Staff Meeting Bulletin
Hospitals of the » » »
University of Minnesota

Hysteria in Children

Volume XV | Friday, February 11, 1944 | Number 15

STAFF MEETING BULLETIN
HOSPITALS OF THE . . .
UNIVERSITY OF MINNESOTA

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INDEX

Published for the General Staff Meeting each week during the school year, October to June, inclusive.

Financed by the Citizens Aid Society, Alumni and Friends.

William A. O'Brien, M.D.

I.

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
CALENDAR OF EVENTS
February 14 - 19, 1944

Visitors Welcome

Monday, February 14

9:00 - 10:00 Roentgenology-Medicine Conference; L. G. Rigler, C. J. Watson and Staff, Todd Amphitheater, U. H.

9:00 - 11:00 Obstetrics and Gynecology Conference; J. L. McKelvey and Staff, Interns Quarters, U. H.

12:30 - 1:30 Pediatrics Seminar; Pathology and Recent Trends in Treatment of Burns; Robert O. Bergan, W-205 U. H.

12:30 - 1:30 Pathology Seminar; Toxoplasmosis; Carl Eklund, 104 I. A.

4:00 - Preventive Medicine and Public Health Seminar; Review of book, "Control of Anopheles Gambiae in Brazil"; M. M. Weaver, 116 M. H.

Tuesday, February 15

8:00 - 9:00 Surgery Journal Club; O. H. Wangensteen and Staff, Main 515, U. H.

9:00 - 10:00 Roentgenology-Pediatrics Conference; L. G. Rigler, I. McQuarrie and Staff, Eustis Amphitheater, U. H.

11:00 - 12:00 Urology Conference; C. D. Creevy and Staff, Main 515, U. H.

12:30 - 1:30 Pathology Conference; Autopsies. Pathology Staff, 104 I. A.

12:30 - 1:30 Physiology-Pharmacology Seminar; Some Recent Studies on Autonomic Drugs, H. N. Wright, 214 M. H.

4:30 - 5:30 Obstetrics and Gynecology Conference; J. L. McKelvey and Staff, Station 54, U. H.

4:00 - 5:00 Pediatric Grand Rounds; I. McQuarrie and Staff, W-205 U. H.

5:00 - 6:00 Roentgen Diagnosis Conference; G. N. Kelvy, C. L. Ould, M-515 U. H.

8:00 - Minnesota Pathological Society; Incidence of Types of Congenital Heart Diseases; B. J. Clawson, Patent Ductus Arteriosus; M. J. Shapiro, MoS. Amphitheater.

Wednesday, February 16

10:30 - 12:00 Otolaryngology Case Studies; Out Patient Ear, Nose and Throat Department; L. R. Boies and Staff.

11:00 - 12:00 Pathology-Medicine-Surgery Conference; Pituitary Myxedema, E. T. Bell, C. J. Watson, O. H. Wangensteen and Staff, Todd Amphitheater, U. H.

12:30 - 1:30 Pharmacology Seminar; Schistosomiasis, Elizabeth M. Cranston, 105 M.H.

Wednesday, February 16 (Cont.)

4:15 - 6:00 Obstetrics and Gynecology Journal Club; J. L. McKelvey and Staff, Station 54, U. H.

4:30 - 5:30 Neurophysiology Seminar; The Liberation of Acetylcholine and other Chemical Substances from Various Nerve Tissues; Howard Hunt, 129 M.H.

Thursday, February 17

9:00 - 10:00 Medicine Case Presentation; C. J. Watson and Staff, Todd Amphitheater, U. H.

10:00 - 12:00 Medicine Rounds; C. J. Watson and Staff, East 214 U. H.

12:30 - 1:30 Physiological Chemistry Seminar; Oral and Dental Biochemistry; W. D. Armstrong, 116 M. H.

5:00 - 6:00 Roentgenology Seminar; Review of Recent Radiologic Literature; Staff, M-515 U. H.

4:30 - 5:30 Bacteriology Seminar; Characteristics of Virus Diseases; R. G. Green, 129 M. H.

Friday, February 18

9:00 - 10:00 Medicine Grand Rounds; C. J. Watson and Staff; Todd Amphitheater, U. H.

8:30 - 10:00 Pediatrics Grand Rounds; I. McQuarrie and Staff

10:00 - 12:00 Medicine Ward Rounds; C. J. Watson and Staff; East 214 U. H.

11:45 - 1:15 University of Minnesota Hospitals General Staff Meeting; Therapeutic Malaria, M. G. Fredricks, Powell Hall Recreation Room

1:30 - 2:30 Medicine Case Presentation; C. J. Watson and Staff; Eustis Amphitheater.

1:00 - 2:30 Dermatology and Syphilology; Presentation of selected cases of the week; Henry E. Michelson and Staff; W-306 U. H.

1:30 - 3:00 Roentgenology-Neurosurgery Conference; H. O. Peterson, W. T. Peyton, and Staff, Todd Amphitheater, U. H.

Saturday, February 19

9:00 - 10:00 Medicine Case Presentation, C. J. Watson and Staff, Main 515 U. H.

9:15 - 11:30 Surgery-Roentgenology Conference; O. H. Wangensteen, L. G. Rigler, and Staff, Todd Amphitheater, U. H.

