How the World Treats Conversion Disorder

A fellowship report for the Winston Churchill Memorial Trust

Richard A.A. Kanaan

Introduction

The goal of this fellowship was to review the way conversion disorder is treated outside of the United Kingdom, to see what we might learn from the success or failure of others. Conversion Disorder is a common and highly disabling psychiatric condition, though it receives little attention from either the psychiatric community, or the media more generally, except as a historical entity.

In the nineteenth century, Hysteria, as Conversion Disorder was then known, was the cause célèbre of both neurology and psychiatry. As the initial case material for Freud’s research it formed the basis of the psychoanalytic theories that came to dominate psychiatry in the early twentieth century. It reached particular prominence as ‘shell shock’ in the First World War, but then went into popular and professional decline so that by the 1960s it was routine to regard hysteria as nothing more than an historical anomaly. Yet while conversion disorder has fallen from prominence the evidence suggests there has been no decrease in prevalence. It continues to present in very large numbers to general practitioners and neurologists but it is rarely referred on to psychiatry. One consequence of this decline in psychiatric awareness has been a corresponding decline in research. A recent review of treatments, for example, found not a single treatment study meeting the accepted ‘gold standard’ for research.

Treatment centres for conversion disorder in the UK such as mine therefore rely on the opinion of experts, on consensus, and on what is done for conditions considered similar. This is clearly inadequate today and the solution is equally clear – to formalise and test the treatments we provide. But while this may be sensible it rules out a potential wealth of approaches from beyond these shores that may be equally untested in formal terms, but no less effective for that. This fellowship set out to explore the treatments employed internationally, to see if and how they differ, and what merits those differences may have.

Treatment in the United Kingdom

There are three centres in the UK for whom conversion disorder is a specialty, though there are others who also see the condition: there is the Maudsley/King’s College Hospital in London, where I work, there is the National Hospital for Neurology, Queen Square, also in London, and there is Edinburgh. All three offer somewhat similar programs. At the Maudsley, I offer an outpatient multidisciplinary assessment and either advice on management to local services or the provision of management at the Maudsley. This will include some mixture of the same constituents: psychiatric follow-up that is educational about the nature of the disorder while accepting of its reality; treatment for any co-morbid psychiatric disorders; the minimisation of unnecessary physical
investigation and treatment; the provision of rehabilitative physical therapy; cognitive behavioural therapy (CBT). The CBT is not a program specific to conversion disorder but draws on elements of the treatments for somatisation, fatigue and other disorders. If symptoms are severe, enduring or if access is particularly a problem treatment may be provided at our inpatient ward. The audit of our results is ongoing, but it is already clear that the treatment does not work for everyone, and that a significant proportion are not helped at all.

At Queen Square the treatment is largely inpatient, and they have a formalised treatment program that combines the above ingredients, but has a mandatory multidisciplinary assessment that acts as a gateway to the inpatient service, and will also tend to filter out those who will be less willing to accept the kind of help offered (so they thus will be treating a select group who should have a better outcome). Nonetheless they report a 70% success rate for those patients who make it to the ward according to their own (unpublished) audit.

In Edinburgh the treatment is largely outpatient, again comprising the same components (though as they have a neurologist with a particular interest in the disorder, I think some of the follow-up that would otherwise be carried out by the psychiatrist is carried out by him) and they have developed a manualised CBT treatment that is self-guided in the main. The results of their trial, though as yet unpublished, though they showed broad improvements, showed little change in symptoms and were disappointing when set against their early hopes.

Selecting Treatment Centres Abroad

For a relatively specialised condition that is somewhat out of the mainstream the search for treatment centres was challenging. As I have a substantial grasp of the field I knew the principle actors in the academic sphere, so the principal method employed was exploring the informal networks of those I knew to be interested in the condition, supplemented by internet searching. An additional constraint was, inevitably, the need to put the centres together in a geographical sequence that could plausibly be visited within my time constraints. The first thing that I learned from this process was that while centres such as those described in the UK above could be readily identified in Europe, they were much harder to find elsewhere. I could find nothing that resembled the set-up we have in London in North America or Australasia, for example, though of course I was relying on those whom I knew in the field to have heard of them. I even attended a conference in the US dedicated to conversion disorder, and could find no one there who knew of such a centre. There was treatment going on, clearly, but not in the same fashion as in Europe. In the end I had to make compromises, and see centres specialising in conversion disorder in children, or see individuals rather than centres, or see treatments for dissociative seizures (a sub-type of conversion disorder that is considered distinct by many). In order to appreciate what was being conducted I also proposed to visit only centres where English would be routinely spoken, or, in one case, German (which I understand a little). The trip thus took the shape of a round-the-world journey, to the US, Australia and India over the winter, followed by a separate visit to Europe in the spring.
Providence, Rhode Island, USA

