Treating Patients with Conversion Disorders
A Theoretical View with Practical Approaches

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Treating patients with conversion disorders is difficult. Establishing a therapeutic alliance, making a proper diagnosis, and choosing a safe, yet effective, course of therapy requires time, tolerance of uncertainty, and patience. The following case reminds us, once again, that the capacity to heal always resides within the patient: it is we clinicians who must discover and use our patient's own unique resources for treatment to be effective. Techniques proven in one patient, with the same diagnosis, do not always work in the next patient. It is a lesson we must relearn throughout our careers.

Conversion disorders have challenged clinicians throughout the centuries. When neurological disorders are excluded by history, physical examination, laboratory studies including radiographic and imaging studies, therapists search for psychological causes. Surprisingly this attempt at insight is often unsatisfying for both the therapist and patient. In fact it has been suggested that the "cause" of these disorders may be found deeply within one's cultural expectations on how non-organic complaints may be present in socially acceptable ways and, as such, are subject to changes over decades from one syndrome to another (Shorter, 1995).

History shows that until the last century, somatization disorder and conversion disorder were considered under the same rubric - hysteria (Guggenheim, 1995). In 1900 B.C., the Egyptians attributed these multiple symptoms to the wandering of the uterus within the female body - reflecting the predominance in adults (not in children) of these symptoms in females. By the mid-1800's, Paul Briquet considered conversion disorder to be a central nervous system dysfunction, and Jean-Martin Charcot suggested inherited characteristics predisposed individuals to this disorder. Freud and Breuer, in describing Anna O., suggested that a somatic complaint was substituted for a repressed thought leading many therapists today to approach the treatment of this disorder by the use of the "uncovering" techniques of psychoanalysis (Guggenheim, 1995). Pierre Janet noted that, in his observations, conversion disorders were associated with dissociation. It seems natural that hypnosis and suggestions were woven throughout the fabric of these emerging theories and therapies and resulted in remissions in some cases.

Conversion disorders are seldom present in isolation. Co-morbid disorders are common; depressive disorders, anxiety disorders, and schizophrenia. It has been estimated that 1/4 to 1/2 of all hospitalized patients with conversion disorders "have a clinically significant mood disorder or schizophrenia," and yet "conversion disorders also can occur in persons with no predisposing medical, neurological, or psychiatric disorder" (Guggenheim, 1995).

Diagnosis over time occurs: 25% develop another episode within 6 years. It is important to remember that no one symptom is pathognomonic of conversion disorder. For instance, not all cases display "la belle indifference." The life experiences to which these patients are subjected are essentially not worse than other patients attending psychiatric clinics.

Experienced clinicians will recognize that cultural support is important in the acceptance of certain types of conversion disorders. Hysterical paralysis which flourished in the time of Charcot has not been prevalent in recent times, whereas modern day neurological complaints without organic findings present as Chronic Fatigue syndrome (Shorter, 1995). As Axel Munthe stated in similar circumstances, "A new complaint had to be discovered to meet the general demand" (Guggenheim, 1995). There is, however, a large current literature on conversion disorders which alerts clinicians to the ubiquity of this syndrome (Boffeli & Guze, 1992).

The purpose of this paper is to report on the treatment of a new case of adolescent male conversion disorder (hysterical paralysis) and compare it with a previous report of the treatment of an adolescent female conversion disorder (also hysterical paralysis). While clinicians can easily be aware of the syndrome, most experienced therapists are still challenged in treating these patients especially when lives hang in the balance. Such was my experience with the young man presented here for the first time.

Clinical cases

I will present two cases: the first I shared at the 6th European Congress of Hypnosis, 1993, in Vienna (Bloom, 1995b). I will briefly review my first case before describing my second case in greater detail.

Case 1

Several years ago, I treated a 12-year-old girl in consultation on the Adolescent Unit of the Institute of Pennsylvania Hospital in Philadelphia. In brief, she became totally paralyzed from the neck down, and despite numerous therapies both medical and psychological, she remained unable to bathe, toilet, or feed herself. Establishing a working relationship had been easy; and soon, in trance, she began moving her left arm, and then her right arm which persisted on awakening from trance. When then challenged that she must learn to stand up to her parents, she smiled understanding the metaphor consciously. Yet she soon began to walk. Concurrent psychoanalytically oriented therapy and family therapy revealed a difficult school adjustment. There were no signs or history of physical or sexual abuse. Following recovery and placement in a private school she became more comfortable. During her last days in the hospital, she asked me if she

were my special patient. "Of course," I said, "you are my special patient and always will be." The experience was helpful to my young patient and exhilarating for me and the floor nursing staff who had joined me in her hypnosis sessions.

