

Conversion Disorder in Children: Characteristics and Gender Differences

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ABSTRACT

Aim: To study the clinical presentations and gender differences of conversion disorder in children less than 16 year old and correlate it with socio-demographic characteristics and stress factors. **Methods:** All case records of children presenting to psychiatry unit of a general hospital during last 5 years (both outpatient and inpatient) and having a diagnosis of ICD-10 Dissociative (conversion) disorders, were reviewed. **Results:** A total of 12 % (n=512) had a diagnosis of conversion disorder, both genders having equal representation. Dissociative motor disorder was more common among males and dissociative convulsions among females. Academic and strained interpersonal relationships were the most common stress factors. Majority had la belle indifference and secondary gain and received outpatient treatment, and had complete recovery at last follow up. **Conclusions:** Conversion disorders are one of the most common diagnosis. Significant gender differences in mode of presentation and nature of stress are present. However the response to treatment is prompt and chance of recovery is high in both genders. **Relevance:** This study was done in a developing country where conversion disorder is seen commonly.

Keywords: Conversion Disorders, Dissociative Disorders, Gender Differences

Dissociative (conversion) disorder [DCD] is one of the common psychiatric disorders among children in India as compared to the west¹. These disorders commonly present with deficits in voluntary motor or sensory functions, awareness of identity and memory without any organic cause and without being intentional². The term 'unintentional' is removed from DSM V as it cannot be proven³. Since the symptoms suggest a medical disorder, initial presentation in most cases is to department of pediatrics⁴.

DSM IV classifies these disorders as conversion disorders under somatoform disorders indicating the absence of underlying medical disorder, and classifies dissociative disorders

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separately². Whereas, ICD-10 combines both of them under DCD giving more importance to the process of dissociation⁵.

These disorders are closely associated with stressors or conflicts at onset⁵. Conversion or dissociative symptoms are understood to occur as a result of conversion of a conflict or disturbing thought into a physical symptom⁶. Reduction of psychological distress due to such conversion is called primary gain. Secondary gain is interpersonal or social gains like increased attention and concern elicited from others or ability to avoid unpleasant activities like school work. Such gains lead to persistence of symptoms.

Historically conversion disorder was classically thought to be a disorder of females⁷. However previous studies have shown that the disorder occurs in males though less common than in females⁸.

There are few studies of conversion disorder and gender differences in children especially in India. Therefore this study aims to study the clinical characteristics and gender differences in children with dissociative (conversion) disorders.

MATERIALS AND METHODS

Data was obtained from both in-patient & out-patient records of all children <16 years evaluated in the department of psychiatry and diagnosed with DCD (as per ICD-10). Children were evaluated using pre-specified typical format. Information was extracted regarding sociodemographic variables, past and family history, temperament, illness variables, co-morbid disorders, presence & type of stress, model, gain, treatment & outcome.

Ethical approval was taken from the institutional ethics committee, and informed consent was obtained from the parents/guardians of all children.

RESULTS

A total of 512 children & adolescents were evaluated in the department of psychiatry in last 5 years. Out of whom 12% (n=60) had a diagnosis of DCD.

Demographic characteristics:

Both boys and girls were equal in number (30 each). Children aged 6-11 years were 47% & 12-16 years were 53%. Majority (92%) were students, from rural background (63%). No gender differences were found on any sociodemographic characteristics.

Majority had well-adjusted temperament and no significant family or past history.

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Illness variables: Table1 and Table 2

1. *Clinical characteristics*

Variable	n=60	%	Boys n=30	Girls n=30	value/chi-square
Symptom duration					
<1 month	22	36.67	13	9	NS
1-6 months	20	33.33	9	11	
>6 months	18	30.00	8	10	
ICD-diagnosis					
Dissociative motor disorder	21	35	18	3	p<0.001 S
Dissociative convulsions	28	46.67	6	22	
Others	11	18.33	6	5	
Stressor					
Absent	16	30.00	3	13	p<0.001 S
Present	44	70.00	27	17	
La belle indifférence					
Absent	23	38.33	12	11	NS
Present	37	61.67	18	19	
Secondary gain					
Absent	13	21.67	9	4	NS
Present	47	78.33	21	26	
Model					
Absent	39	65.00	16	23	NS
Present	21	35.00	14	7	

S-significant NS-not significant

Table 2: Nature of stress

Stressor	frequency	%	Boys n=30	Girls n=30
Academic stress	19	31.67	14	5
Strained interpersonal relationships	18	30	9	9
Physical illness	3	5	2	1
Frightening experience	2	3.33	1	1
Pathological/stressful family environment	13	21.67	12	2

- Few children reported more than one stressor

Majority had a symptom duration of <1 month, Majority did not have any other psychopathology or abnormality on physical examination or co-morbid disorders. Dissociative convulsions was

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most common. Dissociative motor disorder was more common among boys and Dissociative convulsions among girls.

Majority of children reported presence of a stress factor. Girls frequently denied a stress. Academic stress was most common in boys, whereas interpersonal difficulties were most common stress in girls.

Majority had la-belle indifference (an apparent disregard for physical symptoms) & secondary gain. A model was absent in most children. Males had a model more commonly compared to females.

Treatment & Outcome:

Majority (65%) were treated on OPD basis. Most (65%) patients received some pharmacological treatment. Benzodiazepines (48%) were the most common pharmacological agents used. In addition, all children received some psychological treatment: Counselling & individual therapy (83%), suggestion (3%) or a combination (12%)

Most patients (53%) did not come for follow-up. Among those who came majority (35%) had complete recovery and few (10%) had partial recovery.

DISCUSSION

Our study found that 12% of all children seen in psychiatry had DCD, in keeping with previous studies in India¹. It is thought that having a medical illness is more acceptable form of expressing psychological distress in this culture⁹.

Previous studies reported a female preponderance⁸ or slight male preponderance^{9, 10}. An equal representation was seen in present study. None were less than 6 years and adolescents had a higher representation. This is in agreement with previous studies^{9, 10} and indicates that some amount of psychological maturity is required for development of dissociation¹¹. Previous studies found a higher representation from urban background¹⁰ especially in inpatient settings⁹. They argued that children from rural background had less severe forms of illness that did not require inpatient care. A higher representation from rural background in our study could be because both outpatients and inpatients were included and the district hospital where the study was done caters to higher proportion of rural population. Dissociative convulsions / pseudo seizures was most common diagnosis, in agreement with most previous studies^{9, 10}. However, males had dissociative motor disorder more commonly.

Among boys, academic stress was most common followed by stressful family environment. In girls, strained interpersonal relationship was most common followed by academic stress. This indicates the higher importance given to boys in relation to academics and higher pressure on them to perform academically. Previous authors also reported higher academic stress^{9, 10}. Majority of children were enrolled in school. With increasing focus on education in recent years, academic stress is probably increasing over the years in our culture. Girls denying a stress and

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having more dramatic forms of presentation and boys having a model more frequently could be related to gender related social experiences in our culture.

Though a psychological model of illness was presented, most children received some pharmacological treatment. Families would have difficulty in shifting from a medical model to a psychological model, forcing the psychiatrist to prescribe some medication until symptom removal. However, the main stay of treatment remained cognitive behavioral: normalization of child's routine, differential reinforcement of 'normal' behavior, reducing secondary gain, reassurance, family counselling, improving coping skills, family and individual therapy were used as indicated. A short duration of symptoms, of 1-6 months is in agreement with previous studies^{9, 10}. Majority did not require inpatient care suggesting less severe forms of illness and symptoms improved quickly. There was complete recovery in most children who came for follow up. Thus as in previous studies, a short duration of illness with faster and complete recovery was present^{9, 10}.

WHAT IS KNOWN

- Conversion (dissociative) disorders are common in children especially from developing countries.
- Conversion (dissociative) disorders occur in children of both genders.

WHAT THIS STUDY ADDS

- Significant gender differences in mode of presentation and nature of stress are present in children with dissociative (conversion) disorders.

WHAT IS CLINICALLY RELEVANT

- Less severe forms, with short duration of symptoms and prompt response to treatment are common in children especially from developing countries.

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