HYSTERIA*

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Since the days of Greek Medicine hysteria has aroused more interest and more misunderstanding than any other sickness of the mind. Few die from hysteria and hence it is not ordinarily looked upon as a serious illness. Indeed some would scarcely admit that it is an illness, preferring to think of it as a sort of trick played by "neurotic" people to escape from their obligations—a flight into illness. The tendency to accept the layman's notion of hysteria—hysterics—is quite prevalent amongst doctors, as the illness is often accompanied by an emotional disturbance which interrupts the ordered expression of conduct and ideas. But hysteria is a crippling complaint and those suffering from it are worthy of the care and understanding which every patient has a right to expect. Misconceptions arise in the mind of the student if the teacher speaks of those with hysteria in derogatory terms. The patient with hysteria is often unduly sensitive and "difficult" and this produces impatience in the family circle and in the doctor or nurse. In consequence the complaint receives inadequate treatment and so is apt to persist. The description of hysteria which follows gives some—though by no means all—of the characteristics of the condition. This is a necessary preliminary to diagnosis and rational treatment.

I

Hysteria is a psychoneurosis in which dissociation or fragmentation of the mental life replaces normal functioning. This dissociation arises from intrapsychic conflict in which morbid anxiety plays a prominent part; and results in the appearance of symptoms of which anxiety is not one. It has been repressed and so has passed into the unconscious.

The symptoms of hysteria are in two groups:

- (a) Those manifested in the altered functioning of some system of the body such as the motor, sensory, digestive or circulatory systems, and
- (b) Those confined to the mental plane in which there is amnesia for a part, or the whole, of the previous life.

The term *conversion hysteria* is often used in books on psychiatry (though seldom in practice) to

cover both groups, as in each the morbid anxiety associated with the mental conflict has been converted or changed and in its stead appears the symptom. This is not satisfactory as the two are clinically distinct. Here *conversion hysteria* will be employed only for the first group; and *amnesic hysteria* for the second, as amnesia is its main characteristic. A patient may have both conversion and amnesic symptoms, but this is not common, and they will be considered separately.

The appearance of symptoms, both in conversion and amnesic hysteria, marks the fading of the anxiety. This coincides with a feature of the illness of considerable importance, namely, the attitude of the patient towards his symptoms, which is very different in the two forms of hysteria.

In conversion hysteria there is a calm indifference towards the symptoms. The illness, moreover, is not accompanied by any notable change in the personality of the patient. Disabling and inconvenient though the symptoms may be, they produce no distress. One man with a paralysed arm, remarked "I wouldn't let a thing like that worry me." A woman who had been crippled for years with hysterical contracture of both legs and confined to bed, received her guests with smiles. Her favourite slogan was "Never trouble worry till worry troubles you." She was often alluded to in the neighbourhood as having been "beautified by suffering."

The patient with amnesic hysteria has none of this casualness about his symptoms and there may be considerable changes in his personality. Whether the amnesia is uncomplicated or combined with wandering (the fugue state), he is not aware of any symptoms while they last, and so has no reaction towards them as in conversion hysteria. He acts purposefully and calmly during the fugue and always returns, or seeks to return, to an environment where he was untroubled. Consciousness is limited by the dissociation and while this lasts the "normal" personality and mode of life remain hidden. The patient is of course unaware of his previous personality and his behaviour may differ from that of his normal state. But when the period of amnesia is terminated, there is considerable perplexity about the loss of memory. To wander perhaps far from home and to carry on activities of which there is convincing proof, but no recollection, is naturally disturbing. There is anything but a calm indifference to the symptom.

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The memory may be lost again to-morrow, to judge by past experience, and this, in the normal state of mind with a knowledge of life's responsibilities, is most disturbing. One man, suffering from an amnesia covering the whole period of his life, caused concern in the family circle by declaring that he had never seen his wife or children before. When the amnesia was reassociated with the "normal" personality he was distressed lest there should be a recurrence. It is a mistake, therefore, to apply to all with hysteria the well-known phrase of Janet's—*la belle indifférence de l'hystérique*.

