

## Research article Ερευνητική εργασία

# "Hysteria" near the end of the twentieth century in Athens

I.M. Zervas, A. Pehlivanidis, O. Botsari,  
Chr. Dimitrakopoulos, M. Markidis,<sup>†</sup> G.N. Christodoulou

*Department of Psychiatry, Athens University Medical School, Athens, Greece*

Psychiatriki 2007, 18:351–360

The aim of this study was to study the frequencies of clinical manifestations traditionally associated with the concept of "hysteria", namely conversion, dissociation, and somatization in the emergency room of the Department of Psychiatry in Athens in the late 1990s, in a period of significant social change of the Greek culture towards more Western standards. We used a retrospective chart review of all new emergency room cases in a representative two-year period (1995–1997), replicating the method and the diagnostic classification of a study from our Department published 25 years ago, investigating similar changes in these symptoms in previous periods of change in the Greek social structure. Of 7424 new cases 215 (2.9%) fulfilled criteria for "hysteria", a significant reduction from the original study. Of these 28 were foreign, mostly from non-Western cultural settings. Male to female ratio (1:3) and mean age remained unchanged from the original study. Hysterical fits (pseudoseizures) were significantly less in comparison to the original study. Mental and vegetative conversion (corresponding to dissociative and somatoform disorders, respectively) remained unchanged, mixed conversion increased while changes in somatic conversion (conversion disorder) depended on the nationality of the patients. Over the last quarter century in Athens rates of patients with so called "hysterical symptoms" continue to decrease, as do the most dramatic presentations. These reductions however, are not so great to suggest a disappearance of the syndrome, while increase of the mixed forms suggest that sub-syndromes may have common underlying mechanisms. This may point towards a single disease process with multiple presentations rather than separate diagnostic categories. Culture appears to influence clinical expression of symptoms.

**Key words:** Hysteria, somatoform, conversion, pseudoseizures, dissociation.

## Introduction

In a recent WHO lexicon of cross cultural terms, hysteria is defined as: "A syndrome marked by amnesia, fugue, pseudo-convulsions, pseudoparalysis, pseudo-sensory loss, spirit possession, stupor and/or trance; known from classical Greek times when the cause was presumed to be the hystera (uterus) because it occurred almost exclusively in women. Prevalence of this condition can differ greatly from one culture to another, as well as within the same culture over time. Both men and women may manifest this condition".<sup>1</sup> The syndromes associated with this traditional concept of "hysteria" have undergone many transformations in diagnostic classification over the decades. They also seem to have undergone transformations in clinical manifestations.<sup>2</sup>

A study from our Department published 25 years ago,<sup>3</sup> tracked the evolution of hysterical symptomatology in the outpatient services of the Department of Psychiatry at the University of Athens from 1948 to 1971, by comparing data from three sample periods (period A: 1948–1950, period B: 1958–1960, period C: 1969–1971). Hysterical symptoms were found to decrease, male participation to increase, and clinical manifestations to obtain a less dramatic presentation over the decades. These changes were most pronounced between period A and period B and were attributed to the changes in Greek socioeconomic conditions over the interval. Over the last quarter century Greece has moved even further from a non-Western type of social structure and lifestyle towards a Western one, a phenomenon that has been significantly accelerated in the past decade with the country's ties to the European Community. Related to this is the increasing influx of immigrants mainly from the Balkans, the Near East, and the former communist countries.

In this study we decided to address the same questions as the original study, namely to investigate for any further changes in frequency, clinical manifestations, sex ratio, and mean age of the so called "hysterical symptomatology" over the

quarter century following the initial study. In addition we looked for possible differences between patients of Greek and non-Greek nationality. We used the same diagnostic classification as the original study, rather than a contemporary diagnostic scheme, in order to be able to detect actual changes in frequencies, while eliminating the influence of diagnostic practices.

