

HYSTERIA: A CLINICAL AND SOCIODEMOGRAPHIC PROFILE OF 40 PATIENTS ADMITTED TO A TEACHING HOSPITAL, 1985-1995

Tariq Ali Al-Habeeb, MBBS, DPM, RCP&S; Khalid Al-Zaid, MBBS;
Fath El Aleem Abdul Rahim, MBBS, DPM, FRCPsych; Eiad A. Al-Faris, MBBS, MRCP

This is a retrospective clinical study of 40 inpatients diagnosed as suffering from hysteria, as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM III-R), admitted to King Khalid University Hospital at Riyadh over a period of 10 years (1985-95). The female:male ratio was 3:1, 80% were less than 30 years of age and 60% were single. Hysterical conversion was the most common type (95%), whereas hysterical dissociation was rare (2.5%). A stressful situation preceded the onset of symptoms in 62.5% of the cases. Twenty-five percent of the patients were clinically depressed. The typical histrionic personality was rare. *Ann Saudi Med* 1997;17(1):35-38.

Hysteria, as classically defined, is a chronic polysymptomatic illness chiefly affecting women.¹ Breuer and Freud viewed hysterical symptoms as arising from repressed sexuality,² but this psychoanalytic view is less generally accepted nowadays. An alternative behavioral model has been suggested in which conversion symptoms are considered as a form of nonverbal communication.³⁻⁵ A version of this model is seen in studies stressing the interpersonal behaviors of hysterical patients and their impact on the receiver.⁶

The concept of hysteria has undergone repeated changes and even its validity as a psychiatric entity has been questioned.⁷ At present, the term "hysteria" is dropped from recognized classifications of psychiatric disorders (e.g., DSM IV, ICD 10), although it is commonly used in the clinical practice. Possibly as a result of its opponents and the increasing sophistication of society, the use of hysteria as a diagnostic label has declined in western countries.⁸ It was reported in the outpatient department of Bethlem and Maudsley Hospitals, London, that 223 out of 6229 cases (3.5%) were diagnosed as hysteria in 1955-57, whereas in 1967-69, only 45 out of 8585 cases (0.5%) were so diagnosed.⁹

However, in developing countries, it is still early to have comparative figures, although the trend seems to be

similar. Conversion hysteria was reported to be common in northern Sudan, as stated in a report from 1968: "hysterical blindness, mono-ocular diplopia, paralysis, monoplegia, diplegia or hemiplegia, fits and coma are seen daily in the Clinic of Nervous Disorders. In general terms, the less educated or sophisticated the patient, the more gross are the clinical features."¹⁰ In Egypt in the late 1960s, 11.2% of an outpatient clinic's attendees at Cairo were suffering from a hysterical illness, which represented 23.8% of all the neurotic cases.¹¹ A similar figure was reported in Lebanon in 1969, where conversion hysteria accounted for 22.4% of all neurotic disorders.¹² In a more recent study in Eastern Libya, hysteria accounted for 8.3% of all first attendees at an outpatient clinic.⁸ The psychiatric clinic in Khartoum hospital reported that 10% of all patients over a three-year period were suffering from hysteria.¹³

One study from Saudi Arabia estimated the incidence of hysteria in an outpatient clinic to be 5.1%. Out of those, 84.7% were less than 30 years of age; the female:male ratio was 1.8:1 and 61% were single. Conversion symptoms were the most common at 73% and a stressful situation preceded the onset of symptoms in 83%. No great deviations in intelligence were noted in the patients and the typical hysterical personality was rare.¹⁴

The objective of this paper is to give baseline data about clinical features and the sociodemographic status of patients admitted with the diagnosis of hysteria in Riyadh, Saudi Arabia, and to describe their management and outcome. To the best of our knowledge, this study seems to be the first report in the Arab world on hospitalized hysterical patients with possibly more severe symptoms profile.

From the Departments of Psychiatry (Drs. Al-Habeeb, Al-Zaid, Abdul Rahim) and Family and Community Medicine (Dr. Al-Faris), College of Medicine, King Khalid University Hospital, Riyadh.

Address reprint requests and correspondence to Dr. Al-Habeeb: Lecturer, Senior Registrar, Department of Psychiatry, College of Medicine, King Khalid University Hospital, P.O. Box 7805, Riyadh 11472, Saudi Arabia.

Accepted for publication 10 September 1996. Received 14 July 1996.

Method

This is a retrospective descriptive study. The sample consisted of 42 cases of hysteria (both types, conversion and dissociative) as defined in the 3rd edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III-R).¹⁵ Patients were admitted to King Khalid University Hospital in Riyadh, Saudi Arabia, between 1985 and 1995. This hospital provides services to a large geographical region because health care delivery is not restricted by catchment areas. The population served by this hospital is both urban and rural in nature. Before admission, all patients were examined with specific attention to the neurological system. Appropriate laboratory investigations were requested to exclude possible physical illnesses. No intelligence tests were carried out and personality assessment was as defined in DSM III-R. The data were collected from the patients' files by one of the authors (TAA). Two cases were excluded because of insufficient data, restricting the analysis to 40 cases. The data were entered into a PC microcomputer and analyzed using a systat statistical package. Fisher's exact test and Cochran-Mantel-Haenszel statistics (using SAS statistical program) were performed to test statistical significance. A *P*-value of 0.05 or less was taken as significant.

Results

Demographic Characteristics

The majority of the study population were females (75%), young (<30 years of age, 80%), Saudis (70%) and single (60%) (Table 1). Fifty percent of the males in comparison to 36.7% of females were less than 20 years of age. The married:single ratio is more evident in males (1:4) than in females (3:4). The levels of education achieved were low. Nine patients (22.5%) were illiterate and 14 patients (35%) did not go beyond the primary school level.

Clinical Characteristics

The most frequent presentation was with conversion symptoms, in 95% of the cases. While 79% presented with a single conversion symptom, 21% presented with different combinations of symptoms. Loss of consciousness was the most frequent symptom (28.95%), followed by paralysis (26.36%) (Table 2) and there was no difference in the body side involvement. While no specific association with any physical illness was found, depression was the most frequently encountered psychiatric disorder (25%), followed by personality disorder (10%); half were histrionic. A clear precipitant prior to the episode was reported by 62.5% of the cases, while a family history of psychiatric disorders was rare (7.5%). Eight patients

TABLE 1. Sociodemographic characteristics of both genders.

Variable	Male		Female		Total		<i>P</i> -value*
	No.	%	No.	%	No.	%	
Age (years)							
<20	5	50	11	36.3	16	40	0.723
20-30	3	30	13	43.3	16	40	
>30	2	20	6	20	8	20	
Nationality							
Saudi	7	70	21	70	28	70	
Non-Saudi	3	30	9	30	12	30	1.000
Marital status							
Single	8	80	16	53.3	24	60	
Married	2	20	12	40	14	35	0.503
Others			2	6.7	2	5	
Educational level							
Illiterate	2	20	7	23.3	9	22.5	
Primary	4	40	10	33.3	14	35	
Intermediate	1	10	3	10	4	10	0.985
Secondary	2	20	8	26.7	10	25	
College	1	10	2	6.7	3	7.5	
Total	10	25	30	75	40	100	

*Fisher exact test and Cochran-Mantel-Haenszel statistics were appropriate.

(20%) visited traditional healers prior to hospitalization.

Management and Outcome

Almost half of the patients (52.5%) were admitted primarily in the psychiatric ward, while the rest were admitted to neurology (15%), gynecology (7.5%), pediatrics (12.5%), general medical (10%) and surgery (2.5%). Nearly two-thirds responded to support and reassurance, while the rest needed additional drug therapy. Full recovery was reported in 62.5% of the subjects (with no specific demographic or clinical characteristics) and the duration of the episode was less than one day in 62.5% (Table 3). Seventeen patients (42.5%) were kept in the hospital for more than one week, and after discharge, 19 patients (47.5%) reported for follow-up, while no appointment was given for six patients (15%).

Discussion

Although this study was limited to a small number of patients and conducted only on inpatients in a retrospective method, it shows many transcultural similarities, with most of the previous studies conducted on outpatients. Hysteria tends to affect the younger, less mature and less sophisticated person, a finding common to most previous studies.¹³ The predominance of females was compatible with most of the previous studies conducted on an outpatient basis: 2.4:1,¹⁶ 1.8:1¹⁷ and 1.8:1.¹⁴ In 1958, Chodoff and Lyons held the view that hysterical personality was commonly seen in females, while hysterical conversion was seen mostly in males.³ Though this opinion could be true for the hysterical personality,