10:00 - 12:00 Medicine Ward Rounds; C. J. Watson and Staff, E-214 U. H.

11:30 - 12:30 Anatomy Seminar; Richpler's Eventration Versus Omphalocele; L. J. Wells, Study of Aspiration and Imprint Material from Enlarged Lymphnodes; Dorothy S. Reiff, 226 I. A.

II. HYSTERIA IN CHILDREN

R. A. Jensen
A. D. Wert

Hysteria, one of the more accurately defined psychoneuroses, occurs in children and adolescents as well as in adults. Failure to appreciate this fact is frequently responsible for the condition being entirely englected in the differential diagnosis. Consequently treatment of children so afflicted is disappointing, not only to the physician confronted with a stubborn medical problem resistant to his efforts, but also to the child and his family. Furthermore, when such patients eventually come under the care of the psychiatrist or psychiatrically oriented pediatrician, the task of rehabilitation is immeasurably complicated by the previous mismanagement.

That hysteria is more common than ordinarily suspected is well borne out by experience in the Department of Pediatrics and the Psychiatric Clinic for Children during the past several years. Since 1938 we have encountered at least twenty-five children or more who were suffering from either hysteria or severe somatic illness with hysterical features which required similar consideration in their management. For purposes of the present presentation, fifteen children whose ages varied between nine years and fifteen years, and whose illnesses were diagnosed conversion hysteria, have been selected to illustrate the problems encountered in our experience.

Literature:

A survey of the literature[1] from 1930 to 1944 reveals only 16 papers dealing exclusively with the subject of hysteria in children. Seven of these are in the American or British literature. This sparsity of references to the subject in the recent literature stands out in sharp contrast to the keen interest manifested during the period from 1873 to 1915. Kanner[2] has listed the more important titles reported betwen the latter dates - a total of 36.

Since the present world conflict began, many papers have appeared dealing with children's reactions to war conditions. Despert's review[3] of 111 reports in literature fails to mention conversion hysteria as a condition frequently encountered in English, French, or Russian children since the onset of World War II. Gillespie,[4] like Despert, reports the prevalence of anxiety states but he too fails to mention the occurrence of any major hysterical attacks. This is in contrast to the experience encountered in the armed forces where conversion hysteria frequently occurs. Mira[5] sums up his experience with the Spanish Republican forces by saying, "The most common neurotic disturbance was that usually known as conversion hysteria." Similar findings are implied with regard to our own forces in action in the paper by Rome.[6] These discrepancies are difficult to evaluate. Why conversion hysteria should be encountered in some of our children far removed from the trying conditions of actual war and not in war-torn areas is hard to understand. Our experience over the past 5 years leads us to believe that conversion hysteria in children deserves far more attention than it has received during the past few decades. In the hope of reviving interest, our experience is offered for consideration.

The basis of our report is a study of 15 children having a final diagnosis of "conversion hysteria," who were treated in the Department of Pediatrics and the Psychiatric Clinic for Children. Their ages varied between 9 and 15 years, the average being 13 years. Twelve of our patients were females, 3 were males. It is to be noted that the majority of them were in the pubertal age group and that females predominate. This is consistent with findings reported by others during the years when interest in this subject was at its height. Two of our patients earned a rating of superior intelligence, while the others all earned a rating within the average range.

Ten of our patients were hospitalized from one and a half to 16 weeks, the

average stay being 7 weeks. Five were able to manage successfully on an out-patient basis and were placed in a boarding home. This permitted frequent visits to the clinic. The average length of time for those treated on an out-patient basis was 4 weeks.

Case	Presenting Complaints
1	Blurred vision; vertigo, slowing of speech and motor activities.
2	Pain in left face; left pleurodynia; colicky pain left flank and left anterior thigh; restricted motion in jaws; frequency; dysuria.
3	Arthralgia; "stomach pain"; tubular vision; inconstant paraesthesias.
4	Palsy, left arm and leg.
5	Fainting spells; dizziness.
6	Palsy of head and extremities; refusal of food; retention of urine.
7	Unconsciousness; vomiting; delirium; pain in neck; cephalgia.
8	Blindness of left eye; fainting spells.
9	Paralysis of hands and feet; also pain.
10	Nervousness; insomnia; constipation; urinary frequency, paraesthesias; spastic contractures of extremities; occasional clonic movements of extremities.
11	Unconscious spells; preceded occasionally by gustatory or auditory aurae; diplopia; clonic movements of extremities; abdominal gas pains.
12	Arthralgia; cardiodynia; abdominal pain; left hemiplegia; unable to open eyes or jaws.
13	Partial loss of vision.
14	Unconscious spells; weak spells; right frontal headache; right hemiparesis.
15	Contracture of right hand; headache; "nervous chills"; weakness.

One impressive feature is at once obvious. The presenting complaints are multiple, usually involving more than one organ system. Further it is noted that several of these patients offered symptoms suggestive of real organic disease. Patient #2 offered complaints suggestive of renal colic. Her grandmother, of whom she was very fond, had previously been treated by operation for a kidney stone. When the family learned that the father might be released from prison, they all became markedly disturbed, as he had previously made several proven attempts to kill the mother as well as the children. The father of patient #4 had a left-sided palsy following a cerebral accident. At the time of his death she developed similar symptoms.

