

Psychosocial Factors in Children and Adolescents with Conversion Disorder*

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ABSTRACT

Introduction

In view of the limited studies on the psychosocial environment of children presenting with conversion disorders, the present study was carried out to study the psychosocial factors in children with conversion disorders.

Method

40 patients of Conversion Disorder, who presented with 'pseudo seizures' and were diagnosed according to DSM IV criteria, comprised the sample. They underwent detailed psychiatric assessment. The psychosocial events and factors and were elicited by administering the PSLES and by interviewing the parent and child by a semi-structured interview, which covered details of school history, family environment, psychosexual and other behavior: The intellectual level of the patients was assessed by a battery of psychological instruments Relevant investigations, hormonal assays, radiological, EEG etc. were done wherever necessary.

Results

Majority of the patients were educated up to 5th class, had rural domicile and belonged to poor and lower middle SES. They were about equally represented in the two sexes
Borderline Intellectual functioning, improper schooling, family stress and current past/ physical illness were present in 37.5-40 % (N=15-16) of the cases. Incidental radiological and EEG findings and unusual status of the child; only son, only child
or the youngest child; were present in 33% (N=13) of the cases. Conversion/ epilepsy in family/ neighbour / friend and improper parenting was encountered in 22.5-20.5% (N=8-9) of the cases. Lastly, recent loss of loved one and sibling rivalry were seen to be significant in 7.5 to 12.5% (N=3-5) of the cases. 80 % of the patients had 2-3 contributory factors; the remaining had either 4 or 5 contributory factors..

Conclusion:

Stress was apparent in the areas of school, family and body. Greater attention must be paid both by teachers and parents by supervising the children's studies more closely. Parenting skills need to be sharpened for the better functioning of the child. Attention needs to be paid to better physical health during infancy and early childhood.

Key words: Conversion Disorder, Psychosocial, Stress, Children

Introduction

Kanner (1948) took the credit of reporting the first case of childhood hysteria in the scientific literature. Manchanda and Manchanda (1978) observed that hysteria formed the commonest diagnostic group (71.4%) in their sample. Hysteria was observed to be the commonest neurosis in children (Sharma et al, 1980). Conversion disorder is by far the commonest form of somatoform disorder seen in children (Malhotra & Saluja, 2005).

In conversion disorder symptom/ s emerge that closely resemble a major medical or neurological condition, which is often temporally associated with a significant psychosocial stressor, and is not explainable by a psycho-physiological mechanisms or principles. Consequently, the symptoms cause considerable distress to the family and physician, rather than to the patients themselves. This manifests as *la belle indifference*. The symptoms frequently reported in children and adolescents include pseudosiezes, paresis, paraesthesias and gait disturbances (Grattan-Smith et al, 1988)

Majority of studies on Conversion Disorder have been on adults. Psychological factors, particularly adverse family situations (Grattan-Smith, 1988), have been implicated in the etiology of Conversion Disorders in children. However, these have not been studied systematically.

Keeping in view the above limitations the present study was carried out to study the psychosocial factors in patients of conversion disorder presenting at a Child Guidance Clinic in a teaching hospital in Varanasi (Eastern Uttar Pradesh), India.

Material and Method

40 patients of Conversion Disorder, who presented with 'pseudo seizures' at the Child Guidance Clinic of the Out Patient Section, University Hospital, Banaras Hindu University, Varanasi, India, comprised the sample. The patients were diagnosed according to DSM IV criteria (American Psychiatric Association). Only those cases where the family was available to give a detailed history and cooperate for necessary investigative procedures were selected for the study.

Structured Proforma

Information about socio-demographic, psychiatric history, physical and mental status examination was recorded on a Structured Proforma

The Presumptive Stressful life Events Scale (PSLES) (Singh et al, 1981) was administered by an open ended interview to elicit major life events in the past 3 months.

Interview

As the PSLES is more suited for adults, further enquiry was conducted by interviewing the child and parent. Following items were covered by a semi-structured interview so as to elicit any major psychosocial events in the past 3 months.

