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Personal practice

Hysteria

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It is common for paediatricians to be faced in outpatient clinics with children whose presenting complaints cannot be adequately explained on organic grounds. Perhaps abdominal pain and enuresis form two of the commonest of these disorders. A third group of symptoms that leave many doctors perplexed are those relating to the central nervous system or musculoskeletal system which, in the absence of clear cut physical disease, are often referred to as hysterical disorders.

This 'diagnosis' is problematic and risky, and many paediatricians are unhappy to consider it without further investigation. Some children are admitted to hospital for this purpose. A major difficulty is the high percentage of organic disorders that are discovered at a later date and which are then seen to account for the original presenting syptoms.[1] Furthermore, atypical presentations of uncommon neurological disease may be thought 'hysterical' by physicians and psychiatrists unfamiliar with neuropsychiatry and neurology.[2] Given the present state of knowledge, it is not surprising that assessing a potential case of hysteria remains confused and difficult. While guidelines for management have been clearly stated in the published reports[3] (stopping physical investigations, active rehabilitation of the patient, and exploration of any underlying pyschiatric disorder) recognising children who may benefit from this sort of management is less obvious.

A number of clinical features have been proposed as indicative of hysterical disorder.

(1) That symptoms do not conform to an understandable pattern of anatomy or physiology.

(2) Symptoms correspond to the patients' 'idea of physical illness'.

(3) The symptoms serve an unconscious need.

Psychiatrists are asked for opinions when:(a) no physical explanation for symptoms has been found; (b) possible explanatory models of physical illness have been exhausted; and (c) symptoms fail to respond to physical treatment. Under these conditions psychological models are considered as the only alternative explanation for the child's 'illness'. The criteria for a positive diagnosis of hysteria are difficult for the psychiatric amateur to grasp. Inferences need to be made about a child's 'mental state' or assumptions made about unconscious processes.

The concepts of illness behaviour[4] and sick role[5] provide a framework for understanding how individuals with symptoms may be differentially perceived and evaluated by others. The persistence of an inappropriate mode of perceiving, evaluating, and acting in relation to one's state of health has been referred to as abnormal illness behaviour[6] and may lead an individual into seeing greater benefits of sickness over health. A lucid account of the definition and usage of these concepts has recently been provided.[7]

Abnormal illness behaviour and sick role may be difficult to evaluate, however, once a child is in a medical setting,[8] as hospital environments contain an expectation that both these states of affairs will be present. Thus, when psychological information about hysteria is subjected to careful scrutiny it is difficult to discriminate between potential aetiological factors in the unconscious or conscious world of the child.[9]

The problem is a theoretical and a conceptual one which is discussed by Taylor and briefly presented here.[10] Taylor believes that there is an incorrect premise concerning the nature of hysteria, that it is never likely to meet criteria that constitute a syndrome, and that it is probably better to see hysteria as an enactment of sickness in response to a predicament whose presentation is a result of one or a number of alterations beyond the child's control.

Taylor states that what is required is an understanding that a child is placed in an impossible psychological position through circumstances external to him, the necessary result of which is enacted symptom formation. This condition requires a response from someone whose explanation will not come from a consideration of disease or

illness models alone. What sort of conditions give rise to an 'impossible' predicament? They are likely to be drawn from different places, personal or family medical illness, changes in social networks, school, or family disharmony. They are likely to place the child in a position of a psychological last stand.[9] Being in a 'predicament' predisposes to the expression of symptoms that descriptively are referred to as hysteria. In other circumstances the predicament might have had a different form of expression.

Thus, hysteria will not be easy to establish by conventional investigation including a mental state examination (many of these children are free of formal mental disorder, but need not be).

Furthermore, being in a predicament cannot exclude the possibility of having a disease (a structural lesion, for example cerebral tumour) or an illness (a recognisable set of signs and symptoms for example depression).

This conceptual framework furthers the understanding that from a descriptive standpoint a child may present with a single symptom (for example paralysis of a leg, loss of vision), a number of symptoms (for example paralysis of a leg, and sensory loss, and vague aches and pains) perhaps because this is what would be expected of him or her in a medical setting—that is symptoms correspond to the patients' idea of the doctors' idea of physical illness. Under these conditions continuing physical investigations will confirm to the child that there is good reason for enactment because the doctor is worried enough to consider him as 'ill'. The predicamentary state of affairs may thus include the physician allowing sick role and abnormal illness behaviour to flourish in the patient.

Does this mean there is a need to reappraise the issues from the clinical standpoint? We think so. We can be confident that the use of the word hysteria for children will not disappear any more than it has for adults, despite efforts to be rid of it.[11] What the paediatrician requires are some guidelines for children who are at 'predicamentary risk' and not 'critera for a diagnosis of hysteria'.

In this respect the published reports on child psychiatry may be helpful, and in general suggest that when a child presents with odd signs and symptoms that seem outside anatomical and physiological understanding the following factors indicate a potential enactment of sickness.

(1) A model of symptom imitation in the child's personal social or family network.

(2) Recent stressful life events.

(3) A past history of the same of similar symptoms.

(4) A past psychiatric history in the child.

This information is relatively easy to establish and should suggest that a psychiatric opinion be sought to discuss with the physician a possible course of action. This principle of early psychiatric liaison has been emphasised previously[9] and may assist in evaluating the relative contribution of disease, illness, and predicament in cases of suspected hysteria. Many 'predicaments' including problems and difficulties other than hysteria that seem to prevent the child's return to ordinary life have been evaluated in this way. This liaison practice operates as an adjunct to routine referral methods and is proving successful here. Furthermore, it may be the first step in preventing a child in a predicament from rehearsing enactments of sickness to a degree where he or she becomes a permanent dweller in the medical world of illness or even disease.

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