ORIGINAL RESEARCH PAPER
Volume - 12 | Issue - 05 | May - 2023 | PRINT ISSN No. 2277 - 8179 | DOI : 10.36106/ijsr
INTERNATIONAL JOURNAL OF SCIENTIFIC RESEARCH

SIBLING RIVALRY PRESENTING AS CONVERSION DISORDER IN CHILDREN: A CASE SERIES.

Psychiatry

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ABSTRACT

Conversion disorder is a psychiatric disorder and presents with wide range of motor or sensory symptoms in children. These disorders are found to be associated with stressors which the children perceive as not manageable and they cannot cope up with the stressors. Most commonly presents to non-psychiatric practice because of physical symptoms. Inadequate diagnosis and improper treatment lead to increased burden on the children, parents and health care system. Adequate knowledge regarding the disorder helps in early diagnosis and treatment; improved quality of life in children and parents. The following case series describes three cases of conversion disorder due to sibling rivalry and their management.

KEYWORDS

Conversion disorder, sibling rivalry, behavioral therapy, parent child interaction therapy

BACKGROUND:

In children, mental illness is a prevalent and leading cause of disability, affecting almost 10-20% children worldwide. [1] Inadequate treatment can hamper development of the child in various domains including motor, cognitive and emotional development. Psychiatric disorders are a major block in the pathway of a child's achievements.

According to DSM-5 (2013), conversion disorder presents as symptoms or deficits affecting voluntary sensory or motor function.[2] Conversion disorders in children are observed more commonly in the age group of 10-15 years and is almost twice more common in girls in comparison to boys.[3] Various social factors such as emotional neglect, lack of empathy and nurturance, history of sexual abuse or maltreatment, domestic stress, feeling of rejection and unresolved grief, have been found to be contributing factors for development of conversion disorder. Additionally, temperamental traits of low emotional threshold, high intensity of emotional expression, negative approach withdrawal and poor adaptation, place a child at risk for development of the disorder. Common presentations are numbness on one side of the body, paralysis, incoordination, persistent pain, gait problems, speech related symptoms and blindness.[4]

It is a common occurrence that children with conversion disorder symptoms present initially to physicians other than psychiatrists leading to misdiagnosis and delayed treatment which can further lead to significant burden on the patient, their caregivers and the medical care system.

Sibling rivalry refers to the feelings of envy and competition between siblings (whether blood related or not) manifesting in various forms such as repeated fights, aggression in the form of verbal arguments and frank physical aggression. The phenomenon is a common occurrence in most households, sometimes with dire consequences while others being essentially benign.[5]

In this case series, we discuss a few cases presenting as conversion disorder in response to sibling rivalry and attempt to highlight the diagnostic difficulties in childhood conversion disorder.

Case Presentations:

Case 1:

8 years old, male child, experienced sudden onset symptoms of headache, dizziness and blurring of vision of 10 days duration and presented to a pediatrician. Evaluation by the pediatrician was found to be normal and the child was referred for a ophthalmological evaluation, which too was deemed normal. Hereafter, the child was referred for a psychiatric evaluation. On detailed evaluation, it was discovered that in the last 1 month, owing to his younger sister's ill health, the child had experienced relatively less attention from his parents. Additionally, the child had been inconsistent with academic assignments and showed deterioration in performance in the recent examinations. There were instances of temper tantrums when his demands were not fulfilled and aggression towards the sister in the form of hitting and pinching when the parents gave more attention to the sibling. Physical examination was found to be normal. The patient was diagnosed with conversion disorder and relaxation training and behavioral therapy was initiated along with psychoeducation of the family members. The child responded well to treatment.

Case 2:

A 6 years old female child presented with one month duration of symptoms of decreased sensations over left arm to a neurologist. The symptoms were acute in onset and persistent. Neurological examination as well as nerve conduction study of the left upper limb yielded no significant findings. The child presented for a psychiatric assessment which revealed history of similar intermittent symptoms for the last 2 years following birth of her younger brother. The symptoms were reported to mostly occur when the child's mother was feeding or tending to the needs of her brother and also at bedtime. The child's mother responded in the form of consoling the child, massaging her and allowing the child to sleep near her at bedtime. These behaviors of the mother resulted in the relief of child's symptoms. These symptoms were not reported outside home such as playtime and at school. The child was diagnosed with conversion disorder. Mother was psycho-educated and parent management training to manage the child's symptoms were provided. On subsequent follow up, the symptoms were found to be less persistent but intermittent occurrences were noticed.

Case 3:

A 9 years old female child presented with sudden onset difficulty in walking for 2 weeks. The child consulted with a pediatrician and evaluation was found to be within normal limits. The child was referred for psychiatric consultation. On evaluation, there were inconsistencies in walking difficulty, sometimes the child had difficulty over left lower limb and sometimes on right lower limb and there was symptom resolution when the child was distracted. History evaluation found that the child's elder sister performed well on competitive exams 20 days ago and has been receiving praises and gifts from relatives, neighbors and teachers. The child was diagnosed with conversion disorder. Psychoeducation along with parent child interaction therapy were initiated. The child improved but had one episode of walking difficulty on 2 weeks follow up.

DISCUSSION:

A common notion is that conversion disorder does not occur in young children due to inadequate development of essential social and cognitive skills.[6] This belief requires reconsideration as although uncommon, children who are as young as 3 years of age have presented to psychiatric and various other practices with conversion disorder.[7] Another frequent observation is significant sharing of symptoms between somatic pain disorders and conversion disorder, which raises doubts about the nosological classification.

Since the 19th century, there have been multiple reports of correlation between stressful life events and conversion disorder.[8] The older

literature highlights the association between traumatic life events, such as child maltreatment or sexual abuse, with conversion disorder. However, recent studies have revealed that more common stressors such as conflicts in family, separation from caregiver, peer group rejection, have the potential association with conversion disorder.[7] The common occurrence of temperamental traits of low threshold of responsiveness, high intensity of emotional response, slow adaptability may place the child at vulnerability to develop psychosomatic symptoms of distress in response to stressful events.

Birth of a sibling often poses as an emotionally and intellectually demanding situation for a child, especially the older child or the first-born child. Frequently observed reactions are in the form of various regressive behaviors, anger, physical and verbal aggression, confrontational behavior with parents, excessive demands, clinging behavior.[8] These reactions are conceptualized as a strategy employed by the child to ensure attention from the caregivers in the presence of the sibling.[9] The children with difficult and slow to warm up temperamental traits are more prone to develop such reactions to the birth or attention directed towards a sibling.[9]

Considering the implications of biological, social and psychological factors in the development of conversion disorder in children, the management approach needs to be designed to involve not only the child, but also to address the issues in the family environment, family dynamics and patterns of interaction.[10]

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