

HYSTERIA IN MALAYSIAN CHILDREN-FAMILY DYNAMICS AND MANAGEMENT

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SUMMARY

Pseudoseizures, weakness of limbs, elective mutism, dystonia and behaviour problems were the presenting symptoms in three children from three different families with crises superimposed on chronic marital and familial stresses. Lack of open communication among parents and children contribute to the use of physical symptoms as an expression of emotional conflicts. Psychotherapeutic management includes individual and family counselling which begin with obtaining a history of psychosocial background and recent stresses. The families, in addition to seeking modern medical intervention, proceeded with their own religious, cultural and social management.

INTRODUCTION

Hysteria is a symptom of numerous organic¹ diseases, psychological² diseases or problems. From an interpersonal perspective, hysterical conversion is a kind of non-verbal communication couched in a proto-language that arises in and is conditioned by the specific setting of a doctor-

patient relationship.³ In very broad terms, illness behaviour motivated by the fear of disease corresponds to what we call hypochondriasis, and illness behaviour motivated by the advantages of the invalid role to what we call hysteria.⁴

Hysteria, as an example of behaviour disturbances arising from psychological conflict, provides a useful cultural insight not only to the contents of the behaviour disturbance but also an opportunity for a therapist to observe the traditional and prevalent communal efforts in management of conflicts. The universal mental mechanisms of handling conflicts and reduction of anxiety by suppression, repression, projection, etc., and the communal efforts of handling conflicts through group participation in rituals rather than confrontation can be observed.

Aim

The following three cases will illustrate some of their modes of presentation in three Malaysian children and their families in crisis. The communication model provides a guide to the probable meanings of the symptoms of hysteria in these patients and their families and an approach to treatment.

CLINICAL FINDINGS AND MANAGEMENT

Family A

A., an eight-year old girl was admitted to a paediatric ward of the University Hospital, Kuala

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Lumpur on 21 September 1978. A private paediatrician referred her for her sudden behaviour change with an episode of fit. A psychiatric consultant was requested on the same day.

Five weeks earlier, A., an above-average student, was upset that her teacher had reprimanded her for writing poorly and performing poorly in her monthly tests. A month ago, on her birthday, a series of stressful events occurred: in the morning, she saw a neighbour crying and heard her telling her mother about her domestic quarrel and fights; her father had informed her that he would not be able to attend her birthday party because he had to attend two funerals; she was waiting in vain till late evening for her grandmother who did not turn up for her party; that evening, she fainted and said that she was possessed by some spirits. A week later, she had a fit during her sleep. There was uprolling of eyeballs, frothing of mouth and jerking movements of upper and lower limbs. This lasted for about twenty minutes.

Between 6-12 September 1978, she was hospitalised in a medical ward before transfer to a neurological ward of a public hospital. Physical examination, cerebral spinal fluid examination and electroencephalogram showed no abnormality.

The child was very agitated. She mumbled incoherent phrases of "good and bad girls". She could only scribble on a paper. In her unorganised play, she put pieces of papers together. The following day, with encouragement, she drew a person — a figure of a rather sad girl with what appeared to be a dark patch of cloud over her head was drawn.

Intravenous injection of 10 mg diazepam and intramuscular injections of 25 mg chlorpromazine were administered at different times to sedate her over the next week for her violent behaviour towards her mother and some staff.

On 6 October 1978, the parents were informed that all the investigations showed that there was no physical cause for her illness. The biochemistry of the CSF, EEG and brain scan were all normal.

CF antibodies to measles was less than one-eighth. When the parents enquired about emotional fits, the author explained that occasionally fits may be precipitated by emotional stress. A. was aware of the frequent quarrels with in-laws over the alleged incomplete payment of dowry to her father. The parents were encouraged to socialise with the maternal uncle. Chlorpromazine was reduced to 10 mg daily and discontinued a week later when they came for a follow-up.

One year later, they returned for a follow-up on the request of the author. She had no recurrence of symptoms and did well in school. The family and the in-laws socialised well and had not talked about the dowry. The father had become more active in attending religious activities.

Family B

On 11 May 1979, a medical officer of a private hospital referred B., a nine-year-old boy to the University Hospital. He had weakness of both lower limbs over the last one week, followed by generalised stiffness of the body. At school, he was unable to move all his four limbs for several hours. Occasionally, he screamed and ran around the house. There was no history of fever. Physical examination did not reveal any abnormality except for a large *cafe-au-liat* spot over right frontal area.

Interviews with the parents revealed significant recent and chronic stresses. The paternal-in-laws were fighting a legal battle among themselves over inheritance. The father was angry that his wife and her parents were gamblers. The mother had always complained that the father had no time for the children. He had frequently belted the children and even threatened to gorge out B.'s eyes. Just before this illness, he had belted his son because B. turned on the television while he was busy with the accounts of an unsuccessful business venture. On 9 May, the father fainted in a Buddhist temple when he took B. there to seek help for B.'s behaviour. The mother had repeatedly stressed that their son was charmed (hexed) by a non-Christian neighbour.

