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The Hypnotic Diagnostic Interview for Hysterical Disorders, Pediatric Form

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Abstract

This article reports on the use of hypnosis to facilitate the diagnostic process in two cases of pediatric hysterical reactions. The Hypnotic Diagnostic Interview for Hysterical Disorders (HDIHD), an interview tool, specifically designed for these cases, is reported. The first case was an adolescent male with motor Conversion Disorder manifested as paralysis of his lower limbs. The second was a preadolescent girl with sensory Conversion Disorder manifested as reduction of visual field in her right eye. Freudian conceptualization of hysterical reactions was employed as the conceptual basis in the formulation of these cases. This orientation posits hysterical phenomena a psychological defense employed by individuals exposed to traumatic experiences in order to effectuate a defense from intolerable affective material. The emotionally overwhelming material converts into physical reactivity free of the traumatic consequences by keeping the intolerable images and emotions deeply repressed within the subconscious. As the focus on these cases was diagnostic, treatment efforts were avoided. As it turned out, environmental interventions, based on the obtained information from the hypnotic interviews, extinguished the symptoms. The children were symptom free at follow-up.

Keywords: Hysterical disorders, Hypnotic Diagnostic Interview for Hysterical Disorders (HDIHD), conversion motor type, conversion sensory type

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The diagnosis of Conversion Disorder requires a thorough medical work up accompanied, at times, by extensive tests. The research indicates that despite improvements in medical assessment procedures resulting in a historical gradual decline in the incidence of misdiagnoses, Conversion Disorder continues to be a misdiagnosis in 4% of cases. Eventually these cases are found to have organic reasons for the ostensible symptoms of conversion (Stone et al., 2005). The basic premise of this article is that the efficacy of the diagnostic process can be maximized with the inclusion of a psychological hypnotic interview. Since hypnosis has been found useful in the treatment phase of this disorder and since patients with Conversion Disorder have been described to be amongst the highly hypnotizable, it stands to reason that hypnosis may be applicable in the diagnostic stage (Roelofs, et al. 2002). This article advocates this premise and contributes a model (HDIHD) for a hypnotic diagnostic interview for hysterical disorders. The HDIHD, pediatric form, is included in the Appendix.

Conceptualization of Hysteria

Conversion reactions have been recognized since the term *hysteria,* based on the Egyptian theory of the wandering uterus, was created by Hippocrates, (Veit, 1965). Conversion Disorder is thereby historically and conceptually linked to hysteria. Janet and Freud are associated with developing the first modern psychological concepts of hysteria. Toward the end of the 19th century, Pierre Janet conceptualized hysteria as a dissociative disorder and described somatoform symptoms as aspects of this condition (1907). Similarities notwithstanding, marked theoretical and practical differences arose between them. Janet linked conscious and subconscious ideas with psychological symptoms under the rubric of dissociation theory. Freud initially pursued the same course, but branched off early via the premise of inaccessibility due to repression and the dynamics of the unconscious. Breuer and Freud (1955) argued that hysteria was the product of an elaborate mental process employed by traumatized individuals to protect themselves against overwhelming affects. This process was termed dissociation and it involved managing intolerable affects, the result of traumatic experiences, by means of a method through which they become transformed, or *converted*, into physical symptoms, allowing them to be expressed without the associated traumatic material becoming conscious. Current adaptations and further articulation of this model have expanded the scope of precipitating circumstances to encompass immediate social and environmental trauma of significant intensity and intolerability which require a massive repression of the traumatic images and affect. This expansion was commenced by Freud (1966) who, after revamping the earlier sexual-based model, incorporated Janet's thesis and developed his posttraumatic ideational model to cover all hysterical symptoms.

The Freudian conceptualization of hysteria along with conversion symptoms as the result of a defense against intolerable affect was the model employed in the formulation of the two pediatric cases presented in his article.

Classification of Hysterical Disorders

Formerly considered a Dissociative Disorder, Conversion Disorder is classified in the current edition, DSM-IV-TR (American Psychiatric Association, 2000) as a Somatoform Disorder. The common feature of the Somatoform Disorders is the presence of physical symptoms that presage a medical condition but are not fully explained by the medical condition that seemingly is present. The symptoms of hysteria can affect basic aspects of elementary neurological functions including involuntary movements or paralysis, pseudo-epileptic seizures, mutism, urinary retention, hallucinations, pain, reduced field of vision, deafness,

and analgesia. This article reports on the use of hypnosis for the diagnosis of two cases of pediatric conversion: a case of motor conversion paralysis and a case of sensory conversion reduced field of vision.