For many reasons apparent to all of us who work with difficult patients who fully recover, we celebrate our successes in various ways, but mostly quietly and with an underlying respect that such recoveries remain, in part, mysterious and unexplainable. It is an unexpected opportunity for us when we are asked to repeat our originally successful efforts with a new patient whose condition has many similarities with our previous cases such as the girl I have just reported above. Confident that success would come easily, I was in for a big surprise.

Case 2

In December of 1994, nearly two years after the first case, I was invited by the Director of the Adolescent Treatment Program of the Institute of Pennsylvania Hospital to consider working with her and her staff in treating a 15-year-old boy who was functionally paralyzed from the neck down. Only his left arm was free to move normally. The patient had lost nearly 50 pounds (23 kg), about 40% of his body weight. He was starving despite heroic attempts to feed him by nasogastric tube, intensive psychotherapy, and in-patient hospitalization at the Children's Hospital of Philadelphia. Full neurological examinations has been performed including the full array of imaging scans. No obvious neurological pathology was found. With some trepidation and hesitancy, and yet with previous success in treating other very difficult patients, the Director and her staff accepted this patient in transfer with the understanding that I would join the team in consultation. I felt comfortable that I could be of help in light of my previous success. Although I learned that his insurance might not pay for my time, my colleague appealed to my desire to gain more experience in treating conversion disorders. I could not easily refuse.

Jonathan (not his real name) stated his chief complaint: "I am not able to move my right arm or my legs." When I first saw Jonathan, he was in a wheel chair, leaning to one side supported by pillows, a nasogastric tube coming from his nose and resting on his lap. While he was aware of his surroundings, he appeared very weak and responded almost in a whisper to my questions. Much of his history therefore was obtained from his medical records and physician.

His symptoms began gradually with an ear infection. His eardrum had ruptured, and he gradually began to lose balance. In March of 1994, he found his right leg was hard to move. One day he awoke and found he couldn't move it. His right arm became paralyzed, and then the left leg. His left hand began to have difficulties, but a physical therapist was able to preserve its functioning. He reported that he had no sensation, and no movement in these affected parts. He believed that he "had something that nobody could find." Because he was cold a great deal of the time, he thought his metabolism might be at fault, but he was sure that he did not have any psychological problems.

His past history is revealing. His mother is married for the third time. Her second husband is Jonathan's father. Her first husband abused both Jonathan's mother and his older step sister. Her second husband, Jonathan's natural father also abused Jonathan severely, repeatedly declaring, "You (Jonathan) will never grow up to be a man." This father is an alcoholic who once took the family cat outside the house and shot and killed it. His father then told Jonathan he might do the same to him someday. Jonathan has always been terrified of him. Jonathan's full sister, the second child by the second husband, became acutely ill and died at the age of seven. After his mother divorced her second husband, (Jonathan's natural father), she married a man who was kind to the entire family, but is often absent working at night and sleeping during the day.

Jonathan's grandfather committed suicide on Jonathan's own birthday. Jonathan was probably sexually fondled by one of the family members and his mother reports that Jonathan has acted inappropriately with his new step brothers. His mother's third husband's 19-year-old autistic

child from a previous marriage created such chaos in the new family's life that finally he was placed in an institution.

Despite the above history and the difficulties in discovering an etiological cause for such a massive symptom complex, the treatment required immediate, lifesaving, and sometimes intuitive interventions. As the staff fed him with a naso-gastric tube and began individual and family therapy, I approached him confidently and with expectations that my previous skills would be effective.

Initial visit

I first met Jonathan on a 24-bed locked in-patient unit for teenagers from 12 to 18 years old at the Adolescent Treatment Unit of the Institute of Pennsylvania Hospital. The first interview occurred in the presence of the Director.

