

A RETROSPECTIVE STUDY OF HYSTERIA IN A CHILD GUIDANCE CLINIC *

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Introduction

The literature on hysteria in childhood is sparse in comparison with that on adults. Opinions differ regarding the definition and prevalence (Rae 1977, Goodyer 1981). Most studies report that hysteria is equally found in boys and girls and it occurs usually after five years of age (Robins and O'Neal 1953, Caplan 1970, Rock 1971). A review of literature by Goodyer (1981) suggests the importance of repression of mental conflicts, intensive learning experience, imitation and identification with significant persons in the formation of symptoms.

Many Indian studies report hysteria to be a frequently presenting complaint in Child Guidance Clinics and is seen more among girls (Sommasundaram et al 1974, Manchanda and Manchanda 1978, Trivedi et al 1982). The most common symptoms encountered were convulsions of non-neurological origin, tremors and loss of responsiveness.

As pointed out by Trivedi et al (1982), the Indian studies have focussed more on prevalence and related social factors rather than the clinical presentation of hysteria in large samples of children.

The present investigation refers to a retrospective study of hysteria in a Child Guidance Clinic. The aims of the study were to describe the symptoms of hysteria manifested by the children and to analyse

the socio-demographic and psycho-social factors associated with the illness.

Material and Methods

The sample consisted of one hundred consecutive case records of patients diagnosed as hysteria (as per ICD-9) on axis-I and without any diagnosis on axis II and IV (Rutter et al. 1976), at Child Guidance Clinic, NIMHANS, Bangalore, over a period of fourteen months, i.e., from November 1982 to December 1983.

These patients came directly to Child Guidance Clinic or referred from the Department of Neurology. Each case record provided the information regarding case history, behaviour observation and diagnosis. It was found that the information regarding psycho-social factors of the illness was inadequate in some case records. This should be kept in mind while discussing the results.

Results

The results were analysed in terms of percentages. The different aspects analysed were symptomatology, socio-demographic details and other psycho-social factors associated with the illness.

(1) Symptomatology

Hysterical Symptoms: 98% of the patients were diagnosed as having hysterical conversion reactions and 2% as hysterical dissociation.

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The common manifestations of hysteria were episodes of "abnormal motor movements" (34%) and "unresponsiveness" (20%). Other conversion reactions were giddiness (8%), headache (4%), falling down (3%), abnormal behaviour (2%), possession attacks (2%), numbness (2%), inability to talk (2%), difficulties in breathing (2%), stiffness (2%), abdominal pain (2%), inability to open the eyes (1%), shivering (1%), blinking (1%), fearfulness (1%), aches and pains (1%), inability to use a limb (1%), insensitivity to pain (1%), and hiccup (1%). These percentages add up to 91% and rest of the patients (9%) manifested more than one of the symptoms mentioned above.

The duration of the symptoms varied between few days to a month in 50% of the patients. In 33% of the patients, it ranged between two months to six months and the remaining patients (17%) had the symptoms for more than six months.

Associated symptoms: Some of the patients (27%) manifested symptoms which were secondary to hysterical reaction. Of these 6% were reported to be stubborn and disobedient, 4% had disturbed sleep, 3% of the patients showed decreased interest in studies. Various other symptoms reported were poor appetite (2%), enuresis (2%), irritability (2%), fear (2%), aches and pains (2%), crying spells (1%), suicidal threat (1%), talking to self (1%) and restlessness (1%).

(2) Socio-demographic details

The sample consisted of children in the age range between four years to fifteen years, with a mean age of 11.3 years. The peak occurrence was in the age group 8-12 years (57%), 37% of the patients were in the age group 12-15 years. Rest of the patients (6%) were aged between 4-8 years.

Hysteria was found to be equally common in boys and girls (51% and 49% respec-

tively). Other than a small percentage (4%), rest of the sample consisted of school going children.

