

Good Children with Conversion Disorder: Breaking the Silence

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ABSTRACT

The diagnosis of conversion disorder in childhood is shrouded in uncertainty, a lack of satisfactory explanations, doctor–parent hostility, shame and family silence. Speculations as to the aetiology of conversion symptoms have resulted in hypotheses ranging from malingering, self-deceit, unconscious processes, theories of communication, intolerable predicaments and illness behaviour to hypothesized neurophysiological processes. Of note, is the absence of patient perspectives from the literature, and a tendency for families of ‘good’ children with conversion disorder to respond to inquiries about psychological factors with unease, hostility or silence. The child’s experience of conversion symptoms and illness context are valuable sources of information. This article presents two personal accounts of conversion disorder in children with exemplary premorbid functioning. It aims to demystify the circumstances in which conversion symptoms may present, re-establish dialogue about children’s predicaments and rekindle interest in the developmental trajectories of children presenting with conversion symptoms.

KEYWORDS

compulsive compliance, conversion disorder, somatoform dissociation

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AFTER CENTURIES of speculation 'conversion disorders' remain ambiguous and elude understanding. Explanations for conversion phenomena range from malingering (Grosz & Zimmerman, 1965; Turner, 1999; Zimmerman & Grosz, 1966), illness behaviour with secondary gain (Kendell, 1982; Miller, 1987); a social construction of the patient–doctor relationship (Chodoff, 1974; Goodyer & Taylor, 1985; Kendell, 1982; Maisami & Freeman, 1987; Mayou, 1975; Rabkin, 1964; Slater, 1982; Szasz, 1970); self-deceit (Miller, 1987; Turner, 1999), a means of communication (Apley, 1976; Balmory, 1982; Goodwin & Attias, 1999; Grattan-Smith, Fairley, & Procopis, 1988; Kirmayer & Santhanam, 2001; Maisami & Freeman, 1987), unconscious processes (Freud, 1905; Janet, 1889), a response to fear (Head, 1922), trauma (Freud, 1896a, 1896b; Janet, 1889), stress (Gooch, Wolcott, & Speed, 1997; Trieschmann, Stolov, & Montgomery, 1970), or unresolvable predicaments (Taylor, 1986), to hypothesized neurophysiological explanations (Athwal, Halligan, Fink, Marshall, & Frackowiak, 2001; Bryant & McConkey, 1999; Kihlstrom, 1984, 1994; Ludwig & Lexington, 1972; Sierra & Berrios, 2001). Although some authors consider conscious motivations to underpin conversion symptoms, most clinicians accept that the child experiences conversion symptoms as real, and is unaware that they are not the products of conventional pathological mechanisms (Miller, 1988). The belief in conversion symptoms as genuine requires either an acceptance of hypothetical constructs such as 'dissociation' (Janet, 1889), or 'repression and conversion' (Freud, 1905) or necessitates that the clinician adopt an agnostic position with regard to the subjective reality of the symptom (Miller, 1988) and underlying neurophysiological mechanisms.

Despite attempts to move away from unconscious psychological mechanisms and to embrace more testable hypotheses, the association among conversion symptoms, psychological predicaments and relationship difficulties continues to be noted in the literature. A striking feature of adult studies of functional illness (Craig, 1989; Craig, Boardman, Mills, Daly-Jones, & Drake, 1993; Craig, Drake, Mills, & Boardman, 1994; Creed, 1981; M.B. Harris, Deary, & Wilson, 1996; T.O. Harris, 1989) is the way that causal events seem to revolve around entrapment in problematic relationships, rejection, loss of face and less than adequate support during the crises (Craig, 2001). Studies of childhood conversion disorder describe two distinct patterns of relationships. The first group, is characterized by a pattern of chaotic social and family circumstances, multiple family members display somatic symptoms and/or obvious psychopathology; children living in this context are obviously stressed and the diagnosis of conversion disorder is more easily made (Goodyer, 1980; Grattan-Smith et al., 1988; Maloney, 1980; Steinhilber, Aster, Pfeiffer, & Gobel, 1989; Volkmar, Poll, & Lewis, 1984). The second group is characterized by an apparent lack of social, family and psychological difficulties. Families present as tightly bound together, harmonious and socially respectable (Garralda, 1992; Kozłowska, 2001; Redwin, 1998; Seltzer, 1985a, 1985b). High expectations of achievement, high levels of anxiety about illness or loss and increased levels of parental anxiety and hostility in the doctor–parent relationship have been noted, but overall, obvious psychopathology and psychosocial stressors are never easily identifiable and are usually actively denied (Bass & Benjamin, 1993; Garralda, 1992; Grattan-Smith et al., 1988; Kozłowska, 2001; Leslie, 1988; Redwin, 1998; Seltzer, 1985a, 1985b). The sick child typically has a premorbid history of been a good, perfectionist, compliant, highly achieving child who has displayed no previous difficulties and who often demonstrated exemplary functioning in academic, leadership or sporting spheres (Campo & Fritsch, 1994; Caplan, 1970; Dubowitz & Hersov, 1976; Fritz, Fritsch, & Haginl, 1997; Garralda, 1992; Grattan-Smith et al., 1988; Kozłowska, 2001; Leslie, 1988; Redwin, 1998; Seltzer, 1985a; Taylor, 1986).

