Conversion Disorder

Conversion Disorder - what you need to understand

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Crazy Pains? Exploring the Misdiagnoses of CRPS
The diagnosis of CRPS is based primarily on the history provided by the patient’s signs and symptoms. Signs including, but not limited to redness, inflammation, warmth or coolness of the affected part can easily be perceived by the examining physician. Symptoms are sensations that a patient perceives such as reports of burning or bone crushing pain. In medicine, approximately 70% of diagnoses are made based on the following three features - history, symptoms, and signs. Any other testing such as blood tests, MRI, x-rays are done to either confirm or rule out diagnoses. The way in which CRPS is diagnosed is not an exact science and requires familiarity with associated signs and symptoms. Clinicians lacking familiarity with the peculiar symptoms of CRPS will often misattribute patient’s pain complaints to psychological disturbances.

Uninformed health care providers are branding more and more patients with CRPS with Mental Health Disorders such as Conversion Disorder and Pain Disorder. People with these mental health disorders suffer from emotional stress that causes physical symptoms such as pain, sensation changes, and movement problems. Caregivers and patients with CRPS are also misdiagnosed with Munchausen’s Disorder. This is a mental disorder where an illness is either faked or caused by the patient or caregiver in order to assume the sick role. People with Munchausen’s Disorder will deliberately harm themselves or a loved one to receive sympathy and remain in contact with medical professionals. Patients who are given any of the above diagnosis must question the validity of this diagnosis and if it does not describe their symptoms, then acquire another pain evaluation promptly.

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Our understanding of pain has evolved dramatically over the years. As in all change, there are clinicians who stick to old beliefs. One such view is that CRPS is a mental illness, more specifically a Conversion Disorder. Some clinicians believe that CRPS in children is an expression of emotional distress rather than a child’s accurate depiction of crippling pain. As we learn more about CRPS and the disease process, we are assured that CRPS is not a Conversion Disorder or any other mental disorder. For a diagnosis of Conversion Disorder, there must be these five elements present:

1. Symptoms affecting movement or sensation that suggest a neurological disorder or a general medical condition.
2. Stressors precede the initiation or exacerbation of symptoms.
3. Deliberate faking of injury must be ruled out.
4. There must be definite proof that there is no other disease and the symptoms cannot be explained by a medical condition. Or if there is a medical condition present, the symptoms experienced must be greater than what a clinician would expect for the general medical condition.
5. The symptoms cause distress and impair important areas of daily functioning.

Given the above diagnostic guidelines, mental health clinicians with a lack of pain education may label a person experiencing numbness, burning pain and weakness with a conversion disorder, especially if treating physicians have failed to identify the
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cause of the person’s pain complaints. A diagnosis of Conversion Disorder is challenging to make and is usually made over a period of time, usually years, by a psychologist who is working with other treating physicians. In America, less than 1% of patients suffer from a Conversion Disorder, Pain Disorder, or Munchausen’s Disorder. It is crucial that all medical conditions must be ruled out before coming to this conclusion, as such a diagnosis can carry serious consequences for a person living with CRPS, which is a much more common disorder. For example, once diagnosed with a conversion disorder, physicians will likely stop treating pain complaints and related symptoms and thereafter, treatments that could prevent symptom progression will be unobtainable. Although rare, conversion disorder does exist and people with this disorder are in need of mental health treatments to reduce pain and related dysfunction. Unfortunately, stigma surrounding mental illness often prevents people from receiving care that could be life changing.

Patients who develop CRPS have obvious symptoms and signs with or without any obvious external signs of injury. The degree and duration of pain is far greater than any injury and this has significant psychological effects on the patients. Clinicians who are not familiar with CRPS often mislabel these patients with a mental health disorder that is stigmatizing, adding insult to injury. For example, to make a diagnosis of Pain Disorder, the pain experienced by the patient must be greater than what the clinician would expect for the injury. For a CRPS diagnosis, the pain experienced by the patient must also be greater than what the physician would expect for the injury. Given these overlapping symptoms, Mental health professionals who lack knowledge about CRPS, may negligently label a patient’s pain complaints as best captured by Pain Disorder.

To many people’s misfortune, physicians with little mental health training often inform children who are suffering with CRPS that they have Conversion or Pain Disorder and that their pain is emotionally based. Parents hold their doctor’s expertise in high regard and thereafter tend to discount their child’s pain complaints. This results in the child withdrawing and not expressing their pain and suffering out of fear of being branded as a liar, a bad child, or an attention seeker. It is important that parents and caregivers of kids with pain suggestive of CRPS seriously listen to their children’s pain complaints. Moreover, parents/caregivers have the responsibility of making certain that the diagnosis of Conversion Disorder or Pain Disorder is made by a qualified psychologist and that this diagnosis is supported by other medical doctors. Physicians should not make this diagnosis with little to no knowledge of the signs and symptoms of CRPS and with little to no mental health training. Labeling patients that are difficult to treat with a mental illness may be the physicians attempt to hide his/her unfamiliarity regarding the diagnosis and treatment of this complex disorder. Unfortunately, physicians can recklessly document incorrect diagnoses in the patient’s chart, which is then passed on to other physicians. In order to avoid skewing the second physician’s opinion, patients can ask that only certain records be released from their chart.

Does Depression and Anxiety rule out CRPS Pain Complaints?
CRPS (RSD) is often associated with anxiety, depression, and fear in many patients because of the severity and long standing pain and loss of function. Healthcare providers who are not familiar with diagnosing CRPS and are unable to provide appropriate treatment intensify patient’s feelings of hopelessness and anxiety.
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Psychological factors such as depression and anxiety have been suspected of initiating or causing CRPS. Suspecting that psychological factors are responsible for triggering CRPS carries the assumption that pain is "all in the patient’s head" and ultimately blames the patient. This inaccurate belief is damaging to people with CRPS who are in desperate need of appropriate care and treatments. Research has supported that there is no causal relationship between depression, anxiety, anger and sleep disorders and CRPS. Despite finding no support for the mental illness model of CRPS, researchers have logically found that a high pain day (i.e., CRPS flare-up) is predictive of greater depression, anxiety, and anger in several studies. Therefore, mental illness does not cause CRPS, but rather the pain and disability caused by CRPS reasonably causes depressed mood, anxiety, anger, and sleep disturbances.

Either way, treating the psychological distress caused by this painful disorder is necessary to reduce pain exacerbations and increase a person’s quality of life. However, receiving mental health therapies should not invalidate the legitimacy of CRPS pain complaints.

A checklist if you or somebody you know in severe pain has been diagnosed with a mental illness:

1. In order to avoid skewing the second physician’s opinion, patients can ask that only certain records be released from their chart.
2. Request evidence of the diagnosis through obtaining chart records and by requesting a conversation with the treating clinician about how they arrived at their diagnosis. Patients have a right to access their medical records.
3. Ask the clinician if all other medical conditions were ruled out.
4. Assess how much time the mental health provider spent in making the diagnosis, as it generally takes several months to years to rule out general medical conditions that could account for pain symptoms.
5. Find out how much experience the physicians and other providers have in diagnosing CRPS and somatoform disorders by researching their certifications and licensures online. Remember Conversion Disorder, Pain Disorder and Munchausen Disorder are extremely rare disorders. Most clinicians have never seen a case in their lifetime.
6. What tests were administered to assess for a mental health disorder such as factitious disorder, conversion disorder or pain disorder?
7. Were these assessments appropriate for you or the patient (e.g., culture, forensic settings, age, gender, and so forth)?
8. Is there supporting information from loved ones, friends, and from several treating clinicians or is this assessment based on 1 physician’s account of the patient’s symptoms?
9. If this diagnosis is based on a physician’s assessment, is the diagnosis ethical considering his/her lack of mental health training? Does the physician have alternative gains such as writing off a bad surgery?

Although Pain Disorder, Conversion Disorder and Munchausen’s Disorder are very real, they are very challenging to diagnose. Prior to slapping such an extreme label on a
patient, medical and mental health professionals should have at least covered issues outlined in this checklist and have familiarity with pain disorders that could account for the degree of pain the patient is experiencing. They should understand thoroughly, that once a person receives the label of having a mental illness, medical interventions would be quite limited. The person experiencing symptoms will feel disregarded, be under-treated, and may suffer psychological distress from such stigmatic labeling. In the case of the CRPS population, treatment interventions that could slow disease progression will no longer be obtainable. Both physicians and Mental Health Professionals should have adequate medical knowledge about syndromes that share common criteria. Remember, it typically takes years and coordination between multiple healthcare providers to make a Pain, Conversion, or Munchausen Disorder diagnosis.