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Case Study

AYURVEDIC MANAGEMENT ALONG WITH HYPNOTHERAPY IN FUNCTIONAL NEUROLOGICAL SYMPTOM DISORDER (CONVERSION DISORDER)

Anjumol M[1]*, Jithesh M[2], Vinod R[3]

*[1]PG Scholar, Manovigyana Evam Manasaroga, [2]Professor and HOD, [3]Associate Professor, Department of Kayachikitsa, VPSV Ayurveda College, Kottakkal, Kerala, India.

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ABSTRACT

Functional Neurological Symptom Disorder (FND)/Conversion disorder may be broadly defined as the presence of neurologic symptoms in the absence of a neurologic diagnosis, or when a neurologic diagnosis exists, it does not fully account for all of the patient's symptoms. The cardinal symptom is limited solely to neurological symptoms. The diagnosis is made on the basis of the positive findings of the examination demonstrating preserved neurological function. *Yoshapasmara*, described in *Madhava nidana*, is comparable to FND where *Gathi/ Samvedhana* (motor or sensory functions) are lost in the absence of underlying neurological conditions. A 29-year female was admitted with c/o weakness and numbness in the left lower limb for 6 months. She had severe stress factors due to family conflicts. One day after a conflict with her mother-in-law, she felt difficulty walking on her left leg. They consulted a neurologist and done imaging, which was normal. On detailed clinical examination, the diagnosis was FND. She was managed with internal medications and *Udwartana, Abyanga*, and *Vyathyasa chikitsa* (dry and unctuous therapies alternatively). Hypnotherapy was administered in addition to Ayurvedic management to address stress factors. There were noticeable changes in the Perceived Stress Scale (PSS), muscle strength, and could walk without assistance with some difficulty after treatment. The neuropsychiatric perspective incorporating biopsychosocial aspects at the individual level, including consideration of psychological and spiritual aspects wherever relevant, is crucial for better outcomes in such cases.

INTRODUCTION

(FND) or Conversion disorder" is the term used in the DSM-V classification system, originating from the description by Breuer and Freud of pseudo-neurological symptoms resulting from the conversion of an unconscious psychological conflict to somatic representation.[1] It is a psychiatric disorder that is related to either psychic conflict or stressful events and is characterized by symptoms or deficits affecting voluntary motor or sensory function that suggest the presence of a neurological condition.[2]

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Compared to socio-cultural settings, the prevalence of conversion disorder is higher in neurological settings. Women are more likely to experience conversion symptoms, which develop mostly during adolescence.[3] This rate ranges from 1 to 3% in Western nations' psychiatric polyclinics and is around 10% in other countries.[4] Researchers claim that those from rural areas and those with lower socioeconomic status are more likely to experience conversion symptoms.[5]

Different Presentations of FND

Common presentations of conversion symptoms include blindness, paralysis, dystonia, psychogenic nonepileptic seizures (PNES), anesthesia, swallowing difficulties, motor tics, difficulty walking, hallucinations, and dementia.[6] Studies confirm the high incidence of other psychiatric disorders in patients with conversion disorder.[7] High sexual abuse rates have been found among those with conversion

disorder, especially among patients with pseudoseizures. [8,9]

The symptoms and indicators are not being faked by patients with conversion disorder. Despite the lack of a conclusive organic diagnosis, the patient's suffering is extremely real and the patient's experience cannot be controlled at will (i.e., the patient is not malingering an illness).[10] It is a clinical challenge for both psychiatrists and neurologists and the diagnosis can be an unrivalled test of a clinician's skill and belief in his judgment.

