Conversion Disorder Following Termination of Pregnancy

Gary D. Tollefson, MD, PhD, and Michael J. Garvey, MD
St. Paul, Minnesota

A variety of psychologic disorders may present as physical complaints without organic basis. As characterized by Sydenham over 300 years ago, such disorders "mimic all the physical disease to which man is heir." The case here presents the evolution of a conversion disorder (urinary retention) in response to a decision to terminate pregnancy. The predominant disturbance in a conversion disorder is an involuntary loss or alteration in somatic function that is temporally related with an environmental stressor. Conversion, as a defense mechanism, provides primary gain by keeping the conflict from the patient's awareness and secondary gains by generating environmental support and avoidance of undesired activities. Awareness of a patient's current life events, past responses to stress, and support systems is essential in order to recognize and manage this array of physical complaints of functional origin.

The term *conversion* appeared early in Freud's theoretical concepts to represent the discharge of unconscious (repressed) mental energies via restricted, localized somatic expression.[1] Fairburn[2] has described conversion as a defensive technique that prevents the conscious emergence of conflict (primary gain). Often associated is the additional benefit of avoiding a noxious activity or receiving environmental support (secondary gain). Conversion, according to Engel and Schmale,[3] is a psychic mechanism whereby an idea, fantasy, or wish is involuntarily expressed in somatic rather than verbal terms. Symptom choice may be a predetermined function of (1) the patient's conception of physical illness, (2) identification with persons having previously experienced the symptom, or (3) the symptom suitability for symbolic representation of a particular fantasy or conflict.

Conversion has acquired the label of a great imitator of organic disease. Studies suggest that less than 50 percent of suspected conversion cases fulfill the diagnostic criteria of hysteria.[4,5] Guze and Perley[6] have reviewed the differential course of conversion and hysteria (Briquet's). The variable course and individual symptoms of the former stood in contrast to the chronicity, interpatient reliability, and polysymptomatic composition of the latter. In the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III),[7] somatoform disorders are essentially those in which physical symptoms appear without demonstrable organic findings or physiologic mechanism. This group of disorders encompasses somatization (Briquet's syndrome), conversion disorder, psychogenic pain disorder, hypochondriasis, and atypical somato-

From the Department of Psychiatry, St. Paul-Ramsey Medical Center, St. Paul, Minnesota. Requests for reprints should be addressed to Dr. Gary Tollefson, Department of Psychiatry, St. Paul-Ramsey Medical Center, 640 Jackson Street, St. Paul, MN 55101.

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form disorder. Each occurs with at least a strong suspicion that the symptom(s) are linked to psychological factors or conflicts and are mediated involuntarily. According to DSM III, the following are the current criteria for a diagnosis of conversion (psychogenic pain):

1. The predominant disturbance is a loss of or alteration in physical functioning suggesting a physical disorder.

2. Psychological factors are judged to be etiologically involved as evidenced by one of the following: (1) a temporal relationship exists between an environmental stimulus that is apparently related to a psychological conflict or need and the initiation or exacerbation of the symptom, (2) the symptom enables the individual to get support from the environment that otherwise might not be forthcoming, and (3) the symptom enables the individual to avoid some noxious activity.

3. It has been determined that the symptom is not under voluntary control.

4. The symptom cannot be explained by a known physical disorder or pathophysiologic mechanism.

It is essential to recognize that any of the somatoform disorders may appear concurrent or consequent to any other psychiatric disturbance and that other psychiatric disorders such as depression or anxiety may include physical complaints at times not meeting all of the criteria for a conversion. These may range from "functional" complaints to psychophysiologic reactions involving enhanced autonomic activity (eg, panic attacks). In addition, patients may model a conversion symptom after their own physical disorders, eg, pseudoseizure superimposed on a past history of documented electroencephalographic seizure activity. This interface often provides the primary physician with difficult differential diagnoses. Thus, the conversion disorder should be thought of as a "nonspecificity of psychosomatic symptoms which change with reference to the individual's personality" and may be attributable to a variety of psychiatric maladies (eg, an adjustment reaction, major depression, personality disorder, or schizophrenia).[8]

Certain psychic prerequisites appear to facilitate development of the conversion: (1) a condition of deprivation or frustration, (2) symptom suitability to symbolically represent a particular wish or fantasy, (3) self-imposed punishment in response to guilt (eg, pain or loss of function), (4) insulation of the individual from a threatening or disturbing life situation, and (5) the provision of a new mode of relating—a socially sanctioned "sick role" with its spectrum of secondary gain.[3] The following case typifies an acute conversion response to a psychological stressor, the elective termination of a pregnancy.

Case Report

A 25-year-old single white woman (para 0, gravida 1) was hospitalized for termination of pregnancy at 22 weeks of gestation. The patient explained to her physicians, "I didn't know I was pregnant." The operative procedure was uncomplicated, and the patient was discharged. Five days later she presented to the Emergency Room complaining of inability to void. Following catheterization, which recovered 800 mL of urine, the patient returned home; within 24 hours she again complained of an inability to void. Admission to the gynecological service resulted in a 16-day stay involving a continued inability to void requiring repeated catheterizations. Intravenous pyelogram, cystometrogram, abdominal roentgenogram, and pelvic ultrasound were negative. Urologic consultation failed to demonstrate evidence of pathology. Empirical trials with bethanechol (Urecholine) and phenoxybenzamine (Dibenzyline) were unsuccessful. Neurologic consultation revealed only a nonspecific impairment of pinprick discrimination in the perilabial and gluteal regions, although the patient's "peculiar affect" was also noted.

Psychiatric consultation revealed marked immaturity, an inappropriately labile affect, and indifference to her symptoms. In discussing her impregnation, the patient alleged having been "drugged and raped" by three to six men at a wedding reception; however, there was no confirmation. Until the 20th gestational week the patient reported no suspicion of her pregnancy. She characterized her decision to abort the fetus as "impulsive" and "what my father wanted." In the hospital she expressed little concern about her urinary retention, offered little complaint to repeated catheterization, and frequently spoke of a male fetus.

A history of occasional substance abuse was elicited. The patient reported only one serious past relationship with "the only man who ever paid

attention to me." While characterizing this time as positive, she stated that she would work "while he drank evenings at the bars." The relationship had recently terminated when this man returned to his ex-wife. The patient had made a suicidal gesture at that time with an unknown medication.

Upon transfer to the psychiatric inpatient service, the patient began to void spontaneously. A Minnesota Multiphasic Personality Inventory was interpreted as revealing "an intent on emphasizing the goodness and social desirability of her attitude and intentions." After a short stay in a supportive crisis-oriented milieu, regular voiding patterns were established. The patient was discharged with plans for a short-term outpatient follow-up. Her later course was uncomplicated.

Discussion

Only a limited number of clinical papers have dealt with the psychological concomitants of abortion since its legalization. The reported incidence of psychiatric sequelae after therapeutic or legal abortion is low.[9] However, the degree of preabortion emotional difficulty appears in direct proportion to the incidence of postabortion behavioral complications.[10] Termination of pregnancy encompasses an array of stresses, including surgical manipulation, anaesthetic intoxication, disruption of hormonal homeostasis, arousal of conflictual drives, potential for real or imagined social criticism, and personal despair. The quality of support from a series of people important to the patient and a stable social setting appear to be the strongest predictors of outcome.[9] Opposition encountered in the decision to abort results in adjustment problems including anxiety, depression, and hostility. Factors that enhance the risk of psychiatric complications following termination of pregnancy include poor preabortion psychological adjustment, first conception, negative feelings toward partner, absence of support from the conceptual partner, decision made alone to abort, parental opposition to the abortion, and peer group opposition to the abortion.[9]

The selection of a target organ for conversion is often based upon its ability to achieve symbolic representation. In this case, the anatomic proximity of the bladder and uterus is cogent with the Freudian concept of somatic compliance whereby a previous somatic injury or disease may dictate the conversion focus through reactivation of the original event.[11] In most cases of conversion the precipitant is a real, potential, or symbolic loss. In contrast to malingering or factitious disorders, the symptom production is not under voluntary control. The symptom often develops in the setting of psychological stress. Classically the distribution of impairment occurs along nonanatomic patterns of innervation or in the presence of contradicting physical features, such as conversion blindness with normal pupillary response. A decision-tree approach to physical symptoms without organic explanation modified from the DSM III[7] is provided in Figure 1.

Generally the conversion patient engages the physicians' treatment plan with good compliance in distinction to the hypochondriacal patient's defiance. With dissolution of the acute stressor, the conversion may abruptly resolve without the chronic repetitive pattern characteristic of hypochondriasis, malingering, or factitious illness. When a pre-existing physical disorder is exacerbated by psychologic features, it is alternatively classified as a psychological factor affecting physical condition (eg, psychophysiologic disorders). Compensation cases in which symptom exacerbation occurs during convalescence from an injury and concurrent with litigation also are categorized here. Their course, like the conversion, often parallels the length of the precipitating psychosocial event.

Conversion disorder is a diagnosis of exclusion. Those organic disorders that wax and wane or have migratory symptoms, such as multiple sclerosis, often complicate the differential diagnosis. In a two-year follow-up of 85 "conversion patients" (hysteria) Slater and Glithero[12] identified 22 cases with previously undiagnosed organic disease that explained the original symptom. An additional 19 patients manifested conjoint organic and psychiatric diagnoses (eg, seizure and pseudoseizure), while 8 had succumbed from an organic disease. Only 32 individuals (38 percent) retained pure functional diagnoses. This underscores the principal that the clinician needs to refrain from a reductionistic approach that assumes the symptom can only be "functional." An open perspective across time offers the greatest assurances for valid diagnostics in this population. According to Hall et al,[13] the following are characteristics associated with symptoms of psychosomatic origin:

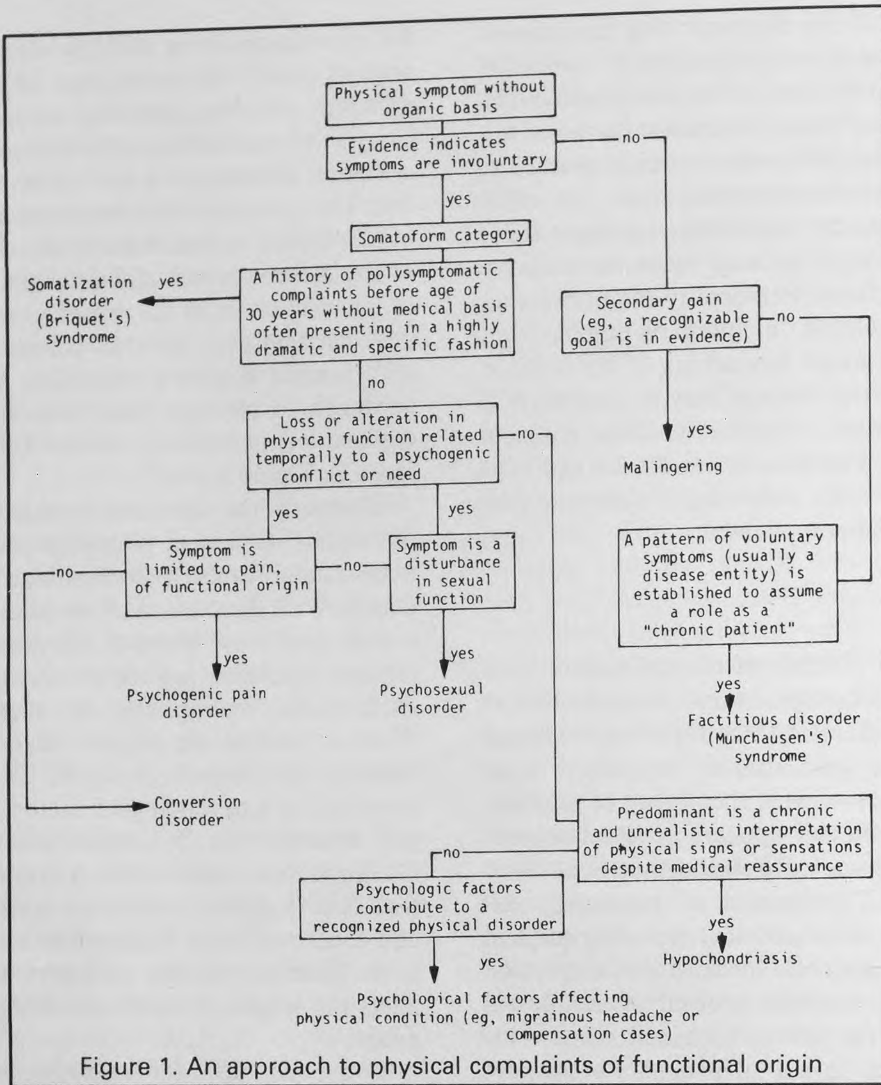

Figure 1. An approach to physical complaints of functional origin

1. Chronic or recurrent problems in living
2. Concomitant or recent antecedent social stressors that wax and wane in proportion with the somatic complaint
3. Bizarre symptoms, nonanatomic distributions of loss, contradictory findings
4. Somatic complaints that generalize to multiple organ systems
5. Denial or unwillingness to consider a functional basis for the complaint, obvious goal-related behaviors (convenient symptoms), and apparent satisfaction with disability or dependency on others (sick role)
6. Poor therapeutic compliance or failure to respond to conventional treatments
7. Abuse of pharmacologic treatments

A conversion disorder also warrants consideration when antedated by an affective history, anxiety state, or certain patterns of characterologic features (eg, despair, grief, or deprivation).[14] Conversely, when physical symptoms without organic etiology are first identified, the clinician should rule out depressive disorder or generalized anxiety states that often coexist (Table 1). For depressive disorder antidepressants are the treatment of choice, whereas for generalized anxiety states either anxiolytics or behavioral techniques should be employed.

In summary, the conversion is a functional defense or coping method by virtue of (1) expression

Table 1. Diagnostic Criteria of Depression and Generalized Anxiety

	Depression	Generalized Anxiety
Continuous symptom interval	At least 2 weeks	At least 4 weeks
Symptom clusters*	Poor appetite or weight loss, sleep disturbance, agitation or retardation, loss of interests or pleasure, loss of energy, feelings of worthlessness or guilt, disturbed concentration or memory, suicidal ideation, passive thought of death	Motor tension, autonomic hyperactivity, apprehensive expectation, hypervigilant, "on edge"

Adapted from DSM-III[7]
*For depression at least 4 criteria are required; for generalized anxiety specific symptoms from at least 3 of the 4 criteria are required

of a repressed conflict, (2) atonement for guilt by the implied suffering or disability, (3) providing insulation from a current life event, and (4) facilitation of an adaptive mode of relating (sick role).

In this case a supportive insight-orientated approach to the symptom facilitated both subjective psychic relief and objective symptom resolution. However, caution should be urged regarding exposure of the functional nature during the acute phase of illness. Conversion is a defense against extreme anxiety and accordingly should be "defused" over time. Explicit reassurance about the expectations of recovery in the context of a concerned, reassurring attitude is essential. Instruction in more appropriate means of coping, appropriate therapy of the primary psychiatric entity (eg, depression), avoidance of unnecessary somatic interventions, and patient insight into a tendency to express distress through somatic channels are useful tactics for the primary care physician.

Awareness of individuals "at risk" includes knowledge of the patient's current life events, pattern of response to past stressors, and current support systems. Such information may help predict the patient's reaction to an impending stressor (eg, termination of pregnancy) as well as improve his or her therapeutic management.

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