Anxiety In Hysteria; An Egyptian Clinical Study

By M.H. Fawzi, M.M. El Maghraby and O.H. Shaheen.

ABSTRACT

Conversion symptoms are traditionally thought to protect or defend the sufferer from anxiety. However, in this study, which was carried out in Zagazig, the capital of Sharkeyah Governorate, Egypt, 50 patients with hysterical neurosis were subjected to a detailed clinical study and assessed by the 'anxiety and Depression Scale' (Shaheen and Rakhawy, 1970) before and one year after treatment of hysterical symptoms, and results showed that patients were experiencing anxiety, which was significantly more marked in those who would develop a sustained rather than episode hysteria. Thus, detection of severe anxiety in a case of hysteria is suggested to be of predictive importance.

The suggestion to classify this series of patients with hysterical neurosis into two types, 'sustained' and 'episodic', derives a support from the statistical analysis which demonstrates a significant difference between 'sustained hysteria' group on a number of demographic and other variables.

The level of anxiety and inadjustment in general, as assessed by the 'Anxiety and Depression Scale' was not improved by attempts to remove the hysterical symptoms. This suggests that such management of hysteria seems not to "cure the disease" as advocated by other workers but to uncover the patient's anxiety.

INTRODUCTION

As pointed out by Lader and Marks (1971) generations of psychiatrists since Freud have been taught that "even in its most severe symptoms no admixture of anxiety is found with the conversion hysteria" This teaching has been associated with the idea that conversion symptoms represent the conversion of "psychic energy" associated with unacceptable anger into somatic symptoms, thus preventing the person from experiencing undesirable effects and their attendant anxiety. Conversion

symptoms are thus thought to protect or defend the sufferer from feeling intense anxiety. This concept, however, has been criticised and an experimental evidence has been produced by Lader and Sartorius (1968) to suggest that conversion hysteria can be accomplished by fear-eliciting anxiety and its physiological concomitants.

Clinical presentations, however, can be influenced by cultural factors (Tan, 1969; Kiev, 1972; Fawzi, 1978) and some evidence suggests that anxiety states may be commoner in certain cultural groups than in others (Tan, 1969; Suwana, 1969). The study which is reported here, therefore, attempts to find out whether admixture of anxiety is found with hysteria in patients from an Egyptian semi-rural culture.

MATERIAL AND METHODS

500 patients, who attended the Psychiatric Out-Patients Clinic, Zagazig University Hospitals, Sharkeyah Governorate, Egypt, in the year 1978, were examined conjointly by three psychiatrists and diagnosed according to the Egyptian Diagnostic Manual of Psychiatric Disorders — "D.M.P.-1" (Egyptian Psychiatric Association, 1975). The first 50 patients with the diagnosis of 'Hysterical Neurosis' were selected for a more detailed clinical study and were assessed by the 'anxiety and Depression Scale' (Shaheen and Rakhawy, 1970). These patients were then treated using mainly suggestive techniques, which varied according to the case, to remove the hysterical symptoms. No deeper interventions were attempted but general supportive measures and short courses of anxiolytic drugs were given. Patients were seen again one year later and reassessed by the same instrument.

RESULTS

Neuroses were the commonest diagnostic category. The most frequent neurosis was hysterical neurosis. However, anxiety neurosis came just next in frequency, but other neuroses were much less frequently diagnosed (Table 1).

Description of the Selected Sample :

The selected sample (N=50) was described using a number of parameters, each of which divided the sample into two groups. The mean age of the sample was 19.6 (S.D.=7.5). The mean age for males was 22 (S.D.=9.5), and that for females was 17.6 (S.D.=4.4).

16 of the females (59% of the females) were house-wives. The rest of the females were mostly students. However, 10 males (43% of the males) were manual workers, and four (17% of males) were students. Other occupations were less represented.

At the time of the study, 32 patients (64% of the sample) were resident in urban areas. Those who had changed their residency, tended to shift from the rural to the urban areas. However, most of the patients (43 patients; 86%) had never changed their type of residency.

Clinical Picture :

Most of the patients (41 patients; 82%) had poly —, rather than mono-symptomatic presentations.

Symptoms included various forms of motor disturbances and varieties of sensory disorders, as well as many mental symptoms. Sleep disorders were also frequent. (Table 2).

Affective states as judged by the clinicians showed that the higher proportion of patients were anxious and depressed.

The course and outcome of hysterical symptoms were variable, but fell into two groups, the "episodic hysteria" group (19 patients; 38%), and the "sustained hysteria" group (31 patients; 62%). "Episodic hysteria" referred to a bout of hysterical symptoms which recovered in less than one month, while "sustained hysteria" referred to a more lasting illness in which the same original smptoms or some other different hysterical symptoms were found at the follow-up.

