

### CLINICAL CASE ROUNDS IN CHILD AND ADOLESCENT PSYCHIATRY

# A Case of Neurological Symptoms and Severe Urinary Retention on a Pediatric Ward: Is this Conversion Disorder?

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## Abstract

**Objective:** a) To illustrate the etiological role of sexual and physical abuse in the development of childhood conversion disorder b) to highlight the importance of collaborative care in cases of conversion disorder c) to identify particular areas or needs for future research in the topic. **Method:** We discuss the case of a fifteen-year old girl who was admitted to pediatrics with medically unexplained neurological complaints, chiefly urinary retention. Psychiatry was consulted after all organic work up was completed. Patient was transferred to the psychiatry ward and we present the unfolding of this case. Pediatrics and psychiatry generated a collaborative management plan. **Results:** The patient presented, initially, with tremors, severe urinary retention and constipation. After her second admission to pediatrics, for severe urinary retention, the girl disclosed chronic sexual and physical abuse and neglect. **Conclusions:** Conversion symptoms often occur in cases of severe psychosocial stresses including sexual and physical abuse. This case highlights the importance of interdisciplinary professional collaboration in the management of complex presentations with unexplained symptoms and psychosocial stressors.

**Key Words:** conversion disorder, sexual/physical abuse, bipolar disorder, urinary retention

## Résumé

**Objectif:** a) Illustrer le rôle étiologique de l'abus sexuel et physique dans le développement d'un trouble de conversion chez l'enfant; b) souligner l'importance des soins en collaboration dans les cas de trouble de conversion; c) identifier les domaines ou besoins particuliers pour la recherche future en la matière. **Méthode:** Nous discutons du cas d'une jeune fille de 15 ans qui a été hospitalisée en pédiatrie pour des plaintes neurologiques, principalement de rétention urinaire, inexpliquées sur le plan médical. La psychiatrie a été consultée après que toutes les investigations somatiques ont été menées. La patiente a été transférée en psychiatrie et nous présentons le déroulement de ce cas. La pédiatrie et la psychiatrie ont élaboré un plan de prise en charge en collaboration. **Résultats:** Initialement, la patiente présentait des tremblements, une grave rétention urinaire et une constipation. Après sa deuxième admission en pédiatrie, pour grave rétention urinaire, la jeune fille a révélé des abus sexuels et physiques chroniques et de la négligence. **Conclusions:** Les symptômes de conversion surviennent souvent dans des cas de graves stress psychologiques, notamment l'abus sexuel et physique. Ce cas souligne l'importance de la collaboration professionnelle interdisciplinaire dans la prise en charge des présentations complexes de symptômes inexpliqués et de stressseurs psychosociaux.

**Mots clés:** trouble de conversion, abus sexuel/physique, trouble bipolaire, rétention urinaire

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## Introduction

According to DSM-IV-TR, the diagnostic criteria for Conversion Disorder is described as:

1. One or more symptoms or deficits are present that affect voluntary motor or sensory function suggestive of a neurologic or other general medical condition;
2. Psychological factors are judged to be associated with the symptom or deficit because conflicts or other stressors precede the initiation or exacerbation of the symptom or deficit;
3. The symptom or deficit is not intentionally produced or feigned;
4. The symptom or deficit, after appropriate investigation, cannot be explained fully by a general medical condition, the direct effects of a substance, or as a culturally sanctioned behavior or experience;
5. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation; and,
6. The symptom or deficit is not limited to pain or sexual dysfunction, does not occur exclusively during the course of somatization disorder, and is not better accounted for by another mental disorder (American Psychiatric Association, 2000).

Although there are anecdotal reports in early literature associating Conversion Disorder with childhood traumatization and sexual abuse, there is little supporting empirical evidence especially in the case of children and adolescents. At present, we have limited knowledge of how psychological stressors, such as sexual and/or physical abuse, are “converted” into physical symptoms.

## Case Report

SA is a fifteen-year old, grade eight student who lives with her biological parents and two younger sisters in a small town in Eastern Canada. The family immigrated to Canada from the United States a year prior to her presentation. SA presented to the ER with right-sided tremors for a four-week period. The tremors started on her right middle finger and moved to her lower extremities causing severe impairment. The tremor was fully investigated including CT head, an EEG, MRI and all blood work all results were within normal range. The tremor was diagnosed as Functional Movement Disorder by a pediatric neurologist. However, the tremors worsened and the patient developed periodic urinary retention. She was unable to void spontaneously in the inpatient ward and needed catheterization every second day. Urinalysis and urine culture was non-contributory. Neurology and urology were consulted and all organic causes of urinary retention were ruled out. The responsible pediatrician consulted psychiatry with the query of a possible Conversion Disorder; as symptoms continued unabated SA was transferred to the child and adolescent psychiatry inpatient ward. Detailed history revealed that at age eight the patient had severe temper outbursts at home and school impairing her function enough for repeated hospitalization.

She was diagnosed with Bipolar disorder at that time and at the time of this admission; she was on Lithium, Quetiapine, Melatonin and Levothyroxine. Developmental history revealed a planned pregnancy with an emergency C-section due to non-progression of labor and transverse lie. Mother denied any alcohol or illicit drugs use during pregnancy. SA achieved all her milestones within normal range. From the age of three years onwards, SA had frequent temper tantrums at home and school, resulting in multiple school changes and 1 year delay in academic progress. SA denied any sexual or physical abuse and any use of alcohol or drugs. Family history was negative for Bipolar Disorder on either side of the family and positive for depression and anxiety on the maternal side including mother herself.

