

RESEARCH

Phenomenological study of 'hysterical neurosis' in Lower Assam

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Abstract

Background: An investigation of 'hysteria' involves a close study of the human being, both from somatic and psychological perspectives and often reveals the intimate relationship they bear to each other.

Material and methods: The sample of the present study consisted of 80 consecutive cases of hysteria attending the outpatient and inpatient department of psychiatry of Gauhati Medical College Hospital from Lower Assam area since 1st April, 1988 onwards. Diagnosis of 'hysterical neurosis' was made according to the ninth revision of the International Statistical Classification of Diseases and Related Health Problems, code 300.1.

Results: The phenomenology of hysteria studied in this sample showed that monosymptomatic hysteria was rare. The most common symptom was 'fits' (episodic loss of consciousness only) to be followed by convulsive movement of the entire body. Except the fits, no other symptoms of dissociative disorder like fugue, somnambulism, multiple personality etc. could be found. Female outnumbered the male patients but male representation in hysteria was increasing. High occurrence was seen in the age group of 16-20 years. Only 19 (23.75%) patients were from urban area and 61 (76.25%) patients were from rural area. However nuclear families were found to be more from rural area than the urban area.

Conclusion: Hysteria is still with us. Our patients still tend to exhibit gross symptom and it may yet some time before we see a change. Although hysteria is still found to be more in females, male representation has increased significantly and this increasing trend is quite prominent.

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Introduction

The phenomenon of 'hysteria' has eluded scientists and prophets since antiquity. The current question raised by many workers over the years is whether or not hysteria is a homogenous phenomenon and whether the varied symptomatology manifested by patients can be considered to be a distinct clinical entity. Despite the clinical and the theoretical models, research in the area of hysteria in the West is at present meagre. There appears to be an anti-hysteria attitude.

In India, the situation seems to be different. 'Neurosis' in Indian patients has its own personal colouring as would necessarily be expected. India is a land of multiple cultures and traditions which form the background model for mental illness. Here again, adherence to social customs and following certain expected familial traditions contribute in no small measure to the causation of neurosis. The inferior status of women in Indian society coupled with various taboos that centre on menstruation marriage, childbirth and her position in the family are indeed important factors in neurosis seen in

the women. Poverty that prevails is indeed responsible to the causation of financial stress but at times acts as a saviour giving the patient to formulate any neurotic behaviour. Poor education, unemployment, inadequate nutrition, lack of adequate housing all seem to have its toll in the contribution to neurosis in this vast country of multiple religions and languages. India is thus a country most suited to the causation of neurosis as so many environmental factors are contributory. People still believe in possession of a person by God, Goddesses, Ghosts etc. India can be compared to some of the developing countries where hysteria can be seen in such full blown form.

Thus it justifies a study or research in the field of 'hysterical neurosis.' Nevertheless there have been many studies or researches on sociodemographic and psychodemographic variables in India. But there are very few studies carried out to understand the phenomenology of this interesting disease. In Assam, no systematic and methodical study regarding the phenomenology of hysterical neurosis has been adopted so far. So in this

clinical work an attempt to understand the phenomenology of hysteria in Lower Assam was undertaken.

Aims and objectives: The present study aimed at a cross sectional study of hysterical neurosis consisting of—

1. Phenomenology as occurring in our population presenting at the Department of Psychiatry of Gauhati Medical College Hospital (GMCH), Guwahati;
2. To compare the rural and urban patients in relation to phenomenology.

Methods and materials

This study was done on the patients attending both the outpatient and inpatient department of psychiatry of GMCH from the Lower Assam area.

Lower Assam: Geographically Assam can be divided into Brahmaputra Valley and Barak Valley. This Brahmaputra Valley can be divided into Upper Assam and Lower Assam area. The following seven districts comprised of the Lower Assam area—Kamrup, Darrang, Nalbari, Barpeta, Kokrajhar, Dhubri and Goalpara (figure 1).

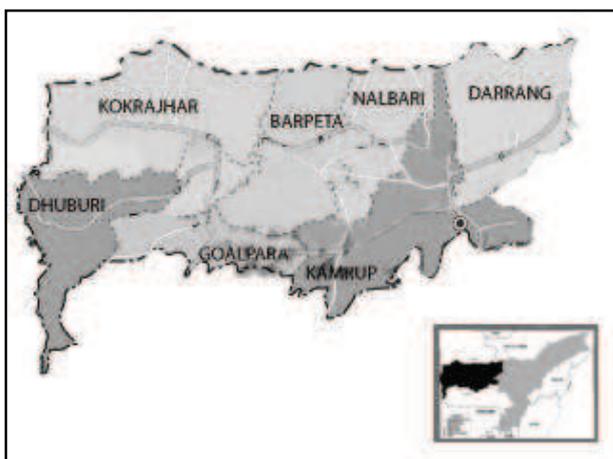


Figure 1 Lower Assam area.

Department of Psychiatry, GMCH: The outpatient department functioned on all week days excepting Sundays. The average attendance in the outpatient was 30 per day and included cases referred from other departments and specialties of the Hospital. About two-third of the cases were from village areas of Lower Assam and the rest from the various urban areas of Lower Assam. There were also cases from neighbouring states like Arunachal Pradesh, Nagaland, Manipur, Mizoram, Tripura, Meghalaya etc. along with the cases from Upper Assam too.

Selection of cases

(a) Criteria for selection

Inclusion criteria—

1. Consultant’s diagnosis of hysterical neurosis as per the ninth revision of the International Statistical Classification of Diseases and Related Health Problems, code 300.1.[1]

2. Patients below 50 years of age.

3. Cases from both the sexes.

Exclusion criteria—

1. Presence of delusion or hallucination.
2. Presence of associated alcoholism or drug abuse.
3. Presence of physical illness which could explain the presenting symptomatology.
4. Presence of delayed milestones of development, mental retardation, head injury, epilepsy and other organic problems.
5. Past history of psychotic illness.

(b) Mode of collection of cases: Consecutive patients, satisfying the criteria, were included in the study.

Description of the tools of enquiry: A proforma had been prepared to document the data. It included—

i) Personal information and sociodemographic data and details of presenting illness.

ii) A symptom checklist. This checklist included 65 neurotic symptoms. These symptoms were selected after scanning 100 case files of hysterical neurotic patients and it also included relevant items from diagnostic criteria for use in psychiatric research,[2] Present State Examination,[3] Post Graduate Institute of Medical Education and Research Health Questionnaire[4] and Cornell Medical Index Health Questionnaire.[5] Within the limit of translation to local language, attempts were done wherever possible to contain the exact verbatim report. Initially the spontaneous report of symptoms was recorded. Then the interview was pursued according to the questionnaire prepared. The sexual symptoms were enquired only in the end. The questions of enquiry for each of the symptoms were prepared before the study and were uniform for all patients. The information variance was minimised as the same investigator interviewed all patients along the same guidelines and questions which were predetermined. The symptoms were simply rated as present or absent if the criteria was satisfied.

After the finalisation of the tool, an inter rater reliability was tested on a set of further ten patients. Two consultants of the department were raters. The two consultants gave independent ratings, each case being alternately interviewed by the raters. A product moment correlation coefficient was found to vary between $r=0.48$ and 0.8 . The translated version of the symptom checklist was also given to a consultant to test its validity. It was found to be a valid one.

Interview procedure: All the 80 cases selected from the outpatient and inpatient department were interviewed in detail using the tools. Data was collected from patient

himself or herself and from a reliable informant. No rigid pattern of interview was set and the sequence of interview was made flexible to elicit maximum data. The total time spent for assessing each patient ranged between 60 to 90 minutes. A detailed physical examination was carried out in all cases.

Analysis of data: As most of the cases attending outpatient department were admitted, the sample could not be divided into a group of outpatient and another group of inpatient. But the sample was divided into urban and rural sample. As the number of male and female patients came out to be of almost equal number, the sample was also divided into male and female groups. Frequencies of symptoms and sociodemographic variables in each group were made. The mean and standard deviation (SD) was calculated for each of these items.

Results and observations

This study was based on 80 consecutive hysteria patients attending the outpatient and inpatient department of psychiatry of GMCH from Lower Assam area since 1st April, 1988 onwards.

Phenomenology

Eighty hysteria patients studied showed varying symptomatology. Monosymptomatic presentations were rare in the sample studied. Most of the patients, besides the chief complaints, had a number of other minor symptoms. The most common chief complaints were 'fits' (episodic loss of consciousness only) (49 patients), convulsive movement of entire body (34 patients) and difficulty in breathing (30 patients). The other chief complaints were headache, chest pain, aphonia and difficulty in walking (table).

The most frequent symptom seen in these patients was fits. It lasted for two minutes to two hours in an average. The fits occurred at any place and at any time but it did never occur during sleep. The patients could not give any description of their attacks once they regained consciousness. The fits usually occurred in the presence of others. Convulsive movement of entire body was the next most frequent symptom reported by the patients. This consisted of wild disorganised thrashing movements of limbs and writhing of the trunk. In 22 patients the convulsive movements occurred in a state of altered consciousness and were never able to give the description of their attacks. In the other 12 patients the sensorium was intact and was able to describe the attack. The episodes of convulsive movement always occurred in presence of others and there was no history of injury, tongue bite, frothing, clinching of teeth or incontinence etc. No post convulsive confusion, headache, nausea or vomiting were also there.

Table. The symptoms complained by the patients, number (%)*

Fits (episodic loss of consciousness only)	49 (61.25%)
Convulsive movement of entire body	34 (42.5%)
Difficulty in breathing	30 (37.5%)
Headache	25 (31.25%)
Generalised weakness	24 (30%)
Tingling and numbness	22 (27.5%)
Poor appetite	21 (26.25%)
Feeling of heat in body	20 (25%)
Chest pain	19 (23.75%)
Aphonia	18 (22.5%)
Palpitation	17 (21.25%)
Giddiness	17 (21.25%)
Difficulty in walking (astasia-abasia)	16 (20%) [7 (8.75%)]
Pain in the abdomen	14 (17.5%)
Heaviness in head	13 (16.25%)
Easy fatigability	13 (16.25%)
Vague sensory symptoms	10 (12.5%)
Easy shedding of tears	10 (12.5%)
Heaviness in stomach	10 (12.5%)
Pain in other parts of body (like back of neck, shoulder etc.)	9 (11.25%)
Nausea	8 (10%)
Feeling of uneasiness in head	8 (10%)
Sexual indifference	7 (8.75%)
Backache	7 (8.75%)
Cramps in leg	7 (8.75%)
Burning of palm and sole	7 (8.75%)
Anaesthesia	6 (7.5%)
Heaviness in eyes	6 (7.5%)
Burning of eyes	6 (7.5%)
Lump in throat	6 (7.5%)
Joint pain	6 (7.5%)
Pain in the extremities	6 (7.5%)
Constipation	6 (7.5%)
Undue concern over health	5 (6.25%)
Burning sensation in head	5 (6.25%)
Urinary retention	5 (6.25%)
Rhythmical tremor of body	5 (6.25%)
Muscle stiffness	5 (6.25%)
Menstrual disorder	5/43 (11.65%)
Blurred vision	4 (5%)
Abdominal burning	4 (5%)
Burning in sex organs	4 (5%)
Weight loss	3 (3.75%)
Difficulty in hearing	3 (3.75%)
Stuffed nose	3 (3.75%)
Paralysis	3 (3.75%)
Fluctuation of weight	1 (1.25%)
Pulling of tongue inside the mouth	1 (1.25%)
Possession state	1 (1.25%)
Jerky movement of upper part of body	1 (1.25%)
Anxiety features	6 (7.5%)
Depressive features	1 (1.25%)
La belle indifference	24 (30%)

*The symptoms complained by the patients according to their frequency (symptoms of conversion disorder and dissociative disorder were dealt with first and other symptoms like anxiety, depression and la belle indifference were dealt with later)

Thirty patients had difficulty in breathing. The breathing was irregular and appeared as if grasping from breath along with hyperventilation. Twenty five patients complained of headache. In some patients it was reported to be very intense and in some patients it was within tolerable limit.

Out of the 80 patients, 24 complained of generalised weakness as one of their symptoms. Some patients even complained of not being able to talk with the interviewer properly due to weakness. The next frequent symptom was tingling and numbness. Patients complained of tingling and numbness of both extremities throughout the course of their illness.

Twenty one patients complained of poor appetite. Feeling of heat in the body was another symptom complained by 20 patients. This was a peculiar sensation complained by them and it was not rise of temperature as confirmed by clinical examination. Nineteen patients complained of chest pain. The pain was diffuse and vague in nature and did not bear any relationship with the phases of respiration. No history of fever, cough and injury to chest was there.