## Material and method

The method followed closely the design of the original study,<sup>3</sup> which was performed in the Outpatient Department of our Hospital. However, in those days, the Outpatient Department functioned essentially as a walk-in clinic with no scheduled appointments. The Outpatient Psychiatric Department at the University Hospital currently includes both emergency and scheduled outpatient services. The scheduled services use an appointment system that usually requires a waiting period of no less than one month for a scheduled evaluation. It also performs evaluations by court order for compulsory admission according to the Greek mental health law. As "hysterical" symptoms tend to be seen under urgent conditions and resolve fairly quickly,<sup>4,5</sup> we were concerned that inclusion of outpatient cases scheduled long time in advance might bias the sample towards falsely lower rates of hysterical symptoms. To test this we screened 500 random records of new admissions in the Outpatient Department during the same time period and found no cases with active "hysterical" symptomatology. We therefore restricted our study to the Emergency Department, considering this to be the best approximation to the original study conditions. We also excluded cases brought by court order for compulsory evaluation and admission as these were not included in the original study.

All charts of new admissions from January 1st 1995 to December 31st 1997 (defined as period D) to the Emergency Psychiatric Department of the University Psychiatric Clinic at Eginition Hospital were reviewed independently by two assessors, for

the inclusion criteria described below. Assessors then compared and discussed "hits". No case was admitted unless there was a consensus between the two assessors. In case there was a disagreement this was resolved by a third senior researcher. This only happened twice. The assessors were instructed as to the application of the criteria by the senior researchers in our team who were also involved in the original study.

Inclusion criteria used to diagnose "hysteria" were: (i) Presence of symptoms compatible with the traditional concept of hysteria as described below under sub-syndrome classification; (ii) Absence of a history of neurological or other physical pathology that might account for the symptoms; (iii) Absence of symptoms suggestive of psychotic, affective or anxiety disorder; (iv) Presence of circumstances temporally related to the onset of symptoms suggestive of psychogenesis or reaction to conflicted or traumatic circumstances; (v) Attention or sympathy seeking behavior during interview or clear evidence of secondary benefit.

### ***Sub-syndrome classification***

Dramatic body arching, thrashing, documented pseudoseizures or similar signs were classified under the category of hysterical fits.

Motor or sensory conversion symptoms, such as paralysis, sensory loss, stupor, blindness, aphonia, gait disturbances etc., were classified under somatic conversion.

Twilight states, fugues, somnambulism, psychogenic amnesia etc. were classified as mental conversion.

Dizziness, fainting, paresthesias, headaches, other aches and pains, nausea or vomiting, other respiratory symptoms etc. went under the heading of vegetative conversion.

Care was taken to exclude from this category clearly documented panic attacks as these would not have been included in the original study. Rather, panic attacks in the 70's would have been classified under "anxiety neurosis".

Finally, various combinations of somatic, mental and/or vegetative conversion were classified as mixed conversion.

## **Results**

Over the time period studied 11,864 referrals arrived at the emergency room. Of these 9,012 were new cases. 1,588 of these cases were excluded, as they were referred by court order for compulsory admission. The remaining 7,424 cases were included into the study. Of these 4,609 were females and 4,403 males, a ratio of 1:1. 7,054 were of Greek nationality and 370 were foreign. Of these patients 50 came from countries with a western culture (USA, Australia, European Community countries etc.) whereas 320 came from countries with non-western cultures (Pakistan, Albania, other Balkan, Asian, or African countries etc). 215 cases (187 of Greek and 28 of foreign nationality – 2 western and 26 non-western) fulfilled the criteria for hysteria. The details of sub-syndromes are shown in table 1.

We first investigated the relationship between diagnosis of hysteria and nationality for period D. Table 2 shows the numbers of Greeks and non-Greeks from Western type and non-Western type cultures with diagnosis of hysteria or other diagnosis from this period. The overall analysis testing the independence of the type of diagnosis from the nationality of the patients proved significant ( $\chi^2(2)=32.84$ ,  $P<0.01$ ). Separate contrasts, however, showed that this result was only due to the lower proportion of Greek patients diagnosed with hysteria compared to their non-Western non-Greek counterparts ( $\chi^2(1)=32.70$ ,  $P<0.01$ ). Comparisons with Western foreigners were not performed as their low numbers do not allow for a valid statistical analysis (expected frequencies too low). However, these results indicated that Greeks and non-Greeks in general could not be treated in further analysis as a uniform group.

We then inquired whether in period D numbers of patients presenting with hysterical symptoms differed from any of the previous study periods.