In a study of 15 such families, Seltzer (1985a) found that beneath this 'supernormal' presentation, lay a tendency for families to dismiss significant events from the past, including problematic family-of-origin histories characterized by a sense of injury, social humiliation, poverty, illegitimacy, victimization and violence. Families focused on future goals and successes which were invested in the offspring, and contingent on their performance, obedience and loyalty to the ruling values of the parental unit (Seltzer, 1985a). Kozłowska (2001) noted that the relationship patterns this subgroup of 'good' children reflected use of the compulsive compliant attachment strategy. In these relationship contexts fear of rejection, fear of parental anger and pressure to perform are central predicaments faced by the child, who used compulsive compliant behaviour to decrease the likelihood of parental hostility or displeasure and to increase closeness and proximity (Crittenden, 1990–1995, 1992, 1997, 1999). The compulsive compliant strategy includes the inhibition of negative affect, the display of positive affect, and careful anticipation of parental expectations (Crittenden, 1990–1995, 1992, 1997, 1999). It allows the child to maintain a non-conflictual relationship which a parent who is demanding and/or easily displeased. In the school-aged years compulsive compliant relationships appear smooth and cooperative, although they lack spontaneity and joy, and require a constant focus on the needs of others, and not the self. For some children the energy required to maintain the strategy may become overwhelming and presentation with conversion disorder reflects a breakdown of the strategy and gives some children an opportunity for psychological reorganization if sufficiently supported (Kozłowska, 2001).

Good children with conversion symptoms therefore demonstrate not only a disruption of motor control and/or sensory perception, but also dysynchrony between the external display of positive affect and inner experience, and a family context characterized by disconnection from emotional pain, dismissal of painful family of origin histories and a child who works hard to fulfil the family's determined efforts towards an idealized future. This disconnection between various aspects of a child's life is evident in the subjective accounts presented in this article and was noted by Janet (1889) more than a century ago. Janet (1889) was stuck by this lack of mental integration in the life of patients with conversion symptoms, that is the discrepancy between the symptoms with which they presented, their lack of introspection into their origins, and their seeming unawareness of events of which they should have been cognizant. Janet (1889) conceptualized the elementary structures or systems of the mind as 'psychological automatism, that is, complex acts, tuned to external and internal conditions, preceded by an idea and accompanied by an emotion' (Janet, 1889). Each psychological automatism represented a rudimentary consciousness, was bound to other elementary automatism to form a united stream of consciousness or personality which operated both in awareness, under voluntary control. Janet proposed that under conditions of severe stress or terror, an individual's field of consciousness or attention was narrowed resulting in disorganization of integrative functions and disruptions in consciousness. This formulation is similar to modern understandings in which extreme arousal is thought to contribute to disturbed cognitive functioning as a result of a significant release of stress hormones (Van der Kolk, 1994). In Janet's model, one or more of the automatism or mental structures could be split off to function outside awareness and voluntary control. Janet (1889) called this 'desegregation', a term which came to be translated as 'dissociation' in English. Janet used hypnosis to help patients bring back to awareness aspects of their mental life which had assumed an automatic way of functioning outside awareness.¹

Janet (1889) made no distinction between body and mind, and dissociative symptoms could include psychological manifestations such as amnesia, or somatic manifestations such as loss of motor function, or site-specific pain. The essential aspect of Janet's (1889)

dissociation theory was the co-existence of separate mental systems that should normally be integrated into the person's consciousness, memory or identity, resulting in an individual's disconnection or disengagement from the environment or the self as a result of a disruption in the integrative functions of consciousness in the context of traumatic experiences. Janet observed that patients tended to avoid reminders of intolerable events, and could present as if 'the event, or even the function, never existed' (Janet, 1935: 325). The subjective accounts presented in this article illustrate that children presenting with conversion symptoms also display other concurrent integrative difficulties such as a disconnection from negative feeling states, and a seeming unawareness of salient life events and circumstances. The effort required to avoid internal and external reminders of intolerable events is significant and can result in exhaustion and chronic states of misery (Janet, 1889, 1909). This observation is also pertinent to modern patients and the children who describe their illness in this article. Kozłowska (2001) noted that in the subgroup of good children with conversion disorder, illness reflected a breakdown of the compulsive compliant strategy, in which the ongoing energy required to inhibit display of negative affect, anticipate the expectations of others and dismiss one's actual experience became overwhelming and untenable. A positive treatment experience should therefore involve not just physical recovery, but an opportunity to consider disconnected aspects of the child's experience and the relationship context within which the child needs to function, in order to facilitate the search for alternate behavioral and mental strategies.

Freud's concepts of repression, a defence mechanism that partly overlaps with the Janetian view, and can be understood in two ways (Hilgard, 1977).² The first conceptualization refers to the inaccessibility of a memory as a result of active forgetting or repression (e.g. Loftus, Polonsky, & Fullilove, 1994; Williams, 1994). The memory, although forgotten, can be retrieved in consciousness and can therefore be classified as dissociation. The second conceptualization of repression is distinct and incompatible with Janet's (1889) dissociation theory. It refers to conflictual material arising in the earliest stages of development (Freud, 1900), which can be inferred but never directly recovered by free association or hypnosis. Freud used the term conversion to describe the hypothetical process in which this unacceptable repressed mental material (usually sexual) was transformed into somatic symptoms (Freud, 1905). Janet did not view dissociation as a defence mechanism to ward off anxiety or pain. He saw dissociation as disorganization in how experience was stored due to a narrowing of the field of consciousness during experiences of extreme stress.