He was sitting in a wheel chair, shoulders humped over in a classic look of despair. He weighed almost 90 pounds (about 41 kgs), and a red naso-gastric tube was taped to his nose. He constantly wiped away drooling saliva and wiped his now reddened nose repeatedly. He met my greetings and introduction with an almost inaudible "hello." I sat next to him, and explained my purpose in visiting him and my expectancy that he might respond to medical hypnosis. He asked how it would work and I described my usual practice: After getting to know him and establishing a therapeutic alliance, I would teach him self-hypnotic techniques using rotating staff members as co-therapists; I would regard him as an equal member of the team; I would be more equal than he by having both the knowledge of hypnosis and the experience in using it in another teenager with conversion disorder who had been on the same floor several years before; while he, on the other hand would be more equal than me in that he would be bringing his skills and talents to making it work for him. All sessions would be tape recorded for his practice between sessions. He stared at me and said blandly, "Whatever you say." We agreed to meet again soon.

I was uncomfortable when I left him, worried that our first session had not gone well. On re-reading my consultation note, it was prescient that I wrote, "The process of this illness is very complex, and progress may be very slow. Prognosis though is good." The later statement was more self reassurance for me.

The course of therapy - Part I

We worked together nine times from December 20, 1994 until February 3, 1995. Our work was briefly interrupted by the Christmas Holidays, and for several weeks in January.

I introduced hypnosis in the usual manner and tape recorded it for his inter-session practice. Very little response was achieved. During our sessions, I tried a number of different images and metaphors. Slowly I sensed a growing awareness that I was trying too hard. I was anxious to treat him successfully and efficiently to minimize my potential financial loss in treating him. Yet I have never denied patients who couldn't pay from seeing me. I was unaware that I yearned to be successful in order to affirm the principles for treating conversion disorders evolved in my earlier case. I gradually fell into a frustrating turmoil with this young man and didn't know really why.

He mentioned his interest in the American Indians and the "power" of their "totems." I too had a similar interest. We devised an elaborate set of images of animals to help move his extremities: a black falcon, and black, and white wolf - one animal for each extremity. I had used similar images several years before with the first case. I repeatedly struggled for contact with this young man.

Following my return after the Christmas Holidays, Jonathan stated unenthusiastically that he had listened to the tape recordings of our sessions. We talked more about the American Indians: a very special Indian gold and turquoise ring I had bought years ago, the Indian lore about "rite of passages," eagles being symbols of wisdom, and his upcoming 16th birthday. It seemed he

enjoyed yet feared his own future passage into fully-fledged teenage life with driving privileges and physical maturity. These were pleasant talks but we seemed to be avoiding the real purpose of our meetings.

Suddenly one day, he mentioned quietly that he had been abused. I accepted what he said, but reminded him that his primary psychiatrist was working with him on these issues. Nonetheless, it was sobering to hear him present alleged abuse as a problem. Perhaps he was, at long last, ready to discuss emotional problems. But even so, would understanding his possible abuse help him walk? I was unsure (Bloom, 1994).

After being away a few more weeks, I visited him briefly at the end of January. It seemed that we had lost what little rapport we had. Yet, on the next day, I observed that he had gained some significant weight, and that the fingers of his right hand were moving. Also it was becoming clear that he was using his legs as a pivot when he transferred from his wheel chair to a regular chair.

I was unprepared when Jonathan "fired" me (that is he discharged me from his further care). He stated that he did not want anymore of the "hypnosis crap!" His social worker encouraged me to visit him again. I felt after some consideration it was important that he have the control to "fire me" and realize that he could set boundaries without being blamed or uncomfortable that he had upset or hurt me. He was terrified with conflict and very passive in expressing himself forcefully. Thus I tried to salvage some good from our work by giving him "space" and hoping for the best.

I asked him if I could still visit with him from time to time just to say "hello" for a minute or so. I was surprised when he eagerly said he would like that. I left the floor relieved, encouraged and confused. I was not to have a rapid "cure" here.

Interim course

During the next two months, I dropped by to see him occasionally. One evening, while staying late at the hospital, I met his parents in the hospital dining room and shared a meal with them. They were nice people. The mother recounted how happy she was finally living with man who was not abusive. She also clarified that the insurance would pay me for my time. It is interesting to speculate what affect this financial news had in my subsequent working with Jonathan.

During this time that I only visited him briefly, he elaborated on the abuse with his primary therapist suggesting other family members had been involved. He further claimed that the paralysis in each extremity was directly related to physical and perhaps sexual abuse involving these extremities. While his story made perfect "sense," there was no corroborating evidence that any of it had occurred; and, despite his claims of abuse providing an "easy" answer to the mystery of the origin of his symptoms, he was still not walking or eating any better. Two months later in early April, his social worker suggested I be invited back to work with him. He readily agreed.

