

# THE CONCEPT OF DISSOCIATION AND CONVERSION IN THE NEW EDITION OF THE INTERNATIONAL CLASSIFICATION OF DISEASES (ICD-10)

Francisco Orengo Garcia, M.D., Ph.D.

Francisco Orengo Garcia, M.D., Ph.D., is with the Unit on Dissociative Disorders, National Institute of Mental Health, Bethesda, Maryland.

For reprints write Francisco Orengo Garcia, M.D., Ph.D., NIMH, 9000 Rockville Pike, Building 15K, Bethesda, Maryland 20892.

## ABSTRACT

*In this article, the author discusses the changes in the new edition of the International Classification of Diseases (ICD-10) related to dissociative and conversion disorders. He comments on the elimination of the concept of hysteria, the introduction of a new group of dissociative (neurotic) disorders and the creation of a new category of organic (dissociative) conversion disorders. The author discusses the differences and similarities of the current edition in regard to the previous (ICD-9) and the influence of the DSM-III-R on the ICD-10.*

## INTRODUCTION

The 1990 publication of the new edition of the *International Classification of Diseases (ICD-10)* presents extensive innovations in Chapter V (F) regarding "psychic disorders" and some of the most important changes merit discussion. This article focuses on the dissociative and conversion disorders. It presents a nosographic analysis and uses the criteria followed to construct this new edition of the *ICD* to demonstrate the present state of the problem of "organic versus psychogenic" in the conception of dissociative and conversion disorders. Finally, an analysis of the previous edition of the *ICD (ICD-9)*, and the revised third edition of the *Diagnostic and Statistical Manual (DSM-III-R)* explains the development of the present concept, as well as the influence of the American classification system on the *ICD-10*.

## THE ICD SYSTEM

The *ICD* is a statistical classification not only of mental disorders but of diseases and other morbid conditions. Its principal use is the classification of morbidity and mortality information for statistical purposes, as the unabridged title of the classification makes quite clear: *The International Statistical Classification of Disease, Injuries, and Causes of Death*. The *ICD* is revised periodically (at approximately 10-year intervals) under the supervision of an international committee of experts of the World Health Organization. Since 1938 (5th edition of the original *International List of Causes of Death*), the

classificatory system includes a separate chapter on mental disorders.

## ASPECTS OF CLASSIFICATION

Chapter V (F) on "psychic disorders" (Table 1) reflects the state of the classification as of April 1989. This *ICD-10* version, which might still undergo slight changes in the final text, is used to analyze the classification of "organic psychic disorders, including the symptomatic ones (FO)" as well as the "neurotic, somatoform, and stress-related disorders (F4)" (Tables 2 and 3). The dissociative and conversion disorders are included in these two sections.

## ABOLISHMENT OF THE CONCEPT OF NEUROSIS

One of the most important changes in the *ICD-10* is the disappearance of the classic distinction between neurosis and psychosis. The authors of the *ICD-10* argue that the same psychic disorder can present both psychotic and non-psychotic manifestations. They state that the concept of neurosis has been used in multiple forms and in various contexts based on its application in theories of intrapsychic causality not recognized by all authors. In the *ICD-10*, the term "neurotic" is used in the exclusively descriptive-phenomenological sense, exempt of theoretical content (Dilling & Dittmann, 1990).

This development towards a separation of the theoretical meaning from the concept no doubt "neutralizes" any attribution of the term to one school or another. At the same time, it follows the direction of a symptomatologic and syndromic conception of the pathology (Glatzel, 1981), in which a classification that includes explicit reference to the etiology of the disorder or disease is completely omitted. Unquestionably, the *ICD-10* edition continues and culminates the tendency already clearly initiated in the *DSM-III* and *DSM-III-R* to organize the classification around the "princeps" symptom of each nosologic group (anxiety disorders, depressive disorders, etc.) and avoid nosologic groups based on theoretical criteria, which are more heuristic in nature.

The *DSM-III-R* still contains (although in parenthesis) the term neurosis (for example: "conversion disorders [or hysterical neurosis, conversion type]"). Nevertheless, in the *ICD-10*, it is no longer associated with a specific typology. It retains its value as a concept for "arrangement" or "grouping," but has no importance for the definition. The *ICD-9* still made considerable use of the term/concept of neurosis (*ICD-9*, 1978). The essential criteria used for this definition were the

absence of an organic basis of the disorder and the intact relation of the patient with reality. The first served to differentiate it from the organic clinical pictures, the second to differentiate it from the group of psychoses. Hysterical neurosis included all the manifestations of conversion as well as alterations of consciousness and personality; curiously, absolutely no mention was made of the term/concept of dissociation. This concept does not appear in any section of the *ICD-9*.

