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Letters to the Editor

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Letters to the Editor

DR. STOUDEMIRE COMMENTS ON CONVERSION HALLUCINATIONS

To the Editor:

The fascinating paper by Kasckow and Maltbie (1) which describes the development of presumed conversion hallucinations in a patient with pseudohypoparathyroidism raises many issues in medical and psychiatric differential diagnosis. This patient had a serious chronic medical illness with multiple complications as well as having been treated with multiple medications. Although her physical problems and medications could all contribute to an "organically" based delirium with psychotic features, the remission of the patient's hallucinations with hypnosis (albeit temporary) support the authors' conclusion that the patient's auditory and visual hallucinations had a predominantly functional component. While arguments could be made as to the patient's primary psychiatric diagnosis and the relative contributions of her ongoing medical and neurological illnesses to the fluctuations in her mental status—the authors' general thesis rests upon the remission of her hallucinations through suggestive hypnotic techniques.

The major diagnostic issue that could be debated in this case is whether or not the patient's symptoms could be more accurately described as factitious rather than conversion in nature. Strictly defined, conversion symptoms in the DSM-III-R system are characterized by "loss or alteration in physical functioning" that cannot be accounted for by known pathophysiological processes. This definition is based upon both historical and observational criteria demonstrating a relationship between the development of the conversion symptoms and the lack of a known physical mechanism to explain them. DSM-III-R, however, does not address response to treatment (the authors' primary criterion in designating this patient's symptoms as conversion) as a criterion for diagnosis.

I would like to suggest a more likely diagnosis which is consistent with the authors' dynamic formulation the patient deriving significant gain from the sick role: *factitious disorder*. As described in the authors' eloquent reconstruction of the patient's developmental and family history, the patient was significantly invested in the regressive aspects of the "sick role" which had become enmeshed in her chronic medical and psychiatric problems. While the definition of a factitious disorder, in DSM-III-R, presumes "conscious" mechanisms as contrasted to the authors' presumed unconsciously determined etiology of the patient's symptoms, it is perhaps more likely that the patient was utilizing her psychotic symptoms to maintain the role of the patient through conscious rather than unconscious mechanisms.

Regardless of the exact psychiatric diagnosis that might be appropriate for this patient's symptoms, the authors have nevertheless assessed and integrated the multiple medical, neurological, and psychiatric factors which were likely interacting in this patient's condition. It is this type of integrated approach to psychodynamic and biological components of mental illness that will be the future standard in psychiatry both in terms

of understanding the etiology of mental disorders as well as planning effective treatment interventions.

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REFERENCE

Kasckow J, Maltbie A: "Conversion Hallucinations in a Patient with Pseudohypoparathyroidism." *Jefferson Journal of Psychiatry* 7(2):30-35, 1989

SUGGESTED ON-CALL READING

To the Editor:

The experience of residency training is arduous. The physical demands of unremitting long workdays, sleep deprivation and irregular meals, emotional turmoil aroused by working with sick and dying patients, and isolation from friends and family all exact their toll. In addition, psychiatric residency has its own peculiar pressures, such as the need to lay aside one's own defenses to empathize with and experience the meaning of the patient's feelings, the "regressive pull" of psychosis encountered in treating seriously ill patients, and the modification (some would say renunciation) of one's identity as a physician as one becomes a psychiatrist. Residents develop strategies to cope with these pressures, some more and some less healthy and adaptive.

We would like to share a strategem which we found to be of great use. As residents in a busy general hospital psychiatry program, we share a combined five years of training experience and over 1,800 total new patient evaluations. Duty nights average 5 or 6 emergency admissions and often as many outpatient evaluations between 4:00 PM and 8:00 AM. Finding sleep between calls elusive, we each independently sought respite in the reading of poetry, prose fiction, essays, and autobiography. When by chance we discovered this similarity, we began to share some of our beloved sources of solace, cautiously at first (as competitive residents can be, reluctant to admit interest in anything but journals and texts). Gradually, our shared love of reading these books became the foundation of a solid and enduring friendship.

Consciously or unconsciously, we selected our books (1-17) according to the following characteristics:

a. They must be divisible into distinct chapters, poems, or essays, to accommodate the frequent, inevitable interruptions by telephone and pager.

b. They must be compelling enough to transport us in imagination from the duty room.

c. They ought to be simple but powerful, allowing access to new thoughts and feelings, able to soothe, sadden or illuminate, to make us marvel, deepen and broaden our appreciation of the human experience. For psychiatrists, few such books are "irrelevant."

d. They are moving and inspiring and tempt us to forego sleep to read them, even when sleep would be otherwise possible.

e. They demand to be shared, discussed, and reread with a kindred soul.

f. To have them, we gladly part with a resident's hard-earned pay.

Below are our agreed upon favorites. Many more could be added to the list. We hope

others may find our nocturnal habit as refreshing and enriching as we have. We eagerly welcome correspondence on this subject.

Mark L. Dembert, M.D., M.P.H.
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