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COGNITIVE-BEHAVIORAL THERAPY FOR FUNCTIONAL NEUROLOGICAL SYMPTOMS (CONVERSION DISORDER): A PATH TO RECOVERY

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Abstract
Conversion disorder is becoming a more prevalent mental health issue among young individuals. To comprehend early traumas, coping mechanisms, self-defense mechanisms, and schemas, such instances require an in-depth study. An 18-year-old girl presented with seizures, loss of sensation, throat constriction, and extreme anger issues. Formal assessment using the Symptom Checklist (SCL-R) led to a diagnosis of Functional Neurological Symptom Disorder (Conversion Disorder F44) based on DSM-5-TR criteria. Cognitive Behavioral Therapy (CBT) was implemented alongside parental counseling to address underlying schemas, trauma, and coping mechanisms. A total of 14 sessions were conducted, resulting in a 70% improvement. The case highlights the importance of strong parental support and a therapeutic alliance in effective treatment, reducing reliance on medication and risk of relapses.

***Keywords**: Functional neurological symptom disorder (Conversion Disorder), Seizures, Cognitive Behavioral Therapy*

Introduction
Clinically substantial mental health illness called conversion disorder, also called functional neurological symptom disorder (FND), is considered as one of the neurological symptoms that are not attributable to any certain medical or neurological etiology. Sometimes these symptoms have no distinct medical cause and are present as physical issues like paralysis, blindness, or convulsions (Allin et al., 2005). In conversion, individuals often complain of symptoms such as lack of vision and hearing, tremors, psychogenic non-epileptic seizures, dystonia, paralysis, speech abnormalities, sensory loss, and other psychomotor weaknesses. A study suggests that psychosomatic symptoms are result of stress that develops by mental and emotional triggers (Ali et al., 2015). According to statistics, conversion disorder and other related mental health issues in youth have age ranges from 13 to 28 years. Environmental dynamics, like stressors, triggers of traumatic events, and risk factors play a significant role in development of brain changes and psychosomatic symptoms (Uhlhaas et al., 2023). Clinical representation suggests that conversion disorder is prevalent at 47.4% clinically and symptoms may appear as result of emotional or psychological abuse, childhood trauma, sexual molestation, physical abandonment, self-destructive, self-manipulative behaviors, and suicidal ideations (Şar et al., 2004). Adolescents with conversion psychopathology undergo low self-esteem, histories of past traumatic experiences of verbal, physical, or sexual assault, and lack of parental support (Sarı et al., 2016)). Another study relates that almost 11.9% of clients referred to psychiatry department suffered from conversion disorder. There has been no effective therapy pronounced for conversion because there is a risk of relapse and often such individuals need multiple sessions for improvement (Sarwar et al., 2023).

The World Health Organization (WHO) identifies conversion disorder as major public health concern and stresses the dire need to provide sufficient care and treatment. According to WHO research, multidisciplinary strategy is effective to address conversion disorders by creating a bridge between mental health specialists, primary care physicians, and other healthcare providers (World Health Organization [WHO], 1992).

Psychotherapy, particularly cognitive-behavioral therapy (CBT) is endorsed by the World Health Organization as one of primary treatments for conversion disorders. The goal of cognitive behavioral therapy (CBT) is to address disproportionate thought patterns and

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behaviors coupled with the disorder, and to assist individuals in developing more adaptive coping strategies to reduce symptom severity (Beck et al., 1979). Moreover, many studies highlight the importance of educating and supporting individuals suffering from conversion disorders and their families to increase awareness of breaking the stigma to achieve efficient symptom management (Agarwal et al., 2020).

Case Study

History of Present Illness & Treatment

The client, an 18-year-old female, presented with recurrent seizure-like episodes, loss of sensation in her limbs, difficulty swallowing, and severe mood disturbances. Her symptoms began two months before seeking clinical intervention, gradually worsening over time.

Initially, she experienced frequent mood swings, heightened irritability, and increased conflicts with family members, leading to significant emotional distress, confusion, and anxiety. Therefore, she developed eating difficulties, including a persistent lump sensation in her throat and troubles swallowing. For several days, she could not consume solid food, relying solely on a soft diet and liquid intake.

Due to ongoing stress at home, she began experiencing episodes of sudden loss of sensation and unexplained unconsciousness. During particularly distressing episodes, she suffered a paralysis-like attack, resulting in a foot sprain and loss of strength in both legs, which led to severe mobility issues. She described a sensation of heaviness in her body, along with stiffness and immobility in her arms and legs.

Four days before her hospital visit, she had a seizure-like episode, followed by another the next day. After the second episode, she lost the ability to walk, reporting that her foot felt "stoned" and barely responsive. This experience was both physically painful and emotionally traumatic.

Upon medical consultation from expert neurologist, she underwent an EEG to determine any neurological basis for her symptoms. The report did not show any neurological seizures. Hence, there was no any evidence of her neurological epileptic seizures. Therefore, she was referred to psychologist for her management of symptoms.

Background Information

Educational History

The client reported being an academically competent student, consistently achieving B grades (above 80%). She expressed a strong interest in reading books and novels and enjoyed completing academic tasks. Her favorite subject was English. During primary school, she maintained positive social relationships and was regarded as cheerful and well-liked. However, due to her physical health issues, she was unable to attend college for two months. She stated that her peers and teachers expressed concern and support for her recovery.

Family History

The client belongs to a middle-class joint family system. She described the home environment as stressful, primarily due to ongoing conflicts initiated by her paternal aunt, who frequently engaged in taunting conversations with her father and uncle. Her father was perceived as an authoritative figure. Despite the family tensions, she reported having a close relationship with her father, grandmother, and grandfather.

The client resides in the same household as her uncle, his wife, and their daughter. She described them as well-mannered and non-interfering in her personal matters. She has four siblings and shares a strong emotional bond with her elder sister. However, she reported a strained and conflict-ridden relationship with her brother, who frequently exhibited aggressive behavior toward her over minor household matters. In contrast, she described her younger sister as lively and reported having a friendly relationship with her.

The client also mentioned that her paternal aunt, who lives with them, has a long-standing

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psychiatric illness. She is accommodated in a separate room and is primarily cared for by the client's mother. The client reported feeling unsafe around her aunt due to instances of aggressive behavior, including throwing objects at others and expressing paranoid delusions that family members intended to harm her. The client's aunt has been on psychiatric medication for an extended period, with partial improvement in symptoms.

The client has a family history of medical conditions, including diabetes in her father and late grandmother. Her grandfather previously suffered a paralysis attack but recovered with medical intervention.

Premorbid Personality

The client described herself as previously active, independent, and sociable. She had a keen interest in makeup artistry, cooking, and was known for preparing meals for family gatherings. However, over time, she became increasingly preoccupied with excessive mobile phone and video game usage.

Following the onset of her health issues, she reported significant mood disturbances, including persistent sadness, irritability, and frustration. She also experienced recurrent somatic symptoms, such as a lump in her throat, walking difficulties, and aggression. Over time, her distress escalated, leading to episodes of numbness, loss of sensation, and self-harming behaviors, including superficial cuts on her arms.

Case Formulation

Conversion disorder, or functional neurological symptom disorder, is characterized by physical symptoms arising from psychological stressors. Psychodynamic theory suggests that these symptoms serve as an unconscious defense mechanism to cope with internal conflicts or past trauma (Trichet, 2011). Freud's perspective posits that unresolved emotional distress is converted into physical symptoms, enabling individuals to express psychological pain without conscious awareness.

In addition to the psychodynamic model, cognitive-behavioral theory highlights the role of hyper-vigilance and catastrophic thinking in symptom magnification. The sociocultural model further emphasizes the impact of familial relationships, societal beliefs, and cultural factors on symptom presentation. Collectively, these theories suggest that conversion disorder is influenced by an interplay of psychological, cognitive, and social elements (Bass et al., 2001).

