Editorial

DOI: http://doi.org/10.4038/sljpsyc.v13i2.8394

Hysteria, possession states and pseudoseizures

R Hanwella

Abstract

Hysteria has been described from biblical times. It has changed its name many times over the years. Possession states and pseudoseizures are subtypes of hysteria. With the two major diagnostic classifications, the DSM 5 and the ICD 10 separating hysteria into different subcategories with dissimilar names, the confusion for clinicians has compounded. Fortunately, the upcoming ICD 11 has taken a sensible approach describing all types of hysteria under one term; dissociative disorder. This term describes its underlying psychodynamic aetiology and will most likely be widely accepted.

The editorial discusses some of the historical roots of the term hysteria and its different names, definitions and clinical features, and their classification with guidelines for management.

SL J Psychiatry 2022; 13(2): 1-3

Hysteria

In 1885, Sigmund Freud took a career break to visit Paris and attend the clinical presentations of the great neurologist Jean-Martin Charcot. He watched as Charcot hypnotised patients and suggested symptoms which the patients faithfully emulated. Afterwards, Charcot removed the symptoms using suggestion. These patients had earlier spontaneously shown these symptoms when not under hypnosis. The prevailing view was that such persons were possessed by the Devil. Charcot believed these patients suffered from a neurological disorder that made them vulnerable to suggestion. Freud developed a different theory even as he changed his career path from being a neurologist to a psychiatrist (1).

Anna O was a patient of Josef Breuer, a Viennese physician and a mentor of Freud. Her symptoms included dual personalities and episodes of amnesia, paralysis, aphonia, deafness, diplopia, visual hallucinations of snakes, memory disturbances, and loss of ability to speak her native language. Breuer diagnosed her as having hysteria and treated her with hypnosis and systematic remembering, which later Freud developed into his technique of free association. Freud never met Anna O but wrote *Studies in Hysteria* with Josef Breuer, where he referred to Anna O(2). He wrote, 'Our hysterical patients suffer from reminiscences. Their symptoms are the remnants and the memory symbols of certain (traumatic) experiences'(2). Freud initially thought these traumatic experiences were actual incidents of sexual abuse but later changed his opinion due to a lack of evidence. He used the term 'conversion' regarding one case in the book. Freud thought that persons with hysteria converted a psychological conflict or trauma into a physical symptom. The name conversion disorder used in subsequent classifications of mental illness was characterised by neurological deficits not fully explained by a known medical pathology. According to Freud, the anxiety caused by the psychological conflict is resolved by its conversion to a physical deficit, which is the primary gain. Social reinforcement and handicapping often maintain the problem and are the secondary gains. Because of the conversion of anxiety, the patient appears indifferent to the problem. Sigmund Freud used the French term *"la belle indifference"* to describe such a patient in his book on hysteria (2).

The term hysteria has undergone several name changes over the years. Dissociation, conversion and somatization are some of these names (3). The French philosopher and psychiatrist Pierre Janet introduced the concept of dissociation in relation to multiple personality disorder (4). He also showed that he could cure hysteria by creating a healthy second personality (5).

The ICD 10 uses the term dissociative disorder as synonymous with conversion disorder (6). According to the ICD 10, "The common theme shared by dissociative (or conversion) disorder is a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements" (6). The ICD 10 states that there is often evidence for psychological causation, as a clear association in time with stressful events, problems or disturbed relationships, but emphasises that concepts derived from any one particular theory are not a criterion for diagnosis. However, the retention of the term conversion disorder even in parentheses implies the psychodynamic concepts of Freud. The American

classification of mental disorders, the DSM 5, has added to the confusion by separating hysteria into two categories, dissociative disorders and conversion disorder as a subcategory under 'Somatic Symptom and Related Disorders' (7). Fortunately, the ICD 11 has not gone down this confusing path but kept conversion disorder under the category of dissociative disorder but changed the name to 'Dissociative Neurological Symptom Disorder', thus removing any psychodynamic implications completely (8). It also included pseudoseizures and trance and possession states in the dissociative disorder category as 'Dissociative Neurological Symptom Disorder', with non-epileptic seizures and without name change as 'Trance Disorder' and 'Possession Trance Disorder'. The ICD 11 has therefore unified into one sensible category all these related conditions under dissociative disorder but without using the term hysteria, presumably because of its derogatory implications.

Notwithstanding the many name changes, the management of classical conversion disorder remains the same. The steps are: differentiating from a neurological disorder, identification of the conflict leading to the conversion, giving insight to the patient on the aetiology, stopping reinforcement of secondary gain and offering a face-saving opportunity for recovery such as physiotherapy, while treating any underlying psychiatric conditions such as depression. Improving coping and problem-solving skills and helping to resolve life stresses will reduce the risk of relapse.

Pseudoseizures or psychogenic non-epileptic seizures (PNES)

The ICD 11 classifies pseudoseizures as 'Dissociative Disorders' subtype 'Dissociative Neurological Symptom Disorder', with non-epileptic seizures. The description is short and states "… it is characterised by a symptomatic presentation of seizures or convulsions that are not consistent with a recognised disease of the nervous system, other mental, behavioural or neurodevelopmental disorder, or other medical condition and do not occur only during another dissociative disorder" (8). Though brief in classification, the correct diagnosis is of clinical importance, as it is often difficult to differentiate from true seizures. Such misdiagnosis leads to inappropriate anticonvulsant treatment, with unnecessary side effects of medication and social restrictions.

The new term with less pejorative connotations for pseudo epileptic seizure is psychogenic non epileptic seizure (PNES) (9). A video EEG during a typical seizure is the gold standard for diagnosing PNES but may not be widely available. Hence, clinical differences that help to differentiate the two are important. The following suggest PNES: long duration (> 10 minutes) of convulsive type seizures, retained awareness, side-to-side head movements, out-of-phase limb movements, eyes closed unresponsiveness, pelvic thrusting, fluctuating patterns of movement, distractibility or stuttering during the seizure (9). No one sign is absolutely specific for PNES. In addition, in a true seizure, there may be a positive Babinski sign and elevation of prolactin. The treatment of PNES is by identifying and managing underlying psychiatric problems and stressors and cognitive behavioural therapy. Hypnosis has also been used. It is important to understand that patients are not feigning seizures and even subtly accusing the patient of such will worsen symptoms and increase distress (9). Once the diagnosis is clear, any antiseizure medicines should be stopped as continuation could worsen the prognosis. The management is similar to that of conversion disorder.

Trance and possession states

"When Jesus stepped ashore, he was met by a demon-possessed man from the town. Jesus asked him, "What is your name?". "Legion," he replied, because many demons had gone into him. And they begged Jesus repeatedly not to order them to go into the Abyss. When the demons came out of the man, they went into the pigs, and the herd rushed down the steep bank into the lake and was drowned". This is an excerpt from the Gospel of Luke in the Bible (Luke 8:30). There are several such scenarios described in the Bible showing that demonic possession and casting out of evil spirits was an acceptable phenomenon in biblical times. Sigmund Freud also wrote on possession states (10). In a 1922 paper titled, *A Neurosis of Demonical Possession in the Seventeenth Century*, he described the case of Christopher Heitzman, a painter who claimed that he had signed a pact with the Devil wowing to belong to him body and soul for nine years (10). Freud observed that this pact with the Devil has been signed at a time of significant psychosocial stress for the painter and conceptualised possession states within a psycho-dynamic frame. He wrote, "What in days gone by was thought to be evil spirits to us are base and evil wishes, the derivative of impulses which have been rejected and repressed".

Sir William Trethowan in his book *Uncommon Psychiatric Syndromes* was one of the first psychiatrists to describe possession states. Now in its 4th edition, it defines possession states, "as the presence of a belief, delusional or otherwise, held by an individual (and sometimes by others) that their symptoms, experiences and behaviour are under the influence or control of supernatural forces, often of diabolical origin". It goes on to say, perhaps with deference to cultural and religious sensitivity, "We make no judgement concerning the absolute reality or not of demonic possession" (11).

According to the ICD 11, in a trance state, there is a marked alteration in the person's state of consciousness or a loss of the normal sense of personal identity (8). There is a narrowing of awareness of immediate

surroundings with restriction of movements, postures, and speech to repetition of a small repertoire that is experienced as being outside of one's control. There are several exclusion criteria. It should not be a part of collective cultural or religious practice. The symptoms should not be because of the effects of a psychoactive substance.

