Case History

- 22 yr old female
- 2 month history of weakness and loss of sensation in R leg
- Sudden onset with no obvious precipitant
- Variable weakness since
- Pattern of weakness and sensory loss does not conform to neuroanatomy
- All investigations normal
Case History

• What is going on?
Case History

• What is going on?
  – Unknown disease process?
  – Deliberate feigning?
  – Any other possibility?
Conversion Disorder

• aka ‘hysteria’, ‘hysterical conversion’, ‘dissociative disorder’

• Essential idea is that physical symptoms reflect underlying psychological conflicts, emotional turmoil, etc.

• Relies on idea of unconscious mechanisms

• Endlessly controversial
Hysteria

• Greek ‘husteros’ – uterus

• from Aretaeus the Cappadocian
  Hippocratic writer of the second century

“In the middle of the flanks of women lies the womb, a female viscus, closely resembling an animal; for it is moved of itself hither and thither in the flanks, also upwards in a direct line to below the cartilage of the thorax and also obliquely to the right or to the left, either to the liver or spleen; and it likewise is subject to falling downwards, and, in a word, it is altogether erratic. It delights, also, in fragrant smells, and advances towards them; and it has an aversion to fetid smells, and flees from them; and on the whole the womb is like an animal within an animal.”
Origins of the concept

• Charcot 1825-1893 – at the Salpetriere

Believed hysteria was due to as yet undiscovered pathology of the nervous system
Viennese ‘mind magic’
Issues

• Theories largely untestable
• Proliferation of rival schools and theories
• Misdiagnosis
  – Slater: suggested many cases actually had undiagnosed neurological disease
Modern developments

• Even if one rejects psychoanalytic theories, problem still exists
• Rebranded as ‘conversion disorder’ or ‘dissociative disorder’
• Many subtypes (motor, sensory, fugue states, etc.)
• Essential controversies remain
Other ideas

• Is there really a clearcut distinction between conscious and unconscious?
• Other examples of behaviours that may shed light on conversion disorder:
  – ‘method acting’
  – Trance and ‘possession’ states
  – Hypnotic suggestion
  – Immersion in sick role, ‘illness behaviour’
ICD-10

- F44: Dissociative (conversion) disorders
  - ...partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements.
  - Amnesia
  - Fugue
  - Stupor
  - Trance and possession
  - Motor
  - Convulsions (non-epileptic seizures)
  - Anaesthesia and sensory loss
  - Mixed
  - Other
    - Multiple personality disorder
    - Ganser’s syndrome (controversial)
    - Psychogenic confusion
    - Twilight state
  - NOS
Dissociation

• “Disruption of the usually integrated functions of consciousness, memory, identity or perception of the environment” (DSM-IV)
Table 1
Dissociative disorders classifications in ICD-10 and DSM-IV

<table>
<thead>
<tr>
<th>ICD-10 dissociative (conversion) disorders</th>
<th>DSM-IV dissociative disorders</th>
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</thead>
<tbody>
<tr>
<td>Dissociative amnesia</td>
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<tr>
<td>Dissociative fugue</td>
<td>Dissociative fugue</td>
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<tr>
<td>Dissociative motor disorders</td>
<td>Dissociative identity disorder</td>
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<td>Dissociative convulsions</td>
<td>Depersonalization disorder</td>
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<tr>
<td>Dissociative anaesthesia and sensory loss</td>
<td>Dissociative disorder not otherwise specified</td>
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<tr>
<td>Dissociative stupor</td>
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<tr>
<td>Trance and possession disorders</td>
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<tr>
<td>Mixed dissociative (conversion) disorders</td>
<td></td>
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<tr>
<td>Other dissociative (conversion) disorders</td>
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<tr>
<td>Dissociative (conversion) disorder, unspecified</td>
<td></td>
</tr>
</tbody>
</table>
Dissociative symptoms

- Holmes et al 2005
  - “Detachment” vs “compartmentalization”
  - Distinction in subjective experience of symptoms
  - E.g. in DPD altered quality of experience IS the presenting complaint
  - Whereas in dissociative amnesia there is an apparent ‘splitting off’ of experience
Facts & Figures

- Incidence approx 5-12 per 100,000 per annum
- Prevalence approx 50 per 100,000 at any given time
- At least 2% of all neurological patients
- Approx 20% of all patients referred to specialist epilepsy services
Conversion vs feigning

- Conversion disorder
- Factitious disorder (incl. Munchausen’s)
- Malingering
  - Idea of primary and secondary gains
PNES

- Psychogenic non-epileptic seizures
- Common: approx 10-20% of people diagnosed with epilepsy actually have PNES
- Similar issues to other conversion/dissociative disorders
- Psychiatric co-morbidities common
- Episodes may be very bizarre but EEG telemetry often required to make diagnosis
- Beware easy ‘rule of thumb’ generalisations regarding seizure semiology
• Compared to epilepsy, PNES episodes tend to be:
  – Longer
  – Less stereotyped

  – Inconsistent with physiology of epilepsy
    • E.g retained awareness during generalised shaking
    • No change in oxygen sats during prolonged generalised shaking
Medically unexplained symptoms

• Although not classified as conversion disorders, most specialties have their own psychosomatic conditions, e.g.
  – Non-cardiac chest pain
  – Atypical facial pain
  – Irritable bowel syndrome
  – Chronic fatigue syndrome (particularly controversial)
  – Somatoform disorder, also hypochondriasis
A Pragmatic Approach

- Don’t get lost in volitional/unconscious argument
- Avoid ‘all in the mind’ or ‘nothing wrong with you’ type statements
- Link body and mind
- Discourage further investigations and medical ‘props’
- CBT plus physical rehab
- Treatment for any associated psychiatric disturbance