Sensory Conversion: Visual Type

Accounts of visual conversion are not preponderant and earlier reports of these cases have a historical association with wartime military personnel. Griffiths and Ellis (2007) reviewed this military literature and concluded that patients with eye symptoms in the absence of organic illness may represent an unconscious or symbolic flight from reality or conflict. Moreover, these authors investigated the case of a harbor pilot who suffered a rapid onset of visual impairment diagnosed as hysterical blindness. This was a most unique case as the patient was devoid of a psychiatric past. Bain, Beatty and Lloyd (2000) reported on a study of non-organic visual loss with 30 children (18 girls, 12 boys). Results from their study showed that non-organic visual loss is relatively common in pre-pubertal children and that this condition can be safely diagnosed using standard clinical tests in the majority of cases. They stressed careful explanation and reassurance to both the child and parents as the mainstay of management.

Motor Conversion: Paralysis Type

The correct diagnosis of conversion disorder presenting with motor symptoms is complicated by the lack of gold-standard diagnostic tests and the absence of a universally accepted set of positive diagnostic criteria (Hurwitz, 2004). Krem, (2004) reviewed the epidemiology, pathophysiology, presentation, differential diagnosis, treatment, and prognosis of motor conversion, placing emphasis on diagnostic validity, reliability, and utility, while evaluating the empirical evidence supporting diagnostic and treatment strategies. The difficult nature of the diagnosis of motor conversion was also appreciated by Atan, Seckin and Bodur (2007). These authors conceptualized hysterical paralysis as an uncommon type of conversion disorder that can be difficult to diagnose. Their conclusion was that in cases in which symptoms are difficult to explain neuroanatomically or are functionally inconsistent, hysteria should enter into the differential diagnosis.

Hypnosis and Diagnosis of Conversion Disorders

Published accounts of the application of hypnosis in the diagnostic phase of conversion disorder are limited. Crasilneck and Hall (1985) reported on the utility of hypnosis for differential diagnosis in functional and organic conditions. They posited that hypnosis can aid in distinguishing between these types of disability. The use of hypnosis to corroborate a working diagnosis of hysterical or psychogenic dermatitis was employed by Iglesias (2005). An approach including direct suggestion under hypnosis (DSUH) proved inadequate and could have led to a premature opinion that the dermatitis was of organic origin. It is significant to note that further interventions with hypnoanalytic questioning revealed repressed conflicts in these cases and corroborated a functional, psychogenic or hysterical component.

The use of hypnosis in the diagnostic process of medical conditions was exemplified by Ambar and Hehir (2000) in a pediatric pulmonology case. This was a case of an 11-year-old boy, wherein hypnotic suggestion was used as an alternative method to achieve a diagnosis of VCD (Anbar & Hehir, 2000). Vocal Cord Dysfunction (VCD) is a condition of paradoxical adduction of the vocal cords during the inspiratory phase of the respiratory cycle. In a study that investigated the applicability of hypnosis in the diagnostic process of

Dissociative Disorder, Frischholz, Lipman, Braun, and Sachs (1992) reached the conclusion that routine hypnotizability assessment may be a useful method in the differential diagnosis of patients with Dissociative Disorders.

The Hypnotic Diagnostic Interview for Hysterical Disorders (HDIHD)

The (HDIHD) interview method draws from the model for idiodynamic signals of Ewin (2002) and Cheek's (1962, 1975, 1976, & 1989) ideomotor methods for analysis and questioning. It also was influenced by Hammond (1998a & 1998b) who incorporated ideas from Cheek & LeCron (1968) and Barnett (1981) towards the development of his handout "Ideomotor Exploration: The Seven Keys." An additional source that the (HDIHD) was modeled after was the "how- to" manual by Ewin and Eimer (2006), an instructive manual in the use of ideomotor techniques.

Clinical Case 1

Background

This was a 17 year old Hispanic male that was held in detention at a South Florida juvenile detention center. He was amongst the more vocal and intimidating individuals in the center and had a reputation for resorting to violence rapidly. This young man came to the attention of the medical staff of the juvenile detention center when he failed to respond to the general order to return to the units at the conclusion of A.M. outdoor period. When approached by the staff he indicated that he was unable to move his lower limbs. His demeanor was calmed and without any fears associated with the inability to move his legs and presented with *la belle indifference*. After an exhaustive medical examination with negative findings, the physician on call requested a psychological consult.

