

Hysteria in Children - A study of Symptoms and Associated Features

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Abstract

The purpose of this study was to describe the symptoms of hysteria in children and highlight other features of the disorder. The sample consisted of seventy children in the age range between 8-12 years diagnosed as hysteria (as per ICD-9). Findings revealed varied symptomatology and presence of precipitating events, model, primary and secondary gains.

Key words -

Children,

Hysterical symptoms

Many Indian studies have reported hysteria as one of the commonest neurotic disorders in children and they have also found it more among girls than boys [1], [2], [3]. The literature suggests that children manifest wide variety of hysterical symptoms involving motor and sensory systems. As pointed out by Trivedi et al [3] the studies have focused more on prevalence and related social factors and on individual cases rather than the clinical presentation of hysteria in a large sample of children. There are a few studies on large samples of hysterical children [4], [5] but these are retrospective in nature. Further, most of the studies are conducted on samples comprising of both children and adolescents rather than confining to children in a specific stage of childhood.

The paper refers to a study on a sample of hysterical children in the middle childhood stage. The present study was part of a larger investigation on childhood hysteria [6] and a section of the findings pertaining to history of present illness is reported here.

The objectives of the study were to describe the symptoms of hysteria in children and highlight other features of the disorder.

Material and Methods

The sample consisted of seventy consecutive cases of school going children in the age range between 8-12 years, diagnosed as hysteria (as per ICD-9) on axis-I and without any diagnosis on axis-II, III and

IV [7] at Child Guidance Clinic, National Institute of Mental Health & Neuro Sciences, Bangalore . An Information Schedule (based on case history proforma used for children at CGC, NIMHANS) was used to elicit information regarding family history, personal history and history of present illness. The section in history of present illness also contained a list of hysterical symptoms which elicited symptoms in the four categories namely, motor, sensory, visceral and miscellaneous symptoms. The data was analysed in terms of percentages and chi square statistics.

Results

There were 30 boys (42.9%) and 40 girls (57.1%). The mean age of the sample was 10.58 years and SD 1.21 years. Of the 70 children, 63 (90.0%) were Hindus. 48 children (68.6%) belonged to urban areas, while the rest of the children (22 ie., 31.4%) came from rural areas.

1.Symptoms of hysteria

Findings revealed that children manifested a variety of hysterical symptoms. It was found that some symptoms were more frequently reported than others. These were:-

(i)

Motor symptoms:

Some of the motor symptoms reported were abnormal movements of the whole body (28.5%), shaking movements of the limbs (17.1%), stiffness in limbs (14.2%), shaking movements of head (14.2%) and walking difficulties (8.5%).

(ii)

Involuntary symptoms:

Most commonly reported symptoms were episodes of unresponsiveness (58.5%), giddiness (35.7%), headache (31.4%), pulling sensation in legs (12.8%) and breathing difficulties (10.0%).

(iii)

Sensory symptoms:

Some of the sensory symptoms were vague aches and pains (18.5%) and attacks of feeling cold (10.0%).

(iv)

Miscellaneous category:

Most frequently reported symptoms were abnormal behaviour (30.0%), possession state (11.4%) and fearfulness (11.4%).

(v)

Visceral symptoms:

There were two visceral symptoms, abdominal pain (11.4%) and moving feeling in the stomach (7.1%).

The comparison of relative occurrence of each of the hysterical symptoms in boys and girls revealed no significant difference.

Twenty signs and symptoms of hysteria which were found in more than 10% of the children were

considered for cluster analysis. The cluster tree (Figure I) showed that the first cluster which was formed at the 7th step consisted of three symptoms. The second cluster which was formed at the tenth step, consisted of nine symptoms.

.Cluster Tree (4=Stiffness in limbs, 6=Pulling sensation in legs, 9=Miscellaneous involuntary symptoms, 10=Attacks of feeling cols, 17=Rapid breathing, 20=Breathing difficulties, 15=Possession state, 3=Abdominal pain, 18=Shaking movements of head, 13=Aches and pains, 12=inability to speak, 2=Shaking movements of limbs, 19=Abnormal behavior, 1=Abnormal movements of the whole body, 16=Headache, 8=Giddiness, 5=Miscellaneous motor symptoms, 7=Unresponsiveness, 11=Falling down, 14=Miscellaneous sensory symptoms)

2.Other features of hysteria

Findings regarding the onset, course and duration of illness revealed that majority of the children had acute onset (81.4%) and episodic course (95.7%). The duration of the symptoms varied between few days to a month in 42.8% of the children. In 44.2%, it ranged between more than a month to 11 months and the remaining children (12.8%) had the symptoms for more than a year.

Examination of the onset of illness revealed presence of precipitating event in 68.4% of children. It was not identified in 15.7% and in the remaining children (15.7%) the information gathered was not adequate enough to relate a specific event to the illness. Findings regarding the nature of precipitating events and sex distribution revealed significant differences between boys and girls ($X^2=7.84$, $df=3$, $p<.05$). The events were identified in 77.5% of girls as against 56.6% of boys. The events at home precipitated the illness in almost equal percentage of boys and girls (23.3% and 22.5% respectively). Table I shows other features of hysteria.

Table II shows the abnormal psycho-social situations of hysterical children, as assessed on the V axis of multi-axial system. It was found that some children had more than one diagnosis on the axis.

Table I - Other features of hysteria

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Table II - Abnormal psychosocial situations of hysterical children

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Discussion

The present study focused on the signs and symptoms of each episode of the hysterical attack. The children manifested multiple symptoms such as motor, involuntary, sensory, visceral and miscellaneous symptoms. Of these, motor symptoms were more frequent. It was found that hysteria was equally common in boys and girls. Other studies on hysterical children also have reported on equal sex distributor regardless of age [4], [5], [8], [9].

