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CONVERSION DISORDER

Abstract

Conversion disorder is an uncommon but highly disabling condition in childhood. Affected children are often severely impaired and at risk of serious long-term physical and psychosocial complications including, educational failure, social isolation and psychiatric morbidity. The condition can be associated with extensive use of paediatric and allied health resources. Despite the huge personal suffering and health resources implications of Conversion disorder, the epidemiology and clinical burden in children has not been documented in the UK. We propose the first study aimed to describe the frequency, pattern and short-term outcomes of Conversion disorder in children in United Kingdom and Ireland. Consultant paediatricians and child and adolescent psychiatrists will be asked to report all cases of conversion disorder every month. A questionnaire will be sent to clinicians reporting a case to gather demographic and relevant clinical information. A follow-up questionnaire will be sent to reporting clinicians after 12 months. The study's findings could help to inform service planning for children with this seriously impairing condition.

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Background

Conversion Disorder is characterised by the presence of motor and or sensory symptoms for which there are no or inadequate medical explanations (WHO 1990, American Psychiatric Association 1994). Typical Conversion disorder symptoms include motor weakness, abnormal movements, non-epileptic seizures, and loss of sensory functions such as sight, hearing, and touch. The symptoms are not intentionally produced and are associated with significant distress. Affected children are often severely impaired, require prolonged hospital admissions (Kozlowska et al 2007, Grattan-Smith et al 1988), and are at risk of serious long-term complications including, educational failure, social isolation and psychiatric morbidity. The condition is associated with extensive use of paediatric and allied health resources.

Conversion disorder has been well documented in population studies of children and adults in other countries. In a recent national surveillance study of Australian children younger than 16 years, Kozlowska and colleagues identified 194 newly diagnosed cases over 2 years (incidence of 2.3-4.2 per 100,000) (Kozlowska et al 2007). This is the only population-based study of younger children with Conversion disorder we are aware of. Other studies of Conversion disorder in children are case reports and case series (Kotagal et al 2002, Kramer et al 1995), Lancman et al 1994, Grattan-Smith et al 1988, Rock et al 1971). There are no systematic epidemiological studies of Conversion disorder in the UK.

Given the huge personal suffering and health resources implications of Conversion disorder in children, documenting the burden, pattern, and short-term outcome in UK and Ireland could be important in planning services and allocating resources for caring for affected children.

Coverage United Kingdom and Republic of Ireland

Duration October 2008 – October 2009 (13 months)

Research Questions

Specific aims of the project are to:

- To estimate the incidence of Conversion Disorder in children in Britain and Ireland
- To describe the clinical features of Conversion Disorder at presentation
- To describe associated co-morbid psychiatric or medical illness and family history of psychiatric illness
- To describe current management of children with Conversion Disorder including investigations
- To determine the duration of illness and the short term outcome

Case definition

Any child younger than 16 years newly diagnosed with Conversion Disorder during the previous month in Britain and Ireland. Conversion disorder is **DEFINED** as:

The presence of one or more symptoms and or signs affecting motor function (e.g. weakness, abnormal gait or movements, difficulty with swallowing, or loss of speech), and or sensory function (e.g. loss or diminished sensation of touch, sight, or hearing), and or non-epileptic seizures (also known as pseudo seizures). **AND**

The symptoms and or signs:

1. Cannot be adequately explained by a medical condition after full investigation (according to the judgement of the treating clinician), and
2. Have no evidence that they have been intentionally produced, and
3. Cause significant distress and or interference in daily activities such as with self care, school attendance, play, or family activities for up to 7 days or longer, and
4. Are accompanied by psychological factors that are judged to be associated with or have contributed to the presentation

EXCLUSION CRITERIA

1. Cases where the clinical picture is predominantly or exclusively pain or fatigue, and or
2. Cases where the dominant picture is another psychiatric disorder such as depression or psychosis diagnosed by a child and adolescent psychiatrist, and or
3. Tic disorder

Reporting instructions

Please report any child, aged up to (but not including) 16 years of age, with suspected or confirmed Conversion Disorder seen by a paediatrician for the first time in the last month. If a paediatrician is uncertain or awaiting confirmation, the child should still be reported.

Methods

Paediatricians reporting a case through the orange card system will be asked to complete a questionnaire seeking demographic and relevant clinical information. A further follow-up questionnaire will be sent after one year to gather information on outcome. Notifications will also be sought from Child and Adolescent Psychiatrists through a separate surveillance system similar to BPSU.

Ethics approval

This study has been approved by the Charing Cross Hospital MREC (Ref: 08/H0711/30) and has been granted PIAG Section 60 Support (Ref: PIAG/BPSU 3-06(FT1)/2008)

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