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# Simultaneous occurrence of conversion disorder in siblings in paediatric age group and its outcome: A follow up study

Agrawal S.[1]*, Sharma D.[2], Sharma D.K.[2], Vijayvergia D.K.[2]

[1]Department of Psychiatry, NSCB Medical College, Jabalpur (M.P.), India
[2]Department of Psychiatry, Government Medical College, Kota (Rajasthan), India
**Correspondence Address:** * Swapnil Agrawal, Department of Psychiatry, NSCB Medical College, Jabalpur (M.P.), India.

**Abstract**
Conversion disorder is commonly seen in adolescents and young adult females. Its occurrence in paediatric age group is not very common. Only few cases have been so far reported in paediatric age group. Simultaneous occurrence of same conversion symptoms in two siblings at the same time has been seen in our case. Significant response after aversion therapy in both the patients signifies its role in the management of conversion disorder. All these things make this a rare case all together to be reported.

**Keywords:** Conversion disorder, Paediatric, Aversion therapy

## Introduction

Conversion disorder is defined as a loss or alteration of a function of the motor, sensory, and neurovegetative systems, which cannot be explained by organic causes [1]. In various reports from India and elsewhere, conversion disorder constitutes 6-15% of all OPD diagnosis and about 14-20% of all neurotic patients[2]. Females usually outnumber males[3] but in children the percentage may be similar[4]. Akdemir D et al reported a considerable decrease in its frequency among children below 5 years of age[1]. It is more common in relatives of people with conversion disorder[4].

We here present a case report of 2 siblings with ICD-10 diagnosis of dissociative disorder. The importance of this case is early onset of similar conversion symptoms simultaneously in two siblings (at an age of 8 years & 12 years) and rapid resolution of symptoms after aversion therapy.

## Case history

### Case 1:

"M" an 8year old male child, student of class 3rd of urban background was brought to the psychiatric OPD on 13th September, 2013 by his mother with complaints of episodes of abnormal body movements and heavy breathing for last 1 month.

These complaints started on 15th August, 2013 just after "M" returned from school. The episode included turning and twisting of neck, abnormal movements of hand and body like an animal, and heavy breathing lasting for 30 - 60 seconds. The movements of body were not tonic-clonic type. The episodes were never associated with any tongue-bite or frothing from mouth, no physical injury or soiling of clothes and also

never occurred during sleep. Such episodes occurred multiple times (9-10 times) during the past one month after first episode and were precipitated by suggestions. On enquiring "M" told that on the day of 15th August, teacher scolded him in school for not wearing proper-uniform. There was history of a similar episode 2months back which resolved without any treatment after consultation to a physician.

Patient belonged to a family of middle socio-economic status and lived with his parents and 2 elder-sisters one 16years and other is "N"12years old (who also presented to the psychiatry OPD with similar complaints described in detail later). There is history of episodes of possessed behaviour in patient's maternal grandmother and history of some psychiatric illness and episodes of possessed behaviour in patient's mother 6 years back for which she took psychiatric treatment for 3 months and has been alright since then.

Patient was admitted in psychiatry ward for detailed evaluation. Physical and Mental state examination did not reveal any abnormality. Routine investigations, EEG and CTscan-head were normal. A diagnosis of Dissociative motor disorder F44.4 was made and patient was started on Tab.Amisulpride[5] 25 mg BD and Tab.Alprazolam 0.25 mg half BD. During his stay in hospital patient had one more similar episode after which Aversion-therapy (Faradic-stimulation i.e. giving an aversive electrical stimulation over wrist and forehead with low amperage electrical current)[6] along with suggestions to stop further recurrence, was given. Individual and family therapy was also given. There was no episode after that during his 5-day stay in the hospital. Patient was then discharged with the same pharmacological treatment. On subsequent follow-up visits after 15 days, drugs were reduced and tapered off. After 2 months of drug free period patient was found to be alright with no recurrence of such episodes.

**Case 2:**

"N"-elder sister of 'M', 12year old female child was also brought along with 'M' with complaints of abnormal body movements and heavy breathing since 15th August starting after the occurrence of similar episode in her brother 'M'. There were 6-7 episodes of similar type in past 1 month. The episodes were similar to 'M' and were never associated with any tongue-bite or frothing from mouth, no physical injury or soiling of clothes and never occurred during sleep. On enquiring she said that everyone at home likes 'M' more than her. She was also admitted along with 'M' in psychiatric ward. Physical and mental state examination was normal. Routine investigations, EEG and CTscan-head also came out to be normal. A diagnosis of Dissociative motor disorder F44.4 was made and Tab. Amisulpride 50mg BD and Tab. Alprazolam 0.25mg half BD was started. Aversion-therapy (faradic-stimulation), individual and family therapy was also given and patient was discharged with the same pharmacological treatment and was followed up subsequently after 15 days when drugs were reduced and tapered off. Patient was alright in follow-ups at 1 and 2 months with no recurrence of such episodes.

**Discussion**

Conversion disorder, somatoform disorder, and malingering remain diagnostic challenges for the clinicians. In our case the diagnosis of conversion disorder was made on the basis of clinical history and examination, in light of a normal neurological examination and normal routine laboratory tests. Conversion disorders usually present in adolescence or young adulthood and are not common before the age of 10 or after 35[7]. The simultaneous presentation of conversion symptoms in "M" and his elder sister 'N' on the same day with similar symptoms along with family history of possessed behaviours supports the notion that conversion disorder is more

common in relatives of people with conversion disorder[4]. This increased frequency may be as the result of identification of himself by the patient with a significant individual, often someone whom the patient associates with loss and has also experienced such symptoms (conversion model)[8] or there may be a genetic base. Schulte-Körne G et al reported occurrence of conversion disorder in 3 successive generations of a family in whom the phenotype and the age of onset were very similar in all the family members affected and this etiology is best understood in terms of a genetic condition and as the result of imitation and identification with an affected family member[9]

There is no fixed protocol for management. Oulis P et al has reported substantial and durable improvement in motor conversion symptoms with low dose amisulpride.[5] Hafeiz and Bagherzadeh-Shahidi et al found aversion-therapy to be as effective as other treatment modalities[6,10] which was applied on our patients and resulted in significant improvement.

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