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A Retrospective Study of Operationally Defined Hysterics

By P.-E. ALMGREN, L. NORDGREN and H. SKANTZE

A group of psychiatric patients were operationally defined as 'hysterics' by their reliance on the perceptual defence mechanism of repression, as disclosed in a valid psychological test. Most of them had dependency conflicts. Only half of them, almost exclusively female, had received the clinical diagnosis hysteria, the diagnosis being apparently founded on bodily complaints, overt aggression, and absence of depressive mood and anxiety. Lack of these characteristics in patients resorting to repression and with dependency conflicts results in diagnostic uncertainty. Clinical and test data justified the separation from operationally defined hysterics of three small subgroups: one with brain dysfunction, one with regressive psychosis, and one with non-regressive schizophrenia. Relevant diagnostic clues in the psychological tests and in the clinical picture are discussed.

Introduction

Hysteria has not yet been satisfactorily defined. It has been stated that it cannot be defined purely descriptively, i.e. by signs and symptoms (Whitlock, 1967). This is supported by studies in which somatic disease and also depression and schizophrenia were disclosed at follow-up in patients initially diagnosed as suffering from hysteria (e.g. Slater and Glithero, 1965).

The prevailing descriptive non-analytical term hysteria is used in one of three meanings: (a) *Briquet hysteria*, i.e. polysymptomatic, recurrent or chronic ill-health in females with frequent visits to physicians and excess of admissions to hospital (Guze, 1975); (b) *Hysterical neurosis*, conversion type and dissociation type (DSM-II, 1968); (c) *Hysterical personality* characterized by self-dramatization, dependency, and demandingness (*ibid*). In these definitions, the level of libido fixation and type of defence mechanism are not taken into account.

Since social and cultural factors play a major role in the diagnosis of hysteria, a descriptive concept demands even more delicate handling. The probably weak relation between hysterical neurosis and hysterical personality adds to the confusion (cf Stefánsson *et al*, 1976).

In psychoanalytic theory the concept of hysteria is based on the proposition that hysteric individuals rigidly and pervasively resort to the defence of repression, the major style of adaptation being dissociation (Schafer, 1948; Shapiro, 1965). The repressed conflict has been presumed to be either oral or phallic or both (cf Lazare, 1971). Zetzel's (1970) subgrouping of hysterical patients in two major groups seems to have clinical advantages. 'Sick' hysterics are characterized by less efficient defence mechanisms; 'healthy' hysterics have potential capacity for tolerating internal reality, partly by means of well-functioning obsessive mechanisms (cf Lazare, 1971; Chodoff, 1974). Dynamically these two groups of patients are regarded as suffering from predominantly oral-dependent and oedipal conflicts, respectively.

The present study approached the concept of hysteria from one dynamic point of view. This was done by selecting patients who were characterized, in psychological tests, by reliance on the defensive and adaptive mechanisms of

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repression and/or dissociation. The tests used were two well-established psychological instruments: the Meta-Contrast Technique and the serial version of the Colour Word Test (see Kragh and Smith, 1970). Test data were compared with mainly descriptive, clinical variables.

Methods

Patients and procedure

Patients with a test diagnosis of hysteria were selected from files comprising results from the two psychological instruments, the MCT and the CWT (see below). In all cases a preliminary diagnosis and a description of main complaints were formulated by a psychiatrist before referral to the psychologist. Other clinical and background data were taken from hospital record notations made up to the date of the testing. Notations after the testing were used only for delimitation of psychotics and for classification of mode of treatment. In all cases the follow-up period was more than one year.

Patients with any of the following preliminary diagnoses were excluded: chronic alcoholism, organic psychosyndrome, and mental retardation. Also excluded were patients more than 60 years of age.

The remaining patients were assigned to one of the following three groups:

Group A (preliminarily diagnosed hysterics): Patients referred for psychological testing with the preliminary diagnosis of hysteria, i.e. conversions and/or Briquet signs, and not diagnosed as psychotics during follow-up (n = 21).