Yoshapasmara, described in *Madhava nidana*, is comparable to FND where *Gathi/Samvedhana* (motor or sensory functions) are lost in the absence of underlying neurological conditions.[11] In the 19th century, researchers discovered connections between hysteria, hypnosis, and conversion disorder. Evidence suggests that those who suffer from conversion disorder are more hypnotizable than average, making hypnosis a potential treatment option for the condition.[12] It is a clinical challenge due to the inconsistency between *Nidana* (etiology), *Samprapti* (pathogenesis), and their presentations. So adopting *Satwavachaya chikitsa* (psychotherapy) along with the treatment of *Avarana chikitsa* is useful to replace unconscious negative thoughts. [13]

Patient Information

The patient attended the hospital along with her husband. She is the youngest daughter of Non Consanguineous parents, born through FTND without any developmental delay. She was much pampered and very much dependent on her parents since childhood. Average in studies showed very much orderliness and perfectionism in her works and was stubborn in nature. After plus two she got married into a joint family. Her husband was working abroad and he was coming once in 2 yrs. His family was very orthodox and they followed strict rules. After 1 week of her marriage, her husband went abroad. The husband and his family always despise her family, as her family was not financially sound. They always used to blame her for even minor matters.

After 1 week of marriage, she was sexually abused by her sister in laws son. It made her very upset. But she didn't reveal it to anyone, because of fear of conflict. After this incident, if there is any problem with the family, she felt giddiness, palpitation, low BP, weakness, etc. which was usually relieved after consultation. Also had frequent migraine attacks whenever on stress. Two months later, her sister-in-law's son again tried to abuse her sexually (he grabbed the dress and try to tear it when she was alone in the room). However, she screamed and ran away from there. As she couldn't recover from this trauma, a few days later she went to her home and revealed it to her parents. Her family was shocked by hearing this incident and informed religious authorities about this incident. They together went to her husband's home to find a solution. But, they were not accepting it and said the story is being made up to embarrass them and her husband also had the same opinion as his family said.

Due to the financial burden on her family, she had to obey what her husband had told her and returned to her in-laws' home. All family members came to know about this incident, and they became embarrassed and, started taking revenge on her due to this matter. Five years back, after a dispute with her husband's family, she started weakness in her right hand. They consulted a neurologist, investigations were done and everything was normal. The neurologist referred her to a psychiatrist as they could not find anything and suspected it could be due to psychiatric issues. But her family was not accepting it as a psychiatric illness, so they refused the intake of any psychiatric medications. They again consulted an Ayurvedic physician, management was done, and recovered from it completely within 8 months.

2 years back they shifted to a new house, near her husband's home. Since her husband was abroad, she has to depend on her brother-in-law for everything, even though they were not in a good relationship. As she was not able to manage everything alone, she sent her daughter to her home and she and her son were staying with her only. Due to pressure from the family, she made her son join a school near her husband's home, so she couldn't go to her home. Due to all these factors, she was feeling very sad, guilty, unable to feel happiness, helpless, and hopeless.

6 months back, after a dispute with her mother-in-law, she felt very tired and thought that something bad is going to happen. The next day morning when she woke up, she was unable to feel her left lower limb and unable to keep it on the ground. So they took her to a modern hospital and were admitted there for 3 days. They did imaging of the brain and spinal cord but which was normal. Did all the examinations, no abnormality was found in clinical examination and investigations, and diagnosed as Functional neurological symptom disorder. As they were hesitant to recognize it as a psychiatric condition, they were admitted to the neurology ward for further management.

Clinical Findings

The patient does not have any allergic history before the present illness and also does not have any family history of psychiatric as well as neurological disorders. No previous history of diabetes mellitus, hypertension, or thyroid dysfunction was found. No

complaints of other systemic illnesses. The patient is a moderately built female with a reduced appetite. Bowel habits were irregular and she was predominantly non-vegetarian.

Pallor, icterus, cyanosis, clubbing, and edema were not present. Weight was 50kg. Blood pressure and pulse were within normal limits. The patient had Vata-pitta prakriti (physical constitution), *Madhyama sara* (excellence of tissue elements), *Madhyama samhanana* (compactness of tissue or organ), *Avara satwa* (psychic condition), *Madhyama satmya* (homologation), *Avara vyayama shakti* (power of performing exercise), *Avara ahara shakti* (power of intake of food), *Avara jarana shakti* (power of digestion of food), and *Hina bala* (physical power). The patient was conscious and well-oriented to time, place, and person. Memory was not impaired.

