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# CASE REPORTS

## THE BOY TO WHOM THINGS HAPPEN: CASE REPORT OF A CONDITION ONCE NAMED "HYSTERIA"

## O RAPAZ A QUEM ACONTECEM COISAS: CASO CLÍNICO DE UMA CONDIÇÃO OUTRORA DESIGNADA "HISTERIA"

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### ABSTRACT

**Introduction:** Although banished from current mental disorders classifications, the condition formerly known as hysteria has clinical manifestations still puzzling to clinicians. Herein is briefly revised the historical concept of hysteria, as well as, psychological mechanisms underlying some of its current derivatives: conversive and dissociative disorders.

**Case report:** A previously healthy 17-year-old boy presented with sudden onset of total strength loss in the lower limbs. After neurological assessment, the boy was diagnosed with conversion disorder. Two months later he developed trance and possession states requiring hospitalization, and later, dissociative amnesia. Despite psychological distress underlying patient's symptoms, la belle indifference was also a meaningful issue.

**Discussion:** This study presents a critical reflection about conversion and dissociative disorders and diagnostic challenges arising from their inconsistent and variable clinical features.

**Conclusion:** With this case report, the authors intend to raise awareness to the risk of recurring care demand for care that can elicit iatrogenic harm and delayed proper treatment.

**Keywords:** adolescent; child; conversion disorder; dissociative amnesia; dissociative disorders; hysteria

### RESUMO

**Introdução:** Embora banida das atuais classificações de doenças mentais, a condição anteriormente conhecida como histeria apresenta manifestações clínicas que continuam a intrigar os clínicos. Neste artigo, é feita uma breve revisão sobre o conceito de histeria, bem como mecanismos psicológicos subjacentes e atuais derivados: perturbações conversivas e dissociativas.

**Caso Clínico:** É descrito o caso de um adolescente de 17 anos de idade, previamente saudável, com um quadro clínico de início súbito de perda total de força nos membros inferiores. Após avaliação por neuropediatria, foi diagnosticada Perturbação de Conversão. Dois meses depois, o adolescente desenvolveu estados de transe e possessão, com necessidade de internamento. Mais tarde, evidenciou amnésia dissociativa. Apesar do sofrimento psicológico subjacente aos sintomas, la belle indifference foi também um aspeto significativo.

**Discussão:** Neste artigo, é apresentada uma reflexão crítica sobre as referidas condições clínicas e dificuldades diagnósticas que podem surgir face à inconsistência e variabilidade das manifestações clínicas que lhes estão associadas.

**Conclusão:** Através deste caso clínico, os autores pretendem alertar para o risco de uma demanda recorrente de cuidados que pode culminar em dano iatrogénico e atraso no tratamento adequado.

**Palavras chave:** adolescente; amnesia dissociativa; criança; histeria; perturbação conversiva; perturbações dissociativas

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## INTRODUCTION

Hysteria, named after the Greek word *hysterikos*, has been described as a clinical condition, for at least four thousand years and was referred to as a medical condition typical of women (disorders in the womb).[1] The first descriptions of hysterical conditions came from the ancient Egyptian medicine. The Egyptians attributed hysterical manifestations to the "upward dislocation of the uterus". The Greeks had a similar hysteria conception to the Egyptians, attributing to the womb the character of a sick animal whose sterility would cause migration through the body and cause all kinds of diseases. It was taken as an exclusively female disorder and sexual satisfaction was the recommended therapy of hysterical women.[1]

The neurologist Jean-Martin Charcot (1825-1893) was the first to describe the occurrence of hysteria in males. His detailed description of the five phases of the great hysterical crisis would become a classic. For Charcot, hysteria phenomena were the result of hereditary determinations, to which other acquired ones were added.[1] Sigmund Freud (1856-1939), a Charcot trainee, assumed that hysterical symptoms had a psychiatric determination that would not be in the patient's consciousness but in a second consciousness – the unconscious.[2] He postulated the existence of a force (repression) that repressed the contents (memories) due to painful or intolerable affection they arouse, thus keeping them dissociated from consciousness. Finally, he concluded that these strongly repressed contents had a sexual origin and that suppressed sexual contents belonging to childhood would be, at the root of all neurotic symptoms. Hysteria manifestations are symbolically related to these contents. Freud also used the term "conversion" for the first time, referring to the derivation of the psychological plan to the somatic field.

