CASE REPORT

Dissociative paraplegia and other fleeting dissociative symptoms: difficulties in evaluation and management: a case report

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ABSTRACT

Dissociative symptoms at times amounting to disorders are common and are culturally accepted in many Asian cultures but presenting not often to the psychiatric facility for management. This case report is to discuss about problems in evaluation of new symptoms during the course and difficulties in different management strategies. This is a case report of a female patient presenting with dissociative paraplegia for more than 8 months duration with resistance and substitution of symptoms during the process of management.

Keywords: dissociative paraplegia, substitution of symptoms

INTRODUCTION:

Dissociative disorders are presumed to be psychogenic in origin, being associated closely in time with traumatic events, insoluble problems, or disturbed relationships. The common theme shared by the dissociative disorders is a partial or complete loss of the normal integration between memories of the past, awareness of identity, immediate sensations, and control of bodily movements. In these disorders it is presumed that this ability to exercise a conscious and selective control is impaired, to a degree that can vary from day to day or even from hour to hour. (1)

There are very few community based psychiatric epidemiological studies in India, and particularly community based dissociative disorder prevalence studies are absent. However an Indian prevalence study in hospital settings has shown that amongst various dissociative disorders, dissociative motor disorder was more common than dissociative convulsions. Female preponderance has been reported. (2)

Functional neuroimaging has revealed selective decreases in the activity of frontal and sub cortical circuits involved in motor control during hysterical paralysis. Based on neuroimaging it is postulated that hysteria might not involve an exclusion of sensorimotor representations from awareness through attentional processes. This might be related to a modulation of such representations by primary affective or stress-related factors. (3) A complete medical assessment is essential in order to rule out any possible organic etiology. A review study about conversion symptoms found that about one fourth to half of such cases might have organic etiology thus stressing the need for evaluation for any underlying organic etiology. (4) Also there is a problem with the concept of dissociative disorder when it is diagnosed on exclusion basis which may lead to extensive medical evaluation consuming lots of money and time. (5) There is a simple test called Spinal Injuries Centre test which may be helpful in differentiating conversion related paralysis of lower limb in comparison to paraplegia due to spine injury. If the patient cannot lift his leg up to the level of knee it is more likely to be conversion than organic as most of the spinal injury patients can perform this test well. (6) In practice most of the dissociative disorders are diagnosed based on clinical history with negative findings on relevant investigations as extensive medical evaluation may not be cost effective.

CASE REPORT

Miss C is 20 year old unmarried lady with high school level of education from urban and middle socio economic background. She was referred by a neurosurgeon with a history suggestive of total 8 months duration of paraplegia, which was sudden in onset. It started as a complaint of inability to walk after few hours of physical fight with neighborhood lady and before the night of the same day she completely lost her ability to walk. She was evaluated by orthopedician and neurosurgeons with appropriate investigations including Magnetic Resonance Imaging of spine. As adequate cause could not be found to explain her paraplegia she was diagnosed as malingering. She remained as inpatient for more than 10...
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weeks during this process of evaluation. She continued to suffer from paraplegia for about 8 months before she was referred to psychiatric hospital.

Following the initial psychiatric assessment she started experiencing persisting hiccups. These hiccups were absent only while she was in conversation with others or while eating or while asleep. Considering the continuous and distressing nature of hiccups she was evaluated by gastroenterologist with necessary investigations including endoscopy and she was diagnosed as malingering as sufficient cause could not be found to explain her symptoms. There was history of low mood secondary to her chronic distressing symptoms. However history was not suggestive of any mood syndrome or anxiety disorder or personality disorder. No history suggestive of any childhood abuse could be elicited.

Her pre morbidity was suggestive of stubbornness, low frustration tolerance, with occasional threats of suicide. Demonstrated attempts were also reported over heated arguments within the family. Dysfunctional patterns of communication within the family were observed during the interview sessions. It was observed that patient's threats of suicide were countered by counter threats of suicide by her family members.

Her sensorimotor examination was normal with normal reflexes. Nerve conduction studies done were normal. Mental status examinations during the admission period revealed distress, depressed mood secondary to her chronic symptoms like paraplegia and hiccups. Expression of death wishes was noticed particularly when her family members have started paying less attention to her symptoms. However when confronted she denied any suicidal intention. An indifferent attitude towards her disability and the burden on her family was noticed. During the admission period it was observed that she was able to maintain her squatting position in the toilet. However she had to be carried in hands to the toilet as she could not walk.

