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Research Article

A single case report of Body Oriented Psychological Therapy for a patient with Chronic Conversion Disorder

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ABSTRACT

This case study describes an innovative experiential Body Oriented Psychological Therapy (BOPT) for a patient with mixed dissociative conversion disorder (ICD-10, F44.7) and co-morbid depression resulting in severe somatoform complaints and emotional distress. The therapy process is informed by the main theoretical hypotheses of BOPT and utilises non-verbal expressive behaviour, body awareness and movement interventions to facilitate a change process through linking the expression of a wider range of emotions to implicit memories on a somatic level. Hereby the patient is enabled to access and bring into consciousness determinants of psychological states including repressed anger and conflicting feelings and ideas. The playfulness in BOPT fosters creative capabilities and embodied symbolic enactments of responses to trauma help to explore alternative coping mechanisms. Over the course of fifty sessions of BOPT important positive changes in the patient's presentation were noted. By the end of therapy the patient was much more able to cope with his disability and he felt empowered to move forward in his life. The positive outcome suggests that this BOPT approach offers a useful alternative intervention when working with patients with conversion disorders.

Introduction

Conversion disorders are complex psychosomatic conditions characterised by a deficit or distortion in somatic functioning, not attributable to an organic pathology. Prolonged manifestations of conversion disorder pose significant challenges to the patient and the therapist whose efforts to treat the condition are often unsuccessful (Kroenke, 2007; Stonnington, Barry, Robert, & Fisher, 2006). New intervention strategies are therefore required and body oriented approaches, e.g. physical therapy (Kaur, Garnawat, Ghimiray, & Sachdev, 2012; Ness, 2007; Espay et al., 2018) have been previously described as potentially useful for the treatment of conversion disorder. The condition has been associated with early childhood traumatisation (e.g. Nicholson et al., 2016) and studies have identified that conversion symptoms may be elicited by a complex interplay of early and later negative life events, emphasising multifactorial stress models (e.g. Roelofs, Spinhoven, Sandijck, Moene, & Hoogduin, 2005). Therapies should therefore offer complex interventions and body oriented approaches have been identified as suitable and effective ways of accessing implicit memory systems as a prerequisite for recovery in integrated trauma therapy (e.g. Rothschild, 2000; Levine, 2015).

Body oriented psychological therapies relate directly, in narratives and also through creative embodied enactments to the unexplained somatic symptoms affecting voluntary motor or sensory function. This paper will describe and reflect on body oriented psychological therapy (BOPT) that was offered to a middle-aged Sikh asylum seeker, who presented with a 3-year history of dissociative conversion disorder (ICD-10, F44.7; DSM IV 300.11; paralysis and sensory deficits of right arm).

Aim

The aim of this case study was to explore systematically how an embodied and creative movement approach (BOPT) can address the specific psychopathology, the deficits or distortions in somatic functioning and/or the related impacts of the disorder on subjective quality of life and coping in conversion disorder.

Research questions for the case study

1 How does the patient respond to and utilise the specific intervention strategy of body oriented psychological therapy?
2 Does the patient benefit from BOPT in respect of symptom severity and/or related secondary consequences and overall subjective

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quality of life?
3 Can any changes that occur over the course of BOPT be captured using standardised outcome measures?

Method

Ethical considerations

The patient was informed about the intention to analyse the case study notes for the purpose of this analysis, he was provided with information regarding the nature of the study; written informed consent was obtained from the patient to conduct the case study and publish anonymised data.

Design

The study was conducted retrospectively, utilising structured therapist's clinical notes and corresponding information from electronic patient records as well as two outcome measures. The therapist is the first author who is a registered dance movement psychotherapist, psychologist and clinical supervisor. The analysis followed the principles of a pragmatic case study method developed by Fishman (2005) which includes, among other features, assessment of patient's problems, formulation and treatment plan and concluding evaluation of the process and outcome of the therapy (e.g. McLeod, 2010).

Oucome measures

The following outcome measures were used for baseline and post-therapy evaluation of treatment outcomes:

1 CORE-OM-34 (Evans et al., 2002): the scale consist of 34 items and each item is scored on a 5-point scale ranging from 0 (not at all) to 4 (most or all the time). The total score is calculated by adding the values of all 34 items (range is 0 to 136). The total mean score is calculated by dividing the total score by the number of completed item responses (normally 34). The scale has four dimension scores (score range): Well Being (0–16), Problems or Symptoms (0–48, Functioning (0–48) and Risk (0–24).
2 Primary Health Questionnaire / PHQ-15 (Kroenke, Spitzer, & Williams, 2002): this questionnaire asks for somatic complaints; scores of 5, 10, and 15 are the cut-off points for low, medium, high somatic symptom severity.