Besides the chest pain specific pain denoting to some part of the body were complained by some patients. Pain in abdomen was complained by 14 patients. This abdominal pain was vague in nature and not localised to any particular area. On examination no tenderness could be elicited in any area of abdomen. Likewise pain in the back of neck, shoulder etc. was complained by nine, backache by seven, joint pain by six and pain in the extremities by six patients. Only four patients complained of pain as their presenting symptom.

Aphonia was another symptom of interest to be presented by 18 patients. No other difficulty like difficulty in swallowing, difficulty in chewing was there. Those who complained of palpitation did not show any other anxiety feature. Heart rates were normal in all of these cases. Giddiness was described by the patients as an unsteady feeling or reeling sensation of the head. No vertigo was reported by any of these patients.

Sixteen patients complained of difficulty in walking. Out of them seven patients (8.75%) had astasia-abasia and gait disturbances sometime in the course of their illness. Along with other complaints 13 patients had the complaints of heaviness in head. Thirteen patients complained of easy fatiguability. Four patients expressed inability to complete the interview in one session because of this reason. Vague aches and pains with pulling sensation all over the body were complained by ten patients. Some also gave a connotation of general weakness to these complaints.

Some of the important symptoms which were of less frequency were menstrual disorders. Five out of 43 female patients (11.65%) had dysmenorrhoea or menstrual irregularity some time or the other. Seven patients (8.75%) showed sexual indifference. Involuntary rhythmical tremor of the body was complained by five (6.25%) patients. One (1.25%) patient complained of pulling sensation of the tongue inside the mouth. One married female patient suffered from possession state. One school going boy had jerky movement of upper part of the body.

Six (7.5%) patients showed anxiety features like cold and calmy extremities with fine tremor. On examination tachycardia was present. One patient complained of depression without suicidal ideation. Out of total 80 patients, 24 (30%) demonstrated la belle indifference. But

the other 56 patients appeared concerned about their illness.

Sociodemographic variables

Out of 80 patients 37 patients (46.25%) were males and 43 (53.75%) were females. The mean age of females was 22.07 (SD 8.86) and that of males was 21.05 (SD 7.96). Out of 37 male patients, 89.1% and out of 43 female patients, 81.55% were below the age of 30 years. Eighteen male patients (48.6%) and 12 female patients (27.96%) were within the age range of 16-20 years. Sixty five percent were single. Among the female patients, 25 (58.25%) were unmarried. Fifty five percent studied up to high school level (23 males and 21 females). Illiterate constituted 16.25%. Forty three patients (53.75%) hailed from lower middle and 61 (76.25%) patients were from lower middle and lower social class. Students constituted 52.5%. Twenty one out of 43 females were household workers. Among the female patients, 74.56% and 70.2% male patients belonged to nuclear family. There was increased number (83.64%) of nuclear families in the rural area (figure 2).

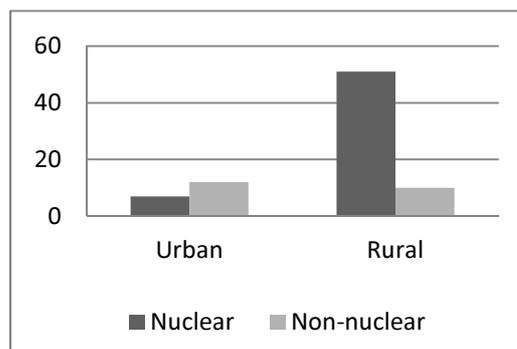


Figure 2 The breakup of families in relation to urban and rural patients.

The distribution of birth order showed the first and last child were same constituting 15 (18.75%) patients in each group, 48 (60%) belonged to ‘any other’ category. Sixty three (78.75%) patients were Hindu. Nineteen patients (23.75%) were from urban and 61 (76.25%) were from rural area. Ratio of female to male patient in urban area was 1.11:1 and that of rural area was 1.18:1.

Discussion

Studies on hysteria are abundant but the numbers of systematic studies about the finer aspects of phenomenology of hysterical neurosis are not very high. The design for such an exploratory study should essentially include the community in the field. But due to certain technical difficulties, the study was restricted only to the outpatient and inpatient department of psychiatry of GMCH. So this sample may be different from the usual presentation of hysteria found in general population.

As far as the inclusion criteria were concerned, no cut off age of onset was provided. This was done to

include the consecutive cases. The chance of inclusion of cases with primary personality or organic disorder was very remote as only those cases fulfilling the criteria for inclusion in the study were included.

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Some of the symptoms from the symptom checklist had to be eliminated from the initial analysis as not a single case reported these symptoms. The symptoms which were eliminated were amnesia, bed wetting, pain during micturition, pain during intercourse, excessive vomiting during pregnancy, multiple personality, fugue state etc. Monosymptomatic hysterics were rare. Besides the chief complaints, all of the patients had a number of minor symptoms. Purtell *et al.*,[6] Nemiah[7] and Abse[8] had mentioned that monosymptomatic hysteria was becoming rare and the findings in the present study agreed with their observation.

The most common symptom reported by the patients was fits. One point for comment here is the gradual decline in the incidence of the dramatic manifestation with which hysteria is historically associated, particularly the hysterical fits in the West. This phenomenon has been noted by most clinicians.[9-11] This can be explained by the fact that if a patient's particular conversion symptoms depend, among other factors, on his conception of illness and his medical sophistication[9] then we may postulate that because of the increasing educational level and the general socioeconomic improvement in the West, patients are now in a position to express their feelings (when more direct expressions are discouraged) by more sophisticated but still equally pathological conversion symptoms.[12]

Sexual permissiveness, one of the characteristic contemporary cultural developments, is also a factor which may partly account for the decrease in the incidence of the major forms of hysteria. It is worth noting that the association of these terms with sexual inhibition, usually attributed to the work of Sigmund Freud, is by no means a Freudian discovery. Ancient Egyptians and Greeks as well as many gynaecologists of the nineteenth century stressed this association.[13] But in this study, fits were the most common clinical presentation (59.4% in male and 62.9% in female). This finding agreed with the observations made by Ray & Mathur,[14] Abse,[8] Pu *et al.*,[15] Ponnudurai *et al.*[16] and Trivedi *et al.*[17]

Of the 370 Indian soldiers Abse[18] studied during the Second World War, 188 patients had fits. Ray & Mathur[14] found fits in 192 of their 330 patients. Episodic loss of consciousness was also a very frequent symptom in the Indian patients studied by Ray & Mathur[14] and Abse.[8] Sood[19] also had similar findings. Ponnudurai *et al.*[16] studied 65 cases of hysteria and the commonest symptom in his study was fits which constituted 31.71% in the females and 25% in the males.

Trivedi *et al.*[17] studied 26 cases of hysteria from child and adolescent group and found the most common presentation as fits (57.7%). Pu *et al.*[15] studied 100 consecutive cases of conversion hysteria in Libya and found the commonest presenting symptom as fits (72.5% of males and 50% of females).

The next most frequent symptom was convulsive movement of the entire body (42.5%). Patients with epileptic convulsion learn the pattern of their attacks and through this knowledge develop hysterical attacks as a problem-solving technique. This was concluded by Roy.[20] Keeping this in mind a detailed history was taken and in each case all possible investigations were done to rule out epilepsy. Gross[21] in a study of 19 adolescent hysteria patients found the symptom of convulsive movement of entire body in 13 patients (57.75%). The finding in the present study agreed with the above mentioned observation (45.9% in male and 39.6% in female).

Difficulty in breathing was presented as one of the most common chief complaints by 30 patients (37.5%) in the present study (43.2% in male and 32.6% in female). Respiratory system was found to be normal at the time of breathing difficulty. Most of the patients also suffered from hyperventilation in the process to overcome the difficulty. Ponnudurai *et al.*[16] from Government General Hospital, Chennai had also reported about finding of breathing difficulty as conversion symptom in 7.2% of cases out of 65 patients diagnosed as hysteria.

Charcot[22] had not mentioned pain as a symptom of hysteria. But now the trend is changing. Purtell *et al.*[6] considered pain as an important symptom of hysteria. Ziegler *et al.*[9,23,24] found that pain was the conversion symptom most often clinically encountered. Abse[8] in his comparative study of phenomenology of hysteria during the Second World War on Indian soldiers at Delhi (India) and British soldiers at Chester (England) observed that headache was a frequent manifestation of conversion reaction in British soldiers whereas abdominal pain dominated the clinical picture of Indian patients. Headache was also observed in 17% of female patients out of 65 cases diagnosed as hysteria by Ponnudurai *et al.*[16] Sood[19] reported pain in 30% of his cases. The findings of the present study were in agreement with theirs. In the present sample 31.25% had headache, 23.75% had chest pain, 17.5% had pain in the abdomen, 11.25% had pain in other parts of body (like back of neck, shoulder etc.), 8.75% had backache, 7.5% had joint pain and another 7.5% had pain in the extremities. Somatic symptoms in the form of tingling and numbness were found in 27.5%. Trivedi *et al.*[17] found its occurrence in their sample of 26 patients diagnosed as hysteria to be 23.4%.

Aphonia as their presenting symptom was manifested by 22.5% patients. One contention of the Freudian concept of hysteria is that the motivation for symptom development must be unconscious. In practice it is almost impossible to distinguish the two and motivation is often partly conscious and partly unconscious. In our series, some of the paralysed patients could move their limb and some of the aphonic patients could talk if they really tried. After persuasion and psychotherapeutic suggestion, all could perform these actions. The reason behind the paralysis and aphonia could possibly be that they did not want to move or talk. The state 'I wish not' leads to 'I will not' and later 'I cannot.' All the patients were easily suggestible and auto suggestion may play an important role in the development of symptoms. Aphonia as a conversion phenomenon was found in a series of 246 females and 135 males studied by Ljungberg.[25] In India Ponnudurai *et al.*[16] had also found it as conversion symptom in their studies.

Giddiness (21.25%) was another symptom that was being presented by 17 patients in the study. Thirty percent of Sood's[19] cases also complained of this symptom. Another common symptom to be mentioned was vague sensory complaints (12.5%). Sood[19] found sensory disturbances in 50% of his patients. He qualified this as paraesthesia. But in our patients it was not paraesthesia. There was no crawling or creeping sensation or pins and needles sensation. Astasia-abasia was complained by 8.75% of our patients. Ljungberg[25] had observed this as the most frequent symptom.

Abse[18] had stated that la belle indifference should be present if the diagnosis of hysteria had to be made. This had been questioned by Chodoff[26] and Stephens & Kamp.[27] Stephens & Kamp[27] found la belle indifference only in 32% and Sood [19] found in 60% of his patients with hysteria. Our finding was also in agreement with their observations since only 30% of our patients showed la belle indifference.

One patient presented with an episodic jerky movement of the upper limbs and upper part of trunk. The psychopathology of the family included a strict authoritarian father and a submissive mother. No opportunity was available for the boy to express his discontent verbally. Changing the environment by hospitalising the patient and with psychotherapy rapid recovery could be achieved. Muluka *et al.*[28] also presented a case study of hysterical fit occurring in three brothers in a family where the father was very strict and authoritarian.

In one patient (1.25%) monoplegia of upper limb was found. Another two patients in our study (2.5%) had paralysis of the lower limb.

Chandrashekar *et al.*[29] studied an epidemic of possession in a school in South India among a group of 25 children and found that the children were highly suggestible and the rewarding nature of the possession state was perpetuating the attack. In our study one female patient was found to be possessed by Goddess. The female was married and led an unhappy married life with lots of psychosocial stress in her in-laws' house. Though only one patient was found to be suffering from possession state, the number of patients suffering from it is not less in Assam. As most of the cases get treated by indigenous faith healer or other means, this accounts for under reporting of this symptom in the hospital. Ponnudurai *et al.*[16] found possession state in 1.5% of patients out of 65 cases.

According to psychoanalytical view conversion symptoms are instrumental for the relief of anxiety in hysteria. Glover[30] states that conversion symptoms bind painful affect. In our study six (7.5%) patients showed manifest anxiety while one showed depression. Thus it appears that though the conversion symptoms may be instrumental in relief of anxiety they do not succeed in all cases.

To sum up the phenomenology of hysteria studied here, the typical patient of this sample was a female below the age of 30 years coming with the chief complaints of fits or convulsive movement of entire body or difficulty in breathing with a number of minor symptoms like headache, tingling and numbness, pain and aphonia.

