Symptoms Frequencies and Stressors in the Hysterical Subjects.

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Abstract

Hysteria is one of the oldest words, derived from Greek word meaning wondering of uterus in the body. Hysterical neurosis was eliminated from DSM-III, and its subsequent editions (DSM-IIIR, DSM-IV, and DSM-IVTR), and its replacement by "dissociation disorders" and "conversion disorders. This study was done to identify frequency of hysterical symptoms and the preceding stressors.52patients was diagnosed according to DSM-IVTR, diagnostic criteria, between July and December2007. Then all

patients were assessed with a semi structured interview, using seven items, about, age, sex, marital status, educational level, occupation, stressors and residential status.81% of the patients were females while 19% were males. The most frequent presentation was with conversion symptoms in 75% of the cases. Loss of consciousness was the most frequent symptom (25%), followed by paralysis (21%). 86% of patients had a history of stressors; while 14% deny any history of stressors. Most patients had a low educational level and they were from rural areas.

Hysterical patients were presenting with one or more symptoms affecting voluntary motor or sensory function, this emphasizes the need for awareness among other specialties of these symptoms. Stressors are present in a large proportion of these patients and identification of these stressors is important for their management.

Key words: Hysteria, stressors, symptoms.

Introduction

Hysteria is one of the oldest words in the medical vocabulary(1).It is derived from Greek word 'Hysteria' meaning wandering of uterus in the body(2). Hysteria as classically defined, is a chronic polysymtomatic illness chiefly affecting women(3).Breuer and Freud viewed hysterical symptoms as arising from repressed sexuality(4),but this psychoanalytic view is less generally accepted now a days. Till very recent past hysteria was considered to be an illness of sexually unsatisfied females, male were not supposed to suffer (5).The concept of hysteria has undergone repeated changes and even its validity as a psychiatric entity has been questioned(6). In the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I), conversion disorder is appeared as "conversion reaction"(7). In DSMII, it was grouped with dissociation disorder under the new diagnostic category of "hysterical neurosis"(8). Subsequently, conversion disorder was conceptualized as disorder of the brain associated with disordered emotions (8). The transition within the DSM to a system that classified psychiatric disorders by clinical phenomenology rather than etiology resulted in the elimination of

"hysterical neurosis", from DSMIII (9) and its subsequent editions (DSM-IIIR, DSM-IV, and DSM-IVTR) (10, 11.12), and its replacement by "dissociation disorders" and "conversion disorders. Conversion was separated from dissociation disorders and categorized as a somatoform disorder (9, 10, 11, 12). DSM somatoform disorders are characterized by disturbances in physical sensation, or in ability to move the limbs or work, whereas DSM dissociative disorder involve involuntary disturbance in the sense of identity and memory (9, 10, 11, 12). Somatoform and dissociative disorders are now also separated in the International Classification of Diseases Tenth (ICD-10) (13) classificatory system, but conversion disorder falls under the category of dissociative disorders. The patterns of defects don't usually conform to recognized anatomical pathways ,and symptoms may fluctuate and intensify when patients are aware that staff are observing them(8).Conversion disorder is thought to occur primarily in societies, with strict social systems that prevent individuals from directly expressing feelings and emotions to wards others(8). Current diagnostic criteria (DSM-IV)(11) requires that stressors must be associated with the onset and course of psychological symptoms rather than paying attention to hypothetical psychological mechanism involved in the etiology of conversion disorder. The 'stressors' which are perceived usually fall into one or more of the following categories: Traumatic events, uncontrollable events, Unpredictable events or event, Challenging the limits of one's capabilities and self-concept (14).The stress reaction includes autonomic responses, endocrine changes and psychological response(15). The patient uses denial mechanisms to cope with stress. The personal experience of illness in relatives or friends determine, the course of sign and symptoms mimic organic disease and allow the patient to adopt "sick role" with consequent relief from precipitating stress or conflict (16).This study was done to identify symptoms frequencies, sociodemographic status and the main stressors in patients diagnosed hysterical neurosis.

Methods

Fifty two patients included forty two female patients and ten male patients who were attending Azadi general hospital (inpatient and outpatient) between July and December 2007. Patients of all ages were included in the study. However patients not fitting into the Diagnostic and Statistical Manual of Mental Disorders 4th edition text revision (12) (DSM-IVTR) diagnostic criteria for conversion, patients presenting with physical disorders, cases with an evidence of mental sub normality, cases with drug dependence and malingering cases were excluded. Patients were diagnosed according to the criteria laid down by DSM-IVTR. Then all patients fulfilling the DSM-IVTR criteria were assessed with a semi structured interview, using seven items data gathering sheet that was designed specifically for the purpose of this study information gathered about, age, sex, marital status, occupation, residential status (urban or rural), educational level and presence of stressors. Statistical analysis was done by Chi square.