The patient

History of presenting complaints and clinical presentation

Mr X was referred to mental health services by his GP as a result of his paralysis following thorough medical investigations which excluded a physical cause of his symptoms. At the time of the referral he also presented with a range of other somatoform symptoms including severe back and leg pain. It was reported that he developed the paralysis of his arm whilst being in prison; the symptoms slowly progressed from his hand to taking over his whole arm. He was seen by a family doctor in prison and comprehensive standard neurological investigations were carried out; these excluded an organic cause for his somatic symptoms. His complaints gradually worsened and he began experiencing severe pain in his back, in the back of his right leg and in the heel of his right foot and it became increasingly difficult for him to walk. He also suffered from insomnia and depression. At the time of the referral he presented to the multi-disciplinary psychological therapy team (including senior psychotherapists and psychiatrists) as being very concrete in his thinking with poor verbal communication skills. The comprehensive assessment concluded that he was not suitable for psychodynamic, cognitive-behaviour or other verbal psychotherapy based on his clinical presentation. It was decided that Mr X would in the first instance be offered 20 sessions of individual BOPT; subject to a re-assessment after 20 sessions and given that he progressed significantly, the therapy was later extended to 40 sessions, with 10 additional sessions for closure.

Personal history and background

Mr X arrived in the UK in 2006 illegally, having fled from India as his life was under threat. Little information could be obtained about his early childhood development. He was married with two young children and had been a thriving businessman in the food (chicken) production industry until the bird flu of 2006 in India destroyed his business overnight. Due to financial difficulties he acquired a loan from a criminal organisation at a very high interest rate, which made it impossible for him to pay the money back on time. He was subsequently "kidnapped" and maltreated, but managed to escape and travelled to the UK whilst leaving his family members, who were also under threat, behind in India.

In the UK he connected with the Sikh community and worked illegally for 2.5 years with forged documents. This arrangement suddenly came to an end when he got into a dispute over accommodation with a man whom he had considered to be a friend and whom he had helped financially. This man reported Mr. X. to the police; he was tried, convicted for fraud because of forging documents and spent 6 months in prison. Afterwards he was transferred to a detention centre where he stayed for 2 months and submitted an application for asylum to the UK authorities in 2009. It was during this time in prison that he developed signs of paralysis of his right arm.

Since discharge from the detention centre in 2010 Mr X has lived in a hostel for asylum seekers, supported by a refugee care service. For over two years he had no response to his application for asylum, which was rejected eventually in 2013. He appealed, was rejected again, and re-appealed. He lives an isolated life though he does speak frequently to his family in India; he has not made friends in the hostel as he describes the other residents as having alcohol and drug problems and exhibiting violent behaviour and he does not want to associate himself with these people. However, he does relate well to two refugee advocates from the refugee service.

Initial assessment for BOPT therapy

On the first occasion Mr X. presented as very cautious and timid and described how he was exposed previously to challenges by medical professionals about his symptoms in a manner that he experienced as "unsympathetic, aggressive and hurtful". He spoke about his distress, his intense pain in his body, his frustration about his paralysed arm, and his very negative and despairing feelings about his situation. Overall, Mr X. was overwhelmed by all the negative effects of his experience and was hardly able to connect with any positive or resilient features in himself. His body posture gave the impression of being beaten down by life with a shrunken gait and a restricted movement range. It seemed that he could harness neither energy nor strength in his postures and movements and consequently there was a sense of passivity. However he was not entirely cut-off or withdrawn and was able to make good eye contact as well as appropriate facial expressions.

Clinical formulation for BOPT

Mr X. was suffering from severe conversion disorder with paralysis and sensory deficits of his arm, accompanied by somatoform pain disorder. Following a sudden onset in 2009 the symptoms developed into a chronic condition, resulting in substantial distress, associated with depressive symptoms and impairment in social and overall functioning. It was impossible to ascertain as to whether earlier childhood traumata or other developmental problems impacted upon his condition. A series of

difficult life events precipitated his illness, these could best be characterised as follows: following significant losses (financial ruin, loss of social status, had to flee the country and leave family behind), a period of hope (starting to rebuild his life, albeit in the context of illegal status) was interrupted when he experienced betrayal with subsequent persecution and this resulted in a state of complete disempowerment and threat (detention, deprived of all means, fear of being deported back to India where his life would be in danger). All these traumatic events occurred suddenly and unexpectedly, and his response to the resulting state of his affairs could be labelled as "being paralysed and numbed", "becoming impotent". He appeared to have expressed this through the somatic equivalent of his conversion symptoms.

