Organic syndromes diagnosed as conversion disorder: identification and frequency in a study of 85 patients


aPsychiatric Hospital, De Grote Rivieren, Overkampweg 115, 3318 AR Dordrecht, The Netherlands
bDepartment of Clinical Psychology, Leiden University, Leiden, The Netherlands
cDepartment of Psychopathology, University of Nijmegen, The Netherlands
dGeneral Hospital “Albert Schweitzer,” Dordrecht, The Netherlands

Received 23 April 1999; accepted 21 July 1999

Abstract

Background: The percentage of patients initially diagnosed with a conversion disorder and later identified as having an organic disorder has been decreasing in recent studies. Method: Consecutive patients with a diagnosis of conversion disorder were referred for psychiatric diagnosis and treatment. Research questions were: (1) What incidence of neurological disorder is revealed by neurological reassessment and by which diagnostic technique is the final diagnosis established? (2) What differences can be observed between true-positive and the false-positive results? Results: Ten (11.8%) of the 85 patients examined appeared to suffer from a neurological disorder. In this sample, variables discriminating between the true positives and false positives were: (1) prior suspicion of neurological disorder; (2) older age at referral; (3) older age at onset of symptoms; (4) longer duration of symptoms; and (5) use of medication. Three variables contributed significantly to the prediction of organic disorder: prior suspicion of neurological disorder; age at onset of symptoms; and duration of symptoms. Conclusions: Although our results are in line with those of other recent studies, the percentage of false positives was still high. The data further emphasize the dangers of making a diagnosis of conversion disorder in the absence of positive evidence. It is important to continue to provide follow up for patients with a diagnosis of conversion disorder. Unfortunately, unreliable psychiatric indications, like certain behavioral characteristics, are still used in the diagnostic process. The results show that a general neurological examination is still a valuable diagnostic instrument in addition to modern diagnostic techniques. © 2000 Elsevier Science Inc. All rights reserved.

Keywords: Psychogenic motor symptoms; Conversion disorder; Neurological reassessment; False positives; True positives; Identification

Introduction

The percentage of patients initially diagnosed with a conversion disorder [1] and later identified as having an organic disorder, in most cases a neurological disorder (i.e., a so-called false positive), has changed from the early days of Slater and Glithero [18], who considered the incidence to be high, to rather lower levels in more recent studies. Table 1 provides an overview of the most relevant studies.

Comparison of these studies is difficult for a number of reasons. First, some studies that find a high percentage of organic disorder, are quite dated. Since these works, major developments have occurred in the technical diagnosis of patients and advanced diagnostic techniques have become available [2–6]. The studies are also difficult to compare due to differences in descriptions of the symptoms and delineation of the relevant symptom patterns (both pseudo-neurological symptoms and pain symptoms or vomiting are mentioned). The fact that the diagnostic categories are often not mutually exclusive further complicates comparison [7, 8]. In such a manner, Weintraub [9] cited a high false-positive rate of 63.5% in a study by Whitlock [10], but his patient group consisted of patients with coexisting neurological or organic disease.

Considerable differences between these studies also exist in the duration of the symptoms, the frequency of repeated
physical examination, the thoroughness and care with which
the diagnosis was performed, the research setting, and the
time of follow-up. It appears that, with increased follow-up
time, there is an increased probability of encountering
neurological disease that can, in retrospect, explain the
initial symptoms.

Finally, in a number of studies, diagnoses were deter-
mined by exclusion of an organic disease without further
positive confirmation on the basis of psychiatric examina-
tion. In contrast, there are indications that patients with a
previous psychiatric history are at a greater risk of having
their neurological symptoms attributed to a psychiatric
syndrome [5].

The aim of the present study was to explore the follow-
ing questions:

1. What incidence of neurological disorder is revealed
by neurological reassessment, and by which diag-
nostic technique is the final diagnosis established?
2. What differences can be observed between the
organic or false-positive group and the conversion
or true-positive group on the basis of the available information?

Method

Neurological reassessments and psychiatric examinations
were undertaken on consecutive patients with a prior diag-
nosis of conversion disorder upon their referral to a Dutch
psychiatric hospital (De Grote Rivieren) for examination

Inclusion criteria for the study were:

- A diagnosis of motor-type conversion disorder (i.e.,
paresis or paralysis, gait disturbances, coordination
problems, abasia–astasia, aphonia, fits, or pseudoe-
pileptic seizures with motor activity).
- No dual neurological diagnosis, no major affective
disorder, or other severe psychiatric diagnosis requir-
ing immediate treatment;
- Duration of symptoms of at least 1 month.
- Both genders between 18 and 65 years of age.
- No problems with speaking the Dutch language.

