

Case report

Management difficulties in a patient with conversion disorder with comorbid bipolar disorder

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Summary

Conversion disorder has several co-morbidities. Bipolar disorder is one of them. There is no definitive treatment protocol for cases like this. In this report, we presented a case of a 30-years-old female who had this kind of condition. Initially, she had a presentation like conversion disorder. But after giving her treatment, features of bipolar disorder had come to the surface. We faced many difficulties regarding the management of this patient. By this case, the clinicians would have a better understanding of this kind of condition. This report might help clinicians in the management of conversion disorder with comorbid bipolar disorder.

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Introduction

Conversion disorder, also called functional neurological symptom disorder,¹ is defined as a psychiatric illness in which symptoms and signs affecting voluntary motor or sensory function cannot be explained by a neurological or general medical condition.² Studies have estimated that 20 to 25 percent of patients in a general hospital setting have individual symptoms of conversion, and five percent of patients in this setting meet the criteria. Bipolar affective disorder is uncommon but can be a comorbid condition of conversion disorder.³

Case summary

A 30-years-old married Muslim homemaker hailing from a rural area was admitted to the National Institute of Mental Health with complaints of increased self-esteem, talking more than usual and decreased sleep for 3 weeks, shortness of breath followed by a fit-like attack and 2 suicidal attempts within 7 months. She started to have fit-like attacks since class 6 mostly during exams because her academic performance deteriorated. In these attacks, she developed shortness of breath followed by fit-like attacks which were not associated with injury, unconsciousness and postictal confusion. It mostly occurred during day time, in presence of others, and after any family conflict. It was later resolved spontaneously. But she could not continue her study further. She continued her study up to class 8. Then in 2009, she got married because her family didn't want to continue her study any further. She lived with her husband and in-laws in a low socioeconomic family. Her in-laws were rude to her. They used to mistreat her frequently. After the delivery of her first stillborn child again, she started having a similar fit attack which

was from 2012 and continued up until 2014. But she did not receive any treatment. It got resolved spontaneously. She was relatively well up to 2021. She developed similar kinds of fit-like attacks for 7 months after her sister-in-law stole 40 thousand takas from her. She was also talking more than usual in these last 7 months mostly about how she wanted to help poor people. She attempted suicide two times within the last 7 months by putting kerosene on her body and lit up her body and by trying to hang herself impulsively in front of her in-laws after a family conflict. She also developed elevated self-esteem as she identifies herself as ma Khadiza for 3 weeks. She also stated that, Allah communicated with her through her mind and Allah had given her a special job to feed the poor people. She was sleeping less for 3 weeks with late-onset and early awakening. She was showing overactivity as she tried to do all household chores by herself and by doing this, she wanted to impress her in-laws. With these complaints, she went to a medical specialist who prescribed her flupenthixol and melitracin combination. But her condition did not improve with the medications. She has comorbid bronchial asthma and taking medications for it. Her elder sister had a history of fit like an attack. She had authoritarian parenting in childhood. The premorbid mood was anxious, and she wanted to work in the perfect way. From mental state examination revealed that, her appearance was tearful, she shook her body and cried for no good reason, but she was cooperative during her interview with no interruption. She had an increased rate and quantity of speech, high volume and high pitch tone but flow and rhythm was normal. Also, there was a depressed mood, she had a grandiose delusion. She also had occasional suicidal thoughts with two attempts. But no current

plan. She stated that, Allah talked with her through her mind. As for Insight, the patient stated, she had mental illness due to her head injury caused by her in-laws and needs treatment for that injury. After admission initially, she was diagnosed with a case of conversion disorder because her conversion symptoms were prominent and her talkativeness and increased self-important ideas could have been explained by her agitation. So she was given sertraline 100 mg twice daily and amitriptyline 25 mg at night. But after 1 week she had a full flare-up of manic symptoms. Then her case got reviewed and after the review, the diagnosis was conversion disorder with a bipolar disorder. She was given quetiapine 600 mg thrice daily and sodium valproate/valproic acid 1000 mg twice daily, and both of her dissociative and manic symptoms got better after 3 weeks. Psychoeducation to the family and patient herself was given. She was also given supportive psychotherapy, relaxation training and cognitive behaviour therapy (acceptance of reality, thought challenge). She was trained to increase her stress-coping ability. Her family was advised to reduce reinforcement. She agreed to continue her treatment and further psychotherapy sessions the following discharge.

Discussion

This case highlighted several important issues and challenges. The first challenge was diagnosing the patient. The second challenge was the treatment protocol. The common presentations of conversion disorder are psychogenic non epileptic seizures which is the most common subtype of conversion disorder. Others are paralysis or weakness, collapsing weakness, and abnormal movement.⁴ The initial diagnosis was conversion disorder based on the presenting symptoms which were shortness of breath followed by a fit-like attack (psychogenic non epileptic seizures). In this case, the patient also presented with talkativeness, depressed mood and delusions of grandiosity. The common presentations of the bipolar disorder are the mood is often elevated or euphoric, in mania. pressured speech, delusions of grandiosity and flight of ideas.⁵ Though in the typical presentation of bipolar affective disorder the mood was elevated however though the patient could also present with mixed features signaling episodes of mania, depression or hypomania accompanied by features of the opposite polarity.⁶ Bipolar disorder was found in 28% of patients with conversion disorder.⁷ The common etiological causes of conversion disorders are trauma, adverse life event, or acute/chronic stressor, history of childhood abuse, poor coping skills and internal psychological conflicts, certain psychiatric disorders (depression, anxiety and personality disorders), multiple somatic complaints, including symptoms like generalized fatigue, weakness, or pain without a known cause actual neurologic illness (such as a stroke or migraine), less educated people,

lower socioeconomic status, living in developing or rural areas.⁸ In this case patient had a chronic stressor which was marital disharmony. Thirty percent of people who had marital disharmony could have conversion disorder.⁹ In this case patient was less educated, from a low socioeconomic background and from a rural area. Bipolar disorder was widely believed to be the result of chemical imbalances in the brain. The chemicals responsible for controlling the brain's functions are called neurotransmitters and include noradrenaline, serotonin, and dopamine.¹⁰ It was also thought bipolar disorder was linked to genetics, A stressful circumstance or situation often triggered it such as the breakdown of a relationship, physical, sexual or emotional abuse or the death of a close family member or loved one. It might also be triggered by, physical illness, sleep disturbances and overwhelming problems in everyday life, such as problems with money, work or relationships. In this case, the patient had a problematic relationship and money issues as stressors. The second challenge of this case was the management of the patient. As per the initial presentation like shortness of breath followed by a fit-like attack initial diagnosis was conversion disorder. Though the patient had symptoms like talkativeness and self-important ideas however at that moment it was not prominent and could have been explained by her agitation. So the initial management was the management of conversion disorder. As per recommendation cognitive behavior therapy¹¹ was applied but there was little improvement. So patient was started on sertraline which was found effective on conversion disorder in some studies at 25 to 300mg of doses. In this case, the patient was given 100 mg twice daily. Due to the patient's sleep disturbances and undifferentiated somatic complaints, amitriptyline was added at night at 25 mg doses. But then the dramatic change in her symptoms appeared. The patient had a full flare-up of manic symptoms. Initially, quetiapine was added and was gradually increased up to 600 mg. There were some improvements. But for better improvement valproic acid/Na valproate was also added at 1000 mg doses.

Conclusion

Sometimes cases like this come to our attention as there is no treatment protocol. The management can be tricky. The management procedure we followed was helpful for this particular case. So this type of management protocol can be followed but for more supporting evidence a wide range of observations and in-depth studies with more samples are needed.

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