A Woman Patient with Conversion Disorder in Psychotherapy: From the Perspective of Self Psychology

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Background: Conversion disorder presents itself with symptoms suggesting a neurological disorder although they are incompatible to any recognized neurological or medical condition. Evidences of mechanism of etiology and restoration are limited. We presented a case for possible mechanism of restoration from the perspective of self psychology. The Study Subject: We reviewed the chart of a 31-year-old single woman suffering from seizures for two years, who was diagnosed as conversion disorder. She was referred to psychiatric clinic and received self psychology-oriented individual psychotherapy. Therapeutic Process and Formulation: The interaction between patient and therapist formed new self experience, which would have integrated with past self experience and improve self cohesiveness. The seizures were gradually subsided after about ten-month psychotherapy without the use of any anti-epileptic drugs. Conclusion: With empathy, there would be formation of selfobject which could connect with the emotion isolated by conversion. The individual could finally face his/her emotion and the conversion would not be presented.

Key words: Conversion disorder, psychotherapy, self psychology, selfobject

Introduction

Conversion disorder (CD) is presented itself with symptoms of a neurological disorder although they are incompatible with any recognized neurological or medical condition [1, 8, 10]. The incidence of persistent symptoms might be 2 to 5 per 100,000 patients per year [1, 8, 10]. Risk factors are maladaptive personality trait, childhood abuse, stressful life events, and the presence of a neurological disease [1,10]. Negative prognostic factors include longer duration of symptoms, less acceptance of the diagnosis, and maladaptive personality trait [8, 9]. The treatments consist of anti-depressants, anxiolytics, lithium, behavioral therapy, hypnosis, and psychotherapy to remove symptoms, address co-
morbidity, and develop true emotional insight. In spite of absence of a standard treatment, confrontation technique is not recommended [2, 9, 10]. Mechanism of treatment effect is still unknown partly due to the lack of definite mechanism of etiology [2, 9, 10].

Janet has suggested the concepts of dissociation and repression to explain disconnection between explicit and implicit information processing [1]. Ensink et al. has recently used mentalization to describe a mechanism between childhood trauma and dissociation [2, 3]. Besides understanding a patient with CD, empathy and open-minded approach with the viewpoint from the patient are recommended [5]. Kohut has developed self psychology to suggest the importance of empathy and concept of self experience standing on the position of a patient [1, 3, 4].

From theories of attachment, mentalization, and self psychology, secure attachment has formed the basis of mentalization [3, 6]. Self psychology relies on the notion of attachment as a central motivation for the establishment and maintenance of self-cohesiveness [3]. Hence, mentalization describes that attachment more as a mechanical element to explain how a mental disorder is improved, but that self-psychology uses that attachment more as an element of psychodynamic condition, about equal to self experience, to understand an individual as a whole [4, 7]. We are presenting a case and describing a possible mechanism of etiology and restoration from the perspective of self psychology.

The Study Subject

We reviewed the chart and recent articles on CD. This study was approved by institutional review board of Jianan Psychiatry Center for publication.

A 31-year-old single woman was born in a family whose members valued patriarchal in power structure. She usually shared less fostering resource than those given to her twin brother and male cousins. She encountered sexual harassment in her age of 12 years in 1997. She asked her parents for help, but they prohibited her to reveal her experience. Her parents did not file a lawsuit against the harassment inflictor, her uncle.

At patient’s grandmother’s funeral in April 2013, she suffered from seizures, when she suddenly saw the harassment inflictor. Then, the seizures recurred whenever she felt extremely angry or anxious even without encountering her uncle. The seizures recurred five times daily, causing her to be disabled from career. She had regular visits in neurology clinic, and had received antiepileptic drugs over one year. But her seizures were persisted.

Under the impression of CD, the patient was referred to a psychiatric center on September 19, 2014. The seizures were diagnosed as CD by a psychiatrist. Then, she intermittently received individual psychotherapy with several male and female therapists. Because her previous therapist went to study oversea, she was referred to the next therapist, a man, in August 2015, for individual psychotherapy.