Neurological testing of all patients was carried out by
two neurologists at a nearby general affiliated hospital. Each
patient was seen by both neurologists. Further diagnostic
techniques were carried out on the basis of the results of the
neurological examination, and of recent previous assess-
ments. When appropriate, the neurologists referred the
patient to another somatic specialist or to a specialist clinic
for further diagnostic procedures.

The psychiatric screening using the DSM-III-R [24]
criteria took place on the same day as the neurological
screening by a psychiatrist from our psychiatric hospital.
The study was approved by the medical ethics committee of
the hospital and patients provided informed consent.

Results

Subject characteristics

Our sample consisted of 85 patients (21.2% men and
78.8% women). Upon referral, their mean age was 38
years (sd = 12.7, range 17 to 65) with a mean onset at
the age of 33.5 years (sd = 12.6; range 15 to 67). The
duration of the symptoms was an average of 4.3 years (sd
= 6.0, median 3.8 years, range 2 months to 34 years). In
27 (32.1%) patients, the onset of the symptoms had been
acute (within 1 week). Forty (47.6%) patients had re-
ported the same or other conversion symptoms in the
past. Fifty-seven (67.1%) patients had received previous
psychiatric treatment. Medication (psychotropic or non-
psychotropic) was being taken by 54 (65%) patients at the
time of referral.

All patients had already been seen by an average of
three somatic specialists, including a neurologist. Previous
assessments took place in general hospitals, research
hospitals, or, in the case of patients with pseudoepileptic
seizures, specialist epilepsy centers. For 26 (30.6%) patients, organicity was previously suspected, but despite
often extended supplemental examination (including EEG,
CT scan, MRI, and CSF), an adequate somatic cause for
symptoms could not be found.

Forty-four patients had motor symptoms (either absence
of motor function; e.g., hemiplegia or paraplegia) or pre-

<table>
<thead>
<tr>
<th>Investigators</th>
<th>N</th>
<th>False positives (%)</th>
<th>Follow-up (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tissenbaum et al. [14]</td>
<td>395</td>
<td>13.4b</td>
<td>1–8</td>
</tr>
<tr>
<td>Gatfield and Guze [20]</td>
<td>24</td>
<td>17</td>
<td>5–12</td>
</tr>
<tr>
<td>Slater and Glithero [18]</td>
<td>85</td>
<td>50</td>
<td>10–14</td>
</tr>
<tr>
<td>Raskin et al. [21]</td>
<td>50</td>
<td>29</td>
<td>1</td>
</tr>
<tr>
<td>Whitlock [10]†</td>
<td>56</td>
<td>63.5</td>
<td>—</td>
</tr>
<tr>
<td>McKechnie [8]†</td>
<td>144</td>
<td>47</td>
<td>—</td>
</tr>
<tr>
<td>Merskey and Buhrich [7]†</td>
<td>89</td>
<td>67</td>
<td>—</td>
</tr>
<tr>
<td>Stefansson et al. [22]</td>
<td>64</td>
<td>12.5</td>
<td>7–16</td>
</tr>
<tr>
<td>Watson and Buranen [23]</td>
<td>36</td>
<td>28</td>
<td>10</td>
</tr>
<tr>
<td>Fahn and Williams [24]</td>
<td>396</td>
<td>40.1</td>
<td>—</td>
</tr>
<tr>
<td>Spierings et al. [2]†</td>
<td>84</td>
<td>6</td>
<td>1–11</td>
</tr>
<tr>
<td>Mace and Trimble [5]</td>
<td>73</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Couprie et al. [6]</td>
<td>64</td>
<td>4.7</td>
<td>7–9</td>
</tr>
</tbody>
</table>

Table 1 Percentage of patients initially diagnosed with a conversion disorder and later with an organic syndrome (false positives)

a Conversion disorder and co-existing neurological or organic disease (not specified).

b After follow-up, 53 of the 395 psychiatric (13.4%) were found to have organic disease; 17 of the 53 (32%) were originally diagnosed as conversion disorder.

† A study with children and youngsters (range 6–17 years).
دریافت فوری
متن کامل مقاله

امکان دانلود نسخه تمام متن مقالات انگلیسی
امکان دانلود نسخه ترجمه شده مقالات
پذیرش سفارش ترجمه تخصصی
امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
امکان دانلود رایگان ۲ صفحه اول هر مقاله
امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
دانلود فوری مقاله پس از پرداخت آنلاین
پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات