

A Case Report of Conversion Disorder Secondary to an Unresolved Childhood History of Sexual Abuse

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ABSTRACT

Conversion symptoms can develop in adults with a childhood history of chronic sexual abuse. Allowing the patient to reconstruct the trauma narrative can result in a diminution of symptoms.

Keywords: Conversion disorder, sexual abuse

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INTRODUCTION

The purpose of this report is to describe a case of conversion paralysis, secondary to a childhood history of chronic sexual abuse, which is not commonly identified in the clinical setting in Jamaica. Conversion disorder is characterized by “unexplained symptoms or deficits affecting voluntary motor or sensory functions that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptoms or deficits” (1). Patients suffer neurological symptoms such as numbness, blindness, paralysis, fits with no existing defined organic cause. Patients who suffer conversion symptoms do not intentionally feign such symptoms, as those described as malingers or those with factitious illness do; they experience them as genuine symptoms. Conversion disorder may occur in isolation; however, in many instances a personality disorder is also seen, most commonly histrionic, passive-aggressive, borderline, or, in males, antisocial. Dysthymia or major depression may also occur concurrently (1).

Generally, the lifetime prevalence of conversion disorder is not known with certainty, and estimates range from 0.01% to 0.5% of the general population. In a community survey of a population in Florence, the one-year prevalence figure for conversion disorder was noted to be 0.3% (2). It is more common in females, with female to male ratios ranging from 2:1 up to 10:1.

CASE REPORT

A 32-year old, right-handed female presented to the mental health service in September 2012 with a history of suggested weakness on the left side.

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The patient reported that she was last well in the early part of 2006 when a dental procedure was performed on the lower left side of her mouth. She reported that since that procedure, she has developed several abscesses on different occasions, a numbness to the left side of her body and a “weakness” to her left lower and upper limbs. Several visits to her dentist did not identify any clear dental health issues and revealed no association between her extraction and her weakness.

She presented to several hospitals since then with recurrent episodes of hemi-anaesthesia and hemiparesis. Several assessments were done and initial diagnosis of recurrent stroke in the young was made on some of these occasions. Of note, she reported that her initial neurological deficits would spontaneously resolve, returning her to baseline functioning. Her diagnosis was inconclusive; there was no confirmation with several computed tomography (CT) scans of the brain and spinal cord. Magnetic resonance imaging (MRI) revealed no focus and her repeated collagen vascular screens were normal.

She continued to have multiple episodes of the symptoms and then began walking with an abnormal gait on the left since about September 2010. The patient began to ambulate with her ankle inverted to compensate for this “weakness” in her lower limb. She continued to associate these symptoms with the dental procedure in 2006.

In September 2012, the patient checked herself into a mental health institution complaining of “feeling depressed”. At that time, she admitted to a long-standing history of recurrent bouts of depressive symptoms. She gave over a 20-year history of recurrent episodes of severely depressed mood, anhedonia, avolition, appetite and sleep changes, excessive feelings of guilt with suicidal ideas and one episode of ingesting an overdose of tablets previously. On presentation to the mental health institution, she had significant depressive symptoms with suicidal plan and intent. She also had reported recurrent limb weakness.

Thorough physical and neurological examination only revealed a flexion deformity of her left ankle and no other neurological deficits accounting for her subjective feelings of weakness.

Psychiatric evaluation revealed significant depressive features; no evidence of gain was identified. She was admitted to the institution and managed for depression with a selective serotonin reuptake inhibitor (SSRI), psychotherapy and two weeks later referred to another mental health institution for more long-term psychotherapy.

Detailed psychological and psychiatric assessments revealed a history of sexual abuse, starting at age eight years. The perpetrator was an adult male member of her family. She described repeated violent acts of sexual abuse that continued on a regular basis until she was able to escape at age 16 years. She also reported a history of severe physical abuse by her female caregiver throughout her childhood and limited emotional support from the adults in her life. She reported that the adults in her life did not protect her even when she attempted to disclose the abuse. This history of abuse also extended into her adult life in the form of physical and emotional abuse from her male partners.

