

COMMENTS ON DR. GARCIA'S ARTICLE

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Dr. Garcia's article on the changes in the classification on the *ICD-10* illustrates positive changes about psychiatric diagnosis, but also continues to illuminate shortcomings and difficulties inherent in trying to classify psychiatric illness.

Traditionally, classification of illness is an attempt at organization. This provides a way in which scientific investigation can categorize similar entities for comparison and study. There are a variety of ways of categorizing illnesses ranging on the one hand with description of symptoms and on the other hand by a description of underlying causality. Classification of diseases over the years has been complicated by the fact that very often the causes of illnesses were misunderstood and descriptive phenomena were all that were available. At other times, illnesses were named after those who discovered them. There has always been a long history of confusion and inconsistency in the classification of medical illnesses. A classification system is useful only if it gives clear categorizations that can be systematically studied.

In the field of psychiatry, there is further complication. This is clearly indicated in the evolution of the *Diagnostic and Statistical Manual* of the American Psychiatric Association and by the classification system of the *International Classification of Diseases*. Originally, mental illness was viewed as either spirit or demon possession or an illness of women reflected by the term *hysteria* or the "wandering womb." Gradually, by the 1800's, an understanding was based on (1) the organic pathology of mental deterioration and (2) a plethora of psychological explanations for mental illness developed as Freud, Janet, and other researchers began to examine psychopathology. A focus on the organic basis of mental illness clearly had understandable roots. In that era, institutions often combined patients who had what we now would call psychiatric disorders with organic patients; with alcoholic brain syndromes, syphilitic encephalopathies and other clearly organic syndromes. This tradition made it difficult to clarify the distinction between a mental illness and a physical illness.

As Freud's thinking emerged and the concept of "hysterical neuroses" became popular, the notion of fantasy and wish-fulfillment became important as an etiological factor in psychiatric illness. Simultaneously, other schools of thought,

such as that of Janet, introduced the concept of dissociation, often referring to very similar concepts but using a different language and a somewhat different viewpoint. Because of this, confusion has emerged regarding the use of dissociative versus hysterical or neurotic terminology. In recent years, the resurgent interest in biochemistry has again led to our interest in organic contributions to mental illness. Clearly, any modern day thinker would not attempt to separate the psyche and the soma in any such complete fashion as noted by Dr. Garcia. Such a dichotomization serves no function but to distract us from the fact that the mind and body are operationally the synthesis of physical, biochemical and psychological contributions. Attempts to arbitrarily separate these miss the point.

The lingering confusion regarding Freud's and Janet's approach, however, continues to pervade classification. The improvement in the *ICD-10*, however, is in its deletion of the term, hysterical, which suggested that dissociative disorders are primarily a fantasy-based illness whether it is considered dissociative or repressed in nature. Terms such as neuroses and conversion continue to try to emphasize underlying etiology rather than descriptive symptomatology. Increasingly, it appears that in mental health, classification attempts to group illnesses according to phenomenological symptoms which can be measured objectively rather than by underlying etiological causes. While this may be difficult for some in the mental health field, it is probably helpful for scientific investigators who want to classify illnesses without being prejudicial as to etiology and who wish to start with a description of symptoms and then categorize the symptoms in some more orderly fashion. I think it is important that *ICD-10* eliminated the distinction between neurosis and psychosis and sees that similar symptoms can occur in each entity.

The attempt by *ICD-10* to categorize dissociative conditions as either dissociative (conversion) disorder—a psychological process, or organic conversion (dissociative) disorder is an improvement in attempting to distinguish between what is organic and what is psychologic but, again as the author notes, dichotomizes the situation more than it may need to. In addition, it seems more difficult to gain perspective from the fact that while we call something organic, we continue to need to use the words conversion and dissociative. Whereas in dissociative disorders, if we need to consider the term *conversion*, it seems to create semantic confusion, rather than realistic terminology, depending, of course, upon the school of thought that one is referring to.