## INTRODUCTION OF THE CONCEPT OF DISSOCIATION IN THE *ICD-10*

The presence of a section termed "dissociative (conversion) disorders (F44)" in the *ICD-10* is not only a novelty, but also another indication of the influence of the *DSM-III-R* on the *ICD*. The first version of the *Diagnostic and Statistical Manual of Mental Disorders* initially considered two different types of hysterical "reactions": dissociative and conversion (American Psychiatric Association, 1952). The second edition incorporated the term neurosis and distinguished two basic types of hysterical neurosis: dissociative and conversion (American Psychiatric Association, 1968). With the decrease in the influence of psychodynamic thought and the strong surge of psychopharmacology, the concept of neurosis in general and hysteria in particular began to lose importance.

Consequently, in the *DSM-III* (American Psychiatric Association, 1980), the dissociative form of hysteria became separate and more important up to the point of constituting

a distinct nosologic group ("dissociative disorders [or hysterical neurosis, dissociative type]"). In contrast, the conversion type disappeared into a new category of "somatoform disorders." Schematically, this dissociative form includes the "psychic" manifestations of classic hysteria (amnesia, fugue, multiple personality, etc.), while the conversion form groups the hysterical disorders of a "somatic" nature (sensorimotor paralysis, aphonia, blindness, etc.).

From the sociologic point of view, the development of the nosologic group, "dissociative disorders" in the *DSM-III* is related to various factors. First is the frequent appearance in Vietnam war veterans of the so-called "post-traumatic stress disorder"; in spite of being considered an anxiety disorder, this sometimes presents dissociative symptoms. Second, during the 1970s and 1980s, numerous articles on child abuse and the subsequent development of dissociative symptoms in adults appeared in the literature (Putnam, 1990). Finally, special emphasis must be placed on the fact that child sexual abuse involved girls in particular, and this problem was taken

TABLE 1

Synopsis of Chapter V (F) of the *ICD-10*

- F0: Organic psychic disorders with inclusion of symptomatic disorders
- F1: Psychic and behavioral disorders due to psychotropic substances
- F2: Schizophrenia and schizotypal and delirious disorders
- F3: Affective disorders
- F4: Neurotic, somatoform and stress-related disorders
- F5: Behavioral alterations and psychic disorders that are associated with functional disorders of the body
- F6: Personality disorders and behavioral disorders in adults
- F7: Disorders that are associated with intellectual impairment
- F8: Disorders of psychic development
- F9: Emotional and behavioral disorders with onset in childhood or adolescence as well as uncharacterized psychic disorders

TABLE 2

F0: Organic Psychic Disorders with Inclusion of Symptomatic Disorders.

The list includes only those disorders relevant to this article.

F06: Psychic disorders without cognitive repercussion due to disease, lesion, or brain function disorder or a body disease including hormonal disorders.

F06.5: Organic conversion (dissociative) disorder

TABLE 3

F4: Neurotic, somatoform, and stress-related disorders. The list includes only those disorders relevant to this article.

- F44: Dissociative (conversion) disorder
- F44.0: Dissociative amnesia
- F44.1: Dissociative fugue
- F44.2: Dissociative stupor
- F44.4: Dissociative type movement disorder
- F44.5: Dissociative convulsions
- F44.6: Anesthesia and alterations of the senses of the dissociative type
- F44.7: Mixed dissociative and conversion disorders
- F44.8: Others
- F44.9: Not characterized

up with great interest by the feminist movements popular in North American society. These very important sociocultural factors undoubtedly contributed to the fact that the *DSM-III* and its successor, *DSM-III-R*, covered the dissociative disorders extensively.

In including this new category in the *ICD-10*, the WHO reveals that the above-mentioned North American reality can be extrapolated internationally. Although the concept of dissociation at first glance appears to be exactly the same in the *ICD-10* and the *DSM-III-R*, there are subtle differences. I shall examine these below.

## THE EQUIVALENCE BETWEEN CONVERSION AND DISSOCIATION

Even though the *ICD-10* attempts to logically present a classification without reference to existing theoretical concepts, this cannot be avoided. Any classification reflects the theoretical concepts of the authors themselves, even when the classification is purely statistical, such as the *ICD*. The concepts of hysterical neurosis, dissociation, and conversion are very good examples of this.

Even with the elimination of the concept of hysteria in the *ICD-10*, its two principal clinical forms are still presented: the conversion form, which through a subtle use of parenthesis has been termed "dissociative (conversion) disorder," appears combined with the dissociative form in a common nosologic group (F44). This effective compromise creates new diagnoses such as "dissociative type movement disorder" (F44.4), "dissociative convulsions" (F44.5), or a combined category termed "mixed dissociative and conversion disorders" (F44.7).