Janet's dissociation theory has re-emerged in recent literature under the constructs of 'somatoform dissociation' (Nijenhuis, Spinhoven, Vanderlinden, Van Dyck, & Van der Hart, 1998; Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1996; Nijenhuis & Van der Hart, 1999), neo-dissociation theory (Hilgard, 1973, 1974, 1977, 1979) and is very similar to Putman's (1997) 'Discrete Behavioral State Model' of dissociation derived from research on behavioural states in infancy (Emde, Gaensbaure, & Harmon, 1976; Pechtl, Theorell, & Blair, 1968; Wolff, 1966, 1987). Somatoform dissociation refers to dissociative symptoms that manifest as body symptoms, reactions and functions such as analgesia, motor inhibition and site-specific pain (Nijenhuis et al., 1996). Neo-dissociation theory (Hilgard, 1973, 1994) conceptualizes the mind as a set of mental structures that monitor, organize and control mental functioning. Connections with other structures are facilitated or inhibited as a function of global and local demands and intentions. Putman (1997) argues that mental states (a condition of being) are core components of consciousness, behaviour and personality. In other words, according to this model, mental states are unique organizations or structures of consciousness and

behaviour recognizable by a distinctive pattern of psychological and physiological variables. Discrete states are linked together by directional pathways forming a behavioural architecture. As they develop, children gradually learn to acquire control over their own states, a process which may be disrupted by traumatic experiences, resulting in abnormal behavioural sequences, and sudden changes in state also referred to as dissociation. The above models are interesting because, like Janet's (1889) model of dissociation, they propose that elementary subsystems of the mind³ to be 'a state' made up of interrelated representations of information, including motor representations (Craik, 1943; Jeanerod, 1997), neurophysiology and/or affective state, with varying degrees of voluntary control and explicit awareness depending on age and neurological maturation, and the individual's life experience. If conversion symptoms are viewed as a form of somatoform dissociation (Janet, 1889; Nijenhuis et al., 1996), and are considered through the lens of dissociation theories, then it follows that reconsideration of child development data in terms of neurobiology, observed behaviour and an understanding of the child's subjective experience and life predicaments may prove useful in extending thinking about conversion symptoms. In this article, the subjective experiences of good children presenting with conversion symptoms are explored.

Despite this wealth of hypothesizing, in medical settings physicians remain uncomfortable with current explanations of conversion disorder and frequently prefer to adopt Miller's (1988) agnostic silent position. The diagnosis of 'conversion disorder' is often avoided with clinicians preferring the use of vague medical explanations such as a 'loose disc', 'possible MS' (Wessely, 2001), stress related, post viral, due to a 'bit of trauma' or being 'a type of migraine'. In other words, the concept of conversion disorder is rarely explored with patients (Wessely, 2001), and is utilized between doctors as a shorthand way of communicating information about 'lack of aetiology' (Wessely, 2001), a loss or distortion of neurological function which cannot be explained by contemporary models of organic disease (Marsden, 1986). The agnostic position focuses on the exclusion of organic causes, and implies a negative verdict, that is, how the symptom cannot be understood, ultimately leaving the child undiagnosed (Slater, 1965) and the family without an explanation.

Avoidance of dialogue about unexplained medical symptoms functions to sidestep issues of shame and to avoid hostility in the doctor-parent relationship. From the clinician's perspective this includes the shame of being seen as ignorant and incompetent, that is, unable to adequately explain the child's severe physical disability. A diagnosis of 'conversion disorder' induces feelings of discomfort, and puts the individual physician in the unenviable position of explaining the meaning of a term which masks medical ignorance (Slater, 1965, 1982), and which implicitly raises questions as to the authenticity of the child's symptoms and the contribution of illness behaviour and negative emotional factors. Furthermore, attempts to explore contextual factors with the family frequently result in a hostile response from the child's parents, who may be incredulous, displeased, angry or insulted (Bass & Benjamin, 1993; Grattan-Smith et al., 1988; Kozłowska, 2001; Leslie, 1988; Redwin, 1998; Seltzer, 1985a, 1985b). A strong negative parental response functions to intensify the physician's anxiety and sense of incompetence, and increases the likelihood of retreat from dialogue about contributing psychological factors. The physician's retreat into silence ensures that shameful or threatening emotional and interpersonal issues remain hidden, and that the family's projected image and apparent solid character are not undermined (Seltzer, 1985a, 1985b).

It is not surprising, therefore, that children's subjective accounts of unexplained severe medical symptoms are absent from the literature. The absence of dialogue between doctors, children and their families hinders exploration of alternate perspectives,

maintains the stigma associated with unexplained medical symptoms, and perpetuates the cycle of shame and patient fears that their illness is seen as feigned, unreal and 'in the head'. This silence also necessitates that physicians make unilateral judgements or guesses about the content of children's minds, the predicaments they face and the role of individual volition in conversion presentations. Ultimately, the lack of dialogue and collaboration has led to a neglect of a major source of information, that is, what occurs from the point of view of the sick child. As a result, the medical profession remains largely ignorant of the mental state and life context of children presenting with conversion symptoms, and conversion presentations remain shrouded in secrecy and silence.

