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A CASE OF STEREOTYPED REPETITIVE MOVEMENTS

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Introduction

Stereotyped repetitive movements are defined in ICD-9 as "disorders in which voluntary repetitive stereotyped movements which are not due to any psychiatric or neurological condition-constitute the main feature. Includes head banging, spasmus nutans, rocking, twirling, finger-flicking mannerisms and eyepoking. Such movements are particularly common in cases of mental retardation with sensory impairment or with environmental monotony (307.3)." Silver (1980) classified head banging as being part of autoerotic behaviour or temper tantrums. According to Silberstein et al. (1966), head banging usually manifests itself in the age group of 6 months to 18 months and rarely later than that.

Case Report

The present case report is of a 28 month old boy who was hospitalized after an acute onset of the illness 18 days prior to admission. The first episode of head banging occured at night when during sleep the child suddenly woke up crying and started striking his head on the floor. The intensity of striking his head banging increased on restrain and he also became aggressive. This behaviour lasted for 30 minutes after which the child calmed down and went off to sleep. There were no apparent precipitating factors. The child had a second attack of headbanging on getting up in the morning and since then the frequency of these attacks was 2-3 times a day till the time of admission. At no stage did the child injure himself or was incontinent. His sleep and appetite were not disturbed and whenever the child was asked about this behaviour he declined to answer. The attacks were not aborted due to the presence or absence of any family member or by any food like toffees or sweets. During this period the child had also become more obstinate and irritable and would become angry if things were not done according to his wishes eg. regarding wearing clothes.

There was no significant past history and in the family he lived with his grand-parents, parents and two elder sisters. The grand-parents were in their sixties and were responsible for the farming which was the only source of livelihood. They were physically and mentally healthy and were overindulgent towards the patient as he was the only male child. The father in his early thirties, was the only son of his parents and described by his wife, to be intellectually dull. Due to this he was illiterate and unable to shoulder responsibilities on his own and thus worked under the supervision of his parents. The mother was in her midtwenties, educated upto class VII

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and primarily responsible for all the household work. The two sisters were seven and four year old and the elder one was studying in class II. She had developed transient abnormal behaviour during a bout of jaundice at the age of 6 ½ year.

Family atmosphere and Inter personal relationship pattern :

Family affairs were mostly dealt with only by grand parents of the child, while parents had very little role in decision making. No matter would be considered eventful and most of the things and happenings were taken as a routine course of time. Parental relationship with each other was on primary level. Although no open quarrels or duels were reported, mother was not sure of her husband's capacity and was totally upset over the situation. As a result, she was withdrawn and apathetic in general towards children and family matters. Grand parents occasionally favoured the only male child (the patient).

In the personal history the child was born of a full term normal delivery at home. His mile stones were within normal limits. The child was described to be intelligent and sharp. He easily played with other children and had no interpersonal problems.

After hospitalization initially the frequency of attacks remained the same. They were sudden in onset and subsided on their own within a period of 20-30 minutes. In between the child behaved normally. His interaction with the therapist was cordial but it was difficult to find a cause for this behaviour. A detailed general physical and neurological examination was not contributory and his intelligence was average. It was noticed that the fits occurred in the presence of the mother – the only family attendant. Hence it was thought that there may be some interpersonal conflict bet ween the two. The patient was treated with small doses of anxiolytics, meanwhile the mother was counselled. As this head banging was thought to be a part of conduct disorder the mother was counselled to ignore the negative behaviour of the child (i.e. headbanging) and to give positive feedback when the child desisted from such behaviour. She was also encouraged to feel responsible for her children – and to interact with them to a greater degree. Along with this the nursing staff was advised to remove the mother from the scene when the child had a fit and to let her come back after the child had remained well for at least 3 minutes. The therapist also talked to the child regarding this behaviour and encouraged him to express his difficulties. The child showed decrease in the frequency, intensity and duration of these fits over a period of one week. Then the child was informed that the therapist would only talk to the patient on the days he did not have a fit. The mother was made to realize the reasons for improvement in her child and subsequently she became more co-operative and conducive to the advice given. After fifteen days of hospitalization the fits were fully controlled and the child was discharged after another three days. The child remained symptom free over a period of one year of follow-up.

Discussion

In the case the stereotyped repetitive movements in the form of head banging were primarily due to conduct problems. The contributory factors were the joint family set up where the child got extra attention on the basis of being the only male child. The other significant factor was the passive role of the father and the parents had practically no say in the family decisions. The frustrations of the mother in this environment made her apathetic and aloof even to her responsibilities towards her children. The child, who was unsure and bewildered by these conflict situations

developed this illness. The counselling of the mother to make her whole heartedly accept her role and the behaviour therapy of the child ultimately got rid of this disorder.

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