Clinical course - Part II

On reestablishing my contact with him for the next thirteen visits, I experienced the full joy of being demanding, goal setting, and limit setting. If he did not work hard with me, I told him I would leave. If he negated the value of my work, I would leave. If he fired me again, I would not return. Therapy with me was up to him, but if he wanted to work I was willing to work hard in return. Again I was surprised when he quickly understood and agreed. I was enjoying the display of my firmness which really masked my anger at being "fired" and my lack of initial success. We therapists remain forever human, do we not?

We began the self-hypnosis training in earnest. I tape-recorded each session for his practice and he learned quickly. He reported practicing between sessions. I taught him deepening techniques and, when he was in trance, I asked him to lift himself up by his arms and maintain a standing position next to his wheel chair. I had seen him stand while he pivoted from the wheel chair

to the regular chair. I thought I could get him to do this in trance and after maintaining his standing, he might be able to walk. Unfortunately, I began to sense I was pushing him again and that he would not respond even though he appeared to be trying hard.

"Trying" versus "doing" is an old hypnotic issue. When we ask a patient to try to move their arm and they can't, we all understand the hidden suggestion not to actually move the arm when they are merely asked to try. I was unfortunately caught in the same bind by asking him to try to stand, fearing that if I asked him to actually stand, our relationship that we worked so hard to achieve might be seriously strained if he could not comply.

He appeared ready to me to walk, but during the next session he just wanted to talk, stating he had been up too late the previous evening and was too tired to work. I continued to see movements in his legs that were very real and possibly voluntary. I suggested that he might look too at his legs and that perhaps he too would perceive the same movements. He said he would pay attention to them during the next few days.

Once again I had the sinking feeling that I would not be successful, that this would be one of those consultations which we all have to accept from time to time - whereby we discharge the patient to home confined to a wheel chair with the only hope that perhaps in time, he would continue to improve. Indeed, I began re-reading the early neurological workups to see if we had missed something - that indeed he was permanently neurologically impaired. I was preparing to stop seeing him anymore. I felt I could offer him nothing more. I was about to "fire" (or discharge) him.

Concurrent therapy

In his family therapy with a large talented young male social worker working on the adolescent unit, Jonathan experienced a very difficult confrontation with his natural father who appeared drunk when attending his only family therapy session. Jonathan was comfortable with the protection of the therapist who was physically larger and stronger than his own father, yet he could barely talk. After finally telling his father he did not want him in his life, Jonathan left the room. He later learned from his social worker that his father had also been quite frightened by the meeting. His father had told the social worker that his son would never become a man, and that he could barely tolerate him. It was a vicious session which provided a real glimpse of the verbal and emotional abuse Jonathan had tolerated for so many years. If insight into alleged abuse did not change him, was this confrontation with his feared father the pivotal point in therapy?

Clinical course - Part III

On returning to my office from a conference, I walked on the floor for our first session in 10 days. Jonathan was standing up and holding on to the back handles of his wheelchair. As I approached him, he smiled and then proceeded to walk, pushing the wheelchair ahead of him, down the hallway. While my initial focus has been on his mobility, I noticed he had gained weight and appeared physically stronger. He now weighed 130 pounds (59 kg), and was able to eat normal food. His 16th birthday would be celebrated in a few weeks.

I felt excited and relieved. Yet I had no idea what had been helpful to him. I liked him, had developed a mutually respectful relationship with him, and had entertained a cautious optimism about him from the first day. But I was totally unprepared for what he told me that first day he walked again in the middle of May.

I asked Jonathan to account for our relationship - what advice he would give me about what had happened between us. He told me slowly and directly as we talked alone that *it is the differences in people not the similarities of diagnoses that make true therapy.* He said that I had assumed that because he had the same diagnosis that my former patient had - whom he had heard about and whom I had treated on the same unit several years before - that my treatment could be

the same. He said it was only my getting to know him as a different and unique individual that let us begin to work together so that he could change. I was stunned. Of course, he was right.