This article aims to address the absence of the patient perspectives from the literature. Two personal accounts of conversion disorder are presented: a structured interview with 11-year-old Karla, and a freehand account by 15-year-old Trish. Both accounts are presented in their original form although probing questions (e.g. so what happened then?), irrelevant sections, and repetitions have been edited. Incoherence in Karla's transcript reflects her anxiety about relating her story and has been retained. Each subjective account is introduced by an extremely brief overview, as details about medical presentation, the diagnosis of conversion disorder, and treatment have been described elsewhere (Kozłowska, 2001). Both girls represent the subset of 'good', 'compliant', 'high achieving' children with conversion disorder (Grattan-Smith et al., 1988; Kozłowska, 2001; Seltzer, 1985a, 1985b), who used compulsive compliant behaviour to manage their attachment relationships and who initially appeared genuinely disconnected from their own experience within the family. In Karla's case, compulsive compliance and caregiving functioned to comfort her distressed parents, to minimize parental anger and to maximize intimacy. In the case of Trish, compulsive compliant behaviour minimized hostility and rejection from an abusive and angry mother, and maximized the likelihood of physical safety. Both families initially denied the existence of any pertinent family issues, found non-organic aspects of the illness difficult to accept, and remained to a greater or lesser degree sceptical of psychological interventions. Karla's family were gradually able to engage in therapeutic intervention and explore dismissed aspects of the family experience, whereas Trish's mother maintained a stance of disbelief even in the face of family break-up and child protection intervention.

Karla

Karla T was a 10-year-old girl living with her 7-year-old brother and upper middle class parents. Karla was a very co-operative, obedient, apparently happy child who excelled in sporting activities including swimming, gymnastics, horse riding and athletics. Karla had three hospital admissions with conversion disorder totalling three months over a period of one year. Karla's symptoms included leg paralysis and intense pain in the side accompanied by various combinations of symptoms including blurred vision, headache, urinary retention and pain and loss of consciousness. On initial presentation Karla and her family denied any worries or contributing emotional factors and Karla showed distress only when her body was in pain. The emergence of family distress occurred four months after initial presentation, when Mrs T's tearfulness during a ward visit was observed. A story of intense longstanding marital hostility and its impact on Karla slowly emerged. The following interview with Karla took place 18 months after initial presentation and 6 months after Karla's last hospital admission. The interview borrows questions from the Adult Attachment Interview (Main & Goldwyn, 1985-1993). Ellipses represent either a natural pause in speech, or the deletion of a segment of transcript.

Karla, can you remember the symptoms you had when you went into hospital?

Well, the first time, I got a throat infection and about two days later I started having really really bad pain in my left side . . . Then three days later, I just got really sick and the pain in my side got really bad, and then it got really hard to walk so Mum took me to the hospital. I also had the problem with my eyes. It was always red and I couldn't read small letters. . . .

How do you now understand why you kept getting so sick?

Well, a lot of events happened that really really upset me. But I didn't want to express my emotions, I kept them inside so it looked like I was okay and because I didn't want everybody to get worried. My parents divorced and then they always used to fight. And another thing that hurt me and still does, is when Spider, the horse I looked after, he left. When the owners of the stable, I used to work there. They said that I can't work there any more so that really did hurt me . . . Because I became so attached to it and it was the one person I could talk to . . . it was the one person that or one thing I could trust, one thing never yell at me or one thing when I cuddled it it would cuddle me back . . . Like all my problems, like, all my secrets I could tell.

Would you ever go to Mum and Dad when you were distressed?

No.

Which was the secret that it was most important to talk to the horse about?

About my parents.

Can you just go back to when you first started getting sick, and can you just remind me what it was like for you with Mum and Dad?

Well, at first they both came in, one time they came in like as a couple, and then after the following week they came in separately and I thought it was because of like Dad's at work, and you know? Yeah, I kind a got worried and I felt upset and in the end it was like building a brick wall, inside of me and . . . I hid, what'd I feel, if there was something worrying me, I didn't want to tell anybody, it was like, they'll probably get angry because even though I was right, they'd get angry anyway. For just speaking up for myself. So I just kept it inside me.

And who did you worry would get angry the most?

Dad . . . That he wouldn't love me and he wouldn't ever want to see me and . . . Because Dad always used to get angry at me . . . like, when we would play cards . . . and I didn't quite understand and I'd tell him and he just start yelling at me to pay attention and to listen. I'd just say, okay, and I'd put the cards down and I'd look at them just for a few seconds and I'd continue to play . . . Um . . . well, I used to . . . when my brother got into trouble, I used to, I always used to get out of the way . . . I always try to be good but if I wasn't good, and I knew that I wasn't good then, I probably go outside or I sit on the bench or something.

When you say that you tried to be good, what did you do trying to be good?

I asked him if he needed any help with any thing, and if he said, oh, could you do the washing, I try to do perfectly, like get every little scratch off and things like that.

Do you remember, if you worked very hard to be good?

Well, I know that I did. Yeah, I did lot of things, like I did clean the house, I swept outside, and I knew that Mum and Dad used to get really happy when I did that.

So if we are thinking about your relationship with Dad then can you think three words, that would describe him?

Nervous . . . I felt, I felt ignorant . . . I felt (after a pause) depressed.

So if you think back to what it was like with Dad then, can you give me an example of the relationship being nervous?

