Psychotherapy for Patients with Hysterical Neurosis

Conversion Type

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ACCORDING to American Psychiatric Association's Diagnostic and Statistical Manual (DSM 11), Hysterical Neurosis is characterized by an involuntary loss or disorder of physiological functioning. Symptoms characteristically begin and end suddenly in emotionally charged situations and are symbolic of internal conflicts of which the patient is unaware. In conversion, the special senses or voluntary nervous system are affected causing symptoms such as blindness and anaesthesia. The patient shows a flat effect known as Labelle Indifference.

History: Mrs 'X', 31-year old, married for 9 years and having two children, one boy aged 5½ years and girl, 6 months, was admitted in the Psychiatric Ward with symptoms of Hysterical Neurosis, conversion type, which consisted of continuous and often violent jerky movements of right shoulder for two weeks.

She was apparently well till about 2 weeks before admission. She started having uncontrollable jerky movements of right shoulder after an argument with her brother.

Present History: Mrs 'X' returned to India from Germany along with her family working there for nearly 9 years. They wanted to settle down in India.

While in Germany her own brother borrowed 1½ lakh rupees under the promise that he would give them a share in the truck which he bought with that money. The patient came to know that he had not done so and she concluded that there was no hope of getting the money back. Then she sent her brother-in-law (husband's younger brother) who was also in Germany to get the truck back from her brother and start the business separately. He did so, but from him also no money was recovered as her husband was a non-assertive and dependent personality. Moreover, the patient discovered that her in-laws were quietly drawing money from her husband. When she came to know this she became very panicky thinking she would have no money left.

Patient's Developmental History shows that she was an aggressive, demanding and a hypersensitive person.

Past-History: About 12 years earlier her elder sister died leaving behind two small children. She could not bear with her death as well as the condition of the children and developed hysterical paresis of legs and recovered after one year.

When she was married off, her husband refused to accept any dowry as he was happy to have her as his wife. Her parents did not offer anything substantial to her, something a girl would like to have. She had the feeling all the time that she was given in marriage as if she was an orphan. She had not forgiven them. Her own brothers did not bother about her welfare. Added to this, she was cheated by her brother.

On their return to India she felt her in-laws were rejecting her. The father-in-law demanded money from her husband and she felt, he was willing to give them money. She became very angry as well as anxious.

One day when she came to her parent's house, the brother, who cheated her also arrived. She demanded an account of the money which ended in heated arguments. She felt like hitting him but did not, and instead she started having jerkey movements of the right shoulder which she could not control. In this condition she was brought to the hospital. While in the Psychiatric Ward it was observed that while sleeping the jerkey movements stopped. However, as soon as she got up, the shoulder tremors started uncontrollably.

The patient was given Tab Librium 10 mgm b-d and 20 mgm H.S. However, symptoms remained the same. Then, Psychotherapy was suggested.

Myself and a co-therapist started a short-term psychotherapy which consisted of 10 sessions.

Clinical interviews indicated the following:

She was angry (repressed her anger); Was very anxious (converted into somatic symptoms); Was depressed due to repressed anger; Narcissistic; Dependent; Manipulative; Environmental stress of home situation was very high. Another symptom appeared as non-verbal communication intended to coerce her husband to some action and paying attention to her.

Goals of therapy were formulated as follows:

Resolution of anger; Lifting of depression; Reduction of anxiety; Facilitate communication between patient and her husband; Teach her assertive behaviour with her brother and in-laws; Map out goals with a well defined and practical action programme. Establish independence and own up responsibility for her behaviour.

Therapy methods used were :

1. Gestalt : "Gestalt Therapy is a type of psychotherapy. It focuses on the awareness of the person's here-and-now experiences rather than on past recollections or future expectations". Several techni-

ques are used and bring about an integrated awareness of experiences, feelings and thinking.[1] One of the skills used is :

A. Double Chair Method : The goal was to experience anger and resolve it. It was tried twice. She did successfully and felt much relieved.

B. Flooding : When the patient was withholding emotions or withdrawing from the actual anxiety situation, she was given a massive doze of anxiety provoking stimuli; this, under therapeutic intervention makes the patient resolve the crisis.