**Table 1.** Detailed data for the 215 patients diagnosed with hysteria in period D (1995–1997).

Symptom	n (%)	Male	Female	Greek	Foreign
Hysterical fits	17 (7.9)	4	13	14	3
Somatic conversion	34 (15.7)	8	26	27	7
Mental conversion	15 (7)	5	10	13	2
Vegetative conversion	107 (49.5)	27	80	94	13
Mixed conversion	42 (19.9)	10	32	39	3
Total	215 (100)	54	161	187	28

**Table 2.** Number of Greeks, foreigners of non-Western and foreigners of Western origin that were diagnosed with hysteria or with another diagnosis in period D (1995–1997) (relative percentages in parentheses).

Diagnosis	Nationality		
	Greek	Foreign (non-Western)	Foreign (Western)
Hysteria	187 (2.7)	26 (8.9)	2 (4.2)
Other diagnosis	6867 (97.3)	294 (91.1)	48 (95.8)

Table 3 shows the number of patients who received a diagnosis of hysteria and the number of patients with other diagnoses for each period. A test of association between the type of diagnosis (hysteria vs other diagnoses) and the period data were obtained proved significant [ $\chi^2(3)=54.57$ ,  $P<0.01$ ]. The pairwise comparisons involving period D showed that while the diagnosis of hysteria decreased since period A [ $\chi^2(1)=45$ ,  $P<0.01$ ], no difference could be found in the proportion of the diagnosis of hysteria to other diagnosis between period D and period B [ $\chi^2(1)=0.07$ ,  $P>0.05$ ], as well as between period D and period C, [ $\chi^2(1)=0.05$ ,  $P>0.05$ ].

Since previous study periods included practically no foreign patients we re-examined our pre-

vious question for Greek patients only (see table 3, period D, Greeks only). Results of this analysis were similar in that the overall test of association between the type of diagnosis and the time period proved significant [ $\chi^2(3)=59.41$ ,  $P<0.01$ ]. Again there was a significant decrease in the proportion of patients diagnosed with hysteria to patients with other diagnosis, in period D compared to period A [ $\chi^2(1)=52.99$ ,  $P<0.01$ ], while the proportion was found to remain stable between period D and period B [ $\chi^2(1)=1.26$ ,  $P>0.05$ ], as well as between period D and period C [ $\chi^2(1)=2.9$ ,  $P>0.05$ ].

Having established that the frequency of diagnosis of hysteria depended on the period the data was gathered, we proceeded to examine whether frequencies of the five subtypes of hys-

**Table 3.** Number of patients diagnosed with hysteria and number of patients with other diagnosis for the four periods studied (data for periods A–C from Stefanis et al, 1976; relative percentages in parentheses).

Diagnosis	Total group				
	Period				
	A (1948–1950) (Greeks only)	B (1958–1960) (Greeks only)	C (1969–1971) (Greeks only)	D (1995–1997) Total group	D (1995–1997) Greeks only
Hysteria	130 (6.0)	189 (3.0)	283 (3.1)	215 (2.9)	187 (2.7)
Other diagnoses	2063 (94.0)	6171 (97.0)	8735 (96.9)	7209 (97.1)	6867 (97.3)

terical syndromes, as defined in the original study, had changed over time. This is presented in table 4 and figure 1. The analyses found an association between time period and subtype of hysteria in three of the five categories, hysterical fits, somatic conversion and mixed conversion.

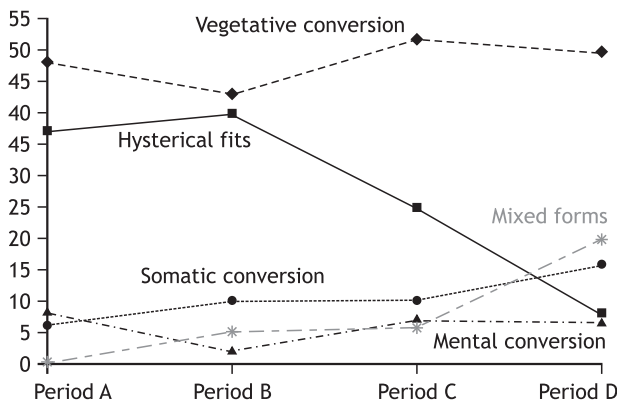
a. *Hysterical fits*. Frequency proved to depend on the time period data was gathered for the total group [ $\chi^2(3)=64.69, P<0.01$ ] and for Greek patients only [ $\chi^2(3)=60.51, P<0.01$ ]. Pairwise contrast involving period D for the total group revealed that the decrease in the number of patients with hysterical fits was significant in comparison to all three former periods (period D vs period A,  $\chi^2(1)=44.61, P<0.01$ ; period D vs period B,  $\chi^2(1)=59.23, P<0.01$ ; for period C,  $\chi^2(1)=24.79, P<0.01$ ). Similarly, for Greek patients only, hysterical fits in period D were much less frequent than in any other period

