Volume: 1 Issue: 10 Pages: 41-43

International Journal of Research in Academic World

E-ISSN: 2583-1615
Impact Factor: 4.714

Received: 10/May/2022 Int. J Res. Acad. World. 2022; 1(10):41-43 Accepted: 16/June/2022

# A Comparative Study of Hysteria Dissociative among Obese Adolescent Boys

**[*1]Dr. Sheikh Shahid**

[*1]Assistant professor, Department of Humanities, Chauksey Engineering College, Bilaspur, Chhattisgarh, India.

**Abstract**

The aim of the present study is compare hysteria dissociative adolescent boys. On the basis of basis of obese-non obese classification. For present study, 200 obese adolescent (Av. age 15.12 yrs.) and 200 normal weight adolescent boys (Av. age 15.25yrs). From various govt. and private schools of Chhattisgarh were selected to serve as sample for the present study. Criteria for selection of subject were based on WHO (1995) classification of body mass index (BMI) between 18.0-24.99 considered to be obese. While BMI>30 is considered to be obese. To assess hysteria dissociative to prepare by Joshi and Malick, Jodhpur multiphasic personality Inventory prepared. (1981) was preferred. Result reveal that obese adolescent boys displayed more magnitude of hysteria dissociative as compared to normal adolescent boys. It can be concluded that obesity is a major contributory factor in social marginalization among obese adolescent boys.

**Keywords:** Obesity, Hysteria Dissociative, Adolescent Boys, Personality Disorders, and Body Mass Index.

## Introduction

### Obesity

Every individual needs a certain amount of body fat for stored energy, heat insulation, shock absorption and/or other functions. However, excessive deposition of fat in the body, which is usually referred as overweight or obesity in literature, is dangerous. Overweight refers to an excess body weight compared to set standards. The excess weight may come from muscles (lean body mass), bone, fat (adipose tissues), sometime tumours and/or body water. Obesity specially refers to having an abnormally high proportion of total body fat (WHO, 1998).

### Etiology of Obesity

Three major factors modulate body weight: metabolic factors, diet, and physical activity, each influenced by genetic traits. Despite recent advances in these areas, the prevalence of obesity in Westernized societies has increased.

**Pathophysiology:** Leptin and ghrelin are considered to be complementary in their influence of appetite. With ghrelin produced by the stomach modulating short-term appetitive control (i.e. to eat when the stomach is empty and to stop when the stomach is stretched). Leptin is produced by adipose tissue to signal fat storage reserves in the body, and mediates long-term appetitive controls (i.e. to eat more when fat storages are low and less when fat storages are high).

**Environment:** Environmental and genetic factors are obviously closely intertwined. If you have a genetic predisposition toward obesity, then the modern lifestyle and environment that has readily available inexpensive food high in fat and low in fruits and vegetables may lead to weight gain and obesity. Fast food.

**Physical Inactivity:** The tremendous increase in obesity and related problems and health risks can only be the direct result of decreased energy expenditure in our daily life. With increasing age, a decreased energy level and more physical inactive life, minimum intake of calories per day may be excessive for someone and could result in overweight.

**Fat Cells:** Our fat cells are formed early in life and increase in both size and number until the end of adolescence. Calorie restriction will decrease only the size of fat cells, not the number. With large number of fat cell formed, a return to an over fat condition is quite easy.

**Metabolic Factors:** Even small changes in metabolic rate translate into large increase in body fat and weight. A 10 percent decline in metabolism could result in a annual weight gain of about 15 lb for the average individual.

Changes in life style ('urbanization'): With improving standards of living, and availability of food in plenty, the upper class societies of India in recent years have urbanized to western levels.

**Seasonal Fluctuation, Age and Body Fat:** Glandular Causes

**Psychological Factors:** Weight Cycling:

### Personality Disorders:

In psychological parlance "personality" refers to a person's unique and enduring pattern of thinking, feeling, and behaving. When viewed in this manner it becomes evident that "personality" encompasses nearly every aspect of human experience. Subsequently, our personalities have the potential to greatly impact our well-being. In particular, the quality of our relationships with others is significantly affected by our personalities. And because human beings are social creatures, this means our personalities greatly influence our overall success and satisfaction with life.

The diagnostic manual of the American Psychiatric Association (APA, 2000) captures these differences between healthy and unhealthy personalities and defines a personality

***Corresponding Author:** Dr. Sheikh Shahid

disorder as follows: "The essential feature of a Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture and is manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control" (Criterion A). This enduring pattern is inflexible and pervasive across a broad range of personal and social situations (Criterion B) and leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood (Criterion D). The pattern is not better accounted for as a manifestation or consequence of another mental disorder (Criterion E) and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, exposure to a toxin) or a general medical condition (e.g., head trauma) (Criterion F). In the present study, personality disorders have been used as dependent variable.

**Hysteria Dissociate**

Under the term of dissociative hysteria are described a set of clinical syndromes characterized by behavioural disorders and psychic activity anomalies. The nature of the symptoms seems very similar to hysterical conversion. Psychogenic amnesia, psychogenic fugues and multiple personality

**Hysteria Dissociate**

Under the term of dissociative hysteria are described a set of clinical syndromes characterized by behavioural disorders and psychic activity anomalies. The nature of the symptoms seems very similar to hysterical conversion. Psychogenic amnesia, psychogenic fugues and multiple personality disorder are described. There is some evidence that the symptoms are related to psychic affective traumatisms and no physiological alteration. Two mechanisms are proposed: dissociation of personality and amnesia. Clinical course generally improves spontaneously. Various forms of psychotherapy may be used.

