuruvilla, 1974; Bagadia et al. 1976).

Table 6 shows that in 41.9% of the patients, the duration of illness was less

TABLE 6—*Duration of illness*

Duration of Illness		No. of Patients	%
0—6 months .. ..	..	124	44.9
6 months—1 year .. ..	..	37	13.4
1 year and above .. ..	..	115	41.7

than 6 months; in 13.4% of the patients it was between 6 months and 1 year; and in 41.7%, the duration of illness was more than 1 year. This is mainly because, many of our patients with hysterical symptoms go to temples and native healers for help. It is quite possible that many recover and only those who do not get well are brought to a psychiatric hospital.

Table 7 shows that 52.5% of patients gave the history of some obvious precipitat-

TABLE 7—*Precipitating factors (P F.)*

P. F.		No. of Patients	%
Present .. ..	..	145	52.5
Absent .. ..	..	96	35.5
Not recorded .. ..	..	35	12.0

ing factors. In 40.6% of the patients, the onset of symptoms was sudden and in 56.1% it was acute (Table 8).

TABLE 8—*Onset of illness*

Onset	No. of Patients	%
Sudden ..	112	40.6
Gradual ..	145	56.1
Not recorded ..	19	3.3

Table 9 shows the personality type of the patients. No psychological tests were

TABLE 9—*Personality type*

Type	No. of patients	%
Introvert ..	65	23.6
Extrovert ..	182	66.0
Not recorded ..	29	10.4

used for this and the assessment was by psychiatric interview. 23.6% were introverted and 66% of the patients were extroverted. Though this assessment was quite superficial it is in keeping with the usual concept of the hysterical personality.

Table 10 shows the distribution of patients in the three different categories of

TABLE 10—*Diagnostic Categories*

Diagnosis	No. of Patients	%
Conversion ..	207	75.0
Dissociation ..	56	20.3
Mixed ..	13	4.7

Conversion hysteria, Dissociative reaction and the Mixed type where both conversion and dissociation reactions are present. 75% were Conversion hysteria; 20.3% Dissociative reaction; and 4.7% belonged to the Mixed group.

Table 11 lists the various symptoms and their occurrence in order of frequency. Somatic aches and pains were the most common, seen in 38% followed by fainting attacks in 17% and fits in

TABLE 11—*Symptomatology*

Symptom	No. of Patients	%
Somatic aches & pains	105	38.0
Fainting attacks ..	47	17.0
Fits ..	29	10.5
Vomiting ..	23	8.3
Dysphonia ..	15	5.4
Breathlessness ..	14	5.1
Abnormal behaviour	14	5.1
Paralysis ..	13	4.7
Involuntary movements	13	4.7

10.5%. The other common symptoms were vomiting, dysphonia, breathlessness, paralysis and involuntary movements. Most of the patients mainly women had numerous symptoms which is in keeping with several other studies (Purtell *et al.*, 1951; Guze and Perley, 1963). More men had monosymptomatic illness. Similar observation is made in other studies also (Robbins *et al.*, 1952). The most frequent symptoms were aches and pains which also is in agreement with other studies, (Guze and Perley, 1963; Vyas and Bhardwaj, 1977). Fainting attacks and fits which are not so common in West were seen frequently in our sample. There were only 2 patients with possession states (dissociative reaction) and both were women. Since this symptom is not considered by many people as sickness (in fact possessed people are often respected in the rural areas) many people with possession states will not seek treatment.

Of the 276 patients, 141 patients (51.1%) did not come for treatment after the initial consultation. This means that though facilities for treatment were available, more than 50% of patients did not make use of them, which poses an important and difficult problem in the organisation of mental health facilities in developing countries. It is often said that there are not enough facilities to meet the mental health needs of the developing countries.

Though this may be true another important factor is that many patients do not make use of the facilities even if they are available. This problem of under-utilisation of mental health facilities is related to prejudices of people to make use of these facilities and these prejudices have to be removed if mental health organisation has to be fruitful (Verghese, 1978).

Table 12 shows the outcome of treatment at the immediate follow-up. 11 recovered completely, 120 were improved, 3 were unchanged and 1 became worse.

TABLE 12—Immediate outcome of treatment

Outcome	No. of Patients	%
Recovered	11	8.1
Improved	120	89.0
Unchanged	3	2.2
Worse	1	0.7
Total	135	100.0

Table 13 shows the long term (4-8 years) follow-up. In order to carry out

TABLE 13—Longterm follow up

Outcome	No. of Patients	%
Recovered	28	30.0
Improved	50	53.6
Unchanged	11	12.0
Worse	2	2.2
Died	2	2.2
Total	93.0	100.0

this follow-up, letters were sent to all the patients enquiring about their state of health after a period ranging from 4-8 years. Only 93 patients (33.26%) replied. These 93 patients were compared to the total sample with regard to parameters such as age, sex, marital status, educational status duration of illness, presence or absence of precipitating factors, nature of onset of illness, personality type and

diagnostic subtyping. There were no differences which suggests that these 93 patients are in fact a representative sample. Of the persons who replied 28 reported complete recovery, 50 reported that they had improved, 11 remained ill as before. Symptoms had become worse in 2 of the patients and 2 had died.