Mental Status Examination

On assessing the mental status examination of the patient, she was well dressed and cooperative towards the examiner, her gait was dragging, and rapport was established with ease. On assessment, the speech was normal. Mood and affect were found to be euthymic. But insight into the illness was in Grade 1 (Complete denial of accepting it as a psychiatric condition).

Pre-morbid personality: Dependent on parents, Depending others to take decision, Getting tensed over minor matters, trait anxious, pessimistic.

Nervous System examination

Examination of higher functions and cranial nerves were intact. On motor system examination Muscle bulk and muscle tone were intact in bilateral upper and lower limbs. Muscle power was intact except in the left lower limb– Muscle power was 2/5the in the hip, knee, ankle, toes, and in the big toe of the left leg and 5/5 in the right leg. On sensory system examination touch, pain, temperature, vibration, and graphesthesia were slightly impaired in the left leg and normal in the right leg. Proprioception, stereognosis, and barognosis were intact in all limbs. Knee and ankle reflexes were diminished in the left leg. On examination Hoover's test was positive, suggesting the diagnosis.

Table 1: Timeline of Development of Symptom

Time	Development of symptoms	Condition of the patient
2013 onwards	Frequent attacks of giddiness, palpitation, low BP, and weakness whenever on stress	Got relieved once consulted and also in the absence of stress.
2018 -2019	Weakness and numbness of right upper limb for 8 months	Unable to do ADL Ayurveda treatment was taken for 1 month Got relieved after 8 months
2022 October onwards	Weakness and numbness of the left leg	Unable to walk

Diagnostic Assessment

As the MRI findings of the brain and whole spine screening were normal (excluded all possible etiologies) and inconsistency with the etiology and neurological manifestation and also on the basis of signs and symptoms, it was diagnosed as Functional neurological symptom disorder (conversion disorder) with weakness and sensory loss, acute episode and with the psychological stressors.[14] Positive Hoover's test was confirming the diagnosis. As per Ayurveda, the diagnosis is *Yoshapsmara.*[11]

Therapeutic Intervention

The details of the intervention are placed in Table 2. Observations were made after giving therapies along with oral medicines for a total duration of 21 days. The patient was advised to take *Drakshadi Kashaya* [15] 15ml *Kashaya* with 45 ml warm water 2 times a day before food. A combination of *Aparajitha churna* [16] (Clitoria ternatea Linn) (4gm) + *Vachachurna* [17] (1gm) was given 2 times a day after food with warm water. *Sukumara erandam* [18] was given 10ml at night with milk. It continued for 2 weeks after discharge.

A hypnosis session frequently includes multiple phases. [31] The initial phase is preparation. This is for developing a rapport between the hypnotist and subject, explaining what hypnosis is and is not, allaying any fears, and removing any misconceptions on the subject's part.

The relaxing technique is the second stage (progressive muscular relaxation). A successful induction results in the subject entering an altered state of consciousness, sometimes known as a trance. Later stages of the induction are referred to as "deepening procedures," when the patient is made to relax by counting from ten to one.

The subject receives instructions and suggestions from the hypnotist in the third stage of the session that are explicitly connected to the session's objective. The hypnotist verbally guides the subject's

imagination to produce the desired alterations in perceptions.

