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TOP TEN STRESSORS IN THE HYSTERICAL SUBJECTS OF PESHAWAR

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Background: Hysteria develops as a reaction to emotional stress or conflict in presence of a series of environmental, biological and personal vulnerability factors or as a part of the current life situation. This study was carried out to determine the top ten stressors in the hysterical subjects of Peshawar. **Methods:** This study was carried out at Psychiatry department of Khyber teaching Hospital Peshawar Pakistan from January to December 1996. Fifty hysterical subjects satisfying the inclusion and exclusion criteria were selected by convenience sampling. They were interviewed and results were analysed from the entries in a proforma. **Results:** Stressors were clearly identified in 45 (90%) subjects while in 5 (10%) subjects there were none. The top ten stressors in our population in order of frequency of subjects were 'disturbed relations with in-laws' (18%), 'engagement/marriage against wishes' (14%), 'disturbed relations with spouse' (12%), 'husband abroad' (10%), 'conflict with parents' (8%), 'conflict at work' (8%), 'failure in exam/study problem' (6%), 'love problems' (6%), 'death of spouse' (4%), 'threat to life (4%). **Conclusions:** We concluded that stressors were present and identifiable in most of Peshawar hysterics. The pattern of stressors in our subjects was unique to our population and most of these stressors were easily treatable.

INTRODUCTION

Hysteria is one of the oldest words in the medical vocabulary [1]. It is derived from Greek word 'Hysterus' meaning wandering of uterus in the body[2]. Galen rejected the idea of 'wandering uterus' and suggested that the abnormality was due to undue retention of uterine secretions. Since then hysteria has been a topic of interest in medicine [3]. The concern about hysteria is evident from the fact that the aetiology, pathophysiology and even nomenclature has been rapidly changing throughout the known history of Medicine.

The approach to aetiology of hysteria has been very unrealistic through out the history and it was believed that only women are sufferers. However with advance in knowledge, skills and after observing 'world war hystericals', the aetiology, sex discrimination and even symptomatology were revolutionized.

Till very recent past hysteria was considered to be an illness of sexually unsatisfied females, males were not supposed to suffer [4]. Similarly the concept of possession by supernatural forces like spirits, evils and genies was very deep rooted.

Briquet and Charcot contributed to the development of the concept of conversion disorder by noting the influence of heredity on the symptoms and the common association with a traumatic event [5]. Now it is suggested that hysteria develops as a reaction to emotional stress or conflict in the presence of a series of environmental, biological and personal vulnerability factors or as a part of the current life situation [6].

Current diagnostic criteria (DSM-IV) [7] requires that stressors must be associated with the onset and course of psychological symptoms rather than paying attention to hypothetical psychological mechanism involved in the aetiology of conversion disorder.

Stress occurs when people are faced with events or situations they perceive as endangering their physical or psychological well being. These events are usually referred to as 'stressor' and the people's reactions to them as 'stress response'. These stressors which are perceived usually fall into one or more of the following categories: Traumatic events, uncontrollable events, unpredictable events or events challenging the limits of one's capabilities and self-concept [8].

The stress reaction includes autonomic responses, endocrine changes & psychological response [9].

The patient uses denial mechanisms to cope with stress. The personal experience of illness in relatives or friends determines the course of signs and symptoms. These sign and symptoms mimic organic disease and allow the patient to adopt "Sick Role" with consequent relief from precipitating stress or conflict [10].

A number of studies have been conducted on hysteria all over the world, but so far a very few Pakistanis have addressed this problem. The Pakistani studies addressing this topic are mostly from the army setup and look at the symptomatology and presentation of hysteria. This study however was done to identify the main stressors in the hysterical patients reporting at Department of Psychiatry, Khyber Teaching Hospital, Peshawar.

MATERIAL AND METHODS

This study was conducted at Khyber Teaching Hospital Peshawar. The subjects comprised of both indoor and outdoor hysterical patients reporting from January 1996 to December 1996. First 50 patients satisfying the inclusion and exclusion criteria were included in this study by convenience sampling method. Both male and female hysterical patients of all ages were included in the study. However patients not fitting into DSM-IV diagnostic criteria for conversion disorder, patients presenting with physical disorders (especially neurological disorders), cases with an evidence of mental sub normality, cases with drug dependence and malingering cases were excluded. Patients were diagnosed according to the criteria laid down by DSM-IV [7]. These criteria are following:

A. One or more symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition.

B. Psychological factors are judged to be associated within the symptoms or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors.

C. The symptom or deficit is not intentionally produced or feigned (as in factitious disorder or Malingering).

D. The symptom or deficit cannot, after appropriate investigation, be fully explained by a general medical condition, the direct effects of a substance, or a culturally sanctioned behaviour or experience.

E. The symptoms or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

F. The symptom or deficit is not limited to pain or sexual dysfunction, does not occur exclusively during the course of Somatization Disorder, and is not better accounted for by another mental disorder.

All the patients were interviewed using a proforma specially designed for this study. The proformas were then processed and the results were summarized for age, sex, occupation, educational status, residential status (urban or rural), marital status, financial/socioeconomic status and presence of stressors.

RESULTS

The age of the subjects ranged from 15–40 years, with a mean of 21.2 ± 5.34 years. Out of 50 subjects, 35 (70%) were females while the rest 15 (30%) were males. Out of the 35 females 27 (77.14%) were house wives, this figure includes some of the unmarried girls staying at home. Out of the rest 6 (17.15 %) were students and 2 (5.71%) were teachers.