This nosologic group undoubtedly implies the recognition of a common pathogenic relation between conversion and dissociation in the original, already classic sense that hysterical conversion reaction is made feasible by a previous state of consciousness that Breuer (Breuer & Freud, 1885) termed "hypnoid" and Janet (Janet, 1889) termed "disintegrated" or "dissociated." Within this context, it is of historical interest to note that the concept of dissociation is attributed to Janet (Putnam, 1889), while that of conversion is the work of Breuer and Freud (Freud, 1894). There has been an obvious revival of Janet's ideas in this edition of the *ICD*, as has been mentioned in recent literature (Nemiah, 1989).

In summary, the *ICD-10* presents a revival of the concept of dissociation not only in the concrete fact that it comprises a distinct nosologic group, but it is also a diagnostic category that includes the concept of conversion (although, as in Freud's time, this still has not been confirmed experimentally). In this sense, in spite of the disappearance of the concept of hysteria, it remains present in its most traditional concept (also adding new aspects of nosology to it, such as the new category termed "state of possession and trance" [F44.3]).

As a result of the "fusion" of the dissociative and conversion disorders into one group, the concept of dissociation has become much more "somatic" (for example, in the case of "dissociative convulsions" [F44.5]), an aspect traditionally reserved for the concept of conversion. At the same time, it is of interest to remark that diagnoses based on pure phe-

nomenological/psychological criteria, for instance multiple personality disorder, lose significance and are listed under "others (F44.8)" (Coons, 1989). With regard to this point, there is a remarkable difference between the *DSM-III-R* and the *ICD-10*.

## ORGANIC (DISSOCIATIVE) CONVERSION DISORDER (F06.5)

*ICD-10* creates a new category in the section "organic psychic disorders (FO)": "organic conversion (dissociative) disorder [F06.5]." The origin of this new category of conversion (dissociative) disorders is undoubtedly found in works by Guze (1967), Slater and Glithero (1965), Weinstein and Lyster (1966), and other more recent authors who demonstrated that a high percentage of patients with conversion symptoms present with some form of cranial trauma before developing the symptom. These authors considered this fact an indirect confirmation of the "organicity" of conversion symptoms.

This classification also addresses the problem of those patients initially diagnosed as "conversion (dissociative) disorder" who were later found to be "false positives" in view of a new organic disease that was diagnosed. This constellation resulted in an unrealistic pressure toward mutual diagnostic exclusion that can now be avoided with the new nosographic group. In this sense, this organic diagnosis offers the possibility of including the conversion disorder concurrent with the presence of another associated organic disease.

I note with interest that in group FO6.5, in contrast to the category "dissociative (conversion) disorder" (F44), the term dissociative appears in parenthesis (Table 2). This difference in syntax is important because it implies that in organic conversion disorders, the dissociative component is assumed even though it is not given—as in the case of neurotics—a conceptual meaning "above and beyond" that of conversion. In other words, conversion disorder is not considered a special case within the spectrum of dissociative disorder but an entity with its own characteristics even though it shares, to some extent, the actual physiopathologic mechanism of dissociative disorders.

In view of this situation, we can readily consider a new nosologic and nosographic organization that would distinguish organic conversion disorders from another new group, which although not defined separately in the classification, would be termed "organic dissociative disorders." This section would include diseases such as "organic dissociative amnesia" (due to ingestion of benzodiazepines, for example), and clinical pictures that can be summarized under the epigraph, "organic dissociative hallucinatory disorder" (in the cases of trauma related injuries or tumors with hallucinatory symptoms that have dissociative characteristics).

Undoubtedly, the creation in the *ICD-10* of a new section, as previously mentioned, reflects the need to include in psychiatric nosology all those clinical pictures of dissociation/conversion produced by medications, drugs, brain lesions, or through methods of suggestion such as hypnosis. In other words, the intent is to introduce through the creation of this new "nosographic space" another distinct causal



principle that underlies an essentially psychodynamic ("neurotic") conception of the problem of dissociation/conversion.

In this regard, the *ICD-10* goes beyond the *DSM-III-R*, which emphasizes the importance of the relation between the conversion symptom and the patient's "conflict or psychologic necessity," thus attesting to the relevance of the patient's psychodynamics. In spite of its more organic direction, the *DSM-III-R* leaves the underlying psychodynamic concept intact without offering nosographic solutions such as presented by the *ICD-10* in the creation of a new category of "organic conversion (dissociative) disorders."