The first leg of the journey was to the US, and to Brown Medical Centre in Providence, Rhode Island. This is a University Hospital where Curt LaFrance is the Director of Neuropsychiatry, and who for some years has been developing and implementing a CBT approach for the treatment of dissociative seizures. He is currently conducting a research-funded four-arm controlled trial of his technique, with Zoloft (an antidepressant) as the other intervention. The importance of his treatment being research-funded is that it is available to those who agree to participate without charge. Psychotherapy is poorly funded by many health insurance schemes in the US, and there are many who are not insured, including many of the poorer and otherwise disenfranchised in American society, who will in likelihood form a disproportionately large group of those with dissociative seizures.

Dr LaFrance based his therapy closely on a CBT manual for use in epileptic seizures, and was planning to publish his own imminently. It used 12 steps, and was heavily manualised. All 12 appointments were arranged at the initial assessment, and all were with Dr LaFrance, who had acquired his CBT experience during his psychiatric training. Each week the subjects were given a big pack of reading and homework which they had to complete and discuss the following week. It began with an outline of the program, and moved onto finding a key supporter, before deciding what to do about medication (patients will commonly be on unnecessary anti-epileptic medication that may nevertheless be difficult for them to do without). Dr LaFrance explained that it follows this pattern throughout – first equipping them with important life skills (such as finding a key supporter, in this case) before tackling problems (such as deciding how to relinquish their medication). Later sessions provided a model for their illness, and explored relaxation techniques, internal stressors and external triggers.

Dr LaFrance has already published an open-label trial of his technique, but the more formal controlled trial was still underway. He told me that his impression was that the success rate was around 90%, with most of those undergoing an abolition of their seizures. Those who tended to do less well were the ‘swooners’ – those who suffered from ‘atonic’ seizures, with repeated head injuries: though they liked the therapy, the frequency of their seizures didn’t decline. Those who had residual problems were sometimes subsequently sent for family therapy or for more CBT. He told me he has adapted this to psychogenic movement disorders, just by substituting the word ‘movement’ for the word ‘seizure’, but has not adapted it for conversion disorder more generally.

Palo Alto, California, USA

My second visit was to Dr John Barry, at Stanford University Medical Centre. He has a longstanding interest in conversion disorder and uses an ‘eclectic’ approach, with an emphasis on insight-orientation, but also
incorporating other techniques. He has a team-member who mainly does CBT, for example. Patients who he feels are resistant to therapy he sends for biofeedback, and then brings them back to him. He uses a lot of hypnosis, to demonstrate that the patient has control over their symptoms - and to give them that control. He runs group-based therapy which he feels is a useful adjunct since the patient will take direct observation from another patient in a way they won't from him.

Dr Barry did not have a formal rating of his outcomes, but he felt his success rate was good. He reports that an online patient group based in the Pacific NorthWest was popular with patients, and generally enthusiastic about him, which is a rare endorsement in a field characterised by doctor-patient discord.

**Sydney, Australia**

My third visit was to Dr Kasia Kozłowska at Westmead Children's Hospital. She provides an inpatient service for adolescents and also sees patients on other words, as a tertiary referral service, taking referrals from neurologists, funded by the state (New South Wales). Treatment begins with a thorough 'work up' and the resulting formulation and treatment plan are delivered to the family and patient together. Patients are only accepted if they sign up to the whole program: if they reject it or part of it, they are discharged but can be accepted at a later date when it is usually clear that the patient is not improving. The program is heavily structured, with school, groups (social groups, art groups, etc, in the afternoon), daily physio-and psychotherapy and weekly meetings with family and patient, which may function as family therapy in disguise.

It is understood that the patient may dislike the psychotherapy – this may even serve a useful function, as patients often need to have one 'bad guy' in the team, and the team accept this. The psychotherapy is eclectic, but focuses on stressors, triggers, and how those can be avoided or ameliorated. The therapy is partly defined by the model of attachment developed in their centre – those with inhibited attachments get work on communication and emotional expression, the combative ones get work on limit-setting and behavioural control.