Sociodemographic variables

The female to male ratio of the sample studied was 1.16:1. Out of 80 patients studied, 68 (85%) were below the age of 30 years. Thirty patients (37.5%) were within the age group of 16-20 years. This finding agreed with Vyas & Bharadwaj[31] who found the highest occurrence of hysterical symptoms in the 16-25 years age group and it was significantly high in females. Ponnudurai *et al.*[16] also found high occurrence (46.1%) of hysteria in the age group of 16-20 years and out of 65 cases the females (63.2%) were significantly more affected than the males (36.9%).

In our study the incidence of hysteria in females was more than in males. This is understandable in a conservative society such as ours where hysterical symptoms in the forms of body language and nonverbal communication are an acceptable way for females to express themselves. Women are mostly unemployed and ultimately are dependent on parents or husbands, a factor influencing the hierarchy of dominance in the family. By simulating illness, albeit unconsciously, they might achieve what cannot be done by confrontation.

But on the other hand our findings indicated that the male participation in hysteria was increasing. The social phenomena of 'defeminisation' of women have produced some amounts of change in our country. They are now much 'liberated' than before. They have gained some degree of freedom from their stereotypic sex-linked or sex-determined behaviour, they take more initiative, receive better education and many of them can choose practically any occupation they want. They can vote, become members of the cabinet, join diplomatic corps etc. As a result they can certainly ventilate their feelings better or channel them into some constructive activity, avoiding in this way emotional discharge through hysterical mechanisms.

All these developments have undoubtedly modified the dynamics of the relationship of the two sexes. Men are gradually losing their patriarchal status, face serious competition from women, have become less secure and since they are no longer allowed to express their feelings adequately (at least to the degree they used to), the unorthodox discharge of their bottled up emotions result in hysterical manifestations. Here a few lines about the impact of long continued Assam agitation on the younger generation needs to be discussed. During the movement from 1979 to 1985 those youths who participated actively, some of them had very high expectations. They shouldered responsibility neither in education nor in social and occupational life. Once the agitation was over, these young boys mostly, had to go back to their study or occupational life without being able to gain some expected personal rewards. This caused lots of frustration in their minds and this factor might contribute to certain extent in the upsurge of the rate of male hysteria patients that had been observed in the last few years (21% male with hysteria in 1986 and 25% male with hysteria in 1987, as per hospital data from GMCH).

In our country traditionally and customarily girls are married at an earlier age than the boys which might have contributed to the higher percentage of unmarried males (72.9%). Nevertheless the unmarried group had outnumbered the married group in both the sexes. This finding agreed with the study of Hafeiz[32] from Sudan who also found 52 patients out of 80 diagnosed as suffering from hysteria to be single and 20 were married. Ponnudurai *et al.*[16] also found similar type of finding. In his study 70.8% were unmarried male and 58.5% were unmarried females.

Literate group outnumbered the illiterate. This deviation from the widely accepted hypothesis that hysteria is more in illiterates may be because the study was undertaken in a state capital city which is not lagging behind other cities in the educational forefront. Another reason might be that people are now realising the value of education and so they are more interested to get educated

than before. Moreover the majority of the patients were from the age group of 16-20 years. This is the age period during which people use to keep on going to school even if they may not become successful in passing out the examination.

Majority of our patients were from low socioeconomic status and rural area. If we consider the pattern of distribution of population in urban and rural area of Assam, this finding is not in great deviance (total population in Assam was 146.25 lacs with urban population 8.4% and rural population 91.2%, as per 1971 Government of India Census). However there can be another explanation for it. The people residing in urban area has easy accessibility to psychiatrists, general physicians etc. So within their limit they prefer to consult a private practitioner for any psychiatric ailment. This may partly explain the urban and rural population in our hospital. No patients from high socioeconomic status reported which may be due to the reason that the patients from this status preferred to go to private practitioner or general practitioner etc. rather than coming to the hospital.

Ponnudurai *et al.*[16] found hysteria in patients of lower socioeconomic status. Trivedi *et al.*[17] found hysteria predominantly in urban area (84.6%) which did not correlate with the present finding. Folk *et al.*[33] did an analysis of 1000 consecutive psychiatric consultations and found subjects with conversion disorder were predominantly from lower socioeconomic status and rural background which agreed with the present study.