A total of 49 individual complaints were offered by these patients at the time of admission. An analysis of these reveals the following parts of the body involved:

1	Central nervous system complaint	38
2	Gastro-intestinal complaint	4
3	Bone and joint complaint	4
4	Genito-urinary complaint	2
5	Cardiac complaint	1
	Total	49

Careful and repeated physical examinations revealed no suggestive or conclusive explanation for the presenting complaints, except to substantiate their

existence. Five of the children with visual disorders had definitely constricted fields as reported by the staff of the Department of Ophthalmology.

Neurological examinations were essentially negative in every case excepting #6. In this patient hypoactive reflexes and bilateral unsustained ankle clonus were observed.

Laboratory data were likewise essentially negative, except for patient #6. In this case, the urine tests showed acetone and diacetic acid, and the plasma CO_2 capacity was 44 vol. per cent, indicating the existence of a mild acidosis. This was probably due to the prolonged self-imposed fast. An average of 6 laboratory examinations was done on each patient. These included urinalysis, blood counts, serology, sedimentation rates, special blood chemistry studies, and x-rays.

The duration of symptoms from the time of onset until admission to our hospital varied from 4 hours to 36 months. The majority of our patients were ill from 2 to 5 months prior to the time of their referral. It was surprising and disconcerting to note that the average duration of symptoms was 8 months. This is highly significant because therapy becomes increasingly difficult when the underlying etiological factors are allowed to go unrecognized for so long a time.

This fact clearly indicates the importance of psychogenic disturbances in childhood is not fully aporeciated by many medical practitioners.

Analysis of the diagnoses made by the referring physician revealed that hysteria was recognized in but 4 of the 15 cases. In one other case it was offered as the last of 3 diagnostic possibilities. In this instance, the diagnoses were listed as follows:

? Kidney stone
?? Tetanus
???? Hysteria

We substantiated the referring physician's diagnosis of hysteria in these 5 patients and made the same diagnosis in 5 additional cases at the time of the latter's admission to the Hospital. Of the remaining 5, hysteria was diagnosed only after a period of several days of critical observation. It is not always easy to make the diagnosis of hysteria with absolute certainty.

Ten patients were treated by various other methods prior to institution of psychiatric therapy. Therapeutic measures previously employed are summarized here to emphasize their ineffectiveness:

Case #3. Two previous hospitalizations. During the first of these, an appendectomy was performed, and during the second was given a vermifuge, salicylates, and sulfanilamides without benefit.

Case #5. Sedation for 1 month resulted in no improvement.

Case #6. Eight electric shock treatments administered during 2 weeks' hospitalization produced only temporary improvement.

Case #7. Chloroform given to control hyperactivity of convulsive-like seizures; also chloral hydrate and morphine. Three diagnostic pneumoencephalograms revealed no abnormalities.

Case #9. Treated by several physicians. Arrived at hospital in splints.

Case #10. Bed rest and sedatives for several months. Treated by 4 physicians, an osteopath, and chiropractor. One physician made a diagnosis of peripheral neuritis, and in the patient's presence told the mother, "Your daughter will never walk again."

Case #11. Appendectomy 6 weeks prior to onset of convulsions. Water restriction and anti-convulsant therapy ineffective.

Case #12. Appendectomy 7 months prior to onset of symptoms. Later hospitalized for 2 weeks with no

lasting improvement.

Case #13 Optometrist changed classes frequently for period of 4 months.

Case #14 Varied complaints for 1 year prior to onset of a transitory hemiparesis. One week later an appendectomy was performed.

Case #15 Cast and splints tried unsuccessfully by local physician. Hospitalized in an orthopedic hospital for 4 months with only slight improvement.

Attention is called to the 4 patients who had an appendectomy. Careful review of their histories suggests the possibility that the abdominal complaints may have been largely hysterical in nature. If this impression is correct, 4 unnecessary operations were performed. One of our patients suspected of cerebral pathology had had 3 pneumoencephalograms and was waiting for a 4th at the time the diagnosis of hysteria was made. Management of hysterical patients as noted above is to be deprecated. It is disappointing to the physician and to the family. Grave injustice is done to the patient, for improper procedures serve only to fix more firmly the emotional disturbances and mental conflicts which are basic in this disorder. Furthermore, secondary gains derived from the illness create additional problems in treatment.

The presenting complaints were sudden in onset in 9 of the patients. For emphasis the precipitating factors have been summarized as follows:

Case #2 Patient feared that father would receive pardon from correctional institution.

Case #3 Feared favorite uncle might be drafted.

Case #4 Father's death.

Case #5 Became extremely angry while chasing a boy.

Case #6 Found a neighbor dead.

Case #7 Family broken up by Court order

Case #8 Drunkard struck at her eye without actual contact.

Case #9 Disliked temporary foster home and wished to return to her own

In the other 6 cases, the onset was more vague and insidious. Patient #5, an only child, with a marked mother complex, feared parental separation. Two patients were adopted children and unhappy; one was unhappy in a foster home. Another was jealous of a half-brother, fearing that he was the mother' favorite.

Stable home conditions are essential for the child's feeling of security. In order to portray graphically the home situation from which our patients come, the following summary has been made. It is largely self-explanatory.

