5 Discrepancies between diagnostic criteria and clinical practice

Simon Wessely

The conventional psychiatric diagnostic criteria for hysteria are unsatisfactory for many reasons. Key concepts such as secondary gain, belle indifference, psychogenic preciptiation, and so on are unreliable and lack validity and prognostic significance. Variables that appear to have clinical and prognostic importance, such as attributions, cognitions, and avoidances, are ignored. Physicians therefore rightly tend to ignore the psychiatric classifications of hysteria, and for the following reasons. First, we keep changing them. Second, they were invented by psychiatrists but used by neurologists. Third, they do not include the patients they should. And finally, the diagnosis cannot be used in front of patients anyway. Instead, doctors tend to use the term hysteria first to simply mean the absence of organic causes, and second, as a complex system of codes and euphemisms. It is now time to finally abandon the classic psychoanalytic derived criteria for conversion disorder, and instead classify hysterical symptoms in clinically relevant ways.

Introduction

In this chapter I shall discuss the problem of classifying conversion disorders, and conclude that there is a wide discrepancy between the official psychiatric classifications of conversion disorders and their use in clinical practice. This is partly a reflection of the dilemmas and ambiguities that underlie the concepts of conversion disorders, and partly because of the general problems of applying psychiatric thinking to non-psychiatric practice.

What are the current classification systems?

In DSM–IV (American Psychiatric Association, 1994) conversion disorder, which includes motor and sensory symptoms as well as non-epileptic seizures, is included under somatoform disorders, and, as many have pointed out, fugue and multiple personality under dissociative disorders. DSM–IV continues to be faithful to the analytic origins of conversion by insisting that conflicts and 'other stressors' are associated with the onset of symptoms. However, DSM–IV seems for once to lack the confidence it shows elsewhere — conversion disorder, unlike much of DSM–IV, is 'tentative and provisional' (American Psychiatric Association, 1994). The current DSM–IV criteria for conversion disorder are shown in Table 5.1.

Table 5.1 DSM–IV criteria — 'conversion disorder (F44)'

Criterion A	Symptoms or deficits affecting voluntary motor or sensory function
Criterion B	Associated psychological factors
Criterion C	Not malingering/factitious
Criterion D	Not organic/substance induced or 'culturally sanctioned'
Criterion E	Impairment necessary
Criterion F	Not another mental disorder (including somatization disorder)

ICD–10 uses a generally similar description to DSM–IV, but the placement of conversion disorder differs between the two. ICD–10 is broader than DSM–IV, including all the neurotic, conversion, and somatoform disorders under the heading of 'neurotic, stress related, and somatoform disorders'. Conversion itself comes under 'dissociation', the preferred term being 'dissociative (conversion) disorders (F44)'. In keeping with its tradition, the glossary does not list formal criteria but gives a clinical description, and links symptoms with traumatic events and with the patient's 'idea' of illness, describing symptoms as 'an expression of emotional conflicts or needs'. F44 is subdivided, with F44.4 (dissociative motor disorders) covering the standard neurological conversion symptoms. The same code (F44) also includes trance, possession, Ganser's, and multiple personality disorder.

The chequered history of the classification of conversion disorder shows why doctors are right to be confused. Mace has usefully traced the history of the idea of conversion (Mace, 1992) through the official psychiatric classification systems. It has, as Roy Porter puts it, 'waltzed in and out of the Diagnostic and Statistical Manual' (Porter, 1995). Perhaps the authors of the DSM system were uncertain — as Micale points out in the casebook that accompanies the advice from the American Psychiatric Association. The authors re-analysed the prototypical patient 'Anna O' and concluded that no fewer than four separate diagnoses were needed to explain her illness — a sign of classificatory disillusionment (Micale, 1995).

How valid are these criteria?

The formal classifications are therefore varied, and all have a negative and positive aspect. On the negative side, all the definitions of hysteria insist that the symptoms are not explained by organic illness — in other words, hysteria is one psychiatric disorder in which we can agree that symptoms are, in the famous phase, 'all in the mind'. But are they?

There are two challenges to this view. One is the classic Slater position. This will be addressed in detail in the chapter by Maria Ron, but suffice it to say that Slater's essential argument, that sooner or later most 'hysterical' conditions turn out to be presentations of classic illnesses, physical or mental, has been overstated (Crimlisk *et al.*, 1998). The other challenge questions the concept of any illness that is 'all in the mind' within the psychosomatic or somatization disorder spectrum (White and Moorey, 1997; Sharpe and Bass, 1992) or the 'pure' conversion disorders themselves (see Spence's chapter in this volume p. 235). In this critique, no disorder can ever be purely psychogenic, and mind-body dualism is suspect in general.

