

A Case Series from Rantauprapat, La Belle Indifference: A Coping Mechanism or Is There Something Organic Behind?

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Abstract

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BACKGROUND: La belle indifference, a term that is inexhaustible to discuss, albeit there is no single definition that best describes the condition. To date, la belle indifference has gotten no place in the DSM-5 criteria for being a distinct entity of mental health issue.

CASE REPORTS: We reported 3 cases with la belle indifference. These patients include a stroke patient with right-sided hemiparesis, a patient suffering from neuropathic pain because of diabetic neuropathy, and a patient with cardiac dyspnea due to chronic heart failure — these three cases presented with a similar clinical profile that is the trigger for developing la belle indifference.

CONCLUSIONS: La belle indifference has varying symptom spectrum, and there is always something called “trigger” to induce it.

Introduction

The term “*la belle indifference*” originated from the French language that means a beautiful ignorance. Sigmund Freud first introduced this term to Elizabeth von R for explaining Hysteria, where hysteria was previously used to describe a conversion disorder [1].

La belle indifference that is often attributed to the conversion disorder, although the presence of la belle indifference is not a measure for making the diagnosis of conversion disorder.

La belle indifference is an altered behaviour characterised by improper ignorance towards serious health condition or symptoms of the underlying medical illness where the patient becomes overly resilient. In some patients, this ignorance is subtle and could not be discovered [1], [2].

In paradox with hypochondriasis, somatoform disorders and such that makes the underlying medical condition as the secondary gain, in la belle indifference, the patients are not happy for being told that they are sick, at least occasionally.

The term la belle indifference is not widely used and does not have any diagnostic criteria in DSM-5, it is not even considered as a distinguishing symptom between pure neurological disorder and feigning in the diagnostic criteria of conversion disorder [1], [2], [3].

Conversion disorder is a mental illness characterised by the presence of at least one neurological deficit that can be perceived as visual impairment, hearing loss, paresis, hypoesthesia, dysarthria, and many others that cannot be explained by the pathologic pathway of any medical and neurological disorders [4].

Case Reports

In the first case, a 62-years-old woman of a Batak descent presented with right-sided hemiparesis and dysarthria. She suffered from an ischemic stroke for one year before admission. The history of diabetes mellitus was not confirmed, and grade 2 muscular rigidity was noted. She completely understood what others said to her, but could not express her response. After being discharged home, her blood pressure was stable at the level of 130-140 mmHg and 80-90 mmHg for systolic and diastolic blood pressure, respectively. After receiving the *kusuk therapy* (like physiotherapy) alongside and regular 5 mg amlodipine and 75 mg clopidogrel taken once daily, her muscle strength was improved only to reach $\frac{3}{4}$, and she could only sit on her chair and say a few words.

The patient lived with her husband and her first son, who had been married and had a child. She had three children; all of them are male. While, her youngest son, was studying at a university, far away from her homes. A unique event was sighted when every time her youngest child came home or even when his name is mentioned. Tracking deep in her inner thought, the youngest one was her favourite son.

The examiner was privileged to have a chance to witness her condition both in the presence of the triggers and not. The patient did not intend to visit our clinic for these symptoms, but instead of having a sleeping disorder, only in a brief moment. Her muscle strength was abruptly increased into 4 / 5; she could walk in a significant distance and say a lot more words.

Her *Global Assessment of Functioning Scale* (GAF Scale) was 70-61. These findings were contradicted with those times when her youngest child was not around. This patient was not given any medical therapy except for her insomnia. The patient only received conditioning therapy, semi-hypnosis to exhibit the same response even when her youngest son is not around.