When he promised us that we go to the zoo or something, and he, say that it was one o'clock and he said that you all get time, but he never did and I always got really nervous because he used to get really frustrated . . . He'd start yelling at, like if like a bird went past the window, he be off his rocket, . . . He'd yell, he'd just yell, get out my sight, and most of the time, I hid in the bathroom. I just stare at my hands.

Can you think of any other examples of nervous?

I was scared he would hurt us. Dad used to hit and kick us. It happened sometimes when we were bad. Like I wouldn't have tidied my room. We knew when he hit, he really hit hard. He used to put his foot out, he would grab us, or just kick us. He hit really hard. It used to happen before, but I still worry about it now. I get scared he will get angry.

Can you give me an example of a time?

I was washing up and my back was sore. I asked if I could get a chair but he said no. When he left I got a chair and stood on it. He came back and got really really angry and I got a big whack.

How old were you then?

About five or six.

Then you said, ignorant, can you think of a time, when you felt like that?

When I first stood up to myself, um, I thought I was right and I was wrong, and I felt so ignorant, I felt embarrassed. He'd . . . um . . . he'd normally um, . . . be just, he'd yell and he'd get frustrated . . . I'd sometime like go away, and may be go into the bathroom again, and just cry.

And your third one was depressed. Can you give me an example, when the relationship was with dad was depressed?

I woke up one day, I always sleep in Mum and Dad's bed and Dad had gone, and I was just sleeping in Mum's room . . . and, I can remember when one morning, when Dad walked in and um, I was just waking up, and um . . . he said, can I please speak to your Mum, and um, . . . and then all I could hear was my Dad saying please, please give me one more chance, just crying and crying and my Mum was crying and there was yelling and screaming. And then my brother walked in and I felt so depressed. Just so horrible.

Okay. So, if you think about your relationship with Mum then, not now, but before, can you think three words that would describe it?

Um . . . um . . . (Pause) . . . I felt alone, ignored, and I felt upset.

So if you think back, can you think your relationship with mum as alone, can you give an example, when you felt like that at any time?

Well . . . um . . . Mum also used to, she used to go places like, she go to my grandmother's and my uncle's and all those times and I felt alone because I did not have anybody to talk to. I guess, I just like, keeping inside me . . . she always used to ignore me.

What did you do with those feelings?

I just kept them inside of me. Just put them away somewhere. Kept them in my head.

What about 'upset'?

I felt upset because Mum was upset because she used to be crying in the nights, and she would cry all the time, and I used to think it was my fault . . . Mum, she'd get really really upset . . . she'd just come home, crying and crying and crying, she was so depressed.

What happened in hospital? What did you have to do to get better?

Well, every day the doctors would come in with all these like, medical instruments and they'd come in with cards and they spend so long in the hospital room and they'd be like tapping me and . . .

And what happened, what actually got you better, do you remember?

When I talked it through. I kind of, didn't have a choice . . . Because if I didn't talk, then I wouldn't get out of hospital and I wanted to go home . . . At first, I felt like, my body got really bad and I had these thoughts about what would happen or what they think of me . . . my parents . . . They would reject me because I told.

So what happened?

Well, they . . . sometimes, Mum would get home and she would be bit angry and sometimes Dad would be angry. She wouldn't be really angry, she be pretty disappointed because I told things, and I hadn't even told her. After a while, pain in my side kind of got better and better.

And Karla can you tell me what you think is different now to before?

But I don't really feel ignored or alone. I sometimes feel alone because Mum goes out with her boyfriend, like she goes out on Tuesday nights and Friday nights. The weekend we have with Mum. We spend all weekend with her.

How is your relationship with Dad changed?

Um . . . well I still feel nervous around Dad . . . Well he still yells at a lot. He still talks about mum with his friends. He . . . um . . . he's a lot calmer. And I feel loved. Well I felt really loved yesterday because I had my big . . . after school drama . . . Dad he was going to M, so I felt really upset because he couldn't come. And he took time off work to come and see me.

And what about with Mum?

Yeah . . . She's happy . . . It means that . . . we can actually like, sit down and we can talk. We can have dinner together without her crying.

And what do you do with tricky feelings now?

I talk about them, I don't really talk about them with Dad, but I talk about them with Mum and I talk about them with you and with D.

So when you think back why do you think your legs couldn't work?

Well, that's like a question I've been asking myself. I can't really answer it, but . . . Sometimes, I make myself believe that it was, um, when they, they hurt a lot, I sort of stopped walking on them and they got weak.

Mm . . . Why did they hurt so much?

My brick wall got too big . . . Emotions . . . Sadness, . . . and loss.

Trish

Trish M. was a 13-year-old teenager, the younger of two children living with a single mother in a rural town. Trish was a good, high achieving and compliant child who had never caused any difficulties. Trish was top of her class and had recently come first in a piano eisteddfod. Trish presented immobile and bed-bound with symptoms of dizziness and complete leg paralysis. She had two hospital admissions totalling seven weeks over a period of two months. Trish and her mother both denied any contributing emotional factors. Trish eventually admitted to significant depressed and suicidal feelings when her tendency to hyperventilate was framed as her body communicating distress. Despite numerous opportunities to discuss her life circumstances, throughout her first admission, Trish agreed with her mother's account that their relationship had lacked any overt conflict and blamed herself for her mother's anger towards her, believing she had failed to please her mother sufficiently. The following account was written by Trish 18 months after initial presentation.

