

Conversion disorder in children and adolescents A 4-year follow-up study

Berna Pehlivantürk*, Fatih Unal

Department of Child and Adolescent Psychiatry, Faculty of Medicine, Hacettepe University, PK 67 Samanpazari 06242, Ankara, Turkey

Received 29 May 2001; accepted 1 November 2001

Abstract

Objective: To assess the outcome of conversion disorder in children and adolescents and to identify factors affecting the prognosis. **Method:** Forty adolescents with conversion disorder were reevaluated 4 years after their initial interview. Changes in demographic and clinical data and the presence of any mood and anxiety disorders were recorded using the Structured Clinical Interview for DSM-IV Axis I Disorder (SCID-I). In addition, Beck Depression Inventory (BDI) and State–Trait Anxiety Inventory (STAI) were applied. **Results:** Thirty-four patients (85%) had completely recovered from their conversion symptoms and two patients had improved (5%), whereas only four (10%)

were unchanged. Fourteen (35%) patients received the diagnosis of mood and/or anxiety disorder. Favourable outcome was associated with early diagnosis ($P=.04$) and good premorbid adjustment ($P=.01$). **Conclusion:** Conversion disorder has a favourable outcome in children and adolescents. However, mood and/or anxiety disorders are encountered at a considerable rate in these patients even after recovery from conversion symptoms. Long clinical follow-up seems appropriate in children and adolescents with conversion disorder. © 2002 Elsevier Science Inc. All rights reserved.

Keywords: Adolescent; Child; Conversion disorder; Outcome

Introduction

Conversion disorder causes major medical, social, and economic problems both in western and developing countries. However, relatively few studies evaluated outcome and long-term prognosis in children and adolescents. While many conversion symptoms remit spontaneously or with minimal intervention after a few days or weeks, some have a less benign prognosis [1]. A favourable outcome is generally reported in children and adolescents, with clinical improvement rates varying from 56% to 100% [2–6].

Although variables predicting poor outcome in conversion disorder are not well defined, polysymptomatic presentation, pseudoseizures, chronicity of the symptoms, comorbid psychiatric or medical disorders, poor capacity to gain insight, severe internal conflict, and serious family dysfunction are accepted as poor prognostic factors while

younger age, early diagnosis, close liaison between pediatricians and child psychiatrists, good premorbid adjustment, the presence of an easily identifiable stressor, cooperation of the child and the family are generally associated with favourable outcome [4,5,7–10].

The aim of this prospective, referral-based study is to assess the long-term prognosis in conversion disorder of children and adolescents in a naturalistic design. Specifically, the following questions were addressed: (a) What are the overall outcome rates of conversion disorder in children and adolescents? (b) What are the influences of the demographic and clinical variables such as age, gender, premorbid adjustment, type, severity and chronicity of symptoms, and comorbid psychiatric disorders on the outcome?

Method

Sample and procedure

In this report, 40 patients with conversion disorder were studied. All children and adolescents aged 9–16 years who

* Corresponding author. Tel.: +90-312-388-5015; fax: +90-312-310-0012.

E-mail address: bpturk@gen.hun.edu.tr (B. Pehlivantürk).

presented to Hacettepe University Hospital with somatic complaints in 1995–1996 were assessed initially in the pediatric and adolescent outpatient clinics to rule out organic disorders by physical and neurological examinations and consultations with pediatric subspecialties. Appropriate laboratory tests such as EEG, video EEG, EMG, CT, and MRI were performed as part of the work-up in the pediatric neurology clinic.