The localised symptomatic focus towards his right (dominant) arm prevented him from engaging actively in his life whilst also symbolically reflecting his inability to "handle" or influence his difficult position. The severe leg and back pain and resulting difficulty in sitting, standing or walking for any period of time conveyed an intense restlessness and discomfort with himself. Symbolically he seemed to be expressing an inability to be settled in himself, to stabilize and ground himself or to move forward with his life. He was in fact stuck in an habitual fear based, inappropriate survival response (Ogden, Pain, & Fisher, 2006).

Planning of body-oriented psychological therapy

BOPT is used in this paper and increasingly so in the literature as an umbrella term (see Röhricht, 2009; Rothschild, 2000; Levine, 2015) for the therapeutic approach that integrates a wider range of skills and interventions from fields such as Body Psychotherapy (Marlock & Weiss, 2016; Geuter, 2015) Dance Movement Psychotherapy (Chaiklin & Wengrower, 2015), and Sensorimotor Therapy (Ogden et al., 2006). The common underlying denominator of these therapy schools is that they emphasise embodiment as the unity of emotions, cognitions, movement and perception (see also Burns, 2012). The therapeutic plan was developed by taking into account the patient's main concerns which revolved around his constant limb and body pain, his incapacity to move (mobilise) and his anxiety and distress related to both his personal situation and his concern about his family in India. These were to be addressed in the context of six of the main pillars of a body oriented psychotherapeutic approach (e.g. Röhricht, 2000; Papadopoulos, 2015), drawing upon clinical experience and evidence from previous research in the treatment of somatoform disorders (Röhricht & Elanjithara, 2014; Röhricht, 2009; Röhricht et al., 2017):

1 Enabling he patient to experience the body in its diversity and not only as a source of pain, discomfort and negative experiences, thereby recognising healthy, well-functioning aspects, highlighting the sense of consistency, stability, continuity and control that the body provides and introducing a more differentiated perspective towards one's own bodily reality.
2 Working with and through bodily aspects of the self, enabling the experience of subtle change processes in a stable environment as a counterpoint to the perception of stagnation.
3 Non-verbal expressive behaviour can encourage the expression of a wide range of feelings through gestures, posture and movement behaviour given the close association between "e-motion" and movements; emotions are hereby brought into consciousness, identified and named. This process can uncover unconscious determinants of the psychological state (e.g. repressed anger, conflicting feelings and ideas).
4 The playfulness in BOPT enables a tangible connection with positive and creative capabilities and can engender hope as a counterpoint to the negative self-image and experience of helplessness.
5 Utilising the positive effect of creative arts therapies on the therapeutic alliance (Heynen, Roest, Willemars, & van Hooren, 2017) and their potential to enable revisiting trauma through enactment within a contained therapeutic space (Haen, 2017).
6 Directly addressing the very nature of the symptom through enactments in therapy, helping to reveal the meaningful nature of both normal and pathological functioning of body parts. In parallel this involves exploring the sensorimotor aspects of (re-)gaining safety as a result of grounding exercises and movement patterns that support a sense of strength, (physical) boundary setting and self-defence. Somatic bottom-up intervention according to the sensorimotor approach implies working: "with the implicit elements of traumatic memories by directing the client's awareness away from the verbal components of memory to the non-verbal residue of the trauma" (Ogden et. al., 2006, p. 275).

Results

The therapeutic intervention – therapuetic process and outcomes

Mr X was seen for 50 sessions on a weekly basis over a period of 1.5 years. This can be divided into three distinct phases, the initial phase (sessions 1–20), the middle phase (sessions 20–40) and the ending phase (sessions 40–50). Although these phases were intrinsically interlinked each phase was able to focus on different aspects of the patient's development as he progressed from being very cut-off in every sphere of his life to becoming much more able to express himself and integrating himself into his local community.

First / initial phase: sessions 1 to 20

Mr X's movement capacity was very limited due to his somatic symptoms and he tired very easily; his use of his body parts and his reach into the space around him were very restricted. He found it difficult to stay either standing or sitting for more than a couple of minutes at a time and would constantly change his position from being seated (on an upright chair) to standing and sitting down again. He described himself as 'drowning' as he felt he had been knocked down so many times, despairing about his situation and feeling completely powerless. The first few sessions were dominated by an exploration of thoughts about death, killing grass "when you trample on it", about what happens to bodies in cemeteries and various other morbid themes. He got overwhelmed by these thoughts and his body appeared irrelevant to him except for the pain he experienced from it; his thoughts were expressed without affect and had no impact either on his emotional expressions or his bodily postures and gestures. He did try to make sense of his traumatic experiences but these thoughts were all expressed as though he was talking about someone else. A noticeable incongruence between his expressive thoughts and his bodily posture and gestures emerged. Despite his ability to make eye contact it was very difficult at times to make mutually empathic contact.

On an emotional level, at first he came to the sessions in a very depressed mood, sometimes so profound that it was barely possible to do much apart from basic self-massage and deep breathing. However, with time he became more able to engage in movement and (bodily) self-awareness work and the interventions offered him ways of exploring bodily sensations in the context of simple warm-up exercises as well as deep abdominal breathing and releasing of tension in the voice box and throat. A range of props such as balls, a parachute, a buddy band, and beanbags were utilized and he found innovative ways of using these to ease his pain despite his severe physical limitations. Through this creative movement he began to experience his body in a more positive manner increasing both his own sense of himself and his self-awareness. He began to connect emotionally with the areas of non-responsiveness in his body and to experience a degree of pleasure and achievement. He even began to practise these exercises at home.

The main emphasis of the work during this phase of the therapy was to begin shifting the focus of his attention away from the negative effects of his overall situation towards actual lived experiences in relation to his body and it's functioning in line with the main pillars of BOPT

described above. Using the props it was possible for him to differentiate positive personal characteristics that were present in him before his adverse experiences occurred and could still be accessed, such as playfulness, enjoyment, a sense of achievement. He discovered aspects of himself that could be described as "a fighter against all odds". This was enacted through gestures, e.g. punching the air with his left fist in an expression of achievement and bouncing the large physio ball with power and force when he connected with his capacity to experience his own strength and his psychological resilience. Whilst gradually shifting the image of a dysfuncytional body, he noticed how his range of physical movement had increased, i.e. bending, stretching and rotating his joints, expanding and contracting his kinesphere which together created both physically and psychologically a sense of increased flexibility. These changes led the therapist to more directly help Mr X to shift his emphasis away from affectless ruminations about morbid themes and towards integrating dissociated aspects of his bodily existence.

Middle phase: sessions 20 to 40

Mr X was encouraged to reflect in a concrete manner on everyday events and themes such as his capacity to successfully complete activities of daily living, travelling with public transport and his new found love of animals which he expressed by going to feed birds on the village green near his home; his resilient features of being a fighter were now becoming apparent to him. It was during this phase that a number of other significant changes occurred: Mr X. began to recognise and experience a wider range of the basic emotions through verbal and facial expressions and even simple enactments of these in creative movement. He was able to identify and differentiate his own experiences of sadness, anger, fear and joy, e.g. he felt acutely the loss of his family and the desire to re-unite with them.

It was during this phase of the work that he re-claimed his faith in God as a positive, supportive feature and this began to guide many aspects of his life. He actively engaged in regular prayer at home as well as visiting the Sikh temple almost daily, hence becoming less isolated; in addition he began attending English language classes and increased his involvement with the local community. In this middle phase of treatment he would arrive at the sessions in a buoyant and happy mood, he no longer identified only with the role of a sick patient. Mr X. began to make more concrete choices about which body oriented activities he would like to work with and which ones he felt were particularly helpful to him. He spoke less about his pain even though he was still experiencing many of the somatic symptoms. The therapeutic process focused on expansion of movement, which allowed him to move forward again, physically and metaphorically.

Concurrently the therapeutic work also revolved around enablement through concrete experiencing. For many weeks he had entered the therapy room with a severe limp and a slightly crumpled body; now he walked into the session with firm, direct, even steps and a smile on his face. He also did not need to keep changing his position from standing to sitting to standing every few minutes as he had done at the beginning of the therapy. His body posture and gait now reflected a new found confidence in himself to move forward in his life. The therapist commented on this change in him, which he acknowledged.