DIAGNOSIS

Since the symptoms of conversion hysteria are protean and may mimic practically any organic condition, the diagnosis is not always easy. It is never conclusive until the possibility of somatic illness is excluded and evidences of psychological disturbance substantiated.

As is readily appreciated, a detailed consideration of the differential diagnosis would be impossible in this brief discussion. Yet a few of the more common childhood conditions need to be mentioned as they may often be confused with the hysterical reaction.

(1) Conversion hysteria is frequently mistaken for rheumatism, rheumatic fever, and chorea. The complaint of body aches and pains with nervousness and perhaps a slight temperature is often found in the hysterical child. To make an error in diagnosis in such a situation means confinement to bed for long periods to the detriment of the patient. Such treatment only serves to further fixate this psychoneurotic reaction and

Case	Age	Sex	Presenting Complaint	Referring Diagnosis	Family Situation	Course
1	9	M	Blurred vision Vertigo	Defective vision	Father: cerebral accident Mother: poor health Brothers inducted into service Brother lost his job	Placed in boarding home awhile Satisfactory course
2	10	F	Multiple pains over left ureter Frequency & dysuria	? Kidney stone ?? Tetanus ???? Hysteria	Father alcoholic: imprisoned for threat to kill family. Family upset. Grandmother operated on for kidney stone two years previous to onset of patient's complaint.	Improved in one week with daily contact
3	10	F	Painful joints Poor vision Abd. pain	?Rheumatic fever ? Partial bowel obst.	Economic insecurity Mother works regularly as a nurse Succession of maids in home - all left because of patient's attitude Fear of war - afraid uncle being drafted. Marked sibling rivalry	No improvement for 2 weeks. Then rapid change. - Only moderate visual improvement. - 4 mos. later good except for slight constricted visual fields.
4	11	F	Palsy - left arm and leg	?Cerebral pathology	Economic insecurity Syphilis in the family Death of father (from cardiovascular syphilis, who had a stroke previously) Family lived in isolation Older sister also had slight palsy following father's death	Satisfactory course Adequate adjustment at 6 mo. return
5	12	M	Fainting spells Dizziness	Petit mal & unconsciousness	Marked intra-parental tension Severe Oedipus complex Mother chronically ill Economic conditions marginal. Patient sold newspapers to help Antagonism to father	One attack in hospital called fake by other boys Satisfactory at 6 mo. check. No further attacks

Case	Age	Sex	Presenting Complaint	Referring Diagnosis	Family Situation	Course
6	13	F	Palsy of head & extremities Refused food Urinary retention	Dementia Praecox	Poor home background - removed from own home. In adoptive home since age of three. Replaced a deceased daughter of the foster parents Discovered adoption from other children	Out of bed in 1 week Moderately satisfactory
7	13	F	Unconscious	Hysteria	Father epileptic and alcoholic Mother unstable Poor financial circumstances All children older left home at early age 14 children in family Father threatened the girl several times	Stormy course for 2 years. 3 spells of amnesia. In psychiatric service several times Prognosis questionable
8	14	F	Blindness, left eye Fainting spells	Blindness Petit mal	Mother married 3 or 4 times Mother punitive to all children - particularly to patient Constant parental tension Poor economic and social circumstances Stepfather not helpful	Improved - many convulsive-like attacks early in hospital stay - several episodes of swallowing objects
9	14	F	Paralysis of hands & feet	Multiple neuritis	Poor economic circumstances Family moved away leaving girl in foster home Marked mother attachment	Improved in foster home - 2 years later entirely well and happy
10	14	F	Spastic contracture of extremities Clonic movement of extremities Bed-ridden	Hysteria	Mother divorced Stepfather drank moderately precipitating parental tension Overcrowding by mother - "She never lets me do anything" Sibling jealousy	Feeding self within 1 week - Legs last to regain function - Dependent edema & cyanosis lower extremities. Cyanosis cleared Prognosis good. Still occasional edema

Case	Age	Sex	Presenting Complaint	Referring Diagnosis	Family Situation	Course
11	15	F	Fainting spells Gas pains in abdomen	Hypotension Epilepsy	Father had spells for years Mother nervous and overprotective Parents unstable and neurotic Poor financial circumstances	- No seizures in hospital or boarding home Prognosis good
12	15	F	Left hemiplegia, abd. pain Eyes closed Jaws partially closed	Neuritis Heart trouble	Mother invalid with rheumatism Father alcoholic Parents want her to work on farm and care for entire family, while patient desires schooling to learn beauty culture	- Improved at that time went to aunt's home - 4 years later had somatic complaints but no hysterical reaction
13	15	F	Poor vision	Hysteria	Mother divorced and remarried Patient did not confide in people Severe family mix-up Conflict about standards of behaviour Resentment against first father	Improved moderately She discontinued clinic contacts
14	15	F	Unconscious weak spells Headache rt. hemiparesis	Neurosis	Father an invalid Brothers taken in service Patient had to care for large farm Intra-family tension - parents vs grandmother	Fairly satisfactory
15	15	F	Contracture of hand Headache Nervous chills Weakness	Hysteria	Worried about health and fear of Tbc. Adopting mother neurotic with invalid reaction Father unreliable - deserted family Foster brother vies for mother's affection Marginal family economic status	- Boarded in town 10 months - Recurrent diarrhea first few months - none since $1\frac{1}{2}$ year check - well adjusted

makes the problem of treatment subsequently more difficult. Several of our patients were so handled. One patient had been confined to bed for a period of four months, treated with injections, splinting to prevent foot drop, and many oral medications to no avail. One hour spent in careful review of the history suggested that the diagnosis could have been made at the time of the onset of the illness.