It is the 'positive' features of the diagnosis of conversion disorder that pose the most problems, since these classic criteria do not distinguish satisfactorily between hysteria and organic disorders. This is a serious challenge, since these classic features of conversion disorder remain enshrined in its official definitions. As Sir Aubrey Lewis predicted, several studies have criticized classic concepts such as psychogenic precipitation, secondary gain, symbolic significance, life events, and belle indifference (Miller, 1988; Chabrol *et al.*, 1995; Gould *et al.*, 1986; see Cloninger's chapter in this volume, p. 49).

The requirement for psychogenic precipitation is certainly questionable. Early studies tended to confirm this (e.g. Raskin *et al.*, 1966), but are open to debate. Even though a patient of Raskin's reported that her right arm dystonia had been caused by a bitter argument with her father during which he had twisted her arm, what are we to make of this? Clearly patients and doctors alike can search after psychological meaning. Other studies cast considerable doubt on the specificity of psychological precipitation (Watson and Buranen, 1979). It may be, however, that psychogenic precipitation becomes more clear-cut in certain settings, such as a military one (see Palmer's chapter in this volume p. 12).

Secondary gain, although often reported as present (Raskin *et al.*, 1966; Baker and Silver, 1987), must be one of the most difficult judgements to make in clinical practice, and is anyway hard to separate from the general advantages of the sick role. For example, Raskin stated that the majority of hysterical patients 'reported using conversion reactions or other physical symptoms as a psychological defence' — but this judgement obviously depends on Raskin's own interview skills and interpretation. There are benefits to being ill, whether one has cancer or hysteria, yet that does not prove that the purpose of developing cancer is to gain extra care and attention and to avoid work.

Clinical experience suggests that patients are rarely indifferent to their symptoms (Kirmayer and Taillefer, 1997). Far from being indifferent, anxiety levels are actually high and physiological reactivity increased (Lader and Sartorius, 1968; Rice and Greenfield, 1969). Even DSM–IV concedes that 'belle indifference' can occur in other medical conditions. Finally, Gould and colleagues looked for all of the classic features of conversion disorder (history of hypochondriasis, secondary gain, la belle indifference, non-anatomical sensory loss, split of midline by pain or vibratory stimulation, changing boundaries of hypalgesia, give-away weakness) in a consecutive series of 30 acute neurological admissions. All subjects showed at least one of these findings; most presented three or four. The authors concluded that 'the presence of these "positive" findings of hysteria in patients with acute structural brain disease invalidates their use as pathognomonic evidence of hysteria' (Gould *et al.*, 1986; see also Cloninger's chapter in this volume p. 49).

Thus, the classic features of conversion disorder, as repeated in the current official classifications, are either unreliable, untrue (belle indifference), unratable (primary gain) or a non specific consequence of being sick (secondary gain).

What happens in real life?

Perhaps for the reasons already given, the current classifications leave much to be desired. In psychiatric clinics around the world, the classification has 'limited utility' (Alexander *et al.*, 1997); the diagnoses are rarely made, whilst the majority of patients for whom the

doctor considers the diagnosis is appropriate do not fit into the defined sub-categories of dissociative (conversion) disorders (Das and Saxena, 1991; Alexander *et al.*, 1997). Instead, in India the two main groups were those with short-term alterations of consciousness (which they called 'brief depressive stupor') and pseudo seizures. In a Japanese psychosomatic clinic the most common DSM–III–R and DSM–IV diagnosis was 'somatoform disorders NOS' (Nakao *et al.*, 1998). Even in the USA the majority of patients with a primary diagnosis of dissociative disorder were placed in that well-known but unsatisfactory category, unspecified or atypical (Mezzich *et al.*, 1989).

There is a further irony. As noted here, DSM–IV has made a determined effort, as part of its nosological drive, to remove the word 'conversion' from hysteria and replace it with dissociative disorder. As part of 'the Second Coming' of biological psychiatry, American psychiatry has been keen to distance itself from its Freudian origins by removing hysteria from its psychiatric classifications. Thus hysteria, from being the quintessential Freudian disorder, becomes dissociative disorder.

However, few clinicians seem to have taken any notice. Why is this? One reason may be that the classic Freudian interpretations of conversion made little impact on the clinicians (non-psychiatrists) who actually treated these patients. One possible exception remained in French psychiatry, where classic interpretations of hysteria survive and prosper, but perhaps more from a sense of nationalistic pride than intellectual rigour.

What do doctors actually do?

