

CLINICAL ASPECTS OF ANXIETY STATE AND HYSTERIA

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THE object of this discussion is to offer a simple and practical clarification of the common variety of neuroses and some data in reference to differential diagnosis. Elaborate and exquisite psychodynamic elements in these neuroses are minimized to avoid confusion and to eliminate material which is too theoretical.

Anxiety state is the neurosis most frequently encountered in private practice at the present time. Generally, factors indicative of physical defects are lacking in this type of neurosis. The patient has undoubtedly consulted many doctors who have failed to reassure him or to minimize his persistent symptoms. He describes these in detail and expresses his apprehensions or fears about the cause of his disease. Frequently the attending physician gets the impression that the patient enjoys relating his symptoms but such aeration is probably more relieving than actually productive of pleasure. The attitude of the patient with anxiety symptoms is one of dependence upon the physician, which is secured by emphasis on the psychosomatic tensions. Although the physical symptoms of anxiety state are numerous, they center primarily about the visceral organs. Anxiety neurosis is usually characterized by attacks of dyspnea, tachycardia, sweating and chronic fatigue. The patient accurately and graphically describes "fast heart," "loose bowels," "lump or butterflies in the stomach," "numbness of the hands," or exhaustion. These symptoms frighten the patient and he finds that he is unable to concentrate on his work; he has a constant sense of foreboding, and at times a sense of impending death or insanity. The degree of this anxiety tension fluctuates from time to time and is manifested by crises and remissions in the subjective symptoms. These crises or episodes of acute anxiety state may come during periods of preoccupation with unrelated matters and even during intervals of relaxation. Premonition of impending disaster is continually present, and is decidedly destructive to general efficiency. Because of these crises and total inability to predict them the patient dreads being left alone, clings to his family or friends, and avoids public gatherings.

The source of fatigue in anxiety state is an important consideration because it is too readily attributed to physical factors such as low metabolism, neuro-circulatory asthenia and hypotension. Actually it is far more depleting than fatigue based on physical disorder because of its tendency to sudden recurrence and fluctuation. The patient usually relates his history of fatigue in ill-defined terms; generally it is described as inertia, lassitude or loss of animation through-

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out the daily routine. Usual chores are performed with exaggerated effort. Careful interrogation reveals that the fatigue is of a definite selective nature, an important point in the differentiation between organic and functional fatigue. For example, while the patient complains of fatigue he may be pacing the floor and will demonstrate a motor restlessness that denies his basic complaint. Primarily, the fatigue of anxiety state is not relieved by rest or sleep. This is a further differential point in psychogenic and organic fatigue. The patient with an anxiety neurosis feels worse on arising in the morning; this failure to rebuild energy is not always due to insomnia that is invariably associated with anxiety state.

The bases of such neuroses are the hereditary temperament and a predisposition to excessive worry over minor physical irregularities. Acute symptoms frequently arise from forewarnings of insecurity, affront to pride and self esteem, or from sexual irregularities (as postulated by Freud). Specific examples are: (1) loss of social or financial position; (2) domestic conflicts; (3) fear of impotence.

It is easier to recognize an anxiety state if one understands the associated dynamics. The source of conflict or tension in anxiety state is merely suppressed and is, in most cases, due to prolonged situational problems such as marital incompatibility, lack of sexual gratification, and financial insecurity. The patient tries to avoid facing these problems because all previous attempts to solve them have proved unsuccessful. However, this inhibition is never complete or consistent and finally the poorly restrained nervous forces are discharged through psychosomatic channels by way of the autonomic nervous system. One would expect this dissipation of nervous energy to greatly relieve the patient; however these discharges are manifested as the very uncomfortable somatic symptoms previously listed: weakness, fatigue, palpitation, irritable bowel, and vague gastrointestinal complaints. These indications of anxiety may, at times, be so sudden and severe that the patient forgets the significance of the primary problem and fears that the symptoms are a new and added threat of organic origin.

The basis of psychogenic fatigue has been variously explained. Janet's theory of quantitative depletion of nervous energy is implied in the term *neuroasthenia* and was reemphasized by Beard in 1880. Freud, however, established the concept that fatigue is due, not so much to fundamental lack of psychic energy, but to a loss of such energy at unconscious levels where it is drained off by conflicts between opposing instinctual drives. This allegedly leaves but little psychic energy to operate normally at conscious levels.