When the hypnosis session is over and the subject is brought out of the trance, the fourth stage takes place. One common method is for the hypnotist to count from one to three while making it seem like the subject is becoming more awake and energized. This way, when the subject opens their eyes at the count of one, they are completely awake and oriented once more.[31]

Table 2: Timeline and Therapeutic Interventions

Day	Procedure	Medicines
2nd– 6th April, 2023	*Udwartana*	*Kolakulathadi churna*
7th– 11th April 2023	*Abyanga* and *Ushma sweda*	*Sahacharadi tailam*
12th – 16th April 2023	*Vyathyasa chikitsa*	✓ *Triphala + Dhanyamla* ✓ *Navadhanya+ bala ksheera Kashaya. Alternative days*
17th -22nd April 2023	*Marsa Nasya*	*Ksheerabala taila (101A) * 1ml*
Hypnotherapy		
8th – 22nd April 2023	Administered once in 3 days	5 sittings were done and also given in recorded from after discharge

Follow-Up and Outcome

The patient was admitted to Inpatient Department (IPD) for a period of 21 days where she was treated with external and internal therapies along with oral medicines. Thereafter, the patient was discharged, and oral medicines were prescribed for a period of 2 weeks. Clinical examinations and assessment with perceived stress scale done after 2 weeks of follow-up. After a total duration of 35 days, improvement was noticed in gait, and muscle power, scoring reduced from 38 to 13 on the perceived stress scale.

Table 3: Results Before and after Treatment

Muscle power (Left leg)		Before treatment	After treatment
Hip	Adductors	3	4
	Abductors	3	4
	Flexors	3	4
	Extensors	3	4
	Internal rotators	3	4
	External rotators	3	4
Knee	Flexors	2	4
	Extensors	2	4
Ankle	Dorsiflexors	2	4
	Plantar flexors	2	4
Toes	Dorsiflexors	2	4
	Plantar flexors	2	4
Big toe	Dorsiflexors	2	4
	Plantar flexors	2	4
Sensory system examination		Slightly impaired in left leg	Improved
Perceived stress scale		38	13

DISCUSSION

FND is a clinical challenge due to its Inconsistency between *Nidana* (etiology) *Samprapti* (pathogenesis) and presentations. So adopting *Satwavachaya chikitsa* (psychotherapy) along with the treatment of *Avaranavata chikitsa* is useful.[19] First, *Udwartana* (powder massage) with *Kolakulathadi churna* was administered to the patient due to its *Rukshana* property, *Kaphaharatwa (Gurutwa, Supthata)* for the initial 5 days but the patient was not responding to it.[20] Then went to *Snigdha chikitsa*

(unctuous therapy) i.e., *Abyanga* and *Ushma Sweda* with *Sahacharadi tailam* [21] for 5 days. Still patient has not reported any improvements in the symptoms. *Vyatyasa chikitsa* [22] (dry and unctuous therapies alternatively) was administered with *Triphala churna* [23] with *Dhanyamla* [24] and *Navadhanya churna* with *Balaksheera Kashaya* alternative days by considering *Avaranatwa* [25] *(Kaphavrita vyana lakshanas)- Gurutwa* (heaviness of left leg), *Skhalitham cha gathou brisham* (postural instability) and the patient responded well to the treatment. It helped to correct *Vyana vayu*, removed *Avarana,* and also treated *Kapha dosha*. At last *Marsha nasya* with *Ksheerabala taila* (101A) [26] 1ml for 7 days was given to correct *Udana anulomana*, and also it reaches up to *Pranastana* thus correcting *Raja tamodosha*. Internal medications- *Drakshadi Kashaya* was selected due to its *vatapittahara* property, *Aparajitha churna* and *Vacha churna* in combination were given to address the stress factor, and *Sukumara erandam* given for *Apana vayu anulomanarta* (proper downward movement). *Avarana chikitsa* was effective along with stress management even though the diagnosis was *Yoshapasmara* as the presentation was similar to *Vata vyadhi* and etiology due to psychological factors.

