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Invited Commentary 1

Similarities and differences in conversion disorder in adults and children

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As a psychiatrist working with conversion disorder in adults, I have always had a degree of envy of those treating children. It has seemed that all parties to paediatric cases treat them with a relative seriousness, that consequently all parties remain relatively engaged, that consequently it's relatively possible to engineer a therapeutic change in the patient's environment, and that outcomes are consequently relatively good. But perhaps the grass merely seems greener. Dr Kozłowska describes a situation with childhood conversion disorder that is familiar, if not identical, in many respects to that with adults. Though in adults we rarely see the whole family in consultation, they usually loom large, and rarely benignly, in the patient's history; the disordered attachments she describes in her child patients often seem to be present in my patients in disordered adult attachments to partners or health providers; the initial resistance to a psychiatric interpretation from families she describes is in adult cases presented by the patient, with the partner sometimes even less, sometimes markedly more, open to such a view.

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However, though I entirely agree that a skilful neurological assessment is vital to further engagement and prognosis, I am not sure how to interpret the moral outrage presented by family regarding their preceding neurological encounters. When I came into the field I had heard enough legends of appalling behaviour by neurologists to think this might hold the key to the whole therapeutic problem of conversion disorder: that their accusations of malingering might force patients to remain ill to validate their distress and prove the neurologist wrong, and to shun psychiatry as representing an acceptance of that neurological dismissal. Though my initial investigations certainly uncovered more legends (Kanaan, Armstrong & Wessely, 2009), the story of current practice seemed much more nuanced. Few neurologists today openly endorse such views (Kanaan, Armstrong & Wessely, 2011), though I think deception remains an issue for them - after all, their investigative approach hinges on 'tricking' patients into doing what they say they can't, or otherwise unmasking a simulation of a neurological disorder (Kanaan, 2010).

Furthermore, when I have explored these previous distressing medical encounters with patients, I am often surprised by how similar the offending neurologist's explanation seems to have been to my own. Of course much nuance may be lost in translation: if neurologists really do harbour significant concerns over feigning these may be revealed in subtleties of emphasis and intonation. It may also be that the neurologist is conveying the same message in a less sensitive way: though I have never met a neurologist I didn't like (well, maybe *one*), neurologists, at least by caricature, are not selected for their empathy. But finally, it may be that the patient seeing me is just further along on their journey of acceptance, and that *whoever* gave that first assessment would have been met with anger: by the time I see them in outpatients, after all, they have already accepted the message to the extent that they are willing to come along and speak to a psychiatrist. I think the stage and the setting make a big difference.

I also find it interesting that the outrage comes from the family in Dr Kozłowska's cases. This may be unimportant of course – the child's shyness or deference to their parents, or their limited grasp of neuropsychiatric subtleties, may be all that's needed to explain their reticence. But I wonder what is the *moral* responsibility accorded to a child with conversion disorder? I assume it is rather less than an adult patient's, perhaps matched with their age. With adults there is a moral

seriousness about their behaviour, with a child there is often rather less – at least in the non-clinical world, and in the very young. Both of my young children developed hemipareses this morning, for example: the first, because they didn't get enough sympathy for a trivial injury; the second because the little sympathy the first got was not equally given to them.

I have no wish to trivialise the issue, or detract from the devastating impact the disorder may have, but seriousness is precisely the point: in children we are able to involve a range of explanations – play-acting, pretending, copying – that would be unconscionable in an adult, in large part because we don't think the child's actions *are* morally serious. To stretch a point, the illness deception widely recognised in non-human species such as monkeys is routinely described as malingering (Byrne and Stokes, 2003), never as conversion disorder. Why? Not because we think they better understand their own behaviour, are more insightful, surely – if anything, we think they are less – but because it *doesn't matter*, morally. To that end the family's outrage may represent something rather different than the child's, or indeed my patients'.

It's interesting too, given the similarities, that I don't see more adult patients in whom it's possible to clearly identify an episode of childhood conversion disorder. To be clear, my patients often have a background of related conditions or symptoms that raise doubts as to their origin, but a clear-cut conversion disorder in their childhood definitely seems rarer than it should – accepting that our epidemiological knowledge of conversion disorder is too limited for me to offer any attempt at a quantification of this. If I'm right, why might this be? It could be, of course, that the treatment offered to children is more successful, as described, but also more comprehensive, addressing the roots of the disorder as well as its symptoms, so that child patients get something closer to a real cure. It could also be that the disorder in adults, though perhaps related, is importantly different – that, for example, the disordered attachment or family dynamics are simply not risk factors or causes of the same significance in adults, or that the different psychological or neurobiological development of an adult translates into a fundamentally different mechanism.

But finally, it could be that these symptoms are not inevitable consequences of a certain kind of development and environment but also depend on an event – a trigger

– as Dr Kozłowska describes – and that such events, though perhaps not uncommon, only produce their effects when the conditions are right, be that in childhood or adulthood. The aetiological relevance of such events is a matter of some debate in the world of adult conversion disorder at present (Stone and Edwards, 2011; Jankovic, 2014) but I have no doubt that their significance will only be properly understood when, as Dr Kozłowska attempts, they are taken in their full bio-psycho-social context.

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