'If you were in a jungle and a tiger was coming for you, you'd get out of that wheelchair and run.' . . . It was almost like he could see right through me, and knew how much I really didn't want to get better. I glanced at my mother, but her face was blank . . . 'He' was the (ear-nose and throat specialist) . . . who also gave the distinct impression that he had better things to do than to sit around analysing a teenage girl's inability to walk . . . I didn't like him much.

What I actually had was a conversion disorder, which is when a person experiences a large amount of stress, then seems to get sick with a particular disease and has all the symptoms, excepting that there is no organic origin. The symptoms are brought on by the mind, basically.

By the time I had the tests, I'd had the conversion disorder for about four weeks. I'd been . . . bed-ridden . . . I'll never forget the day I got 'sick'. Only the day before I'd done my piano exam for the preliminary grade. I'd received an A+. That same night during an active game at a youth group . . . I'd collapsed. I couldn't remember falling, and didn't tell anyone until the next day, when I fell 'ill' . . . When I awoke the next morning, I could not even sit up without feeling sick. I wasn't nauseous; it just felt like my head was swirling. I felt the swirling motion behind my eyes and between my temples . . . I felt quite weary.

My mother waited a week before taking me to the doctor's, as the previous year I'd been suffering from similar symptoms . . . The following week I had an appointment with a paediatrician, who had me admitted to hospital that same day . . . He also arranged for a MRI scan of my head, which showed nothing wrong as far as my brain was concerned.

Being admitted to X hospital was a relief, although I really couldn't explain why. For some reason I was glad to be out of home, and when I realized this I couldn't fathom why I felt that way. I was confused, and was constantly wondering if I was really 'sick' . . . After nine days in hospital with no improvement apart from being able to sit up, and losing the swirling motion, the doctor arranged for me to be transferred to (a tertiary hospital) by air, as he could not understand why I still had not regained my balance, and why I had the symptoms of a disease yet no organic evidence to back up the diagnosis.

He arranged for an 'investigation' as he called it, under Prof. A (neurologist). When he and Dr K (psychiatrist) conceded, after various tests, that I had a conversion disorder, he put me under Dr K.

'Trish, we're taking this wheelchair away from you, as you no longer need it and it's time for you to start using your legs again. Now, I want you to get up, and walk down the hall to the desk'. I stared at the nurse in disbelief and horror. 'I can't do that! I'm not well enough yet!' I began to panic . . . Dismayed, I watched her wheel it away. I wanted to cry, I felt so distraught. I slowly got out of the bed, where I'd been painting. All I could think

about was how sure I was that they were going to send me home. I resented them, and bitterly blamed them for messing up my life, as I felt.

I slowly walked down the hall, clinging to the wall railing, the nurses watching me the whole way. My dismay mounted with every step, as I realized I could walk, although my legs were a little weak. I walked extremely pigeon-toed, as I didn't want the nurses or anyone else to think I was better than I was making out – for some reason that would be like accepting defeat. I truly hated the thought of getting better. Hospital life suited me just fine.

In hospital I had more freedom than I would in my own home, ironically. I was free to roam the hospital and grounds when I wasn't at hospital school, which went for three hours each weekday, seeing doctors, or having physio in the afternoons . . . Bob was a great physiotherapist, and I always had fun in physio. When I'd started we'd use the hydrotherapy pool, and he was always inventing some new exercise or game . . . I had a little routine going, and loved it especially when my mother (left) . . . I couldn't wait for her to be gone.

I was diagnosed by Dr K with depression and anxiety, leading to a tendency to hyperventilate. Both illnesses were induced by the stress of living with my mother and sister, and Dr K wanted to put me on antidepressants. This proved to be a problem for my mother. For myself, being diagnosed with depression was simply a relief. Deep down I'd known for a while that something was not right, had felt that I was not normal or living in normal conditions . . . and it was a relief just to know that I was right, and the problem wasn't with me.

My mother, however . . . the diagnosis rocked her severely, she simply couldn't accept that I was depressed and in need of medication, and at first refused to allow me to have it. She came to instantly see Dr K (and her registrar) as enemies, and immediately called her beloved pastor back (home). My mother was, and still is, fanatically religious, and believed that God would heal me if she had faith, or something like that. She believed Dr K and (her registrar) were putting ideas into my head, that Satan had a hold over me, that God was testing her – she couldn't make her mind up, and went around and around in a circle. To me she became contemptuous, and I couldn't stand the thought of her any longer.

I'd been angry for years but had been bottling it up inside, and by this time the anger was almost unbearable. I was 13 years old, and I despised her, resented her. I'd lived with her all my life, my parents divorcing before I could even remember, and I'd been abused in every way there was. I had been sexually abused when I was six, and whilst it was the doing of another, I was so angry that she didn't do anything when I told her. She just told me not to let it happen again, and literally forgot the whole incident. To this day she doesn't remember a thing, and it tore me to pieces.

I was physically and emotionally abused by my mother, she daily playing mind games and giving guilt trips. I was constantly confused, and feared her immensely. I feared angering her, as some days my sister or I only had to say something the wrong way and she'd be in a rage. Her rages could last a few minutes or go for days. When they went for days, she'd rage over and over again. She'd scream and shout, and either my sister or I would get hit – whoever happened to be in the wrong place at the wrong moment.