This shows that a good majority of the patients who had a long term follow-up maintained improvement. Only about 15% continued to be sick as before. It is worthwhile to reassess these patients to find out whether the diagnosis was correct in these patients. Slater (1965) reported that about 75% of his patients with Hysteria were given some other diagnosis at follow-up and used this finding to argue that Hysteria cannot be considered a diagnostic entity. Our findings do not support this.

Certain drawbacks of this study can be drawn up. It is a retrospective study and thereby objective information regarding personality type was difficult to obtain. It is a hospital population and thus is not a representative sample. Follow-up proved to be difficult because many of the patients had left their former homes and thus could not be traced and the letters remained unanswered.

Even though a death sentence has been passed by many, the upholders of Hysteria are many and it is a common psychiatric disorder in many countries. The majority of psychiatrists would be hard put to if they could no longer make a diagnosis of Hysteria. A tough old word like Hysteria dies very hard. It tends to outlive its obituarists.

#### REFERENCES

- ABRAHAM A., SUBRAMANIAM K. & VERGHESE, A. (1973). Birth order and Psychiatric disturbances. *Indian J. Psychiat.*, 15, 11.
- BAGADIA, V. N., SHASTRI, P. C., & SHAH, J. P. (1973). A study of demographic factors. *Indian J. Psychiat.*, 15, 179.

- BAGADIA, V. N., PRADHAN, P. V., & SHAH, L. P. (1976). Significance of paternal and maternal loss in mental illness. *Ind. J. Psychiat.*, 18, 39.
- GRANVILLE-GROSSMAN, K. L. (1966). Birth order and schizophrenia. *Brit. J. Psychiat.*, 112, 916.
- GUZE, S. B. & PERLEY, M. J. (1963). Observations on the natural history of Hysteria. *Amer. J. Psychiat.*, 119, 960.
- HARE E. H. & PRICE, J. S. (1970). Birth rank in schizophrenia with a consideration of the bias due to changes in birth rate. *Brit. J. Psychiat.*, 116, 409.
- KURUVILLA, K. (1974). Parental deprivation in childhood & Psychiatric disorder in adult life. *Indian J. Psychiat.*, 16, 65.
- LEWIS, A. (1975). Survival of Hysteria. *Psychol. Med.*, 5, 9.
- MATHUR, K. K. (1975). Hysterical reactions in a section of Indian soldiers. *Indian J. Psychiat.*, 17, 179.
- PURTELL, J. J., ROBINS, E., & COHEN M. E. (1951). Observation on the clinical aspects of Hysteria. *JAMA*, 146, 902.
- ROBBINS, E., PURTELL, J. J. & COHEN, M. E. (1952). Hysteria in Men. *New England. J. of Med.*, 246, 677.
- SETHI, B. B. GUPTA, S. C., & RAJKUMAR. (1967). Three hundred Urban families : a psychiatric study. *Indian J. Psychiat.*, 9, 280.
- SLATER, E. (1961). Hysteria. *Journal of mental Science*, 170, 359.
- SLATER, E. (1965). The diagnosis of "Hysteria". *Brit. Med. Journal*, 1, 1396.
- SUBRAMANIAM, K. & VERGHESE, A. (1977). A psychosocial study of 292 schizophrenic patients treated in a psychiatric Hospital. *Ind. J. psychiat.*, 19, 36.
- VENKATARAMAIAH, V. & EMBAR, P. (1969). A review of 50 cases of Hysteria. Paper presented at Second Regional Conference of the Indian Psychiatric Society, Madras.
- VERGHESE, A., AHMED BEIG. (1974). Neurosis in Vellore town. An epidemiological study. *Ind. J. Psychiat.*, 16, 1.
- VERGHESE, A. (1978). Meeting public prejudices against psychiatric treatment. *Ind. J. Psychol. Med.*, 1, 11.
- VYAS, J. N. & BHARADWAJ, P. K. (1977). A study of Hysteria-an analysis of 304 patients. *Indian J. Psychiat.*, 19, 71.
- RAO, S. (1964). Birth order and schizophrenia. *J. Nerv. Ment. Dis.*, 138, 8.
- SUNDAR RAJ, N., & RAO, E.S.S. (1966). Order of birth and Schizophrenia. *Brit. J. Psychiat.*, 112, 112.
- WIG, N. N., VERMA, H. C., & SHAH, D. K. (1969). Parental deprivation and mental illness ; a study of the incidence of parental death in childhood in 2000 psychiatric patients. *Ind. J. Psychiat.*, 11, 1.
- ZIEGLER, F. J., IMBODEY, J. B., & MEYER, E. (1960). Contemporary conversion reaction-a clinical study. *Amer. J. Psychiat.*, 116, 907.