Group B (preliminarily not diagnosed hysterics): Patients referred for testing with a preliminary diagnosis other than hysteria and not diagnosed as psychotics before referral or during follow-up (n = 22).

Group C (psychotics): Four patients referred for testing with the preliminary diagnosis of psychogenic psychosis (Faergeman, 1963). Six patients, two with the preliminary diagnosis of hysteria and four with no preliminary diagnosis, who were diagnosed as non-regressive schizophrenics (Nyman, 1975) during follow-up (n = 10).

Psychological instruments

Both psychological instruments used are based on percept-genetic theory (see Kragh and Smith, 1970). The tests describe, via perceptual processes, the manner in which a person gradually adapts to a novel, contradictory or threatening situation.

The Meta-Contrast Technique (MCT)

The MCT consists of a tachistoscopic presentation of paired stimuli, A and B. The B stimulus is first presented alone at gradually increasing exposure time until a correct description of the picture is given by the subject. Then a new stimulus, A, incongruous with or implying a threat against the B picture, is introduced. A is exposed immediately before B, and is also brought to correct recognition. The subject is asked to report everything seen on the screen at each exposure.

Two series of paired stimuli are used: 'incongruous series' (B = drawing of living-room; A = drawing of car) and 'threat series' (B = picture of boy and window; A = picture of ugly, ape-like face).

The scoring is based on the subject's A interpretations before correct recognition, which are described in terms of perceptual defence mechanisms, and on changes in B interpretations, e.g. disruptions or grave misinterpretations, regarded as signs of regression.

A hypothetical hierarchy of perceptual defence mechanisms, ranging from more regressive to less regressive forms, has been conceptualized for the purpose of this study. The hierarchy is based partly on hypotheses concerning ego defences, formulated by Vaillant (1971) and by Semrad *et al* (1973):

1. *Signs of severe (psychotic) regression:* loss of meaningful structure in B picture, signs of delusional projection.

2. *Signs of less severe regression:* reappearance of previously disqualified A interpretations, signs of sensitivity-projection, lack of signs of perceptual defence.

3. *Non-regressive signs:* signs of repression, isolation, manifest anxiety, depressive stereotypy.

The MCT protocols have been scored by clinical psychologists familiar with the instrument. The inter-rater reliability has proved to be very high for trained raters (Smith and Johnson, 1961; Almgren, 1971).

The Colour Word Test (CWT)

The subject's task is to name as quickly as possible the hue of colour-words printed in colours incongruous with the words (the word 'red' printed in

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blue, 'green' printed in yellow, etc). A page of 100 items is read five times with a one-minute pause between readings.

The reading times of every 20 items in a page form the basis for calculation of R (linear regression) and V (residual variability). The R and V values are classified as high or low according to their relations to the medians in a mixed clinical norm group (Smith and Nyman, 1962). Different combinations of R and V give different designations: S (stabilized), C (cumulative), D (dissociative), and CD (cumulative-dissociative). The most frequent one of the five designations determines the primary type of adaptation. Subjects with an inconsistent pattern of adaptation strategies are designated unclassifiable concerning primary type.

In the present study hysteria was operationally defined as reliance on mechanisms of repression in the MCT and/or dissociative adaptive style in the CWT.

Results

Group A (preliminarily diagnosed hysterics) and Group B (preliminarily not diagnosed hysterics)

Table I gives the preliminary diagnoses and sex and age distribution of the patients in Groups A and B. In Group A there were 18 females and 3 males, in Group B 10 females and 12 males. The groups did not differ significantly in age. Females in Group A were significantly older than females in Group B ($P < \cdot 01$), males in Group A significantly younger than males in Group B ($P < \cdot 01$).