Most of those who sought treatment were students. Household workers constituted 48.93% of patients. In the study conducted by Ponnudurai *et al.*[16] the patients were housewives, agriculturists, semiskilled worker and unemployed. In our study skilled worker constituted 3.75% and unskilled worker five percent. As patients from high school standard formed the majority in both the sexes and in most of the cases their age range was between 16-20 years, they were continuing their studies not engaging themselves to any employment.

Fifty eight (72.5%) patients belonged to nuclear families. There was high incidence of nuclear families in both sexes. This was in contrast with the finding of Vyas & Bharadwaj[31] who found more number of cases from joint family. But the present study agreed with the finding of Ponnudurai *et al.*[16] who found 63.1% of patients coming from nuclear families. The finding in the present study may be explained in terms of the fact that the traditional way of joint family system is gradually dying down in our society due to various reasons. People have to move about from place to place in relation to money, job etc. The changing pattern of life style has also affected us in all spheres of life. Interestingly enough 83.64% nuclear families were found to be from rural area which was in

contrast with the usual idea that in rural area the nonnuclear family system prevailed. This area needs further exploration.

No specific birth order among the patients could be found in the present study which agreed with the finding of Ljungberg [25] who studied 246 female and 135 male subjects diagnosed as hysteria and came to a conclusion that distribution of position of the patients among the group was determined by chance. Hindu patients constituted 78.75% and if we considered the distribution of population in this area in relation to religion the finding did not deviate much from the expectation (72.51% Hindu, 24.56% Muslim and 2.61% Christian, as per 1971 Government of India Census).

Comparison between urban and rural patients:

Analysis of the distribution of urban and rural patients in relation to number and sex showed that out of 19 urban patients, nine (24.3%) were male and ten (23.3%) were female, showing almost equal distribution in both the sexes. Likewise out of 61 rural patients, 28 (75.6%) were male and 33 (76.89%) were female, again showing almost equal distribution in both the sexes. This was in contrast with the finding of Trivedi *et al.*[17] who got 33.3% male and 5.9% female in rural area and 66.7% male and 94.1% female in urban area.

Phenomenology as occurring in urban and rural patients: A comparison between the urban and rural patients with hysteria of the sample in respect to distribution of the chief presenting symptoms was tried. The sample showed almost equal distribution of two symptoms like fits (63.12% in urban patients and 60.68% in rural patients) and aphonia (21.04% urban patients and 22.96% rural patients). Higher percentages were found in the rural sample in respect of the other symptoms though no statistical calculation could be done to see the significance as the number of symptoms in urban patients with hysteria came out to be very low. It is said that with a continuing rise in cultural sophistication of a society, conversion symptoms are replaced by anxiety and depressive ones.[12] In simple term patients with less cultural sophistication and of rural background opt for gross symptoms of hysteria than the patients with more cultural sophistication and urban background who opt for mixed and vegetative forms of conversion symptoms. This could not be verified in the study due to the disparity of the number of patients in the two groups.

Conclusions

The important chief complaints of the patients were fits (61.25%), convulsive movement of entire body (42.5%), difficulty in breathing (37.5%), headache (31.25%), chest pain (23.75%), aphonia (22.5%) and difficulty in walking (20%). Along with the chief complaints they complained of a number of minor

symptoms. Pain as a whole like headache, pain in the abdomen, backache, joint pain etc. also constituted another important symptom. Five (11.65%) out of 43 female patients had menstrual disorder in the form of dysmenorrhoea or menstrual irregularity sometime or the other. Mean age for male was 21.05 years and for female was 22.07 years. Occurrence was higher in unmarried males and females. Illness was more common in persons with lower socioeconomic status. The occurrence of the illness was found to be more with patients of high school and higher secondary school education. Nuclear families harboured greater number of patients. Only 19 (23.75%) patients were from urban area and 61 (76.25%) patients were from rural area. However nuclear families were found to be more in rural area than the urban area which needs further exploration.

Thus a typical patient with hysteria studied in this sample was a female below the age of 30 years from lower socioeconomic status and rural area with school education. This patient came with the complaint of fits or convulsive movement of entire body or difficulty in breathing with a number of minor symptoms like pain in abdomen, joints, backache and tingling and numbness of the extremities etc.

Very few studies have been done so far to see the finer aspect of phenomenology of hysteria. A study conducted in a general population of the community would be more contributory towards the exploration of phenomenology of hysterical neurosis in lower Assam.

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