On the psychiatry ward we instituted a reward based behavior program for spontaneous voiding and age appropriate behavior and as one of the side effects of Lithium and Quetiapine can be tremors, we discontinued all medication which did not lead to any change in mood, however the patient displayed temper outbursts, infantile regressive behavior particularly during parental visits e.g. she would sit in her father’s lap and suck her thumb.

A psychometric assessment showed average verbal expression and comprehension, but suggested a significant non-verbal learning disability. Parents completed a “Connors” and endorsed all domains of severe Attention-Deficit/Hyperactivity Disorder (ADHD), inattentive type.

During this period the father continued to demand that his daughter be discharged home, as they did not have health coverage and he was getting further in debt.

After seven days both behavior and physical symptoms improved significantly and patient was discharged with recommendations for additional educational testing and a trial on a psycho-stimulant. The father wanted no further interventions.

Within five days of discharge, the patient presented to ER with urinary retention, severe constipation, nausea and vomiting. She was readmitted to the pediatric inpatient ward where an abdominal ultrasound revealed 770 cc of urine. There was no abnormality of her kidneys, ureters, ovaries, liver, uterus, spleen or biliary tract. Urology was consulted and all organic causes were ruled out.

Psychiatry was consulted and recommended transfer back to the psychiatry ward. The patient refused to be transferred and informed a pediatric nurse that, she had been physically and sexually abused by her father, and physically abused by her mother since childhood, she refused to see her parents. The pediatric ward informed children’s aid society and the domestic violence team. The parents declared SA was no longer welcome in their home. She stayed in the hospital for about three weeks before she was discharged under the care of children’s aid society. She was voiding spontaneously at the time of discharge.

## Discussion

At the end of the 19<sup>th</sup> century, Pierre Janet, emphasized the relationship between Conversion Disorder and childhood trauma. He viewed dissociation of cognitive, sensory, and motor processes as adaptive in the context of an overwhelming traumatic experience (Janet, 1907; Putnam, 1989). Unbearable emotional reactions to traumatic experiences would result in an altered state of consciousness.

Our case demonstrates the development of Conversion Disorder or psychogenic urinary retention in a fifteen-year old girl in the context of repeated severe psychosocial stressors in the form of sexual and physical abuse, and increasing discrepancy between normal academic and social adolescent demands and poor skills. It is of interest that there was no disclosure of the abuse despite multiple assessments and interventions. This is partly explicable by the developmental stage and age of the child. It is plausible that the onset of adolescence, with its heightened sexual awareness and interest, would have led to the disclosure at 15, rather than much earlier. Other factors like being dependent on the abusers for love and support, threats of harm, having no one to disclose to, can also be considered. This case also raises issues of conceptual frameworks, their utilities and limitations. The treatment of Conversion Disorders in children typically requires the coordinated interdisciplinary efforts of many specialists (Keemink, Koopman, Vecht-van der Bergh, Brouwer, & Peters, 1998) and should include psycho-education and information regarding Conversion Disorder. This information may come from a multidisciplinary treatment team (Fennig & Fennig, 1999) including: psychiatry, psychology, pediatrics, family practice, general practice (Friedman, 1973), neurology, nursing, social work, child protective services, and special education. Proactive involvement of child protective services may be essential in preventing further child abuse and neglect (Brašić, 2002). Psychotherapeutic interventions with children and adolescents with Conversion Disorder may be facilitated by identification of separation and dependency conflicts (Eggers, 1998).

The second issue that needed clarification was that of the pre-existing diagnosis of Bipolar Disorder. Despite increasing evidence supporting the validity of paediatric Bipolar Disorder, discrepancies between clinical and epidemiologic findings suggest that diagnostic misapplication may certainly be common (Goldstein & Birmaher, 2012). The aggressive outbursts starting at age three could be taken as “affective storms” of juvenile Bipolar Disorder, especially in the USA where there are as many proponents as opponents of this disorder (Biederman, Klein, Pine, & Klein, 1998). In the case of our patient, we had no positive family history and no evidence of elevated affect in the patient’s episodes of “mania”. This, together with the observed evidence of oppositional behaviour leading to aggressive outbursts and self/staff report on Connors questionnaires, led us to change the diagnosis from Bipolar to ADHD-Inattentive type with Learning Disability with clear recommendations for in school adaptations and a trial on psycho-stimulants once in

a stable environment. Further, Attention-deficit hyperactivity disorders (ADHD) and posttraumatic stress disorder are the most commonly diagnosed disorders in sexually abused children. There is a high degree of symptom overlap and comorbidity between ADHD and posttraumatic stress disorder, which makes differential diagnosis confusing (Weinstein, Staffebach, & Biaggio, 2000).

## Conclusion

This is a report of a case of psychogenic urinary retention possibly related to childhood sexual abuse and it illustrates the importance of inter-professional collaboration and diagnosis reviews including rare disorders in children with complex presentations. The issue of diagnostic bias is also to be considered as Bipolar Disorder amongst children is still hotly debated and varies from country to country. In our case, the earlier diagnosis was accompanied by pharmacological interventions, which may cloud the picture by possible side effects of medication rather than actual signs and symptoms of the underlying disorder.

## Acknowledgements / Conflicts of Interest

The authors have no financial conflicts to disclose.

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