The next most important type of psychoneurosis is hysteria. The pattern of hysteria is to some degree stereotyped. It develops in people both young and old who have an immature emotional approach to life. These people are often vain, selfish, and coquettish in their reactions. They revel in fantasies, and dramatize themselves. Hysteria can resemble any infirmity which is capable of making a strong and lasting emotional impression on others. The hysterical person unconsciously emulates symptoms of a dramatic nature observed in

others with genuine disease, or conceived by powerful autosuggestion. Therefore, blindness, stupor, epilepsy, and similar disturbances commonly accompany hysteria. The symptoms are either mental or physical.

Although hysterical symptoms develop rather suddenly, careful scrutiny will reveal a definite dissociation of personality which enables the patient to believe in and accept a drastic alteration of his personality capacities. Autosuggestion or powerful external suggestion can permit assumption of a new personality, or of physical characteristics compatible with the newly acquired behavior pattern. This, in the majority of cases, indicates a regression to a lower level of responsibility or efficiency. The acquisition of hysterical symptoms is understandable since the patient is unable to tolerate anxiety or the undue stress imposed by various situations. The new personality is developed as a defense mechanism. By "new personality" we mean a sudden change of apparently organic origin. The patient is unaware that this change or condition has been self-induced. At this point treatment is rather difficult since the patient has slipped to this lower level and consequently has less responsibility and is more comfortably able to cope with situations than he was before his symptoms developed. In this state he may even undergo a regression of his thinking processes, and imply that the pain in his thigh or "stocking anesthesia" needs no explanation, since it actually happened. He is fully content to accept and utilize the infirmity in a juvenile manner. For example, there is the woman who comes into the physician's office complaining of severe abdominal symptoms; she relates a tale of having seen many doctors who have been at a loss to explain satisfactorily the pain. Actually the hysterical person of this type, who has no organic basis for her discomfort, unconsciously wants authoritative confirmation rather than positive relief or a cure. In her case the confirmation of the disease has a psychologic value. A certain type of dissociation is a frequent symptom in hysteria. The patient finds it easy to forget or detach himself from the past, especially if unpleasant situations or problems had existed which were impossible to solve. If this dissociation affects the whole being, it is a fugue or hysterical amnesia. If it affects only a part of the body, then there is usually a focal paralysis or anesthesia, or some similar seemingly organic change. It is interesting to note that when the patient takes flight physically or mentally, as in a fugue, he adopts a personality according to his new concepts, retaining however much of the old behavior pattern. For example, the severely myopic person will rarely discard his glasses.

Physical symptoms are either sensory or motor or both. Hypesthesia and anesthesia take precedence over hyperesthesia in hysterical sensory symptoms. If hyperesthesia or pain is experienced it is, in most cases, mild and rather vague. There is almost always no logical anatomic distribution of the pain.

Hysterical motor symptoms are divided into either irritative or paralytic. Irritative symptoms seem to be more predominant; of them, convulsions, distortion of posture and vomiting seem to be the most common. For example, many of these patients will simulate an epileptic attack with a sudden fall, screaming and severe thrashing of the extremities. However, it is seldom that this type of patient ever injures himself or bites his tongue as is the case in true

epilepsy. Whatever the physical disabilities may be in hysteria, the most important feature is the unnatural indifference which the patient assumes toward his physical handicap.

Mental changes characteristic of hysteria are always alarming. The patient may go into a trancelike state and lie quietly, not even responding to painful stimuli. Such a state is classified as catalepsy. Another mental phenomenon is the previously mentioned fugue or hysterical amnesia. The patient merely blots out periods or situations in his life which are associated with fear or unpleasantness. This type of person is the one who frequently is featured in newspaper headlines, is found wandering in a distant city and appeals to the sympathy and good nature of strangers.

Frequently overlooked is the fact that there are two main types of hysteria, namely conversion and anxiety. As mentioned, conversion hysteria is a state of mental tension that is translated into motor or sensory manifestations which simulate organic disease. However, the patient is not aware of the definite purpose that is being served because the conversion has taken place at unconscious levels. Usually in conversion hysteria the presenting symptom is a somatic disturbance which produces no emotional upheaval.

Anxiety hysteria is a combination of hysteria and anxiety neurosis. The discharge of tension in many instances is through conversion symptoms which represent a definite unconscious wish or purpose. These unconscious wishes are frequently phobic defenses created as a technic by which inner fears and anxieties are projected into outward symbols. To distinguish this from anxiety state one must remember that the latter reflects a continuous sense of disaster—a drifting anxiety, ready to grasp the slightest excuse or concern, fear or worry. However, in anxiety hysteria the process is closer to completion and here the inner fears and anxieties usually have definite symbolization of an outward nature. One must also keep in mind that the discharge of tension is not necessarily through phobic symbolization; it might well be through visceral excitement which represents a definite unconscious wish or purpose.

There are several less common types of hysteria such as anorexia nervosa. This is a hysterical state in which the young woman patient usually refuses to eat, or regurgitates food and, from all outward appearances, is suffering from a progressively debilitating disease. It is almost always precipitated by some problem or emotional disturbance with which the patient cannot cope. Usually an effort to solve the problem, or its complete solution, will result in improvement.

Another form of hysteria is Ganser's syndrome. This is a hysterical reaction upon the part of a prisoner awaiting trial, and it simulates true psychosis for the unconsciously designed purpose of avoiding punishment for a misdeed. The condition is marked by a complete absence of lucid moments. It is interesting to note that hysteria or "hysterics" as known to the layman, is not hysteria at all. Hysterical behavior which is most commonly characterized by alternate spells such as laughing, crying and screaming, is most commonly an indication of nervous instability, which at times of stress affects otherwise normal persons. However, people who are likely to indulge in such outbreaks

are usually immature and somewhat inadequate, but not necessarily neurotic.

In diagnosis and in the differential diagnosis between hysteria and anxiety state (or anxiety neurosis), we must first consider history. With hysteria there is usually a background of sudden onset of some physical or mental manifestation which closely simulates organic disease. If one investigates the history he will find that the presenting and all important symptom is the result of either powerful external suggestion or autosuggestion. These symptoms in hysteria are rather striking such as blindness, deafness, loss of speech, paresthesias and paralysis. Since the hysteric has a flare for the dramatic, his symptoms will be unusual and outstanding. Frequently one finds that an organic symptom is exaggerated beyond its true value and the patient may feign severe suffering and symptomatology. The hysteric impresses one with his attitude of indifference toward his rather severe handicap. As mentioned before, the anxiety state is a continual process in which there is a fear of impending doom which is constantly present and accentuated when the patient is resting or when his mind is unoccupied. It is characterized by rather violent somatic visceral symptoms such as dyspnea, tachycardia, sweating, and fatigue. The patient may be intelligent and have excellent insight into the situation (in contrast to the hysteric); however, he is unable to utilize his intellect to control the attacks. The type of symptom seems to be precipitated by exciting causes based on insecurity or sudden threat to security, loss of prestige before others, or loss of self-respect, position or wealth. This patient is not the immature, short-sighted personality addicted to hysterics.

The main differential point between anxiety neurosis and anxiety hysteria is that, in the latter, the patient develops phobic defenses by means of which inner fears and anxieties are projected into outward symbols. The type of person who develops anxiety hysteria fits into the classification between the short-sighted, immature hysteric and the introspective, hypochondriacal type who develops anxiety neurosis.

If, after discussing points in differential diagnosis some doubt remains, one might apply the Rorschach test. This test is not only useful in diagnosis but also in evaluating the effects of therapy when before and after records of treatment are kept. Another aid in the diagnosis and differentiation of these psychoneuroses is psychiatric interview under intravenous pentothal or sodium amital.

Conclusion

Hysteria and anxiety state should be readily differentiated because they present two separate conditions, and the basic personality of the two types differs in fundamental psychic structure. Hysteria has two major subdivisions, conversion hysteria and anxiety hysteria; and two minor subdivisions, anorexia nervosa, and Ganser's syndrome. Hysterical behavior is not true hysteria, and affects individuals who are not necessarily neurotic. Although the differential diagnosis between hysteria and anxiety state may be made clinically, the Rorschach test and psychiatric interview under sedation are useful adjuncts.