When she struck us she'd clench her hand into a fist and hit us at the temples with the back of it, catching us with her knuckles – one way, then the other, then the other. She'd slap our faces and arms, hit us with her fist on the back and arms – sometimes she'd kick us, too, although kicking wasn't as effective as hitting, and didn't hurt as much.

Before an outburst it was always like the calm period before a storm, and I always found the calmness more terrifying than the actual outbursts. In between outbursts was petrifying, too – she'd sit with a cold cup of coffee, sometimes she'd start a crossword, but always ended up just staring at nothing, and if you asked a question and snapped her out of it she'd just go off at you. If it was dinnertime, too bad, you'd just have to wait until she felt like cooking.

It was always best to stay quiet, in your room, pretending nothing had happened. If I cried, I'd just cop it worse, as I wasn't allowed to cry – my mother believed I was devoid of emotion, and therefore if I cried I was only doing it for attention. She could never believe I ever had anything to cry about, and still retains this belief. My sister, on the other hand, was a different case entirely. My mother allowed her to cry, as apparently she was 'emotional', and would sometimes hug her after an outburst. She very rarely hugged either of us . . . I always planned to run away, but knew I had nowhere to go . . .

I hadn't always lived in X . . . Before that we'd lived in Y . . . I still remember how she came to decide to move to X . . . My mother came home one night – she'd lost her job . . . Her rage that night was spectacular. She blamed her job loss on my sister and I, although my sister copped most of that one . . . After the initial rage . . . when she was in a calm period, I was sitting at the table when she looked at me, and said, 'If she's (my sister) going to take away my opportunities, then I'm going to take away hers.' Just like that. That night she decided to move to the country, picking X. Two weeks later X was exactly where my sister and I found ourselves. Just like that . . .

My mother's pastor talked her around to a certain degree, getting her to agree to get a second opinion about putting me on the pills. He recommended a GP he knew down in Y who had studied a bit of psychology. Anything my mother's pastor said was law, in her eyes, and so off we went. I was determined to get those pills – I knew I needed help, and also knew that without them as physical evidence my mother would eventually discredit anything Prof. A or Dr K had said . . . When I saw the doctor, I said, 'If you don't give me the anti-depressants, I will kill myself' . . . By the time we returned to the hospital my mother had given her consent for me to start having the pills, although she made it clear that she wasn't happy about it. I was exhausted, yet at the same time triumphant in a vague way. And as I lay in bed, I couldn't believe I'd actually done it.

My mother had been talking about taking me home, about how they needed me and missed me, and what with me walking and all again, properly, it looked like I would be going soon. I had started taking the (antidepressant), and the nurses themselves were asking how long it was before I would be going home. My chest was heavy, and once again I felt like crying. I couldn't tell anyone any of this, couldn't explain how I was feeling, how petrified I was . . . all I could think about was how my safe little world was falling down all around me, and there was not a thing I could do about it. I just wished everyone would go away.

Then (Dr K's registrar) came to see me and told me that it was time for me to leave. I told her I wasn't ready yet, that I couldn't possibly go just yet, but she told me there were other kids who needed my bed. Earlier, I'd asked a nurse why there were so many empty beds when there was apparently such a waiting list, and she'd explained that whilst they had the beds, they didn't have enough nurses to attend the beds . . . I couldn't shake how betrayed I felt. I'd thought that they were on my side, that I could trust them, and now here they were, making me go home. I felt sick, and just wanted to scream.

I . . . told my physiotherapist, Bob, that I had to go home. 'Isn't that a good thing?' He asked. I shook my head. I couldn't explain it to him completely, though I did try. I told him how in my mother's eyes I was already a failure – I was supposed to be the perfect child. I wasn't meant to have any problems, nothing ever apparently went wrong for me – heck. I wasn't even supposed to cry . . . If I cried I was just being manipulative, even as a baby. Like I said before, I was meant to be devoid of emotion.

I told everyone I was going . . . That night I panicked really badly, and was desperate for a way to delay my departure . . . I started hyperventilating, and kept going. I returned to my ward and went back to bed, still hyperventilating, until my eyes glazed over and I couldn't feel my hands or feet. My roommate alerted the nurses . . . but after a few minutes I was alright, so they just wheeled me back into my own room. I was deeply disappointed – I was still leaving . . . Hyperventilating had been a last ditch effort to stay in hospital, and

it had failed. I felt foolish and embarrassed, and knew the nurses had seen through me. So I did what any other 13-year-old does when they don't get their way; I sulked . . .

It was actually happening, I was going to go home. Dr K had also been talking to me, and had arranged for some counselling when I returned home with a lady by the name of Mary . . . the train moved off . . . My mother chatted happily next to me, until I excused myself to go to the toilet. Nothing would ever be the same again, and I already wanted to be back in hospital. I returned to my seat and stared out the window.

Afterwards I had a relapse of the conversion disorder a week after I returned home. I didn't go back to school that term, and attended my first counselling session (two weeks later) after an amazing recovery. The next day I began overdosing on the pills, first taking three times the dose I should have. Two days later I took six times, then another two days later I took eight times the dose I should have. My mother had no idea, as I'd put myself to bed before I'd pass out.

The day after my last overdose, I had another session with Mary, and I told her what I'd been doing. I knew I wouldn't have stopped at the pills, that I would have gone looking for something else. That day I didn't return home, and haven't spent a night in my mother's house since. I was suicidal, really didn't care anymore, and as one person later said, I was a 'shell of a girl'. I went to hospital for another six days, where I turned 14, and moved into a (refuge for teenagers) . . . It was another six months before (child protection services) found me a foster placement. The placement failed, and after nearly three months I was found another placement, which is where I am now. I love my foster family, they are my family now.

