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A Study of Hysteria in Early Adolescence

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Abstract

The present study investigated 18 hysterics and 18 normal adolescents in the age group of 12 to 16 years. The hysteric group and the normal group were matched on age, sex and years of schooling. Results show that hysterics have normal intelligence and overall adjustment whereas, normals have significantly higher intelligence and better overall adjustment. The two groups are similar in their dependency needs, both tending to be marginally dependent. However, hysterics have significantly greater number of stresses and also come from poorer socio-economic background.

Key words -
Hysteria,
Early adolescence,
Stress,
Adjustment

Hysteria is the most commonly encountered psychiatric condition in child and adolescent population in India. However, its prevalence in the West is reported to have waned in recent times. Review of literature shows that there are very few reported studies on hysteria in early adolescence. Gross [1] studied four cases of hysterical seizures in adolescent girls as a consequence of forced incestuous relationship with their fathers and suggested that for all girls presenting with symptoms of hysterical seizures a detailed history is to be taken to explore for the possibility of incest. Gross [2] in another study of 19 adolescents says that 13 of the patients were initially diagnosed incorrectly as having epilepsy and says that the therapist should always consider the possibility of psychogenic factors in children and adolescents who present with seizures. Eggers [3] studied 10 girls and 4 boys with a diagnosis of hysteria and found that the most frequent symptoms were astasia-abasia and monoplegias of the upper or lower limbs. From the aetiological point of view, he report ed that oedipalphallic conflicts were predominant.

Studies in India have focussed more on the child population giving little importance to adolescents. Somasundaram et al [4] found that hysteria was the most common illness of childhood and adolescence. Vyas and Bharadwaj [5] studied 304 cases of hysteria and found that high occurrence was in the 16 to 25 years age group and that it was significantly high in females. Larger number of patients came from poor low income families and from joint family system. Sharma et al [6] found that hysteria was the commonest type of neurosis seen in children and that there was a close similarity between symptoms presented by the children and the symptoms of parents who were suffering from neurotic or physical illness at the same time. Ponnudurai et al [7] found a high occurrence of hysteria in the age group of 16 to 20 years, the illness was

more common in females, in persons with lower educational and socio-economic status, and in nuclear families. Trivedi et al [8] found hysteria to be the commonest illness in children and adolescents presenting mainly as fainting fits. The sample predominantly belonged to an urban area and there was a history of neurotic traits in the children. Uma and Kapur's [9] retrospective analysis of 100 cases of childhood hysteria showed that 37% were adolescents. The commonest manifestation of hysteria were episodes of abnormal motor movements and unresponsiveness. Many of the patients had a good premorbid adjustment and average intelligence. In some patients factors such as precipitating event, model and psychosocial stress contributed to the symptoms of hysteria.

Most of the Indian studies have focussed more on prevalence and related socio-demographic variables rather than understanding the psychopathology of hysteria. Hence, there is a need to focus on phenomenology as well as understanding the contributing psychological and psychosocial factors associated with hysteria of different age groups in childhood and adolescence.

The present investigation aims at studying the profile of symptoms and psychosocial factors associated with hysteria of early adolescence by comparing a group of hysterics to a group of normal adolescents.

Material and Methods

The present investigation studied 18 adolescents consisting of 9 boys and 9 girls in the age range of 12 to 16 years with diagnosis of hysteria. A group of 18 normal adolescents matched for age, sex, and years of schooling were also included in this study. In both the groups, subjects had an I.Q. of 70 or above. The clinical population was drawn from the Child Guidance Clinic, NIMHANS, while the normal sample was drawn from schools as well as the community. The normal sample was selected on the basis of General Health Questionnaire [10] and were screened for head injury, epilepsy and other organic problems for the purpose of exclusion.

For the hysterics, a diagnostic profile was obtained on the basis of the multi-axial classificatory system of Rutter [11] and had hysteria (ICD-9 code 300.1) on the first axis, no specific delays in development on second axis, an I.Q above 70 on the third axis, no organic pathology on fourth axis and the fifth axis dealt with psychosocial stresses, which when absent at intake, was further explored by interview and psychological assessment.

Tools

1.**Screening**

i) Bhatia's short scale [12] which is a shortened version of Bhatia's full scale of performance tests of intelligence. This test was used to assess the intelligence of subjects in both the groups.

ii) Goldberg's General Hospital questionnaire [10] consisting of 12 items administered to rule out psychiatric disorders in the normal sample. A cut-off point of one was used.