Therapy is only for two weeks, though they may do repeat admissions: after two weeks, the patient, family and staff are a bit exhausted. Outpatient work continues otherwise. They expect it will take the patient as long to recover as they have been sick. They absolutely will not allow disability benefits or any other 'secondary gains' (other benefits of illness) – they refused to support someone becoming a Paralympian, for example. It is made clear that patients are expected to recover, and this is what they normally achieve: functional improvement with residual symptoms would be unusual. One difficulty they encounter is when parents won't play their part, but success outweighs failure, though again no formal assessment of their success was available.
Adelaide, Australia

My fourth visit was to Dr Jon Jureidini at The Women and Children’s Hospital in North Adelaide. They take inpatient referrals with incapacitating unexplained symptoms (weakness, pain, etc.) from the general wards of a children’s hospital. At the point when they are called in, the patient has usually just had their definitive diagnosis or it may be that they have become more problematic for their doctor. Previously, Dr Jureidini would go and see the family after the referrer, but lost too many to rejection. Now, they have a meeting with the referrer where they try to reach a consensus attribution – often only that they “don’t know” what the problem is - and then ask the family in and go through the same questioning of the referrer in front of them, trying to extend the consensus to them. They are thus ‘agnostic’ at the start, but he feels that is often accurate, and leads to fewer patient rejections. They discuss rehabilitation and pain management, and may hint at a role for psychology in that meeting.

They call their treatment model ‘restrained rehabilitation’, and it draws on the chronic fatigue syndrome treatment model adopted at the Maudsley. There is then a two-week programme, heavily timetabled. It is ‘restrained’ because they take a ‘good days/bad days approach’ (allowing patients to have setbacks), because they don’t rush (median length of stay is 10-14 days), and because they set realistic goals – typically, a return to school without the need for aids. There will be variations in functionality – some may be horseriding while still not able to return to school – and they may use the levelling of these as behavioural therapy. There are five arms to their therapy:

1. Physical rehabilitation

2. Aggressive pain management – ideally not with medication, but with medication if necessary, but using hypnotherapy, physiotherapy, relaxation.

3. A search for the symptoms of predicament – those that answer the question ‘how are they trapped?’ These fall into three camps – those where they don’t find an explanation; those where they do but they don’t think the family will accept it; those where they do and they work with the family to address it.

4. Training in expressing feelings, and showing how that’s healthy.

5. Keeping control of information: though they remain under the referring team, an allocated person will be responsible for managing the flow of information to the family and patient – including deciding with them about tests and treatment.

If the family won’t accept all of 1-5 then there is at least a harm minimisation approach: they get the referring team to see the patient regularly with the goal of minimising harm to the health system as a whole, with their support. They offer a similar model for outpatients, a bit ‘slimmed down’.

He estimates that 80-90% respond. There are about 4-7 per year who don’t get better, of the 30-50 they see each year. He feels they do least well with non-
epileptic seizures, of all their cases, as there's no physical rehabilitation possible. If they don't get anywhere in 2-4 weeks, it's usually because they have serious psychiatric or family morbidity, and they may sometimes transfer those to the psychiatric inpatient unit.

**Chennai, India**

I visited two centres in Chennai, the Institute of Mental Health (IMH), a state asylum, and the Voluntary Health Services Hospital (VHS), a charity hospital. The IMH is an inpatient centre for the care of serious mental illness, but patients with conversion disorder are seen in outpatients. They see them only after every other physician has told them they need to see a psychiatrist. They have little time allotted to them in outpatients so one doctor who was interested in the condition told me he sees them in the evenings, in his free time. What would otherwise be treated with pharmacotherapy (if by a doctor - if not by 'sorcerers'), he told me he treats with what he understands by 'the Oxford textbook' method, beginning with acceptance that they have a problem - he tells them he knows they have a problem, whilst remaining agnostic about what it is. He is generally supportive, without using any therapeutic method, and usually has great success.

At the VHS, and also at his private clinics, Dr Ennapadam Krishnamoorthy told me his patients all get the same treatment, which is rehabilitation-based, with additional CBT, Ayurveda, Social Work and Family Work as necessary. A typical treatment would be for 15 days. The Ayurvedic part is very acceptable in India, though unusual in coming from an occidental doctor. He thinks it helps with some pain and other conditions, indicates to the patient that he’s taking it seriously, and makes the family more accepting of the reality of the patient’s problems. Thinks it works well, with most having some kind of recovery within that 15-day period. His is the only such formal service, he believes, in all of India, and thinks that for everyone else it will be pharmacotherapy alone.

