The Treatment of Conversion Disorder in a Rehabilitation Setting

M.J.L. Sullivan, PhD and D.C. Buchanan, PhD

Rehabilitation settings appear well suited for the treatment of conversion disorder. These settings allow for the implementation of several structured and goal-directed treatment modalities geared toward maximizing physical functioning. A case report describes the successful rehabilitation treatment of a man with long standing conversion disorder. Factors associated with the precipitation and maintenance of conversion disorder are discussed. Issues related to treating conversion disorder within a rehabilitation centre as opposed to a mental health setting are also addressed.

When patients seek medical treatment, it is generally assumed that they do in fact suffer from the condition for which treatment is being sought. There are cases, however, when physical symptoms occur in the absence of discernable organic pathology. In these cases, psychological factors are often considered to be of etiological significance (Merskey, 1983). Treating these patients becomes problematic as they are seeking medical interventions for problems of psychological origin. This paper describes how one such patient was effectively treated within a rehabilitation setting. The case described in this paper meets the DSM III-R classification criteria for Conversion Disorder (APA, 1987). The diagnostic criteria for Conversion Disorder are as follows:

(A) A loss of, or alteration in, physical functioning suggesting a physical disorder.

(B) Psychological factors are judged to be etiologically related to the symptom because of a temporal relationship between a psychological conflict or need and initiation or exacerbation of the symptom.

(C) The person is not conscious of intentionally producing the symptom.

(D) The symptom is not a culturally sanctioned response pattern, and cannot, after appropriate investigation, be explained by a known physical disorder.

(E) The symptom is not limited to pain or to a disturbance in sexual functioning.

Several explanatory models have been put forth to account for conversion disorders. Psychoanalytic models suggest that unconscious conflicts may be converted into physical symptoms (Jones, 1980). It has also been suggested that conversion disorder may serve a communication function where physical symptoms allow the individual to express certain thoughts or feelings which cannot be expressed verbally (Hollender, 1972). More recent models have stressed the role of reinforcement and social learning variables in the etiology of conversion disorder (Kimball & Blindt, 1982; Zoccolillo & Cloninger, 1986).

Regardless of theoretical orientation, clinicians have found it useful to distinguish between primary and secondary gain in discussing the precipitation and maintenance of conversion disorder. Primary gain typically refers to the factors which are responsible for the precipitation or onset of conversion disorder. These may include unconscious conflicts or severe life stresses. Secondary gain refers to the added benefits the patient may receive as a
function of having a physical illness. In other words, secondary gain represents the reward value of physical symptoms. Factors such as financial compensation, interpersonal control, avoidance of responsibility, and receiving increased care or attention may serve to maintain symptom presentation (Celani, 1976; Rabkin, 1964).

Often overlooked are the factors which may interfere with the resolution of conversion disorder. As a function of changing environmental conditions, the reward value of physical symptoms may change over time. However, the spontaneous remission of physical symptoms may lead observers to question the legitimacy of the symptoms. Even in the absence of conscious awareness, few people would place themselves in a situation where their symptoms may be construed as imaginary or fabricated. Thus, the anxiety associated with the threat of invalidation may result in the persistence of conversion disorder even when the costs of maintaining the symptoms outweigh the benefits.

It is difficult to identify with certainty the factors associated with the precipitation and maintenance of conversion disorder. Patients with conversion disorder are often vague in their descriptions of the historical events associated with the onset of their symptoms, and they may selectively omit relevant information. To a large degree, therefore, the clinician must make inferences about the nature of precipitating and maintaining factors. These inferences, in turn, play a major role in the selection of treatment approaches. In the case report which follows, a rehabilitation approach to the treatment of long standing conversion disorder will be described. An attempt will be made to specify the inferences which were made about secondary gain factors, and how these played a role in devising a treatment plan.

**CASE REPORT**

Mr. L. was a 65-year-old married man admitted to The Rehabilitation Centre with a symptom cluster which included left-sided weakness, loss of sensation on the left side, dysphonia, and self-reported memory problems. Mr. L. was ambulating with the use of a wheelchair. Apparently, these problems were the result of a series of strokes, the first of which had occurred 23 years earlier, the most recent of which occurred 3 months prior to admission. He had been receiving a disability pension since his first stroke.

Seven years after his first stroke, Mr. L. reported experiencing a severe stroke which left him unable to walk and unable to speak. Apparently, over the following two years, he regained the ability to speak. However, he continued to use a wheelchair for ambulation. Several modifications were made to his home in order to accommodate his disability. There were no indications in the patient's medical history of reports to either confirm or disconfirm the diagnosis of cerebral infarct. Mr. L.'s family physician had raised questions about a functional problem but it was never investigated.

