HYSTERICAL PSYCHOSIS

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SUMMARY

Clinical features of 88 patients diagnosed as having hysterical psychosis are analysed and compared with those of an equal number of catatonic schizophrenics and conversion reaction. Hysterical psychosis is characterised by acute onset, often following the occurrence of an emotionally disturbing event, absence of any characteristic thought disturbance, and emotional volatility. Prognosis is good. Even though physical methods of treatment like drugs and E.G.T. had to be used in many patients to control the acute disturbance, psychotherapy and family therapy were found to be essential for the abatement of presenting symptoms as well as prevention of their recurrences.

Although Hysteical Psychosis was a popular term in the United States and Europe in the early part of this century no system of classification included this term till the 9th revision of I.C.D. was published which included it under “Other and Unspecified Reactive Psychosis”. Standard textbooks seldom mention it by name, and only by inference can one include it under hysteria, transient situational disturbances etc.

Hinsie and Campbell (1960) mention “this term is synonymous with hysteria and is looked upon as a psychoneurosis rather than as a psychosis. However, at a time a hysterical condition may be closely allied to psychosis and is called hysterical psychosis”. Hollander and Hirsch (1964) describe the following features which they consider are characteristic features of Hysterical Psychosis—

(1) Sudden onset, (2) Onset related to an event which is profoundly upsetting, (3) Manifestation which may be in the form of delusion, hallucination, depersonalization or grossly unusual behaviour. (4) Affectivity is not usually altered. It is usually in the direction of volatility and not flattening. (5) The disorder is generally circumscribed and transient; even though there are delusions and hallucinations, they are more like the simple distortion of reality seen in the very angry or fearful child, which disappear when emotional control is achieved. (6) The acute episode seldom lasts longer than 1-3 weeks. (7) The psychosis recedes as dramatically as it began, leaving practically no residue. (8) Prognosis is generally good. (9) Response to psychotherapy is good, (10) 2nd or 3rd episode may occur. (11) It is commoner in those with hysterical personality and in women.

These authors state that hysterical psychosis is the end point on a continuum beginning with a hysterical character.

Langness (1967) believes that the term has been used, in part at least, because of the difficulty involved in applying standard nosological categories to psychopathology seen in primitive cultures.

He found that hysterical psychosis occurs in males and females, they are non-organic in origin, they are related to culturally defined stressful events and that they are transient. Social responses vary from culture to culture, but may be an important determinant with respect to the course of illness. He found that the behaviour during the attack is stereotyped and is shaped and directed by the particular culture. The only personality characteristics which were shared by the

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patients whom he surveyed from different cultures were the suggestibility, non scientific modes of thinking and perhaps an oversensitivity in responding to stresses. Some of these points are proved in Langeness’s (1965) description of a case of Hysterical Psychosis in the Bena Bena tribe of New Guinea. He found that the psychotic behaviour enabled a man in the tribe to escape his obligations temporarily. He also felt that the attacks are in part, a response to cultural pressures. Aggression which is taboo at other times, is freely expressed during the attack, especially towards the wife and children, who may be considered as symbols of one’s social responsibility. He also found that when an individual has got other modes of escaping from the stressful situation, such as leaving the tribe and going to live in the nearby town, the incidence of hysterical psychosis came down in the culture.

Martin (1971) found that women who have hysterical personality structures and have disturbed marriages are prone to hysterical psychosis. In these disturbed marriages their husbands not only failed to support their wives but also became destructive forces. This breaks the hysterical defensive structures. He considers hysterical psychosis as a type of coping mechanism used when all other mechanisms fail.

AIM OF THE PRESENT STUDY

The present study aims at (a) examining the characteristics of a group of patients who have been diagnosed as having hysterical psychosis, (b) to see how these characteristics compare with those described by previous workers—Hollander and Hirsch, Langeness, etc. (c) to examine the similarities and differences of this psychosis with two other clinical conditions, widely prevalent in the same age group, namely, catatonic schizophrenia and conversion reaction.