[period D vs period A,  $\chi^2(1)=42.24, P<0.01$ ; period D vs period B,  $\chi^2(1)=55.29, P<0.01$ ; period D vs period C,  $\chi^2(1)=23.55, P<0.01$ ]

b. *Somatic conversion*. The increase observed in somatic conversion also related significantly to time period ( $\chi^2=38.86, P<0.05$ ) for the total group. However, comparison with period A was the only one that reached statistical significance [ $\chi^2(1)=7.07, P<0.01$ ] unlike changes compared to period B and the crucial period C. Therefore, change in the last quarter century was not significant [ $\chi^2(1)=3.55$  for B, and  $\chi^2(1)=3.43$  for C, compared to D, for both  $P>0.05$ ]. For Greeks only, somatic conversion remained unchanged across the four periods [ $\chi^2(3)=5.95, P>0.05$ ] indicating that the difference detected for the whole group was due to the foreigner subgroup.

c and d. *Mental and vegetative conversion*. There was no significant relationship between time period and mental conversion for the total group [ $\chi^2(3)=7.07, P>0.05$ ] or for Greeks only [ $\chi^2(3)=7.05, P>0.05$ ]. The same was true for vegetative conversion both for the total group [ $\chi^2(3)=3.88, P>0.05$ ] and for Greeks only [ $\chi^2(3)=3.61, P>0.05$ ].

e. *Mixed conversion*. Interestingly, mixed conversion depended on time of measurement, both for the whole sample [ $\chi^2(3)=52.14, P<0.01$ ] and for Greeks only [ $\chi^2(3)=62.95, P<0.01$ ]. Unlike the case with hysterical fits, period D had significantly more patients with mixed conversion than any other period (period D vs period A,  $\chi^2(1)=28.92, P<0.01$ ; period D vs period B,  $\chi^2(1)=18.20, P<0.01$ ; period D vs period C  $\chi^2(1)=22.8, P<0.01$  for the to-



**Figure 1.** Sub-syndrome of hysteria (percentage of total hysteria sample) for the four study periods (data from periods A–C from Stefanis et al 1976).

**Table 4.** Subtype of hysterical symptoms by time period (asterisk indicates statistical difference between period D and previous study periods).

	Period A	Period B	Period C	Period D
Hysterical fits	37*	40*	25*	8
Somatic conversion	6*	10	10	16
Mental conversion	82	77	52	50
Vegetative conversion	48	43	52	50
Mixed forms	0*	5*	6*	20

tal group. For Greeks only results were similar [period D vs period A  $\chi^2(1)=42.24$ ,  $P<0.01$ , period D vs period B  $\chi^2(1)=55.29$ ,  $P<0.01$  period D vs period C  $\chi^2(1)=23.55$ ,  $P<0.01$ ].

Sex ratio and mean age are presented in table 5. Female to male ratio depended on the time period measured ( $\chi^2(3)=8.53$ ,  $P<0.05$ ) however, with respect to period D there was a significant difference only with period A [ $\chi^2(1)=5.79$ ,  $P<0.05$ ]. This ratio, approximately 3:1 did not change for period D in comparison to periods B [ $\chi^2(1)=0.09$ ,  $P>0.05$ ] or C [ $\chi^2(1)=0.14$ ,  $P>0.05$ ]. As in previous periods, females in period D fulfilled criteria for a diagnosis of hysteria more frequently than men (for the total group:  $\chi^2(1)=51.65$ ,  $P<0.05$ ; for Greeks only:  $\chi^2(1)=48.33$ ,  $P<0.01$ ).

No difference in the mean age of patients with hysteria among periods was detected across the four periods.

## Discussion

Our findings indicate that a quarter century after the original study, conditions that would traditionally be subsumed under the diagnosis of "hysteria" have not decreased further as a group, at least in the psychiatric emergency room at Eginition Hospital in Athens. Moreover, these syndromes tend to co-occur, as "mixed" forms in our study show a rise from previous study periods. And, finally, these clinical manifestations appear to be influenced to a certain degree by culture, as we have found differences in sub-syndrome frequencies

both between cultural groups and between different periods in the evolution of the Greek society. Before we discuss these points further, however, we may need to address the question of the meaning of our study in an era when a diagnosis of "hysteria", officially, does not exist.

The decline of traditional psychiatric syndromes over time is an interesting and infrequently studied phenomenon. Nandi<sup>6</sup> notes that diagnoses such as general paralysis, pellagra psychosis, catatonia, and hysteria, after dominating the psychiatric scene of the early twentieth century, had already become infrequent by the mid-seventies. While disappearance of the first two conditions was attributed to control of environmental factors (e.g. infection and malnutrition), reasons have not been as apparent in the cases of hysteria and catatonia. Further, certain reports imply that decline of both hysteria and catatonia may be related to cultural changes as well as diagnostic practices within a particular culture.<sup>7-11</sup> Indeed, data indicate that the frequencies of these syndromes may have not declined significantly in non-Western cultures,<sup>6,9</sup> an observation that has been interpreted to reflect the degree to which a society allows –or endorses– somatic versus psychological modes of expressing distress.<sup>9,12</sup> Unlike catatonia, Western cultures have deleted hysteria, as a distinct entity, from their disease classification systems. However, the value of this for other cultures has been questioned.<sup>13,14</sup> This may explain why, a syndrome of hysteria is still acknowledged in the domain of cross-cultural psychiatry,<sup>1</sup> while conditions associated with it

**Table 5.** Sex distribution and mean age of patients diagnosed with hysteria for the four periods (data for periods A–C from Stefanis et al, 1976; relative percentages and/or standard deviations in parentheses).

	Period				Total
	Period A	Period B	Period C	Period D	
Male sex	18 (14)	49 (26)	74 (27)	53 (25)	194 (24)
Female sex	112 (86)	140 (74)	209 (73)	162 (75)	623 (76)
Age	34.3 (11.5)	33.7 (11.6)	33.6 (13.7)	35.5 (12.8)	



have been reclassified into different categories in current classification.

Before 1980 for the DSM, and before 1992 for the ICD, all of the sub-syndromes investigated in our study would be classified under hysterical neurosis in DSM-II and ICD-8, and under hysteria in ICD-9 (1978). DSM-III and DSM-III-R (1980 and 1987 respectively) split hysterical neurosis into conversion disorder, dissociative disorder and somatization disorder; hysterical personality into histrionic personality; and hysterical psychosis into brief reactive psychosis and factitious disorder with psychological or somatic symptoms. DSM-IV (1994) retained the same nomenclature. ICD-10 (1992) changed hysteria into dissociative disorder and somatization disorder along with certain other somatoform disorders (somatoform pain and undifferentiated somatoform disorder).

Despite the fact that hysteria ceased to exist, as a diagnostic entity, early in official classification one can still find a multitude of articles in the literature investigating "hysteria", indicating that the concept is still present in clinicians' minds. It is true that hysteria has been too broad a construct to sustain scientific scrutiny. In addition, its vague nature and pejorative connotation has been the cause of significant misdiagnosis of organic problems.<sup>15</sup> On the other hand, some investigators<sup>16</sup> have argued against the splitting of the term, because it provided a unifying context for conditions that appear to co-occur frequently, suggesting thus an underlying common mechanism. Recent work on trauma and dissociation<sup>17,18</sup> may actually provide some clues about the underlying mechanisms unifying the multiplicity and diversity of symptoms incorporated in the traditional concept of hysteria.

In our study, mixed conversion has risen in the last quarter century, accounting for almost 1/5 of our sample, a finding in support of the notion that the sub-syndromes have a close association. Whether this increase is due to a real increase in numbers or more diligent symptom documentation of records by registrars trained in the tradition of DSM-IV and

ICD-10, we do not know. It is, however, consistent with findings by other investigators –in different cultural settings– showing that dissociation is more frequent in conversion disorder patients than in control psychiatric patients.<sup>19</sup> Other studies have documented a high degree of somatization in dissociative disorders,<sup>18,20</sup> an association that may have biological underpinnings.<sup>20</sup> Interestingly, recent imaging data from a case report appear to link neuroanatomical sites activated by hypnotic paralysis to those activated in conversion hysteria.<sup>22</sup> The relationship of hypnosis to dissociative phenomena is a well documented phenomenon.<sup>17</sup>