The contribution, however, is that there is an effort to separate out what may be dissociative (based on a metabolic

or strictly organic pathology) from that which may be a combination of heritability, and environmental and biochemical influences. There is no doubt that amnesic experiences will occur secondary to the influences of metabolic and drug interactions. In this regard, the *ICD-10* does remind us to think more broadly, both organically and psychologically when we think of dissociative symptoms. In the future, it may conceivably be better to get away from such terms as *dissociation* and *conversion* since they both carry with them an etiological concept that may not yet be well worked out. Dissociation now appears to be more closely related to a trauma-induced repression whereas neurosis would be more prone to be understood as a psychoanalytically-based neurosis based on childhood fantasy and repression. In any event, there is a mixing of schools of thought and etiology, but at the expense of clarifying the phenomenology. In the one sense, it can be categorized in a more sensible way. For example, "organic conversion (dissociative disorder)" might be better served if called "organic amnesic disorder." An organic amnesia disorder can eliminate the concept of conversion and dissociation altogether. If this field can agree to use dissociation as a phenomenon rather than as an etiological concept, then I think the term *dissociation* should continue to be used, but the notion of *conversion* needs to be deleted and can be described as an accompaniment of a disorder rather than included parenthetically as though we are still not clear what frame of reference we are using. I agree with Dr. Garcia's expression that there is an "even deeper separation between the same type of diseases that are termed either organic or neurotic" when creating the category of organic dissociative disorders. I also agree that maintaining a dichotomy of organic versus pathologic will continue to be counterproductive.

Dr. Garcia reminds us that progress continues to be made in improving diagnostic categorization in the *ICD-10* and that the elimination of hysteria goes a long way towards unifying international classification with the American Psychiatric Association classification. At the same time, however, confusion persists from the continued use of the old terminologies, suggesting difficulty in giving up the conflicting schools of thinking in the etiology of mental illness.

In any event, a classification of mental illness will only be useful if it maintains a consistent frame of reference either phenomenological or etiological. Given the variety of opinions on etiology, we are probably best served to classify mental illness phenomenologically until there is clearer agreement about the interplay of etiology with phenomenology. A consistent diagnostic system provides a sound basis for research and a way of organizing data and material for further study. ■

COMMENT ON
GARCIA'S
"THE CONCEPT OF
DISSOCIATION AND
CONVERSION IN
THE NEW ICD-10"

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The idea that conversion disorders should be classified as dissociative disorders has been discussed by the consultants to DSM-IV on dissociative disorders (Spiegel, 1990, personal communication) and by the ICD-10, DSM-IV Committee of the International Society for the Study of Multiple Personality and Dissociation (Coons, 1988, personal communication). In response to Garcia's analysis of the issues, I would like to provide four supplementary arguments as to why conversion should be thought of as a form of dissociation.

1. Similarity of Monosymptomatic Conversion to Psychogenic Amnesia

Psychogenic amnesia consists of the dissociation of a limited aspect of a single cortical function: one forgets only a limited amount of psychic material. Psychogenic amnesia is precipitated by trauma (Coons & Milstein, 1989), is often self-limiting, and may be treated with psychotherapy, hypnosis, or sodium amytal interview. It may be a feature of more complex, chronic dissociative disorders.

A conversion paralysis consists of the dissociation of a limited aspect of a single cortical function: one forgets how to move only part of the body. Conversion paralyzes are precipitated if not by overt trauma by psychological conflict (Ford & Folks, 1985), are often self-limiting, and may be treated with psychotherapy, hypnosis, or sodium amytal interview. They may be features of more complex chronic dissociative disorders.

There is no particular reason why dissociation should be limited to the areas of the cortex responsible for memory and identity. It is more likely that dissociation can occur in any area of the brain (Ross, 1989). If this is the case, then dissociation of any given psychic function will result in a monosymptomatic dissociative disorder, or occur as a component of a complex, chronic dissociative disorder.

2. Observations of Pierre Janet

There has recently been a revival of interest in Janet (Kluft, 1989; Nemiah, 1990; Putnam, 1989; Ross, 1989; van

der Hart & Friedman, 1989; van der Kolk & van der Hart, 1989). If Janet could comment on Garcia he might turn to the following passages from his book, *The Major Symptoms of Hysteria* (1907/1965):

(1) Let us apply the same notion to our paralyzes; we shall see that the facts are absolutely of the same kind. Besides anesthesia, on which we dwelt for some time, there

TABLE 1

Frequency of Seven Conversion Symptoms in 102 Cases of Multiple Personality Disorder

Symptom	% of Subjects Positive
Blurred vision	56.9
Paralysis or muscle weakness	41.2
Trouble walking	36.3
Double vision	35.3
Loss of voice	28.4
Deafness	20.6
Blindness	9.8

TABLE 2

Frequency Distribution of Conversion Symptoms in 102 Cases of Multiple Personality Disorder

Number of Symptoms Positive	N	%	Cumulative %
0	27	26.5	26.5
1	16	15.7	42.2
2	18	17.6	59.8
3	16	15.7	75.5
4	7	6.9	82.4
5	7	6.9	89.2
6	7	6.9	96.1
7	4	3.9	100.0

are other mental phenomena which accompany hysterical paralyzes. The most curious are connected with a kind of indifference, analogous to the one we remarked on in anesthesia. If we had a paralyzed arm, it would inconvenience us exceedingly, we should fret very much about the disease, we should perpetually regret our former state and be forever making desperate efforts to recover the motion we had lost. We cannot help therefore being somewhat surprised and ill-humoured when we attend a paralyzed hysterical. This kind of patients vexes us with their calm indifference and inertia. One of their limbs being out of use does not appear to incommode them; they think it quite natural to walk with but one leg, and do not make the least effort to use the other leg. It was just this that determined the famous distinction Charcot made between helicopode and helicopode gaits (p.174).

(2) The affected subject with organic hemiplegy, they said, has a *helicopode* walk; he walks helically, throwing his paralyzed leg sideways by a movement of his loins. The subject affected with hysteric hemiplegy has a *helicopode* walk; he drags his paralyzed leg in walking as if he did not trouble himself about it in the least, as if it no longer existed at all (p.146).

Janet is pointing out that conversion paralyzes involve all four dimensions of the BASK model of dissociation (Braun, 1988a; 1988b). There is a dissociation of behavior manifest as a paralysis. At least in the nineteenth century there was always a dissociation of sensation in the form of anesthesia. There was a dissociation of affect usually referred to as *la belle indifference*. And there was a dissociation of knowledge. The affected person lost the *concept* of the affected area of his body and could not imagine it or think of it. The affected area in a conversion disorder is cognitively absent. Janet's clinical observation was that a conversion paralysis is always a complex dissociative disorder involving a number of cortical functions.

3. Observations of Oliver Sachs

In his book *A Leg to Stand On* (1984), the neurologist Oliver Sachs tells the story of a peripheral nerve injury he suffered in a hiking accident. He damaged his peroneal nerve and had a flaccid paralysis of his left leg, from which he eventually recovered. During the period of paralysis, much to his surprise, he lost the *concept* of the affected limb. It was no longer part of his body; he could not experience it as part of himself visually, affectively, or cognitively. The central program of the leg had been deactivated by the loss of peripheral input or feedback due to a purely peripheral nerve injury.

Noticing this about himself, Sachs then mentally reviewed his previous clinical experience. He realized that he had met numerous patients who had similarly lost the idea of a paralyzed limb. He tells a number of humorous anecdotes, one of which is reprinted in *The Man Who Mistook His Wife For a Hat* (1985). In the chapter entitled, "The Man Who Fell Out of Bed," Sachs describes a young man with a paralyzed leg who attempted to throw his own leg out of his bed, thinking that it must be a cadaveric leg put in his bed by the nurses as a practical joke.

If we substitute for Janet's word *idea* a more modern term *central program*, we realize that the central program of a limb

may be deactivated by several mechanisms. One is by going to sleep. Another is peripheral nerve injury which interrupts an as-yet-unidentified input to the cerebral cortex; this input normally maintains the program in an activated state. Another mechanism is psychological in nature, and presumably originates in the cortex and limbic system; this we call dissociation.

All these program deactivations result in a loss of function, but only some should be classified as dissociative disorders. If I may digress a moment, abnormal failure to deactivate a central program on loss of a limb results in *phantom limb*. Phantom limb is the opposite of a conversion paralysis, because affect, sensation, and knowledge are preserved, along with an illusion of behavior, in the absence of a limb. In conversion all these are lost in the presence of a limb.

4. The Prevalence of Conversion Symptoms in Multiple Personality Disorder

If conversion symptoms are dissociative in nature, they ought to occur commonly in complex, chronic dissociative disorders affecting many areas of the brain. Multiple personality disorder is such a disorder. It is characterized by dissociation not just of identity and memory but of affect, sensation, autonomic arousal, immune response, visual function, muscle tone, gait, facial expression, and virtually any human function one could name (Coons, 1988; Miller, 1989).

In a study of 102 cases of multiple personality disorder (Ross, Miller, Reagor, Bjornson, Fraser, & Anderson, 1990), we enquired about all the *DSM-III-R* symptoms of somatization disorder. Conversion symptoms are very common in multiple personality disorder. This finding is shown in Table 1, which depicts the percentage of the 102 subjects who endorsed each of the classical conversion symptoms, and in Table 2, which shows the frequency distribution of conversion symptoms in the 102 subjects.

I would like to thank Dr. Garcia for his contribution. My commentary is a supplement to his discussion rather than a critique of it. ■

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