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Hysterical Conversion: A Prognostic Study

By H. B. HAFEIZ

SUMMARY This is a study of the symptoms and treatment of 61 patients with hysterical conversion. The incidence rate is high and the clinical picture showed different qualities from that seen in other studies. Treatment by suggestion under various procedures produced favourable results. All symptoms were removed, and after twelve months follow-up only 12 patients relapsed. Symptom substitution was minimal. The prognosis is related, among other things, to the duration of the symptoms before treatment.

Hysteria, though known since antiquity, is still a controversial disease and some still question its existence as a separate entity (Slater, 1965). Hysterical conversion, with which we are dealing in this paper, is the most well-defined and widely accepted form of hysteria. The Freudian view that it is the conversion of a mental conflict into physical and mental symptoms, with primary gain and unconscious motivation, has frequently been modified. The Glossary to ICD–9 (WHO, 1978) defines conversion as a psychogenic disturbance of function in some part of the body, produced by motives of which the patient seems unaware. The disturbance may be of advantage and symbolic value. The diagnosis in this paper is thus limited to symptoms of such a nature after exclusion of physical illness.

Method

The study included all cases diagnosed as hysterical conversion, as defined above, who attended the psychiatric clinic in Khartoum General Hospital over the period of three years (1975–1977). A total of 61 of the 80 patients were seen, treated and followed-up by myself and the other psychiatrist in charge of the unit. Physical examination and investigations were carried out to exclude physical illness. The treatment was aimed at the removal of the symptoms by the simple method of suggestion. This was carried out under the following procedures:

(1) Faradic stimulation; applied briefly to lower or upper limbs.

(2) Somlec: an electro-sleeping machine that produces considerable relaxation and occasionally sleep. It is applied to the head, usually for 30–60 minutes while suggestion is carried out.

(3) Sodium amylobarbitone; 250 mg in 5 ml given intravenously at the rate of 1 ml per minute.

(4) Methylamphetamine (Methedrine) 10 mg by the intravenous route.

Patients were randomly allocated to one of these procedures or, occasionally, to a combination of them if one method failed. The whole procedure is simple: first the patient is informed that his symptom is considered seriously by the therapist and that it will disappear after treatment. Then, while undergoing one of the above-mentioned procedures, suggestion is given that the symptom is disappearing and the patient is instructed to practise the lost function until full recovery is achieved by the end of the treatment. One method is repeated three to four times before another is undertaken. The removal of the symptom is usually accompanied by emotionally charged scenes with sighing, tears or shaking. Encouragement, support and discussion with the patient then follow. Subsequently patients were followed up once or twice a month at the out-patient clinic for at least 12

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months. Four patients failed to keep regular appointments and were excluded from the study.

Results

The total number of patients who attended the psychiatric clinic during the study period was 824; of these 80 patients were diagnosed as hysteria, i.e. an incidence of 10 per cent. Of all hysterics 76 per cent were suffering from conversion hysteria.

Of the 61 patients 86 per cent fell in the age group 10–25. Only two patients were above the age of 35 years. There were 56 female and 5 male patients, a ratio of 11.5:1; 44 patients were single, 11 married, 4 divorced and 2 widowed.

The dominant complaints of patients are shown in Table I. These were usually accompanied by other symptoms such as headache, vague bodily complaints, aches and pains, insomnia and anorexia, usually expressed in an exaggerated and dramatic manner. The symptom intensity ranged from mild to very severe forms of the disability, for example, from vomiting occasionally and after meals to vomiting continuously for months. Dysphonia occurred in four patients and complete loss of voice in eight patients. Breathlessness, another common feature, was usually rapid and shallow. Weakness of the lower limbs and especially of one limb (three patients) was frequent. The simulative nature of fits in four patients was evident, usually occurring in the presence of others and without injury. Tremors were coarse and usually involved the whole of the upper limbs. One patient complained of diplopia and another complained of complete blindness. In two patients the jaw was stiff and tight, obstructing food intake but allowing verbal communication; two patients were dysarthric and could hardly speak. The two patients with retention of urine were referred from a urological clinic after being catheterized many times. Other symptoms were rare, but it was not uncommon for some of the patients to have many complaints. The duration of the symptoms before treatment are shown in Table III; 80 per cent had their symptoms within the first six months. A comparison of symptoms in this study with two other studies is shown in Table II. Pre-

TABLE I

Symptoms and response to suggestion

Dominant symptom	Number of cases	Response		Relapse
		Rapid	Delayed	
Aphonia	12	11	1	2 (17%)
Dyspnoea (breathlessness)	12	10	2	1 (11%)
Vomiting	10	2	8	2 (20%)
Fits	6	1	5	3 (50%)
Retention of urine	2	—	2	1 (50%)
Sensory disturbances	2	1	1	—
Blindness	2	—	2	1 (50%)
Speech disturbances	2	2	—	—
Motor disturbances (paralyses, tremors, lockjaw, head-nodding, torticollis, sneezing)	13	9	4	2 (15%)
Total	61	36	25	12