When frequencies of particular sub-syndromes are examined in our study, "hysterical fits" (gross pseudoseizures) is the only category consistently on the wane since the initial study period A. All other entities (somatic, mental, and vegetative conversion – that is, conversion, dissociative and somatoform disorders in current classification) have retained a stable frequency over the last 35 years, ever since the initial decline in measured frequencies in the late forties at least for Greek patients in Athens. Sex ratio, after the initial increase in male participation in the fifties, has remained the same (1:3) until the nineties. Mean age has also remained the same. These observations possibly speak as well in favor of the survival of syndromes that may appear in less dramatic forms but retain otherwise many of their characteristics. Similar observations have been made for catatonia.<sup>23,24</sup> Leff<sup>9</sup> relates these two conditions by characterizing hysteria as the somatization of neurosis while stating that catatonia may be seen as the somatization of psychosis.

Besides mixed conversion, the only other increased frequency in our sample was in the category of somatic conversion, which was due to the high frequency of these symptoms in the foreigners' subgroup. It has been said that "culture is the DNA of society".<sup>25</sup> One could claim that culture may play a part in the manifestation of a particular condition. In fact, regardless of classification, all of the above conditions have been shown to be influ-

enced by culture.<sup>26-28</sup> If, however, culture were the only determinant one might expect a much higher reduction in "hysterical symptoms". In our sample, subjects coming from non-Western cultures have increased the somatic conversion component of our sample. Further, dramatic presentations, such as hysterical fits, have consistently declined with changes in the Greek society. The main change in the Greek society over the past decades has been the progressive "westernization"—intensified over the past decade presumably due to the association with the European Community. This is meant in the sense that educational level and standard of living are higher, family ties are looser, mores are more liberal, psychological mindedness and individualism are more ubiquitous, and financial and professional practices and social hierarchical structures follow patterns typical of the Western cultures. However, frequency of symptoms of hysteria have not dropped further in the last 50 years, the period truly representing the wave of urbanization in Greek society.<sup>3</sup>

Hysteria, if one applies the traditional criteria, does not appear to be on the wane. However, if one looks closer at the data, it becomes apparent that certain forms are indeed on the wane while others, along with indices such as sex ratio and age, show a remarkable stability. Taken together, these may mean that "hysteria"—if one accepts that such a construct still exists in the minds of clinicians—may indeed be transforming rather than disappearing. Cultural influences and common pathogenetic mechanisms between sub-syndromes appear important enough to require further study.

There are obvious limitations in our study. One should mention at least the retrospective design, the changes that may have taken place in the population serviced by our Emergency department over the decades, and the choice of study of psychopathological entities that are hard to define, vague and determined by multiple factors, not to mention the small numbers in certain categories (i.e. mental conversion) that might lead to a type

II error. Further, the retrospective design does not allow us to safeguard our conclusions against the well established fact that a certain proportion of "hysterics"—up to 30%—<sup>29</sup> may suffer from medical illnesses, even though newer studies show that this proportion may have actually be significantly less.<sup>30</sup> Our study, however is a comparison with an older similar study and this limitation would apply to the original study too. Our study is, after all, a comparison study investigating the application of criteria to make a diagnosis, rather than a study to prove the actual existence of a condition.

Another limitation may be the fact that the data come from a single hospital. This might make results comparable to the original study but not necessarily generalizable as far as Greece is concerned. Our Hospital however, as the only tertiary university psychiatric facility in Athens at the time of the study, admits a significant number of cases from all over Greece. In that sense, results may be regarded as fairly representative of the Greek reality. They obviously do not cover, however, the cases serviced by primary care facilities, which however existed at the time of the original study as well.

Diagnostic routines within a particular culture may be another potential limitation. For example if a construct, such as hysteria, is alive in the minds of clinicians, this may impact on selective documentation of symptoms. This would be a systematic culture-related bias that could not be corrected in a retrospective study. If anything though, recent charts have been much more detailed in symptom documentation than older charts and one would expect a decline in ratios of hysteria in favor of other diagnoses. Our team assigned diagnoses from symptom lists, not from diagnostic labels on the chart.

We believe that future investigations should include a prospective design, current diagnostic criteria, multi-center investigations in various hospital settings in Athens (i.e., primary care facilities) and comparisons between particular ethnic groups with attention to immigration stress factors.