The Committee of Dissociative Disorders has received suggestions regarding the preparation of the *DSM-IV* (Putnam, personal communication) to also create this category of organic dissociative disorders. Nevertheless, this solution offered by the *ICD-10* is inconvenient because it creates an even larger gap between the same type of diseases that are termed either "organic" or "neurotic."

### THE PROBLEM OF "ORGANIC VERSUS NEUROTIC"

The first question asked in any discussion on dissociative disorders is whether this type of behavior can develop in an individual who is not predisposed to it. In other words, is there an "organic" basis to the dissociative behavior in the sense of a natural defense mechanism (Kretschmer, 1926; Ludwig, 1983) or, in contrast, is this a behavioral development secondary to the appearance of a specific psychological trauma? This last version is unquestionably associated with the "psychologic" concept (or "neurotic" according to the *ICD-10* terminology) of dissociative disorders.

The *ICD-10* considers these as two versions of the same type of symptoms and establishes a clear etiologic nosography, following the direction of classic Cartesianism. The tendency now reflected in the group of organic conversion (dissociative) disorders had already been established in other groups such as those of depressive disorders, manic disorders, anxiety disorders, etc., to which the term "organic" had been added.

In spite of this dichotomized vision again proposed by the *ICD-10*, discussion of this polarized statement should no longer be necessary. First of all, it is recognized that in childhood, dissociative behavior is normative, and this behavior progressively decreases as the capacity for psychic integration in the individual increases.

Second, it has been demonstrated that a traumatic event in the psychic life of an adult can trigger a dissociative response. Therefore, in principle, dissociative behavior does not have to be pathologic, just as crying or discouragement are not, by definition. Chronic dissociative disorders (amnesia, fugue, hallucinations, etc.) would be the result of a massive dissociative reaction triggered in an absolutely natural and necessary manner and whose presence means nothing more than the presence of a psychologic "scar."

On the other hand, the development of dissociative behavior as the result of the ingestion of a certain type of drugs or under the effect of hypnosis supports the existence of a state of consciousness and/or behavior whose appear-

ance is not related to a specific type of stimulation ("neurotic" or "organic"). Conceived as such, dissociation would be one more of the classic "types of exogenous reaction" described by Bonhoeffer (Bonhoeffer, 1917).

It is my opinion that both the organic basis and the psychologic state of the patient are fundamental in triggering a dissociative/conversion reaction. In summary, the Cartesian "organic" versus "functional" dichotomy is not found in the purpose of the study (dissociative/conversion behavior) but in the method of approaching the problem.

The above leads to a unified vision of the dissociative/conversion disorders, which according to what has been established should be conceived in nosologic terms as "dissociative disorder and/or conversion disorder associated with..." In this case, the etiologic category added (including cases in which this is not recognized) would give a nosologic and nosographic meaning to the dissociative symptoms. This does not occur in the present case where, in spite of the strictly "descriptive" intent, both an etiologic and "theoretic" character are given insofar as the nosologic method used supports very clear empirical-phenomenological positions.

In summary, while the division between "organic" and "neurotic" is preserved, the error in the statistical evaluation of some entities that appear separately because of their double attribution is inevitable. The dichotomization of the various nosologic groups is counterproductive as it results in an excessively "compartmentalized" vision of the disease, and this leads to the loss of the concept of dissociation as a whole.

### CONCLUSION

The new edition of the *ICD* presents important nosographic changes in the chapter on dissociative/conversion disorders. The theoretical contents of a traditional concept such as neurosis is eliminated, and a purely "organizer" meaning of the nosology is attributed to the concept in accordance with a diagnostic, strictly operative tradition (as in that of the *DSM-III-R*). It also eliminates the term/concept of hysteria, which nevertheless persists in two more classic clinical forms (dissociative and conversion) in a common nosologic group (F44). At the same time, it introduces a new nosologic category of the dissociative disorders that was not in the previous edition (*ICD-9*) (WHO, 1978).

Finally, a new nosologic and nosographic concept is introduced in the category of "organic conversion (dissociative) disorders" (F06.5). For the most part, all these changes assume the concepts of the *DSM-III-R* (APA, 1987) and result in an operational classification system whose advantages have already been demonstrated in the field of experimental (psychopharmacology) and clinical investigation.

The advantages of this new diagnostic proliferation in the field of daily clinical practice and its relevance to the evaluation of the distinct methods of psycho- and psychotherapy are still unknown. We must wait several years before we can evaluate the introduction, at the international level, of a new classification created with the intention of covering a transcultural diagnostic spectrum.

### ACKNOWLEDGEMENT

The assistance of Pedro E. Martinez, M.D., and Frank W. Putnam, Jr., M.D., in the preparation of the final version of this paper is gratefully acknowledged. ■

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