

Over-Diagnosing Dissociative (Conversion) Disorders

To the Editor: The word *hysteria* has been used in so many contexts that it no longer has any one meaning. Therefore the word *hysteria* has been removed from DSM-IV as well as from ICD-10.

Breuer and Freud¹ hypothesized that “hysteria” was the result of a traumatic experience currently hidden from consciousness. The emotions were not expressed directly but through offering a response to the trauma. Freud theorized that the treatment of hysteria involved recalling the offending experiences to consciousness and confronting them. Once unexpressed emotions were released, they did not need to present themselves as various symptoms.

John Ferrier (1795) used the word *conversion*² for the changing physical symptoms, and Pierre Janet (1889) coined the word *dissociation*,³ which meant that the conscious mental elements become unconscious because of deficiency of mental energy.

Lord Brain (1963)⁴ described the possibility of coexistence of hysteria with other physical and psychiatric disorders. In 1965, Elliott Slater^{5,6} published a highly influential study in the *British Medical Journal* that described a 10-year follow-up study of patients admitted to the National Hospital for Nervous Diseases with a diagnosis of “hysteria.” He found that over half of the patients developed clear-cut neurological or psychiatric conditions during follow-up. Since the 1960s, several studies investigating

the subsequent incidence of neurological disorder in patients with a diagnosis of “hysteria” or “conversion disorder” have been published, and rates of up to 25% have been reported.⁷ Slater cautioned against the use of the diagnosis “hysteria” and said that “the diagnosis of hysteria is a disguise for ignorance and a fertile source of clinical error.”

DSM-IV conversion disorder is considered a dissociative disorder in ICD-10.

Conversion disorder is defined as an illness of symptoms or deficits that affect voluntary motor or sensory functions, which suggest another medical condition, but that is judged to be due to psychological factors because the illness is preceded by conflicts and stressors. Symptoms or deficits are not intentionally produced, not due to substance, and not limited to pain or sexual symptomatology. Gain is primarily psychological, and not social or monetary or legal.

Differential diagnosis with neurological illnesses is important in such cases, as 6%–30% of these patients are subsequently found to have a medical illness that can account for their symptoms:

- Concomitant or previous neurological disorder or a systemic disease affecting the brain was reported in 18% to 64% of cases of conversion disorder.
- 25%–50% of cases classified as conversion disorder eventually receive diagnoses of neurological or nonpsychiatric medical disorders.
- A 7- to 11-year follow-up study of 99 patients found that 22 (30%) of 73 available participants had an organic illness accounting for pre-

senting symptoms that were initially diagnosed as conversion disorder⁶

- A 2.5- to 10-year follow-up study of 24 patients discharged from the neuroscience services of a teaching hospital with a diagnosis of conversion disorder found that five (21%) of 24 had a diagnosable neurological disease.⁸
- A 6- to 12-month follow-up study of 50 patients discharged from the neurology service of a teaching hospital with conversion in differential diagnosis found that seven (14%) had organic illness and three (6%) had hysterical elaboration of organic pathology.⁹
- Sixty-four patients with a diagnosis of conversion disorder after psychiatric consultation service were followed for an average of 3.3 years, and eight (13%) had an organic illness¹⁰

Some of the neurological/medical disorders to be considered in differential diagnosis include the following:

1. Dementia and other degenerative disorders
2. Brain tumors, subdural hematoma
3. Basal ganglia disease, myasthenia gravis, multiple sclerosis
4. Polymyositis, acquired myopathies
5. Optic neuritis
6. Partial vocal cord paralysis
7. Acquired myopathies
8. Guillain-Barré, Creutzfeldt-Jakob, periodic paralysis
9. AIDS (early neurological manifestations)
10. Systemic lupus erythematosus
11. Idiopathic and sarcoma-induced osteomalacia
12. Acquired, hereditary, and drug-induced dystonias

Case Reports

We report two patients initially diagnosed with conversion disorder who were later found to have neurological disorders.

Case 1

A 19-year-old Hindu woman was referred to us with chief complaints of paroxysmal movement disorder for the past 1 year. These involuntary movements would be induced by emotional excitement and sudden movement. The areas affected were the facial musculature mainly in the perioral area and the neck region. The movements would be sudden in onset and partly under the control of the patient and resembled flickering and twitching movements of perioral and periocular muscles, with rhythmic jerky movements of the head to one side. Twisting movements in both upper limbs would also be present. She was fully aware of her surroundings during the attacks, which usually lasted 30–60 seconds, and rarely up to 2 minutes. These episodes would occur 5–6 times per day, with rare symptom-free periods of 2–3 days. These movements would increase when attention was paid to the patient and were not present while she slept.