Only limited information could be gathered about the patient's background. He was vague and often tangential in describing his past. Mr. L. explained that he had served in the armed forces during the second world war. After the war he reported that he had held several unskilled labour jobs.

Mr. L. was referred to the psychology department for routine neuropsychological screening. During the initial interview, Mr. L. showed several characteristics commonly associated with hysterical (histrionic) personality. His conversational style was vague and dramatic. He tended to exaggerate the importance of his previous accomplishments, with particular emphasis on his exploits during the war. In addition, he showed little affective concern for the severity of his disability.

Although Mr. L. complained of severe memory difficulties, tests of memory function revealed no evidence of impairment. Tests of intellectual function yielded scores in the average range. There were however, several inconsistencies in test responses which raised questions about the
Conversion Disorder

held with team members about the nature of conversion disorder, emphasizing that symptom presentation was not under voluntary control. It was agreed that the goal of rehabilitation would be to maximize physical functioning and that the patient would be treated in ways similar to other stroke patients. Where treatment staff occasionally commented amongst themselves on the psychological basis of the patient’s problem, treatment focus was maintained and there was no evidence of negative patient-staff interactions. In the present case, the likelihood of negative staff reactions may also have been reduced by making treatment contingent on improvement. In other words, this condition of treatment may have set limits of the degree of manipulative behavior exhibited by the patient and seemed to have increased the patient’s motivation to improve. Treatment staff are less likely to react negatively if their treatment efforts are associated with clinical improvement.

DISCUSSION

In the case described above, several factors appeared crucial in determining treatment success. One factor was the provision of a non-threatening means of relinquishing symptoms. The patient’s claims about the physical basis of his symptoms were validated by the prescription of physical treatment, and physical treatment held the promise of symptom resolution. A second factor contributing to treatment efficacy was the condition that continued treatment would be contingent on improvement. This condition reduced the probability of regressive behavior during treatment, and consequently, reduced the probability of negative staff-patient interactions. In addition, the interdisciplinary structure of the rehabilitation setting allowed for the implementation of several treatment modalities with a common treatment philosophy. It is important to note that the patient’s initial agreement to the conditions of treatment may also be construed as his gladness to relinquish his symptomatology.

This report joins a growing literature demonstrating that conversion disorder can be effectively managed through a structured and directive rehabilitation approach. To date, there have been several reports of the successful treatment of conversion disorder in rehabilitation settings, primarily in patients with conversion paralysis (Blanchard & Hersen, 1976; Cardenas, Larson, & Egan, 1986; Findlater, 1986; Oberfield, Reuben, & Burkes, 1983; Stewart, 1983). While the duration of treatment has varied considerably, a number of authors have reported marked symptom reduction within 6 to 8 weeks of in-patient treatment (Blanchard & Hersen, 1976; Cardenas et al., 1986). The case reports cited above describe treatment programs consisting of physical therapy in combination with psychological interventions either in the form of behavior therapy or psychotherapy. At this time, it is unclear whether the inclusion of a psychological treatment component is essential for successful outcome. However, the involvement of a mental health professional in treatment planning is recommended. Conversion disorder may be complicated by personality, emotional or social problems which may interfere with a patient’s ability to benefit from rehabilitation treatment (Zoccolillo & Cloninger, 1986).

In the current case, conversion disorder was conceptualized as the patient’s means of managing life stresses. It could be argued that while the stroke symptoms were appropriate targets for intervention, treatment should also have fostered the development of more adaptive coping strategies. In this regard, it is important to note that coping strategies cannot simply be given to patients. A prerequisite to most psychological interventions is that the patient recognize the need for change, and be motivated to effect such change. This level of insight and motivation is often absent in patients with conversion disorder, thus making them unsuitable for traditional psychotherapeutic approaches (Stewart, 1983). Our experience in this area suggests that treatment focussed primarily on psychological factors tends to be
authenticity of his complaints. Mr. L. reacted with considerable anxiety to the administration of a Rorschach test. He rejected several cards claiming that they meant nothing to him. He became increasingly agitated and demanded to know why he was being given such a test. His MMPI profile showed an elevated Hypochondrasis score.

