(hysterical conversion disorders, motor and sensory hysteria)

1. Various attempts have been made to formally classify psychiatric disorders, the two major systems being:

   1.1. The **ICD-10 Classification of Mental and Behavioural Disorders** (World Health Organisation, Geneva) is part of the 10th edition of the International Classification of Disease. This Appendix follows the common abbreviation of **ICD-10**. It is the international system used by the majority of clinical psychiatrists in Great Britain.

   1.2. The **Diagnostic and Statistical Manual of Mental Disorders (fourth edition)** (American Psychiatric Association Washington DC). References to it in this Appendix follow the common abbreviation of **DSM-IV**. It is a system devised mainly by and for workers in the USA; however, UK psychiatrists were consulted in its formulation.

2. The two systems above have been in existence for many years but only in their current editions have they been closely comparable. This Appendix discusses the clinical features and aetiology of the conversion and dissociative disorders and is generally based on the ICD-10 system, with any major comparisons and distinctions with DSM-IV being discussed where relevant. The ICD-10 codes (numbers usually prefixed with F) are also provided.

DEFINITION OF TERMS

3. The term “conversion” was introduced by Freud to mean the rendering innocuous of dangerous or threatening ideas by “converting” them into physical symptoms.

4. The terms “dissociation” and “conversion” are virtually synonymous; however, conversion has been applied to physical symptoms, i.e. motor and sensory deficits, while dissociation has been applied to the mental symptoms.

5. The central feature of conversion disorders is the loss or impairment of function, which superficially may appear to be due to a physical cause, but in fact is a representation of underlying psychological conflict.

6. Dissociative disorders operate through similar psychological mechanisms and are representations of inner conflict, but are characterised by the disruption of integration between consciousness, memories, identity or perception of the environment.

CLINICAL MANIFESTATIONS

CONVERSION DISORDERS

7. The syndrome is characterised by sudden onset of symptoms, usually unobserved, in close time relationship to stress. The nature of this stress is often related to inner psychological conflicts for which the person can find no solution. It may also be a response to more chronic insoluble life stresses. These responses are unconscious. The diagnosis involves a clinical judgement, based on careful history and information from other informants that there are unconscious motives. However, the unconscious motives, by their very nature, may never become apparent and their elicitation is not necessary for a diagnosis to be made.

8. The patient often shows less concern than would be expected of someone with such symptoms, the so-called "belle indifference"; however, this is not inevitable and should not be used as a diagnostic pointer since some stoical individuals with physical disorders may minimise their distress.

9. Symptoms may be divided into motor and sensory disorders, the former including abnormal gait, apparent "paralysis" of voluntary muscles, trembling, tics, tremors, inability to stand unaided ("astasia-abasia"), aphonia, mutism and convulsions. Sensory symptoms include paraesthesiae, anaesthesia, deafness, blindness and other visual defects.

10. A diagnostic feature of conversion disorder is discrepancy between the physical or anatomical signs and symptoms, or that the symptom is inconsistent: a "paralysed" extremity will be moved inadvertently whilst dressing, an arm placed above the head will fall to the side and avoid striking the head, or there may be a loss of all sensory modalities, i.e. touch, pain and temperature.

11. The nature of the symptoms varies depending on the level of medical knowledge. In those with knowledge of disease, the symptoms closely resemble physical illness and diagnosis may be difficult. In those who have little understanding of disease, for example children, the symptoms may bear little relationship to anatomy and physiology. Previous experience of illness in either themselves or others may also determine presentation, for example those who have had a head injury with a period of amnesia may recapitulate this experience (dissociative amnesia). Similarly, epileptics may develop "pseudoseizures" which are indistinguishable from the usual fit.

DISSOCIATIVE DISORDERS

12. **Dissociative amnesia** (formerly **psychogenic amnesia**) **F44.0**

    This is a potentially reversible loss of memory, usually of important events or important personal information, which is too extensive to be explained by ordinary forgetfulness or fatigue. It may be reported as gaps in recall in the patient's life history, often related to traumatic or stressful events, the loss being usually partial and selective. If the loss is global, the diagnosis of dissociative fugue may be more appropriate.