Table II lists the main complaints of the patients in the two compared groups. The most frequent subjective symptom in Group A referred to bodily functions (10 patients out of 20), whereas the dominant complaints in Group B were depressed mood and anxiety (19 patients out of 22). This difference was significant ($P < \cdot 05$).

Signs of overt aggression, as described in the hospital records, i.e. temper tantrums or blaming others, occurred somewhat more often in Group A, but the difference was not significant. After exclusion from Group A of patients with conversion reaction the difference became significant ($P = \cdot 009$, Table III).

Almost three-fourths of the patients in both groups were considered unusually dependent on individuals and/or institutions. Six patients in each group were unclassifiable in dependency style. Of those six patients in Group A who were unclassifiable, as many as five had conversion reaction. The over-dependence was more often described as aggressive for patients in Group A (11 out of 15) and passive for those in Group B (9 out of 16), though the difference was not significant.

The total investigation material contained six patients with objective evidence of brain

TABLE I

Preliminary clinical diagnoses, sex distribution and mean age in Group A (preliminarily diagnosed hysterics) and Group B (preliminarily not diagnosed hysterics)

Preliminary clinical diagnosis	Group A		Group B	
	Females	Males	Females	Males
Hysteria	16	3	0	0
Immature personality	2	0	0	0
Anxiety neurosis	0	0	2	3
Neurotic depression	0	0	1	2
Neurosis NUD	0	0	2	3
None	0	0	5	4
Totals	18	3	10	12
Age, Mean	36·3	20·0	26·7	35·3
SD	12·3	1·6	5·4	12·5

Female age: Group A/Group B, $P < \cdot 01$ (t-test)
Male age: Group A/Group B, $P < \cdot 01$ (t-test)

TABLE II

Main complaints in Group A (preliminarily diagnosed hysterics) and Group B (preliminarily not diagnosed hysterics)

Main complaints	Group A		Group B	
	Females	Males	Females	Males
Depression	6	1	5	8
Phobic anxiety	1	0	1	2
Free-floating anxiety	1	1	3	0
Conversion reactions	8	1	0	0
Hypochondriasis	1	0	1	2
Totals	17*	3	10	12

* One unclassifiable patient.

Depression-Anxiety *v.* Conversion Reactions-Hypochondriasis: Group A/Group B, $P < \cdot 05$ (χ^2-test).

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TABLE III

Overt aggression in Group A (preliminarily diagnosed hysterics) and Group B (preliminarily not diagnosed hysterics)

	Group A	Group B
Overt aggression ..	12 (3)	6
No overt aggression ..	9 (6)	16
Totals	21 (9)	22

Figures in brackets: patients with conversion reactions.
NS (χ^2-test).
Conversion reactions excluded: P = ·009 (Fisher Exact Probability Test).

dysfunction (four with clinical and test signs of cognitive reduction, one with brain stem encephalitis and epilepsy, and one with dyslexia). Five of these six patients belonged to Group A (NS). Four of the six patients with brain dysfunction lacked repression in the MCT, their test diagnosis being based exclusively on dissociative adaptive style in the CWT. The same test pattern was found in only one of the patients without evidence of brain dysfunction (P = ·0006, Table IV).

In each group eight patients reported disgust for sexual activities. Fourteen in Group A and 12 in Group B lived in a continuous relation with parent or spouse. However, this was more frequent among females in Group A than females in Group B (14 out of 18, and 4 out of 10, respectively; NS).

A majority of the patients in both groups (17 out of 21 in Group A and 14 out of 22 in Group B) were admitted to the Psychiatric Clinic by somatic specialists. Nineteen patients in Group A and 17 in Group B became inpatients. All were prescribed psychoactive drugs, chiefly benzodiazepines or tricyclic antidepressants. Only one in Group A and two in Group B were considered to fulfil requirements for 'insight' psychotherapy, whereas 9 and 14, respectively, were treated with 'supportive' psychotherapy. Fully half of the patients in Group A and a third in Group B were not treated with psychotherapy.