Therapeutic Process and Formulation

Formulation of psychodynamic psychopathology and overview of therapy

Our patient experienced negative attitudes from authority in the childhood. Her parents care more about her twin brother. When she suffered from sexual harassment by a male authority, the caregivers did not protect her, indicating an under-response self-experience. Although she could
cope with average stresses, without empathetic self experience, she could neither gain proper motivation to maintain self cohesiveness nor to form a self-object to cope with extreme anger. When she encountered extreme anger without a way to avoid or reduce it, the self finally used conversion to isolate it to compensate for the weakened self cohesiveness, but the self was still fragmented for lack of self-object. The conversion also isolated self-object needs which produced motivation to establish rapport with a male authority and prevented the patient from processing anger of being sexually harassed.

The patient received 28 sessions since August 13, 2015, until June 24, 2016. Every session lasted for 60 minutes. She did not ask for any skipping of sessions. The themes of every session were decided by the patient herself.

The opening phase--fearful contact with a male therapist

The patient was too anxious to sit beside the therapist in the first session. Initially, he invited her to sit nearby but she rejected it. He respected her will and asked her about the reason for request of psychotherapy. The patient indicated that she wanted a full-time job, and that she so needed to control her anxiety when talking with males, e.g. a male boss. She disclosed the sexual harassment. After harassment, she never encountered the inflictor till at her grandmother’s funeral, when she had first seizures. In the final ten minutes, she sat beside the male therapist after invitation. “I am still a little nervous but getting better now.” she responded.

This process empathetically/optimally responded to her anxiety and to her will to establish rapport with a male authority. She had conflicts between the distrust to males, and the will to establish a rapport. The insistence upon sitting nearby became an under-response self experience because her anxiety had been ignored. No final invitation could become over-response self experience because the therapist could not contain his anxiety and possibly evolved into boundary violation, e.g. unwilling to take her position with the collusion of therapist who acquiesce her resistance.

The early mid-phase--emotions to males

The therapist often encouraged free association during the sessions. The patient usually actively mentioned the themes in previous sessions. He never emphasized on confrontation of the cause of seizures but on interaction in counselling room, which could form new self experience and integrate past self experience.

In the first two months, the patient described males as rude fools. “I didn’t have a boyfriend or intimacy outside family.” She said. “I just distrust any man even at first sight,” she said, “especially those who always used four-letter words!” She also said, “a male salesclerk can make me nervous; I will never go into that store alone.”

She also narrated that when she sat down beside the therapist in the first session, she suddenly noticed the closeness between their legs and she was afraid of the accidentally physical contact with a male at that time.

In the third session, the therapist asked, “Who would come into your mind if I ask you to imagine.”

“My brother.”

“Did you trust him?”

“Yes, because he understands me and can help me solve many problems.”

Although she appreciated her brother’s help several times in therapy, she also complained that her brother always received more gifts or favors from her parents than she.
“He (my brother) had good grade in English and Japanese. I want to learn Japanese partly because of him.” she said. “My brother did very well in English. Once we had homework to speak English to a recorder. My brother needed only once but I tried 10 times. Mother always blamed me for the poor grade.”

“What’s the feel?”

“Angry! What mistake did I have on earth? My brother always had easy time. I even hid my test papers because of the poor grade. Finally, I gave up learning English.”

Addition to the envy and competition attitude toward her brother, the patient reported much angry and helplessness in her childhood, which were more aggravated by the incidence of the sexual harassment. It could be possible that these huge emotions were evoked by a sudden notice of potential physical contact with a male.

The mid-phase—the process and a branch

The therapist encouraged the patient to express feeling toward males. She gradually noticed the unreasonableness of her attitude and confessed not to judge a male immediately and to try to trust males. And she mentioned more themes in counselling room.