Apart from a strictly Freudian conceptualization, hysteria was a clinical condition often diagnosed in the clinical practice for most of the XX century. However, difficulty in defining a syndrome with such variable clinical manifestations (potentially including a wide range of symptoms, as: somatic, psychological manifestations, and personality traits) and the stigma associated to the word hysteria, led to its replacement on the Diagnostic and Statistical Manual of Mental Disorders (DSM) III (published in 1980) and in succeeding mental disorder classifications in several categories, mainly Conversion Disorder and Dissociative Disorder. Conversion Disorders often identify a psychological conflict preceding the onset of inconsistent physical symptoms. Referring to children's sexual experiences, is not the experience itself that is traumatic, but the memory that emerges afterwards. To suppress a distressing conflict, emotion, or event, it has been postulated that the mind translates or "converts" it into a physical expression. Thereby, at the root of hysteria symptoms would be libidinal or aggressive content, repressive powers, and conflict resolution through symptoms that have a symbolic relationship to repressed contents. Dissociative Disorders are characterized by a disruption or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control and behavior. Dissociative symptoms can potentially disrupt every psychological functioning area. These are experienced as unbidden intrusions into awareness and behavior, with accompanying loss of continuity in subjective experience (i.e., "positive" dissociative symptoms, such as identity fragmentation, depersonalization, and derealization) and/or inability to access information or to control mental functions that are normally readily amenable to access or control (i.e., "negative" dissociative symptoms, such as amnesia). Dissociative Disorders are frequently found in the aftermath of trauma, and many symptoms, including embarrassment and confusion about symptoms or a desire to hide them, are influenced by trauma proximity. On DSM-5, Dissociative Disorders are placed next to, but not part of Trauma and Stress-Related Disorders, reflecting the close relationship between these diagnostic classes.[3]

Some of these patients show an impressive calmness and relatively lack of concern towards their symptoms, despite acute presentation or associated functional disabilities.[4] Family and even the medical team usually display more concern and anxiety about patient´s physical symptoms than himself. This astonishing feature has been named *la belle indiference* and, although regarded as a typical symptom of conversion disorder/hysteria, is not specific to this condition.[4]

## CASE REPORT

A high-functioning 17-year-old male, with no prior psychiatric or other relevant medical history and zealously fulfilling all family and social expectations ("exemplary boy"), suddenly presented to the Pediatric Emergency Department with total loss of strength in the lower limbs and swallowing difficulty. Symptoms had started the week before and the boy had been assessed by a neurosurgeon on day 3 of complaints. Cranial computed tomography (CT) was normal, as was analytical study. On day 4 of complaints, he was evaluated by a psychiatrist, and medicated with olanzapine, amisulpride, mirtazapine and diazepam in SOS, without improvement. He missed school classes for the entire week due to "paralysis" of the lower limbs that made him feel very weak and unable to go. At the Pediatric Emergency Department, the boy was assessed by a pediatric neurologist, who performed a complete neurological examination and ruled out organic pathological. He was subsequently assessed by a Child and Adolescent Psychiatrist and a Conversion Disorder (Functional Neurological Symptom Disorder) was diagnosed, in accordance with the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5 TM). The current medication was discontinued, placebo was prescribed, and the patient was referred to crisis intervention at the Child and Adolescent Psychiatry Department. At first consultation, 11 days later, he displayed clear symptomatic improvement, had restarted attending school and had regained strength in the lower

limbs despite feeling very tired and poorly concentrated. According to him, it was very difficult to make decisions because "the mind wanted to go to one side and the body to the other". During the following two months, the boy was stable, with only sporadic crisis, and had started weaning of placebo. After that, crisis went from conversive to predominantly dissociative, rapidly progressing to trance and possession states, with exuberant psychomotor manifestations expressing aggressive (self and heteroaggressive) contents. These episodes kept the boy again out of school for fifteen days, for being afraid of putting himself or others in danger. In this context, he was started on a low dose of an antipsychotic drug. One week later, due to growing family and school alarm, he was admitted to Children and Adolescent Psychiatry Inpatient Unit to interrupt the cycle of pathological interactions and unblock the therapeutic process. During hospitalization, the boy completed psychological assessment, which identified great desirability and a pattern of personality in line of passivity and dependence, with excessive conformation to rules and authority, and necessity to respond to the needs and desires of others. He presented a hysterical narcissistic record with predominance of neurotic defence mechanisms and evident repression of sexual and aggressive drives, unacceptable to his self-conscious. Major difficulties in adolescence tasks were mainly highlighted by separation/individuation, with great difficulty in relations with parental images and some identity issues. By promoting a physical separation between the boy and his environment, hospitalization enabled addressing these issues. Additionally, he also started Psychodrama sessions. During hospitalization, traumatic memories about a sexual experience occurring during childhood slowly emerged and the boy was able to talk about it. He learned and developed coping strategies to deal with his “attacks” (as he called them), including earlier episode identification, slow-breathing exercises, relaxation techniques and also grounding exercises (as described by Kasia Kozlowska), experiencing very good symptomatic improvement.5 Family beliefs were also approached. Due to the boy´s exuberant and “mysterious” symptoms, the family resisted in accepting the Conversion/Dissociative Disorder diagnosis and even admitted performing exorcism on the teenager. A close liaison school was made to reduce school-related stress and deal with conflicting expectations between the adolescent, family and teachers. The boy was discharged without pharmacological therapy, resuming school attendance and other daily activities. A serious dissociative episode was reported approximately fifteen days later when the adolescent felt “invaded” by an intolerable sexual drive followed by selective amnesia and by total oblivion of people related to the event. Despite this worrying amnesia, he described it to the medical team with total indifference. Cognitive distortions arising from the distressing event were slowly worked on and the boy gradually started remembering things. During the following months, he maintained follow-up in consultation, attended Psychodrama sessions and, progressively, was able to better address his negative emotions, namely aggression, and be assertive. He is currently of legal age, remains asymptomatic and completely functional, and acknowledged the need to address remaining emotional issues, having been referred to Psychology consultation.