TABLE 2. *Pattern of symptoms and their frequencies.*

Symptoms	No.	%
Loss of consciousness	11	29
Paralysis	10	26.4
Fit	8	21.1
Aphonia	8	21.1
Abnormal movements	7	18.4
Weakness	5	13.2
Loss of sensation	1	2.6
Unable to urinate	1	2.6

TABLE 3. *Duration of the episode and length of hospitalization.*

	No.	%
Duration of the episode	10	25
<1 hour	15	37.5
1-24 hours	5	12.5
>1 day-7 days	9	22.5
1 week-4 weeks	1	2.5
>4 weeks		
Length of hospitalization	12	30
1-3 days	11	27.5
4-7 days	17	42.5
>7 days		

conversion still seems to affect females in Arab society, as men have more advantages and do not have to adopt the sick role.¹³ Although our figure seems to be similar to what was found in western societies, the explanation may be different. In conservative societies such as Saudi Arabia, hysterical symptoms are an acceptable way for females to express themselves. In addition, Saudi females today feel more individualistic, less dependent and exposed to more stresses due to conflicting opinions regarding the exact role of females in a society which is in transition from closed to semi-open. There was a greater incidence of hysteria in males than in females under 20 years of age; this may be because females of that age are not yet exposed to large amounts of stress, being mostly unemployed and dependent on either parents or husbands. In addition, the average age of marriage seems to be exceeding 20 years of age in Saudi Arabia, which in turn decreases the stresses on female teenagers. Most patients had a low educational level, which is compatible with other studies,¹⁸ but this cannot be considered significant, because education in Saudi Arabia is still not well developed, although it is progressing quickly. Conversion symptoms were evident in 95% of the subjects, compared with 25% reported by Woodruff et al.,¹⁹ 76% reported by Hafeiz¹³ and 73% reported by Hafeiz et al.¹⁴ This may be due to the social acceptability of hysteria in the Arabic society and the increased attention to its physical symptoms by physicians. Among the symptoms, which are usually gross, the most common were loss of consciousness, paralysis, fits and aphonia. The presenting symptoms of the subjects in the

current study differ from those reported elsewhere. Aphonia is more represented in this study (21.1%), compared with 4% in the study conducted in eastern Saudi Arabia.¹⁴ It is almost similar to the figures obtained from studies in Sudan²⁰ and Egypt.²¹ Carter reported aphonia in 29% in 1949,²² compared with only 1.3% reported by Ljungberg.¹⁷ In contrast, fits were underrepresented (21.1%) in the present study, compared with 47% in eastern Saudi Arabia.¹⁴ Fits were reported to be 7.5% in Sudan,²⁰ 34% in Egypt²¹ and 20% in the Ljungberg series from Scandinavian countries.¹⁷ It seems that the changing face of hysterical symptoms varies not only between different cultures, but also within the same culture.²³ The astasia abasia (i.e., inability to stand or walk) reported previously¹⁷ was not seen in this study. It is postulated that with cultural sophistication and development, gross hysterical symptoms decrease and are replaced by anxiety and depressive symptoms, as comparisons of hysterical patients in the two world wars showed.¹³ However, our group tends to exhibit gross symptoms and it may yet be some time before we see a distinct change. Previous neuropsychological studies have suggested that unilateral nonphysiological motor and sensory dysfunction occurs more commonly on the left side of the body.²⁴⁻²⁶ However, other investigators have described more common involvement on the right side of the body.^{27,28} In the present study, left side involvement was equal to right side involvement. The typical histrionic personality was rare (5%), which is comparable with the eastern Saudi Arabia study.¹⁴ Social unacceptability and conservatism of Saudi society may, to some extent, inhibit some histrionic behavior and make proper personality assessment difficult. A stressful situation preceded the onset of symptoms in 62.5%, compared to 83% in eastern Saudi Arabia.¹⁴ Although the latter figure is higher, both are still less than usual for this syndrome. Again, conservatism may play a role. It was reported that 49% of Saudi psychiatric patients visited traditional healers over a period of 12 months before attending a psychiatric clinic.²⁹ Only 20% of our subjects were seen by traditional healers prior to hospitalization, possibly due to the acute nature of the symptoms.

Almost half of the patients (52.5%) were admitted primarily to the psychiatric ward, while the rest went to other wards, which emphasizes the need for awareness among other specialties of the different clinical presentations of hysteria. It was stated that "no branch of medicine is free from the puzzling manifestations of hysteria."³⁰ It seems that a delayed diagnosis and the need for investigation led to 42.5% of the patients being kept as inpatients for more than a week.