Once, she only expressed her cheerful experience in playing computer games without mentioning the themes of becoming mature, which she had been encouraged to discuss in last session. But she also mentioned the hope to reduce playing.

The therapist felt her enjoyment with similar experience in playing, but also assumed that there might be a resistance. In the final 10 minutes, he said that this session was like her current life, full of enjoyment. Then, he mentioned her hope to quit playing games and that maturity meant that one knew how to arrange one’s own life. She left the counselling room with a smile and could actively express emotions about these themes in successive sessions.

He recognized the enjoyment and suspected resistance, probably regression, which otherwise satisfied patient’s needs of being respected in childhood. But confrontation or interpretation became an under-response self experience because they represented the therapist’s own wish for treatment. But merely expressing enjoyment became over-response self experience. To give optimal response, he did not interrupt her expression with empathetic consideration of the unsatisfied wish to play but the mention of phenomena in counselling room and empowerment to discuss previous themes were both given in the final 10 minutes. The optimal self experience occurred, not being prohibited again as in her childhood by authorities.

Terminal phase—“a long journey but fast to end”

Patient’s seizures were gradually subsided. No seizures have been reported since September 2015, even when she experienced the grief due to her auntie’s death who always treated her as her own child. She also experienced a huge anxiety without seizures when she worried about danger in her mother’s travel in June 2016.

The patient narrated more clearly and actively about the first seizures in the final session. “I was exhausted at the funeral. And I thought that you, my grandmother, who always looked down upon me and my family, finally died.” She said. “But when I sudden saw him (the uncle) coming to sit by my left side. I remembered the incidence of the harassment and did not have way to escape because an electric fan was on another side.” Then, under huge fear, she fell down from chair while having seizures.
The patient confessed to feel an integrated mind during psychotherapy. "The therapy is a long journey but fast to end." According to her, it was long because she integrated many emotions, but fast because she was facilitated to process them. The confession indicated the self experience and partially suggested the formation of self-object, coming from a male authority.

The psychotherapy was terminated as scheduled. In August 2016, the patient regained a full-time job. As the chart was reviewed in November 2016, she had no longer shown any seizures.
Discussion

From the perspective of self psychology, Figures 1 and 2 depict the mechanism of etiology and restoration. The simultaneously or consecutively processes of inclusions or exclusions of psychological structures formed the nuclear self first and the processes occurred too substantially for lacking self cohesiveness. Self-object, as intrapsychic events or emotions, produced those processes and the motivation to establish rapport. The empathetic/optimal response formed a selfobject to improve cohesiveness. When self cohesiveness is weak (Figure 2), the individual presents an alteration between two disabling conditions, either “over-close” or “over-distant.” In the former, the inclusions occurred too substantially. The self cannot realize the boundary between the self’s emotions and the object’s emotion, contaminating the response from object, and he/she would violate interpersonal boundary.

In the latter, the exclusions occurred too substantially with defense mechanisms, e.g. The self is struggled to exclude the under- and/or over-response self experience but in vain because the object’s responses have been received [4, 7]. Whatever, the self uses conversion, to compensate enfeebled self cohesiveness and to isolate self-object needs.

When the object responded empathetically to weakened self cohesiveness and finally formed a selfobject, the self would feel that his/her all feelings were accepted. The self-object could connect with the emotions originally isolated by defense mechanisms and the individual would face his/her emotions [4, 7]. Consequently, the defense mechanism would not be used enduringly.

Limitations

• The limitation of a case report through chart review should be considered. We should be careful not to generalize the conclusion.
• The perspective of self-psychology might exclude other viewpoints although we used it in whole mechanism describing etiology and restoration.

Summary

Forming a self-object needed time but was worthy for restoring a fragmented self through deep and continual empathetic responses. Empathy helps an individual to discover his/her own emotions due to therapist’s attitude of acceptance. We also suggest that the ideas of self experience and selfobject are important concepts in treating CD patients psychotherapeutically.

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References

45: 157-82.