(2) Another condition which needs careful consideration is the kind and type of convulsive disorder which is present. There is increasing evidence to suggest that a convulsive-like attack in children can be and often is hysterical in nature. Electroencephalographic studies and the water pitressin test can be of real value in these cases.

(3) Various complaints referrable to the gastro-intestinal tract need special consideration. Periodic acute attacks of vomiting and abdominal pains with minimal or no confirmatory physical findings and with rapid recovery should make one cautious in his evaluations.

(4) The possibility of brain tumors or other cerebral pathology cannot be ignored. Several of our patients needed very careful neurological study and evaluation to rule out central nervous system pathology. In one patient, three needless pneumo-encephalograms had been done and a fourth was scheduled when the true nature of the problem was defined! A word of caution is in order at this point. Grave injustice has been done many children who have erroneously been classified as hysterical when in reality they were organically ill. Within the past four months 2 such children, each suffering from a brain tumor, were diagnosed and treated as neurotic--one for nearly one year, the other for several months prior to hospital admission.

The question naturally arises: how can one make a diagnosis if it is so difficult? Several suggestions which we have found helpful are offered for consideration.

(1) In no other condition is it more essential to secure a complete history. Thoroughness and attention to detail are required. Several items are of special importance:

(a) The history of the onset. While in many patients the hysterical reaction has a slow insidious onset, it has been estimated that fully 50 per cent follow a sudden severe emotional shock or experience. Such factors as these, sudden loss of a member of the family, illness in a parent or favorite sibling, or parental conflict are most common as exemplified in the present small series of cases. It should be emphasized that these traumatic experiences often precipitate a hysterical attack and are not always essentially the causative factor. In patients developing symptoms more insidiously minor worries, conflicts, and emotional tensions can be as significant as the more severe and sudden traumatic experience.

Careful inquiry into any changes noted in the child following onset of his symptoms is often fruitful. It is not uncommon to note that a child previously nervous, fidgety, fearful, and anxious has suddenly become quite the opposite when the hysterical symptoms appear.

(b) Investigation of the emotional atmosphere in the home is important. Parental disharmony often bears a direct relationship to the child's difficulties. How do the parents get along? Is the child, as well as other siblings, being given fair consideration in the family pattern? Are the parents (particularly the mother) too fussy, exacting, or too austere in the demands made on the child? Is the child compelled to take sides in parental conflicts?

(c) The child's personality needs accurate definition both from the point of view of the history as well as direct observation. Contrary to current opinion, the child most prone to develop a hysterical reaction is the extremely sensitive, shy, modest, reserved or serious youngster who, for

one reason or another, is not able to handle everyday relationships in a healthy, out-going manner. As with other hysterical patients, the child assumes an attitude of utter indifference to his affliction, or at times, when carefully observed, a peculiar satisfaction in his symptoms and the attention given him.

(2) The absence of any conclusive physical findings. At times this is most distressing for in the study of such a patient, minimal findings are sometimes noted. Unless evaluated against the total situation, these may cause the attending physician to procrastinate "just in order to make sure." The attitude of the child during the examination is often revealing as is his behavior. Often he presents the "belle indifference" so commonly encountered in adults suffering from a major hysterical reaction.

(3) It is also well to observe the patient during periods of sleep. We were helped materially by noting the reactions which occurred either during spontaneous sleep or sleep induced by the use of sedatives. Patients suffering from "paralyses," hyperaesthesias, and aches and pains in the muscles and joints, were able to move about in a normal manner during their sleeping hours. Likewise any spasticity that may have been noted disappeared. Such observations are extremely helpful in arriving at a satisfactory diagnosis which then becomes essentially an evaluation of the total situation rather than of the presenting symptoms.

This can best be accomplished by one well acquainted with children as well as the various illnesses encountered in childhood.

PROGNOSIS AND COURSE

The prognosis for recovery from the original conversion symptoms is good. The majority of children will regain their former state of health in a comparatively short time, if managed properly. Rehabilitation is slower in those children managed without regard to the psychological nature of their illness. One of our patients unsuccessfully treated for three years required approximately two years of intensive therapy, while another, whose condition was accurately diagnosed at the onset required only two weeks hospitalization before she was ready to go home.

In general, the more dramatic the onset, the easier it is to define the precipitating situation. The task is then less difficult, for it enables the understanding physician to proceed with confidence and assurance.

The hysterical reaction which is slow and insidious in its onset is more difficult to deal with for the basic disturbance is often buried deep within the psychic structures of the personality and is better organized. Likewise, the secondary gains which the child has derived from his illness are relinquished with greater struggle. One of our patients--a boy age nine--ill for four months and confined in three hospitals prior to admission here, required a prolonged period of treatment before he suddenly and dramatically recovered. Another patient--a 13 year old girl who had been treated in her own home for four months, proved more difficult in management than would have been expected had she been adequately handled early in her illness.

