

Hysterical Reaction in Children

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Introduction

Published studies have given widely different figures for the incidence of hysteria in children. This is not surprising in view of the different diagnostic criteria used as well as no definite delimitation of age for childhood. Other relevant factors are the extent of facilities available for handling child psychiatric cases and the attitude of the public towards psychiatric treatment in general. All this, however, does not preclude the possibility of socio-cultural differences. Indeed, socio-cultural factors not only influence the frequency of a psychiatric disorder but also to some extent determine its symptomatology. Thus, gross hysterical reactions such as hysterical blindness, aphonia, fits and paralysis which were common in Euro-American countries two or three decades ago but have since almost disappeared are not uncommon in Hong Kong. These manifestations as well as hysterical possession are related to folk beliefs and education level of the population. Nevertheless, in order that comparisons of different studies, especially cross-cultural ones can be meaningful a prerequisite is that all definitions and criteria should be explicitly described.

All agree that the diagnosis of hysteria must be based not only on the absence of clear organic findings but also on a clear psychodynamic formulation which can explain the symptoms. However, functional symptoms

can be present in all neurotic reactions and anxiety-provoking factors like disturbed parental relationship, intense sibling rivalry and conflict in school situation may be the underlying causes for all neuroses and are not specifically present only in hysteria. Therefore, emphasis has to be laid on the motivational aspect, that is to say, hysterical symptoms serve a purpose, unconscious or even vaguely conscious. However, in psychoanalytic viewpoint all neurotic symptoms serve a purpose in that they form a compromise substitute for an instinctual satisfaction. Then comes the postulate that the dominant point of fixation in hysteria is in the early genital stage but this does not help much in arriving at an initial diagnosis since the fixation point can only be gauged by the evolution of symptoms and speculation of parent-child relationship in earlier life. The practical question is whether or not there is a specific symptom-cluster for a specific fixation point. There is as yet no consensus on such a symptom-cluster on which the diagnosis of hysteria could be based.

Aims and Material

The aims of the present study are:

- (i) to analyse our cases of hysteria with regards the aetiology and the treatment,
- (ii) to study their outcome at the end of a follow-up period and
- (iii) to compare the incidence with that found in Western countries.

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The sample. This consists of 15 hysteric children seen consecutively by the author at the Yaumatei Psychiatric Centre from Mid-1967 to Mid-1970. Only frank conversion and/or dissociation were chosen in as much as these terms bear the meaning as described by Babinski (1), Janet (6), Kanner (7) and Proctor (9). Their ages range from 6 to 14 years.

Eight were referred by the physicians and paediatricians, 3 by the casualty officers, 2 by the general practitioners and 2 from the general out-patient's clinics. These 15 cases constituted 8.5 per cent of the children seen by the author during this period.

Findings

Sex incidence. There were 12 boys and 3 girls. This ratio of 4:1 for male:female is in great contrast to what has been found in the Western countries. Thus, in Robins and O'Neal's (10) mixed series there were 16 males and 25 females and, taking the children presenting with conversion reactions or mixed conversion and psychophysiologic reactions in Loeff's (8) sample the ratio of male to female was 1:7. The findings of other studies were, as pointed out by Kanner (7) about equal distribution between the sexes. (The 1967 By-Census in Hong Kong gave 52 per cent boys and 48 per cent girls in the age range of 5 to 13 years.)

Social class. The families of these children were classified into 5 social classes and the classification was based mainly on the income and occupation of the principal earner of the family. Social class I is the uppermost level and V the lowest. It was found that 1 belonged to class II, 4 to III, 5 to IV and also to V. Thus, the great majority of them came

from lower social class families. As a matter of fact half of them lived in the Resettlement Estates.

Intelligence. The intelligence of the hysteric children was assessed by means of the Progressive Matrices Test which is comparatively not culture-bound. It was found that of the 15 cases 1 belonged to grade I, 3 to grade II, 3 to III and 3 to grade IV. This indicates that hysteric children tend to have intelligence either above or below the average.