Out of the 15 male subjects, 5 (33.33%) were farmers, while labourers and students were 4 (26.66%) each. One (6.66%) was a teacher and 1 (6.66%) was a banker. Only 1 (2%) of the 50 subjects had a masters degree, 5 (10%) were having intermediate qualification, 10 (20%) were matriculate, 2 (4%) were middle and 10 (20%) were educated up to primary. The remaining 20 (40%) were illiterate.

Forty (80%) of our subjects belonged to the rural areas around Peshawar, while 10 (20%) subjects came from an urban background. Out of the 50 subjects, 15 (30%) were single, 30 (60%) married and 5 (10%) widowed. In 35 female subjects 23 (65.71%) were married, 7 (20%) were single and the rest 5 (14.29%) were widowed. While in the male subjects 8 (53.33%) were single as against 7 (46.67%) married male subjects.

Table-1: Stressors in the subjects

S. No.	**STRESSOR**	**Cases** (%)
1	Disturbed relations with in laws	9 (18 %)
2	Engagement/Marriage against wishes	7 (14 %)
3	Disturbed relations with spouse	6 (12 %)
4	Husband Abroad	5 (10%)
5	Conflict with parents	4 (8 %)
6	Conflict at work	4 (8 %)
7	Failure in exam/study problem	3 (6 %)
8	Love problems	3 (6%)
9	Death of spouse	2 (4 %)
10	Threat to life	2 (4 %)
11	Nil	5 (10%)

Forty Five (90%) out of the total 50 subjects had a history of stressors, while the rest 5 (10%) could not come up with any. Based upon the history, the commonest stressors were listed. These are given in Table-1.

DISCUSSION

The biggest evidence of stressors came from “War Hysteria” patients during World War I & II. Thousands of men were affected. The conflict between the danger of death and fear of being declared coward led to symptoms of hysteria [11]. Hurst (cited by Julian) was of the opinion that hysterical symptoms were the largest class of war neurosis [12].

Holmes and Rahe [13] developed life event scale to measure the impact of life changes. The life events were ranked in order from the most stressful to the least stressful. However this scale has its limitations in different segments of population for example the most stressful event 'death of spouse' is in no way a major stressor in the male tribal populations like those seen in some Asian and African countries. This is also evident in the studies conducted in developed countries. European subjects rank 'death of a close family member' as less stressful than do the American subjects [14]. Similarly older adults rank 'sex difficulties' 13th from the top while adolescents put them as 5th.

Jasper [15] suggested three criteria for deciding whether a psychological state is a reaction to particular stressor or not.

- Events having temporal relation to the onset of psychological state.
- A clear connection between the nature of the events and content of psychological disorder.
- Psychological state should disappear when the events cease.

A number of studies have addressed different aspects of hysteria. Different researchers from different setups have reported a long list of conversion symptoms. However in Pakistan, very few studies have been done on hysteria and those too came from army setups. In the civilian populations of NWFP no such study has been done before. We specially chose to address the topic of stressors.

Our identified stressors fell into ten categories. Although a number of stressors are similar to contemporary studies of other countries yet the order and frequency of stressors is different from most of the studies. Similarly some stressors are unique for our population.

Cooper and Sloan [16] assessed sources of stress in 442 commercial airline pilots. It was found that self-perceived poor performance was associated with job related factors such as fatigue and anxiety about required courses, performance check and insufficient flying time particularly among older pilots. Overall mental ill health was found to be associated with lack of autonomy at work, fatigue, flying patterns, together with inability to relax and a lack of social support.

McConnell *et al* [17] reported cases of seizures, occurring on or immediately before the wedding day. They concluded that seizures occurring at the time of psychological stress may be either neurological or psychiatric in origin.

Kendell and Zeally [18] are of the opinion that conversion hysteria is characterized by the sudden onset of symptoms in clear relation with the stress.

Looking at the significance of associated findings of this study like age, sex, marital status, educational level and socioeconomic status in relation to contemporary studies we find that conversion disorder can occur at any age from childhood to old age, but it is most common in adolescents and young adults. Data indicates that conversion disorder is most common among rural population, less educated persons, those with low intelligent quotients and in lower socioeconomic class [19].

There is no obvious consensus about the marital status. Mathur [20] and Subramanian *et al* [21] reported that it was married population of India that was more prone to hysteria. On the contrary a study in Libya reported that just 15 % males and 25 % of female hysterical patients were married [4]. It is now an established fact that hysteria is more common in people with limited education [20, 21]. The incidence of hysteria decreases with increasing level of education. In the study population of Pu *et al* [4], 5 % were university graduates, 21 % had secondary school, 44% preparatory school, 22 % primary school level education and 8 % were illiterate.

In a similar Indian study [22], 30 hysterical ladies were included and the authors reported that women with conversion hysteria were below the age of 35 but the possession cases were older. Subjects were poor, mostly illiterate, married, from a rural background, working and Hindus by religion. Most of the subjects had only one living parent and the living father was found to be authoritarian and close-minded. Life stressors in these hysterical women were found to be more than the comparative male hysterics.

We conclude that stressors are present in a large proportion of our hysterical population. Identification of these stressors is very important for proper management of these hystericals.

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