# Η «υστερία» στο τέλος του 20ού αιώνα στην Αθήνα

I.M. Ζέρβας, A. Πεχλιβανίδης, O. Μπότσαρη,  
X. Δημητρακόπουλος, M. Μαρκίδης,<sup>†</sup> Γ.Ν. Χριστοδούλου

A΄ Ψυχιατρική Κλινική, Πανεπιστήμιο Αθηνών, Αιγινήτειο Νοσοκομείο, Αθήνα

Ψυχιατρική 2007, 18:351–360

Το 1976 μία μελέτη που είχε δημοσιευθεί από την Ψυχιατρική Κλινική του Αιγινήτειου Νοσοκομείου (Stefanis CN, Markidis M, Christodoulou GN. *Br J Psychiatry*, 1976) ανίχνευε τις μεταβολές της συχνότητας των κλινικών εκδηλώσεων που παραδοσιακά έχουν συνδεθεί με την «υστερία» σε περιόδους μεταβολών της Ελληνικής κοινωνικής δομής, μελετώντας ενδεικτικά τρεις αντιπροσωπευτικές δετιές (1948–1950, 1958–1960, 1969–1971). Σκοπός της παρούσας μελέτης ήταν η παρακολούθηση των μεταβολών των ίδιων εκδηλώσεων, δηλαδή της μετατροπής, την αποσύνδεσης και την σωματοποίησης (με βάση την τρέχουσα διαγνωστική ορολογία) στα επείγοντα εξωτερικά ιατρεία της ίδιας κλινικής 25 χρόνια μετά, δηλαδή στα τέλη της δεκαετίας του '90, σε μια περίοδο σημαντικών μεταβολών στην Ελληνική κοινωνία στην μετακίνησή της προς πιο Δυτικά πολιτισμικά πρότυπα. Όπως και στην αρχική μελέτη η καταγραφή των περιστατικών ήταν αναδρομική και αφορούσε μια αντιπροσωπευτική δετιά (1995–1997). Επαναλάβαμε την ίδια μέθοδο, τα ίδια διαγνωστικά κριτήρια και το ίδιο νοσηλευτικό πλαίσιο ώστε να μπορούν να γίνουν οι διαχρονικές συγκρίσεις με τις δετιές της αρχικής μελέτης. Από τις 7424 νέες περιπτώσεις, οι 215 (2,9%) πληρούσαν τα κριτήρια της αρχικής μελέτης για «υστερία», πράγμα που αποτελεί σημαντική μείωση συγκριτικά με την αρχική μελέτη. Από αυτά 28 ήταν ξένοι από μη Δυτικά πολιτισμικά περιβάλλοντα. Η αναλογία ανδρών προς γυναίκες (1: 3) και η μέση ηλικία παρέμεναν αμετάβλητες από την αρχική μελέτη. Οι μεγάλες υστερικές κρίσεις (ψευδοεπιληπτικού τύπου) ήταν σημαντικά μειωμένες σε σχέση με την αρχική μελέτη. «Ψυχική» και «σωματική μετατροπή» (αποσυνδετικές και σωματόμορφες εκδηλώσεις με την τρέχουσα ορολογία) ήταν αμετάβλητες, η «μικτή μετατροπή» αυξήθηκε, ενώ οι μεταβολές στην σωματική μετατροπή εξαρτώντας από την εθνικότητα των ασθενών. Εν κατακλείδι, στην τελευταία εικοσιπενταετία της μελέτης (ως την παρούσα έρευνα) τα ονομαζόμενα «υστερικά» συμπτώματα συνεχίζουν να μειώνονται, και το ίδιο φαίνεται να ισχύει για τις πιο δραματικές εκδηλώσεις (ψευδο-επιληπτικές κρίσεις). Η πολιτισμική καταβολή δείχνει να επηρεάζει τις κλινικές εκδηλώσεις.