The distinction between conversion hysteria and amnesic hysteria is of importance in treatment. Conversion hysteria is difficult to cure for the symptoms have brought an advantage which is still present and continues. In amnesic hysteria the question of advantage does not arise while the amnesia lasts; and when it passes (that is when the patient is once more his "real" self) the symptom is looked on with disapproval and so treatment is welcomed.

The conception of dissociation, so illuminating in understanding the psychology of hysteria, bears a superficial resemblance to the explanation of hysteria given by Hippocrates. He believed the uterus had become displaced and, moving within the body, caused the symptoms. Plato held a similar opinion: in the womb was an indwelling creature desirous of childbearing but denied it, and in consequence it strayed and thus cast the body into distress causing all kinds of maladies. This bizarre theory pointed the way to treatment—marriage and pregnancy and the use of mechanical methods to keep the womb in position. Nauseous draughts were given by mouth and sweet-smelling substances placed at the vagina to force or induce the womb to return to, and to remain in, its appropriate site. Medicines of unpleasant taste are still prescribed for hysteria by some presumably unfamiliar with the Hippocratic aetiology. Hippocrates coined the word hysteria (from the Greek word for the uterus) and believed the disorder was found only in women. In this he was followed by all clinicians until fifty years ago, if we except a brief period of enlightenment in the seventeenth century. We know now that hysteria is found as often in men as in women; and that it may occur at any age.

II

The symptoms of conversion hysteria are usually described as protean from the god Proteus who was able to assume different shapes and elude the grasp unless secured by fetters. The symptoms, however, have an individualistic significance and are always to be understood symbolically. Individual

problems are protean and the symbolic form given to them in the symptom relates directly to the patient. In this they differ from the physiological symptoms in the anxiety state, which may be found in a transitory form, in normal fear. The priest whose hand trembled violently when administering the chalice, the woman who developed aphonia when asked about her husband's unfaithfulness, the soldier whose right arm became paralysed when firing a field gun at a visible enemy, all illustrate the individual quality in hysterical symptoms.

Any symptom of bodily ailment, of which the patient has previous knowledge, may appear in hysteria; and it will appear in a form which fits the patient's conception of the disability.

In days gone by in this country, hysterical fits were common. The description of these, by non-medical observers, corresponded closely to epileptic fits. Gross hysterical paralysis with gait disorders are now rarely seen in these islands. But it is interesting to note that hysterical fits and extensive gait disorders were commonplace amongst a certain type of Indian soldier in the Second War. These were frequently encountered in European soldiers in the First War, but they were less common in the last campaign; and in civilian practice they seldom occur.

The most usual forms of conversion hysteria encountered in the west nowadays are less spectacular. Motor involvement such as tics, writer's cramp, stammering, aphonia or contracture is more usual than total paraplegia or hemiplegia. Sensory symptoms are often found with motor disturbances, and the distribution of the anaesthesia or hyperaesthesia does not follow the known neurological sensory paths. Areas of anaesthesia are probably commoner than the glove and stocking variety. The quality or intensity in functioning of an organ of special sense may be affected. The visual or auditory senses are disturbed more frequently than the olfactory, gustatory or labyrinthine. Cardiovascular and respiratory phenomena, such as tachycardia and tachypnoea, which ordinarily accompany emotion, may persist in hysteria and may be intensified by over examination. Pyrexia for which no physical cause can be discovered may be hysterical. Enuresis may result from certain organic conditions, but it is nearly always a symptom of conversion hysteria. Gastro-intestinal symptoms are often present. The most usual are a sense of choking (globus hystericus), dysphagia and vomiting. Anorexia nervosa is the most striking of the visceral symptoms of hysteria and it may have a fatal termination. The attitude of calm indifference, already mentioned, should be looked for when any of these symptoms is found.

