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Brief Reports

Conversive Hallucinations

Conversive hallucinations are rare in the psychiatric literature. The authors present a case which demonstrates the psychogenesis and phenomenology of conversive hallucinations in a young female patient.

Hallucinations are usually considered to be psychotic in nature. Conversive hallucinations are very rare. Nemiah (1980) stated that they are rare and usually visual in nature, and are of complex scenes of fragments of action that appear repeatedly and with stereotyped repetition after reproducing the scenes of a real past event of emotional significance to the patient. Farley *et al* (1968) defined conversive symptoms as "neurological symptoms (excluding pain) which are clinically inexplicable". They have reported that the hallucinations occurred as conversive symptoms in 12 of 100 unselected post partum cases. Hirsch & Hollender (1969) described conversive hallucinations in hysterical states. Levinson (1966) reported on an hysterical patient who had auditory hallucinations. McKegney (1967) described two cases of auditory hallucinations as a conversive symptom. Fitzgerald & Wells (1977) described a complex of visual and auditory hallucinations in a young woman as a conversive reaction. Modai *et al* (1980) reported on conversive hallucinations, visual and auditory in nature. Andrade & Srinath (1986) reported on true auditory hallucinations as a conversive symptom in a 10-year-old girl.

Case report

Mrs H – a 28-year-old woman, born in Israel, of Iraqi origin, married and mother of three children – was admitted to Geha Psychiatric Hospital, Israel, because of increased psychomotor activity and visual and auditory hallucinations. She was the third of eight children. The domestic atmosphere was very difficult and tense. She worked in various jobs from the age of 10 years, when her studies stopped. She never felt well at home, and at the age of 15 years she left home and married a 21-year-old man, a delinquent and drug addict without permanent occupation. She gave birth to three daughters. The family lived on welfare funds and Mrs H worked from time to time as a cleaning woman. Her husband was put in jail for long periods for drug-pushing. Mrs H was left alone to cope with the hard reality. While he was at home, her husband exhibited violent behaviour towards his wife and daughters. Despite the constantly deteriorating relationship, she refused to divorce him.

A week before her admission, her husband was discharged from jail and demanded that she give him money for drugs. Mrs H reacted to this demand with increased anxiety, lay in bed, refused to eat or talk, and became restless every time someone tried to contact her. At this stage she was admitted to our psychiatric ward.

On admission, her restlessness, apprehensiveness, anxious affect, and visual and auditory hallucinations were prominent. Her consciousness was clear and her temporal and spatial orientation were intact. She did not exhibit any delusions. The auditory hallucinations were peoples' voices in her ear that prohibited her to eat and talk and threatened to murder her if she talked to anyone. The visual hallucinations were composed of tiny monsters having a human body without a definite colour, very figuratively, that appeared while her eyes were closed at a distance of 5–6 m. Their appearance and disappearance was sudden and they frightened her very much. The hallucinations were tension and spatial-dependent: they appeared only at her home in the presence of her husband. She had insight that the hallucinations were not real. Her physical examination was intact. Her laboratory tests were within normal range. Her electroencephalograph and computerised tomography of the brain were normal.

The patient was diagnosed as having a histrionic personality disorder with conversive hallucinations. This diagnosis was based on her overly dramatic and intensely expressed behaviour, as manifested by exaggerated expression of emotions, incessant drawing of attention to herself and overreaction to minor events, egocentricity, demanding, and dependence and constant seeking of reassurance. She was treated with diazepam 5 mg t.i.d. and psychotherapy.

Twelve hours after her admission the tension, anxiety, and hallucinations disappeared and she resumed her normal level of functioning. After several days she went home for a short time, and the hallucinations recurred at night with the same characteristics as described above. She was brought back to the hospital and as she entered the ward she calmed down and the hallucinations disappeared. During her stay in hospital, together with the individual psychotherapy she and her husband were treated with couple psychotherapy. She was discharged after six weeks in a good remission. At six-month follow-up the hallucinations had not reappeared.

Discussion

Mrs H suffered from two types of hallucinations, namely visual and auditory, while awake. Her visual hallucinations were very primitive and naive. Visual hallucinations of this type, not real, that appear

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in the inner subjective space out of the dark fields of the eyes with a sense of distance, and suddenly appear and disappear, might be termed pseudo-hallucinations according to Kandinsky, as cited by Jaspers (1963).

These hallucinations had frightened Mrs H, who was in a state of permanent anxiety because of her husband's threatening and her incompetence to cope with his violent behaviour. The hallucinations were an expression of her ambivalent projected aggression towards her husband, a feeling and attitude that were very prominent in her from childhood, when the object of this ambivalence was her father. Her aggressive drives towards her husband and her desire to get rid of him were suppressed by very deep guilt feelings and a fear of being punished for these drives and prohibited wishes. In this way she was able to escape from guilt feelings and at the same time to express her aggression towards him. Using Engel's criteria (1970), this patient was expressing clinically a conversive phenomenon. Engel described four targets of the conversive symptom:

(a) allowing the expression of prohibited wishes (in our case it was a wish to escape from punishment because of her deep guilt feelings);
(b) punishment through guilt feelings (the patient punished herself by becoming ill and suffering from frightening hallucinations);
(c) avoidance of a threatening situation (Mrs H's detention in hospital let her run away, at least temporarily, from coping with her husband's behaviour and attitude toward her);
(d) accepting the sick role (and indeed she received a new role – that of a psychiatric patient).

We can see that our patient had expressed through the conversive hallucinations all four of Engel's criteria. The symptoms originated as a consequence of psychological stress and their appearance offered the patient an escape from a life-threatening situation. Freud (1948) wrote: "flight from a disturbing life situation could take the form of wish-fulfilling delusions and hallucinations". Our patient fits to this statement by her symptoms as described above.

Hirsch & Hollender (1969) stated that a person in a state of extreme anxiety can lose his ability to react promptly to a situation and at this point symptoms like hallucinations can appear.

The only solution which was left for our patient was the production of a conversive symptom, and through it to change the role of a wife and mother for that of the invalid.

Usually the conversive symptom serves a primary gain and a secondary gain. Mrs H's primary gain was preventing the severe anxiety which resulted from unresolved aggressive and sexual conflicts. The secondary gain was running away from a life-threatening situation at home, being detained in hospital and treated as a psychiatric patient, and developing a dependency on the medical and nursing personnel and through it gaining protection and security.

In discussing this case we have to discuss the concepts of hysterical psychosis, culturally sanctioned psychoses, and acute paranoid reaction (boufée delirante). Merskey (1979) wrote that hysterical psychosis is a debatable concept. 'Hysterical insanity' was used by Kraepelin (1904) for severe prolonged hysterical symptoms without delusions or hallucinations being present. 'Hysterical psychosis' was used by Breuer & Freud (1893–1895) in a more usual way, but Bleuler (1950) and Reichard (1956) criticised the term; it was, however, revived by Hollender & Hirsch (1964) for psychotic symptoms of sudden onset and brief duration, arising in patients with hysterical personalities after a period of increasing stress. The symptoms included delusions, hallucinations, depersonalisation, and grossly unusual behaviour, and usually lasted 1–3 weeks.

Mallet & Gold (1964) described 13 patients, all women, that at some point had been diagnosed as schizophrenic because of unsuccessful treatment, emotional emptiness and bizarre depersonalisation, phenomena, paranoid ideation, and dramatic visual and auditory hallucinations. All the patients displayed hysterical personality traits. In every case, admission to hospital followed an acute episode of violent or negativistic and symbolic behaviour or a suicidal attempt. (Five of the patients ultimately committed suicide.)

Hirsch & Hollender (1969) suggested that the illness might present in three ways:

(a) as socio-culturally sanctioned behaviour
(b) as simulation of psychotic behaviour
(c) as a true psychosis with temporary ego disruption and impairment of repression.

Siomopoulos (1971) considers that the delusional ideas in hysterical psychosis lack the characteristics of incorrigibility, which is an essential feature of the delusion proper. The patient described by us differs from the hysterical psychotic patients described above in that she lacked delusions, depersonalisation, and grossly disturbed behaviour. The hallucinations were spatial-dependent and she had insight that they were not real. All these characteristics excluded the diagnosis of hysterical psychosis.

The differential diagnosis of our case should include culture-bound or exotic syndromes. The first are what Hirsch & Hollender (1969) noted where a cultural practice sanctions extreme behaviour. Other

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examples include latah, ainu, amok, piblokto, wihtigo, voodo and phii pob, all of which are described by Merskey (1979). Allodi (1982) stated that many of the exotic conditions are regarded now as the equivalent of hysterical, obsessional, and anxiety syndromes in which there may be a partial or transient withdrawal from reality; they have been ascribed to the idiosyncratic ego organisation of people living in rural or pre-technological societies and to the conditions prevalent in those cultures. These types of behaviour are determined by the prevailing belief system of the given culture. In contrast to this essential feature, our patient's behaviour as described above was determined far more by individual dynamics than by the prevailing belief system of our culture, or social considerations.

The last entity to be differentiated is the acute paranoid reaction studied by Allodi (1982), named also bouffée delirante in the French literature and psychogenic psychosis in the Scandinavian literature. This diagnosis refers to a subcategory of reactive or other non-organic psychoses which reportedly occurs frequently among immigrants, refugees, and other groups subjected to major social stress. Our patient does not fit this diagnosis because she lacked delusions, had good insight into her hallucinations, did not lose reality-testing, did not have rapid switches from elation to depression, and was not a new immigrant or refugee.

We would like to close this discussion with a quotation from Merskey (1979): "culturally sanctioned behavior, simulation of psychosis, reinforcement of repression, and gross regressive behavior occur in a variable mixture in different syndromes. It is easier to understand these illnesses than to group them systematically."

The authors suggest that psychogenesis and phenomenology of this type in a non-psychotic and non-dissociative patient represent conversive hallucinations and are similar to the descriptions of Fitzgerald and Modai. In the background of these hallucinations were repressed aggressive and libidinal drives that could not be expressed in the patient's daily life with her husband. Only via the conversive hallucinations she was able to express them deliberately. The appearance of hallucinations in the clinical symptomatology does not imply a psychotic state, and the clinician should bear in mind that they can reflect a conversive phenomenon.

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