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Hysterical paralytic conversion

(About two clinical cases)

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Abstract

The concept of disorders related to hysterical conversion has long been controversial. Although the diagnosis mentioned is confirmed by competent clinicians and psychiatrists, several authors still consider this diagnosis to be equivalent to an inability to detect an organic cause for the disorders reported by the patient. Conversion disorder consists of one or more unconsciously and involuntarily produced neurological symptoms or deficits, usually affecting voluntary motor skills or sensory functions. The manifestations are incompatible with known physiopathological mechanisms or anatomical pathways. The onset, worsening, and maintenance of conversion disorder symptoms are often associated with psychological factors, such as stress or trauma. Diagnosis is based on history after exclusion of physical disorders. Treatment begins with the establishment of a therapeutic relationship marked by empathy and support; psychotherapy can help, as can hypnosis. Our study is part of a psychopathological research involving two children with somatic conversion disorders.

Keywords: hysterical conversion, involuntarily, neurological symptoms.

Introduction

The cases presented in our study are those of two male children, aged 9 and 11, with symptoms of somatic conversion. Symptoms of somatic conversion are paradigmatic for hysteria in adults. In a context of criticalization of neurosis in new international classifications, the interest of a psychodynamic approach remains essential. It makes it possible to raise the question of the relevance of the reference to the concept of neurosis in children and to open the debate on the difference between the observable symptom and the underlying psychopathological organization.

Observation

Observation No 1

This is a 9-year-old child from a non-consanguineous marriage with good psychomotor development hospitalized for paraplegia.

The admission clinical examination found flaccid paraplegia, with abolition of the patellar and achilles ROT, and a skin-plantar flexion reflex, with retention of sphincter control.

Additional assessments are carried out during an etiological assessment, including magnetic resonance imaging (MRI) of the brain and medulla (redone 3 times), a biochemical and cytobacteriological study of the cerebrospinal fluid, an electroencephalogram (EEG) and video EEG, as well as electroneuromyogram, all returned without abnormality.

The course was marked by a spontaneous improvement in the motor deficit, the family survey and the child psychiatric examination revealed excessive

authoritarianism on the part of the father and excessive introversion and shyness in the child.

Observation No 2

This is an 11-year-old child, from a non-consanguineous marriage, with good psychomotor development, who presented dizziness and headache complicated by tetra-paresis with trismus and bilateral ptosis, the whole evolving in a context of disorder of conscience.

Admission clinical examination found an obnubated child with GCS 12, flexible neck, trismus with aphasia and bilateral ptosis, He presents with tetraparesis with osteotendinous reflexes present, Babinski indifferent, superficial and deep sensitivity retained.

Additional assessments are carried out during an etiological assessment, including magnetic resonance imaging (MRI) of the brain and medulla (redone 3 times), a biochemical and cytobacteriological study of the cerebrospinal fluid, an electroencephalogram (EEG) and video EEG, as well as electroneuromyogram, viral serologies, testing for anti NMDA and anti MA2 antibodies in the context of autoimmune encephalitis, as well as testing for toxins in the blood and in the urine, all returned without abnormality.

The evolution was marked by an improvement in the motor deficit, after putting on anxiolytic and child psychiatric monitoring, the family investigation found introversion and excessive shyness in the child, as well as persecution in the school environment.

Discussion

"Conversion disorder" is defined by the DSM-IV-TR (American Psychiatric Association) as follows: "Conversion is a symptom; neither intentionally produced nor simulated [1]. This is a loss or damage to a function of voluntary motor skills or sensoriality suggesting a general medical or neurological condition but which cannot be fully explained by such a condition. Psychological factors are believed to be associated with the symptom as long as the onset of the disorders is observed to be preceded by conflict or other stressors ".

Hysteria has been described in women since the 15th century, while cases of hysteria in children and adolescents have only been reported since the middle Ages. And it was not until the 19th century that infantile hysteria was recognized, in particular, by BRIQUET and FREUD. FREUD allowed the recognition of the psychological origin of hysteria, he understood by the notion of hysterical conversion the displacement on the somatic level of an intrapsychic conflict where the repressed unconscious fantasies would be symbolized in the language of the body [2].

Conversion disorders are observed in a privileged way in pediatric wards and only the most serious clinical forms are approached from a truly psychopathological angle and are seen by child psychiatrists, hence a probable underestimation of this disorder. It is necessary to delimit from what age one can speak of conversion **[3].**

The age of use of this concept varies widely depending on the author. Conversive disorders involve the child's recognition of their body, and often their gendered body. The hypothesis of the existence of a psychosexual intrapsychic conflict underlying the symptom formation. This postulate is inspired by the work of Freud and his successors. The spectacular conversions observed at the "PitiéSalpêtrière "**[4]** led Freud to the discovery of the infantile sexual etiology of neuroses. According to him, conversion is part of a neurotic process of symptom formation, that is to say of research of compromise between desiring motions and censorship, carried by differentiated psychic bodies - conscious, preconscious and unconscious, according to his first topic. These irreconcilable representations are repressed in the unconscious and the charge of affect associated with them

is transposed into the body, converted into energy of "somatic innervations", as Freud puts it [3-5].

Most authors admit that we can speak of hysterical conversion from 8-10 years old, and that there is a frequency peak with the first pubertal transformations.

Symptoms of conversion disorder often develop suddenly and their onset can often be related to a stressful event. Typically, symptoms include apparent deficits in voluntary motor skills or sensory functions, but sometimes involve tremors and disturbances in consciousness (suggesting seizures) and abnormal limb position (suggesting another general neurological or physical disorder)[6]. Conversion disorder is characterized by the presence of symptoms or deficits affecting voluntary motor skills or sensory functions, suggesting a general neurological or medical condition; we are talking about pseudo-neurological disorders. Patients may have a coordination or balance disorder, muscle paralysis or weakness in an arm or leg, loss of feeling in part of the body, seizures, unresponsive state, blindness, diplopia, deafness, aphonia, difficulty swallowing, a lump in the throat, or urinary retention. They may present either a single, generally short episode, or several repeated episodes of conversion; symptoms can become chronic [7].

The diagnosis is based on the presence of clinical characteristics specific to each dissociative disorder, the absence of any argument in favor of a physical disorder capable of accounting for the symptoms, the demonstration of arguments in favor of a psychological origin, c 'that is, a clear temporal relationship between the onset of the disorder and that of a stressful event, a traumatic problem or a disturbance in interpersonal relationships [8].

A triggering event is almost always found, the neurological examination is normal, and motor skills are released during sleep.

The therapeutic management requires the presence of the pediatrician and the child psychiatrist. Mainly includes psychotherapy, pharmacological treatment is rarely necessary.

Conclusion

The diagnosis of hysterical conversion is a diagnosis of elimination which remains difficult, the elimination of a somatic pathology comes up against the limits of sensitivity of preclinical explorations on the one hand, and on the other hand, a positive psychopathological explanation is far from certain. " Be systematically found when no organ city is retained to explain symptoms, you must know how to think about it when the exploration does not reveal any organic anomaly.

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