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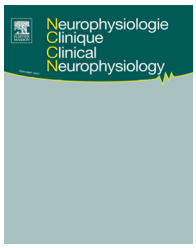

REVIEW/MISE AU POINT

Conversive disorders among children and adolescents: Towards new ''complementarist'' paradigms?

Troubles conversifs de l'enfant et de l'adolescent : vers de nouveaux paradigmes complémentaristes ?

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Summary This paper aims to describe current questions concerning conversive disorders among children and adolescents. We first describe prevalence and clinical characteristics of these. Many unresolved questions remain. Why do patients show excess, or loss of function? Attachment theory offers a relevant framework to answer this question. Does neurobiology of conversion disorders shed light on conversive processes? Current neurobiological research paradigms focus on the symptom, trying to infer processes, instead of proposing paradigms that test theoretical hypotheses. The most convincing theoretical framework that has already proposed a coherent theory of conversion is a psychodynamic one, which has not yet been tested with neurobiological paradigms. The interest of studying child and adolescent conversive disorders is to provide a means to more deeply investigate the two challenges we face: theoretical, and clinical ones. It provides the opportunity to access a pathopsychological process at its roots, not yet hidden by many defensive, rationalizing attitudes, and to better explore environmental features. We propose a ''complementarist'' model, which allows the combination of different approaches (neural, cognitive, environmental, attachment, intra-psychic) and permits proposal of different levels of therapeutic targets and means.

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Attachement

Résumé Cet article propose une revue des questions actuelles concernant les troubles conversifs de l'enfant et de l'adolescent. Il en décrit la prevalence, les caractéristiques cliniques. Mais il reste des questions non résolues. Pourquoi les patients ont-ils tantôt une perte, tantôt un excès d'une fonction ? La théorie de l'attachement propose un cadre pertinent pour répondre à cette question. Les données neurobiologiques actuelles sur la conversion éclairent-elles les processus conversifs ? Les paradigmes neurobiologiques actuels se concentrent sur le symptôme, essaient d'en inférer des processus, plus qu'ils ne proposent des paradigmes qui testent des hypothèses théoriques. De fait, le cadre théorique le plus pertinent jusqu'ici pour comprendre les troubles conversifs est psychodynamique ; il n'a pas encore été testé avec des paradigmes neurobiologiques. L'intérêt d'étudier les troubles conversifs de l'enfant et de l'adolescent est d'aider à répondre aux deux challenges restants : théorique, et clinique, en permettant d'avoir accès au processus, à ses origines, avant qu'il ne soit remanié par des défenses ou des attitudes rationnalisantes, et de mieux explorer les caractéristiques environnementales. Nous proposons un modèle « complémentariste », qui permet de combiner différentes approaches (neurale, cognitive, environnementale, attachementiste, intrapsychique), et de proposer différents niveaux de cibles et moyens thérapeutiques.

Lasègue (1816—1883) wrote: ''Hysteria has never been defined, and never will be'' [26]. This sentence remains true for conversive disorders, a term which has supplanted that of hysteria. The DSM-V and ICD-10 classifications differ in describing conversive disorders [1,46]. This disorder is often confused with somatization disorder. Diagnoses of exclusion are more frequent than positive ones. It is therefore difficult to accurately characterize conversive disorders, especially among children and adolescents, mainly because the prevalence is lower than in adult cases, and referrals come from various sources (general practitioners, pediatricians, psychiatrists, child neurologists, orthopedic surgeons, and so on). Finally, this diagnosis is often accompanied by medical counter attitudes, variously named and badly accepted by the patients [41]: hysteria and conversion are stigmatizing diagnoses. It is a great challenge to try to characterize conversive disorders among children and adolescents, because this allows access to the roots of a pathopsychological process, not yet hidden by many defensive, rationalizing attitudes. Family involvement and environmental features are easier to explore, since family is involved, and this can help in understanding such a process.

Characteristics of conversive disorders among children and adolescents

Prevalence

The prevalence is hard to determine: studies cite from 2.3 to 4.2/100,000 in pediatric clinics [19]; 0.2% to 2% of children in child psychiatry out-patient clinics [11,13,27,28]; and 0.78% of inpatients for somatoform disorders with 57.3% of conversion disorders [13]. Some authors have described cultural differences in prevalence (14.8% in an Indian sample [40]).

Sex-ratio

Girls are more represented among conversion disorder patients, and represent a higher proportion compared to other groups of somatoform disorders (2.1:1 ratio in somatoform disorders, [13]).

For some authors, sex-ratio depends on the age: 57% girls before 10 years, versus 76% in a 10—16 years sample [19], though not for others, reporting 75% female in both groups, under 10 years and 10—15 years old [2].

Sex-ratio also depends on the symptoms, although this feature is somewhat controversial since more boys 5—10 years and more girls after 12 years are reported to have psychogenic non-epileptic seizures (PNES) [16]. The prevalence seems to have changed across time: from 15.8% boys between 1987 to 1996, to 52.2% from 1997 to 2006, probably due to increasing extrafamilial stress [14].

Age

Symptom onset is reported in most studies to occur around 12 years (median age 12.5 years, [2]), but this seems to depend on the type of symptoms. It appears earlier in PNES (8.2 years for boys, 9.4 years for girls, [3]). Conversive disorder rarely appears before 8 years. It takes 11.6 months between the first episode and the diagnosis [2,35], more in the case of PNES (1.3 years, [16]).

Symptomatology

The most frequent symptoms are PNES (52.1% fainting attacks [or ''pseudosyncope''] [9] and pseudoseizures (21.1% [13]; 40% [2]; 84% [35]), and motor symptoms (64% [5], motor weakness 63.3% and abnormal movements 43.2%, [2]). Sensory symptoms are less prevalent: 7.5% [35] to 24% [19]. Pain is associated in 34 to 68%. Usually, more than 2 symptoms appear (57% [32]; 20% [24]; 55% [19]). A ''borrowing'' symptom exists in 29 to 54% cases, in which the physical symptoms appears to be copied from a family member [12,24,29]. The classical sign of ''belle indifference'' is discussed (46.7% [9]; 27.1% [2]), but seems to be non-pathognomonic in adults [42].