School History:

1. Scholastic performance
2. Relationship with peers

Table 1		
Socio-demographic Characteristics of sample		
Variable	N	%
Age		
5-8 years	6	15
9-12 years	27	67
13-16 years	7	18
Sex		
Female	22	55
Male	18	45
Domicile		
Rural	25	65
Urban	15	35
Education		
Up to 5 th Class	28	70
6 th to 10 th Class		
SES (PCI/month)		
Up to Rs 500/-PCI	24	60
>500 to 1000/-	16	40
NB: Socio-economic status (SES); Per capita income (PCI)		

3. Relationship with teachers
4. Tuitions
5. Monitoring of Studies
6. Coercion During Teaching

Family:

1. Relationship with parents, siblings other relatives
2. Family discord
3. Similar symptoms in family/ neighbour
4. Physical abuse
5. Sickness in family

Psychosexual:

1. Any boy / girl friend problem
2. Sexual abuse

Other:

(If any)

Investigations:

The intellectual level of the patients was assessed by a battery of psychological instruments; Bhatia Battery of Tests of Performance, Ravens Coloured and Standard Progressive Matrices, and Indian Adaptation of Weschler's Intelligence Scale for Children. (Malin, 1979).

Table 2		
Contributory psychosocial factors		
	N	%
1. Borderline Intellectual functioning	16	40.0
2. Improper schooling	16	40.0
3. Family Stress	16	40.0
4. Current past/ physical illness	15	37.5
5. Incidental Radiological / EEG findings	13	33.3
6. Only son /Only child/ Youngest	13	33.3
7. Conversion disorder/ epilepsy history in family/ neighbour/ friend	9	22.5
8. Improper parenting	8	20.0
9. Recent loss of loved one	5	12.5
10. Sibling rivalry	3	7.5
(N=40)		

Relevant investigations such as hormonal assays, Computerised Tomography scan of brain, EEG etc. were done wherever necessary.

Results

Majority of the patients were educated up to 5th class, had rural domicile and belonged to poor and lower middle SES. They were about equally represented in the two sexes (Table 1).

The psychosocial factors / events elicited by administering the PSLES or by interviewing the parent and child are listed in Table 2.

Borderline Intellectual functioning, improper schooling, family stress and current past/ physical illness were

Table 3		
Contributory psychosocial Factors)		
No	N	%
2	15	37.5
3	17	42.5
4	7	17.5
5	1	2.5
(N=40)		

the commonest psychosocial contributory factors being present in 37.5-40 % (N=15-16) of the cases.

Incidental radiological and EEG findings and family factors like being the only son, the only child, or the youngest child; were next most common factors and were present in 33% (N=13) of the cases. Conversion/ epilepsy in family/ neighbour / friend and improper parenting was also fairly common and was encountered in 22.5-20.5% (N=8-9)of the cases. Lastly, recent loss of loved one and sibling rivalry were seen to be significant in 7.5 to 12.5% (N=3-5) of the cases

80 % of the patients had 2-3 contributory factors; the remaining had either 4 or 5 contributory factors (Table 3).

Discussion

This investigation attempted to study in a systematic manner the psychosocial environment of children presenting with conversion disorder at the child guidance clinic of a teaching hospital (University Hospital, Banaras Hindu University, India) in Varanasi (Eastern Uttar Pradesh). This was done by utilizing the PSLES and by conducting a semi-structured interview of the child and parent. It is pertinent to mention that the University Hospital caters to a vast population that hails from Uttar Pradesh, Madhya Pradesh, Bihar and even Nepal. Majority of the patients attending the hospital have a low level of literacy, and are economically and socially underprivileged. The findings of this study should be interpreted in light of the socio-cultural context

Psychosocial factors have been implicated in genesis of conversion disorders. Severe and sudden emotional stress serves to precipitate conversion reaction in predisposed children. The symptom serves to solve the conflict and the gain obtained served to perpetuate the illness (Sousa et al, 2004).

In the present enquiry the significant psychosocial factors were encountered and these were related to 10 different areas of functioning. Stress relating to 'studies' was the most common and present in 40% of the children. Poor quality of teaching in schools, little or no monitoring of studies at home, hardly any communication between parents and teachers regard progress, and little realization by the parent about the child's deficiencies were the amongst the problems encountered. Most children were left on their own. For some, tuitions were arranged, but then there was no follow-up to see to what extent they were helpful. High expectations from the parents and low level of parents' education, added to their difficulties of children.

Intelligence of children has been cited as a factor in the etiology of conversion disorder. Both superior intelligence, because it is associated with greater reactivity to environmental events, and borderline intellectual functioning, because impairs the ability to cope effectively, have linked to the development of conversion symptoms

in children (Sousa et al 2004). 15 children had (IQ between 71-84) because of which they could not cope well at home and school.

Family factors have been known to play a significant role in the expression and persistence of conversion symptoms (Malhotra & Saluja, 2005). Grattam-Smith (1988) identified 2 broad patterns of disturbances among families of children with conversion disorder (1) anxious families preoccupied with diseases and (2) disorganized and chaotic families.

Disturbed family environment was seen in an appreciable proportion (40%) of the cases. In joint families in India the child is often looked after by several carers; grandparents, parents, uncles and aunts. In 40% of the cases there were repeated clashes between the primary carers (mothers /fathers) and the surrogate carers (grand parents, uncles, aunts), either covertly or overtly. The former was generally punitive while the latter was over protective and over indulgent. Another source of stress was that the child did not want to live in the village and manipulated the environment so that his uncle or father could take him to the city, where there were not only better schools, but also good opportunities for enjoyment.

Association of conversion symptoms with previous medically identifiable illness or injury varies from 10 % (Grattan-Smith et al, 1988) to 60% (Spierings et al, 1990). Sometimes a mild medical injury precedes a conversion disorder. It was interesting to see that past physical illness in some way contributed to the production of conversion symptoms. 14 children had recurrent febrile and other illnesses during their infancy or early childhood which made them very sensitive about their bodily functions. One child lost one eye in an accident when he was just 5 years old and after extensive medical and surgical treatment was given a false eye. This became the reason for excessive somatic concern.

Incidental investigation findings such as borderline EEG record, EEG record suggestive of a seizure disorder, calcification seen in CT of brain etc, though clinically insignificant, did go to sensitise the child and his parent towards his bodily functioning. Non-significant investigation reports were present in 33% of the cases.

Unusual status of the child was seen to be significant in about 1/3 of the cases. Being the only child, especially if he was born / adopted several years after marriage; being the only son amongst several daughters, or being the youngest child conferred a special status to the child. In such situations parents were overindulgent and this perpetuated stress.

Witnessing a relative or friend in school with conversion symptoms or epilepsy was fairly common and seen in 8 cases. It must be remembered that children learn by identification and imitation, which explains conversion reactions in parents and their children more clearly (Sousa et al, 2004)

Improper parenting was also evident in 20 % of the cases. For example, no proper guidelines were set for the behaviour of children; no definite routine was to be followed; beating, abusing and threatening the children, rather understanding and helping them; insensitivity to the child's needs etc. Often the father was out of the

house for farming or business and mother busy with her domestic chores. The child received little or no supervision..

In 5 cases there was a recent loss of loved one (supportive figure), either an aunt or a parent or grand parent, to whom the child was attached both emotionally and for instrumental help.

Sibling rivalry was also seen in 3 cases. While the female child was coerced into domestic chores, the male child was overprotected and did none of them. Besides, the parents discriminated against the female child in many other ways.

All the children who presented with conversion symptoms had 2 or more contributory factors. Also, acute and chronic events seemed to have an additive effect on the child.

In summary, it may be stated that the most important areas in which stress was apparent was in school, family and body. Greater attention must be paid both by teachers and parents by supervising the child's studies more closely. Parenting skills need to be sharpened for the better functioning of the child. There is a need to educate families about the importance of better care of physical health during infancy and early childhood to prevent recurrent illnesses and excessive sensitization toward the functioning of one's body.

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