These two groups were found to differ significantly from each other by some demographic and other data.

Thus, while the distribution of male sex showed no statistically significant difference between the two groups, female sex was significantly more common in the "sustained hysteria' group (p 0.05). The total sample studied tended to be of young age. However, all those above 30 years of age belonged to the 'sustained hysteria' group (0.05 p 0.10). Again, the birth order of the hysterical patients studied was frequently found to be of the first or last child category (Table 3). Nevertheless, this was a more marked feature in the 'sustained hysteria' group (p 0.02). As regard the level of education, there was no statistical difference between the two groups for education not exceeding the primary level, but for the level of above primary education, more patients belonged to sustained hysteria group (p 0.025). As regard marital status, most of the patients were single. This was a more observable feature of the sustained hysteria group (p 0.025) and as regard residency, a significantly higher number of patients from the 'sustained hysteria' group than from the 'episodic hysteria' group had urban residency (p 0.02).

Visceral symptoms in the sample were frequent, with little change between initial assessments before treatment and one year later (p 0.05). However, comparing the initial presentation of the episodic hysteria group with that of the sustained hysteria group, using the chi-square test, statistically significant differences emerged (Table 3).

Psychosomatic disorders were evident in three cases with sustained hysteria. One patient was asthmatic, another had peptic ulcer, and the third was suffering from spastic colon. A patient with episodic hysteria had been similarly suffering from a spastic colon.

Scores on 'Anxiety and Depression Scale' :

Differences of scores on 'Anxiety and Depression Scale', between various subgroups of hysterical patients including rural and urban,

younger and older, and between male and female patients, failed to reach any acceptable level of statistical significance.

However, when patients were classified into two groups according to the course and outcome, and a comparison was made between the initial assessment of these two groups using the 'Anxiety and Depression Scale', a statistically significant difference appeared with the sustained hysteria group having higher scores on all the parameters of the scale (Table 4). Similar results were obtained when these two groups were compared one year later (Table 5).

DISCUSSION

The results show that hysteria is the most common form of neuroses in Sharkeyah Governorate. Next to it is anxiety neurosis. These findings are more or less in keeping with those reported at other Egyptian centres, in which hysteria however, was not as prominent as in our findings (e.g. Okasha, 1968; Ahmed, 1979) but are markedly contradicting with most of the Western reports which suggest that hysteria or at least its classical manifestations are disappearing (e.g. Walshe, 1965; Hollender, 1972; Lewis, 1974; Stephanis **et al.**, 1976) and which suggest that the decline in the incidence in the West is either because the patient is now treated before the stress becomes sufficiently severe to provoke a hysterical reaction or because such a dramatic presentation is no longer necessary to stimulate the interest and help of relatives and doctors. Increasing medical sophistication has now made it possible for a patient to receive the same degree of attention from a doctor by complaining of anxiety as he might by complaining of a paralysed arm (Reed, 1971). However, whether it is hysteria that is decreasing or the willingness of clinicians to diagnose their patients with such a label is not clear. Also, to what extent the change in the theoretical concepts of diagnosticians has contributed to the decrease in the incidence of hysteria is not answered.

Hysteria, however, played an early part in the development of the theories of psychoanalysis. Freud emphasised the difference between

'anxiety hysteria' and 'conversion hysteria'. In anxiety hysteria, the anxiety is free-floating, though the conflicts producing the anxiety may remain repressed. In conversion hysteria, however, psychic conflict related to unresolved infantile sexual problems arises in stressful situations. The patient can neither resolve the conflict nor directly express it, or its associated anxiety, because of its threatening nature. By the mechanism of conversion, this intolerable anxiety-provoking conflict is changed into a physical symptom which has some symbolic relationship to the repressed material. The conversion dissipates anxiety, thus producing what is named by Charcot "la belle indifférence" and is said to be typical of hysterics. The physical symptom, is not believed to provoke distress but rather to save the patient from experiencing conflict and anxiety.

The results of the present study, however, are not in keeping with this traditionally-held view, but they provide a further support to the more recent inclination to acknowledge a manifest anxiety in conversion hysteria, and are thus in agreement with the findings of Lader and Sartorius (1968) which suggest that conversion hysterics were more anxious than anxious phobic patients and with correspondingly higher autonomic activity as shown by the more spontaneous fluctuations in skin conductance level and the less habituation of galvanic skin response.

