



A Case Report of Conversion Catatonia

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INTRODUCTION

Catatonia is characterized by marked psychomotor disturbance and was first described by Karl Ludwig Kaulbaum in 1874.¹ Later, it was evaluated as a subtype of schizophrenia. After the 1960s, it was revealed that other conditions can also cause catatonia.² Gelenberg (1976) said there could be more than 40 cases that could cause catatonia and many new ones have emerged since then.³ Previous data suggest that catatonia is more common in mood disorders than in schizophrenia. The other causes of catatonia can be due to medical causes like endocrine disorders, infections, electrolyte imbalance, epilepsy, and traumatic brain injury. An excessive dosage of drugs or substances like cocaine, ecstasy, disulfiram, and levetiracetam can also result in catatonia.^{4,5}

Catatonia due to conversion is a rare condition and there is insufficient data available in the literature, to address this issue and its management. In 1984, Jensen published a report dealing with conversion-related catatonia and hypnosis activity.⁶ Dabholkar reported a case of hysterical catatonia in 1988.⁷ In 2012, Shah *et al.* wrote an article that includes the response of consultants on conversion catatonia and its cultural interaction. In this case report, we present a 19-year-old female patient suffering from a complex case of conversion catatonia who responded to electroconvulsive therapy.

ARTICLE INFO

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Dates:

Received: 13-08-2022

Accepted: 23-09-2022

Published: 05-11-2022

How to Cite:

Singh S, Anjum N, Khan
Z, Reyazuddin M.

A Case Report of
Conversion Catatonia.
Indian Journal of
Behavioural Sciences.
2022;25(2): 152-154.
doi: 10.55229/ijbs.v25i2.12

CASE PRESENTATION

A 19-year-old Indian female had complaints of social withdrawal, decreased speech, decreased oral intake, and decreased self-care for the past 6 months. For these complaints family members consulted multiple private practitioners who prescribed antipsychotics, antidepressants, and anxiolytics but there was no significant improvement in her symptoms. Later on, family members brought the patient to the emergency department of our tertiary care hospital with complaints of mutism, rigidity in all four limbs, poor oral intake, and soiling of clothes from the last 2 days. As we suspected it was a case of catatonia, the Busch Francis catatonia rating scale was applied, and a score came out to be 18. Lorazepam challenge test was done with Injection of lorazepam 2 mg slow iv, and it came out to be positive (patient started blinking, there was increased speech output and decreased rigidity).

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The patient was now admitted to the psychiatric ward, however after admission patient became significantly more catatonic with mutism, negativism, stupor, and posturing. The patient's vitals were within normal limits. Her physical examination was apparently normal with exception of the patient's muscular rigidity and marked resistance to any movement and inability to comply with parts of the neurological examination. Her initial medical workup was within normal limits i.e., routine blood investigations (complete blood count (CBC), Renal function tests (RFT), Liver Function Test (LFT), serum electrolytes) and Head imaging (computed tomography (CT) and magnetic resonance imaging (MRI)). A detailed history was taken from family members. There was no significant psychiatric and medical history in the past. There was a family history of some psychiatric illness (schizophrenia) in her mother. There was no history of substance use/drug known to cause catatonia. We also took a consultation from the neurology department and no organic pathology was found.

Seeing the patient's deteriorating condition, a nasogastric tube and intravenous line (IV) line was started to maintain nutrition and hydration as the patient stopped the oral intake of food and medicines completely. The patient was started on injection lorazepam 2 mg IV and had a rapid response with the blinking of eyes, following simple commands, however patient again returned to a catatonic state including mutism, negativism, stupor, posturing, and formation of a copious amount of saliva. Injection Lorazepam iv was administered to the patient for the next three days with titration up to 2 mg every 4 hours. Initially patient had some improvement in her symptoms. The patient was observed conversing with family members but within 24 hours, she returned to a stupor and subsequently responded very little to lorazepam. On day 4, tab memantine was added and titrated up to 5 mg twice a day but there was no improvement.

Due to deterioration in the patient's nutritional status, Electroconvulsive therapy (ECT) was planned. 24 hours before giving ECT, lorazepam was stopped. She received her first ECT on day 7 of admission. Two days after the first ECT, the patient showed improvement. On mental status examination, the

patient explained how she felt prior to entering a catatonic state "My mother is ill, my father doesn't stay at home due to work, I have a good relationship with my brother but in lockdown, he left home and went to distant place for his job. I felt alone, this upset me. I escaped into silence, like light out." On inquiring about her mood, she used to say that she was sad while smiling at the same time and didn't show any concern for her symptoms (*la belle indifference*). The patient displayed no disturbance in perception, thought form, and content. Her affect was appropriate, she had a sense of self and showed no impairment in role functioning. She showed interest in activities and exhibited no impairment in interpersonal functioning. On asking her about future plans after discharge, she said she wanted to remain in the hospital as she made friends there and was getting the required attention from her family members unlike earlier. A total of 4 cycles of modified ECT were given and the patient reached baseline. Tablet lorazepam was continued and tablet memantine was stopped. Patient was discharged on tab. lorazepam 2 mg three times a day (TDS). On the basis of detailed history and repetitive mental status examination, a diagnosis of conversion catatonia was made. According per Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), it can be categorized as unspecified catatonia.

Four days later, the patient again came to the emergency with a catatonic episode and the patient was admitted. The patient was given 8 cycles of maintenance ECT and was discharged in improved condition.

DISCUSSION

It is interesting to find catatonia as conversion/hysteria due to a lack of motor activity and response to external stimuli while fully conscious. The term conversion disorder was replaced by functional neurological symptom disorder in DSM-5. It consists of criteria like motor symptoms, not related to general medical condition and substance, not related to a neurological disorder, and clinically significant distress and impairment in social, occupational, or other important areas of functioning or requires medical evaluation.

Conversion disorder is a diagnosis of exclusion. Conversion disorder can present as blindness, mutism, paralysis, dissociative anesthesia, aphonia, ataxia, sensory loss, hysterical seizure, or psychogenic deafness according to DSM-5.⁸ But a rare symptom of conversion can be catatonia which is not included in DSM-5. Therefore, according to DSM-5, such cases can be classified as unspecified catatonia. This category applies to cases where catatonic symptoms cause clinically significant distress or impairment in social, occupational, or other key areas of functioning but the underlying mental disorder or another medical condition is unclear, the full catatonic criteria are not met, or there is not enough information to make a more specific diagnosis (e.g., in emergency room settings).

There is no standard treatment protocol for treating conversion disorder. It requires a multi-disciplinary approach that is a pharmacological approach and psychotherapy viz Cognitive Behavioral Therapy (CBT) and psychodynamic therapy. Hypnosis can also be tried in treating conversion disorder.⁹ Jensen described the successful hypnotic treatment of a patient with an acute catatonic reaction.⁶ Furthermore, he stated that the conversion mechanism may underlie some presentations of catatonia.

In our case, it was a difficult decision to use ECT as there has been limited evidence, and is not widely disseminated among practicing clinicians.¹⁰ As there was an incomplete response to lorazepam and deterioration of the patient's condition, additional intervention was required. There was a dramatic response after the first ECT which was not sustained, hence 3 more ECTs were given and the patient reached baseline. Dabholkar reported a case of hysterical catatonia developing twice in a year and on both occasions responding to ECT.¹⁰

CONCLUSION

Catatonia has only rarely been described as a form of conversion disorder. We present a case in which the patient responded to environmental stress and her anger by developing an acute catatonic reaction. The patient responded to ECT. ECT may act earlier than drug treatment. Conversion catatonia may be used in psychiatric classification systems such as DSM.

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