CHILDHOOD PSYCHOGENIC SNEEZING

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ABSTRACT

Sneezing in childhood is a common occurrence which is often organic in nature. In some cases however intractable sneezing may be psychogenic in origin. We present herewith a case of a 10 year old girl with intractable sneezing of psychogenic origin that responded to psychological interventions.

Key words: Childhood Psychogenic Sneezing.

INTRODUCTION

Common cold and sneezing are common occurrences in children but intractable sneezing in children is a rare occurrence. A large number of cases since then have been reported in adolescents with hardly 10 reports in children alone. Majority of these were psychogenic in origin with multifactorial causative factors[1] It has been noted that the occurrence has a female preponderance[2] and that sneezing persists when awake while there is no sneezing during periods of sleep[3].

Organic sneezing has been shown to respond to topical nasal anesthesia[4] while various psychological therapies such as supportive psychotherapy, relaxation therapy and hypnotherapy have all been effective in sneezing that is psychogenic in nature[5]. In most cases of psychogenic sneezing there is an underlying psychiatry history and psychological stressor that needs to be ascertained. Sneezing may have neuropsychiatric origins such as neuroimmunological[6], epileptic and vasomotor causes.

It has been noted that psychogenic sneezing is made up of aborted or pseudosneeze with little or no inspiratory phase, short nasal grunting and minimal aerolization in the nasal secretions[7].

Here we report the case of an 11 year old girl with intractable sneezing of psychogenic origin that responded to psychological interventions.

CASE HISTORY

A 11 year old girl studying in Standard VI was brought by her parents with complaints of continuous sneezing and heaviness in the head for the past 1 week. The child was normal prior to that and a week back had suddenly developed sneezing. There was no associated nasal discharge, watering of the eyes, cough and fever. The sneezing was continuous and did not however occur during sleep as reported by the parents. There was no past history of allergies, bronchial asthma or medication sensitivity. The child was seen by the ENT physician who gave her a trial of antihistamnics, bronchodilators and intranasal corticosteroid aerosols. This caused no improvement in her symptoms. Local nasal examination, ENT check up and X Ray Nasal Sinuses were normal. A CT Scan of the Head also revealed nothing. She was also evaluated by two pediatricians, two chest physicians and another ENT physician who were not successful in reducing her symptoms. All medications were tapered off in 3 weeks and the child was sent for a psychiatric evaluation.

On detailed psychological assessment it was noted that one of her classmates had bronchial asthma and uncontrollable sneezing. The child had seen these episodes. She had noted that the classmate was given special treatment and attention in the school by all the teachers. Her classmate was also missing school regularly due to her medical problems and would probably be missing her examinations as well. The child in our case when questioned further revealed incongruent parenting practices between both her parents as well as a pressure on her to perform well in the forthcoming school examinations.

The child was given individual supportive psychotherapy and was given suggestion and explained the nature of her symptoms. Her family was also called in for joint and separate sessions with their goals for the child being revised as well change in parenting practices being suggested. Marital counseling was offered to the parents for their differences. The parents were counseled about the nature of their child's illness, its onset and aggravating factors. The child was also given exam related counseling to alleviate exam stress and was started on Tab. Clonazepam 0.25mg half a tablet twice a day to reduce her anxiety. This was tapered off in 3 weeks once counseling was successful in reducing the frequency of her sneezing followed by complete remission. On following her up monthly for the next 6 months she did not re-develop any sneezing.

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DISCUSSION

The child in our case report had intractable sneezing. The examination and investigations were normal. Detection of psychological stressors and the conversion model was paramount in the amelioration of her symptoms. It was noted that once the underlying stressor as a cause of her symptoms and the secondary gain desired from teachers as well as the primary gain were explained to parents and to the child, there was a marked improvement in her symptoms. Here we used anxiolytic drugs like Clonazepam to reduce the initial intense anxiety and make the child more amenable to psychotherapy. The role of supportive psychotherapy, behavior therapy, hypnosis, relaxation therapy and family support in the management of these problems have already been documented.

Delayed diagnosis often results in extensive medical investigations, visits to multiple physicians and specialists, stress for the child, stress for the parents as well loss of academics due to absenteeism from school. Though rare, intractable psychogenic sneezing must be kept in mind when dealing with the vexing problems of conversion and somatoform disorders in children.

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