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Hysteria: An Evaluation of Specific Diagnostic Criteria by the Study of Randomly Selected Psychiatric Clinic Patients

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In 1962, Perley and Guze introduced specific criteria for the diagnosis of hysteria based on clinical observations made in 1951 by Purtell, Robins and Cohen. A number of reports have been published since 1962 evaluating the limits and usefulness of these criteria. A recent paper by Guze (1967) summarizes a large part of this work and explores various problems of definition and methodology. In 1968, two papers appeared in this journal evaluating the criteria for hysteria by applying them to women with chronic medical illnesses (Woodruff) and to normal women (Farley, Woodruff and Guze). The present study is an extension of the method used in those reports.

In this investigation we have evaluated patients randomly selected from the intake of our psychiatric clinic. The purposes of the study are several:

1. To determine to what extent the diagnostic criteria are specific for hysteria, or to what extent false positives occur; that is, how often patients with obvious diagnoses other than hysteria also meet our criteria for hysteria.

2. To determine the prevalence of conversion symptoms among patients with various illnesses commonly encountered in the psychiatric clinic.

3. To explore the possibility that the diagnosis of hysteria might be made as accurately by an abbreviated form of our present criteria, or by means of simplified criteria which rely less on a wide variety of symptoms and more on specific symptoms highly correlated with the illness.

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4. To begin to collect index cases for prospective follow-up studies and family studies which will provide information concerning the relationship of hysteria to other psychiatric illnesses. In addition, to begin a prospective evaluation of patients given a diagnosis of "undiagnosed psychiatric illness" to determine if some of these patients have atypical or attenuated forms of hysteria.

Method

Our subjects were the first 100 patients collected in a newly formed research clinic functioning within the structure of the Washington University Psychiatric Clinic. Approximately four new patients per week are selected randomly from the larger clinic intake. These research patients are interviewed with a structured technique which has been described previously by Woerner and Guze (1968).

The majority of our patients are given a single diagnosis. Approximately one in five receive multiple diagnoses. When multiple diagnoses are made, the illness which antedates the others is designated as the primary diagnosis. When a patient is found to be mentally retarded, another diagnosis may be considered primary if it exists as the predominant clinical problem.

Each of the 100 patients was evaluted by the specific criteria for hysteria (Perley and Guze, 1962). There are three criteria: First, the patient must have a complicated or dramatic medical history beginning before age 35. Second, the patient must report the presence of a minimum of twenty-five symptoms in nine of ten special review of symptom areas (Woodruff,

1968, Table I). Third, the twenty-five symptoms must be medically unexplainable.

Results

There were thirty-seven male patients and sixty-three females. The mean age was 38 with a range of 15 through 78. Seventy-two patients were white and twenty-eight were negro. Fifty-five patients were married, twenty-one were single, nine were divorced, seven were separated and eight were widowed. Both male and female patients were evenly distributed throughout the socioeconomic range.

Primary diagnoses

Primary diagnoses assigned to each of the one hundred patients were as follows: Thirty-four patients were given the diagnosis primary affective disorder (three of these were manic). Twenty-six patients were judged to have an undiagnosed psychiatric illness. There were nine anxiety neurotics, eight schizophrenics or probable schizophrenics, seven hysterics, four alcoholics, four patients with sexual deviation, three patients with mental retardation or probable mental retardation, three with sociopathic personality, and two patients with an organic brain syndrome or epilepsy.

Secondary diagnoses

Seventy-nine of the 100 patients received no secondary diagnosis. Twenty-one of the 100 patients received the following twenty-six secondary diagnoses: eight patients were diagnosed as having alcoholism or probable alcoholism; four patients were diagnosed as definite or probable drug addicts; there were four patients with secondary affective disorder; four patients with a secondary undiagnosed psychiatric illness, two with mental retardation; two with sociopathic personality; one with anxiety neurosis; and one with an organic brain syndrome.

The frequency with which symptoms were reported (whether or not medically explainable) in each area of the review of symptoms is illustrated in Table I.

When all symptoms, whether or not medically explainable, were averaged for the entire group of 100 patients the mean number was fourteen. Twenty-nine patients reported medically explainable symptoms. When unexplained symptoms were averaged alone the mean remained fourteen. Total numbers of unexplained symptoms reported by both males and females fell into Gaussian distributions. The mean for the thirty-seven male patients was ten. The mean for the sixty-three female patients was seventeen.

Table I

Frequency of symptoms in various areas: 37 male and 63 female patients

Area of review of symptoms	Per cent of patients reporting symptoms	
	Male	Female
One	22	45
Two	19	29
Three	18	54
Four	17	46
Five	15	59
Six	9	26
Seven	0	37
Eight	2	26
Nine	9	36
Ten..	35	60

Unexplained neurological symptoms (conversion symptoms) are obviously of special interest in any consideration of hysteria. These symptoms are inquired about in area 2 of the review of symptoms. Table II illustrates the frequency with which each symptom of area 2 was reported by each sex, as well as our opinion as to how often each symptom was unexplained by a history of medical illness. It is awkward to consider medically unexplained hallucinations as conversion symptoms in a sample of patients with psychiatric illnesses. Hallucinations are included in Table II for the sake of completeness. Hereafter, reference to patients with unexplained symptoms in area 2 will not include patients whose only symptom was that of hallucination. Forty-eight of 100 patients reported symptoms in area 2. Thirty-six of these forty-eight patients reported symptoms in area 2 which we considered unexplained. Twenty-four patients (nine males and fifteen females) reported unexplained symptoms other than hallucinations.

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TABLE II

Reports of symptoms in area two

Symptom	Number of times symptom reported		Number of times symptom unexplained	
	Males	Females	Males	Females
Blindness	1	6	1	5
Paralysis	2	9	0	7
Anaesthesia	1	7	0	6
Aphonia	0	5	0	5
Seizure	5	4	3	0
Unconsciousness	3	1	2	1
Amnesia	1	1	1	1
Deafness	3	1	0	1
Hallucinations	8	15	6	15
Urinary retention	1	1	1	1
Other	1	6	1	4
Total reports of symptoms	26	56	15	46

Primary diagnoses of the twenty-four patients who reported unexplained symptoms in area 2 exclusive of hallucinations are illustrated in Table III. In the second column of Table III figures are given to indicate the per cent of patients from each diagnostic group who reported conversion symptoms. Conversion symptoms were seen most frequently among patients with primary diagnoses of sociopathy, hysteria and alcoholism.

TABLE III

*Diagnoses among 24 patients with unexplained symptoms in area two**

Primary diagnosis	Number of patients	% of primary diagnostic group
Primary affective disorder†	4	12
Undiagnosed psychiatric illness	8	31
Anxiety neurosis‡	1	11
Schizophrenia or probable schizophrenia	3	38
Hysteria	4	57
Alcoholism	2	50
Sociopathy	2	66
Total	24	

* Patients with hallucinations alone not included.

† No manic patients involved. Two patients had diplopia, one a seizure, another blindness and paralysis.

‡ One episode of unconsciousness.

Among the twenty-four patients illustrated in Table III, seven had received secondary diagnoses. Among the four patients with primary affective disorder, one received a secondary diagnosis of mental retardation. Among the eight patients with undiagnosed psychiatric illness, one was given a secondary diagnosis of drug addiction. One of the four hysterics was an alcoholic. Both patients with alcoholism were given secondary diagnoses: sociopathic personality and undiagnosed psychiatric illness. Likewise, both patients with sociopathic personality were given secondary diagnoses: drug addiction plus anxiety neurosis, and drug addiction plus alcoholism.

The diagnosis of drug addiction was made four times in the sample of one hundred patients. It was always a secondary diagnosis. Three of the four addicted patients reported unexplained symptoms in area two.

Our diagnosis of hysteria is a quantitative concept depending on the presence of at least twenty-five unexplained symptoms in a minimum of nine areas of the special review of symptoms. Other studies have given us considerable information concerning the prognosis of patients who meet the specific diagnostic criteria for hysteria. There is little information about borderline patients who almost meet the criteria: for example patients with slightly fewer than twenty-five unexplained symptoms,

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or patients with twenty-five or more unexplained symptoms who do not score in nine areas.

Fifteen of the 100 patients in the sample reported twenty to twenty-four unexplained symptoms, regardless of the number of areas the review of symptoms involved. The diagnoses given these fifteen patients were as follows: undiagnosed psychiatric illness, seven; primary affective disorder, three; primary affective disorder with probable mental retardation, one; primary affective disorder with alcoholism and drug addiction, one; anxiety neurosis, one; anxiety neurosis with alcoholism, one; and, schizophrenia, one.

Three patients reported twenty-five or more unexplained symptoms, but failed to report symptoms in two or more of the ten review of symptom areas. Two of these patients were undiagnosed; the third was an anxiety neurotic with a secondary affective disorder.

One patient reported twenty-five unexplained symptoms in nine areas and was not given the diagnosis of hysteria. This patient was a false positive for the diagnosis of hysteria by our criteria. She was a 44-year-old woman who had been seen for years in our psychiatric clinic with the diagnosis, hysteria. Ultimately she developed extensive, persistent delusions and hallucinations. Her diagnosis in the clinic was revised to schizophrenia.

To determine if the diagnosis of hysteria might be made by means of briefer criteria, we evaluated the correlation of various clusters of symptoms with the Perley-Guze diagnosis. None was significant. No single small group of symptoms predicted the diagnosis of hysteria. For example, fourteen patients reported symptoms in both areas 2 and 8. Only five of these fourteen patients met the full triad of criteria for hysteria. Furthermore, two patients in our sample of 100 who did meet the Perley-Guze criteria did *not* have symptoms in both areas 2 and 8.

Finally, we evaluated the effect of *minor* modifications of our existing criteria for hysteria. The full triad of Perley-Guze criteria excluded ninety-two of 100 patients. Eight patients qualified for the diagnosis of hysteria by our criteria, including one schizophrenic woman whom we considered to be a false positive.

If we had made the diagnosis of hysteria by the presence of twenty-five symptoms alone, without reference to the medical explainability of symptoms or to age of onset, twelve of the 100 patients would have qualified. If we had required that the twenty-five symptoms be *unexplained*, eleven patients would have qualified. If the only requirement for a diagnosis of hysteria had been that symptoms be present in nine of ten areas regardless of number or medical explainability, ten patients would have qualified. If we had required twenty-five symptoms (explained or unexplained) in nine areas, with a complex illness beginning before age 30, eight patients would have qualified for the diagnosis of hysteria. These are the same eight patients who met the Perley-Guze criteria.

Among the patients of this sample, the requirement that symptoms be medically unexplained could be dropped if the requirement for age of onset of a complex illness were lowered from 35 to 30. It should be emphasized, however, that many of the patients of this sample had undergone medical screening prior to referral to our psychiatric clinic.

No rearrangement of the criteria allowed us to exclude the one false positive schizophrenic woman.

Discussion

A previous study (Woodruff, 1968) indicates that the Perley-Guze criteria distinguish effectively between chronic medical illness and hysteria. Women who have many symptoms as the result of multiple medical illnesses seldom meet the specific criteria for hysteria. In the present study we find a similar phenomenon. The specific criteria for hysteria do not simply select a sample of women with multiple complaints resulting from multiple psychiatric illnesses. Of the seven women given a final diagnosis of hysteria, only one had a second diagnosis. In this single case, the second diagnosis was alcoholism, which we do not consider incompatible with hysteria.