My mother and sister moved back to Y, in an effort I suspect to scare me into going back home. I'm still in X. Inside I've changed so much. I can't even recognize the person I was when I was in hospital. I'm so much stronger now; I'd forgotten how weak I once was. I've dealt with (many) issues . . . I'm even working on forgiving my mother. I ring her maybe every three weeks or so. I've been off the (antidepressant) for 8 months now, and I'm the best I've ever been – just ask Mary. I'm content with my life and happy to be alive; there's not a lot I want.

I don't deny it's been tough; I've had many sleepless nights, and cried bucket loads of tears. There were times when I didn't think I'd make it; in those times determination kept me going. But I got through, and I know God's always watched over me. I'm also a Christian now, but different to what my mother saw as Christianity.

I have great friends now, too, and this year I hope to start training to become a Leader with an organization called 'O'. 'O' holds camps to help teenagers get back on track with their lives through creating a safe environment where they can talk about the issues that are holding them back, and raising their self-esteem . . . I started picking up the pieces of my life when I left hospital; now I'm putting them back together.

Discussion

The girls' accounts raise many interesting issues about childhood conversion disorder. First, they underline that conversion symptoms do not present in a vacuum. Like many emotional disorders such as anxiety and depression, conversion symptoms are embedded in a life context. As in studies of adult functional illness, entrapment in problematic attachment relationships, isolation and lack of support in the face of unresolvable predicaments such as rejection of the child by the parent, fear of parental anger or displeasure emerge as key issues in the above accounts. Trish's apparent lack of a confiding relationship is striking, as is Karla's relationship with the horse Spider, who functioned as a confidant and a provider of comfort.⁴ Second, in line with Janet's observations more than a century ago, the accounts illustrate the girls' lack of reflection and

disconnection from their own experience within the family at the time of presentation. For example, Karla's account describes the family context in which her illness presented, although at the time Karla's first two hospital admissions, existing family predicaments remained unacknowledged by both Karla and her parents for a period of four months. At termination of treatment Karla remained unable to prevent relapses of conversion symptoms. It was her mother who became practised at averting further episodes by noting early signs of leg weakness and helping Karla communicate underlying feelings of distress. Third, the girls' disconnection from family issues mirrored the parental tendency to dismiss significant events from awareness. For example, Trish's mother never reached a position where any difficulties were acknowledged. For Karla's family, the process of making family predicaments overt came as a shock. Her father described the process in the following words,

I was totally unprepared, and it took me by total surprise,
and toward the end of therapy her mother shared the following reflection,

There was so much unhappiness built up within me and I mean, you acknowledged, you recognized with me that I was at breaking point. I didn't even want to recognize it then, because I was in denial such a long time. I would probably still be there, being a very unhappy, unhappy family.

In the context of the family's disconnection from reality, Karla's reluctance to tell her story and her fear of parental rejection if she 'told' is not surprising. 'Telling' was not an act of recounting facts, but an act of breaking family silence about painful and unspeakable aspects of family life.

In view of her greater maturity, Trish's account reflects not only her life circumstances, but also awareness as to how the process of reorganization was accomplished. She describes in detail her journey from 'not knowing' to 'knowing' and underlines the psychological shift from disconnection to emotional discomfort and pain. Trish also describes in detail the developmental shift from a compulsive compliant strategy, which she used in childhood, to experimentation with coercive behaviors⁵ in the context of ongoing danger, to a more balanced position in the context of a safe and supportive foster placement. Her account explicitly discusses the progression of conversion illness from involuntary symptoms, to nodal points where Trish had gained significant control over her paralysis and had started to reflect about her life context but felt angry, powerless and overwhelmed by her life predicaments. At these points, the use of coercive strategies, including abnormal illness behaviour functioned as a protective strategy to avoid exposure to undisclosed and unmanageable abuse and parental rejection.

Conclusion

Not everything is as it seems. Despite the apparent lack of social, family and psychological difficulties, the presentation of conversion symptoms in good children with exemplary functioning requires consideration of unacknowledged distress in the context of the child's attachment relationships. This article addresses the absence of the children's subjective experiences of conversion disorder from the literature, and presents two personal accounts of conversion illness. The girls' accounts are powerful in presenting a child perspective and underline that the child's experience is a valuable source of information. Dialogue and collaboration with children and their families enables professionals to move beyond the unenviable position of hypothesizing about the content of the child's mind, the predicaments they face and the role of individual volition

in conversion presentations, and allows for treatment strategies which result in physical recovery, and resolution of unbearable predicaments.

Notes

1. See for example the case of Marie (Janet, 1889; also translated in Ellenberger, 1970).
2. For an in-depth discussion of the contributions of Freud and Janet see Ellenberger (1970) and Perry and Laurence (1984).
3. Referred to as automatisms (Janet, 1889), cognitive structures (Hilgard, 1977, 1979), or mental/behavioural state (Putman, 1997).
4. Karla's second admission was precipitated by the loss of Spider.
5. Coercive behaviours refer to angry behaviours which function to elicit caregiving and action by responsible adults, e.g. threats of suicide, illness behaviours and overdosing.

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