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Letter to the Editor

From conversion disorder (DSM-IV-TR) to functional neurological symptom disorder (DSM-5): When a label changes the perspective for the neurologist, the psychiatrist and the patient

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The term "conversion disorder", as used in DSM-IV-TR, describes symptoms such as weakness, epileptic-type attacks, abnormal movements or sensory disturbance that are not attributable to a structural damage to the nervous system or to feigning and that are considered to be associated with psychological factors [1]. The traditional label "conversion disorder" refers to a hypothesis based on a psychological aetiology. In fact, historically, psychological and emotional factors, such as trauma, conflict or distress, have been suggested as causal factors of conversion disorders [2]. This explanation is also reflected in the various alternative terms used to describe these disorders, such as psychological, psychogenic, psychosomatic, or even hysteria. Distress and psychological trauma are indeed seen at higher rates in these patients than the healthy population, but recently they have not been found to be either sensitive or specific markers [3]. Thus, an alternative, perhaps equally problematic terminology focuses on what patients do not have (non-organic, medically unexplained symptoms) [4]. Indeed, the related debates regarding the "psychogenic" or "non-organic" causes of these disorders portray a compartmentalized, dualistic brain and mind relation that has not been supported by centuries of scientific research.

Although long dominant, the psychodynamic hypothesis is now just one of the many competing etiological hypotheses and has little supportive empirical evidence. This is why a new (but not new) term (functional neurological symptoms) has been recently coined in order to give a more proper and respectable definition to these symptoms. The adjective "functional" refers to the main characteristic of these symptoms, namely that normal function is always possible; on the other hand it does not provide any causal link either to psychological or to any other possible aetiological factors, focusing more on "how" symptoms might be produced than on "why" [5–7].

As a result, there has been a reduced emphasis on psychological and emotional events prior to the development of symptoms (i.e. sexual abuse, remote or recent life events). Indeed, several studies have demonstrated that such traumatic events, although clearly important, might not play a unique role in the aetiology of these symptoms [3].

Another significant aspect is that the label "conversion disorder" has not been widely accepted by either doctors (both neurologists and psychiatrists) or patients. Clinicians, scientists and patients therefore have needed a name that sidestepped the traditional brain/mind dichotomy, being clinically more widely used and more accepted.

These are the reasons why, after a long debate, the most recent version of the DSM provided the additional denomination, also if just in brackets, of "functional neurological symptom disorders". In addition, the requirement for the presence of a psychological stressor preceding onset of symptoms has been downgraded from an essential to a supportive criterion and has been replaced by a criteria emphasizing the need for positive diagnostic symptoms and signs.

This change, which is just apparently a nomenclature change, actually leads to significant diagnostic and therapeutic modifications. In fact, first, it leads to a significant modification in the consideration of these symptoms from the clinicians' perspective. Neurologists have started considering these patients as their patients because of the "neurological" part of their name, namely the role of the neurological clinical examination, which becomes the main diagnostic instrument. The International Classification of Diseases (ICD-11) is also being revised for its 11th edition in 2015; for the first time, it is hoped that functional neurological disorders will appear in the neurology section as well as the psychiatry section. Neurologists have started thinking these patients as genuine patients, exactly as patients with multiple sclerosis or Parkinson's disease. On the other hand, psychiatrists have started to collaborate with neurologists since they do not feel alone with these patients, which often are difficult to treat. Last but not least patients have started feeling themselves as genuine patients because the new "functional neurological symptom disorders" name and definition have started giving them that dignity they have never felt.

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References

[1] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 4th edition American Psychiatric Association, Arlington, VA, 2000 (Text revision).
[2] M. Hallett, S. Fahn, J. Jankovic, et al., Psychogenic Movement Disorders. Neurology and Neuropsychiatry, AAN Press, Lippincott Williams & Wilkins, Philadelphia, 2006.
[3] K. Roelofs, P. Spinhoven, Trauma and medically unexplained symptoms towards an integration of cognitive and neuro-biological accounts, Clin. Psychol. Rev. 27 (7) (2007) 798–820.
[4] F. Creed, E. Guthrie, P. Fink, P. Henningsen, W. Rief, M. Sharpe, P. White, Is there a better term than "medically unexplained symptoms"? J. Psychosom. Res. 68 (2010) 5–8.
[5] M.J. Edwards, J. Stone, A.E. Lang, From psychogenic movement disorder to functional movement disorder: it's time to change the name, Mov. Disord. Vol. 29 (No. 7) (2014).
[6] C. Ganos, R. Erro, K. Bhatia, et al., Comment on psychogenic versus functional movement disorders, Mov. Disord. 29 (13) (2014 Nov) 1696.
[7] S. Fahn, C.W. Olanow, Psychogenic movement disorders: they are what they are, Mov. Disord. 29 (7) (2014 Jun) 853–856.

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