A husband falters, his wife falls

Commentary by
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What is the best approach to managing this woman, who has been feeling unsteady, dizzy and increasingly worried about falling since an episode of psychological stress?

Case scenario

Laine, a 55-year-old woman, presented with a complaint of dizziness. A few months previously she had caught her husband having a brief flirtatious texting fling with an overseas colleague whom he had met at an international conference. Nothing physical had resulted, he assured her, and he seemed sincerely to regret his silly behaviour (which is the only time he has done such a thing).

Afterwards, Laine began to find herself becoming unsteady and 'dizzy'. She is also worried about falling, and she experienced a single fall shortly after the conversation in which she confronted her husband about the text messages. As a result, for the past few months she has relied on him or another family member for physical support whenever she has left the house. She is becoming increasingly isolated.

A neurological referral and appropriate scans have been arranged and found no cause for Laine's constant unsteadiness and dizziness. She denies depression and is convinced she has a real, undiagnosed medical condition; indeed, she is cross with the neurologist for not confirming it. She does not want to see a psychiatrist but is willing to see a balance physiotherapist, as long as her husband will accompany her. Her husband is concerned about Laine and wants her to get better.

What is the best approach for managing this patient?

Commentary

My provisional diagnosis for Laine is conversion reaction (also known as conversion disorder or hysteria), and I offer several reasons. Firstly, her symptoms have following a psychological stressor, which supports – but does not prove – a psychogenic cause. Secondly, the neurological symptoms have persisted despite appropriate investigations and reassurance by a neurologist. Thirdly, there is the level of the patient's conviction, despite this reassurance, that she has a neurological problem. A potential fourth reason – that the symptoms and signs on examination are not compatible with a neurological disease – is not provided in the history but might be suspected if the diagnosis of conversion reaction is valid.

Conversion reactions are relatively primitive responses to psychological insults. As detailed by Julian Leff, they have become less common in Western countries as communities have become more sophisticated about psychological and psychiatric states and they are now rarely seen in pure form.[1] Conversion reactions are commonly accompanied by la belle indifférence or a lack of concern about the symptoms, but this is not a requirement for the diagnosis. Conversion reactions are usually unconscious, and therefore contrast with malingering and feigning of illness in which individuals deliberately construct their symptom world. Consequently, individuals with a conversion reaction will generally be extremely indignant if there is any accusation or intimation that they might be 'putting it on'.

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There is usually a psychological message that can be postulated for the symptoms. Examples include a person who claims to be blind because of not wanting to 'see' something or a virginal woman who has great anxieties about intercourse and develops a hemiparesis the week before her wedding. In the case of Laine, her symptoms might be interpreted as a reaction to feeling 'rocked' by her husband's fidelity falter and her need to have him 'support' her and be, in effect, her crutch. If he were to take up this role and become her constant companion (there is a secondary gain component to most conversion reactions) she would effectively have her 'straying' partner on a leash. It is difficult to imagine that her symptoms would improve in this situation.

In managing such a state, confrontation must be avoided. Laine needs to be allowed to retain her dignity – and regain its trammelled components. Her pride has gone before her husband's fall from grace. Rarely does such a patient accept a diagnosis of conversion reaction. This is euphemism territory, although most managing physicians are tempted to suggest that stress has probably played a part in bringing about the condition. And generally to little avail other than for the patient's trenchant denial to offer support of the diagnosis. So, forget psychotherapy. Work around the edges. Offer a strategy that fits with her assumptive world. A useful approach would be to arrange for a physiotherapist to help her develop strategies to 'improve her stability' and 'build up her muscles'. The guilt-ridden husband should be encouraged to not become her phobic companion.

Psychiatrists are often reluctant to diagnose conversion reaction, aware that they risk medical hubris with some neurologist or immunologist salivating to inform them that their patient does instead have some esoteric 'real' condition. There is a history to such diagnostic frissons. In 1965, Eliot Slater, one of the leading academic psychiatrists in London, published a classic paper in the *British Medical Journal*, reviewing and challenging the diagnoses of 112 patients diagnosed with hysteria at the National Hospital in London, and suggesting that most had diseases that had been misdiagnosed or which were to emerge later.[2] He concluded that: 'The diagnosis of "hysteria" is a disguise for ignorance and a fertile source of clinical error. It is in fact not only a delusion but a snare'. It was poor science but resounding rhetoric at the interface of neurology and psychiatry, making even psychiatrists cautious about making a diagnosis of hysteria, and with the proposed alternative diagnoses of many of the 112 patients iterating down the ages. MT

References

1. Leff JP. Psychiatry around the globe: a transcultural view. 2nd ed. London; Gaskell Books: 1988.
2. Slater ET. Diagnosis of "hysteria". Br Med J 1965; 1: 1395-1399.

COMPETING INTERESTS: None.