Amnesic hysteria has a limited range of symptoms—unlike conversion hysteria. The loss of memory

may cover a short period or it may be for the whole previous life. The amnesia indicates that some experience or experiences, have been emotionally disturbing and have been repressed. When this is accompanied, as it often is, by a fugue, a previous phantasy or line of action preferred to present circumstances is translated into action, without, of course, a conscious awareness that this is happening. Fugues were familiar during the two last wars, but they are encountered in peace time and appear to be more usual in men than in women.

Conversion hysteria and amnesic hysteria have one feature in common—the sudden onset of the symptom. In amnesic hysteria this is clearly seen.

Careful enquiry will often reveal the day and hour at which conversion symptoms first occurred. The emotional atmosphere in which the symptoms appear is always significant and may indicate why certain symptoms rather than others were appropriate.

III

The diagnosis of conversion hysteria is beset with difficulties. When the symptoms are of the motor or sensory type the possibility of an organic nervous disorder must be excluded. If the functional loss at the time of examination does not correspond to that found in organic disease there may yet be some doubt in the mind of the examiner when the patient speaks of symptoms experienced in the past. Disseminated sclerosis, myasthenia gravis, syringomyelia, paralysis agitans, and encephalitis lethargica, present no difficulty when well advanced, but in the early stages these, and other organic conditions, are not infrequently labelled conversion hysteria. Hysteria is also mistaken for idiopathic epilepsy, particularly if the duration of the fit and the calmness and alertness of the patient on its termination are not noted. The neurological examination should be repeated from time to time, particularly if new symptoms occur; and it should be borne in mind that the hysteric is very suggestible. Tests for sensory or motor defects should therefore be carried out by methods unfamiliar to the patient. Conversion hysteria may of course accompany an organic disease.

Amnesic hysteria should not be diagnosed without a careful examination. Disorders of memory are common in senility, arterio-sclerosis, cerebral tumour, senile dementia (Alzheimer's disease), toxic confusional states, Korsakow's disease, and other conditions. The possibility of a psychosis should also be remembered.

A quiet investigation of the emotional setting of the illness, during which the number of questions

is reduced to the minimum, is recommended. Anything in the nature of an interrogation will cause resentment and make the examination more difficult. Patients with conversion hysteria welcome an examination but they have an uncanny knack of disquieting the doctor who "suspects hysteria." Hysterical symptoms are often acquired by those who are dull and backward. When the case history indicates that the patient has had difficulty with school work, or has been unable to compete on equal terms with his fellows, an intelligence test should be given.

IV

The taking of a case-history requires considerable care. The patient may consciously or unwittingly distort the story; and memory transformation is probable when emotion is prominent. The interview with the patient should be followed (not preceded) by a talk with the relatives. The physician should exercise care in framing questions and avoid those suggesting answers. A good opening remark is: Tell me about the onset of your illness? A bad start would be: Have you pain in your paralysed arm? For later reference it is useful to record the words used by the patient in describing the ailment. The tone of voice in taking the history should be conversational rather than inquisitorial. The anamnesis should not be prolonged, and it should be followed by a physical examination. If the illness is thought to be hysteria, this term should not be used to the patient or relatives. It is wiser to say that the condition is a form of nervous breakdown for which psychological treatment is advised. The temptation to use physical methods for the removal of symptoms has the drawback, common to all treatment by suggestion—it does not touch the essential features of the malady. It is true that the symptoms may be removed by suggestion and the temporary improvement may be mistaken for cure. But this is ordinarily followed by the return of the old or the appearance of new symptoms. The patient should therefore be referred to a psychiatric clinic, or elsewhere, so that analytical treatment may be obtained.

SUMMARY

- (i) The symptoms of hysteria are in two groups:
 - (a) conversion hysteria, and
 - (b) amnesic hysteria.
- (ii) The symptoms are described.
- (iii) Difficulties and pitfalls in the diagnosis of hysteria.
- (iv) Taking the case history.