She was diagnosed as having dissociative motor disorder and dissociative autonomic dysfunction of upper gastrointestinal type according to International Classification of Diseases- 10th edition (ICD-10). (1) During the hospital admission period abreaction was performed using thiopentone sodium after obtaining consent from patient. Conflicts identified included continuing caretaker burden on her as she had to take care of her elder sister with mental retardation. She wanted to get rid of this burden by getting married, however for many other reasons her marriage was getting postponed. She was in a continuous dilemma and struggle about this. Her other hope of getting rid of this burden was her brother's marriage, so that the new sister-in-law would take over or share her responsibility. But this wish also was not getting fulfilled as her brother's marriage was getting postponed because of financial problems. Stressors and conflicts were identified and patient was made aware of the possible relation between her dissociative symptoms and underlying conflicts.

During the initial phase of management symptom removal was focused to gain the confidence of the patient and her family members as they were not convinced with psychological model of illness. Initial attempts of symptom removal using aversion were of limited success as it would be immediately followed by another symptom. Complaints of paraplegia, speech loss, persistent hiccups, amnesia for recent and remote events, and loss of vision were interchanging during the initial period of the hospitalization. Her family members were keen on finding etiological basis for her every new symptom. She was evaluated by gastroenterologist, ophthalmologist and neurologist and everywhere she was suspected to be malingering.

Benzodiazepines were used to control her symptoms (during her attempts of attention seeking from medical staff) like rolling on floor, and persistent hiccups. As she was expressing depressed mood and sleep disturbances, imipramine up to 75 mg/day was used on trial basis without any significant improvement in her mood. During the admission period as she was complaining about sleep disturbance due to persistent hiccups, low dose chlorpromazine was used without any improvement.

Family members were strictly advised to cut down secondary gains and their support in her sick role maintenance. She was encouraged to walk with support initially, later with walker. She started walking independently after about 8 months of bedridden status. The possible relation between her underlying chronic stressors and her current symptoms was discussed during the sessions. Her maladaptive ways of coping with stress like threats of suicide were discussed.

She was admitted for about 8 weeks. However it was observed that psychiatric hospitalization was also reinforcing her symptoms by undue attention from her family members and medical staff. It was decided that she should be discharged and followed up on outpatient basis. Till date on outpatient follow up she continues to exhibit occasional hiccups in response to verbal disputes in the family but significant reduction in severity and frequency is noticed.

DISCUSSION

Though dissociative symptoms like pseudo-seizure is frequently found in psychiatric outpatient clinics, very few cases of dissociative paraplegia have been reported. Also, this case has posed various challenges in evaluation and management.

As in this case an early diagnosis of conversion disorder would have helped in lesser allocation of medical resources as opposed to prolonged hospitalization in
medical wards. When a patient develops new symptom as part of symptom substitution the strategy of thorough evaluation has limitations. The main problem is in taking a decision for how long and for how many days patient should be evaluated for every new symptom. There is a risk that such evaluations can themselves act as reinforcers. But refusing further evaluation for new symptoms against the wishes of patient and her family might sometimes prove to be counterproductive. Balancing such decisions is found to be difficult. Further the strategy of symptom removal may have short term benefit but its efficacy in long standing dissociative disorders is very limited. Classic concept of bringing subconscious conflicts in to conscious awareness may not always reduce conversion symptoms as happened in this case. Further, while dealing with chronic dissociative disorders continuous attempts should be made to psycho-educate the family members that their behavior can act as strong reinforcer, and hence they should minimize their attention to such undesirable symptoms. During this process efforts should be put to clarify that not paying attention is different from neglecting the complaint as many care givers feel both are same. In the present case abreaction was found to be helpful in dramatic reduction of symptoms. However the benefit was only short lasting. Dysfunctional patterns of communication and disputes in the family should be identified and addressed, as such patterns were observed in the present case, and these were associated with symptom worsening. Whenever patient had dissociative symptoms, her mother was asking her to die. Patient's mother could not be involved in the management as she could not come for follow up. In the outpatient follow up this was found to be one factor responsible for maintenance of her dissociative symptoms.

CONCLUSIONS

Though to what extent patients should be evaluated for their new symptom is tricky in chronic dissociative disorder patients, such decisions should also take into account family members' concerns. Symptom removal by means of aversion has limited role in chronic cases. In chronic cases individual interventions have limitations compared to the involvement of family. The treating psychiatrist should be ready for long term follow up with anticipation of intermittent worsening. Constant efforts should be put to improve adaptive coping strategies and to minimize gains to the patient.

CONSENT

Written informed consent was obtained from the patient for publication of this case report and any accompanying images. A copy of the written consent is available for review by the Editor of this journal.

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REFERENCES