The prevalence of Trance Disorder is highest among young adults with a mean age of onset of 20 to 25 years with no gender difference. The duration of trance episodes is usually brief but could be recurrent over years. Emotional stress because of domestic problems, war-related trauma, and interpersonal conflicts can trigger trance states. The psychopathology of trance and possession states are very much coloured by the cultural and religious backgrounds of the patients (9). Interestingly, spiritual healers are at higher risk of developing trance states themselves outside of their cultural and spiritual practice. Possession trance states are trance states where the individual's personal identity is replaced by an external identity usually attributed to a spirit or deity. Single and transitory possession trance experiences lasting minutes to hours, often because of a mood disorder or anxiety disorder, do not warrant the diagnosis of a Possession Trance Disorder (8).

Unlike other psychiatric disorders, the treatment of possession trance states is sanctioned by cultural and religious rituals. The Roman Catholic Church authorises the use of exorcism for such states, but with the proviso that medical examination has excluded a mental illness (10). The literature is sparse as to the specific treatment of Trance or Possession Trance disorder by psychiatrists. But Trethowan's book offers good advice. It reminds us that the treatment is that of the underlying condition and emphasises the value of a careful and detailed medical and social history. Also, it advises that the psychodynamic and phenomenological aspects have to be understood while showing respect for the belief systems of the patient (11). The general management principles of conversion disorder apply to Trance and Possession Disorder.

What is the prognosis of this group of disorders? Over 50 years ago, Eliot Slater published a decade-long follow-up study of patients admitted with conversion symptoms to the National Hospital of Nervous Diseases, London (14). He reported that over half had developed clear neurological or psychiatric conditions during follow up. Later, Helen Crimlisk, using Slater's own data sources, showed this conclusion was incorrect. She confirmed the diagnostic stability of these conditions and emphasised that overzealous investigation of conversion disorder can be expensive and harmful (15).

It is incumbent on the present-day psychiatrist to be familiar with and know the proper management of this interesting group of disorders.

Conflicts of interest

None declared.

R Hanwella, Department of Psychiatry, Faculty of Medicine, University of Colombo, Sri Lanka

Email: raveenhanwella@psych.cmb.ac.lk

http://orcid.org/0000-0002-3020-0316

References

1. Jones E. The Life and Work of Sigmund Freud: Edited and abridged in one volume by Lionel Trilling and Steven Marcus. Basic Books;1961.
2. Freud S, Breuer J. Studies in hysteria. London: Penguin; 2004.
3. North CS. The Classification of Hysteria and Related Disorders: Historical and Phenomenological Considerations. Behav Sci (Basel) 2015; 5(4): 496-517.
4. Janet P. Les actes inconscients et le dédoublement de la personnalité. Rev. Philos1886. 22(2): 212-23.
5. Janet P. L'automatisme psychologique. Essai de psychologie expérimentale sur les formes inférieures de l'activité humaine. Paris: Felix Alcan. 1889.
6. World Health Organization. The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. World Health Organization; 1992.
7. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders 5th Edition. Washington, DC; 2013.
8. World Health Organization. ICD-11 Classifications of mental and behavioural disorder: clinical descriptions and diagnostic guidelines. Geneva. World Health Organisation. 2022.
9. Tilahun BBS, Bautista JF. Psychogenic nonepileptic seizure: An empathetic, practical approach. Cleve Clin J Med 2022; 89(5): 252-9.
10. Freud S.A seventeenth-century demonological neurosis. Standard Edition of the Complete Psychological Works of Sigmund Freud. London: Hogarth Press, 1923.
11. Enoch MD, Puri BK, Ball HN. Uncommon psychiatric syndromes. Fifth ed.London: Routledge; 2020.
12. Hanwella R, de Silva V, Yoosuf A, Karunaratne S, de Silva P. Religious beliefs, possession states, and spirits: three case studies from Sri Lanka. Case Rep Psychiatry 2012; 2012: 232740.
13. Weller PT. The Roman ritual, in Latin and English, with rubrics and planechant[!]. Milwaukee,: Bruce 1947-52; v.; 1950.
14. Slater E. Diagnosis of "Hysteria". Br Med J 1965; 1(5447): 1395-9.
15. Crimlisk HL, Bhatia K, Cope H, David A, Marsden CD, Ron MA. Slater revisited: 6-year follow up study of patients with medically unexplained motor symptoms. BMJ 1998; 316(7131): 582-6.