A neurological examination revealed that all vital signs were within the normal range. There was inconsistent left hemiparesis with muscle tone varying across examinations. Deep tendon reflexes and plantar responses were normal. Mr. L. also presented with occasional tremor of the extremities. However, the tremor did not readily fit into any category of organic tremor. He demonstrated a positive Hoover's sign. The results of a CT scan revealed no evidence of cerebral infarct or any other brain trauma to account for the presenting symptomatology. On the basis of Mr. L.'s presentational style, the neuropsychological findings, and the neurological examination, the diagnosis of conversion disorder was made.

Mr. L. was a poor historian, and it was difficult to identify environmental stresses which may have been associated with the precipitation of conversion disorder. It appears that one stroke occurred when his daughter was planning to leave home, another occurred while on vacation with his wife, and the most recent occurred during a holiday family gathering.

**TREATMENT**

Several inferences were made about the nature of Mr. L.'s presenting symptomatology. First, Mr. L.'s symptoms appeared to function as a form of coping strategy. In the face of severe environmental or interpersonal stresses, the occurrence of a stroke would absolve him of many responsibilities. In addition, his symptoms seemed to have increased his interpersonal control within the family and provided him with financial security. However, having reached the age of 65, and being eligible for old age pension, his symptoms were no longer needed for this function. In light of this change in his life situation, the cost of maintaining stroke symptoms may have begun to outweigh the benefits.

Based on this reasoning, it seemed that Mr. L. might relinquish his symptomatology if he was provided with a non-threatening way to do so. To accomplish this, Mr. L. was told that the results of testing indicated that whatever cerebral damage he may have sustained in the past appeared to have completely healed. In addition, he was told that with 4 weeks of intensive physiotherapy, occupational therapy and speech therapy, his symptoms should resolve. In order to avoid manipulative behaviour or symptom maintenance during his in-patient stay, Mr. L. was informed that treatment would be contingent upon improvement. If he stopped improving, or if his condition worsened, he would be discharged. He agreed to these conditions.

A structured goal-oriented physiotherapy program was implemented aimed primarily at increasing lower extremity strength. Mr. L. attended physiotherapy twice daily and goals were set at the beginning of each week. Mr. L. was also seen on a daily basis in occupational therapy in order to increase his independence in activities of daily living. On the ward, increased independence was verbally praised by the nursing staff and illness behaviour was ignored. By the end of the fourth week, Mr. L. was ambulating independently with the use of a single point cane and was independent in activities of daily living. The symptoms of dysphonia did not respond to treatment. At one year follow-up, treatment gains had been maintained.

Previous reports have described the negative staff reactions which may arise in the treatment of patients with conversion disorder (Stewart, 1983). Rehabilitation team members may feel frustrated or angered if they perceive their efforts as being wasted on patients who are "faking" their symptoms. To avoid negative staff reactions toward the patient, discussions were
less effective than treatment focussed on physical symptoms. Patients may perceive the prescription of psychological treatment as questioning the legitimacy of their presenting problem, or they may construe such treatment as inappropriate in light of their belief in the physical basis of their problem. These factors need to be considered in devising treatment plans for individuals with conversion disorders.

In conclusion, while there is insufficient data to make strong statements about the treatment of choice for conversion disorder, it is becoming increasingly clear that rehabilitation settings are well suited for this purpose. The symptom focussed approach of rehabilitation allows for rapid reduction in presenting symptomatology and can also address the iatrogenic problems which may result from multiple medical interventions and long periods of inactivity. Additional efforts in this area are needed to determine the strengths and limitations of rehabilitation approaches to the treatment of conversion disorder. It will be necessary to document information about various patient and treatment characteristics such as personality and emotional functioning, the nature, number and duration of treatment components included, the degree of symptom reduction, and the maintenance of treatment gains.

Les centres de réadaptation semblent constituer des environnements privilégiés pour le traitement des personnes ayant des difficultés d’adaptation. Ces environnements permettent l’application de plusieurs traitements spécifiques destinés à maximiser le fonctionnement physique. Une étude de dossier décrit la réadaptation heureuse d’un homme longtemps affecté par des difficultés d’adaptation. L’article discute des facteurs ayant engendré et perpétué ces difficultés d’adaptation, et se penche également sur les thèmes reliés au traitement de ces troubles au sein d’un centre de réadaptation par opposition à un centre pour déficients mentaux.

REFERENCES


---

**M.J.L. Sullivan**, Department of Psychology. The Rehabilitation Centre, 505 Smyth Road, Ottawa, Ontario K1H 8M2, Canada.

**D.C. Buchanan**, Department of Psychology. The Rehabilitation Centre.

Please address all correspondence and print requests to Dr. M.J.L. Sullivan.