**Λέξεις ευρητηρίου:** Υστερία, σωματόμορφες διαταραχές, μετατροπή, ψευδοκρίσεις, αποσύνδεση.

## Βιβλιογραφία

1. Westermeyer J, Janca A, Sartorius N et al (eds) *A lexicon of cross-cultural terms in mental health*. WHO, Geneva, 1997
2. Mace CJ. Hysterical conversion I. A history. *Br J Psychiatry* 1992, 161:369–377
3. Stefanis C, Markidis M, Christodoulou G. Observations on the evolution of the hysterical symptomatology. *Br J Psychiatry* 1976, 128:269–275
4. Kent DA, Tomasson K, Coryell W. Course and outcome of conversion and somatization disorders: A four year follow-up. *Psychosomatics* 1995, 36:138–144
5. Tignol J. Urgences hysteriques. *Rev Pratiq* 1995, 45:2563–2567
6. Nandi DN, Banerjee G, Nandi S et al. Is hysteria on the wane? A community survey in West Bengal, India. *Br J Psychiatry* 1992, 162:87–91
7. Mahendra B. Where have all the catatonics gone? *Psychol Med* 1981, 11:669–671
8. Kleinman A. Neurasthenia and depression: a study of somatization and culture in China. *Cult Med Psychiatry* 1982, 6:117–190

9. Leff J. *Psychiatry around the globe. A transcultural view*. 2nd ed. The Royal College of Psychiatrists, London, 1988
10. Bhatt A, Tomenson B, Benjamin S. Transcultural patterns of somatization in primary care: a preliminary report. *J Psychosom Res* 1989, 33:671-680
11. Pataki J, Zervas IM, Jandorf. Catatonia in a university in-patient service (1985-1989). *Convulsive Ther* 1992, 8:163-173
12. Singh SP, Lee AS. Declining incidence of hysteria. *Br J Psychiatry* 1992, 160:87-91
13. Okasha A, Seif el Dawla A. Reliability of ICD-10 research criteria: an Arab perspective. *Acta Psychiatr Scand* 1992, 86:484-488
14. Alexander PJ, Joseph S, Das A. Limited utility of ICD-10 and DSM-IV classification of dissociative and conversion disorders in India. *Acta Psychiatr Scand* 1997, 95:177-182
15. Mace CJ, Trimble MR. Ten year prognosis of conversion disorder. *Br J Psychiatry* 1996, 169:282-288
16. Watson CG, Tilleskjoer C. Interrelationships of conversion, psychogenic pain, and dissociative disorder symptoms. *J Consult Clin Psychol* 1983, 51:788-789
17. Frankel FH. Dissociation: the clinical realities. *Am J Psychiatry* 1996, 153:64-70
18. Van der Kolk BA, Pelcovitz D, Roth S et al. Dissociation, somatization, and affect dysregulation: the complexity of adaptation to trauma. *Am J Psychiatry* 1996, 153:83-93
19. Spitzer C, Spelsberg B, Grabe HJ et al. Dissociative experiences and psychopathology in conversion disorders. *J Psychosom Res* 1999, 46:291-294
20. Saxe GN, Chinman G, Berkowitz R et al. Somatization in patients with dissociative disorders. *Am J Psychiatry* 1994, 151:1329-1334
21. Mai FM. The psychobiology of hysteria. *J Psychiatry Neurosci* 1996, 21:313-314 (Editorial)
22. Halligan PW, Athwal BS, Oakley DA et al. Imaging hypnotic paralysis: implications for conversion hysteria. *Lancet* 2000, 355:986-987
23. Fink M, Taylor MA. Catatonia: A separate category in DSM-IV? *Integr Psychiatry* 1991, 7:1-10
24. Bush G, Petrides G, Francis A. Catatonia and other motor syndromes in a chronically hospitalized psychiatric population. *Schizophr Res* 1997, 27:83-92
25. Breuer L. The theatre and its trouble. In: Sister Suzie Cinema: *The collected poems and performances (1976-1986)*. Theatre Communications Group, New York, 1987
26. Drinnan MJ, Marmor MF. Functional visual loss in Cambodian refugees: a study of cultural factors in ophthalmology. *Eur J Ophthalmol* 1991, 1:115-118
27. Chandrasekaran R, Goswami U, Sivakumar V et al. Hysterical neurosis-a follow-up study. *Acta Psychiatr Scand* 1994, 89: 78-80
28. Simon GE, VonKorff M, Piccinelli M et al. An international study of the relation between somatic symptoms and depression. *N Engl J Med* 1999, 341:1329-1335

---

Corresponding author: I.M. Zervas, 72-74 Vas. Sophias Ave., GR-115 28 Athens, Greece  
Tel. +30 210 72 42 032  
e-mail: izervas@med.uoa.gr