In the second case, a 42-years-old Malay woman presented with diabetic neuropathy. She complained of having trouble to sleep at night due to an intense pain felt around her legs. She suffered from chronic, poorly-controlled diabetes mellitus. Her random blood glucose level could sometimes exceed 300 mg/dL despite an adhered treatment with Biguanide and Sulphonylurea. The patient was diagnosed with type 2 diabetes mellitus for five years ago. Her vital signs were a normal status, also with a physical examination. The examiner was lucky to see her condition both in the presence of the triggers and not. Her trigger was her married daughter, who came to visit her. She had four children, three sons and the youngest daughter. The patient was consulted to a

psychiatry clinic by the neurology department because of her insomnia. By the neurology department, she was given gabapentin, mecobalamin, 2 mg Glimepiride and 850 mg metformin taken twice daily.

Her attention was concentrated and consciousness altered like a semi-trance phenomenon that was evidenced by her straightforward gaze and barely blinked and was easy to be given a suggestion. Her mood was slightly expansive. There was evidence of logorrhoea. There were also no signs of delusion, illusion, and hallucination. Her GAF scale was 70-61. These findings were contradicted with those times when her daughter was not around. This patient was not given any medical therapy except for her insomnia. She was encouraged to continue her medication as prescribed by her treating neurologist. The patient only received conditioning therapy.

The third case presented a 51-year-old man of a Batak descent who worked as a chairman of a mass organisation in his region. He was referred from the internal medicine clinic due to his depressive disorder that was attributed to chronic cardiac dyspnea and chest pain. The patient frequently suffered from dyspnea attacks due to his congestive heart failure precipitated by coronary heart disease. The patient routinely visited the internal medicine clinic and was given clopidogrel, isosorbide mononitrate, and bisoprolol, and sometimes received furosemide. In the past two weeks, the patient felt so sad, had decreased appetite, and avoided interaction and spent his time alone. He got too excited when he found his organisation members facing some difficulties. He suddenly came without concerning his condition. The patient came with his family. He was subsequently given 50 mg fluoxetine taken once daily after breakfast and was encouraged to continue taking other medications prescribed by his treating internist.

Around five days following his visit, his son revisited the psychiatry clinic and reported that his father was hospitalised due to progressive shortness of breath. The complaint appeared when he was doing his work in the organisation, and he was urgently admitted to the hospital by his men. His son said that the patient had never taken his medications. He said that his father always complained of having difficulties with his breathing when he was not with his men indeed, and his son did not want his father falling down to sick then he was admitted to the hospital repeatedly. After receiving the referral form from the internal medicine department, the psychiatrist immediately visited the patient. The results of the current assessment were in contrast with the previous session.

His attention was concentrated here and consciousness altered like a semi-trance phenomenon that was evidenced by his straightforward gaze and barely blinked and was easy to be given a suggestion. Initially, the examiner

thought that the patient was faking his well-being, but it rather not. His mood was extremely expanded to that extent of euphoria. His affect was appropriate, and there was no sign of depressive mood, as showed in the previous session. The content and flow of his thoughts were normal, yet there was evidence of logorrhoea. No signs of delusion, illusion, and hallucination were observed. His insight was considered at level 1 with critical judgment. His GAF scale was 40-31 (All of the symptoms presented when his team members were around with him).

The patient was given an intramuscular injection of 5 mg Haloperidol followed by 2 mg Risperidone taken twice a day. After the 3-day course of treatment, the patient gradually realised that what he had done was wrong. He asked for forgiveness to his family. He also showed the same mood and effect as it was in the first session even when his team members were around. The patient was cooperative during the treatment. His attention was considered normal, and he showed good temporal, spatial, and individual orientation.

Discussion

We presented this case report to describe the unique behaviour of a human being with all its complexity. Since la belle indifference is very associated with conversion disorder, let alone la belle indifference does not have a place in DSM-5, our discussion focused on conversion disorder.

We observed these three patients coincidentally and classified as a la belle indifference for several considerations. In the first case, a 62-year-old woman who suffered an ischemic stroke and showed a better good response when her son was beside her. In the second case, a woman 42-year-old who presented diabetic neuropathy and had completed a serious pain until disturbed she slept at night and then complained was better when her daughter was with her. In the third case, a 51-year-old man of a Batak descent who worked as a chairman of a mass organisation in his region who had suffered from shortness of breath because of his chronic heart failure illness. All of his complaints were decreasing when his men were with him.

From the three cases above, there are some similarities such as There is a clinically evident symptom or functional impairment either in the form of neurological deficit or not. There is evidence of triggering factors that predispose to an alteration in the patient's behaviour as if he/she forgets about their illness. There is a mild functional alteration in the presence of the triggers. Feigning factor can be ruled out. Those four statements referred to conversion disorder, and we add manifestation a trance-like

syndrome as an additional information suggestion to show more about la belle indifference [5], [6].

The discussion that we would try to describe is from psychological approaches and neurobiological approaches.

Psychological approaches

There are several studies to learn about coping mechanism in conversion disorder, one of them is Maqbool A and Kausar R in 2003 in Pakistan. They said that avoidance focused and active-distracting coping strategies are the most of the ego and the mechanism of defence that often used. They also said that avoidance focused copying is one of the factors to predict the maintenance and persistence of somatoform disorders [7]. Still, in Pakistan, Ahmad QA, Bokharey IZ in 2013 made a cross-sectional study, and they researched conducting in five teaching hospitals of Lahore, Pakistan. The total sample was 100; they included both men and women with ages 18 years and above in the study. They Compare resilience and coping strategies in the patients with general medical conditions and conversion disorder with tools *State-Trait Resilience Inventory (STRI)* and *Coping Strategies Questionnaire (CSQ)*. The Result of that study revealed that avoidance-focused coping strategies and low trait resilience seem to be important phenomena in the onset of conversion disorder. Patients with general health conditions preferred to use active-practical coping strategies than patients with conversion disorder (SD = 0.82) [7].

Neurobiological Approaches

Since the progress of neuroimaging technology, a recent study of the brain and mystery of conversion disorder revealed slowly. Although once again, still now the single ideology or exact cause of conversion disorder is not discovered, this development of those studies gives more information about the brain neurofunctional [8].

There are some fMRI findings due to conversion disorder. Some of them could be reported here. Aybek et al., reported that increasing of left amygdala activity in the CD group in response to both sad and fearful faces that observed in sad, neutral, fearful faces and had to identify the sex of each (12CD) and face while in scanner (14 CD) and increasing activity in two clusters – periaqueductal gray (PAG) matter and a frontal region (bilateral premotor/supplementary areas, left DLPFC, and left cingulate cortex) – in the CD group in response to sad and fearful faces. Both of them were motor weakness manifestation. Aybek et al., reported that recall of stressful life events while in the scanner: defined Escape vs Severe as increased activity in left DLPFC, and decreased in the left hippocampus during the

Escape vs severe condition, accompanied by increased right SMA and TPJ activity (12 CD). Voon et al., in 16 CD and 16 HC reported that failure of habituation and abnormal amygdala-SMA connectivity during responsible to movement disorder had to observe in sad, neutral, fearful faces while in scanner and Werring et al., in 5CD and 7 HC; Suppression of visual cortices paired with increased activity in the left inferior frontal cortex, insula, limbic structures, and bilateral striatum in CD group had to observe periodic (monocular) 8 Hz visual stimulation [8].

In conclusion, La belle indifference, until recently, is not considered a distinct entity of mental disorder and does not differ a conversion disorder from pure medical illness or even feigning. Psychological approaches and neurobiological approaches would approach la belle indifference. La belle indifference has a varying symptom spectrum. In general, la belle indifference does not require any treatment, and instead, it exerts benefits to the patient until it reaches a point that causes a great burden for both the patient and the family. These case reports, methodologically have many biases to measure; as a note, this is a case report with the descriptive study. It needs more study and bigger source or sample to give a clearer description of la belle indifference.

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