2. Abreaction Method : To lift depression as well as anger. "Abreaction is a process by which the repressed material, particularly a painful experience or a conflict, is brought back to consciousness. In the process of abreacting the person not only recalls, but relieves the repressed material, which is accompanied by the appropriate affective response."[2]

3. Rational Cognitive Therapy : To set goals and plan of action.

4. Confrontation Method to establish independence.

5. Skills in communication.

6. Aversive Therapy : In this we used ammonia : "Aversive Therapy is a form of conditioning whereby an individual is made to associate an unpleasant or painful experience with undesirable behaviour in an effort to eliminate the undesirable behaviour patterns."[3]

1. Alfred M. Freedman, H.I. Kaplan and B.J. Sadock, *Modern Synopsis of Comprehensive Textbook of Psychiatry* (U.S.A: The Williams and Wilkins Co/Bathimore, 1972) p. 769.
2. Alfred M. Freedman, p. 749.
3. Alfred M. Freedman, p. 754.

We had about 10 sessions with her. In the first few sessions whenever she narrated the painful experiences her right shoulder jerk accelerated. She became more anxious. To reduce anxiety injection Diazapam, 10 mgm I/V or I/M was given.

Medication : She was put on : 1. Tab Sintamil : 75 mgm H.S oral x 7 days, 2. Cap. Seconal : 50 mgm THS P.R.N. x 7 days, 3. Tab Librium 10 mgm b.d and 20 mgm H.S. x 7 days.

As her anger, anxiety and depression decreased the jerky movements of right shoulder also decreased.

After 13 days of hospitalization jerkey movements of right shoulder completely stopped, she was allowed to go to the city for a change. She remained alright throughout.

Of the seven goals established prior to the therapy session, anxiety, anger, depression were resolved, facilities in communication increased, she had established some workable goals and had mapped out an action programme to lead a happy life.

On the 14th day of hospitalization she was discharged.

References

1. Alfred M. Freedman, H.I. Kaplan and B.J. Sadock. *(Modern Synopsis of Comprehensive Textbook of Psychiatry,* (U.S.A. The Williams and Wikins Co., 1972), p. 769, p. 749, p. 754.
2. Ivor R.C. Batchelor. *Henderson and Gillespie's Textbook of Psychiatry,* London, Oxford University Press, 1963, p. 156-162.
3. Charles K. Hofling, Madleine M. Leininger, *Basic Psychiatric Concepts in Nursing,* J.B. Lippincott Co., Toronto, 1967, p. 219-228.
4. Mary Topalis and Ruth V. Matheney, *Psychiatric Nursing,* 5th ed. The C.V. Mosby Co., Saint Louis, 1970. p. 178-190.

The Student as a Nurse

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you go to the clinical area. It is important to remember (1) all the steps, (2) what equipment you will need, and (3) the technique to follow so that you will bring comfort and relaxation to the patient and carry out the procedure in such a way that the patient will have confidence in you.

One rather discouraging thing about learning is that sometimes we seem to be going along very well, and then we more or less come to a standstill. This is called a learning plateau. Sometimes it seems if we have to absorb and digest what has been presented before going on to new material.

Sometimes our emotions block our success in learning—we may not "like" a particular teacher, we may not feel we have had a "fair deal", or we may have personal or family problems. Whatever may be the reason, we are not likely to learn well when emotionally upset. If the problem is one that you yourself cannot solve, it may be wise to consult with your advisor, your physician, or the director of the school.

Guidance and Counselling for Students

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who is older and more mature, understands behaviour of a nursing student and is sympathetic to her or his problems.

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3. Gardon, Ira, J. *The Teacher as Guidance Worker.* New York : Harper and Brothers Publishers, 1956.
4. Longhary, John W. *Counselling in Secondary Schools,* New York : Harper and Brothers, Publishers, 1961.
5. Ingmire, Alice E. 'Functions of a Guidance Programme'. *AJN* (Sept., 1943 43.9 pp 839.45.
6. Slaldirg Engenia K. 'Planning for Guidance, *AJN* (1941). 41 : S pp. 940.42.