



International Journal of Psychology and Psychoanalysis

CASE REPORT

Escape: A Study in Conversion Disorder

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Abstract

Culture is thought to be key determinant of conversion disorder presentation, with culturally-normed social expectations being one possible influence, yet this is rarely studied. We present a case of a young woman from a cultural background where social expectations were strong, now living in Australia, who developed conversion disorder in the context of struggling against these expectations, and expressed this as a desire to escape. We discuss the aetiological role this desire may take in cases of conversion disorder, and what that tells us about conversion disorder in other cultural contexts.

Keywords

Conversion disorder, Life events, Trauma, Recall

conflicts were eventually acknowledged by the patient their symptoms would cease. This notion is of course key to the original Freudian concept of conversion disorder [3], but revealing such hidden conflicts is not the usual experience of the authors, working in a conversion disorder clinic in metropolitan Australia. Perhaps it is because we spend too little time looking for these conflicts, which research suggests may be found if one is prepared to look carefully [4,5]; perhaps it is because they are simply not present as often, or to the same degree, in societies such as ours, where social expectations are weaker.

We present a case of a young woman who presented to us with conversion disorder in circumstances of social expectation she found overwhelming, and explore the extent to which this case may inform conversion disorder in other cultural contexts.

Introduction

Conversion Disorder is the presentation of neurological symptoms, most commonly weakness, which are thought to be a response to life stressors. Culture is commonly thought to play an important role in its aetiology, for example through the illness ideas of the patient's community [1]. Though this has not clearly led to any variation in prevalence across cultures, as it is relatively common wherever it is studied [2], there may yet be other ways the role of culture is revealed. For example, a psychiatrist running a conversion disorder clinic in an Indian public hospital told the authors that all his patients had some irreconcilable conflict between what they wanted and what was expected of them—he gave the examples of concealed homosexuality, or an intolerable co-habiting mother-in-law—and that when these

Case Report

E was a 23-year-old woman of South Asian background, living in Melbourne with her husband of 4 years, studying for a degree and working part time in a fast-food outlet. She had an emergency neurology admission following a sudden onset of quadriplegia and speech difficulties, including intermittent mutism. After extensive neurological work-up she was given a diagnosis of functional neurological disorder (conversion disorder), and referred to our outpatient clinic.

When she saw us these symptoms had resolved and she denied any further episodes of paralysis or speech difficulties, but described daily “jaw tension” and feel-



Citation: Kanaan RAA, Jamroz D (2018) Escape: A Study in Conversion Disorder. Int J Psychol Psychoanal 4:026. doi.org/10.23937/2572-4037.1510026

Accepted: June 02, 2018; Published: June 04, 2018

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ing as if something was “squashing [her] head”, with episodes of heart palpitations, dry mouth, and numbness and tingling in her hands and feet, lasting from a few minutes to a few hours. Though stress was a common trigger, at times her symptoms came “out of the blue”.

E said that she was under a lot of pressure from her parents and her husband to finish university that year. She had never wanted to study her degree course, but it was chosen for her by her mother. She said she had “lost” herself and didn’t “know who” she was. She felt she “lived for [her] parents” and now also for her husband, but was unsupported by them and wanted them to acknowledge that she needed help. She said she had “no one to confide in” and felt like “screaming for help”, but “no-one was listening”. At the same time, she said she felt “emotionless” and “couldn’t express [her] feelings any more”. She felt like “running away” from everyone she knew “to start afresh”.

Her difficulties had started about 2 years earlier, when she moved out of the family home to live with her husband. She had thought this would be liberating, but started feeling “lonely”, “isolated” and “overwhelmed with responsibility” instead. She lost contact with her friends and spent most of the time home alone, while her husband was working two jobs. E also felt that her husband wanted her to stay “the same 16-year-old girl he had fallen in love with”, while she had matured and was “not the same person” anymore. E started experiencing fatigue, dry mouth, loss of appetite and felt “there was no one to look after [her]”. Over the following months, she noticed problems with her memory and concentration. She was supposed to finish her degree but failed two subjects because she “couldn’t concentrate”. She developed her first episode of paralysis shortly after she received these results, while she was at work. She started feeling numb in the left, then right, hand and couldn’t use a cash register. She decided to take a break, whereupon her legs “went numb” and she collapsed. She realised she couldn’t “speak properly”, while still able to understand others. Her husband took her to her GP, where she “became paralysed”, and was taken by ambulance to the local emergency department. Her symptoms fluctuated over the following days, with periods of total remission.

E was born in South Asia and migrated to Australia when she was 5. She described her childhood as “good” and denied any major trauma or abuse, but said she had “blocked out ninety percent of [her] past” and “[didn’t] remember much”, apart from her parents “arguing a lot”. She did well academically, but was an anxious child who “felt like vomiting every day before going to school”. She met her husband, from a different cultural background, when they were teenagers. They were married 3 years later despite her parents’ disapproval, but E wanted “to be independent”.