## DISCUSSION

Conversion disorder prevalence worldwide is unknown.[6] However, a national surveillance study of Australian children seen by pediatric specialists with diagnosis of conversion disorder indicates that it is rare condition, present in 0,2% to 2% of children in child psychiatry out-patient clinics and in 0,78% of inpatients for Somatoform Disorders with 57,3% of conversion disorders.[7]

According to Lasègue (1816-1883) “hysteria has never been defined, and never will be”. This sentence remains true for conversive/dissociative disorders, which have supplanted hysteria.[8] DSM-5 and ICD-10 classifications differ in the description of Conversive Disorders.[3,9] Kozlowska has put forward one of the most interesting proposals. According to her, conversive symptoms during childhood or adolescence could be a sensory-motor component of two different ethological organizations: conversion negative symptoms, seen as components of the animal “freezing response”, and conversion positive symptoms, related to a different animal behavior type called “behavioral deception” or “deceptive signalling”. The latter would be a behavior convenying “false” information to the receiver, like an exaggerated behavioral display, to attract attention and confuse predators by using false signals”.[7]

Despite the rarity of these disorders, this case report is of particular interest because the patient went through three different stages: conversion/dissociation, trance and possession and dissociative amnesia episode. Trance and possession is a disorder characterized by involuntary and transient loss of awareness associated with perfect environmental awareness.[2,10] DSM-5 classifies all these conditions as dissociative identity disorders, commonly known as multiple personalities, consisting of presence of two or more distinct personality states or an experience of possession and recurrent amnesia episodes. In this state, changes are described in the tone of voice, facial expression, aggressive/sexual content verbalization, and psychomotor manifestations (tremors, stereotyped movements), associated or not with auto or heteroagressivity and often followed by full or partial amnesia.[3,11] Dissociative amnesia is the inability to remember important personal information, usually traumatic or stressful; the learning ability remains intact, as does cognitive function. Accurate dissociative amnesia assessment can be hampered by several factors, including subject’s lack of awareness or tendency to hide, deny, adjust to, or compensate for it.[12]

These inconsistent and variable clinical manifestations make diagnostic challenging. Usually, it is not easy to differentiate between conversion/dissociative disorders and neurological or other organic conditions. Absence of neurological or other organic diseases was required to establish diagnosis in the present clinical case, but

conversive/dissociative disorder should not be diagnosed just because abnormal findings are missing or symptom is "bizarre".[3] It should be highlighted that a functional diagnosis is a positive diagnosis, as it is based on positive signs or clinical criteria, and not merely a diagnosis of exclusion, which is characterized by psychological issues that are important to identify and treat. Additionally, although absence of abnormal findings on medical examination may induce symptom falsification, conversive/dissociative disorders are very different from factitious disorders, in which the individual, intentionally, presents himself to others as ill, impaired, or injured.

Suggestibility is a common feature in these patients, and explains clinical improvement after placebo prescription. Besides lack of a sustained effect, the use of placebo raises important ethical issues and should be avoided in the clinical practice. In this clinical case, placebo was chosen as a strategy of least possible damage, as the patient presented in the Pediatric Emergency Department with "disabling symptoms unresponsive to four different drugs" and was not predictable that he would be reassured if discharged without medication.

Throughout his clinical course, and in contrast to the drama surrounding clinical manifestations, the adolescent always displayed a friendly contact, quietly and comprehensively reporting his symptoms with total affective distance from them. A systematic review reported median frequency of *la belle indifference* of 21%, in 356 patients with conversion symptoms, and 29% in 157 patients with organic disease.4 Although not universal or pathognomonic, *la belle indifference* was a meaningful issue in this case report, with the adolescent presenting himself not as an active subject, but as "a character in a plot written by someone else": the boy to whom things happen.

## CONCLUSION

Use of health services is high in children and adolescents presenting with conversion symptoms. Although Conversion Disorder is not common in children, it places a substantial burden on consultation time and diagnostic resources and can represent a significant burden for families, physicians, and medical system.[13] With this case report, the authors intend to raise awareness to the risk of a recurring demand for care that can produce iatrogenic harm and delay proper treatment. Furthermore, it should acknowledge that this clinical condition can be aggravated by providing the patient with secondary gain and worsening prognosis.

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