MATERIALS AND METHOD

All patients diagnosed as Hysterical Psychosis in Unit I of Department of Psychiatry, C.M.G., Vellore, during a period of seven years are included in this study. The criteria used for a diagnosis of hysterical psychosis, at the time of initial diagnostic evaluation were:

1. an acute onset (symptoms appearing in their full fledged form within two weeks of having been totally asymptomatic),
2. appearance of symptoms following a psychologically stressful event as reported by the patient or a close relative and
3. presence of histrionic behaviour on mental examination. Every patient had come to the clinic accompanied by one or more close relatives from whom details of the presenting complaints, precipitating factors, premorbid personality etc., were obtained and detailed permanent records were maintained on each patient as a regular practice in our centre. Details about precipitating factors were further verified from the patient’s themselves during the course of treatment when they became well enough to have free discussions with the therapist. These were entered in regular progress notes.

The present report is based on a retrospective analysis of the case records of all such patients with regard to demographic variables, clinical features, precipitating factors and response to treatment. The case records of an equal number of patients with diagnosis of Catatonic Schizophrenia and Hysterical Neurosis chosen by random sampling were also analysed with regard to the same factors. In addition to the retrospective analysis of case records, the patients with hysterical psychosis were also followed up for an average of three years each.

RESULTS

Among the 4390 patients who were seen by the Unit during the seven years
88 (2%) were diagnosed to be having hysterical psychosis.

### TABLE-I. Some Demographic Characteristics

| Characteristics | Hys. Psycho. | Cat. Schiz. | Hys. Neu. |
|-----------------|--------------|-------------|-----------|
|                 | (A) (N=88)   | (B) (N=88)  | (C) (N=88)|
| **a. Age (Years)** |              |            |           |
| 20              | 36           | 40.8       | 23        | 26.1      | 25        | 28.2      | 4.0 | p<0.05 |
| 21—40           | 50           | 56.8       | 64        | 72.7      | 58        | 63.9      |     |        |
| 41—60           | 2            | 2.2        | 1...      | 1.2       | 5         | 5.6       |     |        |
| **b. Sex**      |              |            |           |
| Male            | 29           | 32.9       | 60        | 68.1      | 29        | 32.9      |     |        |
| Female          | 59           | 67.1       | 26        | 31.9      | 59        | 67.1      |     |        |
| **c. Marital Status** |          |            |           |
| Single          | 40           | 45.4       | 38        | 43.2      | 33        | 37.5      |     |        |
| Married         | 48           | 54.6       | 50        | 56.8      | 55        | 62.5      |     |        |
| **d. Domicile** |              |            |           |
| Rural           | 51           | 57.9       | 50        | 56.8      | 46        | 52.2      |     |        |
| Urban           | 37           | 42.1       | 38        | 43.2      | 42        | 47.8      |     |        |

The age distribution of hysterical psychosis is significantly different from Catatonic Schizophrenia but not from hysterical neurosis. Thus there are a higher proportion of young persons (aged less than 20) in the hysterical psychosis group than in the catatonic schizophrenic group.

The sex distribution of hysterical psychosis is also significantly different from catatonic schizophrenia with a larger representation of females in the former group. In contrast, the hysterical neurosis group has the same sex distribution as hysterical psychosis.

The marital status of hysterical psychosis is not significantly different from the other two groups. Same is the inference about the rural-urban domicile.

### TABLE-2. Type of Onset & Duration of Complaints

|                     | Hys. Psycho. | Cat. Schiz. | Hys. Neu. |
|---------------------|--------------|-------------|-----------|
|                     | (A) (N=88)   | (B) (N=88)  | (C) (N=88)|
| **a. Type of onset**|              |            |           |
| Acute               | 65           | 73.9       | 44        | 50        | 47        | 53.4      |
| Insidious           | 23           | 26.1       | 44        | 50        | 41        | 46.6      |
| AVs B : $x^2=9.60$, p<.01; AVs C : $x^2=7.10$, p<0.01 |
| **b. Duration of Complaints** | | | |
| Less than 1 week    | 26           | 29.5       | 10        | 11.3      | 12        | 13.6      |
| 1-2 weeks           | 21           | 23.9       | 12        | 13.6      | 10        | 11.3      |
| 2-3 weeks           | 6            | 6.8        | 5         | 5.6       | 2         | 2.6       |
| 3-4 weeks           | 7            | 7.9        | 1         | 1.2       | 1         | 1.2       |
| More than 4 weeks   | 28           | 31.3       | 60        | 68.1      | 63        | 71.6      |
| AVs B : $x^2=27.0$, p<0.01; AVs C : $x^2=29.0$, p<0.01 |

