

DUBLIN BUSINESS SCHOOL

ELIZABETH LENNON

10155277

**THE TREATMENT OF CONVERSION DISORDERS FROM A
PSYCHOTHERAPEUTIC PERSPECTIVE**

**THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF
THE HIGHER DIPLOMA IN COUNSELLING AND PSYCHOTHERAPY**

SUPERVISOR: MR. CATHAL O'KEEFFE

6TH MAY 2016

CONTENTS PAGE

CONTENTS PAGE	1
ACKNOWLEDGEMENTS	2
ABSTRACT.....	3
INTRODUCTION	4
DSM-5	6
THE HISTORY OF CONVERSION DISORDER.....	8
FREUD’S THEORIES OF REPRESSION AND RESISTANCE.....	11
A PSYCHOANALYTIC UNDERSTANDING OF CONVERSION DISORDER.....	13
FREUD’S VIEWS ON WOMEN AND HYSTERIA.....	15
MALE HYSTERIA	18
THE BODY, PSYCHE, LANGUAGE AND THEIR ROLE IN THE SYMPTOM.....	20
A CONTEMPORARY UNDERSTANDING OF CONVERSION DISORDER.....	22
THE ROLE OF THE THERAPIST	24
CONCLUSION.....	25
BIBLIOGRAPHY	27

ACKNOWLEDGEMENTS

I would like to thank Dr. Gráinne Donohue and Mr. Cathal O’Keeffe for their support and direction throughout this research.

ABSTRACT

*The aim of this dissertation is to explore conversion disorders from a psychotherapeutic perspective. This will involve the two discourses of psychiatry and psychoanalysis. The objective of this research is to give the reader a comprehensive understanding of the aetiology and treatment of conversion disorders. There will be an introduction to some of the key historical figures who have studied conversion disorders which was formerly known as hysteria. The scope of this research has largely involved the works of Freud and Breuer, particularly their *Studies on Hysteria*. Additional theorists have been used to illustrate their views regarding the genesis and subsequent manifestation of conversion disorders. This dissertation has been a desk-based endeavour with the findings of the research having opened the author's mind up to the existence of male conversion disorders and their potential gain. The previous belief being that these disorders were largely attributed to women. The principal conclusion that the author has arrived at is based on the belief of Freud and Breuer (1895) that conversion disorders do indeed serve a purpose!*

INTRODUCTION

This dissertation will explore the condition known today as *conversion disorder* from a psychotherapeutic perspective. This will include the discourses of psychiatry and psychoanalysis. The author will present the reader with an understanding of what is meant by the term. The latest version of the *Diagnostic Statistical Manual 5* (DSM-5) will be used in order to give the reader a comprehensive understanding of what is meant by conversion disorder including the criteria that professionals use as a means of diagnosing the condition.

The following section will then examine the history of conversion disorder. Due to word constraints there will be a brief introduction to some of the key figures that inspired the young Freud. Conversion disorder was historically known as *hysteria* which is fundamental to the creation of the school of psychoanalysis. Therefore, an understanding of hysteria will be given to the reader with case examples to support relevant theories throughout.

There will be an exploration of the psychoanalytic concepts of *repression* and *resistance* and the role that they play in symptom formation. This will include examples of the unconscious intrapsychic conflicts that one experiences with this disorder which contributes to the formation of the hysterical conversion.

Freud believed that the role of women was limited and that hysterical symptoms resulted from unrealistic goals and sexual dissatisfaction. This view will be explored further to determine if sexual passivity in women or their denial of a voice played a contributory factor in the manifestation of somatic symptoms. Due to word constraints, the notion of male hysteria will be briefly examined from a specific standpoint. The aim is to demonstrate to the reader its existence and the gains that can be achieved through somatic conversions.

The school of psychoanalysis proposes that traumas that have occurred impact on the ego resulting in the emergence of unexplained somatic symptoms such as those with conversion

disorder. An understanding of the role of the body, psyche and language in symptom formation will be provided.

The final part of this dissertation will look at the contemporary views of conversion disorders. This will include modern thinking styles, prevalent complaints and recommended treatments. There will be some focus on the work of *somatics* however due to word constraints the emphasis will be solely on the work of Thomas Hanna due to the relevance of his techniques with modern symptoms. This dissertation will conclude with the author offering an evaluation of the efficacy of certain treatments for specific conversion disorders.

DSM-5

Conversion disorder is the manifestation of psychological pain into a physical symptom however there is no apparent medical explanation. The resulting symptom(s) experienced by the individual can be either constant or intermittent and are so severe that they interfere profoundly with the person's life on a social, occupational and/or relationship level. The most common symptoms experienced by individuals include paralyses, motor disturbances, involuntary actions, sensory loss, speech symptoms, pains or hallucinations (American Psychiatric Association, 2013).