At this critical moment in the therapy he received a rejection to his appeal to gain asylum status in the UK. Understandably, almost immediately, he withdrew into a depressed state and it was as though all energy was drained out of him. His thinking became more tangential and once again basic movement exercises became important to reground him and help him to regain a positive sense of himself. After a few weeks he began to express profound anger and it appeared that a 'volcanic' eruption emerged which was being held and controlled in his very body fibres as though he had armour around him. This was an opportunity to begin working with his repressed anger through the safe but aggressive use of props such as the physio ball and the parachute shaking it vigorously with his one hand, and the versaltility of these objects triggered a wide range of feelings accompanied by a sense of frustration in relation to his traumatic experiences and his current situation.

These embodied enactments facilitated the recognition of associated physical, emotional and psychological capabilities allowing him to regain some control over himself. Remarkably, despite his pain and this severe setback, three of his four limbs were now functioning more effectively. Unfortunately his paralysed arm, which had not moved for many years, remained motionless as if it were a 'dead weight'.

A most significant change emerged in Mr X in relation to his dissociated thinking after his asylum claim had been rejected. He introduced a much more grounded 'real' image of himself, a metaphor of himself as a builder and he enacted in expressive movement the role of the builder (using his left arm), building a wall with bricks. He spoke about how someone comes along and knocks the wall over every day (referring to the rejection of his asylum claim), which he demonstrated with his foot. Following this destruction he enacted re-building the wall again and he wondered how long he could go on re-building. Sadness, despair and fear were prevalent as he voiced these concerns. It was important for him to connect bodily with these feelings and express them fully through gestures and postures so that they did not remain locked in his "body armour" (i.e. rigid and immobile postures and gestures representative of a previously formed somatic response towards those experiences). This was achieved by asking him to create body shapes representative of these feelings and it helped to prevent him from reverting back to old response patterns and getting stuck with despairing feelings. Shortly afterwards he connected with a more positive self-image and a tangible feeling of self-confidence, comparing the role of the builder (who carries out someone else's plan) to an architect who creates a plan for a building. Mr X now identified himself with the (creative) architect, which immediately brought more uprightness and centeredness into his body posture.

Ending phase: sessions 40 to 50

The last few months of therapy focused on consolidating the gains he had made in terms of his view of himself and his capacity to cope with his disability, depression, and pain. He retained his new found strength and was able to lead a much fuller life. Despite receiving two more refusals of his asylum applications he did not withdraw into a deep depression; rather he became distressed in what would be considered to be within the normal range of human responses to negative life events. In a session immediately following one of his refusals he described himself as 'frozen in his head' and not able to concentrate on anything. This was a most significant shift away from his bodily conversion responses. It was a symbolic response to his difficult life situation, which reflected the immobility he was facing. However this 'paralysis 'of his head did not last long suggesting that there was now flexibility in his capacity to deal with adverse events and this feeling melted rapidly over the following week. This was understood as representing a shift from the immobilising nature of his conversion symptom (i.e. paralysis of a limb), towards responding to adversity more effectively. As he had made significant psychological progress in therapy it was decided that further sessions would not be beneficial at that moment in time. Even though he had not recovered from the most debilitating conversion symptom, his secondary somatoform pain had improved, his perception of himself had changed significantly and he now recognised that he could access his resources to move forward. At our last session he spoke about himself as follows:

> "I'm becoming stronger and do not feel defeated by anything that comes my way. I am controlling myself better with all the problems that continue. It is very easy to preach [about doing things correctly] but practising this is more difficult. Once one starts walking this path of doing more positive things, which is very hard, your thinking changes. Lot's of thorns on the way, but [I] keep going. All that got me in trouble was money; I have completely changed my view of money"."I felt all powerful / omnipotent when killing

chickens for my business. Now I see it as a big mistake; I am much more respectful of the preciousness of life. When you look in different directions you understand things better. Now I look for goodness in people; before it was about money that I could get; when you see things in that way things go very wrong."

Outcome measures

The BOPT was well adhered to and appreciated by the patient as evidenced by 100% attendance at sessions.

CORE-OM 34 showed significant improvement in two areas:his subjective well-being changed from 12 to 8, the problems / symptoms score reduced from 47 to 38; the other two scores, i.e. functioning and risk remained the same; the total score reduced from 79 (total mean score 2.32) to 66 (total mean 1.94). He had moved out of the bracket of severely mentally ill to moderately mentally ill. The PHQ-15 somatic symptom score reduced from 22 at baseline to a score of 15 post therapy.