B. was sedated with chlorpromazine 50 mg intramuscularly when he repeatedly tried to run out of the ward. On the third day of hospitalisation, he was encouraged to draw while the parents discussed B.'s behaviour. He withdrew to a corner to draw and produced a drawing of a pox-marked male with the words "stupid man". The father had very prominent scars from chicken-pox. The mother smiled while the father agreed that such expressions helped his son to vent out his anger. During another family session, he was mute but wrote out in bold letters: "I promise to get well when I get the control plane". His father had earlier refused to buy a remote control toy plane for him.

During a home leave, his parents took him to see a private neurologist. A CAT Scan showed a probable arterio-venous malformation in the left temporal lobe. An EEG was normal. They requested for discharge on 30 May 1979, when our neurosurgeon suggested an angiogram. In August 1979, the family returned for a follow-up. The family continued to be active in church group activities after B.'s behaviour improved with a pastor's help on 5 July 1979. B. had less temper tantrums and stopped using abusive language after his new belief in Christ. The child showed further improvement in school work and interpersonal relationship when he was reviewed in May 1980.

Family C

C., an eleven-year-old boy was referred by a general practitioner for management of suspected encephalitis. He had a one-day history of fever, sudden stiffness of the body and mutism on the morning of referral.

There was no history of drug ingestion nor epilepsy. He had "scrapping" marks over the neck and back resulting from a form of traditional therapy and a cane-mark on his right thigh. He had marked opisthotonus with tilting of his head to the left. He had spasms of the left face muscle and turning of the eyes to the left.

The author was requested to see him immediately. C. was the youngest of two children of the fourth wife of an artist. His sixteen-year-old sister was admitted two years earlier for overdosage with her mother's stemetil (prochlorpromazine) which resulted in marked stiffness.

The child's stiffness relaxed after the mother and sister were asked to wait in a separate room. He had monosyllable answers on the day of admission. The following morning, he was more verbal. He wanted to stay in the hospital. He was angry that his mother forced him to practise martial arts. He wished that his seventy-year-old father would teach him martial arts again. He had just recovered from a recent stroke. At a family interview, a few days later, the father agreed to teach him. The child was followed-up three times at intervals of three weeks. His behaviour continued to improve with his father supervising his martial art. The mother requested for termination of treatment.

DISCUSSION

Numerous psychiatrists⁵ have discussed the cultural influences on manifestation and management of child psychiatric problems. Patients and their families will choose socially and religiously congruent forms of help.

The medical practitioners should consider psychosocial stress as a probable etiological factor of physical and behavioural symptoms. A.'s behaviour problem and pseudo-seizures are contributed by recent academic and personal stresses superimposed on a child in a family with chronic family problems. B.'s weakness of the limbs and generalised stiffness of his body occurred after a severe physical punishment by his father. His parents had financial problems in addition to chronic marital problem. C.'s dystonia and elective mutism occurred after his mother caned him when he was disobedient. His father had a stroke recently and the family was preparing to migrate overseas. When indicated, referral for psychological management may avoid unnecessary and expensive physical investigation. Liaison and

consultation psychiatry enables psychological management to occur while physical management is proceeding.

In some Malaysian families, parents assume that the children are too young to react emotionally to conflicts. They seldom listen to their children. They may ignore their comments. Some children stop discussing their problems with their parents. Failure and absence of conscious efforts by their parents to discuss openly and resolve their conflicts contributed to the hysterical symptoms of these three children — A., B. and C. The children's dramatic illness prompted the parents to take joint actions, absent for some time in the family, to care for the sick child. While all the three parents continued to search for a physical etiology to explain their sickness, the need for the children to persist with their symptoms would continue. The psychiatrist with the help of his paediatric colleagues, raised the possibility of a psychological etiology to the family. He demonstrated the need for adults to comprehend the non-verbal communications of their children. The child A., communicated her depression in her drawing. B. went further to write down what he was unable to say to his father: "You are a bastard!" In the safety of the hospital with the mother interviewed by the doctor, C. was less tense and relaxed his strange posture. He requested the doctor initially for longer hospitalisation — thus breaking his initial elective mutism.

Open discussion of conflicts either within the family or with the psychiatrist, was still a new behaviour pattern for these families. They also give rise to the loss of face in their ways of interaction and guilt for what they have done. B.'s parents are still convinced that they are being charmed or hexed by their non-Christian neighbour. This projection reduces their anxiety, but it also isolated and alienated them further from their neighbour. Their resort to the religio-magical method of cure does enable them to meet and socialize with fellow Christians. Through these joint activities, the family is working towards love and unity among themselves.

There is a need not only to understand the role of culture in medicine and psychiatry⁶ but also to accept the potent power of faith and hope in any therapy. Jerome Frank⁷ writing on the *Two Faces of Psychotherapy* concluded: "In short, the religio-magical and scientific faces of psychotherapy are coming increasingly to resemble each other. Perhaps the ideal psychotherapist of the future should be able to use methods of either or both when appropriate, thereby enhancing his psychotherapeutic effectiveness". Just as mere intellectualization and rationalization do not contribute to change of behaviour in psychotherapy, the mere external performance of religious activities without the practice of a broad concept of love, forgiveness and respect may not bring about improvement of interpersonal relationship and intrapsychic peace.

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