The authors of DSM-5 have categorised conversion disorder under *Somatic Symptom and Related Disorders*. It is described as a psychiatric condition in which the patient endures physical symptoms however there is no apparent physical cause (American Psychiatric Association, 2013). In order for the patient to be diagnosed with conversion disorder, they must meet several diagnostic criteria as set out by DSM-5.

- The symptom(s) is affecting the motor and/or sensory functions of the body.
- The patient's symptom(s) are characterised by one or more neurological symptoms which are unexplained by medicine or neurology.
- The symptom would appear to have an underlying medical cause however one cannot be found.
- There is no other mental disorder attributing to the symptom.

DSM-5 has expanded the term 'Conversion Disorder' to include Functional Neurological Symptom Disorder (FNSD). This newest edition also provides us with a noticeable shift in the portrayal of conversion disorders. There is evidence to suggest that the authors have tried to classify the disorder in a more positive manner. These changes of attitude have led to the

banishment of the dichotomous (medical or psychiatric) hierarchy (medical first, psychiatric later) that patients used to encounter (Staab, 2015).

Historically, patients were told that their symptoms were ‘stress related’ which left little room for teaching them how to deal with their distress. The shift in thinking of DSM-5 demonstrates more of an appreciation of the physician and patient relationship for the successful treatment of conversion disorder (American Psychiatric Association, 2013). Bakal supports how the school of psychiatry is now looking at conversion disorders from two models. The first model considers the somatic symptom as the result of a defense originating from social or personal problems. The second model concentrates on the negative thoughts that the individual has about their symptoms which are compounding their problems (Bakal, 2001).

The medical model’s approach to conversion disorder has acknowledged the role of unconscious material and its role in symptom formation. The authors are still highly scientific with their diagnosis which is founded due to the fact that some 15%-30% of patients have been later diagnosed with an underlying condition (Thornhill, 2008). However, there is more of an acceptance and understanding of the psychological origin of conversion disorders and the anguish that patients suffer. Marshall provides a comprehensive list of the sensitive manner that doctors should adopt today when engaging with patients of conversion disorder (Marshall, 2015).

The following part of this dissertation will introduce the reader to some of the key figures who studied conversion disorder which was formerly known as hysteria.

THE HISTORY OF CONVERSION DISORDER

Conversion disorder was formerly known as *hysteria*. Theories about the cause of hysteria date as far back as the 5th century BC where the Greek physician Hippocrates believed that the condition was experienced solely by woman and was caused by abnormal movements of the womb. Freud named the condition *hysteria* as he also believed it to be predominantly women who suffered from the disorder. The word hysteria originated from the Greek word *hysteria* meaning *uterus* (Freud, 1901-1905).

The 18th and 19th century saw many studies undertaken on the condition of hysteria. The main personage was the French Neurologist Jean Martin Charcot (1825 - 1893), the French Neuropsychiatrist Pierre Janet (1859 - 1947), Dr. Josef Breuer (1842 - 1925) and Sigmund Freud (1865 - 1939).

Their studies were largely based on women whom they deemed to be suffering from hysteria due to their elusive somatic symptoms. These unexplained symptoms appeared to be caused by psychological stressors. The most common symptoms included speech disorders, contractures, paralysis and hallucinations to name but a few (Freud, 1925-1926). It was Freud who suggested the term 'conversion' to illustrate how the symptom moved from the psychological to the physical (Nasio, 2004, p. 72).

Charcot, Janet and Breuer believed that these unexplained physical symptoms originated from a trauma which had disturbed the patient's nervous system. The hysterical symptom was the result of tension that was not discharged at the time of the trauma (such as that in fight or flight). The psychical energy that was attached to that event would remain in the unconscious until such a time as it re-emerges. The psychotherapeutic benefit being arrived at when the affect is brought into being through speech (Breuer & Freud, 1895).

This form of treatment involved the use of hypnosis and suggestion from the analyst. This allowed the patient to recall certain events thus allowing them to discharge the affect associated with that memory (Borossa, 2001). The affect that was created by the trauma which had been repressed unconsciously as a defense was brought into consciousness thus allowing the patient to achieve catharsis. In doing this, Freud believed that the psychological significance of the symptom would be uncovered thus resolved (Freud, 1905, p. 41).

The efficiency of these techniques is evident when we consider the case of Bertha Pappenheim (Anna O). Although Freud is the father of psychoanalysis, Anna O is widely regarded as the patient with whom it originated. She presented to Breuer with a variety of physical and psychological symptoms. During Anna O's treatment, Breuer noticed that through hypnosis and the repetition of her own words that she would experience distress but soon afterwards her symptoms would thus showing signs of improvement. It was in this act that Anna O herself coined the two terms 'chimney sweeping' and 'talking cure' (Breuer & Freud, 1895, p. 30). Breuer himself witnessed the resolution of some of Anna O's symptoms proving to him how a psychological event which had produced a hysterical symptom could be abreacted through language (Breuer & Freud, 1895).