A prospective multicenter outpatient-based study of hysteria is being undertaken which, it is hoped, would help in drawing a more precise comparison with the studies in

the Arab world, most of them focused on outpatient subjects. It is also hoped that it will shed more light on the many unanswered questions.

References

- George E. The clinical management of hysteria. *JAMA* 1982;247:2559-65.
- Breuer J, Freud S. *Studies in Hysteria*. New York: Monograph 61, 1895.
- Chodoff P, Lyons H. Hysteria: the hysterical personality and hysterical conversion. *Am J Psychiatr* 1958;114:734-40.
- Chodoff P. The diagnosis of hysteria: an overview. *Am J Psychiatr* 1974;131:1073.
- Rabkin R. Conversion hysteria as social maladaptation. *Am J Psychiatr* 1964;27:349-63.
- Celani D. An interpersonal approach to hysteria. *Am J Psychiatr* 1976;133:1414-8.
- Szasz TS. *The myth of mental illness*. 1961, New York: Harper and Row.
- Pu T, Mohamed E, Imam K, El-Roey AM. One hundred cases of hysteria in eastern Libya. A socio-demographic study. *Br J Psychiatr* 1986;148:606-9.
- Hare EH. Triennial statistical report. Bethlem Royal Hospital and the Maudsley Hospital, London, 1965.
- Elsarrag ME. Psychiatry in the northern Sudan: a study in comparative psychiatry. *Br J Psychiatr* 1968;114:945-8.
- Okasha A. *Contemporary psychiatry (in Arabic)*. Cairo: Anglo Book Shop, 1969.
- Katchadourian H, Racy J. The diagnostic distribution of treated psychiatric illness in Lebanon. *Br J Psychiatr* 1969;115:1309-22.
- Hafeiz HB. Clinical aspects of hysteria. *Acta Psych Scand* 1986;73:676-80.
- Hafeiz HB, Al-Maghrabi MM, El-Sayed SM. Hysterical pattern in eastern Saudi Arabia. *Ann Saudi Med* 1988;3(6):461-5.
- American Psychiatric Association: *Diagnostic and statistical manual of mental disorders*. 3rd Edition (DSM III-R). Washington D.C., American Psychiatric Association, 1994.
- Ziegler FJ, Imboden JB. Contemporary conversion reactions. *Arch Gen Psychiatr* 1962;27:349-63.
- Ljungberg L. Hysteria: clinical, prognostic and genetic study. *Acta Psychiatr Neurol Scand* 1957;32:S112.
- Purtell JJ. Observation on clinical aspects of hysteria. *JAMA* 1951;146:902-9.
- Woodruff RA, Clayton PJ, Guze SB. Hysteria: studies of diagnosis, outcome and prevalence. *JAMA* 1971;215:425-8.
- Hafeiz HB. Hysterical conversion, a prognostic study. *Br J Psychiatr* 1980;136:548-51.
- Fawzi M, El-Maghrabi M. Anxiety in hysteria. *Egypt J Mental Health* 1982;23:94-8.
- Carter AB. The prognosis of certain hysterical symptoms. *Br Med J* 1949;1:1076-9.
- Veith I. *Hysteria: the history of a disease*. Chicago: University of Chicago Press, 1965.
- Stern DB. Handedness and the lateral distribution of conversion reactions. *J Nerv Mental Dis* 1977;164:122-8.
- Galin D, Diamond R, Braff D. Lateralization of conversion symptoms: more frequent on the left. *Am J Psychiatr* 1977;134:578-80.
- Flor-Henry P, Fromm-Auch D, Tapper M. A neuropsychological study of the stable syndrome of hysteria. *Biol Psychiatr* 1981;16:601-26.
- Fallik A, Sigal M. Hysteria: the choice of symptom site. *Psychother Psychosom* 1971;19:310-18.
- Stefansson JG, Messina JA, Meyerowitz S. Hysterical neurosis, conversion type: clinical and epidemiological consideration. *Acta Psychiatr Scand* 1976;53:119-38.
- Al-Subaie AS. Traditional healing experiences in patients attending a university outpatient clinic. *Arab J Psychiatr* 1994;5(2):83-91.
- Leff J. *Psychiatry around the globe. A transcultural view*. London: Caskell, 1988.