The patient participated in 12 weekly therapy sessions between October and December 2012 and bi-monthly follow-up sessions in January to March 2013. The therapeutic approach used was trauma-focussed cognitive behaviour therapy [TF-CBT] (3). Components of TF-CBT included:

- Psychoeducation about childhood sex abuse and emotional and behavioural reactions to trauma.
- Introducing patient to relaxation techniques such as deep breathing exercises.
- Affective expression and regulation – assisting patient to identify salient emotions connected to the trauma and to appropriately express them. Also, assisting patient to manage emotional reactions to reminders of the trauma.
- Cognitive coping and reframing – assisting patient to explore and correct inaccurate attributions about the cause of and responsibility for the trauma, as well as assisting the patient to place in perspective any blame for the results of the traumatic experiences.
- Trauma narrative – patient was allowed, through gradual exposure exercises to the traumatic experiences, to reconstruct her childhood experience, as an adult, in the safety of the therapeutic space.

In summary, the therapeutic space provided a safe place for the patient to ventilate and reconstruct her trauma narrative. The patient was motivated to change, and by the end of the initial 12-week treatment course, began to show improvement in gait and a diminution of her physical complaints. She also was weaned of the antidepressant and was observed for recurrence of symptoms.

DISCUSSION

Toward the end of the 19th century, Pierre Janet, a pioneering French psychologist, conceptualized a relationship between conversion disorder and childhood trauma, viewing the dissociation of cognitive, sensory, and motor processes as adaptive (4, 5). In a recent study, Roelofs *et al* found that patients with conversion disorder reported a higher incidence of physical/sexual abuse than the patients with affective disorder and that the patients with conversion disorder mentioned a larger number of different types of physical abuse, longer-lasting incidents of sexual abuse and incestuous experiences more often (4).

The course of the development of the symptoms of conversion disorder in the index case report resembles that of another case identified in the literature in an adolescent patient (6). In that case, a 16-year old adolescent developed a series of severe somatic symptoms following Salmonella poisoning. Organic causes were excluded after the diagnostic procedures and a diagnosis of conversion disorder was established after detailed psychological and psychiatric assessment linked its aetiology to a history of sexual abuse (6).

Another adolescent case was identified in the literature where a 15-year old girl was admitted to paediatrics with medically unexplained neurological complaints, chiefly urinary retention and also tremors and constipation (7). After the organic evaluation, the patient was transferred to the psychiatric ward for further management. As the case unfolded, this adolescent disclosed a history of chronic sexual and physical abuse and neglect.

Another study investigating childhood trauma, dissociation and other psychiatric co-morbidity in patients diagnosed with conversion disorder (5) found that at least one psychiatric disorder was found in most of the sample (89.5%). The most prevalent psychiatric disorders included undifferentiated somatoform disorder, generalized anxiety disorder, dysthymic disorder, simple phobia, obsessive-compulsive disorder, major depression, and dissociative disorder not otherwise specified. In the sub-group with at least one psychiatric disorder identified, it was found that they more frequently reported childhood emotional and sexual abuse, physical neglect, self-mutilative behaviour and suicide attempts (5).

CONCLUSION

This is a case of conversion paralysis identified in an adult woman with a chronic history of childhood sexual abuse. The trigger event for the development of symptoms was a dental procedure to which the patient attempted to establish a plausible explanation for her somatic symptoms. The dental procedure was conducted in 2006 and the patient entered mental health care in 2012. The case highlights the importance of an interdisciplinary approach in the management of cases, particularly those with longstanding histories of multiple hospital admissions for undefined causes and for

those with histories of somatic complaints for which organic causes cannot be established. Providing the patient with a safe environment to ventilate and reconstruct her childhood trauma narrative formed the basis for a diminution of her somatic symptoms.

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