Charcot had initially been suspicious of the hysteric however his viewpoint changed after the publication of Freud and Breuer's *Studies on Hysteria* (Borossa, 2001). They suggested that there were three principals at play with cases of hysteria. Firstly, they believed that the hysteric's symptoms made sense. Secondly, the trauma was to do with libidinal impulses and thirdly the cure rested in the catharsis of the trauma. The successful treatment of Anna O confirmed this for Breuer. Warwick (2004) later uses the case of Anna O as an example of how success can be achieved through psychoanalytic techniques and the therapeutic alliance. This also supported the three principals that were set out by Breuer and Freud that the

symptoms experienced by the hysteric were not random but had a sense to them and that fundamentally ‘hysterics suffer mainly from reminiscences’ (Breuer & Freud, 1895, p. 34).

From as early as 1893 Freud had suggested that in cases of hysteria the conscious subject was cut off from part of their own representations (Dor, 1998). This suggested to Freud that the unconscious was an autonomous field which was home to repressed memories. The successful resolution in cases of hysteria involved accessing these memories. The school of psychoanalysis was therefore born from the influences of the work of Breuer with Anna O coupled with Freud’s analytic techniques including free association and the use of the transference (Breuer & Freud, 2001).

The following section of this research will discuss Freud’s theories of repression and resistance.

FREUD'S THEORIES OF REPRESSION AND RESISTANCE

Freud believed that the manifest symptom(s) in cases of hysteria were the result of a process which he named as repression (Freud, 1925-1926). Repression being the rejection of something from consciousness which has the potential to cause affects. It exists in our unconscious until such a time as an event awakens the memory thus bringing it into consciousness via dreams or neurosis (Freud, 1915). Freud also believed that the process of repression resulted from resistance. Resistance from a psychoanalytic perspective is the force that opposes psychological ideas from becoming conscious (Freud, 1923 – 1925, p. 14). The work of psychoanalysis involves the removal of this force through the psychoanalytic techniques of free-association and transference. These techniques were later described by Winnicott as the tools necessary for restoring an individual to psychological health (Winnicott, 1986, p. 31).

Freud compounded these theories by suggesting that in cases of conversion hysteria it was the cathexis (mental energy that is invested) of the repressed idea that became the innervation of the symptom and in order to arrest these somatic innervations, the affect must be discharged (Freud, 1915). Breuer's work with Anna O had proven to him that hysterical conversions were due to abnormal expressions of emotion by the body and that the discharging of these emotions was how psychological equilibrium was maintained (Breuer & Freud, 1895).

Freud's theory of repression as a factor in hysterical conversion is evident on considering the work of his student, Wilhelm Reich. Reich's work is important for illustrating how psychological threats/traumas can potentially lead to conversion disorders. Reich's work focused on his theory of muscular 'armouring' and uses the example of a child that is prohibited from crying to demonstrate this theory. In an effort not to cry, the child engages in behaviours such as holding their breath or contracting their facial muscles. However, if this behaviour is

practised regularly, it becomes integrated into the child and so too does the muscular ‘armouring’ that goes with it making it habitual and unconscious (Hoffman, 2009). This example of ‘armouring’ illustrates how what starts out as a defense can become a somatic burden on the individual due to the energy spent in maintaining the ‘armouring’.

This concept is important in the treatment of conversion disorder as it illustrates how the human brain is capable of associating actions with an actual trauma even after the threat has been neutralised (Hoffman, 2009).

Freud’s theories of repression and resistance have been introduced to demonstrate to the reader how they can influence the bodily symptom. The following section will expand on these forces.

A PSYCHOANALYTIC UNDERSTANDING OF CONVERSION DISORDER

The foundation of psychoanalysis is based on the belief that the psyche is divided into a conscious and unconscious. An understanding of how these two entities operate is necessary for working with pathologies such as conversion disorder (Freud, 1923-1925). Psychoanalysis is fundamentally about human sexuality and the unconscious. The development of the subject, their unconscious and their sexuality are all intertwined. This psychosexuality is made up of conscious and unconscious fantasies (Rose, 1982). However, some of these fantasies are painful and bring shame to the individual. As seen earlier, the ego attempts to defend the psyche from these psychogenic pains via repression. The unconscious is home to these repressed complex wishes that cannot be satisfied such as incestuous desires from early childhood (Mitchell & Rose, 1982). Conversion disorder originates from these psychogenic pains. The role of psychoanalysis is to help the client to seek out the origin of the pain thus enabling them to discharge the negative psychological energy that is attached to these complex wishes (Rose, 1982). Examples of this include the ambivalent feelings of love and hate to the 1st other (mother) and the 2nd other (father) that the child can encounter during their psychosexual stages of development. These feelings if not resolved during the child's *oedipal drama* and integrated can result in conflicting emotions thus defense mechanisms by the ego. The resolution of the oedipal drama tackles the child's narcissistic tendencies and their understanding that we are all expendable (Borossa, 2001, p. 65).