Summary of Case Formulation

The client exhibited heightened sensitivity to bodily sensations, catastrophic interpretations of symptoms, and a tendency to associate physical distress with potential medical illnesses. This led to an exaggerated response to somatic symptoms, reinforced by her family's heightened attention to illness.

Primary and secondary gains contributed to the persistence of symptoms. The primary gain included receiving increased emotional care and attention from her parents, while secondary gain involved external benefits such as excessive internet use and exemption from responsibilities, including college attendance and household tasks.

- **Predisposing factors**: A stressful family environment, particularly conflicts involving her paternal aunt.
- **Precipitating factors**: Stressors at home, difficulties with emotional self-regulation, aggression, and emerging conversion symptoms.
- **Perpetuating factors**: Family reinforcement of illness behaviors, persistent aggression, and involuntary symptoms such as seizures and functional impairments.
- **Protective factors**: Parental support in seeking psychiatric intervention, insight into her condition, and willingness to engage in therapeutic interventions.

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Conclusion

The client's presentation aligns with conversion disorder, influenced by psychological stressors, familial interactions, and cognitive misinterpretations of symptoms. A multidisciplinary approach, including psychotherapy, cognitive restructuring, and behavioral interventions, is recommended to address underlying emotional distress and develop adaptive coping mechanisms.

Psychological Assessments

For assessing the actual diagnosis of the client, proper clinical history was gathered including the client's background, nature of symptoms, and maintaining factors for evaluating and managing the problem. Psychological assessment was carried out on two levels; informal and formal.

Informal Assessment

Clinical Interview: A clinical interview includes a conversation between therapist and client typically intended to develop an understanding of client's presenting problems and history of background information in order to explicate diagnosis and develop therapeutic intervention plan. It is conversation with a purpose, which is used in a series of therapeutic session including structured, semi-structured, or unstructured based clinical interview. It involves series of questions to be asked by clinician probably designed before conduction of interview with the client (Comer, 2013).

Present clinical psychologist ensured empathetic listening. She empathized with client without letting it impede her clinical judgment. Semi-structured interviews revealed client's background information, relationships with family members, and siblings, personal information, educational history, general home environment, and history of present illness and psychiatric illness in family. Client was cooperative and answered in harmony that ensured accuracy of information provided.

Pre-Subjective Ratings of Client's Problematic Symptoms

Pre-Subjective ratings of client's problematic symptoms were taken on 0-10 scale to assess their preset severity level, which is displayed in the table below.

Table.1: *Table Showing Pre-Subjective Ratings of Client's Symptoms on 1-10 Scale.*

Symptoms	Client's Ratings
Difficulty walking	10
Trouble in swallowing	10
Seizure	8
Paralysis	8
Loss of sensation	9
A feeling of lump in my throat	10
Aggression	9

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Formal Assessment

Symptom Checklist-90-R (SCL-90-R)

Symptom Checklist Rating Scale was discussed, which is relatively brief self-report psychometric instrument, designed for clinical assessment. It helps to evaluate wide range of psychological problems of psychopathology. It is used in measuring progress and outcome of psychological treatments.

Quantitative Assessment

Table 2 *Shows score ranges, cut off, and Interpretation*

Subscale	Cut-off	Raw scores	Interpretation
Depression	37	30	Average
Somatoform	**41**	**62**	**Clinically significant**
Anxiety	56	20	Average
OCD	19	6	Average
LFT	47	24	Average
Schizophrenia	17	0	Average

Qualitative Analysis

Client scores on symptom checklist explain that she was facing somatic issues and concerns about her self-interpretation on the above 5 subscales. The cut-off score for somatoform subscale was reported to be 41. However, client obtained 62 scores, which indicates higher level of somatic form disorder.

Summary of Case Formulation

Table format according to the BPS (Biopsychosocial) model:

BPS Model Factors	Details
Biological Factors	Difficulty walking, trouble swallowing, seizure, paralysis, loss of sensation, lump in throat.
Psychological Factors	Aggression, stress, emotional distress, catastrophic thinking, self-control issues.
Social Factors	Stressful home environment, family conflicts, excessive family attention, avoidance of responsibilities.
Predisposing Factors	Stressful family environment.
Precipitating Factors	Home stress, emotional dysregulation, aggression, conversion symptoms.
Perpetuating Factors	Family reinforcement of illness behavior, involuntary symptoms, avoidance of responsibilities.
Protective Factors	Psychoeducation, family support, therapy engagement.
Assessment	Symptom Checklist SCL-R.
Diagnosis	Functional Neurological Symptom Disorder (Conversion Disorder) DSM-5 TR.

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BPS Model Factors	Details
Management	CBT techniques, anger management.
Outcome of Therapy	70% improvement after 14 successful sessions.

Diagnosis

From the previous medical reports and records, it was observed that the client did not showed any history of epileptic seizures. Through careful assessment and based on DSM-5 TR criteria, the client was diagnosed with **Functional Neurological Symptom Disorder (Conversion Disorder, F44)** (APA, 2013; Nussbaum, A. M., 2022).

Suspected Problem

The client presented with unexplained neurological symptoms, including difficulty walking, paralysis, loss of sensation, and seizure-like episodes. These symptoms appeared in response to psychological stressors, indicating a potential conversion disorder.

Differential Diagnosis

To rule out other possible conditions, differential diagnoses considered included:

1. **Neurological Disorders (e.g., Epilepsy, Multiple Sclerosis)** – Ruled out through EEG and neurological assessment, which showed no epileptic activity.
2. **Somatic Symptom Disorder** – Unlike conversion disorder, somatic symptom disorder involves excessive preoccupation with health concerns, which was not the primary presentation.
3. **Factitious Disorder or Malingering** – No evidence suggested intentional symptom fabrication for external gain.
4. **Dissociative Disorders** – Some overlapping symptoms were observed, but primary symptoms were neurological in nature, aligning more with conversion disorder.
5. **Panic Disorder with Somatic Symptoms** – Symptoms were persistent beyond acute panic episodes, making panic disorder less likely.

The final diagnosis of Functional Neurological Symptom Disorder was made after ruling out medical and psychiatric conditions that could better explain the symptoms.

Therapeutic Treatment

The following strategies were used as short-term and long-term goals with client as an intervention plan and implemented on her to resolve conversion symptoms.

1. Psychoeducation

The therapist provided psychoeducation on Functional Neurological Symptom Disorder, explaining the role of counseling, treatment plans, diagnosis, and the course of illness to the client. The rationale for therapy, informed consent, confidentiality, and treatment duration were discussed. Initially, the client found it difficult to accept that her symptoms were influenced by psychological distress rather than a medical condition. However, after gaining awareness, she became more focused on self-improvement and showed a willingness to engage in therapy.

2. Rapport Building (Client-Therapist Alliance)

The therapeutic relationship was established in the initial sessions to foster trust and create a safe space for the client. Techniques such as active listening, validation, and empathy-based dialogue were used to ensure the client felt understood and supported. As a result, the client became more open to therapy and actively participated in therapeutic activities.

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3. Motivational Interviewing (MI)

Technique Used: OARS (Open-ended questions, Affirmations, Reflective listening, Summarization)

The MI approach was utilized to enhance intrinsic motivation for change. Initially, the client was in the pre-contemplation stage**,** blaming others (e.g., her aunt) and showing resistance. Through reflective questioning and guided self-exploration**,** she progressed to the action stage**,** where she took accountability and actively worked on behavioral changes.The client rated her motivation 10/10 for working on anger management and therapy participation.

4. Motivational Analysis

The client rated her motivation level from 0-10, where she initially showed reluctance but later reported 10/10 in her willingness to manage anger and take responsibility for her well-being.

5. Relaxation Techniques

a) Deep Breathing (Diaphragmatic Breathing)

Since shallow breathing can increase anxiety and emotional distress (Gholamrezaei et al., 2021), diaphragmatic breathing was introduced. The client practiced inhaling deeply through the nose, holding for a few seconds, and exhaling slowly through the mouth to regulate emotions during aggression episodes. She reported a 9/10 effectiveness rating for this technique.

b) Progressive Muscle Relaxation (PMR) with Guided Imagery

PMR involved systematic muscle tension and relaxation to release stress. Combined with guided imagery, the technique helped the client visualize a calming environment, further reducing anger and physical symptoms. The client rated her relaxation level 10/10 after implementing this method.

6.Activity scheduling

Exercise, walking, and reading time were scheduled in daily routine to help client start walking, leaving wheelchair and continue her studies. Client with help of her parents used to walk but gradually she started walking without any support. It was observed in session that she started walking again. She reported it was difficult for her but with consistent effort she improved.

7.Anger Management

Since aggression was one of the client's presenting complaints, specific anger management techniques were introduced to help regulate emotional responses and improve behavioral control.

1. **Anger Line Technique**
   This technique helped the client identify anger triggers and map out behavioral responses. Through guided self-reflection, the client recognized alternative coping strategies. For example, instead of reacting impulsively to her aunt, she practiced calm responses, such as greeting her and continuing with her routine activities.
2. **Cognitive Restructuring (Reframing Negative Thoughts)**
   The client was introduced to cognitive-behavioral techniques to understand how thoughts influence emotions and behaviors**.** She learned to identify negative thinking patterns**,** such as overgeneralization and catastrophic thinking**,** which previously escalated her anger. She reported an improved ability to reframe stressful thoughts, preventing them from triggering aggressive responses.
3. **Distraction & Emotional Regulation Techniques**
   The client engaged in healthy distraction activities like coloring, blowing balloons, and using stress balls to manage anger effectively. These activities provided an outlet

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for frustration, helping her channel emotions in a controlled manner instead of engaging in verbal conflicts or emotional outbursts.

4. **Optimistic Thinking & Behavioral Modification**
   The client acknowledged that negative thoughts fueled her anger**,** and by practicing optimistic thinking**,** she became less reactive to stressful situations. She reported consciously avoiding verbal arguments with her parents and choosing constructive emotional outlets instead.

She also identified her inner negative beliefs and reframed it with positive coping beliefs. She made self-coping statements, which also helped her feel relaxed. Practicing and understanding anger management, challenging the unhelpful thoughts, Identifying A-B-C model of anger through situation feelings and thoughts, relaxation, finding distractions, problem-solving, breaking down to solutions, looking after yourself like healthy lifestyle (client will apply), understanding communication styles, like assertiveness-communication, learning "I" statement to make communication better and expressing more feelings, taking criticism to respect for self and others **(**Beck & Fernandez 1998). In end of session feedback was given by client, she reported of developing awareness of her problems and she realized she have so many alternative solutions rather than getting angry on herself or others. She reported that she was able to understand communication through assertiveness and she practiced it other than therapy sessions.

8.Cognitive Behavior Therapy (CBT)

Therapeutic Agenda

Prior techniques for session were explained to the client. It could be divided into 20-20-20 and each section could include different topics for intervention.

Daily Thought Record (DTR)

Cognitive Behavioral Therapy (CBT)

CBT utilizes DTR as a structured approach to identify and challenge maladaptive thought patterns. The client completed a five-column thought record**,** tracking situations, automatic thoughts, emotions, alternative thoughts, and outcomes.

1. **Syncing Thoughts with Case History**
   The client frequently had thoughts of helplessness and frustration, particularly regarding family stressors**,** conflicts with her brother**,** and interactions with her aunt**.**
   She had automatic negative thoughts such as:
   - "No one values me in my family."
   - "If I stay unwell, they will care for me more."
   - "I am not capable of handling my emotions."

These thoughts contributed to mood swings, aggression, and avoidance behaviors**,** reinforcing her conversion symptoms (e.g., walking difficulty, loss of sensation, and lump in throat).

2. **Cognitive Restructuring**
   Through DTR**,** the client learned to identify, challenge, and reframe her irrational beliefs.
   She replaced self-defeating thoughts with adaptive beliefs, such as:
   - "I can express my needs without becoming ill."
   - "My family cares for me even when I am healthy."
   - "I am in control of my emotions."

Behavioral Contingency

To address maladaptive behavior patterns, particularly avoidance behaviors (using screen time to escape responsibilities and reinforcing conversion symptoms**),** behavioral contingency strategies were implemented:

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1. **Screen Time Restriction**
   The client used the Internet excessively as a coping mechanism for emotional distress, reinforcing secondary gains (e.g., attention from family, avoiding studies, and household responsibilities). A structured screen-time plan was set, restricting Internet use to 30 minutes per day, monitored by both the client and her parents.

2. **Responsibility Reinforcement**
   The client gradually resumed daily activities**,** including attending college, participating in household tasks, and engaging in therapy exercises**.** She reported improved awareness of how avoidance behaviors contributed to her symptoms and started taking accountability for her routine.

3. **Reduction in Secondary Gains**
   Over time, the client reduced reliance on physical symptoms (e.g., walking difficulty and conversion-related behaviors) to seek attention. Parents noted an improvement in her ability to self-regulate emotions rather than relying on illness-driven behaviors for support.

Goal settings

Client has listed her goals, which she will work on later after getting therapy. She mentioned that she aspires towards a physically healthy life where she could also practice anger management to acquire a peaceful state of mind. Along with that she strives to become a successful beautician. This setting was done to help client self-actualize and develop goals and, in this activity, she showed compliance.

Self-coping statement

In this activity based on anger issues, client was given rationale and purpose for making coping statement for herself. These coping statements will be used by her when there is triggering situation for her aggression and used by her in that situation. These coping statements were practiced in Anger management sessions by client through filling worksheets identifying unhelpful situations into finding coping statements for self.

Cost-benefit analysis

This activity was carried out with client to view cost (consequences) and benefits with or without aggression. In session client reported benefits without aggression were peaceful. When she doesn't react, the situation at home doesn't get worse.

Double Column Technique (Identification)

Identification through Double Column Technique involved providing client with Cognitive Behavioral Therapy (CBT) based chart for week. The primary objective for client was to record negative automatic thoughts in one column and to concurrently identify and document cognitive distortions/errors in another column. This process aims to raise client's awareness of cognitive errors and facilitate their identification.

Triple Column Technique (Replacement)

Following Double Column Technique, Replacement phase introduced Triple Column Technique, which is advanced version of former. Triple Column Technique comprises three columns, with first dedicated to negative automatic thoughts, second to identifying cognitive distortions/errors, and third to replacing negative thoughts with positive ones. This technique was implemented to assist client in restructuring her detrimental thought patterns into more constructive and positive ones.

Cognitive Restructuring

Client was guided about DTR, Dysfunctional Thought Record in which she mentioned her thoughts and feelings in response to situation (Burns, 1980). She was then provided with

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double column paper to scribble her thoughts for identification of cognitive errors. Then triple column paper technique was done in which she was asked to write about alternative coping thoughts. After this activity, problem-solving skills were done to aid her cognitive restructuring.

9.Problem Solving

In session, the identification of unhelpful thoughts was carried out and client was made to think of possible coping balance thoughts. This activity was practiced in session by filling worksheets. Problem-solving skills were taught to maintain her timetable for her studies. Therefore, she was able to keep a balance between her study and activities for therapeutic sessions. Her parents also reported that she was following the timetable accordingly, however, she lacked on managing a few activities during the day but overall, she showed distinct improvement. She also started going to school and was able to manage her stress.

10.Extinction

Behavioral contingency plan was applied when client had first session. She was on a wheelchair and with the help of contingency plan; extinction technique was carried out. Extinction was made on Internet use, and she was guided to deal with anger and physical symptoms independently. Later in physical symptoms, client reported fewer problems and aggression issues. She felt aggression and irritation (extinction burst) due to restrictions imposed in behavioral contingency plan but was motivated towards therapy and she showed compliance towards therapist. She reduced screen-use time to half an hour instead of the whole day. Client also started walking independently and continued her college studies.

Parents Counseling

Parents counseling was done, and they were given guidelines pertaining to client's stress, aggression management. Parents were also guided to help her practice time management. When client showed tantrums, they had to avoid or ignore her demands but if she obeys, she was given reward. Additionally, they were given psychoeducation for abandoning overprotective and neglected parenting style in order to deal in such circumstances.

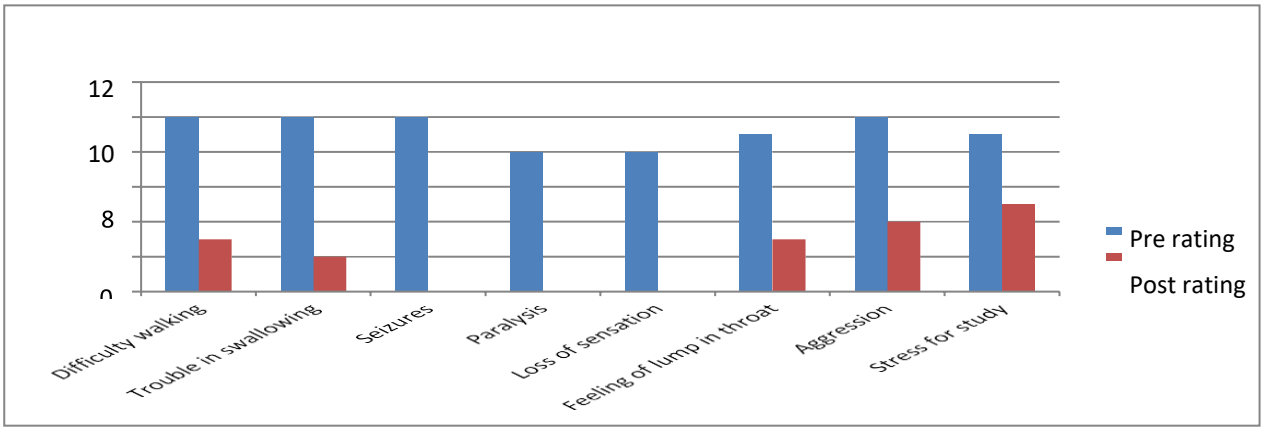
Termination

In termination, therapist discussed progress of client, reviewed treatment goals, and took her feedback for therapy. Client was satisfied with therapy and felt confident to manage her aggression. Therapeutic blueprint was also shared with the client.

Therapeutic Blueprint

Client was given therapeutic blueprint by discussing her early warning signs of symptoms, assessment, and possible therapeutic techniques applied for management of problematic areas. Client was satisfied with therapy and felt confident to manage her symptoms-related problems.

Pre and Post Rating



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Post-Subjective Rating of Problematic Areas

Post-Subjective ratings of client's problematic symptoms were taken by therapist, on 0-10 scale to assess their preset severity level, which are shown in table below:

Table.3 *Showing Post-Subjective Ratings of Client's Symptoms on 1-10 Scale as Reported by Client*

Symptoms	Client's Ratings	Post Rating Score
Difficulty walking	10	3
Trouble in swallowing	10	2
Seizure	8	0
Paralysis	8	0
Loss of sensation	9	0
Feeling of lump in throat	10	3
Aggression	9	4
Stress for study	9	5

Symptom Checklist-Revised (SCL-R):

The post-treatment rating was taken from client on symptom checklist on 0-3 scales.

Table 4 *Showing the post-treatment score of the client*

Levels	Depression	Somatoform	Anxiety	OCD	LFT	Schizophrenia
Post Treatment Score	*8*	*13*	*12*	*03*	*09*	*00*
Cutoff	*37*	*42*	*56*	*19*	*47*	*17*

Discussions

Effectiveness of Cognitive Behavioral Therapy (CBT)

The effectiveness of Cognitive Behavioral Therapy (CBT) for the client has been demonstrated through this case study. Research indicates that CBT is one of the most effective evidence-based treatments for conversion disorders, as it helps individuals identify maladaptive thought patterns, develop coping mechanisms, and improve emotional regulation (Sharpe et al., 2019).

The client exhibited notable behavioral shifts, suggesting that CBT can be beneficial for young individuals experiencing conversion symptoms. Studies have shown that conversion symptoms often emerge as a response to psychological distress, particularly in individuals exposed to chronic stress or trauma (Brown et al., 2020). The client's stressful family background, characterized by frequent interference from relatives and a strained sibling relationship, contributed to her psychological distress. Childhood adversity, particularly physical or emotional maltreatment, has been strongly linked to somatization and conversion symptoms (Roelofs et al., 2018).

The client exhibited passive aggression, which she was previously unaware of, as a means of coping with stress. Passive-aggressive behaviors often manifest as avoidance, procrastination, or indirect expressions of frustration, particularly in individuals with unresolved emotional distress (Linehan, 2015). Through therapy, the client gained insight into her emotional triggers, self-acceptance, and the ability to set realistic healing goals.

Additionally, parental counseling played a crucial role in the therapeutic approach. Research highlights that family involvement in therapy enhances treatment outcomes for conversion disorder, as it reduces reinforcement of maladaptive behaviors and promotes a supportive

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environment (Perez et al., 2012). The client's reliance on excessive screen time as a coping mechanism was also addressed, as studies suggest that screen dependency in adolescents often serves as an escape from real-life stressors (Twenge & Campbell, 2018).

With the guidance of a mental health practitioner, the client acquired effective coping strategies, learned to manage her aggression, and took steps toward developing a healthier lifestyle. This case reinforces the importance of structured therapy in addressing conversion disorder and improving emotional well-being.

Results

The therapeutic intervention comprised a total of 14 sessions, culminating in a successful treatment outcome with a 70% improvement in the client's condition. Throughout the course of therapy:

- Aggressive tendencies significantly decreased, and the client demonstrated improved emotional regulation.
- The client regained the ability to walk unassisted, indicating progress in managing conversion symptoms.
- She resumed her college routine, showing enhanced motivation and functional recovery.

A future follow-up was recommended to ensure sustained progress and prevent relapse.

Suggestions

Based on the therapeutic approach, the involvement of parents was identified as a crucial factor in the client's progress. However, parent-focused sessions were limited, as the primary focus remained on the client's direct treatment.

Parenting Support & Psychoeducation

More parental counseling sessions should be conducted to help them understand stressors, triggers, and coping mechanisms that can support the client's long-term well-being.

Relapse Prevention

There is a possibility of symptom relapse in the future. Parents and the client have been provided with psychoeducation to recognize early warning signs and seek timely therapeutic intervention if needed.

Long-Term Therapy

Continued sessions focusing on emotional regulation, cognitive restructuring, and stress management would be beneficial in reinforcing the client's progress.

Limitations

The study was limited to 14 sessions, which may not have been sufficient for comprehensive long-term behavioral change. Parental involvement in therapy was minimal**,** which could impact sustained improvements in the home environment. External stressors, such as family conflicts, were beyond the therapist's control and may influence the client's emotional stability post-treatment.

Future Implications

Parental support and therapeutic alliance have been discussed in case study as helpful in dealing with client's symptoms of conversion. Other mental health professionals are encouraged to employ cognitive behavioral therapy in their therapeutic settings for young individuals due to its efficacious procedures, which have demonstrated beneficial outcomes. It is clear that if psychological, emotional, or physical triggers are disregarded, serious clinical manifestations could result. Consequently, if someone exhibits any symptoms that are dysfunctional in nature, it is helpful to interact with mental health professionals who can assist in resolving psychological problems and promoting healthier lifestyle.

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Conflict of Interests

The author of the manuscript declares, no financial or non-financial conflict of interest in the subject matter or materials discussed in this manuscript.

Data Availability

Data availability is not applicable as no new data was created.

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