There were recent stressful life events concerning the patient. After about one month she became irritable and stopped interacting with family members. She would complain of sadness of mood and disinterest in pleasurable activities, and she confined herself to her house and stopped going to work. She sought medical care 1 month after the onset of these signs. General physical and neurologic examinations produced normal results.

An EEG (during the episode), MRI of the brain, and laboratory workup (liver function test, kidney function test, blood glucose levels,

erythrocyte sedimentation rate, antinuclear antibodies, antiphospholipid antibodies, a CBC, a comprehensive metabolic panel, T4, TSH, and urine organic acids) produced unremarkable results.

The patient was being treated for dissociative movement disorder with depression for the last 10 months, and because there was no improvement in her condition, she was referred to us. A diagnosis of paroxysmal kinesigenic dyskinesia was rendered, and the patient was prescribed phenytoin. At 100 mg twice a day (initially 50 mg twice a day), she achieved a complete resolution of signs. This resolution has persisted for the past 1 year, and she has not reported any side effects of the medication.

Case 2

A 22-year-old Hindu woman was referred to us presenting with episodic loss of power in both lower limbs, inability to speak, and urination in her clothes for the past 1.5 years. She also complained of gradual-onset left-sided visual loss and paresthesia and numbness on the left side of her face and body. This illness was precipitated by a stressful life event concerning the patient and her family. These episodes were subacute in onset and would last for approximately 2 months with a 3- to 4-month symptom-free interval, and each episode was worsened by psychosocial issues.

During the episodes, the patient seemed unconcerned regarding her symptoms and looked optimistic and cheerful (labeled *la bella indifferenza*). She stopped going to work because of her illness and stayed back at home. She sought medical care 1 week after the onset of these signs.

General physical, ophthalmological, and neurological examinations produced normal results. An EEG, MRI of the brain, and a laboratory

workup (liver function test, kidney function test, blood glucose levels, erythrocyte sedimentation rate, antinuclear antibodies, antiphospholipid antibodies, a CBC, a comprehensive metabolic panel, T4, TSH, and urine organic acids) produced unremarkable results. She was treated for mixed dissociative disorder, and each episode remitted completely with inter-episodic full recovery. The patient presented to us in the fourth episode and with similar symptoms.

Physical and neurologic examinations were within normal limits. Ophthalmic examination revealed pallor of temporal halves of the optic discs. CSF examination revealed moderate elevation of proteins, and electrophoresis showed oligoclonal bands. A brain MRI revealed periventricular white matter abnormalities. In consultation with a neurologist, the patient was transferred to a neurology ward with a working diagnosis of relapsing and remitting multiple sclerosis and was started on corticosteroids. The patient showed marked improvement in her symptoms and is maintaining well for the past year.

Discussion

These two cases are examples of how early signs and symptoms of physical disorders can be misdiagnosed as dissociative disorders. The factors that prompted the diagnoses were the temporal correlation of illness with psychological factors and psychosocial stressors. The episodic nature of the symptoms, complete to near-complete inter-episodic recovery, and normal examination along with normal laboratory results also aided in the false diagnosis. In case 2, the *la bella indifferenza* toward the symptoms aided the conclusion.

Case 1 is an example of clinical ignorance for episodic neurological illnesses, which are idiopathic and

rarely occur. Case 2 is the classic example of a neurological disease presenting with "psychiatric" symptoms in the early phase, without overt characteristic physical signs and symptoms (clinical, biochemical and imaging) which surfaced during the course of the illness.

Mitigating factors can explain misdiagnosis. In both patients, the diagnosis was missed because some symptoms and signs have only recently been recognized as neurological entities.

Conversion disorder can be a misleading diagnosis. In the past, up to 30% of patients diagnosed with conversion symptoms were subsequently discovered to have misdiagnosed organic illness.¹¹ However, with the availability of neuroimaging techniques such as MRI, and other new investigative methods, missed organic illness may account for 4% to 15% of individuals initially given a diagnosis of conversion disorder.^{7,12} To avoid

this error, all patients must be medically investigated thoroughly before a diagnosis of conversion disorder is given.

In summary, a psychiatrist should be encouraged to make a positive diagnosis and keep the level of suspicion high for other potential diagnostic candidates. The opportunity to seek a neurological disorder and treat it appropriately (in consultation) should not be missed.

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