
Two Cases of Conversion Disorder

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The paper reports two cases of Conversion Disorder, one without any underlying physical pathology and the other coexisting with physical pathology. The patients presented with neurological symptoms including weakness of both lower limbs and gait disturbance and inability to walk. The severity of symptoms, in these patients could not be explained on the basis of medical examination and laboratory investigations. Medical treatment given were ineffective. On psychological interviewing, stress factors were detected which may have precipitated in the observed symptomatology. With the provisional diagnosis of conversion disorder, the patients were given appropriate psychotherapy. The patients were able to walk without any support.

Introduction

Patients with bodily symptoms or somatic preoccupation are common in both primary care and psychological settings and yet receive little attention, relative to their prevalence and severity of their illnesses. For decades they have been treated pejoratively by both medical specialists and psychologists and labelled “crocks”. The past decade has demonstrated the seriousness of their clinical condition and offered a new hope for treating them (Goldbloom, 2008).

All of the somatoform disorders share some common elements. The first is that the symptoms that somatoform disorder patients experience cannot adequately be explained by a known general medical condition or direct side effects of a substance-- either a drug of abuse or medication. All laboratory investigations are non contributory and are unable to substantiate the severity of symptoms. All of the somatoform disorders require that the symptoms are not intentionally produced, as occurs with factitious disorder or intentionally feigned for conscious gain, or with malingering. Somatoform Disorders, as defined by DSM IV TR, includes somatisation disorder, undifferentiated somatoform disorder,

Conversion disorder, Pain disorder, Hypochondriasis, Body Dysmorphic Disorder and Somatoform disorder not otherwise specified. In this article, we present two cases of conversion disorder, one without any underlying physical pathology and the other, coexisting with physical pathology (Goldbloom, 2008).

The term somatoform derives from the Greek word “soma” which stands for body. And the disorders, termed as somatoform disorders, make a broad group of illnesses that have bodily signs and symptoms as a major component. These disorders encompass mind-body interactions in which the brain, in ways still not well understood, sends various signals that impinge on the patient’s awareness, indicating a serious problem in the body. Additionally, minor or as yet undetectable changes in neurochemistry, neurophysiology, and neuroimmunology may result from unknown mental or brain mechanisms that cause illness. In fact physical and laboratory examinations persistently fail to show significant data about the patient’s complaints, which are, nevertheless, vigorous and sincere. Patients with these disorders are convinced that their suffering comes from

some type of presumably undetected and untreated bodily derangement (Kaplan & Sadock's, 2003).

For the first time in 1980 in the third edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-III), somatoform disorders have been defined as those disorders in which bodily sensations or functions, as the patient's predominant focus, are influenced by a disorder of the mind (Kaplan & Sadock's, 2003).

The text revision of the IV edition of DSM (DSM-IV-TR) recognizes five specific Somatoform Disorders (Kaplan & Sadock's, 2003) :

1. **Somatization Disorder:** characterized by many physical complaints affecting many organ systems.
2. **Conversion Disorder :** characterized by one or two neurological complaints.
3. **Hypochondriasis :** characterized less by a focus on symptoms than by patient's beliefs that they have a specific disease.
4. **Body Dysmorphic Disorder:** characterized by a false belief or exaggerated perception that a body part is defective.
5. **Pain Disorder:** characterized by symptoms of pain that are either solely

related to, or significantly exacerbated by, psychological factors.

According to DSM-IV-TR, there are two more Residual Diagnostic Categories of Somatoform Disorders (Kaplan & Sadock's, 2003) :

1. **Undifferentiated Somatoform Disorder** : Includes somatoform disorders not otherwise described that have been present for six months or longer.
2. **Somatoform Disorder not otherwise Specified:** Includes category for somatoform symptoms that do not meet any of the somatoform disorder mentioned above.

There are few necessary elements for diagnosis of all of these Somatoform Disorders (Goldbloom, 2008):

- A detailed history is obtained and a thorough physical examination is conducted.
- The symptoms cannot be explained by a known general medical condition or the direct side effects of a substance or drug abuse.
- The Diagnosis of all somatoform disorders require that all appropriate medical investigations have been performed and are within normal limits.

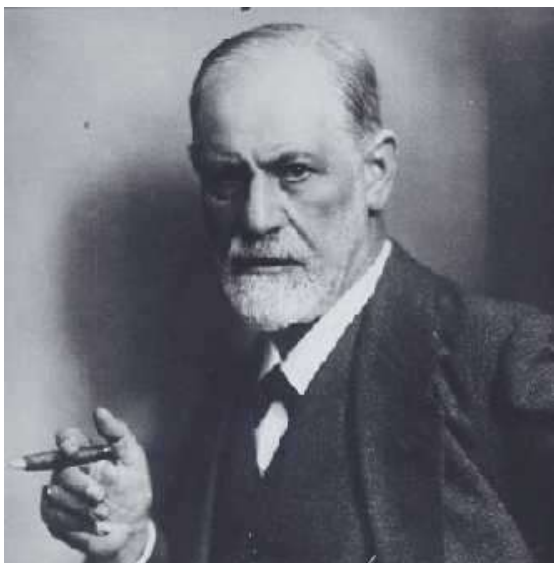
To sum up Somatoform Disorders involve a somatic symptom physiologically unexplained but genuinely felt ailment. The incidence of these bodily symptoms varies among different cultures. In these disorders

the distressing symptoms take somatic form with no apparent physical cause (Kaplan & Sadock's, 2003). A person may have a variety of complaints as shown in Table 1.

Table 1: Complaints shown by patients with Somatoform Disorder

<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	Dysphagia (Difficulty in Swallowing)
<input type="checkbox"/>	Severe & Prolonged pain
<input type="checkbox"/>	Insomnia (Sleeplessness)
<input type="checkbox"/>	Fatigue (Getting Exhausted)
<input type="checkbox"/>	Weakness
<input type="checkbox"/>	Headache

Although the symptoms may be psychological in origin, they are nevertheless genuinely felt.



The term conversion was introduced by Sigmund Freud, who, based on his work with

Anna O, hypothesized that the symptoms of conversion disorder reflect unconscious conflicts (Kaplan & Sadock's, 2003).

Patients with conversion disorder may unconsciously model their symptoms on those of someone important to them e.g., a parent or a person who has recently died may serve as a model for conversion disorder. During pathological grief reaction, bereaved persons commonly have symptoms of the deceased (Ahuja, 2001).

Case 1

The first patient was A.N, 16 yrs. old female, studying in 10th class, has a rural background

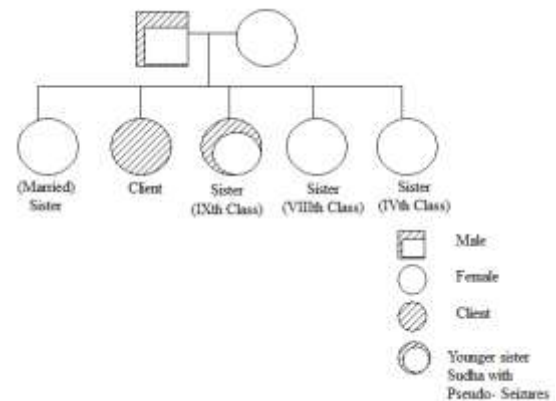
(Himachal Pradesh) and has four female sibs. Her father was a labourer in water supply, and mother was a housewife. The subject felt headache since the age of 11 yrs, and giddiness for the last six months, She had undergone five to six episodes of unresponsiveness lasting for about one to two hours (twice in her school, once at home and 4 times when at tuition). she also complained of extreme contraction of her leg muscles and inability to walk and step forwards. There was no history of any tonic or clonic movements, frothing mouth or any tongue-bite. She was brought to the hospital in lap by her father.

Past History

Closed head injury at 5 years of age and Post Traumatic Headache. The client started complaining of headache since the age of 11 yrs after she sustained closed head injury by accidentally striking her head against a door.

Family History

She had four female sibs. Elder sib was married. Younger sib was having pseudo seizures. Younger sibs were well. Father was alcoholic



Psychological and Stress Factors

- **Separation from parents as a toddler:**
Patient was separated from her Parents at a tiny age of 3 years as she was adopted by her paternal aunt.
- **Adoption by “Bua” (her hather’s sister):** She stayed with her “Bua” thereafter for the next 11 to 12 years and all her initial physical, mental and social development took place in her 'bua's' house.
- **Unable to develop a loving bond with “Bua”:** She could never develop loving bond with her “bua” during her stay in “bua's” house (insecure attachment). She kept remembering her parents from time to time (showing separation anxiety).
- Joined her family after 11-12 years.
- Feeling of non-acceptance in the parental family.