Occasionally patients with attendant disturbances in affect or mood are encountered. If the patient exhibits depressive or anxiety features during the process of treatment, the prognosis must be more guarded.

Though the hysterical symptoms clear spontaneously under proper guidance and therapy, the outlook for the patient's future mental health is not always too promising. The prognosis in a patient who has suffered severe and persistent symptoms is less favorable. Often such patients are unable to enter easily or wholeheartedly into a psychotherapeutic relationship, offering many subtle resistances to one's best efforts. When this occurs, the ultimate outlook becomes even more uncertain. A bad family history needs full consideration in evaluating the ultimate course of the patient's mental health as does any

tendency to be seclusive, asocial, or overconscientious. Repeated hysterical reactions are also discouraging signs.

In general, however, the child suffering from an attack of acute conversion hysteria who responds easily and favorably offers a good immediate recovery and subsequent satisfactory development. It is not necessarily true that "once hysterical, always hysterical."

PSYCHOPATHOLOGY

Many theories have been advanced to explain the nature of hysteria. The one point on which all authorities agree is that it is primarily psychogenic in origin. Charcot emphasized the constitutional factors, believing it to be an inherited, degenerative condition. He also pointed out the important part played by imitation. The significance of suggestion was emphasized by Babinski and Bernheim. Dejerine called attention to strong and acute emotional upheavals prone to accompany the hysterical reaction. He and Janet recognized the process of disassociation and the symbolic nature of the symptoms. Janet also pointed out the immediate advantages derived by the patient from illness. Freud and the adherents of the analytical school still maintain that the basis of hysteria is related to forgotten or repressed conflicts emanating from sexual trauma. Freud stressed the role of substitution which is often important in hysteria. White[7] regards substitution as being "the cause of the most obvious symptoms in hysteria." He further states, "It is substitution but the substitute is a part of the individual's own body. This form of substitution is technically known as conversion and means that the mental difficulty has been converted by this mechanism into a physical difficulty." While none of these theories has explained the total process of the hysterical mechanisms, all have helped to clarify it.

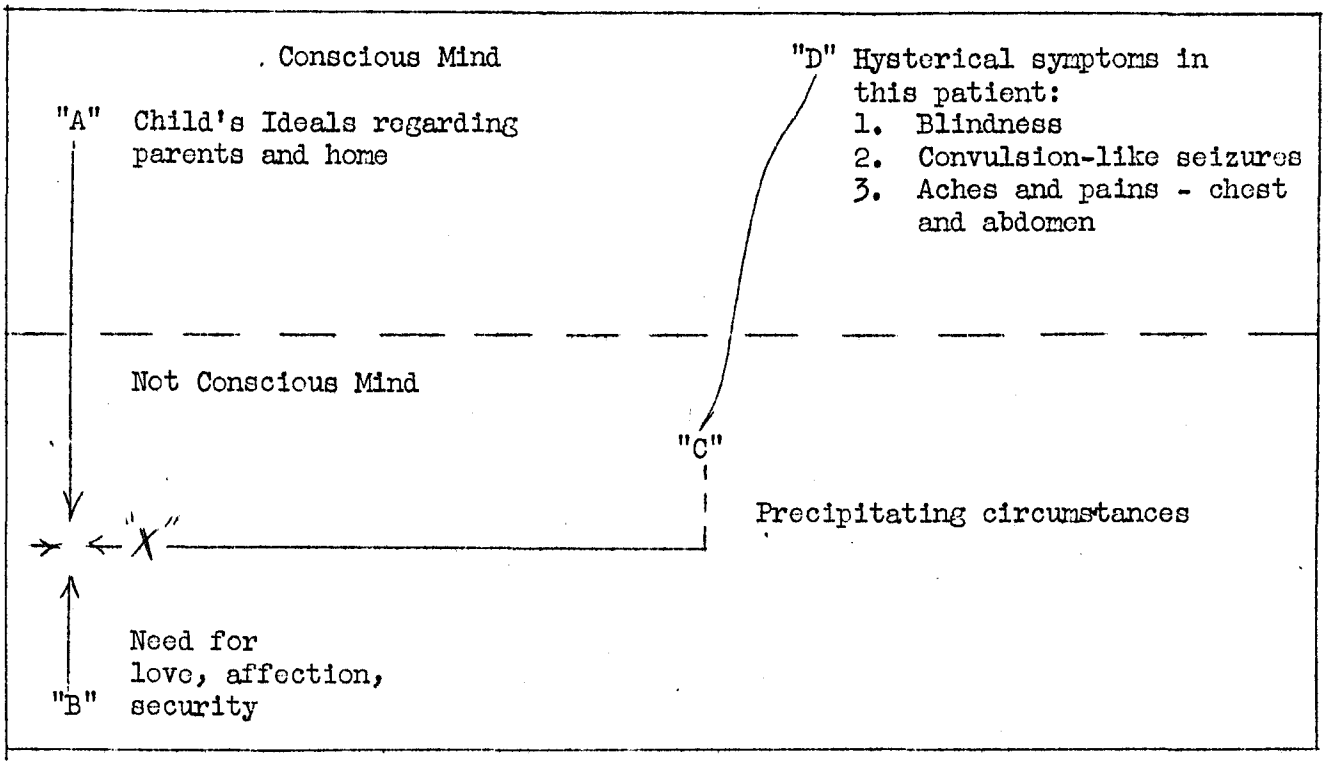
Hysteria is essentially more than a symptom or constellation of symptoms. It is a specific reaction to difficulties accruing from the everyday adjustments required of the individual as he attempts to find satisfactions in daily living. The appearance of the hysterical symptom or symptoms is solely dependent upon the individual's emotional reactions to his own life situation. In this sense, hysteria is one pattern which the individual may adopt to solve his mental conflicts which may or may not be conscious. The reaction may occur more readily in those individuals so predisposed--it may involve imitation, suggestion, repression, or any of the other various mechanisms offered in the theories suggested above. Whatever the specific mechanism, when the conflict is resolved, the individual is relieved and content. Thus his illness has meaning for him and assumes symbolic significance.