Discussion

Evaluation of the process and outcome of therapy

Despite the fact that the diagnosis of conversion disorder has always been controversial, it falls under the category of dissociative (conversion) disorders (F44.) in the International Classification of Disease, ICD–10. Dissociation is understood to be a process that attempts to achieve psychological protection, containment or detachment from "overwhelming experiences, usually traumatic or stressful in nature. Dissociation is conceptualized as analogous to the 'animal defensive reaction' of freezing in the face of predation, when fight/flight is impossible" (Brand & Lanius, 2014, p.1. with reference to Schauer & Elbert, 2010). The authors also discuss emotion dysregulation as a key feature of chronic complex dissociative disorders and emphasise that trauma has been linked to emotion regulation difficulties. Emotion regulation skills' training was successfully utilized as a process that provides a framework for trauma exposure narratives (e.g. Cloitre, Petkova, Wang, & Lu, 2012); this is now recommended for the treatment of complex trauma patients (staged approach). In the context of physical and emotional numbness or even 'analgesia' it seems therefore indicated to devise novel psychotherapeutic intervention strategies as attempts to help patients to regulate their emotional responses to adversity more effectively. The pillars of BOPT as outlined above provide these tools with an emphasis on emotional expressiveness and affect regulation whilst focusing upon individual skills/strengths in parallel. This single case study illustrates how non-verbal expressive behaviour (gestures, posture, and movement) facilitated the expression of a wider range of emotions and helped to access and bring into consciousness determinants of psychological states including repressed anger, frustration and conflicting feelings and ideas, related to the implicit memories of the traumatic events. The playfulness in BOPT enabled the patient to experience a tangible connection with creative capabilities and in conjunction with the other BOPT interventions he became hopeful about himself and his life. In relation to the first four pillars of BOPT there was noticeable and significant improvement.

Although the nature of his symptoms were not directly addressed through enactments in therapy (fifth and sixth delineated pillar of BOPT above, p.9) because of his limited capacity to reflect psychologically about himself, there was definite improvement in the normal functioning of most of his somatic processes, though there remained pathological functioning in relation to his paralysed arm. More extended longer term work may or may not have assisted with this, but at this point in time it was not deemed appropriate to continue the therapeutic work as his condition was no longer disabling him to such a great degree. The decision to terminate the therapy was in line with current clinical evidence in relation to chronic conversion symptoms (duration longer than 6 months), which indicates that once a conversion disorder has been in place for more than six months it is unlikely to be reversible (Ford, 2010) and as the therapeutic intervention began two years after the conversion disorder it was not the main aim of therapy to undo it. Instead, the BOPT approach aimed to achieve a change in Mr X's perspective of himself, improving his ability to better self-manage whilst using his body experiences as the prime example for experiential learning. Mr X responded well to the BOPT interventions and significant changes occurred. Moreover, despite the fact that there had been no significant changes in the paralysis of his right arm he was not entirely consumed by his somatic symptoms any longer and had created new strategies to cope with them. These changes occurred on different levels: in terms of his relationship to his body, on an emotional level in how he was able to differentiate and express more clearly his emotions, on a relational level in that he engaged in social and communal activities and afforded more importance to his relationships. According to Ogden et al. (2006), p. 275) "evoking the patient's exploration system in therapy stimulates curiosity about how they can combat and/or inhibit habitual fear-based survival responses. At the moment of threat, instinctual survival defences take precedence over cognitive functions." Most significantly in the case of Mr X as described by Ogden et al, his habitual fear based responses lessened as he became more engaged in a concrete and symbolic manner with his body, resulting in more balanced and appropriate responses to himself, his situation and his environment.

Poole, Wuerz, and Agrawal (2010, p. 91), in a study on conversion disorder, stressed the fact that "despite the renewed interest there remains a paucity of studies addressing therapy". Given the severity and chronicity of the condition, BOPT was identified as an option for this particular patient, even though the evidence base for this kind of approach in conversion disorder has not been established. This was done in order to introduce a therapeutic intervention strategy that lends itself to working with the patient on the level of his core physical symptoms without explicitly referring verbally to psychological processes.

More systematic research is needed to address the question of therapeutic change processes and also with the view to establishing specific effects of this BOPT in cohort studies and adequately powered clinical trials.

Strengths and limitations of the study

This case report offers an in-depth account of the BOPT journey of Mr X who was suffering from a conversion disorder and depressioin. To date there have been no similar case reports or studies that offer this kind of innovative approach for the treatment of conversion disorders. There are limitations to this study: the preliminary nature of the findings are based upon a retrospective case analysis and the patient voice is not systematically utilised in the write up and therefore has not formed part of the case study process.

Declarations of interest

None.

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