- Lack of development of loving bond with her sibs.
- Younger sister, a student of IXth Standard had pseudo-seizures and attracted the attention of all the family members, and consequently A.N. felt more dejected.
- Father's image got shattered in her mind. as he was alcoholic.
- A.N. was scolded at school for trivial things.
- Her ego was hurt due to teacher's misbehaviour at school
- She had developed fear of not being able to achieve her aim of becoming a nurse.

Examination/Investigation/Medical Treatment

- Patient's physical examination was normal
- Neurological examination was within normal limits.
- MSE (mental status examination) didn't reveal any abnormality either.
- All Laboratory Investigations were within normal range
- Psychiatry treatment given was ineffective.

Diagnosis

As the detailed examination and all the investigations were within normal limits and medical treatment proved to be ineffective, a provisional diagnosis of a psychological disorder. The stress factors were explored which suggested an underlying conflict leading to the present symptomatology and a diagnosis of Conversion Disorder was made. According to Cameron (1963) and DSM IV the conversion reaction is a process whereby an unconscious conflict is transformed (converted) into a body symptom which reduces tension and anxiety by expressing conflict symbolically. Coleman (1976) described this type of hysterical neurosis as involving a neurotic pattern in which symptoms of physical illness appear without any underlying pathology.

Finally diagnosis of Astasia Abasia was reached as the predominant symptoms were motor symptoms that included weakness and paralysis of both lower limbs. When made to walk she elicited gait disturbance characterized by wide based staggering ataxic, dramatic or irregular gait.

Astasia Abasia is one major motor symptom of conversion disorder. It is a motor coordination disorder characterized by inability to stand despite normal ability to move legs when lying down or sitting.

Therapy

Careful listening and development of good rapport: Ravi listened to the client carefully and made her comfortable. He motivated her to come out with all her good and bad feelings that have been affecting and modifying her behaviour and pushing her to a stressful situation since early childhood. The therapist developed good rapport with her and had a humanistic and encouraging approach towards her.

Motivation to think positively: Ravi asked her to develop a positive insight and shun all the negatives feelings.

Family Therapy: Father and other caretakers were advised to look after the client and devote some time to her so as to bring her out of stress and get her rid of false sense of discrimination that had been polluting her mind.

Suggestions: The father was also advised to leave alcohol as this habit of his was adding to the stress on the mind of A.N. She was given various convincing suggestions that her symptoms were purely because of stress.

Relaxation and Behaviour Therapy: She was given relaxation and behaviour therapy to cope with her stress.

Suggestions to think positively: She was advised to think positively. Ravi told her that each individual has to face stress in daily life and one should try to face them with courage.

Ravi advised her to relax her body and mind to get rid of stress and tide over her symptomatology. For this Ravi also took help of certain relaxation exercises.

Relaxation exercises in an attempt to convince the client that she had no "true" paralysis: Ravi requested the client to lie down comfortably on the bed and instructed her to imagine that she had no physical problems. On this assertion, she showed a few movements of her legs. Ravi asked her to relax further and raise her legs one by one in air as far as possible but she failed to do that. To provoke her further, Ravi took help of a pen and held it at a vertical distance of about 2 to 3 feet from her legs. Ravi suggested to her to make an attempt to raise her legs to touch my pen. She showed some movements of her legs but was unable to touch my pen. Then Ravi brought his pen further down, near her legs, and asked her to try to touch my pen again with her legs one by one. She raised one of her legs and almost touched my pen. But at this point, Ravi raised the pen slightly from the previous level. She gradually raised her legs successfully up in the air in an attempt to touch my pen and was successful in doing so. Now she was convinced that she could move her legs and was not suffering from any pathological disease. This simple behavioural therapy, motivation and physical exercises accompanied by my verbal encouragement changed her mind and symptoms of

conversion reaction significantly. She repeated the manoeuvre ten times and was finally reassured that she didn't have any or 'true paralysis'. The total time taken during this behavioural test was around 15 to 20 minutes

Re kindling her desire to become a nurse, as a tool to get her out of psychological conflict:

Ravi hypothesized that her suppressed desire to become a nurse could be rekindled and used as a tool to get her out of the conflict. Therefore Ravi suggested her that in case she really wanted to become a nurse, she had to study and work hard. Not only that, she was suggested that she could work better as a nurse if she could walk on her legs. After this counselling she was asked to smile as a nurse because in the profession of a nurse she has to keep smiling to give relief to her patients. Ravi drew a picture of a nurse before her as a lady who doesn't bother about her own suffering but gives relief to the patients, always with a smiling face. If she had to become a nurse, she also had to forget about her suffering and learn to smile. Soon smile appeared on her face (Her parents, who were nearby were surprised to see her smiling and laughing with me).