Strecker[8] has suggested that (1) the basis of the hysterical reaction is in unresolved emotional conflicts which have been converted into clear-cut somatic symptoms, easily discoverable upon objective examination; (2) the hysterical symptoms are always protective in nature; (3) they represent an escape from a situation which is intolerable to the individual; and (4) various factors such as predisposition, fatigue, and emotional trauma may act in a precipitating role.

The diagram, (modified from Strecker[7]) is presented to illustrate the probable mechanism in one of our patients.

— — —

For years the patient had lived in a home situation which, according to all available reliable information, was a very inadequate one. Parental discord, a severely maladjusted mother who took peculiar delight in severely punishing her children, particularly our patient, contributed to the marked instability in the home situation. The family consisted of a stepfather, mother, (at least three times married) and five children living--our patient being the oldest. Two older step-siblings by a former marriage had been removed from the mother's custody years before.



Our patient--sensitive, bright and responsive--had since an early age tried desperately to reconcile her own ideas and ideals of home and parents "A" with that which actually existed. Since the age of five she had felt a keen sense of rejection particularly by the mother. She, however, had never been able to accept the actual home conditions and had lived in the hope of "something changing for the better."

Thus we see the conflict "X" developing in her attempt to justify the lack of satisfaction of her fundamental needs of love, acceptance, and affection "B". Because she had so desperately wished for her mother's love and acceptance, she had for years pushed away (repressed) the thought that her mother actually didn't love her. In its place she had always thought "someday everything will work out for me." But instead of improving, her home situation became progressively worse. This past summer she realized how irreconcilable were her hopes and wishes with her life. About this time, when her conflict was at its height, a drunken man reeled toward her as they passed on a bridge, "C", (the precipitating situation). She promptly developed her hysterical symptoms "D" and was admitted to the hospital. (During her five months of hospitalization, her mother visited her only twice, early in her hospital stay, and then for three months made no inquiry about her. Just prior to foster-home placement, she received a short, matter-of-fact note from the mother to the effect--"if you write me, I'll do something nice for you.")

Acceptance, security, and particularly love are the fundamental needs of children, and are satisfied as the child aligns (or identifies) himself with an older person or persons (usually parents) who represent to him strength, stability, and security. It is out of these that he builds for himself a sense of adequacy, security, and self-reliance. When these needs are not gratified, conflict arises which may resolve itself by "falling ill." Schilder[9] has said "the hysterical person is one who needs love." We think this is particularly true of children.

TREATMENT

The success of the treatment of hysteria in children depends upon a number of factors. (1) First and foremost is the orientation of the physician. To be successful, he must not only accept the psychological nature of the disorder, but must have an understanding of the fundamental etiological factors and mechanisms. Without this, he ignores the true nature of the illness and may create further dangers and hazards by reinforcing the fundamental problem as he attempts to treat the presenting symptoms.

One of the fundamental aims in therapy is the removal of symptoms. However, it is more important to assist the patient to understand the nature and meaning of his symptoms than to attack the symptoms directly. One psychologically oriented will not make the mistake of using prizes, deception, or such cruel methods of treatment as punishing or ignoring the patient suffering from hysteria. Nor should the child be accused of malingering.

(2) Likewise, any unnecessary physical treatment should be avoided. Electrical treatment, massage, and physiotherapy generally should be discouraged, except when a real need exists. However, actual physical needs should not be neglected. Malnutrition, if present, should be dealt with. Any real physical disability should be treated as in every ill child.

(3) We believe the child should be removed early from his home and placed either in a hospital or in a suitable boarding home. Such a plan reduces the opportunities for unwholesome attitudes and feeling states to become fixed. Likewise the friendly but objective attitude of understanding foster home parents, nurses, and house staff makes more possible the wholesome handling of the child without further reinforcing him in his illness. The physician dealing with the child or family should be self-confident and reassuring. His confidence and security are of great importance. Some have objected to removal of the child from the home. However, we are of the opinion that temporary removal is to be preferred.