Freud had initially thought that hysteria was the result of sexual trauma experienced during childhood. This view changed over time. He went on to believe that internal factors such as the hysteric's own fantasies or desires and the anxiety that they produced were the cause (Freud, 1905). Freud named this infantile sexuality and added that it was the traumatic autoerotic libidinal energy that arose in the child's body during the psychosexual phases of development which affected the ego that resulted in pathogenic disorders. Each case of

hysteria that he encountered was marked by some premature sexual experience (Freud, 1896). This hypothesis is still popular in more contemporary times. Nasio also believed that the undischarged energy from early sexual encounters was the primary causal factor in hysterical conversions (Nasio, 1998).

The ensuing symptom is the ego's way of defending itself from repression by taking the language of the drives from within and translating them to emotions that reveal themselves in consciousness (Nasio, 2004). This repressed material acts as a compromise of sorts between the id and the ego. The neurosis that ensues is the result of the ego's fight against the symptom (Freud, 1923-1925). The hysterical symptom is the ego's struggle with defense and resistance. The psychical force that the ego has driven out of consciousness via repression is now being resisted by the ego thus hindering the patient from curing the symptom. In fact, this is the hysteric's 'not knowing' the cause of their symptom being in fact the 'not wanting to know' the cause of their symptom (Freud, 1895, p. 270). Freud uses the case of the Wolfman to demonstrate why a patient would engage in such behaviour. The genesis of the symptom originates from the individual's unconscious feelings of guilt arising from experiencing pleasure/satisfaction and their unconscious need for punishment (Freud, 1925-1926, p. 98).

The following part of this dissertation will discuss Freud's views on women and hysteria.

FREUD'S VIEWS ON WOMEN AND HYSTERIA

Freud spent much of his career attempting to answer the question “what does a woman want” (Jones, 1955, p. 421)? Freud was a man of his times and his views on women were based in a time when many prejudices about women and their capabilities existed. Freud believed that women manipulated their environments to meet their own requirements and that their hysterical symptoms satisfied some primary or secondary gain (Freud, 1925).

Female sexuality perplexed Freud and he believed that women were restricted by their biology as they did not have a penis. Consequently, they never realised their sexual development and it was the repression of their sexual desires that were the root cause of hysteria (Freud, 1925). This *penis envy* for Freud was the male equivalent to castration anxiety occurring during the phallic stage of psychosexual development when girls move away from their mothers and devote themselves to their fathers in order to symbolically 'gain' a penis. They later realise that they can't identify with their father/'gain' a penis as they are girls and seek to have children instead (Freud, 1933). Freud's views were criticized by female psychoanalyst Karen Horney as being degrading to women. She had her own concept of male inferiority believing that men suffered from *womb envy* and that they were jealous of women as they could not have children. However, Freud believed this to be Horney's *penis envy* in action (Freud, 1933).

Helene Deutsch was the first woman to join Freud's Vienna Psychoanalytic Society in 1918 and like Freud also believed in women's sexual inferiority to men. Deutsch believed that the inferiority of the female clitoris was responsible for little girls growing passive and turning away from their active sexuality (Deutsch, 1925). Freud believed that these repressed sexual desires were fundamental to symptom formation adding that hysterical patients were

unconsciously capable of somatising things that they did not want to know as they were typically repressed fantasies of sexual seduction (Freud, 1895).

The link between woman's dissatisfaction and hysteria was rife in the late 19th and early 20th century discourse. Attempts were even made to discredit the suffragettes with accusations of hysteria due to the fact that they inhabited a patriarchal society of inequality and were deprived of a voice. The lack of recognition, acknowledgment and oppression contributing to the mechanism of repression as is characteristic of the hysteric (Gallagher, 1995).

Freud and Breuer (1895) argued that many of their patients were intelligent women however it was clear from their case studies that some of these women were experiencing frustrations in their social settings. This was not a novel idea. Gallagher also suggested that the etiology and symptomatology of hysterical symptoms were there to highlight frustrations and dissatisfactions with one's place in society. The unconscious desire that had not been acknowledged was forced to express itself as the difficult and burdensome symptom (Gallagher, 1995). However, an argument could be made that the hysterical symptom acted as an unconscious tool of empowerment for some of these women. For example, Anna O ended up being a pioneering figure in the German women's movement in which she dedicated herself to issues around women's welfare (Borossa, 2010).

Gallagher (1995) also theorised that questions regarding existence and sexuality if left unanswered could cause pathology adding that this was not exclusive to women. The answering of two fundamental questions was where the hysteric's resolution lay. The questions of 'who do you say that I am' and 'is my body lovable as a man or a woman' (Gallagher, 1995, p. 115). Gallagher believed that the symptom was an unconscious tool used by the hysteric in an effort to find someone who could help them to answer these questions.

This theory has the same basis as Freud's theory of *somatic compliance* which pointed to the vulnerable time when there is a lack of unity and identity in the hysteric (Gallagher, 1995).

As briefly mentioned in the above paragraph, hysteria was a complaint that was not exclusively attributed to women. The following section will look at the existence of male hysteria providing the reader with examples to highlight its prevalence.

MALE HYSTERIA

The 19th century discourse surrounding men and hysteria was very different to that of women. It was believed that men suffered distress due to physical shocks rather than psychical ones (Borossa, 2001, p. 57). Male hysteria was first acknowledged in the trenches of World War 1. These *war neuroses* that doctors witnessed took on many different forms including conversion hysteria, somatisation, phobias and disorders relating to thoughts, sensations and consciousness (Gunther & Trosman, 1974). Doctors of the time referred to the condition as *shell-shock* in an effort not to de-masculine the patient but also as there was no known precedent (Borossa, 2001).

Studies dating as far back as the early Greeks suggested that hysteria was a condition exclusive to women however modern studies have proven this not to be the case. Ustinova & Cardena (2014) illustrate how conversion disorders in men were identified as far back as 490 BC at the Battle of Marathon where the Greek soldier Epizelus witnessed the brutal killing of another soldier. Epizelus was not harmed himself during the altercation however he inexplicably lost his sight. This example of psychogenic blindness was common amongst soldiers of that time and later through history and was referred to as *hysterical blindness*. Other conditions included *surdomutism* which was the inability to speak (Ustinova & Cardena, 2014).

The primary and secondary gain of these symptoms in conversion disorder is easy to comprehend when the symptom becomes a solution to the burden of male masculinity (Bakal, 2001). War is an unnatural activity that is full of horror, fear and hate (Forrest, 2005). On considering the traumatic situations that soldiers find themselves in, it is easy to understand the underlying motive that one would enjoy from the development of a conversion disorder.

The most prevalent complaints that soldiers of modern times present with include symptoms affecting their sensations, movements and speech (Schauer & Elbert, 2010). Freud and Breuer (1895) proved that the symptom is there to fulfil certain purposes. In this example the purpose being that the individual does not want to be ill but they also do not want to be present in a terrifying combative environment (Gunther and Trosman, 1974).

The following section of this dissertation will look at the role of the body, psyche and language in the formation of symptoms.

THE BODY, PSYCHE, LANGUAGE AND THEIR ROLE IN THE SYMPTOM

The connection between the body, mind, language and the symptom is widely regarded as the work of psychoanalysis. Successful treatments require looking at these from a holistic point of view. Bakal highlighted this when he stated that "the mind and body flourish or perish together" (Bakal, 2001, p. 2). The role of language in symptom formation is crucial as it acts as a substitute for an action. Language allows the affect to find an outlet through speech. As already stated, the purpose of this is to help an affect reach a catharsis thus allowing the individual to rid themselves of the troubling symptom (Breuer & Freud, 1895).

The body in psychoanalysis is viewed as 'an enjoying substance'. However 'enjoying' depicts pleasure and displeasure (Carbonell, 2015, p.91). Lacan summed it up well when he suggested that the unconscious is structured like a language and the body is its writing pad (Verhaeghe, 2001). Lacan believed that the formation of symptoms in the body was the result of language. Many other theorists have put this idea forward too. Zizek suggested that symptoms emerge in the body when symbolic communication has broken down resulting in the body finding its own way to communicate the failed or repressed words or memories in a coded and ciphered form (Zizek, 1989). The viewpoints of these theorists have been used to illustrate how primordial the relationship is between the body, psyche and language in symptom formation. In order to fully grasp some understanding of how psychical troubles can cause physical symptoms, it is imperative that there is an appreciation of this intricate relationship. It is in the failing of the coming together of language and the body in a coherent manner that results in symptoms such as those that are experienced in conversion disorders (Carbonell, 2015).

For Freud these bodily expressions were the symptoms way of joining in on the conversation and making their presence known (Freud, 1895). The part of the body that would be targeted by the symptom is arrived at with 'extraordinary acuity' via the ego (Nasio, 2004, p. 16) with the affected bodily region acting like a 'somatic imprint' (Nasio, 2004, p. 73).

Symptoms are unconscious desires which seek to manifest themselves somatically in order to serve a purpose. For Freud and Breuer (1895) they go beyond the pleasure principle as they produce pleasure but psychoanalysis has taught us that pleasure can also be unpleasant. Lacan believed the symptom or 'signifier' is the body's way of finding release from excessive satisfaction or *jouissance*. This *jouissance* represents a satisfaction that has gone beyond the pleasure principle. The case of Little Hans illustrates these theories on considering the *jouissance* that the boy enjoyed from his masturbatory habits and the libidinal attachment that he had to his mother. The symptoms experienced by Little Hans were examples of how signifiers serve a purpose. In this particular case, they served as the unconscious tools which ultimately helped Little Hans resolve his oedipal drama (Carbonell, 2015, p. 91).

A CONTEMPORARY UNDERSTANDING OF CONVERSION DISORDER

The modern treatment of conversion disorders varies depending on the symptom that the patient is presenting with. There are several conditions that are prevalent in modern clinics including Irritable Bowel Syndrome (IBS), fibromyalgia, seizures, non-cardiac chest pain, chronic fatigue syndrome (CFS) which professionals are attributing to the condition (Bakal, 2001, p. 28). As already illustrated there has been a notable shift in thinking styles particularly with the authors of DSM-5 regarding the treatment of these conditions. There is more encouragement for the practise of techniques such as those of *somatic awareness*. Somatic awareness aims to get the patient to understand that their thoughts can play a part in their symptom (American Psychiatric Association, 2013). The therapeutic approach involves teaching the patient how their thoughts, feelings and bodily symptoms are all intrinsically linked. This form of cognitive restructuring allows for patients to learn new ways of changing old thought processes thus allowing for new ones (Bakal, 2001).

Thomas Hanna spent much of his career emphasising the relationship between the body and the psyche and how they work together as one. Hanna believed that all things physical began internally and that our inner structure had no other way to manifest itself but in our physical structure. Hanna devised somatic procedures to help patients who were suffering with muscular and/or restrictive movements associated with conversion disorder (Hanna, 1991). These forms of treatment tackle Motor Sensory Amnesia (MSA). The viability of treatments such as these is evident on reconsidering the theory of ‘armouring’ as suggested by Reich in which certain muscles had basically forgotten how they were supposed to function. Hanna’s techniques work by teaching the patient exercises in order to reverse their specific form of MSA (Thomas Hanna, 2016). However, a shortcoming of this technique is that they take time to master and therefore would not be suitable as a short term treatment.

Contemporary attitudes in psychiatric discourse show us that there is more of an appreciation of the physician and patient relationship for the successful treatment of conversion disorder (Fritz et al., 2013). These attempts illustrate the efforts that are being made to remove the stigma via a more positive portrayal of conversion disorder. This has allowed for additional treatments such as *cognitive behavioural therapy* (CBT) to be employed. This form of psychotherapy has achieved credible results in patients who have presented with chronic symptoms such as seizures that are psychogenic in nature (Lifespan, 2014). CBT teaches patients techniques such as *cognitive restructuring* which encourages them to be aware of their thought patterns. This form of therapy also empowers the individual giving them a greater sense of control (Gillett, 2009).

A shortcoming for the use of CBT is that it is generally regarded as a short term form of therapy. The treatment of conditions such as psychogenic seizures would suggest a longer time frame necessary for recovery. This suggests that the severity of the conversion disorder should determine the form of treatment. Patients with conversion disorders due to traumatic encounters such as those illustrated in the section on *male hysteria* would require a more sensitive approach of therapy. While Freud and his colleagues would have encouraged an emotional engagement with the patient, the clinician must always be aware of the threat of re-stimulation. In cases such as these, history would support the practise of psychoanalysis as the more efficient approach. As discussed in the case of Anna O, it is evident how the use of psychoanalytic techniques combined with the therapeutic alliance can provide meaningful results. Alongside CBT, relaxation techniques are a popular choice of treatment however Schauer & Elbert (2010) add that these forms of treatment are not appropriate or useful in conversion disorders which are attributed to traumas.

THE ROLE OF THE THERAPIST

The role of the therapist is to help the client uncover how their psyche has been affected and find an appropriate course of action thus helping the individual regain some control through helping them make sense their symptom (Jameson, 1996). The psychotherapist encourages some form of distress in their client as a means of helping them to uncover their symptoms. In severe cases, the integration of other interventions such as pharmacotherapy has been acknowledged as being synergistic. These simultaneous treatments allow the client to embark on their journey of understanding and behaviour change while enjoying symptom reduction (Beitman et al., 2003).

CONCLUSION

The first chapter of this dissertation acquainted the reader with the condition of conversion disorder. The DSM-5 was the textbook used due to its relevance in psychiatric discourse. The author explored some of the shifts in the thinking as per the authors of DSM-5 including their steps to include psychoanalytic theories and their newfound emphasis on the doctor/patient relationship.

The subsequent section examined the history of conversion disorders. In doing so, the author introduced the reader to the term hysteria including some of the pioneering theorists in the field. Their techniques for dealing with cases of hysteria were introduced thus providing the reader with a brief understanding of how the school of psychoanalysis came into being. In addition, some case examples were used throughout this dissertation to highlight relevant theories.

The psychoanalytic concepts of repression and resistance and the intrapsychic conflicts that they produce were explained in order to illustrate how a symptom can manifest itself in the body. To compound this point, the role of the body, mind and language was explored to demonstrate to the reader how fundamental their relationship is in symptom formation. Examples were used to show how a symptom can emerge and why it affects a specific part of the body.

There was an introduction to the role of sexual trauma in cases of hysteria. This led the author to explore Freud's views on women and hysteria. The theory of symptom formation arising from women not being content with their place in society was examined. This led the author to explore male hysteria and the role that it played in unconscious symptom formation.

The following section looked at some of the complaints that patients are presenting with in modern settings which are being attributed to conversion disorders. The increasing use of

somatic techniques was discussed with emphasis on the work of Thomas Hanna. The author offered an understanding of some psychotherapeutic techniques and their relevance for the treatment of specific conversion disorders.

To conclude, there is a vast amount of material on the subject of conversion disorder hence the brief introduction to certain areas. The main limitation encountered during this research was the word count. This dissertation has raised some questions which could be explored further. The research surprisingly illustrated that cases of hysteria was not exclusive to women and that conversion disorders were rife amongst men through history. This finding was briefly explored from a combative perspective to highlight the gain that an individual can enjoy from unconscious symptom formation as those of conversion disorder. However, a future study regarding the prevalence of male conversion disorders would be welcomed due to the author's initial belief that the condition was widely limited to women.

BIBLIOGRAPHY

- Aguayo, J. (1986). Charcot and Freud: Some Implications of Late 19th Century French Psychiatry and Politics for the Origins of Psychoanalysis. *Psychoanalysis & Contemporary Thought*, 9(2), 223-260.
- Association, A. P. (2013). *Diagnostic and Statistical Manual of Mental Disorders (5th Edition)*. Arlington, VA: American Psychiatric Publishing.
- Bakal, D. (2001). *Minding the Body: Clinical Uses of Somatic Awareness*. New York: Guilford Publications.
- Benvenuto, B., & Kennedy, R. (1986). *The works of Jacques Lacan: An introduction*. United Kingdom: Free Association Books.
- Bernard D. Beitman, B. J. (2003). *Integrating Psychotherapy and Pharmacotherapy: Dissolving the Mind-Brain Barrier*. New York: W.W. Norton & Company, Ltd.
- Borossa, J. (2001). *Hysteria: Ideas in Psychoanalysis*. Cambridge: Totem Books.
- Bowie, M. (1991). *Lacan (modern masters)*. Hammersmith, London: Fontana Press.
- Breuer, J., & Freud, S. (2001). *The Complete Psychological Works of Sigmund Freud: Studies on Hysteria Vol. 2*. London: Vintage Classics.
- Carbonell, N. (2015). The Knotting of Language and the Body in Childhood. *Lacunae Issue* 10, 87-101.
- Cavasola, R. (2016). A Reading of Contemporary Hysteria from Lacan's Teachings. *European Journal of Psychoanalysis*.

- Deutsch, H. (1925). *Psychoanalysis of the Sexual Functions of Women*. London: Karnac.
- Dor, J. (1998). *Introduction to the Reading of Lacan: The Unconscious Structured like a Language*. New York: Other Press (NY).
- Education, H. S. (n.d.). *About Hanna Somantics*. Retrieved from hannasomantics.com:
http://hannasomantics.com/index.php/about_somatics/history_and_founder/
- Eysenck, H. (1965). *Fact and Fiction in Psychology*. London: Penguin.
- Forrest, D. V. (2005). Elements of Dynamics VI: The Dynamic Unconscious and Unconscious Dynamics. *Journal of the American Academy of Psychoanalysis*, 33(3), 547-560.
- Freud, S. (1915). *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIV (1914-1916)*. London: The Hogarth Press.
- Freud, S. (1917 - 1919). *The Standard Edition of the Complete Psychological Works of Sigmund Freud An Infantile Neurosis and Other Works Vol. XXVII*.
- Freud, S. (1925). *The Physical Consequences of the Anatomic Distinction Between the Sexes*.
- Freud, S. (1925). *The Standard Edition of the Complete Psychological Works of Sigmund Freud Vol. 19*. London: The Hogarth Press.
- Freud, S. (1925-1926). *The Standard Edition of the Complete Psychological Works of Sigmund Freud Vol. XX An Autobiographical Study, Inhibitions, Symptoms and Anxiety, Lay Analysis and Other Works*.
- Freud, S. (1933). *New Introductory Lectures on Psychoanalysis*. New York: Norton.

Freud, S. (2001). *The Standard Edition of the Complete Psychological Works of Sigmund Freud Vol. XIX (1923 - 1925) The Ego and the Id and Other Works*. London: Vintage.

Freud, S. (2001). *The Standard Edition of the Complete Psychological Works of Sigmund Freud: A case of hysteria. Three essays on sexuality and other works (1901-1905)*. London: Vintage.