13. **Dissociative fugue** **F44.1**

In addition to the features of dissociative amnesia above, the individual undertakes a purposeful journey of varying duration, during which time behaviour appears completely normal to independent observers. The person is able to take care of himself, obtaining meals and a place to stay, and is perfectly capable of simple interaction with strangers. It must be differentiated from the 'wandering' seen in a confusional state after epileptic seizures or in dementia. Differentiation from conscious simulation may be very difficult, and claims of suffering from this state have been used fraudulently to avoid the consequences of domestic or business imprudence, etc.

14. **Dissociative stupor** **F44.2**

The patient appears to be stuporose; however, muscle tone, posture and eye movements indicate that he is not unconscious. There is profound diminution or absence of normal responsiveness to sound, touch or light. The onset is sudden, unlike that of depressive stupor which is a gradually developing condition.

15. **Dissociative identity disorder** (or "multiple personality") **F44.81**

This is a very rare disorder which is, however, more commonly diagnosed in some cultures, notably the USA. The essential feature is co-existence of two or more discrete personalities within an individual, only one being evident at any one time. Each personality is distinct and complete, with its own set of memories, behaviours and preferences. The change from one personality to another is, in the first instance, closely associated with traumatic events, childhood sexual abuse being a well documented area. Most dramatic cases have been documented during psychoanalysis. It has also been faked as a defence to avoid the death penalty, completely fooling many expert psychiatrists and psychologists.

16. **Depersonalisation disorder** **F48.1**

This state produces a sensation in which the person feels unreal, remote or like an automaton. There is a sense of detachment from the body and a sense of "not me" when they see parts of themselves. "Derealisation" refers to the same quality of sensation, but it is the surroundings which appear unreal. The phenomenon may transiently occur in normal people when under stress, when fatigued, in states of sensory deprivation or when falling asleep or waking up. As a disorder in its isolated form it is rare, and it is more commonly seen in association with depressive illnesses, phobic disorder or anxiety disorders.

AETIOLOGY

17. The immediate cause of these disorders is the ability to disconnect aspects of psychological function from each other. Several theories exist, the most widely accepted being the Freudian theory.

18. The process of converting threatening ideas into physical symptoms is unconscious: the relief of internal conflict is termed "**primary gain**". The physical symptoms may have a symbolic meaning and, while this makes certain behaviour in some patients understandable, it is not generally applicable to most people.

19. “**Secondary gain**” is the more directly observable advantages that having a symptom brings, such as gaining sympathy and attention, the avoidance of usual obligations, or obtaining support both in practical and financial terms.

20. Following on from the concept of secondary gain, Parsons developed the idea of the “sick role” in the early 1950s. When someone is ill and this has been sanctioned by professionals, they are allowed to assume the “sick role”, which carries concomitant advantages in that the sick person is:

    20.1. exempt from the usual social obligations

    20.2. they no longer have to work or go to school

    20.3. they are treated with sympathy and understanding

    20.4. they are allowed to show weakness and distress.

    20.5. **However**, in order to gain these advantages, they are obliged to seek appropriate help and accept treatment. They cannot be given the above four advantages if they do not comply with this obligation: to fail to do so calls into question the validity of the illness.

21. Previous experience of illness, either in themselves or observed in others, has an influence on the way people behave when they are ill and, in this way, the sick role may be a learned phenomenon, with “rewards” learned, such as time off work and being waited on reinforcing further similar behaviour. These concepts apply to many people but to differing degrees, and the adoption of the sick role when genuinely physically ill is normal and desirable.

22. The basis of the disorder is, therefore, rooted in the personality, and the methods which the individual consequently uses to cope with disturbing and distressing thoughts, feelings or situations.

23. Conversion or dissociative symptoms are more common in the less sophisticated, those for whom the range of coping mechanisms is reduced, and those who find it difficult to express distress verbally or in more direct forms.

24. They are also more common in the anxious and highly aroused personality, these factors being determined by temperament, this being the inherited component of the personality.

CONCLUSION

25. The **conversion and dissociative disorders** are physical and mental representations of (usually) unconscious underlying psychological conflict. Conversion disorders may occur concurrent with neurological disorders or other medical conditions, and should be considered if the symptoms are not fully explained, given the nature and severity of the physical condition. The aetiology of conversion and dissociative disorders lies in the personality structure and the methods which the individual consequently uses to cope with difficult situations, thoughts or feelings.

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