What’s so special about conversion disorder? A problem and a proposal for diagnostic classification

Richard A. Kanaan, Alan Carson, Simon C. Wessely, Timothy R. Nicholson, Selma Aybek and Anthony S. David

Summary
Conversion disorder presents a problem for the revisions of DSM–IV and ICD–10, for reasons that are informative about the difficulties of psychiatric classification more generally. Giving up criteria based on psychological aetiology may be a painful sacrifice but it is still the right thing to do.

Declaration of interest
None.

The problem of conversion disorder
Conversion is not only a problem for nosological harmony; it threatens the whole physiological somatoform construct – for if conversion disorder can be purely psychological, why not tension headache? It also mandates explanatory criteria – psychological processes and the absence of feigning – that are unpopular, unproved and hopelessly unreliable.7 Neither of the criteria is formally decidable: there is no plausible clinical investigative system that will tell us whether there is a psychological explanation or whether the patient is feigning. They can sometimes be determined positively: sometimes, of course, a psychological explanation is clear; sometimes the patient is caught in acts of obvious feigning; but that leaves an abundance of cases where neither is shown. Should we conclude that these patients are not feigning because we have not proved it, that they do not have psychological explanations because we have not found them, and send them back to their neurologists?

That response is not hypothetical. Neurologists describe a common scenario in which they demonstrate that there is no neuropathological explanation for a patient’s symptoms and refer them to a psychiatrist, who sends the patient back saying that no psychiatric disorder can be found.8 What are we to make of such patients? They are caught between two specialties, explained by neither. Nevertheless, there is a difference: the neurologist will have done more than simply thought the presentation unusual and off the examination couch, although often there will only be symptoms incommensurate with investigations, or only incongruity with known disorders. Concerns that this leads to excessive false positives can be laid to rest, however;9 neurologists seem to reliably define their diagnostic group of ‘functional’ patients.

Richard A. Kanaan (pictured) is a consultant neuropsychiatrist at the Maudsley Hospital, where he runs a clinic specialising in functional neurological disorders, and researches conversion disorder at the Institute of Psychiatry in London. Alan Carson runs a neuropsychiatry service for patients with acquired brain injury and a general neuropsychiatry service in a regional clinical neurosciences unit in Scotland. Simon C. Wessely is Professor of Epidemiological and Liaison Psychiatry at the Institute of Psychiatry, and consultant psychiatrist at the Maudsley Hospital. Timothy R. Nicholson is a clinical researcher in conversion disorder and honorary psychiatry specialist registrar at the Institute of Psychiatry. Selma Aybek is a board-certified Swiss neurologist, currently completing a research fellowship at the Institute of Psychiatry dedicated to the neural correlates of conversion disorder. Anthony S. David trained in neurology before switching to psychiatry. He is Professor of Cognitive Neuropsychiatry and a consultant neuropsychiatrist at the Maudsley Hospital.
A proposal for conversion disorder

Our proposal is this: the diagnostic criteria for conversion should simply be the following:

(a) the patient presents with symptoms suggestive of a motor or sensory neurological deficit of significant severity;

(b) neuropathological explanations have been excluded, with a qualifier acknowledging the degree of confidence in that exclusion.

The requirements for a psychological association and the exclusion of feigning should be dropped. Not because they are not relevant, but because at present should be determined. They can be retained as explanatory guides, as exhortations to vigilance, as reminders for therapy or even as (strongly) supportive factors when present. Indeed, the nomenclature should be changed to reflect this, with the diagnosis as a whole relabelled ‘functional neurological symptoms’, with the subgroup with a determinate psychological explanation retaining the name ‘conversion disorder’. Finally, the criteria in ICD and DSM should be fully harmonised, and the diagnosis housed within the somatoform disorders chapter rather than with dissociative disorders, since the process suggested by the latter grouping is also a presumption.

The goals of classification

Although simply stated, the choice of labels here was anything but simple. Diagnostic labels serve partly to communicate with colleagues, partly to communicate with patients and partly as an approximation to the truth. All of the terms available met some and none met all of those goals, but these represent a healthy compromise. The proposals may not seem particularly radical; they merely propose a further downgrading of the psychological assumptions that have been weakened with each iteration of the diagnostic criteria. Indeed, similar proposals were considered for the last round of revisions, as the psychological criteria ‘lacked evidence’ and were conspicuously aetiological rather than descriptive.

Although the psychological criteria are unreliable in application and discrimination, they have a tenacious grip on our sense of validity. No one who has had a patient develop a dysphonia before going on stage or a hand dystonia after signing an unwelcome document is left in any doubt that there is a psychological story that makes sense of their problem; and so compelling is this that we presume a similar story could be told of any other patient if they would only reveal it. Dispensing with this criterion would seem to give up something precious – the last toe-hold of Freudian theory – and one of the few remaining criteria where psychiatrists seem to have something unique to add, at a time when their value is under growing threat; for it would mean neurologists could diagnose the disorder, just as gastroenterologists can diagnose irritable bowel syndrome. In addition, it would mean acknowledging that in some cases conversion really was unexplained by all branches of medicine, including psychiatry. However, that is the reality of our current state of knowledge, notwithstanding renewed – and exciting – research directions.

Richard A. Kanaan, MRCPsych, Kings College London, Institute of Psychiatry, London; Alan Carson, FRCPsych, School of Molecular and Clinical Medicine, University of Edinburgh; Simon C. Wessely, FRCPsych, Timothy R. Nicholson, MRCPsych, Kings College London, Institute of Psychiatry, London; Selma Aybek, MD, Kings College London, Institute of Psychiatry, London, UK, and University Hospital, Lausanne, Switzerland; Anthony S. David, FRCPsych, Kings College London, Institute of Psychiatry, London, UK.

Correspondence: Dr Richard Kanaan, Department of Psychological Medicine, Institute of Psychiatry, Weston Education Centre, PO62, London SE5 9RJ, UK. Email: richard.kanaan@kcl.ac.uk

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