Discussion on Hypnotherapy

Evidence suggests that people with conversion disorder are more susceptible to hypnosis than the general population, making hypnosis a potential treatment for the problem. [27] It is arising in relation to some psychological stress or conflict, but is not consciously produced or intentionally feigned. [28] It is hypothesized that hypnosis and conversion are characterized by similar brain processes.[29] Subjects under hypnosis are suggested to consciously demonstrate motor or sensory phenomena, while patients with FND have unconscious fixed ideas based on unconscious suggestions or autosuggestions that remain isolated from the rest of their mind and are expressed through motor or sensory disturbances. Thus changing the ideas or unresolved conflicts hypnotherapy can be adopted. [30]

CONCLUSION

FND is a psychiatric illness affecting voluntary motor or sensory function that cannot be explained by a neurological condition. The basic pathophysiology is the conversion of unresolved unconscious thoughts into somatic presentation. So the replacement of emotions/unconscious thoughts can be done by Hypnotherapy, thus reducing stress levels. As the presentation of the disease is the same as *Kaphavrita vyana*, *Avarana chikitsa* can also be adopted. Thus, the combined use of *Avarana chikitsa* along with *Satwavachaya chikitsa* will be useful in conditions presenting as FND with weaknesses and sensory loss. *Yoshapasmara* is one of the unexplored areas in Ayurveda where more clinical and conceptual researches need to be done to unravel more in this area.

Declaration of Patient Consent

Authors certify that they have obtained the patient consent form, where the patient has given his consent for reporting the case along with clinical information in the journal. The patient understands that her name and initials will not be published and due efforts will be made to conceal her identity, but anonymity cannot be guaranteed

REFERENCES

1. Breuer J, Freud S: Studies on hysteria, in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol. II. Edited and translated by Strachey J, Strachey A. London, Hogarth Press and the Institute of Psycho-Analysis, 1955, pp vii–xxxi, 1–311 (original work published 1893–1895)
2. American Psychiatric Association (2000) Diagnostic and statistical manual of mental disorders, 4th ed. Text Revision. Washington, DC (2020): 64-68.
3. Dhruv Beri and K Jayasankara Reddy. An Overview of Conversion Disorder: Prevalence, Causes, and Treatment. Acta scientific neurology 3. 10[2020]: 64-68
4. Tomasson K, Kent D, Coryell W (1991) Somatization and conversion disorders: comorbidity and demographics at presentation. Acta Psychiatr Scand 84:288–293
5. Deveci A, Taskin O, Dinc G, Yilmaz H, Demet MM, Erbay-Dundar P, Kaya E, Ozmen E. Prevalence of pseudo neurologic conversion disorder in an urban community in Manisa, Turkey. Social psychiatry and psychiatric epidemiology. 2007 Nov; 42: 857-64.
6. Marshall S, Bienenfeld D. Conversion disorder. Medscape. Drugs and diseases. June 26, 2013. [May 30, 2015]
7. Gulseren S, Ozmen E, Onal C, Kuey L, Mete L (1993) Symptom distribution and sociodemographic characteristics in patients with conversion disorder. J zmir State Hosp 31: 373–377
8. Bowman ES, Markand ON (1996) Psychodynamics and psychiatric diagnoses of pseudoseizure subjects. Am J Psychiatry 153: 57–63
9. Spitzer RL, Spelsberg B, Grabe HJ, Mundt B, Freyberger HJ (1999) Dissociative experiences and psychopathology in conversion disorders. J Psychosom Res 46:291–294