Conversion disorder is widely regarded as being more common in third world countries such as India. The view of those I spoke with was that it arises in India because of difficulties that the patient cannot otherwise express, for example a problem between a wife and her mother-in-law, or a socially unacceptable sexual orientation. Families in India offer extremely high levels of support for family members with illness, by contrast with the west, but the situation is often almost the reverse for mental health. As mental illness is comparatively poorly understood, the patient is commonly seen not as ill but merely as difficult or perverse, and the family rejects them. There is a social and educational gradient as to how psychologically minded people are. If they are not, it may often only be on the 10th assessment that they reveal their problems, so a lengthy treatment is necessary, but clearly poses problems when resources are limited.

**Bergisch Gladbach, Germany**
My final visit was to Dr Ulrich Shultz-Venrath, at his treatment centre in Bergisch Gladbach, a small town outside Cologne. Here he has an inpatient ward as part of a psychiatric unit attached to a general hospital. The ward catered for disorders considered related, in addition, such as eating disorders or personality disorders. Dr Schultz-Venrath takes referrals locally, and has built up very good relationships with local referrers. If the patient is uninterested, will sometimes use paradoxical inducement – agreeing that, yes, it’s not for you, you shouldn’t get this kind of help, which is sometimes effective in motivating the patient to participate. The approach was something like a therapeutic community, with extensive group work, as well as individual psychotherapy initially, heavily guided by the principles of mentalizing-behaviour therapy (MBP), a kind of psychodynamic therapy. The group therapy was seen as the key component, led by MBP-trained facilitators. The challenge of explaining the nature of the patient’s problem was not addressed directly, where possible, but relied on the patient reaching an understanding of the relationship between their thoughts and feelings and symptoms through the group work, and recovery happens along the way.

The facility was extraordinarily well equipped, with a stone sculpture room, for example, paid for by the community, an exercise room, art therapy, and music therapy. This makes them very expensive, but they continue because they’re so effective: Dr Schultz-Venrath estimated their success rate as 90%, becoming symptom-free within a period of three weeks.

Discussion

I saw a number of approaches, whose practitioners described success rates that I would regard as higher than those achieved with our methods. There are significant differences, however, that prevent simple comparison: some of the methods were applied to children, some were applied to non-epileptic seizures alone, and some were applied inpatient. Children, in particular, present several differences – they are less independent, in a real sense, and though treatment was nowhere forced on anyone, the child or adolescent may feel much less able to reject a treatment that their family accepts for them. They is also no real alternative to activity for them: while adults are familiar with the ideas of unemployment, medical retirement or simply being off sick, children are used to going to school no matter what. There was thus no real resistance to being provided with a full programme of activities, which might be very different for adults, and which was a key element of both inpatient child treatments.

Nevertheless it is possible to draw out certain useful commonalities to the success I saw: non-confrontation; an obliqueness of therapy; equipping with emotional skills; a formal programme. Non-confrontation was evident in the recruitment methods, but also in the avoidance or explicit diagnosis early in the process. This is in direct contrast to the approach we have adopted here, which employs unusually frank diagnoses to minimise the confusion that surrounds and facilitates the patients medical care. The non-confrontational approach may be associated with greater acceptance of treatment, and of allowing that treatment to grow naturally into something more explicit. Dr LaFrance’s method
was a notable exception to this, as it included very explicit diagnosis and detailed modelling of the symptoms, and is worth particular discussion.

I did not see his final CBT patients' manual, but my impression was that it was very didactic – telling patients, in no uncertain terms, that this was what their seizures were. Though the formulation was simplistic, it did offer some advantages. It had a medical flavour – in terms of brain waves, for example - which is destigmatising and can be very persuasive. And in other ways, Dr LaFrance's methods capture much of what was common to the success that was reported: it did not seem to engage with what psychiatrists are used to thinking of as the core problems – the family conflict, abuse history, etc. - and delegated some difficult parts of the encounter to homework; in these respects it was perhaps non-confrontational. In addition, the focus of the therapy was on equipping with skills, and it was obviously part of a formal programme.

Not addressing either a model for the symptom (which is extremely difficult, not to say impossible for motor symptoms) or poring over the life stresses that may have led to them becoming unwell, are also in conflict with the traditional approach, the approach we use and the essentially traditional methods I saw in use in India. Having a thus 'oblique' therapeutic approach which addresses perceived limitations in the patients emotional skills, or offers physical rehabilitation, but without challenging the patient with either a psychological model they may feel obliged to reject or an analysis of life problems they may not wish to see as relevant, may give them the time and space to recover.

There may be limitations, as discussed, in the full application of these approaches to our setting in the UK – with adults, outpatients, and with a variety of symptoms – but they do suggest the basis for an approach that is different in its outlook and fundamental approach, even if it includes many of the same therapeutic elements.