(3) Other psycho-social factors associated with the illness

Table 1 shows the results regarding the birth order, premorbid adjustments, past history of illness, precipitating factor, model and secondary gain.

Table 1
Associated psychosocial factors

Birth order%	Premorbid adjustment	%	Past history of physical/ mental illness	%
Eldest	22 Well adjusted	69	Present	5
Youngest	26 Behaviour problems	28	Absent	95
Middle	49 Information not available	3		
Only	3			
Precipitating factor	Model	%	Secondary gain	%
Present	37 Present	24	Present	16
Absent	53 Absent	19	Information not available	84
Information not available	10		Information not available	57

On axis-V, the number of psycho-social stresses that can be coded are 19. Percentage of patients diagnosed on each of these stresses was calculated. Stress at school was found in 39%, familial overinvolvement in 36%. Other psycho-social stresses were inadequate and inconsistent disciplining (28%), discordant intrafamilial relationships (25%), anomalous family situations (12%), mental illness in the family members (7%), intrafamilial psychosocial stress (7%), inadequate living conditions (3%), lack of warmth in intrafamilial relationships (3%). It was found that some of the patients had more than one diagnosis on this axis.

Discussion

(i) *Hysterical symptoms*

In the present study, dissociative reactions were found to be rare. Similar findings were reported by Rock (1971) and Goodyer (1981).

Majority of the patients manifested conversion reactions involving sensory and motor systems. This is in accordance with the findings of the earlier studies (Somasundaram et al. 1974, Shetty 1975, Trivedi et al. 1982).

The conversion reactions found in the present study, such as, abnormal behaviour, fearfulness, inability to open eyes and shivering attacks have not been reported in the earlier studies of hysteria in children. Similarly, some of the symptoms reported by other workers were not found in the present study. For example, difficulties in opening mouth (Robins and O'Neal 1953), difficulties in walking, hearing loss, loss of vision (Rock 1971) and disorder of gait (Goodyer 1981), this illustrates the importance of studying the role of cultural and social factors in determining the kind of hysterical symptom.

(ii) *Sex distribution*

We found that hysteria was equally common in boys and girls. Rock (1971), and Goodyer (1981) also reported an equal sex distribution regardless of age. The finding is at variance with that of Caplan (1970), Rae (1977) who found preponderance of girls, particularly in the post-pubertal period.

(iii) *Precipitating factors*

The illness was precipitated by a stress factor in 37 patients. While some patients were scolded by their family members prior to the onset of illness, others were reportedly beaten by the teachers. Few patients reported fearful experience like se-

eing a dead body, witnessing an accident.

(iv) *Past history of psychiatric illness*

The results showed that only few patients had a past history of psychiatric illness. This finding is at variance with that of Goodyer (1981), who reported 12 of the 15 patients had a past history of psychiatric disorder.

(v) *Psychosocial Stresses*

Though high percentage (95%) of the patients had average intelligence, some of them had stress at school. Similar findings were reported by Rock (1971), Goodyer (1981). They found that hysterical children had poor peer relationships. Further in the present study, a number of psycho-social stresses such as familial overinvolvement, inadequate disciplining, discordant intrafamilial relationships and so on were found in the families. Earlier studies describing the stresses are mainly case reports. Expressing a similar view point, Goodyer (1981) commented that, there are no empirical studies to show that conversion reactions are a direct result of abnormal patterns of family situations. The present study shows that, assessment of family influences as well as study of psychosocial stresses is important in understanding hysterical illness in children.

In the present study, hysteria was found more in the age group 8-12 years and it was common in both boys and girls. The frequently reported symptoms of hysteria were episodes of abnormal motor movements and unresponsiveness. Many of the patients had a good premorbid adjustment and high percentage had average intelligence. In some patients factors such as precipitating event, 'model' and psychosocial stress contributed to the symptoms of hysteria.

The present study being a retrospective analysis has its own limitations. However

the findings can be helpful in planning out studies focussing on phenomenology, psychosocial stress and management in large sample of children with hysteria.

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