Findings revealed that boys and girls reported similar types of hysterical symptoms. The comparison of the individual symptoms in different categories revealed that some symptoms were more common than others. These were episodes of unresponsiveness, abnormal movements of the whole body, giddiness, aches and pains, headache and abnormal behaviour. The classical hysterical symptoms described in the

literature, such as hysterical fits were found in the children. Other classical symptoms found were variations of asthasia-abasia, mutism and visual problems. The variations of asthasia-abasia was that the children had walking difficulties, but were capable of sitting and standing. Similarly, mutism was found to be selective. The children had difficulties in speaking with some people only. Children with visual problems complained of blurred vision and not total blindness. Children reporting eating difficulties had swallowing problems but not 'lump in the throat' feeling, a characteristic feature of 'Globus hystericus'.

Some of the symptoms found in the present study were reported in earlier studies too. There were walking difficulties associated with stiffness in limbs [5], [8], [10], difficulties in standing and abnormal gait [11], giddiness, hyperventilation, vomiting, headache [4], [5], [12], [13], aches and pains [11], [14], abdominal pain [4], [5], [15], possession state [5], [16], [17], inability to speak [4], [5], [11], [18], [19], hallucinations and fearfulness.

Symptoms such as possession state, abnormal behaviour, pulling sensation in the body, attacks of feeling cold and some motor symptoms found in the present study have not been reported commonly in the western studies reviewed. Similarly symptoms such as paraplegia, hearing loss, cough, intractable sneezing, itching and multiple personality disorder reported in the western studies were not found in the present study. These findings perhaps seem to suggest the possible role of cultural factors in the manifestation of hysterical symptoms in children.

The cluster analysis of the hysterical symptoms suggested that first cluster consisted of subjectivity felt manifestations of hysteria. These were stiffness in limbs, pulling sensation in legs and miscellaneous involuntary symptoms. In the second cluster, most of the symptoms such as breathing difficulties, possession state, shaking movements of head and limbs were observable in nature. The category of symptoms which did not form any clusters was a combination of subjectively felt and observable manifestations of hysteria. These were abnormal behaviour, abnormal movements of whole body, headache and so on. In the present study only the signs and symptoms found in more than 10% of children were entered into cluster analysis. Further studies could examine the clusters by considering all the hysterical symptoms irrespective of the frequency of occurrence.

In a large number of children the onset of hysterical symptoms was related to a stressful event. It was found that the children whose illness was precipitated by a family stress, manifested symptoms both at school and home and children who faced a stressful event at school manifested symptoms only at school. Some of the events that precipitated the illness were parental quarrels, punishment (verbal and physical) by parents and teacher, quarrel with peers, change of school and fearful experiences. The fearful experiences were reported by the child himself hence the reality of these experiences could not be ascertained. For eg., one child reported that when she was standing alone she saw some 'form' dressed in white. She thought it to be a 'ghost' and was terrified. Another child reported that when he was walking alone he was pushed down by a stranger. The individual sessions with the children revealed preoccupation with the precipitating events. When faced with the event, they had difficulties in verbalising the feelings of fear and anger and were unable to discuss their problems with significant 'others'.

Findings regarding other features of the illness revealed that the family members and peers provided model for hysterical symptoms. It was found that the child's previous experience with sick role behaviour influenced the presentation of hysterical symptoms. Many other studies have emphasised the role of imitation and identification in the formation of hysterical symptoms [14], [20].

The phenomenon of La bella indifference often described in hysterical adults is not a consistent feature of childhood hysteria as revealed in the present study. Children in fact showed concern for the symptoms and were willing to discuss their problems. The findings are in agreement with those of Maloney [4] and Goodyer [14].

The primary gains were evident in many children. In these children, the hysterical symptoms led to the reduction of anxiety arising from psychological problems. In addition to the primary gains, secondary gains in the form of increased attention, sympathy and concern from the parents, were identified in high percentage of children (90%). The parents treated the children as physically ill and allowed them to take rest at home. The demands of the children were immediately satisfied. It was found that the parental concern and anxiety reinforced the hysterical symptoms. These findings suggest the importance of parental counselling in the management of hysterical children. Similar observation was made by Davis [21] and Gold [22].

The findings regarding secondary symptoms revealed that some children had features of emotional (fear/anxiety/loneliness) and conduct (stubborn/demanding and disobedience) disorders. It should be noted that these secondary symptoms were characterised by short duration and were less severe to be diagnosed as emotional or conduct disorder. Other secondary symptoms manifested were scholastic backwardness, sleep problems and enuresis. The abnormal psychosocial situations identified on V axis were many. Of these, majority of the children had stress in school. They had disturbed relations with peers and teachers, difficulties in adjusting to new school and coping with school work. Earlier studies have reported academic stress in hysterical children [5], [8], [14] but have not commented on their interpersonal relations at school. This area seems to be important from the point of view of understanding the aetiology of hysteria and in planning management strategies.

Other stresses identified were disturbed relations between family members, lack of parental control and supervision.

The findings of the present study suggest evidence for possible aetiological factors such as stresses in the school, family, role of 'model', presence of primary and secondary gains. These factors need further exploration so that a tentative hypothesis of childhood hysteria can be put forth. Such knowledge obtained may lead to effective intervention programmes including not only the child but also the significant 'others' namely, family members, teachers and peers.

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