We cannot claim that our criteria for hysteria select a sample of patients entirely free of psychiatric illnesses incompatible with the diagnosis of hysteria. One false positive for hysteria occurred among our sample of 100

patients. This schizophrenic woman had been given a diagnosis of hysteria for a number of years in our clinic. It was only gradually apparent that she was schizophrenic. We have found several similar patients in the last year and a half. All of them are women, and in each case extensive abnormalities of mental content with a chronic, indolent course have led us to a revised diagnosis of schizophrenia. These patients suggest the syndrome "hypochondriacal paraphrenia" as described by Leonhard (Fish, 1962). We believe that in some cases of early schizophrenia the distinction cannot be made between schizophrenia and hysteria by means of our criteria. We have no other evidence of false positives.

We have been unable to demonstrate useful clinical predictors of hysteria which allow us to make the diagnosis by substantially simplified means. A brief screening interview exploring the symptoms of areas 2 and 8 might be used to exclude the diagnosis of hysteria. If a patient has no symptoms in both areas, she cannot, by definition, have hysteria. On the other hand, the presence of symptoms in areas 2 and 8, or in other limited clusters, does not predict hysteria. This finding supports our previous impression that the cardinal feature of hysteria is that it is a polysymptomatic illness with a wide variety of symptoms. This impression is supported further by the fact that the presence of symptoms in any nine of ten areas of the special review of symptoms is by itself well correlated with our diagnosis of hysteria.

The issue of whether or not it is necessary to judge the medical explainability of individual symptoms is difficult. The decision is often unsatisfactory, based on incomplete information. Whether or not a given symptom is considered medically explainable varies with the extent and quality of the available medical information and also with the judgement of the individual physician. The requirement that symptoms be medically unexplained is probably the weakest of the Perley-Guze criteria. This study suggests that among patients referred to a psychiatric clinic the presence of any twenty-five symptoms in nine areas, with a complex illness beginning before age 30, selects the same sample as do the existing Perley-Guze criteria. Further study of this issue will be required among patients with multiple medical illnesses as well as among psychiatric patients. Our data suggest that we may ultimately be able to discard the requirement that symptoms be medically unexplained.

Once more we find the history of conversion symptoms ubiquitous. In other studies we found such a history common among both normal women and women with chronic medical illnesses. In this study we find conversion symptoms common among patients with various psychiatric illnesses. Conversion symptoms occur most frequently among patients with drug addiction, sociopathy, hysteria and alcoholism, but conversion symptoms also occur among other patients. We caution that a diagnosis of hysteria made on the basis of conversion symptoms alone is unwise.

Those patients who have many symptoms, but too few for a diagnosis of hysteria are of special interest to us. Among patients with twenty to twenty-four unexplained symptoms, the most common diagnosis is "undiagnosed psychiatric illness". It is possible that some of these patients have an attenuated form of hysteria. That issue cannot be resolved by cross-sectional studies, but will depend on follow-up studies of index cases as well as family studies of first-degree relatives. At present, we plan to continue to collect index cases to an N of 500. Thereafter, family and follow-up studies will begin.

Summary

One hundred patients from the out-patient clinic of a university hospital were collected systematically and investigated by means of specific criteria for the diagnosis of hysteria. Conversion symptoms (unexplained neurological symptoms exclusive of pain) were found to be ubiquitous and particularly prevalent among patients with drug addiction, sociopathy, alcoholism and hysteria. Using specific criteria for the diagnosis of hysteria, little overlap was found between hysteria and other psychiatric illnesses. One female patient with schizophrenia was considered a false positive for the diagnosis of hysteria. Several similar patients have been seen in our clinic. We believe that in some early cases of schizophrenia the distinction

cannot be made between that illness and hysteria.

We have not found evidence to suggest that a grossly abbreviated form of our present criteria for hysteria would allow us to make the diagnosis with accuracy. On the other hand, this study provides preliminary evidence that the requirement that symptoms be medically unexplained may not be needed under certain circumstances.

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