Signs of less severe regression in the MCT occurred significantly more often in Group A than in Group B (P < ·02, Table V).

TABLE IV

Relation between brain dysfunction symptoms and test signs

Brain dysfunction symptoms	No repression in the MCT —dissociative CWT pattern	Repression in the MCT —irrespective of CWT pattern
Present	4	2
Absent	1	35*
Totals	5	37

* One patient not tested with the CWT.
P = ·0006 (Fisher Exact Probability Test).

Group C (psychotics)

Four female patients (mean age 26·3, SD 7·3) of the ten in this group were preliminarily diagnosed psychogenic psychosis. None of them exhibited symptoms of schizophrenia during follow-up. Six others in this group, three male and three female (mean age 25·2, SD 8·3) during follow-up were diagnosed non-regressive schizophrenics (Nyman, 1975). Two of them had had the preliminary diagnosis of hysteria, one anxiety neurosis, and one depression or possibly non-regressive schizophrenia. For two patients a preliminary diagnosis was lacking. Three presented with bodily complaints (dysmorphophobia, anorexia, somatic delusions), one with depressive mood without retardation, one with cannabis abuse, and one with ideas of reference in the sexual sphere. All six reported ambivalence regarding their sexual identity. Overt aggression was described in only one patient.

TABLE V

MCT signs in Group A (preliminarily diagnosed hysterics), Group B (preliminarily not diagnosed hysterics)

MCT signs	Group A	Group B
I. Severe regression ..	0	0
II. Less severe regression	11	3
III. No regression ..	10	19
Totals	21	22

Regression *v.* No regression: P < ·02 (χ^2-test)

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MCT signs of severe regression were found in three of the four with psychogenic psychosis. In the group of non-regressive schizophrenics none exhibited signs of severe regression. Three lacked regressive signs in the MCT and presented with neurotic signs only. In the adaptive style, defined by the CWT, the non-regressive schizophrenics differed from the rest of the material. Five of the six had an unstable adaptive pattern and could not be classified according to primary type, compared with five unclassifiable patients out of the 46 in the rest of the material ($P = \cdot 003$, Fisher Exact Probability Test).

Discussion

A retrospective study based on filed information collected and evaluated by different examiners usually suffers from weaknesses, for instance scarcity of relevant data common to all subjects, and questionable validity and reliability of the variables. The present investigation, however, defines the psychiatric condition under study, hysteria, in a reliable, valid, and operational way, i.e. by means of well-established psychological test instruments: the MCT and the CWT. But because only those patients have been studied who were referred for diagnostic testing, a selection factor of unknown magnitude is introduced. This means that clear-cut (and perhaps 'typical') cases of hysteria are under-represented, and patients with uncertain or mixed symptom pictures over-represented, as is reflected in Table I: for as many as 9 Group B patients no preliminary diagnosis was suggested; for a further 5, the diagnosis was 'neurosis' without specification. The very high proportion of patients admitted for psychiatric care by a non-psychiatric physician might also reflect a selection bias, as might the high incidence of hospitalization in the material (84 per cent), patients with less incapacitating conditions not being referred for testing and consequently being excluded from the study.

The definition of hysteria in the present study is based on the presumption of repression being the characteristic defence mechanism and/or dissociation the major style of adaptation. In clinical, descriptive diagnostics of hysteria social and cultural factors have played a major role and possibly account for the much more common application of the diagnosis to female patients than to male (Lerner, 1974). Our definition of hysteria minimizes the influences of such factors, except for their possible relevance for the very formation of defence mechanisms and adaptive styles. The influence of social and cultural factors is probably reflected in the sex distribution of the preliminary diagnoses of hysteria. The female to male ratio is 6 to 1, which the test diagnosis reduces to approximately 2 to 1. Other factors that seem to foster the clinical hysteria diagnosis are: higher age and a continuous relation to a spouse in female patients; bodily complaints, especially conversions; relative absence of depressive mood and anxiety; presence of overt signs of aggression and aggressive dependency. The frequency of depressive complaints in Groups A and B (47 per cent) closely corresponds to the finding by Stefánsson *et al* (1976) of depression in 50 per cent of a group with hysterical neurosis.

Although, in the present study, the clinically diagnosed hysterics seem to have descriptive traits characteristic of so-called Briquet hysteria (Guze *et al*, 1972), the observations are probably best understood in a dynamic frame of reference. Thus the clinically diagnosed hysterics correspond to the 'sick' hysterics regarded as suffering predominantly from oral conflicts demandingly expressed by overt aggression and immature defences (cf Zetzel, 1970; Lazare, 1971). This interpretation is supported not only by observed dependency and overt aggression but also by less mature defence mechanisms in the MCT.

Patients in Group B resemble those in Group A not only in resorting mainly to repressive mechanisms but also by presenting dependency problems. Thus the central conflict and major defence seem to be identical, and differences between the groups might be interpreted as a difference in degree of mental decompensation, i.e. regression.

Group A patients seem to direct aggression either overtly, towards others, or in conversions, towards their own body. In Group B patients, who experience a depressive mood or anxiety, aggression seems to be directed towards the self.

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The suggestion that 'hysterical' behaviour patterns are sometimes determined by malfunctoining of the brain (cf Slater, 1961; Whitlock, 1967) is supported by our finding that five out of six with brain dysfunction symptoms were clinically diagnosed hysterics. This constitutes 14 per cent of our non-psychotic patients, which agrees with Stefánsson *et al* (1976). Four of the five who lacked repression in the MCT, displaying a dissociative behaviour pattern in the CWT, had brain dysfunction symptoms.

Three of the four diagnosed psychogenic psychosis, in current nosology cycloid psychosis (cf Perris, 1974), displayed in the MCT severely regressive, i.e. psychotic, signs in addition to signs of hysterical adaptation. This test pattern corresponds to the least mature level in the ego defence mechanism hierarchy proposed by Vaillant (1971).

Two of the six with a final diagnosis of non-regressive schizophrenia were preliminarily diagnosed hysterics. The fact that symptoms and signs considered to justify the diagnosis hysteria might overlay a schizophrenic psychosis has been pointed out previously (e.g. Lewis and Berman, 1965; Slater, 1961; Slater and Glithero, 1965; Barnet, 1971). However, all six in this group presented with typical symptoms of non-regressive schizophrenia, for instance, ruminations on sexual identity, polysymptomatic neurosis, vague ideas of reference, hypochondriasis in the setting of a change in body image (Nyman, 1975). It perhaps seems remarkable that three of the schizophrenic patients in the MCT presented with neurotic signs without regressive tendencies, but this could support the view that, among other factors, more mature defences may prevent a psychotic regression. The non-regressive schizophrenics exhibited MCT signs similar to the preliminarily diagnosed hysterics—Group A (see Table V).

The unclassifiable primary type in the CWT has earlier been explained by reliability weaknesses; consequently, it has not been considered to possess any diagnostic value. However, as this test pattern was found significantly more often in the non-regressive schizophrenics compared with the rest of the material, it might be a diagnostic clue.

Conclusions

Two groups of hysterics, both resorting to the defence of repression and with oral-dependency problems, were differentiated in psychological tests by level of regression and clinically by their handling of aggression. Three small groups with the same test diagnosis could be separated from the hysterics: one with clinical and test signs of brain dysfunction, another with clinical and test signs of psychotic regression, and finally, one with clinical symptoms of non-regressive schizophrenia and a test pattern without signs of psychotic regression but with an adaptive style in accord with difficulties in habituation.

It should be considered hazardous to base the diagnosis hysteria exclusively on behavioural characteristics, overlooking phenomenology, nature of conflict, defence pattern, and brain dysfunction.

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