Examination

The examination of this patient demonstrated an individual that had a well-established untenable position of recalcitrance, unyielding oppositionality and a presence of "machismo" that projected a lack of fear and indifference about consequences. He had a history of alcohol and illicit drug abuse and had become sexually active at the age of 13. The family history was unavailable as he was placed for adoption at birth and there were no family medical records. The medical records indicated that he had been diagnosed with Conduct Disorder and Bipolar Disorder and was on Lamictal and Risperdal. Upon examination, he was not psychotic or hypomanic, and his thinking was clear. He was not delusional and was not anxious, appeared calm, and was devoid of depressive symptoms. He was not worried about his legs 'not working' and presented *la belle indifference*. The interview indicated awareness on the part of the patient of a scheduled imminent transfer to a unit reserved for the most violent and incorrigible adolescents. He denied any worries about this transfer. Not by coincidence, however, he developed the paralysis on his lower limbs prior to the transfer.

He appeared to meet all the criteria for Conversion Disorder (American Psychiatric Association, 2000) in that symptoms: 1) suggested a neurological condition; 2) were preceded by psychological factors such as personal stressors or conflict; 3) were not intentionally presented; 4) could not be explained with appropriate investigations indicating a medical cause, effects of substances, or culturally sanctioned behavior; 5) were severe or enduring to the extent that clinical investigation was warranted; 6) were not linked to pain or sexual dysfunction; and 7) could not be explained by any other medical diagnosis.

Hypnotic Interview

The hypnotic interview with the HDIHD provided evidence towards a differential diagnosis of conversion disorder motor type. The fact that the adolescent was able to move his lower limbs under hypnosis upon suggestion proved to be additional evidence that corroborated the diagnosis of hysterical process. Moreover, the interview with the HDIHD contributed essential information for the development of a formulation. The hypnotic interview gleaned evidence that the adolescent was indeed significantly frightened to be transferred to a unit known for its history of violence and aggression. The HDIHD provided supportive evidence that the patient was unable to address this fear at the conscious level. Post hypnotic amnesia for the findings was suggested.

Formulation

Despite the façade of bravado and machismo this adolescent was deemed to be frightened about the imminent transfer of unit. Data obtained from the administration of the HDIHD corroborated the fact that a) he was frightened, b) these emotions were unacceptable and maladaptive within his culture of violence and bravado, and c) the conflict was accordingly repressed. Finally, d) the conversion paralysis was understood as a face saving alternative to the alarming situation.

Intervention

Although the consult was limited to diagnostic purposes, the administrator of the center requested suggestions on how to proceed. A recommendation was made to the on-call physician to announce to the adolescent that he was going to be transported to the hospital for additional tests. At the same time the center administrator was advised to announce through the public address system that the unit in question was full and that all transfers would need to be redirected to other units. Two hours later there was spontaneous remission and the adolescent was up and moving and regained total function of the lower limbs. He was symptom free at follow up two weeks later.

Clinical Case 2

Background

This was an 11 year old girl that was seen by the senior author for a psychological consult upon referral from a pediatric ophthalmologist. She lived with the biological parents who were experiencing marital discord due to the husband's alcoholism. The parents were in marital therapy with another practitioner. The child was brought in after several visits to a pediatric ophthalmologist who examined her for loss of vision in the peripheral region of her right eye. The school counselor advised the parents of this problem after a teacher noticed and reported the matter. The child was not especially concerned and had not told anyone. The medical examination was negative and the physician diagnosed the problem as R/O Circumscribed Hysterical Blindness and ordered a psychological consult.

Examination

This was a preadolescent girl who appeared timid and submissive and who was reluctant to answer questions about her life and her family. The family history was unremarkable for psychiatric disorders. There was a family history of alcoholism, however, for all the males on the paternal side. The patient did not show cognitive or perceptual

disorders and there was no evidence of psychotic features. She had a depressed mood and affect, but was not suicidal. She was not sexually active and did not use drugs or alcohol. The patient had no prior history of psychiatric care. She was not taking any medicines. She was unconcerned about the reduced field of vision in her right eye and could not appreciate the urgency that adults were evidencing for this phenomenon.

She appeared to meet all the criteria for conversion disorder (American Psychiatric Association, 2000) in that symptoms: 1) suggested a neurological condition; 2) were preceded by psychological factors such as personal stressors or conflict; 3) were not intentionally presented; 4) could not be explained with appropriate investigations indicating a medical cause, effects of substances, or culturally sanctioned behavior; 5) were severe or enduring to the extent that clinical investigation was warranted; 6) were not linked to pain or sexual dysfunction; and 7) could not be explained by any other medical diagnosis.

Hypnotic Interview

The hypnotic interview with the HDIHD provided evidence towards a differential diagnosis of Conversion Disorder sensory type. During hypnosis the child was able to open her eyes and her peripheral vision was not compromised. The interview indicated that the biological father, after a night of heavy drinking, would abuse the mother in the presence of this child. He would threaten the girl with physical punishment if she dared to look at what transpired during the abusive episodes; she was ordered to keep her eyes glued to the television. Post hypnotic amnesia for the findings was suggested.