In the present study, the 'belle indifférence' was not an observable feature. On the other hand, anxious mood was reported in 58% of the cases, and frequent symptoms included insomnia (62%), irritability and nervousness (54%), apprehension and fear (44%) and fainting and dizziness (40%). There were also frequent chest and heart symptoms (44%), gastrointestinal symptoms (54%) and genitourinary symptoms (44%). Many of these visceral and autonomic symptoms are typical of anxiety states.

These features were significantly more frequent, from the start, in those who were found one year later to continue to have hysterical symptoms ('sustained hysteria' group). It may be that in 'episodic hysteria', the employment of the hysterical mechanism could be effective

enough to deal with the anxiety-producing situation and hence less anxiety is found in this short lived episode.

However, hysterical mechanism may be dragged on for a long period of time in 'sustained hysteria' but fails to offer the sufficiently effective solution. In this case, therefore, the anxiety level is high and the course of illness is prolonged.

Thus, it may be said that the detection of a severe anxiety in a case of hysteria is of a predictive importance. It speaks of an unsurpassable anxiety-provoking situation which could not be adequately resolved by the hysterical mechanism, and then, both hysteria and anxiety would be sustained, as it was found in the patients with the 'sustained hysteria'.

The suggestion to classify our series of hysterical patients into two types, 'sustained' and 'episodic', derives a further support from the statistical analysis which demonstrates a significant difference between 'sustained hysteria' group and 'episodic hysteria' group on a number of demographic and other variables.

The relationship between anxiety features and poor outcome also emerged in predictive studies of other psychiatric syndromes such as in affective disorders (Kerr et al., 1972; Paykel et al., 1974). Of all neurotic patients, however, Greer and Crawley (1966) found that, hysterios had the best prognosis with 41 per cent recovery rate at discharge and a 42 per cent recovery rate at a three year follow-up. Our figures suggest a more or less recovery rate (38% at the one-year follow-up). Nevertheless, a very poor prognosis has been found by Guze and Perley (1963) with their special definition of hysteria. But a large number of the symptoms which qualify for this diagnosis of hysteria appear to be the very manifestations of anxiety and 'poor prognosis' is a part of their definition any way.

It is of interest to also note that in the present study, patients with the poorer outcome ('sustained hysteria' group) had scored significantly

higher on the 'Anxiety and Depression Scale' than those with the better outcome. The scale used is a self-rating instrument that has been found in other studies to be adequately sensitive to mood change (Fawzi and Ghali, 1979), and is a useful test for the assessment of inadjustment in general. However, one year after treatment, essentially directed towards removal of the presenting symptoms, there were no improvements of scores. In other words, attempts directed towards removal of hysterical symptoms seemed, not to "cure the disease" as advocated by Eysenck and Beech (1971), but to uncover the patient's anxiety, or as Freud (1893) put is "you must not imagine that very much has been gained by this (symptomatic cure) for the therapeutics of hysteria".

REFERENCES

AHMED, M. M. (1979) *Clinical Picture of Hysteria in Egyptian Patients* M. Sc. Thesis. Cairo University.

EGYPTIAN PSYCHIATRIC ASSOCIATION (1975) *Diagnostic Manual of Psychiatric Disorders*(*D.M P.*—1) Cairo : Egyptian Psychiatric Association.

EYSENCK, H. S. and BEECH, H. R. (1971) Counter conditioning and related methods in behaviour therapy. In *Handbook of Psychotherapy and Behaviour Change* by E. E. Bergin and S. L. Garfield (Eds.). New York : Wiley.

FAWZI, M. (1978) Hysterical symptomatology in schizophrenic patients in Saudi Arabia. *Zag. Univer. med. J.*, **1** : 67-75.

FAWZI, M. and GHALI, A. (1979) The effect of a suppressor of milk secretion 9 (bromocriptine) as an antidepressant. *Zag. Univer. med. J* , **2** : 339-348.

FREUD, S. (1893) Lecture quoted in *Standard Edition of Complete Works*, edited by J. Strachey, Vol. 3. London : Hogarth, 1962.

GATFIELD, P. D. and GUZE, S. B. (1962) Prognosis and differential diagnosis of conversion reaction : Follow-up study. *Dis. Nerv. Syst.*, **23** : 623-695.

GREER, H. S. and CRAWLEY, R. H. (1966) : *Some Observations on the Natural History of Neurotic Illness.* Sydney : Australian Medical Publishing Co.

GUZE, S. B. and PERLEY, M. J. (1963) Observations on the natural history of hysteria *Amer. J. Psychiat.*, **119** : 960-965.