Results

The age of the study population ranged from 16-45 years, with mean of 22.3±5.24 years. Out of 52patients, 42(81%) were females while the rest 10(19%) were males. Out of the 40 females 28(67%) were house wives. Out of the 10 male patients, 8(80%) were unoccupied. 60% of males in comparison to 29%females were less than 20 years of age. The married: single ratio is more evident in males(1:9) than in females(12:20).The levels of education achieved were low.16patients(31%)were illiterate and 24 patients(46%)did not go beyond the secondary school level. the residence of patients were 33 patients(64%) were from rural while 19 patients (37%) were from urban areas.Table2 shows symptoms frequencies in patients. 85% of patients presented with single conversion symptom while 15% of patients presented with different combinations of symptoms. The most frequent presentation was with conversion symptoms in 75%of the patients. Loss of consciousness was the most frequent symptom (25%), followed by paralysis (21%).Depression was the most frequently encountered psychiatric disorder (35%), and followed

by histrionic personality disorder (6%).Table 3, shows stressors frequencies in the patients. 45patients (86%) had a history of stressors while 7 patients (14%) deny any history of stressors. Stressors in our patients in order of frequency of patients were, disturbed relations with spouse(17%), conflict with parents and older brothers (14%), love problem (14%) , marriage against wishes (12%), threat to life (10%), death of spouse' (6%), first wife syndrome(The 1st wife in polygamy; Muslim men are llowed to practice polygamy and can have more than one wife at the same time, up to a total of four), (6%), failure in examination (6%), conflict at work (2%), and husband abroad(2%).

Table1 .Sociodemographic characteristics of patients

Variables	Male		Female		Total		p-value
	No.	%	No.	%	No.	%	
Age(years)							P<.01*
<20	6	60	12	29	18	35%	
20-30	3	30	18	43	21	40	P<.01*
30-40	1	10	10	24	11	21	
40>	-	-	2	5	2	4	
Marital status							P<.01*
Single	9	90	20	48	29	56	
Married	1	10	12	29	13	25	P<.01*
Divorced	-	-	4	10	4	8	
Widowed	-	-	6	14	6	12	
Education							
Illiterate	4	40	12	29	16	31	
Primary& intermediate school	6	60	18	43	24	46	
Secondary school	-	-	10	24	10	19	
College	-	-	2	5	2	4	
Residence							
Rural	6	60	27	64	33	64	P<.01**
Urban	4	40	15	36	19	37	
Occupation							
Occupied	2	20	14	33	16	31	P<.01+
Unoccupied	8	80	28	67	36	69	
Total	10	19%	42	81%			P<.01++

*: Highly significant, **: Highly significant (between rural &urban areas)
+: Highly significant (between occupied&unoccupied)
++: Highly significant (between males &females)

Table 2.Symptoms frequencies

Symptoms	Frequencies	
	No.	%
Loss of consciousness	13	25
Paralysis	11	21
Fit	10	19
Aphonia	8	15
Abnormal movement	8	15
Weakness	5	10
Blindness	4	8
Ptosis(drooping of the upper eyelid)	1	2

Table3 .Stressors in the patients

S. No.	Stressors	Cases	
		No.	%
1.	Disturbed relations with spouse	9	17
2.	Conflict with parents and older brothers	7	14
3.	Love problem	7	14
4.	Marriage against wishes	6	12
5.	Threat to life	5	10
6.	Death of spouse	3	6
7.	First wife syndrome	3	6
8.	Failure in examination	3	6
9.	Conflict at work	1	2
10.	Husband abroad	1	2
11.	The patients deny any stressors	7	14

Discussion

Hysteria tends to affect the young, less mature, less educated, and from rural area, a finding compatible with most of the previous studies (17, 18). The study shows a significant difference in predominance of females 81% than males19% with hysteria, and this was compatible with most of the previous studies (17, 18). There was a great incidence of hysteria in males than females under 20 years of age, with a significant difference. This may be because females of that age in our society are not yet exposed large amounts of stress, being mostly unemployed and dependent on either parents or husbands. While there was a greater incidence of hysteria in females than in males in age between 20 and 40 years with significant difference, and this was similar to study of Al-Habeeb (17). There was a greater incidence of hysteria among males (90%) against females (48%) who were single. According to educational level, 77% of patients with hysteria were illiterate and had a low education level, which was compatible with other studies (19,20) . There was more incidence of hysteria in rural area (64%) than in urban area (37%) and this was similar to Indian study(20) .Conversion symptoms were evident in 75% of the patients, Compared with 76% reported by Hafeiz (18) and 74% reported by Hafiz etal (21). This may be due to the social acceptability of hysteria in the Arab society and the increased attention to its physical symptoms by physicians (17). The most common symptoms were loss of consciousness (25%), paralysis (21%), fits (19%), aphonia (15%), and abnormal movements (15%) and these were similar to the figures obtained from Al-Habeeb (17) and Fawzi (22). The typical histrionic personality was rare (4%) which is comparable with Hafeiz etal study (23). About the stressors, the biggest evidence of them comes from "War Hysteria "patients during world war I & II. Thousands of men were affected. The conflict between the danger of death and fear of being declared coward led to symptoms of hysteria (23). Stressful situation preceded the onset of symptoms in 86%, compared to 83% in eastern Saudi Arabia (21).

This study shows the following conclusions

1. Hysterical patients were presenting with one or more symptoms affecting voluntary motor or sensory function. It was stated that "no branch of medicine is free from puzzling manifestation of hysteria"(24), this emphasizes the need for awareness among other specialties of the different clinical presentation of hysteria.
2. Stressors are present in a large proportion of our hysterical patients (86%). Identification of these stressors is very important for proper management of these patients.

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