Most doctors probably do not use the classic psychoanalytic formulations and certainly hardly ever use 'not otherwise specified' (NOS), atypical, and the like. So what do they do? In an interesting study, Mace and Trimble (1991) conducted a survey amongst British neurologists regarding their diagnostic practices. The first point to note is that when asked in what percentage of cases psychological factors were important, answers ranged from 1 per cent to 90 per cent! The second confirms one's own intuition that neurologists use terms such as 'functional', 'hysterical', and 'psychogenic' interchangeably, whilst 'conversion' is distinctly less popular. The term 'somatoform' might as well not exist as far as UK neurologists were concerned.

Instead, Mace and Trimble demonstrated that neurologists tended to make both formal and informal diagnoses. For example, 29 per cent said they never used the term 'hysteria', but another 18 per cent said they used it 'informally', by which they meant in conversation with their colleagues. Many years of hospital research and discussions at conferences have convinced me that this indeed is the case. I would argue that doctors use hysteria in two ways — the formal one being the hysterical symptom, in which the cardinal, and indeed only rule, is that the symptom cannot be explained by organic disease. At the same time doctors also use it in an informal, behavioural sense, touching on the concept of abnormal illness behaviour, and using the concept to mean a distortion of the doctor– patient relationship. 'Hysteric' is one of the many synoymns that doctors have adopted for the difficult patient, joining 'heartsink' and so many other terms — although in practice the difficult patient is more often part of the multi-symptom/somatization disorder class (Hahn *et al.*, 1996; Jackson and Kroenke, 1999).

Why don't doctors use the term 'hysteria'?

Why are doctors so reluctant to follow the strictures of psychiatric classification when confronted with a patient with unexplained loss of function? Perhaps the most obvious reason lies in the professional demarcation between neurology and psychiatry. It is psychiatrists who are most involved in the formal classification of hysterical symptoms — and anyone who reviews the rich intellectual history of psychiatric writings on hysteria might be forgiven for thinking that dealing with hysterical patients is at the heart of psychiatric practice. Not so. Indeed almost the opposite is true. Psychiatrists have increasingly little practical experience in dealing with neurosis of any kind (Wessely, 1996), let alone the complex disorders that exist in general hospitals. Of those actually diagnosed with conversion disorder in general practice in Nottingham, only one third had been referred to psychiatrists (Singh and Lee, 1997). Numerous studies have demonstrated that the patient with medically unexplained symptoms in general, and conversion disorder in particular, is rarely seen by a psychiatrist (e.g. Ewald *et al.*, 1994; Hamilton *et al.*, 1996; Anon, 1995).

We therefore have the paradoxical situation of psychiatrists deciding the diagnostic rules for patients who are largely under the care of physicians. As Mace has pointed out, during the last hundred years hysteria has become progressively more identified with the syndromes of neurology, and 'finally exclusively so' (Mace, 1992). At the same time, the psychiatric literature has become crowded with titles on the 'end of hysteria' (Slavney, 1990) and bemoaning the disappearance of 'Anna O' (see Micale, 1993).

In practice, neurologists have a rather more straightforward view of conversion — they use the term when there is loss or distortion of neurological function which cannot be explained by organic disease (Marsden, 1986). Used in this way, Marsden estimates that hysteria accounts for about 1 per cent of admissions to the National Hospital for Neurology in London, and has done so for the last 50 years. This is unlikely to change.

The problem of somatization

A rarely discussed issue is the diagnostic status of somatization disorder. In theory, these patients should be different — even if the St Louis school confused matters by widening the scope of hysteria to include multiple medically unexplained symptoms, as in Briquet's hysteria, and subsequently somatization disorder. 'Conversion is conceptual, somatization is purely descriptive' (Martin, 1999) — but in practice it is not so simple. There is no rigid distinction between the categories, despite what the nosologists have tried to convince us.

Mace and Trimble (1996) reported that although only 4 per cent of patients in their study initially received the diagnosis of somatization disorder, ten years later 64 per cent met criteria for the disorder. Likewise, among the 23 cases that GPs 'thought fulfilled the criteria' for conversion disorder, six were polysymptomatic and one fulfilled criteria for somatization disorder (Singh and Lee, 1997). In Marsden's clinical practice of conversion disorder at an in-patient neurology ward in London, perhaps one fifth would satisfy diagnostic criteria for somatization disorder (Marsden, 1986). Researchers themselves seem not to heed such distinctions (Ewald *et al.*, 1994). There are numerous other studies

suggests that doctors frequently use anatomical or pathological terms loosely and not always accurately (Kouyanou *et al.*, 1997).