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TABLE II

Comparison of major symptoms with previous studies

Symptom	This study (61 patients)	Ljungberg's (1957) (381 patients)	Carter's (1949) (100 patients)
Aphonia	20%	1.3%	29%
Dyspnoea	20%	—	—
Vomiting	16%	—	6%
Paralyses	10%	10%	23%
Fits	10%	20%	6%
Tremors	3.3%	10%	10%
Blindness	3.3%	0.8%	3%
Astasia-abasia	—	47%	—

TABLE III

Relation between symptoms' duration before treatment and relapse

Symptom duration	Number of patients	Relapsed
Less than 30 days	33	2
,, ,, 6 months	13	2
,, ,, 1 year	4	2
,, ,, 3 years	7	6
Total	57	12

Over 6 months compared with less than 6 months, χ^2 (Yate's correction) = 18.22, df 1, P < .001.

cipitating factors, such as problems at home, school, work, illness and emotional problems could be traced in 90 per cent of cases. In others, no evident cause was noticed but the attention they received from being ill seemed to be involved. No gross deviations from average intelligence levels were detected.

Suggestion under faradic stimulation and Somlec produced 90 per cent and 84 per cent response, respectively. Response to methedrine injections was 81 per cent and to amylobarbitone only 20 per cent; in fact the latter was abandoned after being tried in five patients with four successive failures. The response to suggestion of various symptoms is shown in Table I; 28 patients responded immediately, with the removal of the symptom after the first application. In others, the procedure had to be repeated but within three months of starting treatment all symptoms resolved. Motor disturbances, aphonia and breathlessness had the best response, while vomiting, fits and blindness were significantly less responsive.

Twelve of the 57 patients (21 per cent) relapsed within the follow-up period; 8 patients relapsed with the same initial symptom, although in different situational settings. Four patients had frequent relapses and two of these were almost weekly attenders at the clinic. Most of the symptoms relapsing had been present for a longer duration before treatment; two patients had symptoms more than two years (Table III). The two variables (duration and relapse) are significantly associated. There is a linear trend in the probability of relapse with duration of symptoms.

Discussion

The high incidence of hysteria in this study (10 per cent) compared with previous studies (e.g. 6 per cent in Bethlem and Maudsley series 1948–51; Hare, 1965) could partly be explained by the facts that: (a) females in our society leave the home less frequently and conversion

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symptoms could be an acceptable way of communication; (b) conversion symptoms being of dramatic and seemingly physical nature compel relatives to bring more patients to medical care; (c) anxiety neurosis is dealt with in general practice, while some of the psychotic patients are still looked after by religious healers so that these two groups are under-represented. As in other previous studies hysteria is significantly more frequent among the young age group and females. Men, being higher in the dominance hierarchy in the society, seem not to suffer from conversion symptoms.

Clinically, the changing faces of hysterical symptoms has been frequently stressed, and this is confirmed in the present study. It is also thought that, with a continuing rise in cultural sophistication of a society, conversion symptoms are replaced by anxiety and depressive ones (Stefanis *et al*, 1976). However, our patients still seem to opt for gross symptoms, and aphonia, breathlessness, vomiting and paralysis are the commonest. The number of males in this group is too small to make reliable inferences on sex differences in symptomatology and the material is treated as a whole.

The direction of treatment towards removal of the symptom is usually deprecated by advocates of psychoanalytic approaches who consider the symptom to be a primary defence, loss of which causes anxiety, depression and sometimes psychosis. Nonetheless we had to rely on suggestion, as other methods were not available, due to lack of trained staff, time and financial resources. On the other hand removal of the symptom did not prove adverse and symptom substitution was negligible. All patients responded to suggestion favourably. Symptoms such as motor disturbances, dyspnoea and aphonia had favourable prognoses while fits had a poor one, a fact mentioned by previous writers (*inter alia* Carter, 1949; Ljungberg, 1957). Faradic stimulation, Somlec and methedrine proved superior to amylobarbitone.

The relapse rate was low and significantly related to duration of the symptoms before treatment i.e. the longer they were present the more they relapsed. Previous studies on the outcome of treatment in hysteria, using traditional methods, gave a gloomy outlook of the condition. Thus Luff and Garrod (1935) reported recovery rates of 51 per cent, Ljungberg (1957) 62 per cent in the first year and Greer and Cawley (1966) 41 per cent after three years. Using behavioural techniques, probably the most comparable studies to this one, Carter (1949) reported 66 per cent recovery rate after a follow up period of four to six years and Dickes (1974) reported 90 per cent remission on discharge.

The wide differences in recovery rates are however explainable in the light of differences in definition, selection of patients, duration of the illness and length of the follow up. The high recovery rate in the present study is perhaps influenced by the short duration of the illness and short period of follow up. However, enough is left to justify adopting suggestion as a practical treatment of conversion hysteria.

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