Parental attitudes. Admittedly assessment of parental attitudes must to some extent involve bias on the part of the assessor. In this study parental attitudes were classified similar to those used by Kanner (7), but only the mothers were assessed because it was not possible to get more than a minority of the fathers to come for interview. Seven mothers (including 1 mother-substitute) were found to have an over-protective attitude, 4 a perfectionist attitude, 2 over-rejection and only two mothers whose attitude could be regarded as acceptance and affection.

Precipitants. Precipitating factors are always present in hysterical reaction and in this group of children the factors are rather obvious. There were reprimand for school performance or oncoming examination in 6 cases, quarrels or being scolded at home in 4 cases, fright in 2 cases, mild physical illness in 2 cases and birth of a younger sib in 1 case. Obviously, all of these which occur frequently should be regarded as the last straw for the hysteric children who have been under an adverse environment and/or who have a vulnerable personality.

Symptomatology. The main symptoms are outlined in Table 1.

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Table 1
Outline of Descriptive Aspect of Cases

| | <i>Sex</i> | <i>Age at attendance</i> | <i>Age at follow-up</i> | <i>Presenting symptoms</i> | <i>Condition at follow-up*</i> |
|-----|------------|--------------------------|-------------------------|---|--------------------------------|
| 1. | Male | 8 | 11 | Tenderness of scalp when touched, intermittent deafness, bizarre gait and posture. | Slight improvement |
| 2. | Male | 10 | 14 | Hearing "voices" calling his name and writing in the air; clinging to aunt all the time. | Much improved |
| 3. | Male | 11 | 15 | Sudden flushing of face and walking with rocking movements in automatism. Episodes lasted 1 minute or so with subsequent amnesia. | Symptom-free |
| 4. | Male | 10 | 13 | Hiccup, dyspnoea or hyperventilation; following father all day long. | Improved |
| 5. | Female | 12 | 13 | Faints, twitching of eyes and spasm of extremities. | Improved |
| 6. | Male | 10 | 11 | Recurrent abdominal pain, identifying any physical or mental symptoms perceived. | Much improved |
| 7. | Male | 10 | 13 | "Scenes" of horses and ghosts on the wall; "voices" calling his name. | Much improved |
| 8. | Male | 12 | 13 | Altered state of consciousness with aggressive behaviour lasting for a short period. | Symptom-free |
| 9. | Male | 10 | 11 | Writer's cramp | Symptom-free |
| 10. | Male | 11 | 13 | Recurrent abdominal pain, faints, hands held in queer posture. | Symptom-free |
| 11. | Male | 9 | 13 | Tics; visual hallucinations; somnambulism with complicated movements. | Symptom-free |
| 12. | Female | 8 | 10 | Fainting attacks, talking like a baby. | Much improved |
| 13. | Male | 8 | 10 | Tremor and rigidity of right upper limb. | No change |
| 14. | Male | 6 | 7 | Recurrent abdominal pain. | Symptom-free |
| 15. | Female | 12 | 14 | Eyeballs rolling upwards and tongue protruding out with cyanosis and fear. | Symptom-free |

* Refer to section on follow-up.

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Management

Our principles of treatment followed those outlined by Kanner (7). The underlying motives were first explored since as mentioned earlier hysterical symptoms serve a purpose. This was done by an overall study of the child's life situation and emotional development. With this as a profile the child was allowed to express his feelings and problems through a series of interviews or if necessary especially for younger children by means of projective methods like play and drawing. Five of them were admitted to the day hospital for a period varying from a few weeks to a few months. More information was obtained from reports of the nurses and the occupational therapist. The child was next helped to re-construct a more realistic situation which could be equally satisfying in his goal. Social workers did much in modifying the parental attitude and family tension as well as reducing unwarranted expectations. This parental guidance would make the child's adjustment easier. When there was conflict in the school situation, suggestions and solutions were also provided.

In some cases where initial symptoms were gross, prestige suggestion or abreaction was employed. The case of writer's cramp (Case 9) illustrates the rapid improvement of hysterical symptoms with these simple measures. He was right-handed but sustained an injury of his left elbow during a fall from a height. However, his right hand began to shake when he wrote and the shaking movements gradually extended to involve the whole limb and the neck as well. His cramp had already been present for 4 months before he attended our Centre for treatment. When first seen his writing was so blurred that it was hardly recognizable but after strong suggestion and assurance his writing became improved and within a week after admission to the day hospital he was symptom-free. However, in the majority of cases complete abolition of hysterical symptoms or prevention of their

recurrence would depend on solution of the under-lying conflicts. This is clearly shown in the case of hysterical twilight state (Case 3). His attacks varied from once or twice to many times a day. Each attack lasted about 1 or 2 minutes in which the patient suddenly had flushing of face, was in an altered state of consciousness and walked about with rocking movements. He was amnesic after each episode. His episodic disturbances occurred after a fright. He was walking up the hill very early one morning when it was still fairly dark with the intention of studying for his final examination. Suddenly, a piece of cloth was blown over him and at that moment he thought that someone would rob him. In a state of panic and with much unnecessary struggle he got rid of the piece of cloth and ran back home. Although finally he realised what had actually happened yet whatever lessons he had prepared earlier seemed to be forgotten and he was very much worried. The next day the attacks began. The rocking movements were similar to his own description of the struggle he had had to rid off the cloth. Subsequent interviews revealed a long-standing conflict between him and a neighbour who had often bullied him. His behaviour during the attack frightened this neighbour. Thus, the internal tension due to the stress of examination and the conflict towards the neighbour was triggered off by the fright and expressed in a "pantomimic discharge" during the episode, serving a purpose as well. Incidentally, his attacks decreased with hypnosis and strong suggestion but it persisted for months until finally a law suit between his family and the neighbour had been settled in court. Two cases did not continue to therapeutic termination because once the child's presenting symptoms were alleviated the parents thought that the child was cured and there was a decline in motivation to carry through a more prolonged treatment. One case (Case 13) attended only twice because the parents could not afford the time to bring the child to attend owing to the home-clinic distance.

Follow-up

Five of the children were still attending the Centre regularly for follow-up. For those who were not the parents were contacted by telephone or by post to bring their children for interview. All turned up except one. For the latter case (Case 13) the author had to make a home visit. The condition of the children was assessed along three dimensions: (i) hysterical symptoms irrespective of whether or not they were the same as those at first attendance, (ii) relationship with others especially members of the family and (iii) intellectual functioning. The three dimensions were rated as shown in Table 2 in which the degree of improvement in each was given a score. For example, a child who was symptom-free, socially

well-adjusted and of normal intellectual functioning at follow-up had a total score of 12. A total score of 12 to 9 was regarded as fully recovered or much improved, a score of 8 to 5 as improved and a score of 4 to 0 as slightly improved or unchanged. The improvement score for the 15 cases is shown in Table 3. Based on this overall assessment it was found that at the end of 6 months 2 children were symptom-free, 2 were much improved, 6 improved, 3 slightly improved and 2 unchanged. At the end of the follow-up period which ranged from 1 to 4 years with a mean of 2.3 years 7 children were symptom-free, 4 much improved, 2 improved and 2 slightly improved or unchanged. As for prognostic pointers the sample was too small for such an analysis.

Table 2
Rating of Improvement

| <i>Improvement score</i> | <i>Hysterical symptoms</i> | <i>Relationship with others</i> | <i>Intellectual functioning</i> |
|--------------------------|----------------------------|---------------------------------|---------------------------------|
| 4 | Symptom-free | Well-adjusted | Normal |
| 3 | Much improved | Satisfactory | Satisfactory |
| 2 | Improved | Fairly satisfactory | Fairly satisfactory |
| 1 | Slightly improved | Not satisfactory | Impaired |
| 0 | No change | Poorly adjusted | Grossly impaired |

Table 3
Improvement Score for the 15 Cases

| <i>Improvement Score</i> | <i>Number of cases</i> | |
|--------------------------|------------------------|---------------------|
| | <i>6 months</i> | <i>At follow-up</i> |
| 12 | 2 | 7 |
| 9-11 | 2 | 4 |
| 5-8 | 6 | 2 |
| 1-4 | 3 | 1 |
| 0 | <u>2</u> | <u>1</u> |
| | <u>15</u> | <u>15</u> |

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Discussion

The 15 cases constituted 8.5 per cent of all new children cases seen by the author in a period of 3 years. This figure is quite high as compared with those given by English and Pearson (3) and Creak (2). However as pointed out earlier different studies could not strictly be compared because of differences in diagnostic criteria and in the age limit. Nevertheless, since the criteria used in this study was comparatively more strict it is not inappropriate to say that the incidence of childhood hysteria is higher in Hong Kong than in Western countries, despite of the adverse attitude of the public towards psychiatric treatment. Such a finding could only be explained in terms of cultural differences. Culture is a significant determinant of whether or not a particular drive is the source of a conflict and of the way such a conflict is integrated. In Hong Kong about one quarter of the population are now living in the Resettlement Estates where families are housed in small units of multi-storey buildings with long corridor common to many flats. In this part and to a lesser degree in other areas it is not uncommon to see children running naked or women breast-feeding their babies in the corridor or in the pavement down the street. Of greater importance is the fact that due to overcrowding children often sleep with their parents up to an advanced age especially boys with mothers. Under such circumstances it is reasonable to suspect that many of these children must have witnessed primal scene of their parents although it is difficult to obtain confirmation from the children themselves. On the other hand in children sexual play and verbal expression on sexual topics are strongly prohibited. Such a cultural background certainly enhances sexual phantasy, oedipus complex and castration anxiety if Freudian theory could be applicable to Hong Kong. At this junction it may as well note that one (Case 15) of the three female cases had this peculiar protrusion of tongue associated with cyanosis and fear. The tongue as mentioned by Fenichel (4) appeared as a phallic symbol and this

may give support to Ferenczi's (5) concept of hysterical "materialization".

Quite different from various Western studies boys were significantly over-represented in this study. One possible explanation is that boys are more liable to over-protection by mothers and they are given more attention if odd. Furthermore, it is more common to have sons sleeping with mothers than daughters with fathers until early adolescence. In the present sample half of the boys slept with their mothers even when they first attended for treatment.

The majority of hysteric children had either a higher or a lower than average intelligence. An interesting finding was that for the few intelligent ones their mothers were illiterate and unable to provide solutions to satisfy the child's queries and curiosity. It is possible that these parents would develop inferiority feeling and compensate by over-protecting the children, thinking that the latter would raise the family's future social status. On the other hand for the dull ones their parents demanded a higher performance in school than they could afford. This could explain why the onset of illness often coincided with the oncoming school examination. Examinations assume a disproportionate degree of importance in Hong Kong and are a frequent source of stress on the students and their parents. Not uncommonly the parent-child conflicts were centred around the academic achievement which is highly competitive even in primary schools. This conflict is illustrated by the case of writer's cramp (Case 9). As mentioned by Fenichel (4) children have the conception that work is "duty" demanded by authorities. The writer's cramp in this child could be regarded as an expression of anti-authority because he expressed much resentment towards his elder brother who would beat him if he did not write as assigned to. One further observation about this group of children confirmed Loeff's (8) conclusion that children with

conversion reactions were characterized by marked difficulty in verbally expressing affect.

Hysterical symptoms presented by our children were seldom monosymptomatic and in a few cases there had been shifts of symptoms within a short period of time. Hysterical symptoms are contagious and as early as 1943 Schuler and Parenton (11) reported "epidemic" of hysterical twitching and trembling in a girl's school in Louisiana. This was vividly seen in one case in our sample (Case 6). The child developed additional symptoms and later shifts of symptom simply in contact with other patients in the day hospital. Verbal description or even direct questioning by the staff could produce the same effect on this child—a practical point which has to be remembered in the handling of hysteric children.

There have been very few follow-up studies on hysteria in childhood. In Robins and O'Neal's (10) study there were strictly speaking 4 hysterical cases out of his sample of 41 children. Of these 4,3 showed severe disability and one mild disability at the end of a follow-up period ranging from 10 to 17 years. One point to note is that his children were all hospitalized cases. In the present study 67 per cent of the children became well or fairly well at the end of 6 months and this increased to 87 per cent at the end of a mean follow-up period of 2.3 years.

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