2.**Main Study**

i) Checklist of stressful life events [13] consisting of 45 items.

ii) Pre-adolescent adjustment scale (PAAS) and Pre-adolescent dependency scale form -B (PADS-B) [14] to assess psychosocial adjustment.

iii) Thematic Apperception Test [15] to assess (TAT) personality and interpersonal relationships. The test consists of 10 cards and is an Indian adaptation of the TAT. Bellak's [16] method of

interpretation was used to analyse the stories.

In addition, a biographical data record with details of sociodemographic factors family history and personal history was used. A brief version was used with the normal sample as information was sought only from the subjects.

Results and Discussion

The results will be dealt with in the following sections:

i) Nature of symptoms in the hysteric sample

ii) Socio-demographic factors

ii) Psychosocial factors associated with hysteria

a) intelligence

b) stressful life events and

c) adjustment

(i)Nature of symptoms in the hysteric sample

Functional fits was the main presenting complaint and was seen in fourteen cases. The illness was acute in onset in seventeen cases and gradual in one case; course was episodic in sixteen cases and continuous in two cases; duration was below six months in 13 cases, six months to one year in four cases and more than one year in one case. Precipitating factor was present in fifteen cases whereas it was not apparent on initial work up in three cases. As revealed by the case history, of the eighteen hysterics, four were stubborn, demanding and attention seeking by nature, eight were shy, reserved, sensitive and obedient and six were friendly and cheerful. This does not support the contention that hysteric patients have typically histrionic pre-morbid personality.

(ii)Socio-demographic factors

A significantly larger number of hysterics belonged to lower social economic status when compared to normals (x^2=13.85; $p<0.01$). However, it must be noted that the normal sample was drawn from school going urban population, while the hysteric sample consisted mainly of rural and urban children. There was no significant difference between the two groups on the variables of family structure, consanguinity, number of siblings and order of birth.

(iii)Psychosocial factors associated with hysteria(a)

Intelligence

On the Bhatia Short Scale, the mean I. Q of the hysterics and normals was 92.1 (± 16.6) and 104.4 (± 17.5) respectively. Although the hysterics were of normal intelligence, there was a significant difference between hysterics and normalize, 't' value being 2.15 which is significant at 0.05 level, indicating that the level of intellectual functioning in hysterics is lower when compared to normals.

(b)

Stressful life events

Stressful life events over a period of one year was taken into account and it was found that hysterics had a greater number of stressful life events than normalize (mean number of stresses for hysterics was

5.55 ± 3.29, and that of normals was 2.33 ± 1.97; the difference was significant at .01 level 't' value being 3.52).
(c)

Adjustment

This was measured by two questionnaires and a projective test, namely Pre-Adolescent Adjustment Scale, Pre-Adolescent Dependency Scale Form B, and the Thematic Apperception Test. The Pre-Adolescent Adjustment Scale measures the adjustment of the student towards home, school, peers, teachers and general matters. The following table shows the mean scores of the hysteric and normal group in these areas. Positive scores indicate good adjustment.

Table I shows that although the hysterics are well adjusted in the areas of home, school, teachers and general adjustment, the normals have significantly better adjustment in these areas. However, in the area of peer adjustment there is no significant difference between the two groups. As can be seen from the table there is greater variability in the hysteric group in the different areas of adjustment when compared to normals.

Table 1 - Mean and standard deviation in the various areas of adjustment in a sample of hysterics and normals

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On the Pre-adolescent Dependency scale the hysterics get a mean score of 0.50 (± 4.68) and the normals a mean of 0.11 (± 3.99) indicating that both the groups are marginally dependent with no significant difference between the two groups as far as dependence is concerned (t=.27). However, there is a greater variability on this measure in the hysteric group when compared to the normals.

On the thematic apperception test the hysterics were found to be more anxious or worried over poverty and denied sex to a significantly greater extent that normal (x^2=4.05; $p < 0.05$). Evidence of oedipal themes was present in the stories of both normals and hysterics. Preoccupation with poverty can be explained in terms of the impoverished background of the children, whereas the sexual and oedipal conflicts need to be explored further.

The results of the study show that hysterics are well adjusted in the areas of home, school, peers, teachers and general adjustment and have average intelligence. However, they have significantly more number of stresses in their life when compared to normals. Psychopathology of hysteria in early adolescence can be interpreted at two levels. On the surface level it appears to be related to stresses. At a deeper level, psychoanalytical explanations may be espoused in view of evidence of sexual repression at work as projected in the TAT stories.

To sum up, it may be seen that hysterics have normal intelligence and overall adjustment whereas normals have significantly higher intelligence and better overall adjustment. They are similar in their dependency needs, tending to be marginally dependent. However, it is interesting to note that the hysterics have significantly greater number of stresses and also come from poorer socioeconomic background. The role of oedipal conflicts in addition to stresses in the production of hysterical symptoms needs further exploration.

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