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ORIGINAL ARTICLE/ARTICLE ORIGINAL

Conversion disorders: Psychiatric and psychotherapeutic aspects

Psychiatrie et psychothérapie de l'hystérie

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Summary Hysteria is still stigmatized and frequently associated with lying or malingering. However, conversion disorder is not malingering, nor factitious disorder. The first step for the clinician faced with suspected conversion disorder is to make a positive diagnosis, which is in fact an integral part of treatment. In the emergency situation, it is important to look for an underlying somatic disorder. Although no specific treatment exists, there is a consensus in favor of a positive role of psychotherapy. First of all, the main problem is to explain to patients that their physical complaint has a psychological cause. In order to deliver the diagnosis in the most appropriate and useful manner, physicians have to first convince themselves before trying to convince patients. Combined consultation (medicine and psychiatry) is a useful tool to help patients. With or without combined consultation, this approach requires patience and open-mindedness to motivate patients to recognize the value of psychotherapy. Coordination between specialists and general practitioners is an important part of this treatment, which frequently requires long-term intervention.

MOTS CLÉS
Hystérie ;
Troubles conversifs ;
Troubles somatoformes ;
Psychothérapie ;
Traitement ;

Résumé On continue régulièrement à stigmatiser l'hystérie en tant que tableau fréquemment associé au mensonge ou à la simulation. Or, les désordres conversifs ne sont ni de la simulation ni des désordres feints. La première étape pour le clinicien confronté à une suspicion de conversion est de poser un diagnostic positif, ce qui constitue en fait une partie intégrante du traitement. En situation d'urgence, il est évidemment essentiel d'exclure un problème somatique sous-jacent. Bien qu'il n'y ait aucun traitement spécifique, il existe un consensus d'opinion en faveur du rôle positif de la psychothérapie. D'abord et avant tout, le premier problème est d'expliquer au patient que ses plaintes physiques sont d'origine psychologique. Afin de pouvoir transmettre ce diagnostic de la manière la plus appropriée et convaincante, le médecin doit

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en être personnellement convaincu avant d'essayer de convaincre le patient. Une consultation combinée (médecine et psychiatrie) peut constituer un outil utile d'aide au patient. Que la consultation soit ou non organisée de manière combinée, l'approche requiert beaucoup de patience et d'ouverture d'esprit afin de motiver le patient à reconnaître la valeur de la psychothérapie. Une coordination entre les spécialistes et les médecins généralistes est essentielle en vue de ce traitement qui demande régulièrement une prise en charge au long cours.

Introduction

Hysteria is still stigmatized, being frequently associated with lying or malingering. However, precise definitions have long existed, but these still generally fail to overcome the a priori assumptions of doctors, other paraclinical personnel and patients' families (as well as those of the general population).

Conversion disorder is not equivalent to malingering, whose symptoms and motivation are conscious, nor to factitious disorder, whose symptoms are conscious but in which motivation is unconscious.

In conversion disorder, production of symptoms and motivation are unconscious phenomena and benefits are both primary (being an attempt to resolve feelings of anguish) and secondary (with a function of patient protection, but also a powerful reinforcement of symptoms) as summarized by Zumbrummen [22] (see Table 1).

These definitions are an indispensable prerequisite for practice, since a good definition of conversion disorders (i.e., medical or neurological definition) involved in the diagnostic process is inextricable from the treatment process. Those definitions have also been confirmed in the diagnostic and statistical manual for psychiatry in which conversion disorder is classified as a subtype of somatoform disorders [2].

The therapeutic process from the doctor's point of view can be summarized in three parts:

- make the diagnosis and be convinced of it;
- announce the diagnosis to the patient;
- and help the patient to engage in psychotherapy.

The first therapeutic step when faced with suspected conversion disorder involves active search for any physical illness.

In contrast to what was previously suspected, according to Slater and Glithero's works [18], in which organic disease was finally discovered in 2 cases of 3 at 10-year follow-up. Stone et al. [20] showed in fact that diagnostic error rate decreased with time. However, the authors' explanation is that improvement of diagnosis is less connected to advances in medicine (such as development of neuroimaging) than the improvement of the study methodology and evaluation criteria. Thus, the current misdiagnosis rate of conversion disorder stands at 4%, comparable to the misdiagnosis' rate for schizophrenia (8%) [20].

Therefore, for any suspicion of conversion disorder, the first therapeutic step involves active search for a physical illness. This is particularly true for patients seen in the emergency department, since the cultural and social plasticity of hysteria means that virtually any form of clinical presentation may be seen. On the other hand, since the diagnosis of conversion disorder is based on clear-cut positive arguments, further researches toward a presumed organic disease can be seen as unnecessary, or rather deleterious. In fact, before the diagnosis of conversion disorder has been established, a so-called ''physical illness'' should first be investigated, but as soon as the diagnosis of conversion disorder is established, there is no need for further diagnostic tests. Multiplicity of additional tests may have iatrogenic consequences particularly because of ''medical nomadism''. For example, we report the case of a patient suffering from chronic chest pain who presented with radiation-induced coronary artery disease due to multiple coronary angiographies performed acutely in different hospitals over many years.

Psychiatric evaluation must also be alert to the possibility of medico-psychiatric involvement. Indeed, neurolupus may present with psychiatric clinical signs (malignant catatonia, psychotic depression), which could prove lethal if not detected and appropriately treated.

Thus, we insist on the importance of good collaboration between physicians and psychiatrists to provide recognition of the unity of symptomatology. Acceptance of the diagnosis is a critical outcome predictor [5].

Diagnosis of conversion disorder

Diagnosis of conversion disorder is very difficult. First of all, the physician must beware of overconfidence in his (her) own judgment and symptoms that seem to fit ''too nicely''. Stone et al. [20] reported 4% false positives and found a combination of a conversion disorder with a somatic disorder in 10 to 25% of cases (raising the interesting question of whether people are good at imitating what they have). In other words, everything that is strange is not necessarily psychogenic.

As long as the diagnosis appears unsure to the patient, improvement of symptoms will be delayed. A careful distinction must be made between:

- an unusual, somewhat ''strange'' clinical presentation that deserves full ''somatic'' investigations, and:
- established conversion disorder where there is less need to embark upon extensive examination.

For example, we report the case of a patient presenting with theatrical and histrionic symptoms who was admitted to the emergency department with protraction of her tongue and unexplained tremors; this turned out to be due to serotoninergic syndrome secondary to fluoxetine treatment