Ninety-eight patients without positive medical findings were referred to the department of child psychiatry. Two child and adolescent psychiatrists independently evaluated all subjects according to DSM-IV diagnostic criteria, and only subjects diagnosed by both clinicians as conversion disorder were included in the study. The interrater reliability was high ($\kappa = .877$). From 98 initial inquiries, 27 subjects were excluded because they were diagnosed with other somatoform disorders: undifferentiated somatoform disorders ($n = 13$), pain disorders ($n = 8$), somatoform disorders not otherwise specified ($n = 4$), and somatization disorders ($n = 2$). Further 16 subjects were excluded since their somatic symptoms were better accounted for by anxiety disorders: panic disorders ($n = 7$), separation anxiety disorders ($n = 5$), generalized anxiety disorder ($n = 1$), and anxiety disorders not otherwise specified ($n = 3$). Other exclusion reasons included patients who had difficulties in cooperation due to mental retardation or psychotic disorders ($n = 4$). A final group of 51 children and adolescents with the diagnosis of conversion disorder was included in the study. Their clinical features have been described in another article [11].

Patients received treatment for conversion disorder and comorbid disorders according to the protocols of the Department of Child Psychiatry. As it was not intended to evaluate treatment methods, no attempt was made to randomize the therapeutic interventions, which included informing patients and parents about the clinical characteristics of conversion disorder; eliminating misbeliefs and unrealistic worries, encouraging insight gaining about factors initiating or aggravating the symptoms, diminishing anxiety, dealing with secondary gains, and teaching how to avoid somatic language and express emotions verbally. Integrative treatment modalities that included the whole family were used to develop more effective communication patterns in the family. In addition, 28 patients (55%), mostly with comorbid psychiatric disorders, were treated with psychotropic medication.

An attempt to contact these 51 patients was made after a mean interval of 4 years (S.D. = 0.2, range 3.5–4.5) from their initial interview. Forty-two (82.3%) adolescents and their families could be reached and 40 (78.4%) of them agreed to participate in the follow-up study. There were no statistically significant differences in demographical and clinical parameters between these adolescents and those who could not be contacted or declined to participate ($n = 11$, 21.6%). The same child psychiatrists recorded the changes in the demographical and clinical data using a semistructured interview. Mood and anxiety disorders were assessed with the Structured Clinical Interview for DSM-IV

Axis I Disorder (SCID-I), and symptom severity, with the Clinical Global Impression Scale (CGI). In addition, Beck Depression Inventory (BDI) and State–Trait Anxiety Inventory (STAI) were applied to 39 (97.5%) patients.

Measures

Interview form

This form, developed by the authors, consisted of two parts: the first part recorded demographical and clinical data obtained at the initial visit, such as the complaints of the patient and the family, age of onset, referral time, the duration of the symptoms, premorbid adjustment, school performance, precipitating medical and psychosocial factors, previous medical problems, and included the DSM-IV criteria of somatoform disorders, anxiety disorders, and affective disorders. This part was completed and confirmed with hospital records.

Parents' opinions about their children's premorbid adjustment and relationship patterns with peers and themselves were assessed by open-ended questions. The presence of at least one of the following behavioural characteristics, which was described earlier [12], was defined as premorbid conduct problems: incompatibility, disrespectfulness, arrogance, aggressivity, argumentativity, oppositional behaviour, or difficulty to get along.

The second part of the interview form was designed to record the changes in demographical and clinical data 4 years after the initial interview and included the course of the symptoms, relapse, and appearance of new symptoms.

SCID-I, clinical version

This semistructured interview form was developed by Spitzer et al. [13] and reviewed for DSM-IV by First et al. [14]. Çorapçıoğlu [15] provided the Turkish version of the instrument.

BDI

This is a self-report instrument developed by Beck et al. [16] for depression. Evidence supporting the instrument's reliability and validity for Turkish population is provided by Hisli [17] in adolescents, and its cut-off for depression was determined as 17 points.

STAI

This self-report instrument was developed by Spielberger et al. [18] to measure the subjective level of anxiety both in special situations and in general. STAI was standardized by Öner and LeCompte [19] for Turkish population and the mean values in the normative study ranged from 36 to 41 points, with higher scores indicating higher levels of anxiety.

CGI

Severity ratings for the conversion symptoms on the CGI scale were as follows: 1 = normal, 2 = borderline, 3 = mild,

متن کامل مقاله

دریافت فوری ←

ISIArticles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات