CASE REPORT

Exploring Age Regression in Conversion Disorder: A Case Series from North India

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Abstract

Regression, as described by Sigmund Freud, is an unconscious defense mechanism where the ego reverts to an earlier developmental stage to cope with stress, frustration, or trauma. In children, regression is common and often signals distress, which can usually be resolved by addressing unmet needs. In adults, regression may occur at any age, triggered by feelings of insecurity, fear, or anger. It involves retreating to a time in life when stress was minimal, or support from a caregiver provided a sense of safety. Regression, particularly age regression, can be a clinical feature of dissociative/conversion disorders, including dissociative identity disorder. In this presentation, individuals may revert to earlier developmental stages, displaying behaviors or emotions consistent with a younger self. This is often a response to trauma, where a younger identity or state is accessed to manage stress or distressing memories. However, despite its prevalence, such presentations are frequently underreported or misdiagnosed as psychosis or personality disorders. This misdiagnosis underscores the need for a thorough assessment to differentiate dissociative symptoms from other psychiatric conditions. We report a series of four such cases from a tertiary care medical college and hospital in North India. All 4 patients were females from different age-groups but shared a similar cultural background. Two patients also presented with symptoms of dissociative motor disorder (conversion disorder) in the form of pseudo-seizures and exhibited regression following hospitalization. Over 6 months, they were treated with a combination of psychotherapy and pharmacological interventions, leading to favorable outcomes.

Keywords: Case series, Case report, Conversion disorder, Dissociative disorder, Regression, Stress.

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Introduction

Regression, as defined by Freud, is an unconscious defense mechanism where the ego reverts to an earlier developmental stage in response to stress or trauma.[1] Regression can manifest as sadness, anger, sleep disturbances, or impaired functioning. In those with borderline traits, regression is more pronounced, often expressed through hostility, substance abuse, or self-harm behaviors.[2] Regression, particularly age regression, can be a clinical feature of dissociative/conversion disorders.

There is a scarcity of studies discussing regression or age regression in the context of conversion disorder. In light of this, we present a series of four cases in which patients exhibited age regression as the primary clinical manifestation of conversion/dissociative disorder.

Informed consent was obtained from all patients for publication of anonymized clinical information in this report.

Case Description

Case 1 – Ms. A

Ms. A, an 18-year-old class 12 student from rural North India, presented with a 2-month history of unusual behaviors and physical symptoms. These included excessive eye blinking, headaches, reduced sleep, and episodes of unresponsiveness lasting 15–30 minutes, accompanied by impaired memory for the events during the episodes of unresponsiveness. She also exhibited age-regressive behaviors like babbling, crawling on all fours limbs, and gesturing for food, which would last for 2–3 hours and then resolve spontaneously. There was regression in her speech wherein she would talk like a child, often stammering, using one to two incomplete words, for example, saying "wat-, wat-" when she needed to ask for drinking water, exhibiting loss of previously acquired communication skills. These episodes were often triggered by verbal altercations with her parents or being asked to attend school, and coincided with a reprimand for declining academic performance at school. During this incident, the patient was reprimanded by the class teacher in front of other children for not completing her assignment, which she reported to her parents the same day to be extremely embarrassing and humiliating for her, especially in the presence of her friends and peers. She had reported to her parents that her peers were laughing in the classroom during the incident and later during recess and after school brought it up multiple times in ways to mock her. This was particularly challenging for her since she had never been in such a situation earlier with the teachers or her peers. The patient had been avoiding school, and the symptoms started 4 days after

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the reprimand. During the outpatient assessment, she reported significant stress related to academic pressures and the school incident. She experienced an unresponsive episode characterized by speech loss, not responding to verbal commands, decreased sensitivity to pain during the interview, which lasted for around 30 minutes and was admitted for further evaluation. During this episode, there were no involuntary motor movements, no tongue bite, involuntary passing of stools or urine, no frothing at the mouth, and she did not sustain any injury. Magnetic resonance imaging (MRI) of brain and video electroencephalogram (EEG) were done to rule out the possibility of seizure disorder. The diagnosis of conversion disorder was made after evaluation. The treatment plan included sertraline tablet (50–100 mg/day) and daily supportive psychotherapy. Family psychoeducation was provided, which included educating the family about the nature of illness, need to cut down the secondary gains, and focusing on reducing academic pressure and enhancing communication. Collaboration with the school was also recommended. Over 2 weeks of in-patient care, Ms. A showed significant improvement, with reduced frequency and duration of the dissociative episodes, disappearance of regressed behavior and better emotional regulation. By discharge, she was engaging in age-appropriate behavior and had improved insight into her condition. The patient was followed-up for another 2 months. She was maintained on sertraline tablet 100 mg/day and was advised to continue for another 1 month, following which it was planned to gradually taper the medication. Her therapy sessions continued at a weekly frequency for the initial 2 months. In her supportive psychotherapy sessions, the focus was on building a trusting therapeutic relationship and providing emotional support to help her process the distressing school incident and related academic pressures. The therapist helped her develop healthier coping strategies, enhance emotional regulation, and reinforce age-appropriate behaviors. Sessions also worked on improving her self-esteem and communication skills, while gently challenging maladaptive behaviors. Additionally, psychoeducation was integrated to help her understand her symptoms and their link to stress. Follow-up visits showed continued progress, with minimal symptoms, and she resumed attending school regularly, displaying improved academic and social functioning.

Case 2 – Mrs. B

Mrs. B, a 39-year-old from rural North India with comorbid hypothyroidism, presented with a 5-year history of episodic unresponsiveness and involuntary limb movements lasting 10–15 minutes. These symptoms began approximately 1 month after the traumatic loss of her son in a road traffic accident and would occur almost daily since then. Prior to her current admission, she had undergone multiple hospital visits and engaged in various cultural and religious healing practices for her condition. Despite multiple admissions and pharmacological treatments, including escitalopram tablet, olanzapine tablet, and paroxetine tablet, her medication adherence was poor, leading to inadequate symptom control. Ten days prior to her visit, her symptoms worsened, with frequent and sudden episodes of unresponsiveness characterized by abnormal body movements, loss of response to external stimuli, lasting for 30–40 minutes, usually preceded by talks about her deceased son, persistent headaches, and transient vision loss. After informed consent, she was admitted for inpatient care. Magnetic resonance imaging of brain, video EEG, and ophthalmoscopy and fundus examination were unremarkable. Her routine blood investigations, including complete blood counts, serum electrolytes, and renal, liver, and thyroid function tests, were also within normal limits. During her hospital stay, she developed prominent age-regressive behaviors, including childlike speech, whining, periods of mutism, temper tantrums, and inability to recognize her family members correctly at times. She would often assume the fetal position, rocking back and forth, demanding a comfort object such as a stuffed toy, and engaging in pacing and verbal abuse toward the hospital staff. These behaviors complicated her management by disrupting the therapeutic environment and limiting engagement with nonpharmacological interventions, particularly psychotherapy, which she refused following the onset of regression. Despite this, her episodes of unresponsiveness and vision loss episodes improved. Treatment included sertraline tablet (50–100 mg/day), clonazepam tablet (0.5 mg twice daily), and quetiapine tablet (25 mg at night, for an off-label use for her sleep disturbances at night). No identifiable trigger for the emergence of the regressive symptoms during admission was noted. However, the patient refused further psychotherapy after her regression episodes, limiting nonpharmacological interventions. Psychoeducation sessions were held with her family, focusing on the nature of dissociative disorders, the importance of consistent medication adherence, and the need to reduce secondary gains by discouraging excessive attention or reinforcement of illness behavior. It was clarified during these sessions that she had two daughters older than her deceased son, and she was not blamed by her family or others for his death.

Two weeks after discharge, Mrs. B showed reduced frequency and intensity of unresponsive spells and vision loss episodes. Mild depressive symptoms prompted an increase in the dose of sertraline tablet to 150 mg/day. Over 6 months, her regression symptoms decreased in frequency and intensity, and the family reported overall improvement in her functioning, despite challenges with medication adherence and follow-up visits.

Case 3 – Mrs. C

Mrs. C, a 31-year-old from a semi-urban area in North India, presented to the psychiatry outpatient with her elder sister. With no prior psychiatric history, she developed unusual behaviors and physical symptoms 3 months after her husband's road traffic accident, which left him unable to walk. The onset of symptoms coincided with mounting caregiving and financial stress. Initially, she reported headaches and poor sleep, which progressed to episodes of unresponsiveness lasting 15–30 minutes. During these episodes, she exhibited involuntary limb movements along with pronounced age-regressive behaviors, such as thumb-sucking, clutching a soft toy, crawling, whining, and inconsolable crying. Her speech regressed markedly—she often spoke in a high-pitched, childlike tone, used baby talk, and produced short, repetitive phrases like "Don't leave me," "I want my doll," or "No school," sometimes accompanied by stammering or mutism. She also displayed temper tantrums, demanded to be fed or cuddled like a child, and showed confusion in identifying family members, occasionally calling her husband "Papa" or misnaming her children.

These episodes were often triggered by discussions around her husband's condition. During her outpatient evaluation, she had an episode and was admitted for further assessment. Blood investigations, MRI of brain, and video EEG were unremarkable. In the inpatient setting, she continued to display dissociative symptoms consistent with conversion disorder. She was also evaluated for depression, but did not fulfil the criteria for the

same. She was started on escitalopram tablet (5–10 mg/day) and clonazepam tablet (0.5 mg twice daily) for acute episodes. Psychotherapy focused on trauma processing, guilt, and caregiver stress. Family psychoeducation emphasized shared responsibilities and reducing household stressors.

Over 2 weeks, her symptoms improved significantly. At discharge, biweekly follow-ups and therapy sessions were planned. Clonazepam tablet was tapered and stopped over a period of 1 month. Sessions included supportive therapy to build emotional resilience, cognitive restructuring to address maladaptive thoughts related to guilt and helplessness, and stress management techniques, such as guided relaxation and problem-solving strategies. Psychoeducation was also provided to help her understand the mind–body link in dissociative symptoms, and assertiveness training was used to help her express needs without regressing to childlike behaviors. Family sessions were done to encourage open communication and realistic role expectations within the household. At 6 months, she remained adherent to treatment (escitalopram tablet 10 mg/day), with no recurrence of regressive behaviors and improved emotional coping.

Case 4- Mrs. D

Mrs. D, a 25-year-old from urban North India, was brought to the Psychiatry outpatient by her parents with complaints of severe headaches, which were unilateral in nature, throbbing and pulsatile, and precipitated by sunlight and loud noises, followed by episodes of unresponsiveness lasting around 30 minutes. During these episodes, she displayed regressed, childlike behaviors—drawing stick figures with crayons, speaking like a 10-year-old, and seeking praise with "stars" for her drawings. These episodes could last up to 12 hours, followed by prolonged sleep. The symptoms began a month earlier, coinciding with separation from her husband after 5 months of marriage due to interpersonal conflict, including intimate partner violence and dowry harassment. Legal proceedings were ongoing. During assessment, her behavior fluctuated between adult-like and child-like states. While admitted for evaluation, she continued to exhibit regressed behaviors, such as requesting bedtime stories and referring to herself in the third person. Her speech during the regressive episodes was markedly altered, resembling that of a young child both in content and tone. She frequently used simplified, age-inappropriate language, often referring to herself in the third person using phrases like "She wants water" or "Good girl did drawing." Her tone was high-pitched and playful, sometimes laced with baby talk, and she often used exaggerated expressions to seek approval, such as "Did I do good?" or "Give me star!" She showed limited vocabulary and sentence structure consistent with that of a school-aged child, occasionally stammering or repeating words for emphasis. At times, she switched abruptly between her regressed and adult modes of speech. A diagnosis of dissociative disorder was made. Magnetic resonance imaging of brain and video EEG were unremarkable. She was started on sertraline tablet (50–100 mg/day), amitriptyline tablet (10 mg/day for her headaches as we considered them to be suggestive of migraine headaches), and clonazepam tablet (0.5 mg twice daily). Though she refused therapy, her parents were educated about managing her symptoms.

Over 2 weeks, her symptoms reduced in frequency and intensity. Improvement in her headaches was also noted. At 6 months, despite poor medication adherence and missed follow-ups, gradual improvement was observed, with increased adult-like interactions.

Discussion

Analysis of four cases revealed age regression alongside conversion disorder, indicating a complex link between psychological defense mechanisms and somatic symptoms. This highlights the need for further exploration of the relationship between regression and conversion disorder, including triggers, underlying conflicts, and unconscious processes in symptom formation and diagnosis.

Clinical Presentation of the Patients

Our observations from the case series indicate that all four patients were female, aged between 18 and 39 years. Notably, the 39-year-old patient experienced symptom onset at the age of 34. It is widely recognized that conversion disorder is more prevalent in women and can manifest at any point across the lifespan, unlike somatization disorder, which primarily affects younger women.[3] The patients exhibited physical symptoms, such as dissociative seizures and involuntary movements of body parts. Additionally, they frequently experienced sudden episodes of unresponsiveness. Various studies have documented a wide range of symptoms in conversion disorder, including blindness, paralysis, dystonia, anesthesia, mutism, hallucinations, and psychogenic nonepileptic seizures.[4] In our cases, age regression was also observed, further highlighting the complex interplay between psychological and somatic manifestations in conversion disorder. Regression is a common occurrence in psychodynamic psychotherapy and psychoanalysis, often serving as a phase of reorganization that ultimately facilitates progress by bringing unconscious elements into conscious awareness. In individuals with conversion disorder—characterized by pseudo-neurological symptoms without an identifiable organic cause—regression tends to manifest more through physical or somatic symptoms rather than psychological ones.[2]

Diagnostic Challenges

Diagnosing conversion disorder with prominent regression poses classification challenges. In our cases, thorough assessments ruled out psychiatric comorbidities like depression, anxiety, and post-traumatic stress disorder, as well as organic causes, such as seizure disorders. While Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, classifies conversion disorder under somatic symptom disorders, this creates difficulty when regression—typically linked to dissociative disorders—is present. Conversely, 10th revision of the International Classification of Diseases' broader category of dissociative (conversion) disorders, and 11th revision of the International Classification of Diseases' dissociative neurological symptom disorder, better align with such cases. Given the symptom profile, subclassification as mixed dissociative (conversion) disorder was deemed appropriate. These differing frameworks draw attention to the complexity and need for nuanced diagnostic approaches when regression is evident.

Psychodynamic Understanding of Conversion Disorder and Regression

Both regression and conversion disorder are frequently preceded by significant traumatic or stressful life events, making it difficult for individuals to process and integrate these experiences consciously.[5,6] In response to overwhelming emotional distress, defense mechanisms like regression and conversion disorder may emerge. Regression involves reverting to childlike behaviors, while

conversion transforms emotional conflict into physical symptoms, both serving to shield the individual from psychological pain.[2,7]

Studies have demonstrated that individuals diagnosed with conversion disorder often have a history of adverse childhood experiences, including neglect, abuse, or other forms of trauma. These early-life stressors may impair emotional regulation and the ability to verbalize emotions, leading to alexithymia—a condition where individuals struggle to identify and articulate their emotional states.[5] Individuals with trauma histories may be more vulnerable to conversion symptoms as unconscious expressions of unprocessed emotional pain. Regression and conversion act as adaptive defenses—regression offering protection and conversion expressing distress physically. Links to female sex, alexithymia, and childhood trauma underscore the importance of trauma-informed, emotionally attuned care.

Conclusion

Our case series emphasizes the complex interplay between regression and conversion disorder, with psychological distress manifesting as somatic symptoms. The four female patients exhibited pseudo-seizures, involuntary movements, and unresponsiveness, with age regression suggesting an overlap of conversion and somatic elements. Diagnosing this condition was challenging, as psychiatric comorbidities and seizure disorders were excluded. Regression and conversion disorder serve as defenses against unresolved trauma, often linked to childhood adversity and emotional dysregulation.

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