Since dissociative identity disorder (DID) has symptoms similar to schizophrenia, such as auditory hallucinations and delusional thoughts of being controlled, there are difficulties in its differential diagnosis. A 16-year-old adolescent male patient who was previously diagnosed with schizophrenia from a different hospital was admitted to our inpatient psychiatric unit for the evaluation of auditory hallucinations and suicide attempts. Through psychiatric evaluations, it was determined that the patient suffered from identity alternation, dissociation, and amnesia. As for the diagnostic evaluations, the following measures were implemented: a psychiatric interview regarding the diagnostic criteria, mental status examination, laboratory tests, brain imaging studies, electroencephalography, and full psychological test for adolescents, and the self-reported measure of the Adolescent Dissociative Experiences Scale.

**Methodology**

For the present study, 200 obese adolescent boys and 200 normal weight adolescent boys from various govt. and private school of Chhattisgarh were selected to serve the sample for the present study. The criterion for selection of subject was based on WHO (1995) classification of body mass index (BMI) in which BMI between 18 to 24.99 is considered to be obese. To select the desired number of subject for the present study, in all 1200 school children between age ranges 11-15 years was screened and from this population 200 obese and 200 normal weight adolescent subjects were selected.

In order to classified subject into normal and obese categories, WHO's classification for body mass index was preferred in the present study,

The international classification of overweight and obesity proposed by the world health organisation (WHO, 2000, P. 8-9) and the expert panel on the identification, evaluation, and treatment of overweight in obesity in adults (1998) are based on the increase of risk morbidity and mortality in deferent population

The Jodhpur Multiphasic Personality Inventory prepared by Joshi and Malik (1981) was administered to each subject according to availability and in a laboratory like condition. For finding of dissociate among obese and normal weight adolescent boys.

**Statistical Procedure**

To solve the hypotheses stated in it was decided that to verify the hypotheses one by one with appropriate statistical technique. To solve differential hypotheses t-test was used

To verify hypothesis obese adolescent boys will show higher degree of dissociative type of hysteria as compare to normal weight adolescent boys "t" test was used. The obtained result of such statistical analysis is presented in table

**Table 1:** Comparison of component of personality disorder i.e. hysteria dissociate among obese and normal weight adolescent boys.

| Variable | Obese Adolescent Boys (N=200) | Normal Weight Adolescent Boys (N=200) | | | Mean Diff. | "t" |
|---|---|---|---|---|---|---|
| | M | S,D, | M | S.D. | | |
| Hysteria Dissociate | 22.24 | 9.31 | 8.95 | 7.76 | 13.28 | 15.49** |

***Significant at .01 level*

From the analysis of table of it is clear that obese adolescent children have more magnitude of dissociative type of hysteria (M=22.22) as compared to normal adolescent boys (M=8.95). The reported t=15.49 boys deny their personal responsibility for their unacceptable behaviour much more as compared to normal adolescent boys.

Since dissociative type of hysteria was found to be markedly high in obese adolescent boys when compared with normal adolescent boys, hence differential hypothesis is accepted.

**References**


1. Ackard DM, Neumark-Sztainer D, Story M. Overeating among adolescents: Prevalence and associations with weight-related characteristics and psychological health. *Pediatrics*. 2003;111(1):67-74.
2. Allport G. *Institutional Behavior*. Chapel Hill: University of North Carolina Press; 1933.
3. Allport G. *The nature of prejudice*. Reading, MA: Addison Wesley; 1954.
4. Sánchez-Villegas A, Pimenta AM, Beunza JJ, Guillen-Grima F, Toledo E, Martinez-Gonzalez MA. Childhood and Young Adult Overweight/Obesity and Incidence of Depression in the SUN Project. *Obesity*. 2010;18(7):1443-1448.
5. American Alliance for Health, Physical Education, and Recreation and Dance (AAHPERD). *AAHPERD youth fitness test manual*. Revised 1976. Reston, VA: Author;

1976.
6. American Alliance for Health, Physical Education, and Recreation and Dance (AAHPERD). *Health related fitness test*. Reston, VA: Author; 1980.
7. American Alliance for Health, Physical Education, and Recreation and Dance (AAHPERD). *Health related physical fitness technical manual*. Reston, VA: Author; 1984.
8. Mikkelsson L, Kaprio J, Kautiainen H, Kujala U, Mikkelsson M, Nupponen H. School fitness tests as predictors of adult health-related fitness. *Am J Hum Biol*. 2006;18:342-349.
9. Millon T. *Disorders of Personality: DSM IV and Beyond*. 2nd ed. New York: John Wiley and Sons; 1995.
10. Morgan CM, Tanofsky-Kraft M, Wilfley DE. Childhood obesity. *Child Adolesc Psychiatric Clin N Am*. 2002;11:257-278.
11. Murphy N, McVey D. *Treating Severe Personality Disorder: Creating Robust Services for Clients with Complex Mental Health Needs*. London: Routledge; 2010.