E spoke openly about her existential and identity is-

ues, as well as the challenges within the family structure. She accepted that her symptoms were functional and related to anxiety and was willing to engage with a psychologist. Unfortunately, she did not attend her next appointment with us, nor see the psychologist we recommended, but she re-attended a year later. She told us she had somewhat improved, with no further collapses, but continued to experience significant anxiety symptoms. She had made some decisions, but had not quite carried them through. Though she had decided to end her relationship with her husband, she still cohabitated with him; though she had decided to leave her job, she had taken another, similar one; though she had decided to give her course another try, she had not re-enrolled. She still felt “stuck”, and still fantasised that she could run away and start her life again somewhere else.

Discussion

E presented herself as trapped between her family’s expectations and the desire to establish her own identity. Her symptoms of mutism and paralysis clearly mirror this conflict, however we might understand their aetiology. Though her symptoms developed gradually, her episode of conversion disorder began acutely after she heard she had failed the two subjects that would otherwise have seen her ready to graduate, and left her with a dilemma - to finish her course, and follow the path chosen for her, or escape from those expectations, and perhaps forever disappoint her family. E had grown up with family conflict and high expectations, and developed a particular aversion to them. Although she had no further episodes of paralysis, at the time of our assessment she was still symptomatic with anxiety and possibly panic, indicating how significant this aversion remained, and how difficult this conflict would be to resolve.

We have previously described such events and difficulties as having the characteristic of ‘Escape’ [5]-where becoming ill allows patients to escape from the event’s consequences. In E’s case, a severe illness would allow her to escape from as it would render her too ill to study or work, without having to disappoint her family by a refusal. Though we had usually understood ‘Escape’ metaphorically, such as avoiding unwelcome tasks, this is one case where a literal meaning seems appropriate - in E’s expressed desire to ‘run away’ from her situation.

If E’s conflict is more stark than many of those we have seen, this embodies a cultural set, with strong familial bonds and clear expectations, which appears in contrast to the typical 23-year-old Westerner’s values of independence and autonomy (but would perhaps have been familiar in Freud’s Vienna). And if the presentation and resolution are still not quite as clear as those described by that South Asian registrar, perhaps this reflects something of the cultural blend of a patient of South Asian origin, growing up in Australia: Able to defy her parents to some extent, but only so far.

Though the immediate temporal association between stressor and symptoms makes some kind of causal relationship hard to avoid [6,7], this leaves the mechanism opaque. The orthodox explanation has been in terms of primary gain-the reduction of intrapsychic anxiety and its conversion to symptoms-and this of course makes much sense here. If the symptom allowed her to escape then she wouldn't need to deal with her problem; she wouldn't need to dissipate the tension as she wouldn't need to think about it. Explanations other than primary gain are perfectly possible, however, and are exemplified in this case: She had familial experience of strokes which provided a model [8] on which illness motor behavior was scaffolded [9]-but why her symptoms should have happened then, at that moment when she learned of her results, is not explained by such theories. No doubt E's exam results were a shock, even if they were not a surprise; no doubt she experienced intense physical sensations, of anxiety, of alarm, of weakness; but interposed somewhere along any plausible causal chain has to be an idea of illness. For if there were no idea of illness, even unconsciously, why would illness modelling be invoked?

But does this mean there has to be an idea of escape? Does this mean the patient has had to have recognized the possible implications of their illness, and weighed them in the balance? This is, of course, one of the most uncomfortable tensions in conversion disorder: The extent to which any illness benefit, or secondary gain, may have motivated the illness itself. As it appears that it is largely those events which confer the most 'escape' potential that precipitate conversion disorder, or at least those cases which endure [5], this tension is particularly great. If escape is more than just a descriptor of events that happen to lead to illness, but supplies an active ingredient-the motivation to escape into illness-then this may suggest patients have a purpose behind their illness, which may sound alarmingly close to saying they became ill on purpose. But that is an inference too far. It is true that acknowledging the escape characteristic means acknowledging a change of aetiological direction - they are not only a reaction to past traumas, but also an anticipation of future benefits, or the avoidance of future harms [10]-which inevitably sounds more deliberate, more conscious. Yet the very first demonstration of unconscious conditioning-Pavlov's dogs' drooling-had precisely this anticipatory character, as does all classical conditioning, not only so-called "escape conditioning" [11]. Anticipating the future, it is argued, is just what brains do, right down to the neuronal level [12], and consciousness is not a requirement.

To deny that patients with conversion disorder anticipate likely outcomes would therefore be implausible; to deny that would influence them is equally implausible: But that does not mean the patient took anything like a conscious decision to become ill. Though patients will be as influenced by such considerations as anyone else, the mechanism of any subsequent illness may remain obscure. Modern approaches to therapy aim to

demonstrate that mechanism to the patient, with often excellent results [13]-but that Indian outpatient clinic's dramatic cures suggest that the Freudian method of revealing the aetiological stressors may yet have its place in therapy, if only those stressors were clear.

This case is striking because those stressors were not only clear to the doctor, but to the patient. She clearly wanted-indeed, still wants-to escape from her situation, and was able to articulate that desire; yet her illness and its mechanism remained mysterious to her. In other circumstances, where the bonds of expectation are weaker, or more obscure, so awareness of them and the possibility of their evasion may be less clear. In E's case, escape seems an unusually apt characterization of what illness offered, but such cases serve to highlight what is present far more widely, but perhaps concealed by their cultural context [5]. Finding the escape stressor may hold the key to understanding many more conversion disorder cases, and to their recovery.

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