(4) The only rational approach to hysteria itself follows ordinary psychiatric principles. The child should be included in this process, and the type of approach to the problem will vary with his age. If he is under ten years, play therapy is often helpful. In children older than ten, principles of psycho-therapy ordinarily employed with adults are often fruitful. Repeated friendly discussions with the child of his feelings about himself and others, of his dreams, and of his own reactions to everyday experiences, will often provide sufficient release from emotional tension to permit the gradual dissipation of the symptoms. Out of these friendly talks, he develops insight and understanding, with the result that presenting symptoms disappear. This may be gradual, or it may be sudden and dramatic.

(5) Treatment of the family, particularly the mother, should go hand-in-hand with treatment of the child. As soon as the diagnosis is made, the physician should give strong reassurance that recovery will take place. It is well to be candid, pointing out that the underlying difficulty is an emotional disturbance and that the main aim of treatment will be to get at its source. Oftentimes this is enough to enable the parents to understand what has happened, and will elicit pertinent material helpful in further understanding the problem.

If, after an appraisal of the total situation, it is learned that the environmental factors in the home offer little or no promise of modification, permanent removal from the home is the procedure of choice. It should be decided only after thorough investigations have been made. Permanent foster home placement is best planned with the view to continuing contacts with the child for some period of time after placement. This is done to assure continued support and encouragement, which the patient may need early in placement.

In dealing with hysteria, it is well to remember that we are treating individuals rather than organs; that their

symptoms are essentially protective in nature; that they are purposeful; and that once understanding is developed, they will gradually disappear. In general, our approach should be a broad, all-inclusive one, directed toward the development of insight in the patient and in those who have an active part in molding him and his reaction patterns.

SUMMARY

1. Attention has been called to the fact that conversion hysteria continues to exist as a medical problem in children.

2. Findings on 15 patients varying in age from nine to fifteen years treated at the University Hospitals have been presented.

3. Psychopathology, course and prognosis, diagnosis and principles of treatment have been briefly discussed.

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III. GOSSIP

Welcome snow has again made Minnesota look homelike. Temperature is down to normal for this section of the country....The course in Otolaryngology drew 48 specialists in this field. They have been having a good time down at the Curtis Hotel where the sessions are held. Everyone is anxious to move back to the Center and start the ball rolling. Larry Boies, Director of the Division of Otolaryngology has done an outstanding job in putting over this course but Larry never fails to do any job well. The enthusiasm of his associates and the prominent position he is assuming in national affairs speak well for the future of this division. The new director of the Division of Ophthalmology, Erling W. Hansen, who replaces Frank E. Burch (resigned) is another popular leader with his associates and in the national scene. Erling is already laying his plans for next year's course in Ophthalmology...In Galesburg today to speak to Teachers Institute of Knox County, on Recent Advances in Medicine and School Health Examinations. The high school's orchestras and Glee Clubs are already using "Oh What a Beautiful Morning." The other speakers on the program include the usual array of newspaper correspondents, authors, travelers, lecturers, and radio personalities. Illinois still has the county plan of teachers' institutes, which suits its more populous districts.. ..Over the weekend to the old home town, Fairbury, Illinois and then to Chicago for the midwinter meetings, in hospital affairs, medical education and other fields...The teachers of Minneapolis have decided to make practical applications of health knowledge by submitting to periodic health examinations. Service examinations given to women who have entered the various governmental branches indicate the possibility of detecting occult disease through standard procedures. Original examinations did not include pelvic investigations. These are now routine in the services, and have uncovered many defects....A student brought me an essay by Robert Benchley on the Romance of Digestion. One paragraph which describes a cookie on the way to the stomach appeals to me as good Benchley: "And then, such a hurry and bustle as goes on in the mouth! "Foodie's going to visit Stomach!" all the little teeth cry, and rush about for all the world as if they were going themselves. "All aboard, all aboard!" calls out the tongue, and there is a great ringing of bells and blowing of whistles and bumping of porters and in the midst of it all, the remnants of that delicious cookie seated nervously on the tongue, ready to be taken down on its first journey alone, down to see Prince Charming. For all the joyousness of the occasion, it is a little sad, too. For that bit of cookie is going to get some terribly tough treatment before it is through."....This item came in response to my story by Dr. Rockwell who told of his device for calling out special digestive juices. A contraption is placed around the jaw and the bell rings when the morsel has been chewed 100 times. A little bit trickles on ahead to tell the stomach which juice to get ready. He was chewing popcorn one day, but the device failed to work, and he chewed many extra times. The stomach thought popcorn was coming, but when it arrived it was so finely powdered it passed on unrecognized to the blood and it came out on the man's head as dandruff....Freshman medical students still continue to amaze me with their knowledge of clinical medicine. Each week the new class meets to observe methods employed in clinical diagnosis. We ask the students to observe the outstanding features displayed by the patient and then to give possible suggestions as to the cause. I have never yet seen the class fail to make the proper suggestions. Someone always knows the answer, and it is not the same person in each instance. A patient with Addison's disease was shown a few weeks ago. Seven students knew it was Addison's disease because they had seen previous examples. A few years ago one of our patients had difficulty in obtaining a diagnosis of Addison's disease. After spending the winter in Arizona, her skin became deeply pigmented. She went out one day to do a little fishing. A woman angler near by watched her for some time. Finally the inquisitive woman pulled anchor and rowed over. She took a good look at our patient and asked her if she knew what she had. She said "No." "You have Addison's disease," and she rowed back to her fishing.