Formulation

Most nights while the child watched TV, the adults carried on with their arguments and the inevitable battering of the mother. The child obeyed as she was told not to stare at what went on and to keep her eyes straight ahead on the TV. However, peripheral vision being what it is, she was still able to witness, by the peripheral vision on the right eye, the battering. Out of fear of her father but even more significantly, from her psychological inability to cope with the brutalizing beatings that her mother was sustaining, she developed hysterical circumscribed blindness as a defense.

Intervention

The focus of this consult was for diagnostic purposes only and as such, there were no attempts at treatment. Instead, as part of the diagnostic process, the parents were confronted with the findings and admitted that the episodes of fighting in view of the child were indeed true. The results from the consult were reported to the pediatric ophthalmologist who reported the findings to Child and Family Services. The follow-up medical examination with the ophthalmologist 2 weeks later demonstrated that the symptoms had remitted completely.

Conclusions

Despite significant advances in the diagnosis of conversion disorders there remain a percentage of cases that are misdiagnosed. These cases, eventually, receive an appropriate diagnosis of organic pathology. A high rate of misdiagnosis of conversion symptoms was reported in early studies but this rate has been only 4% on average in studies of this diagnosis since 1970. This decline is probably due to improvements in study quality rather than improved diagnostic accuracy (Stone, et.al, 2005). Hypnosis, as an adjunctive diagnostic tool, can play a pivotal role in the diagnostic phase of pediatric conversion disorder. As

such, the HDIHD as a tool for use in the diagnostic work-up of conversion reactions and its application in two cases of pediatric conversion was reported. The detailed nature and extensive questioning of this interview method was employed to increase the diagnostic effectiveness of the method. This article was an account of the use of hypnosis for the exclusive goal of addressing differential diagnosis in pediatric conversion cases.

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Appendix

After hypnosis is induced by the practitioner's preferred method, the following direct suggestions are given:

> You can now go to your favorite place and keep busy while taking part in (*the adolescent/child's favorite activity*). You will be so completely busy and distracted enjoying (*favorite activity*) that at times my voice will seem very far away and at other times you may not even hear it. The deep part of your mind will hear me and will be able to follow along with my questions even though you will be doing what you like so much (*activity*).

(At this point a very brief explanation of the function and role of the deep part of the mind is given.) I like to speak in terms of the ever vigilant and all knowing functions of the deep part of the mind.

You will be able to answer questions without having to interrupt your favorite game. You will use this finger to answer 'Yes' and this other finger to answer 'No' and this is the 'I don't know finger.' I am going to speak with the deep part of your mind and ask it questions about this problem that you have.

1) Is it alright with the deep part of your mind for me to ask questions regarding the problem you are having?

2) Does the deep part of your mind know if this problem is a real problem with your (*part of body or function affected by hysterical reaction*)?

3) Does the deep part of your mind know if this problem was made by your mind?

4) Does the deep part of your mind know if this problem was made to help you?

5) Is it helping you with something that was too hard for you to have to do?

6) Does this problem help you to do something you could not do on your own?

7) Does it do something important for you?

8) Does it stop you from doing something?

9) Does it protect you from something you are afraid of?

10) Does it help you not to have to do something, or keep you from doing something that you don't want to do?

11) Does it let you control or be the boss of someone or something?

12 Does it punish someone? Is it a way to discipline or get back at someone?

13) Does it help to make sure that nothing changes who or how you are?

14) Does it help you not to be embarrassed or made fun of?

15) When I count to three the problem will come to your mind and you will be able to tell me how this problem is trying to help you. You are still in hypnosis yet you can speak to me. You can tell me now how this problem is trying to help you. You can now go back to (*safe place*). I have some more questions for the deep part of your mind.

16) Does the deep part of your mind know what has to take place for this problem to be able to go away?

17) When will the deep part of your mind decide to stop this problem?

18) When I count to three the deep part of the mind can tell me what needs to happen before the problem will go away. You are still in hypnosis yet you can speak to me. You can tell me now what needs to happen before the problem will go away. You can now go back to *(safe place*). I have some more questions for the deep part of your mind. You are in hypnosis and in hypnosis you can do things that are impossible for you when you are awake. For instance you are unable to (*hysterical symptom*) yet if I asked you while in hypnosis to (*remove hysterical symptom*), it is very likely that you will be able to (*remove hysterical symptom*).

19) Will the deep part of your mind allow you to do this so that you can see that you are the boss of your life? When I count to three the deep part of the mind will allow you to (*perform the action).* You can now go back to *(safe place*). I have some suggestions for the deep part of your mind. The deep part of your mind will help you by not allowing you to remember any of the questions and your answers and the information that has been received. There is plenty of time for you to be able to remember this information when you are able to and not any sooner.