The reluctance of doctors to use the term hysteria has had another unlikely side-effect: patients can suspect that it is being applied to them when that is probably not the doctors' intention. It is a rare patient in our chronic fatigue clinic who does not report that one or more doctors have implied or insinuated that their problems are hysterical (Deale and Wessely, in press). Conversion disorder is actually relatively uncommon in a chronic fatigue clinic, but all too often we have the impression that the lack of diagnostic clarity, the fear that the doctor says one thing and means another, and a simple misinterpretation of the meaning of phrases such as depression, means that the spectre of hysteria hangs over all encounters between patients with medically unexplained symptoms and their conventional doctors.

Nortin Hadler has outlined the dilemma facing patients with medically unexplained symptoms in general, and conversion in particular (Hadler, 1996). That is, to get well in these circumstances is to abandon veracity. Patients will be more inclined to get better when they have satisfactory explanations for their problems (Brody, 1994). By satisfactory I mean from the patient's point of view, from a symbolic or even metaphorical perspective — not in a narrow scientific sense (Coulehan, 1991; Kirmayer, 1993; Butler and Rollnick, 1996). Explanations that are not acceptable are not immediately discarded. Instead, the patient may embark on a mission to actively prove them false. Hysteria then, is a term used by doctors, but not shared with patients. Hysteria is, as David has remarked, the 'H' word — the diagnosis that dare not speak its name (David, 1993).

What has been proposed?

A group of international researchers experienced in this area made a laudable effort to improve the classification of psychosomatic disorders, but their efforts on conversion disorder remained trapped in history (Fava *et al.*, 1995). Symptoms and loss of function were joined, and belle indifference, histrionic personality, precipitation by stress (but of which the patient is unaware), and a history of similar symptoms 'observed in someone else or wished on someone else' were retained.

Another suggestion is to have a category of 'specific somatoform disorder' (Rief and Hiller, 1999), based on the presence of at least one symptom (but not multiple symptoms, which is included under their proposed polysymptomatic somatoform disorder), and in which the only other mandatory requirement is for disability. Within this category will appear not only conversion disorder but also 'chronic fatigue sub-type' — a proposal not likely to endear the authors to some. Others place conversion disorders firmly under the heading of somatization disorders (Martin, 1999).

However, perhaps the most persuasive solution is simply to regard conversion as a symptom, rather than a diagnosis (Ebel and Lohmann, 1995; Binzer *et al.*, 1997). It seems that that is how neurologists use it in practice (Marsden, 1986) — it is a 'descriptive neurological shorthand' (Marsden, 1986), in the same category as an hemianopia. Even DSM-IV concedes that it is 'tentative and provisional' (American Psychiatric Association, 1994).

Another reason for the difficulty in classifying conversion disorder is the ambiguity of the term. The contributors to this volume, who have carefully reviewed the issues, remain in considerable doubt as to what hysteria actually means. So what chance does the average doctor have? The term hysteria is unsuited to the diagnostic process anyway — a diagnosis is supposed to determine what a patient has, but as Slavney points out, hysteria is more what a patient is, or what a patient does (Slavney, 1990).

Conclusion

The formal diagnostic criteria for hysteria are unsatisfactory for the following reasons:

1. we keep changing them;
2. they were invented by psychiatrists but are used by neurologists;
3. they have too many categories, which are too unreliable for both clinical and research purposes;
4. they do not include the patients they should, or do so via categories such as NOS;
5. they cannot be used in front of patients;
6. they do not relate to variables that have clinical and prognostic importance, such as attributions, cognitions, and avoidances;
7. in severe cases, hysteria is indistinguishable from somatization disorder.

Instead, doctors tend to:

1. use a system of codes and euphenisms;
2. use hysteria as a symptom, not a diagnosis;
3. distinguish between symptoms and loss of function;
4. use it simply in a crude organic versus non-organic form.

So, what should we do or propose?

1. The classic psychoanalytic-derived criteria for conversion disorder should be dropped once and for all.
2. We should classify in clinically relevant ways — the suggested distinctions that appear to have some empirical and practical validation would be a diagnosis that continues to insist that either symptoms and/or loss of function be inexplicable in conventional biomedical terms, and then distinguish between symptoms and loss of function, and between acute and chronic onset of either.
3. Finally, whatever we call these conditions, we can anticipate that in time they will acquire the stigma now associated with the term hysteria. Stigma comes not from the term itself, but from the dualistic way in which doctors continue to approach medically unexplained symptoms, and the way in which the physical/psychological divide carries so much subtext of deserved/undeserved or real/unreal (Kirmayer, 1988).

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