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American Medical Association Journal of Ethics
March 2008, Volume 10, Number 3: 158-160.

CLINICAL PEARL

Recognizing and Treating Conversion Disorder

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Our current understanding of conversion disorder dates back to late 19th-century Paris. At that time, Sigmund Freud was studying neurology with Jean-Martin Charcot and became intrigued with the connection between the mind and body, particularly in women who displayed unusual neurologic symptoms. Many of these women were subsequently diagnosed with hysteria. Freud coined the term “conversion” based on his understanding that these individuals *converted* a psychological conflict or trauma into a physical symptom. Indeed, it was Freud’s study of these patients that led him to develop his initial theories of psychoanalysis.

Conversion disorder remains characterized by neurologic deficits that are not fully explained by a known neurologic or medical pathology. Psychological factors, such as conflicts or stress, are believed to either cause or exacerbate the symptoms. According to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, conversion disorder is classified as a somatoform disorder [1]. Studies have reported that 5-15 percent of psychiatric consultations involve patients with conversion symptoms. The female-to-male ratio of those who suffer from this ailment has ranged from 2-to-1 up to 10-to-1. Although conversion disorder can occur at any age, it is most common in adolescents and young adults, and it is seen more frequently in individuals from rural areas, with less education, with lower IQ, and in military members exposed to combat [2].

The etiology of conversion disorder most likely involves psychological as well as biological and neurological factors. Classically, its symptoms have been explained as a result of unconscious conflict between a forbidden wish of a patient and his or her conscience. The conversion symptom symbolically represents a partial wish fulfillment without the individual’s full awareness of the unacceptable desire. An example of this phenomenon is the person who experiences sudden paralysis of his arm due to an unconscious desire to strike his wife. The resulting condition both prevents him from acting on his wish and, in addition, may express underlying aggression by forcing his wife to compensate for his new disability. Biological factors that may characterize conversion disorder include impaired cerebral hemispheric communication, excessive cortical arousal that inhibits the individual’s awareness of bodily sensations, and possibly subtle impairments on neuropsychological tests.

The *Diagnostic and Statistical Manual of Mental Disorders* diagnostic criteria for conversion disorder require the presence of all of the following [3]:

- A. One or more sensory or motor deficits suggesting a neurological condition;
- B. Psychological factors (stressors or conflicts) associated with the initiation or exacerbation of the symptom;
- C. Symptoms not produced intentionally (as in factitious disorder or malingering);
- D. Symptoms not fully explained by a general medical condition, the effects of a substance (medication or drug/alcohol), or a culturally sanctioned behavior;
- E. Symptoms cause clinically significant distress or impairment of function;
- F. Symptoms not limited to pain, sexual dysfunction, or part of somatization disorder.

The most common deficits of conversion disorder are paralysis, blindness, and mutism. Other common symptoms are anesthetics, paresthesias (particularly of the extremities), deafness, abnormal movements, gait disturbances, weakness, tremors, and seizures (so-called pseudoseizures). In all of the above, the presentation and physical exam are not consistent with a known neurological, anatomical, or physiological pathology. *La belle indifférence* (the patient's lack of concern regarding the apparent magnitude of the deficit), once believed to be a hallmark of conversion disorder, is not consistently present.

The most important and difficult step in treating conversion disorder is making the correct diagnosis. Studies have found that 25-50 percent of patients diagnosed with conversion disorder are eventually discovered to have a medical condition that could have caused the symptoms. A thorough medical and neurologic workup is therefore essential for patients with suspected conversion disorder. Pathologic conditions that can look like conversion include brain tumors, multiple sclerosis, myasthenia gravis, basal ganglia disease, optic neuritis, Guillain-Barre, Creutzfeldt-Jakob, and AIDS. Somatization disorder may manifest with conversion characteristics, but patients with the former have a chronic course with physical symptoms in multiple other organ systems. Conversion disorder is often confused with both factitious disorder and malingering. In factitious disorder, individuals consciously create illness as a means to assume the sick role. Malingers consciously fake symptoms or illness to achieve secondary gain (e.g., avoidance of work, jail, or military duty or obtaining compensation).

Psychiatric disorders that are often present with conversion disorder include somatization and depressive, anxiety, and personality (particularly histrionic) disorders. It is not uncommon for patients with a conversion disorder to actually have some underlying neurologic pathology (such as a seizure disorder), in which case their conversion symptoms are elaborated.

In most patients, conversion disorder tends to be self-limiting. As high as 90-100 percent of symptoms resolve in several days to a month. While many individuals never experience another episode, up to 25 percent have further episodes during times of stress. A better prognosis is associated with a sudden onset, a definite

stressor, good premorbid functioning, lack of comorbid psychiatric disorders, and absence of litigation proceedings related to the illness. The longer conversion symptoms are present, the worse the prognosis.

Confronting patients about the “psychological nature” of their symptoms can and usually does make them worse. Supportive psychotherapy, focused on coping with the underlying conflicts and stress, can help bring about a resolution to conversion disorder. Hypnosis and relaxation exercises can also be helpful. Administration of amobarbital or a benzodiazepine may help to obtain further history, particularly after an unremembered traumatic event. Other forms of psychotherapy, such as insight-oriented or short-term psychotherapies can also be of benefit.

Notes and References

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: American Psychiatric Association; 1994:445.
2. The description of the general nature, prevalence, and treatment of conversion disorder and the probable prognosis for those with the disorder draws substantially from Sadock BJ, Sadock VA. *Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences, Clinical Psychiatry*. 9th ed. Baltimore, MD; Williams & Wilkins; 2002.
3. American Psychiatric Association, 457.

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