SUBJECT: CONVERSION DISORDER

1. **PURPOSE:**

   This policy will provide guidelines for the appropriate care and treatment of those individuals with a diagnosis of Conversion Disorder.

2. **POLICY:**

   All individuals at Coalinga State Hospital shall be provided with the highest possible quality of evidenced-based, appropriate care and treatment, based on their diagnosis and presenting symptoms, in a professional manner, with respect and dignity.

3. **GENERAL INFORMATION:**

   Conversion disorder is classified as a type of Somatoform Disorder, which are characterized by complaints of physical symptoms that cannot be explained by known physical mechanisms. All of these disorders have the common belief that the physical symptoms are real despite any evidence to the contrary. The physical symptoms are not under the Individual’s voluntary control. The Individual experiences changes or loss in physical function, and there is significant impairment in social or occupational functioning.

   Conversion disorders are characterized by the development of a symptom or deficit suggesting a neurological disorder (blindness, deafness, loss of touch or pain sensation), or an involuntary motor function (aphonia, impaired coordination, paralysis, seizures, etc.). The symptom or deficit is not due to malingering or factitious disorder and is not culturally sanctioned. The symptom or deficit causes marked distress, impairment in occupational and/or social functioning, and/or requires medical attention.

4. **ASSESSMENT:**

   A complete and thorough physical and mental status evaluation is especially important for individuals suspected with this disorder. The Individual with a known history of a somatoform disorder may also have a co-existing medical condition that may go undiagnosed. Careful screening is essential to rule out
medical problems. There is an increased risk of suicide and substance abuse/dependence disorders in individuals with an untreated somatoform disorder. Mood disorders, especially depression, are a common co-morbid problem in individuals with somatoform disorders. The following are some of the important components of a thorough nursing assessment.

MENTAL STATUS

- Appearance and behavior
- Consciousness
- Speech activity
- Thought process, content and perceptions

PHYSICAL COMPLAINTS

- Current and past history as well as duration of problems
- Insure diagnostic testing is completed
- Number of health care providers consulted
- Types and amounts of medications taken and whether self medicating (over the counter) or prescribed

PSYCHOLOGICAL PROCESSES

- Perception of illness and current stressors
- Self-concept and body image
- Secondary gains from physical symptoms
- Mood
- Suicide potential

SOCIAL FUNCTIONING

- Ability to function in social and work situations
- Impact of symptoms on the Individual's relationships, especially family relationships
- Diversional and recreational behavior
- Identification of stressors related to self-concept, role performance, life values, social status, and support systems
- Benefits (primary and secondary gains) and risks of the presenting symptoms

5. PARTIAL LISTING OF POTENTIAL NURSING DIAGNOSES:

Decreased adaptation to stress related to:
  - Feelings of inadequacy
  - Ineffective interpersonal relationships
  - Diminished interpersonal strengths and coping strategies
Limitation(s) in physical functioning related to:
- The physical conversion symptom
- Inability to resolve the precipitating conflict

Decreased ability to express feelings related to:
- Feelings of inadequacy
- Feelings of fear or guilt
- Ineffective interpersonal relationships

Anxiety related to:
- Multiple physical symptoms
- Belief that serious disease exists

Ineffective Individual coping related to:
- Preoccupation with physical symptoms

6. PLAN:

*The Individual will:*
1. Experience relief from acute stress or conflict
2. Be free of actual physical impairment
3. Identify the conflict underlying the physical symptom
4. Verbally express feelings of fear, guilt, or inadequacy
5. Successfully resolve the conflict without recurrence of the conversion disorder.
6. Develop interpersonal and intrapersonal strategies to handle life stresses

7. IMPLEMENTATION AND INTERVENTION:

Identify the source of conflict or stress:

**NURSING ACTION**  
A. Obtain a thorough history. Contact family or significant others.

**KEY POINTS**  
A. To identify the source of the conflict or stress.

Determine the basis of the symptom(s):

**NURSING ACTION**  
A. Observe Individual closely when symptoms occur. Look for precipitating events.

**KEY POINTS**  
A. To determine the basis of the symptom(s) and R/O organic basis.
Relieve the Individual’s stress or conflict:

**NURSING ACTION**

A. Avoid making demands or requiring decisions that are similar to the Individual’s pre-hospitalization conflict.

**KEY POINTS**

A. Such demands would recreate or intensify the conflict.

Diminish the Individual’s focus on the physical symptom(s). Prevent secondary gain from the symptom(s):

**NURSING ACTION**

A. Involve Individual in usual activities. Do not excuse due to physical limitations.

B. Assess food and fluid intake, elimination, and rest as unobtrusively as possible.

**KEY POINTS**

A. To decrease Individual’s focus on physical symptoms and to reduce secondary gain.

B. To maintain adequate nutrition, hydration, elimination, and rest; to minimize the physical aspects of the Individual’s problem.

Encourage expression of feelings and discussion of conflict. Facilitate recognition of the relationship between the conflict and the physical symptom(s):

**NURSING ACTION**

A. Encourage Individual to discuss feelings and conflicts. Avoid discussing physical symptoms. Withdraw attention if necessary.

B. Give praise when the Individual is able to discuss the physical symptoms as a method used to cope with conflict.

**KEY POINTS**

A. To facilitate recognition of the relationship between conflict and physical symptoms.

Help the Individual resolve the conflict, or deal with it in ways other than by producing physical symptoms:

**NURSING ACTION**

A. Explore alternative methods of expressing feelings and coping with conflict.

**KEY POINTS**

A. Offer suggestions, alternative methods. Avoid telling Individual what to do and/or how to do it.

8. **EVALUATION:**

Documentation should reflect:

1. Individual’s current status and progress towards meeting short and long-term goals
2. Changes in Individual’s condition
3. Nursing interventions for unusual or sudden behavior changes
4. Response to treatment interventions
5. Attendance and participation in scheduled groups
6. Response to medication
7. Effects illness has on:
   - Eating
   - Sleeping
   - Hygiene
   - Elimination
   - Behavior
   - Individual education