

CONVERSION DISORDER: A CASE REPORT

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ABSTRACT:

Conversion/dissociative disorders are more prevalent in childhood and adolescence, generally affecting females more than males. They are associated with stressors which are perceived as unmanageable, and the symptoms generally

reflect a means to avoid the stressor. The case report presents a successful intervention involving five sessions.

Mesh words: Conversion disorder, case report

INTRODUCTION:

Conversion disorder refers to mild and temporary symptoms which can be motor or sensory in nature involving anaesthesia or paresthesia, especially of extremities, abnormalities of movement, gait disturbance, weakness and paralysis, gross rhythmical tremors, choreiform movements, tics and jerks[1]. Any sense modality may be involved. Reflexes remain normal. There might be associated primary and secondary gains which act as maintaining factors[2]. The disorder is more common in adolescence than in childhood[3,4].

CASE REPORT

A 10 year old boy, Standard V student, presented complaints of stiffness in body and inability to flex knee joints.

History revealed occasional complaints of body pain for the last 2 months which was relieved by body massage. One week back the boy complained of body pain and vomited after having breakfast. He was not sent to school. He slept for about 2 hours and woke with stiffness of body and inability to flex upper and lower limbs. He was admitted in a hospital, where he regained mobility of the upper limbs but was not able to bend his knees and walked with a stiff gait. His mother noticed that when the child was asleep his limbs were not rigid and would be flexed. The following morning he was able to walk and run. When discharge was planned there was a relapse. He was then referred to the Department of Clinical Psychology, SRU.

There was no significant past history of psychiatric or neurological disturbances. Developmental history was reported to be unremarkable. Family relationships were reported to be cordial. Problems in the school were reported. A gradual decline in performance was reported He feels discriminated and victimised by his class teacher and expressed strong resentment for not getting required attention and reinforcement from his class teacher.

Psychological evaluation using Children's Apperception Test (CAT) and Malhotra's Temperament Scale (MTS) did

not give more insight. However, good prognostic indicators were elicited in terms of resolution of problems and favourable outcomes. The clinical picture is indicative of a diagnosis of *Dissociative Motor Disorder, F 44.4*, according to ICD 10[5].

The child was seen for five therapy sessions. On the first visit the child was seen to be sitting in the chair with his legs held parallel to the ground since he was not able to flex his knees. He was dragging his feet while walking. The child was provided reassurance regarding the management of symptoms. Possible consequences of persistence of symptoms were also discussed. He was made to do movement exercises by slightly moving his feet preceded by deep breathing. As he was moving his feet suggestions of increased flexibility were given. With continued effort of 10 – 15 minutes he could bend his knees and sit in a normal position for a brief period. His effort to move his lower limbs were encouraged and appreciated. The child was asked to continue the movement exercises at home and given a suggestion that he would flex his knees at right angles. In the second session held the next day child walked less stiffly and was able to bend his knees to right angles as suggested. His parents were educated about the psychosomatic nature of his symptoms and advised to encourage him for developing a symptom free lifestyle. They were also told not to pay attention to his complaints of physical symptoms

By the third session held the next day, his gait was normal. He reported to have pain in his lower limbs but was able to flex his knees. He was still unable to bend his knees fully. He was reinforced for the improvement and asked to continue the movement exercises at home and resume all usual activities.

Addressing the school related issues he was allowed to talk about alternatives available to deal with the current situation. His parents were advised to allow him to communicate his difficulties freely, look at issues objectively and help him develop an adaptive coping style.

The child was asymptomatic and had resumed his earlier routine by the fourth session which was held the next day. He was seen once more after a period of one week during which improvement was maintained. Follow up was maintained for 2 more sessions with the parents with a week's interval in between during which also improvement was maintained. Telephonic contact was maintained upto 3 months during which he continued to be symptom free.

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Conversion disorder, somatoform disorder, and malingering remain diagnostic challenges for the clinicians. The prompt identification of these patients, use of appropriate and validated physical examination manoeuvres, and coordination of care and information exchange between all members of the care team may facilitate the expeditious care of these patients in a cost effective manner[6]. Early themes including stress and conflict are linked to conversion symptoms[7]. Psychogenic symptoms should be treated using suggestions, patience and reassurance[8]. Early recognition of a conversion disorder will limit unnecessary tests and medications. The quality of doctor-patient relationship can influence outcome. The existing literature supports a multidisciplinary treatment approach, with specific interventions, such as cognitive behaviour therapy for cognitive restructuring and psychodynamic therapy for addressing symptom connections to trauma and dissociation[9].

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