HOLLENDER, M. H. (1972) Conversion Hysteria. *Arch. Gen. Psychiat.*, **26**, 311-315.

KERR, T. A., ROTH, M., SCHAPIRA, K. and GURNEY, C. (1972) The assessment and prediction of outcome in affective disorders. *Brit. J. Psychiat* , 121 : 167-174.

KIEV, A. (1972) *Transcultural Psychiatry.* London : Penguin.

LADER, M. and MARKS, I (1971) *Clinical Anxiety.* London William Heinmann.

LADER, M. and SARTDRIUS, N. (1968) Anxiety in patients with hysterical conversion symptoms. *J. Neurol. Neurosurg. Psychiat.*, **31** : 490-495.

LEWIS, W. C. (1974) Hysteria. The consultant's dilemma. *Arch. Gen. Psychiat.*, **30** : 145-151.

OKASHA, A. (1968) Preliminary psychiatric observations in Egypt. *Brit. J. Psychiat.*, **114** : 949-955.

PAYKEL, E. S., KLERMAN, C. L. and PRUSOFF, B. A. (1974) Depressive prognosis and the endogenous-neurotic distinction. *Psychological Medicine*, **4** : 57-64.

REED, J. H. (1975) Hysteria. In : *Contemporary Psychiatry: Selected Reviews from thn British Journal of Hospital Medicine.* (Ed. T. Silverstone and B. Barraclough). pp. 141-149. London : Headley Brothers.

SHAHEEN, O. and RAKHAWY, Y. (1970) *Preliminary applications of Anxiety and Depression Scale.* Cairo : Al-Takaddom. (Arabic).

STEPHANIS, C. N., MARKIDIS, M. P., CHRISTODOULOU, G. N. (1976) Observations on the evolution of the hysterical symptomatology. *Brit. J. Psychiat.*, **128** : 269-275.

SUWANA, A. B. (1969) Effect of cultural change in anxiety in women in Thailand. *Australian and New Zealand Journal of Psychiatry*, 3: 267-270.

TAN, E.S. (1969) The symptomatology of anxiety in West Malaysia. *Australian and New Zealand Journal of Psychiatry*, 3: 271-276.

WALSHE, F. (1965) Diagnosis of hysteria. *Brit. med. J.*, 2: 1451-1454.

AUTHORS

MOUNIR H. FAWZI, M.R.C. Psych., D.P.M., Assistant Professor of Psychiatry, Faculty of Medicine, Zagazig University, Zagazig, Egypt;

MAHER M. EL-MAGHRABY, M.B., B. Ch., Clinical Demonstrator, Faculty of Medicine, Zagazig University, Zagazig, Egypt.

OMAR H. SHAHEEN, M.D., D.P.M. and N., D.M., Professor and Head of Psychiatric Department, Faculty of Medicine, Cairo University, Cairo, Egypt.

TABLE 1

Neuroses

DMP-1 Code No.	Diagnosis	N (240)	% (100)
10.0	Anxiety neurosis	69	28.7
10.1	Hysterical neurosis	79	32.9
10.10	Conversion type	42	17.5
10.11	Dissociation type	37	15.4
10.2	Phobic neurosis	8	3.3
10.3	Obsessive-compulsive neurosis	8	3.3
10.4	Depressive neurosis	38	15.8
10.5	Neurasthenic neurosis	4	1.6
10.6	Hypochondriasis neurosis	25	10.4
10.7	Reactive and situational neurosis	10	4.1

TABLE 2

Clinical picture

Symptom	f	%
Motor symptoms.		
Weaknesses, paralyses, torticollis and lockjaw	39	78
Head-nodding, sneezing, tics, tremors and fits	42	84
Speech disturbances	9	14
Curious gaits	8	16
Sensory disturbances:		
Anaesthesia	14	28
Paraesthesia	28	56
Hyperesthesia	1	2
Pain	17	34
Symptoms related to special senses.		
Blurring of vision	2	4
Blindness	1	2
Glaring of vision	2	4
Deafness	2	4
Mental symptoms.		
Mentally tired / Cannot concentrate	20	40
Fainting and dizziness	20	40
Irritability and nervousness	27	54
Apprehension and fear	22	44
Amnesia	8	16
Fugues	5	10

f = absolute frequencies; % = relative frequencies.

TABLE 3

Visceral symptoms in 'episodic' and 'sustained' hysteria groups.