Gallagher, C. (1995, Spring). *Hysteria: Does it Exist?* Retrieved from Lacan in Ireland:
<http://www.lacaninireland.com/web/wp-content/uploads/2010/06/Hysteria-Does-it-Exist-Cormac-Gallagher.pdf>

Gillett, G. (2009). *The Mind and its Discontents*. Oxford: Oxford University Press.

Grundy, D. (2001). Hysteria: Where has it Gone? *Contemporary Psychoanalysis*, 37(2), 335-353.

Gunther, M., & Trosman, H. (1974). Freud as Expert Witness; *Wagner-Jauregg and the Problem of the War Neuroses*. 2, 3-23.

Hanna, T. (1991). Somatics. *Journal of the Bodily Arts and Sciences*, Vol. VIII (2), 50-56.

Henn, F., Sartorius, N., Helmchen, H., & Lauter, H. (2013). *Contemporary Psychiatry*. Mannheim: Springer Science & Business Media.

Hoffman, D. (2009, May 22). *Wilhelm Reich - Armouring*. Retrieved from No Nonsense Psychology: <http://nonnonsensepsychology.blogspot.ie/2009/05/wilhelm-reich-armoring.html>

Interactive. (2016, April 21). *Muscle Spasms in Back - Stiff Neck - Muscle Spasm*. Retrieved from Association of Hanna Somatic Education:
http://hannasomatics.com/index.php/about_somatics/what_is_somatics

- Jameson, K. (1996). *An Unquiet Mind*. London: MacMillan.
- Jones, E. (1955). *The life and work of Sigmund Freud (Vol. 2)*. New York: Basic Books.
- Lacan, J., Rose, & J, t. b. (1982). *Feminine Sexuality*. London: Palgrave Macmillian.
- Lifespan. (2014, July 2). *New approach to treating conversion disorder reduces seizures, improves co-morbid symptoms*. Retrieved from Science Daily:
<https://www.sciencedaily.com/releases/2014/07/140702170028.htm>
- Marshall, S. (2015, November 9). *Conversion Disorders Treatment & Management*. Retrieved from emedicine.medscape.com:
<http://emedicine.medscape.com/article/287464-treatment>
- Mitchell, J., & Rose, J. (1982). *Feminine Sexuality: Jacques Lacan and the école freudienne*. London: The MacMillan Press Ltd.
- Nasio, J. (2004). *The Book of Love and Pain: Thinking at the Limit with Freud and Lacan*. New York: SUNY Press.
- Nasio, J.-D. (1998). *Hysteria from Freud to Lacan: The Splendid Child of Psychoanalysis*. New York: The Other Press, LLC.
- Radden, J. (2007). *The philosophy of psychiatry: A companion*. United States: Oxford University Press.
- Schauer, M., & Elbert, T. (2010). Dissociation Following Traumatic Stress: Etiology and Treatment. *Journal of Psychology, 218(2)*, 109-127.
- Silverstein, C. M. (2008). From the Front Lines to the Home Front: A History of the Development of Psychiatric Nursing in the U.S. During the World War II Era. *Issues in Mental Health Nursing, 29(7)*, 719.

- Sklar, J. (2008). Hysteria and Mourning - A Psychosomatic Case. *Journal of the American Academy of Psychoanalysis*, 36(1), 89-102.
- Skues, R. A. (2006). *Sigmund Freud and the history of Anna O.: Re-opening a closed case*. Basingstoke: Palgrave Macmillian.
- Staab, J. (2016, March 22). *Somatic Symptom Disorders Part III: Fallacy of Medically Unexplained Thinking*. Retrieved December 16, 2015, from YouTube:
<https://www.youtube.com/watch?v=LQWfU-h6kHM>
- Stern, D. N. (1998). *The Interpersonal World of the Infant: A View from Psychoanalysis and Development Psychology*. New York: Karnac Books.
- Strachey, J. (2001). *The Standard Edition of the Complete Psychological Works of Sigmund Freud*. London: Vintage.
- Thornhill, J. (2008). *Psychiatry*. Columbia, South Carolina: Lippincott Williams & Wilkins.
- Tolpin, M. (1993). The Unmirrored Self-Breuer's Case History of Anna O. *The Unmirrored Self, Compensatory Structure, and Cure: The Exemplary Case of Anna O*, 157-177.
- Ustinova, Y., & Cardena, E. (2014). Combat Stress Disorders and their Treatment in Ancient Greece. *Psychological Trauma: Theory, Research, Practice, and Policy* 6(6), 739-748.
- Verhaeghe, P. (2001). Beyond Gender. From Subject to Drive. *Subject and Body. Lacan's Struggle with the Real*, 65-97.
- Winnicott, D. (1986). *Home is where we start from (Essays by a Psychoanalyst)*. London: Penguin.
- Zizek, S. (1989). *The Sublime Object of Ideology*. London, New York: Verso.