Case 2 (with physical pathology)

My second patient is S.K a 44 yrs. old female, a school teacher by profession, who presented with complaints of inability to walk

properly with an ataxic, unstable and irregular gait along with complaint of weakness of both lower limbs. She also complained of symptoms of depression in form of not feeling like working, loss of interest in daily routines, remaining confined to her house, reduced appetite and insomnia. Also she gave history of having spells of myoclonic jerks every two to three months with occasional fall to ground, but no injury; there was no history of unconsciousness during these episodes of fall. She complained of occasional abnormal movements of her right hand. There was no significant past or family history.

General Physical Examination didn't reveal any specific finding except that she had mild pallor. Systemic examination and detailed neurological examination were non-contributory.

Investigations and Clinical Diagnosis

Her EEG showed bilateral parasagittal slow wave neuronal dysrhythmia. There was no evidence of epileptogenesis from this EEG. A cerebral MRI (Magnetic Resonance Imaging) showed bilateral fronto-parietal cerebral atrophy (Figure-1). Cerebellum also showed atrophic changes (Figure-2). Her ECG was normal and no other investigation showed any substantial finding.



Figure-1: MRI of S.K. with bilateral fronto-parietal cerebral atrophy.

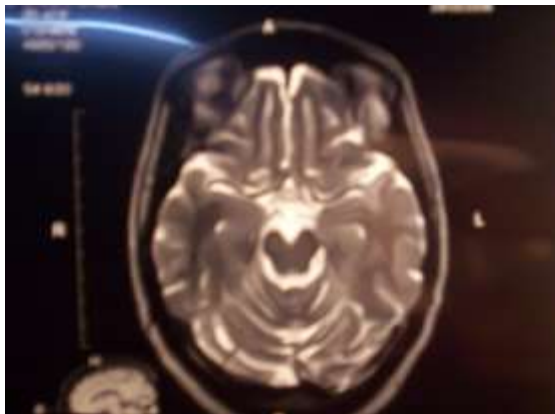


Figure-2: MRI of S.K. with atrophic changes in cerebellum.

A clinical diagnosis of bilateral cerebral and cerebellar atrophy with symptoms of depression was made.

Treatment Given

The patient had already had medical treatment from general physicians, psychiatrist and neurologist. The patient was given antidepressants, anti-convulsants and symptomatic therapy along with

physiotherapy. All these treatments had no effect.

Psychological Opinion

Finally, a psychological opinion was sought. When she was brought to Krishan Diagnostic & EEG Centre, the major symptom was weakness of both legs with ataxic and irregular gait and inability to stand. Symptoms of depression were also seen.

Stress Factors

Family History revealed that she was living in a nuclear family and didn't maintain good relations with her family members. The husband was in service and didn't devote enough time to her. For many a days, he didn't even meet her. Repeatedly, she revealed that her husband had absolutely no time for her and she had not seen his face, sometimes even for months. Most of the times, before she could get ready for her school, the husband used to leave the house and at night as well, he made it a point to enter the house only when she was fast asleep. Even on holidays, he had no time for her. She has a daughter who is studying in matric. The daughter also didn't have any time for the mother. S.K. felt very lonely and having come back home from her school, she didn't have anything to do. She always dreamt that she is unable to walk and her husband is

taking her to a doctor and her daughter is standing beside her bed.

MSE

Her mental status examination was normal. She could inter-act well with normal eye-to eye contact.

Psychological diagnosis

A provisional diagnosis of Conversion disorder and Depression (with physical pathology) was postulated.

Treatment Given

Having listened to the patient carefully, Ravi developed a good rapport with her. In two to three sessions only, she started discussing her family details with me accusing her husband all the times for not taking care of her.

She was given behavior therapy and psychotherapy with abreaction. Gradually, she was brought to conscious awareness that she had no true paralysis of her legs and if tried, she could walk well and at least attend to her school. This was followed by supportive psycho-therapy. Family therapy was also given as an adjuvant with a few sessions with both the husband and the daughter. Appropriate drug therapy was continued as per advice of the treating physician.

Most of her symptoms got abated after the therapy. She started walking properly with a normal gait and could attend to her school regularly.

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