Type of onset of hysterical psychosis shows a significantly different pattern compared to catatonic schizophrenia and also hysterical neurosis. This points out to the fact that a large proportion of the hysterical psychosis had an acute onset compared to the other two groups. Similar observation was made regarding the duration of complaints. Hysterical psychotics reported to the centre with shorter duration of complaints than catatonic schizophrenia and also hysterical neurosis.

Precipitating factors were present in almost all cases of hysterical psychosis. This is significantly different both from catatonic schizophrenia and hysterical neurosis. The most common precipitating factors were family quarrels, marital discord, unsatisfactory marriage prospects and educational difficulties. The distribution of type of precipitating factors of hysterical psychosis is not significantly different from the other two groups.
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### Table 3. Premorbid Personality & Precipitating Factors

|                   | Hys. Psycho (A) | Cat. Schiz. (B) | Hys. Neu. (C) |
|-------------------|-----------------|-----------------|--------------|
| Total No. studied | N=88            | N=88            | N=88         |
| a. Hysterical Personality | 22 25.0 2 2.3 28 31.8 | 3 3.4 50 56.8 25 28.2 | 2 2.3 28 31.8 |
| AVs. B: Z=44; p<.001* |                 |                 |              |
| b. Precipitating Factors |                 |                 |              |
| Absent            | 3 3.4 50        | 2 2.3 28        | 2 2.3 28     |
| Present           | 85 96.6 38      | 63 71.6         | 63 71.6      |
| AVs. B: x²=57.1, p<.001; AVs C: x²=18.7, p<.001 | |
| c. Type of Precipitating Factors |                 |                 |              |
| Family quarrels   | 29 32.9 9 10.2 12 13.6 |                 |              |
| Marital discord   | 18 20.4 5 5.6 5 5.6 |                 |              |
| Unsatisfactory marriage prospects | 11 12.5 4 4.5 1 1.2 |                 |              |
| Educational difficulties | 10 11.3 9 3.4 13 47 |                 |              |
| Other             | 17 19.3 17 19.3 32 36.3 |                 |              |
| AVs. C: x²=25.0, p<.001 | | | |

* Test for proportions

Psychosis is significantly different from hysterical neurosis. More specifically marital discord and unsatisfactory marriage prospects are found in a higher proportion of the hysterical psychosis than hysterical neurotics.

Past history of conversion symptoms is a significant difference between hysterical psychosis and catatonic schizophrenia, but not between hysterical psychosis and hysterical neurosis. On the contrary past history of psychotic illness were significantly present in the catatonic schizophrenics but not in hysterical psychosis and hysterical neurosis.

A hysterical premorbid personality, as reported by the patients close relatives, were more common among the hysterical psychosis and hysterical neurotics than among the catatonic schizophrenics.

On examination, the hysterical psychotics showed marked lack of cooperation much like the catatonics and vastly different from the hysterical neurotics. As a result of the poor cooperation, assessment of attention, concentration, memory and orientation in many of them were difficult. In spite of the poor level of cooperation the examiner could, with some effort make a more adequate assessment of these in the catatonic schizophrenics. Vagueness and poverty of ideas which characterised the Catatonic Schizophrenics thought process was not seen in the hysterical psychosis, while delusions were present in both groups. The presence of auditory hallucinations were also more in the catatonic than in the hysterical psychotics. While both patients with catatonic schizophrenia and hysterical psychosis tended to have irrelevant talk, the latter group showed special characteristics like giving approximate answers and answers which vary from time to time during the same interview. While a significant number of catatonics showed blunting of affect, the emotional reaction of the hysterical psychotics varied from anger, and irritability to elation. In many, the emotional reactions changed from one to another during the same interview and all these emotions were quite intensely expressed. As Richman & White (1970) remarked, hysterical psychotic impresses the observer as an actor who can take on a part, rather than as someone who becomes the part he is playing.
### Table 4. Mental Status Examination

|               | Hys. Psycho. | Cat. Schiz. | Hys. Neu. |
|---------------|-------------|-------------|-----------|
|               | (A) (N=88)  | (B) (N=88)  | (C) (N=88) |
| **Total No. studied** | N %   | N %   | N %   |
| a. Cooperation |          |          |         |
| Good          | 22      | 25.0   | 23     | 26.1 | 73    | 82.7 |
| Fair          | 35      | 38.7   | 42     | 47.8 | 10    | 11.3 |
| Poor          | 31      | 35.1   | 23     | 26.1 | 5     | 5.6  |
| AVs. C : $X^2=60.1$, p < .001 |
| b. Histrionic Behaviour | 68      | 77.3   | 0      | 0    | 21    | 23.8 |
| AVs. B : $Z=14.4$, p < .001* |
| AVs. C : $Z=7.1$, p < .001* |
| c. Attention & Concentration |          |          |         |
| Good          | 25      | 28.2   | 23     | 26.1 | 82    | 93.2 |
| Cooperation variable | 45      | 51.1   | 63     | 71.6 | 2     | 2.3  |
| Markedly Uncooperative | 18      | 20.4   | 2      | 2.3  | 4     | 4.5  |
| AVs. B : $X^2=14.2$, p < .001; AVs. C : $X^2=78.6$, p < .001 |
| d. Orientation |          |          |         |
| Good          | 40      | 45.5   | 35     | 38.7 | 81    | 92.0 |
| Cooperation variable | 7       | 7.9    | 36     | 40.8 | 0     | 0    |
| Markedly Uncooperative | 41      | 46.6   | 17     | 19.3 | 7     | 7.9  |
| AVs. B : $X^2=19.4$, p < .001; AVs. C : $X^2=37.2$, p < .001 |
| e. Memory     |          |          |         |
| Good          | 43      | 48.9   | 40     | 45.4 | 82    | 93.2 |
| Cooperation variable | 6       | 6.8    | 31     | 35.1 | 0     | 0    |
| Markedly Uncooperative | 39      | 44.3   | 17     | 19.3 | 6     | 6.8  |
| AVs. B : $X^2=25.6$, p < .001; AVs. C : $X^2=30.3$, p < .001 |

* Test for proportions

### Table 5. Mental Status Examination (continued)

|               | Hys. Psycho. | Cat. Schiz. | Hys. Neu. |
|---------------|-------------|-------------|-----------|
|               | (A) (N=88)  | (B) (N=88)  | (C) (N=88) |
| **Total No. studied** | N %   | N %   | N %   |
| a. Thought Process |          |          |         |
| Vagueness and Poverty of ideas | 1      | 1.1    | 46     | 52.2 | 0     | 0    | (Z=7.7; P<.001)* |
| Delusions | 28      | 31.8   | 35     | 39.6 | 0     | 0    |
| AVs. C : $Z=5.8$, p < .001* (Z=5.8; P<.001)* |
| b. Perception |          |          |         |
| Auditory Hallucinations | 17      | 19.3   | 30     | 34.1 | 0     | 0    |
| AVs. B : $Z=2.2$, p < .05; AVs C : $Z=4.4$, p < .001* |
| Visual Hallucinations | 10      | 11.3   | 7      | 7.9  | 0     | 0    |
| AVs. C : $Z=3.2$, p < .001* |
| Other | 2       | 2.3    | 1      | 1.1  | 0     | 0    |
| c. Speech |          |          |         |
| Irrelevant | 59      | 67.1   | 62     | 70.5 | 2     | 2.3  |
| AVs. C : $Z=9.0$, p < .001* |
| Approximate answers | 17      | 19.3   | 1      | 1.1  | 1     | 1.1  |
| AVs. B : $Z=4.0$, p < .001; AVs C : $Z=4.0$, p < .001* |
| Inconsistent answers | 20      | 22.7   | 0      | 0    | 0     | 0    |
| AVs. B : $Z=4.7$, p < .001; AVs C : $Z=4.7$, p < .001 |
| d. Affect |          |          |         |
| Appropriate | 14      | 15.9   | 2      | 2.3  | 37    | 42.1 |
| Angry       | 16      | 18.2   | 3      | 3.4  | 2     | 2.3  |
| Elated      | 16      | 18.2   | 6      | 6.8  | 2     | 2.3  |
| Blunted     | 10      | 11.4   | 45     | 50.9 | 4     | 4.5  |
| La Belle Indifference | 1    | 1.1    | 0      | 0    | 26    | 29.4 |
| Other       | 31      | 35.1   | 32     | 36.3 | 17    | 19.3 |
| AVs. B : $X^2=44.7$, p < .001; AVs C : $X^2=62.0$, p < .001 |

* Test for proportions
Table 6. Treatment

|                        | Hys. Psycho. Cat. Schiz. | Hys. Neu. |
|------------------------|-------------------------|-----------|
|                        | (A)                     | (B)       | (C)       |
| N %                    | N %                     | N %       |

A. Acceptance of Treatment

- First visit only: N=88, 38.4% completed treatment, 61.6% dropped out.
- Completed treatment: N=88, 75.6% completed treatment, 24.4% dropped out.

B. Type of Treatment

- Inpatient: N=88, 50% completed treatment, 50% dropped out.
- Outpatient: N=88, 75.6% completed treatment, 24.4% dropped out.
- No treatment: N=88, 25% completed treatment, 75% dropped out.

The dramatic and disturbing nature of the symptoms resulted in most of the hysterical psychotics being regularly brought for treatment. 50% of them needed inpatient care, like the catatonics and unlike those with hysterical neurosis. But there was no significant difference among the three groups regarding the duration of stay, in the hospital. Patients with hysterical psychosis were treated with drugs like Chlorpromazine, E.C.T. & Psychotherapy. But those who needed ECTs were significantly less than in the catatonic group. 78.4% of the hysterical psychotics completed the treatment whereas only 40.8% of the hysterical neurotics did so. 43.2% hysterical neurotics attended the hospital only for initial consultation. This finding probably shows that the dramatic nature of hysterical psychosis and the profound impact it has on the patients’ family, compels them to pay more attention to this patient and his illness than to the one with a conversion reaction.

Other observations made during the treatment of the hysterical psychosis were:

1. Chlorpromazine was found to be most effective in controlling the symptoms while other drugs like Trifluperazine, haloperidol, etc., were not very useful.

2. Even while under regular treatment many of these patients showed sudden bouts of increase in symptoms and these coincided with some events in the environment like visit by a relative with whom patient has a strained relationship.

3. In some of them, the disturbed behaviour continued for several weeks, in spite of treatment and then all the symptoms disappeared suddenly, almost overnight. During subsequent psychotherapy sessions it was often discovered that such dramatic improvement often followed a sudden change in the environ-
ment which resulted in the removal of an emotional stress which had been troubling the patient till then.

### TABLE 7. Outcome

|                      | Hys. Psycho. | Cat. Schiz. | Hys. Neu. |
|----------------------|--------------|-------------|-----------|
| (A) (N-69)           | (B) (N-62)   | (C) (N-36)  |
| **Total No. studied** | **N %**      | **N %**     | **N %**   |
| Recovered            | 32 46.4     | 1117.7      | 2775.1    |
| Markedly improved    | 9 19.0      | 3150.0      | 0 0       |
| Partial improvement  | 26 37.7     | 1524.2      | 5 13.8    |
| Unchanged            | 2 2.9       | 5 8.1       | 4 11.1    |

\[AVs B: X^2=26.5, p<.001; AVs C: X^2=9.8, p<.01\]

46.4% of the patients with hysterical psychosis recovered totally from all the symptoms of the illness while only 17.7% of the Catatonics reached a state which can be called recovery.

### TABLE 8. Total Duration of Illness

|                      | Hys. Psycho. | Cat. Schiz. | Hys. Neu. |
|----------------------|--------------|-------------|-----------|
| (A) (N-69)           | (B) (N-62)   | (C) (N-36)  |
| **Total No. studied** | **N %**      | **N %**     | **N %**   |
| Less than 4 weeks    | 16 23.2      | 11.6       | 9 25.0   |
| 4 to 6 weeks         | 10 14.5      | 8 12.9     | 3 8.3    |
| 6 to 8 weeks         | 23 33.3      | 11 17.7    | 13 36.1  |
| More than 8 weeks    | 8 11.6       | 36 54.8    | 2 5.6    |
| Data not available   | 12 17.4      | 8 12.9     | 9 25.0   |

\[AVs B: X^2=33.9, p<.001\]

An analysis of the duration of illness show that hysterical psychosis run a shorter course than a catatonic schizophrenic episode.

### TABLE 9. Follow-up Data On Hysterical Psychosis Duration of Follow-up : 3 Years

| Number followed up | 60 (68.1%) |
|---------------------|------------|
| Maintaining the improvement | 41 (68.3%) |
| Recurrent attacks of hysterical psychosis | 12 (20.0%) |
| Conversion symptoms | 7 (11.6%) |
| Assessment of environmental stresses done on follow-up | 57 (95%) |
| Relapse of psychosis despite change in stresses | 2 (3.5%) |
| Conversion symptoms in those with change in stresses | 2 (3.5%) |
| Relapse of psychosis in those with no change in stresses | 11 (19.3%) |
| Conversion symptoms in those with no change in stresses | 15 (26.5%) |

We are able to follow-up 68.1% of these patients for an average period of three years. 68.3% of them were found to be having no psychotic symptoms at all. Another 20% had further episodes of psychosis characteristics of which were again suggestive of hysterical psychosis, while 11.6% had episodes of conversion hysteria. When an assessment about the environmental factors were made during these follow up contact, it was found that the recurrence of psychosis and appearance of conversion symptoms were more common (26.5%) in those who experienced no change in their environmental stresses ; on the other hand among those who reported or implemented changes in the environmental factors only 7.2% had further psychotic or conversion episodes.

### CONCLUSION

Our data seems to show that hysterical psychosis can be differentiated from schizo-
phrenia on one hand and hysterical neurosis on the other. Our patients showed many of the features described by Hollander and Hirsch (1964), namely, sudden and dramatic onset precipitated by an upsetting event and manifested by grossly unusual behaviour very different from schizophrenia. No characteristic thought disorder was observed, there was no flatness of affect, rather the change was more in the direction of volatility. The episode was of short duration, the occurrence was more in hysterical personalities and more in women, especially those with marital difficulties. The follow up data also shows that the long term prognosis of these patients is good, but continuing life stresses tended to bring on similar attacks in some. The occurrence of conversion reaction before and after a particular hysterical psychotic episode is an interesting finding and possibly shows that the psychotic illness may also be an escape from a stress situation. Our observations are in keeping with the view of Richman and White (1970) that hysterical psychosis, like conversion reaction can be an alternative, when repression fails and that this choice of illness can be best understood in the family context. Siomopoulos (1970) suggested that hysterical psychosis could be considered as a regression to the specific form of thought activity involved in children's play. Reality testing in hysterical psychosis is not impaired yet fantasy diffuses into reality. The two states, acted out fantasy and reality, exist side by side, functioning in their own right and obeying their own rules. Our observations support Wig and Narang (1969) observation that hysterical psychosis is not uncommon in our culture where conversion hysteria symptoms are frequent and endorses his plea that hysterical psychosis should be viewed separately from schizophrenia.

ACKNOWLEDGEMENT

The authors are very thankful to Dr. J. Richard, Senior Lecturer, Department of the Biostatistics, Christian Medical College for his help in the statistical analysis of the data.

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