10. Ali S, Jabeen S, Pate RJ, Shahid M, Chinala S, Nathani M, Shah R. Conversion disorder-mind versus body: a review. Innovations in clinical neuroscience. 2015 May 1; 12(5-6): 27.
11. Madhaava nidana, parishishtadhyaya, Yoshapasmara, Choukambha Sanskrit Bhawan series Varanasi, 2006
12. Van Dyck R, Hoogduin K. Hypnosis and conversion disorders. American Journal of Psychotherapy. 1989 Oct; 43(4): 480-93.
13. Kashinath sastri (Translator), Caraka Samhita. Sutra sthana, Trisreshaneeya, Chapter 11th. Verse 54, 2017th ed. Vol.1. Varanasi: Chowkhambha Sanskrit series office; P168.
14. American Psychiatric Association (2000) Diagnostic and statistical manual of mental disorders, 5th ed. Text Revision. Washington, DC. P 318
15. K.R Srikantha Murthy (Translator), Ashtanga hridaya, Chikitsa sthana, Jwara chikitsa, Chapter 1, Verse 55b-58. Varanasi: Chowkamba krishnadas academy 2010; P183
16. Jain NN, Ohal CC, Shroff SK, Bhutada RH, Somani RS, Kasture VS, Kasture SB. Clitoria ternatea and the CNS. Pharmacology Biochemistry and Behaviour. 2003 Jun 1; 75(3): 529-36
17. Esfandiari E, Ghanadian M, Rashidi B, Mokhtarian A, Vatankhah AM. The effects of Acorus calamus L. in preventing memory loss, anxiety, and oxidative stress on lipopolysaccharide- induced neuro inflammation rat models. International journal of preventive medicine. 2018;9.
18. K.R Srikantha Murthy (Translator), Ashtanga hridaya, Chikitsa sthana, Vidradhi-vrddhi chikitsa, Chapter 13, Verse 41-47. Varanasi: Chowkamba krishnadas academy 2010; P398-399
19. Kashinath sastri (Translator), Caraka Samhita. Sutra sthana, Trisreshaneeya, Chapter 11th. Verse 54, 2017th ed. Vol.1. Varanasi: Chowkhambha Sanskrit series office; P168.
20. K.R Srikantha Murthy (Translator), Ashtanga hridaya, Vol 1 Sutra sthana, Dinacharya adhyaya, Chapter 2, Verse 15. Varanasi: Chowkamba krishnadas academy 2010; P25
21. K.R Srikantha Murthy (Translator), Ashtanga hridaya, vol 2 Chikitsa sthana, Vatavyadhi chikitsa, Chapter 21, Verse 67-69. Varanasi: Chowkamba krishnadas academy 2010; P509
22. Ram karan sharma, Vaidya Bhagavan dash, (Translator) (2010 ed.). Caraka Samhita, Chikitsa sthana. Vatavyadhi chkitsa: chapter 28. Varanasi: Chowkhambha Sanskrit series office.P79.
23. K.R Srikantha Murthy (Translator), Ashtanga hridaya, Sootra sthana, Annaswarupa Vijnaniya, Chapter 6, Verse 159. Varanasi: Chowkamba krishnadas academy 2004; 104-105.
24. Vaidya Jadavji Trikamji Acharya, Sushrut Samhita of Sushrut with Nibandha samgraha Commentary of Sri Dalhanacharya, Sutrasthana, 45/214-216, Chaukhamba Samskrit Samsthana, Varanasi
25. K.R Srikantha Murthy (Translator), Ashtanga hridaya, Nidana sthana, Vatashonita nidana, Chapter 16, Verse 47. Varanasi: Chowkamba krishnadas academy 2010; P167.
26. K.R Srikantha Murthy (Translator), Ashtanga hridaya, Chikitsa sthana, Vatashonita chikitsa, Chapter 22, Verse 45-46. Varanasi: Chowkamba krishnadas academy 2010; P521.
27. Van Dyck R, Hoogduin K. Hypnosis and conversion disorders. American journal of Psychotherapy. 1989 Oct; 43(4): 480-93.
28. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. Washington: APA; 1994.
29. Vanhaudenhuyse A, Laureys S, Faymonville ME. Neurophysiology of hypnosis. Neurophysiologie Clinique/Clinical Neurophysiology. 2014 Oct 1; 44(4): 343-53.
30. Bell V, Oakley DA, Halligan PW, Deeley Q. Dissociation in hysteria and hypnosis: evidence from cognitive neuroscience. J Neurol Neurosurg Psychiatry 2011; 82(3): 332-9.
31. Heap M. EBOOK: Hypnotherapy: A Handbook. McGraw-Hill Education (UK); 2012 Jul 16.

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***Address for correspondence**
Dr. Anjumol M
PG Scholar,
Manovigyana Evam Manasaroga,
Department of Kayachikitsa,
VPSV Ayurveda College, Kottakkal.
Email:
dranjumohan159@gmail.com
Mobile: 9745814486