Symptoms	Episodic hysteria (N=19) f	%	Sustained hysteria (N=31) f	%	Total (N=50) f	%	X2	p<
Chest and heart symptoms (breathing difficulty, chest pain and palpitations)	8	8	18	36	22	44	6.549	0.02
Gastrointestinal symptoms (anorexia, vomiting, colic, weight loss, flatulance, indigestion and disturbed bowl habits).	6	12	21	42	27	54	4.729	0.05
Genitourinary symptoms (frequency, dysuria, retention, dysmenorrhia, bleeding, irregular bleeding and frigidity / impotence	5	10	17	34	22	44	3.889	0.05

TABLE 4

Means of [illegible] assessment scores on 'Anxiety and Depression Scale' of sustained and episodic hysteria groups

	Sustained hysteria	Episode hysteria	t	p<
Anxiety scores :				
Mean	18.1	15.2	2.131	0.05
S.D.	5.0	3.8		
Depression scores :				
Mean	17.3	14.8	2.267	0.05
S.D.	4.0	3.2		
Introversion scores :				
Mean	17.2	15.1	2.009	0.05
S.D.	3.7	3.2		
Total scores :				
Mean	54.5	47.3	2.227	0.05
S.D.	11.5	9.8		

TABLE 5

Means of scores on 'Anxiety and Depression Scale' of sustained and episodic hysteria groups, one year after treatment.

	Sustained hysteria	Episodic hysteria	t	P<
Anxiety scores :				
Mean	17.8	14.7	2.381	0.025
S.D.	4.8	3.6		
Depression scores :				
Mean	17.2	14.6	2.107	0.05
S.D.	4.6	3.3		
Introversion scores :				
Mean	16.7	14.5	2.011	0.05
S.D.	3.9	3.2		
Total scores :				
Mean	52.1	45.6	2.094	0.05
S.D.	11.2	9.1		

S.D. = standard deviation.

دراسة اكلينيكية لحالات الهستيريا

ان الشائع السائد أن تعتبر الأعراض التحويلية (الهستيرية) كفيلة بحماية المصاب من القلق دفاعيا ، وقد أظهرت هذه الدراسة التى أجريت على خمسين مريضا عندهم عصاب الهستيريا فحصوا اكلينيكيا بمقياس القلق والاكتئاب (شاهين والرخاوى ١٩٧٠) قبل العلاج وبعده بسنة أظهرت هذه الدراسة أن المرضى كانوا يعانون من القلق ، وقد كان القلق شديدا بدرجة دالة فى هؤلاء الذين يعانون من أعراض هستيرية مستديمة أكثر من أولئك الذين يعانون من أعراض هستيرية نوبية (فجائية مؤقتة) ٠

وقد اقترح تقسيم هذه المجموعة من المرضى الى نوعين النوع المستديم والنوع النوبى ، وقد دعم هذا الفصل ما أجرى من احصاءات أظهرت فروقا ذات دلالة على عدد من المتغيرات الديمجرافية وغيرها ٠

ولم يتحسن مستوى القلق أو سوء التكيف العام (كما ظهر فى اختبار القلق والاكتئاب) نتيجة لازالة الأعراض الهستيرية ، وقد أدى ذلك الى اقتراح أن هذا العلاج للهستيريا لا يؤدى الى « الشفاء من المرض » كما زعم باحثون آخرون ، وانما هو يعرى القلق لدى المريض ٠

ABSTRAIT

L'anxiété dans l'hystérie : une étude clinique égyptienne

Les symptômes de conversion ont pu protéger et défendre celui qui souffre de l'anxiété. Cependant, dans cette étude qui a été effectuée à Zagazig, la capitale de la governorate de Sharkya en Egypte, 50 malades présentatnt une névrose hystérique ont été sujets à une étude clinique détaillée et examinés par l'échelle de l'anxiété et de la depression (Shaheen et Rakhawy, 1970) avant et après le traitement des symptômes hystériques. Les résultas ont montré que les patients qui auraient développé une hystérié prolongée plutôt que épisodique ont éprouvê de l'anxiété d'une façon significative et prononcée.

La suggestion de classer les séries de patients ayant une névrose hystérique en deux genres "prolongées" et "épisodiques" provient du fait que l'analyse statistique qui a montré d'une façon significative une différence entre le groupe de l'hystérie prolongée et l'hystérie épisodique suivant un nombre de variables démographiques et autres.

Le niveau de l'anxiété et de l'adaptation en général comme examiné par l'échelle de l'anxiété et de la depression n'a pas été amélioré par les essais de dissiper les symptômes hystériques. Le travail d'autres rechercheurs suggère qu'un tel traitement de l'hystérie apparait ne pas pouvoir traiter la maladie si ce n'est que de révéler l'anxiété.