His primary psychiatrist postulated that by defeating me the second time when I wanted to send him home still crippled in a wheel chair, he gained the final freedom to walk himself. It also had been his weight gain and stabilization that helped him be strong enough to walk, he insisted, as he always had, that there was no psychological cause to his illness but that it was all physiological. His social worker postulated that he somehow unlocked his psychic energy that was no longer damned up or blocked up, and that, subsequently, he was better able to express his feelings after confronting his father. Jonathan later had the last word on this.

The next four or five weekly sessions were quite different from our previous ones. We walked outside the hospital on our beautiful grounds. We ate in the dining room where his mother, stepfather, and I had dinner some weeks earlier. We began our good-byes in anticipation of his discharge and he almost began to cry. His discharge was delayed briefly because his stepmother had noticed on weekend trial excursions to his home, that he was abusive to his younger stepbrothers coming close to sexually fondling them. He had a great deal of trouble accepting that he was doing to them what he claimed had been done to him. Nonetheless, he was scheduled to go home soon, after nearly a full year in various hospitals including our own.

On our last session, I again asked to explain again how he thought I might have helped him in therapy. Here is what he said. *"By (eventually) working with the uniqueness of each patient, the 'little heroes' are brought out," that is the parts that are deep down inside that are initially undiscovered but are there. It is, he reiterated, not the similarities but the differences between people that allows us to truly know each individual person. He said that I let him know himself better and that helped.* I left each of us emotionally moved and reflective. We had deeply touched and been touched by the other. He remains well six months later (December, 1995).

Discussion

In working with the desperately ill, the therapeutic relationship or the human to human bond that is created is the basis for healing. As therapists, we first must do no harm. We then nourish with food, support with physical therapy, medications, and the social interactions of a hospital milieu. In time, family issues are explored and confrontations are made. Indeed, these measures work.

But what about this second case - what specifically helped? I accept the patient's comment that I had failed to regard him as a unique individual in my attempts to apply many of the techniques I had previously found successful in my former patient. However, I believe the following interventions contributed to his improvement and were important: His primary psychiatrist was pleased I would share in the care of this patient; I elected to continue to visit him after he fired or discharged me so he could experience safely the power of his saying "no" to something he didn't like while creating satisfying personal boundaries; I resolved my discomfort about accepting this patient at no fee on finding out that insurance was available; I felt free to experience my anger at his "refusal to get well" using my techniques; his safe confrontation with his father; the many unrecorded contacts with the nurses and especially the talented physical therapist who continued working with him after preventing the second arm from becoming paralyzed in the first place; and above all, his intensive care with his primary therapist. It had truly been a team effort.

It seems perhaps that we had "stumbled" onto his recovery. I do believe we gave him, in a variety of ways, a "face saving" way to get better. I also think it was fortunate that we did not cling to one theory on how he became ill in the first place, but remained creatively open to all possibilities. In sum then, I really cannot point to the reason he became ill nor the reason he recovered. Perhaps simply our culture had shifted once again to accepting hysterical paralysis as a means of expressing complex concerns that remain unconscious in our patients. What ever the cause, we must still strive to successfully treat these patients.

In accepting our work with these patients, we must be willing to work with inadequate information and incomplete understanding of the many variables that make for change. It is the ambiguity of clinical care that defines much of the life of the honest clinician. I have come to realize that the power of persistent optimism, openness, and pushing for new ways to be creative often turn the tide. As I had to painfully relearn once again, this kind of therapy has no techniques that can be applied from one patient to another. Wisdom often reposes with the patient no matter how young, or with colleagues who watch, see our work, and advise.

As I finally bonded with this young man, I felt changed in my work with him. As Georg Groddeck (1949, p. 228) of Baden-Baden wrote: I was confronted with the strange fact that I was not treating the patient, but that the patient was treating me..." In my own words, the patient will change you so that you are more useful to him. How hard it is to let go, but how wonderful the feeling when you do.

Conclusion

In treating conversion disorders, it is tempting to attribute many variables in the patient's life to the cause of the syndrome. In addition, as is this case, it is very tempting to treat a new case with techniques that were successful in previous cases. Clinicians work with incomplete knowledge and must remember that it is the unique differences in each patient that gives us the clues for success. Recognizing these differences openly and using them to form a deep personalized contact unique to that patient creates a richer context for healing. In the final analysis, each patient must take the responsibility to use what he or she can from the therapeutic environment and become whole again. It is a mysterious process for both patient and therapist; true knowledge is always shared knowledge, and must be learned again and again.

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