

## COMMENTARY: ICD-10 AND BEYOND

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I am delighted to see an article appear regarding the proposed classification scheme for dissociative and conversion disorders to be included in the *International Classification of Diseases* or *ICD-10* (Garcia, 1990). In this article, Garcia summarizes and discusses the following major revisions in the dissociative and conversion disorder category.

1. The term "hysteria" has been eliminated.
2. Dissociative and conversion disorders remain grouped together.
3. Two new disorders have been introduced (i.e., dissociative stupor and dissociative convulsions).
4. A new category of organic conversion (dissociative) disorder has been introduced.

These changes reflect both the influence of the *Diagnostic and Statistical Manual of Mental Disorders* or *DSM-III-R* (American Psychiatric Association, 1987), plus other scientific reports which suggest the existence of organic dissociative disorders (Aktar & Brenner, 1979; Good, 1989). Additional revisions of the *ICD-9* (World Health Organization, 1978) not mentioned by Garcia include the following (Sartorius, Jablensky, Cooper, & Burke, 1988):

5. Deletion of multiple personality.
6. Deletion of factitious illness.
7. Addition of trance and possession states.

Although this draft of *ICD-10* makes some welcome changes over the *ICD-9* and the *DSM-III-R*, it raises a number of troublesome issues. For example, dissociation and conversion have been linked in such a way that they appear to be synonymous (i.e., "dissociative [conversion] disorder"). Although dissociative and conversion disorders are certainly closely related, they are not synonymous and should be listed separately under the same heading.

Another problem, true of the entire *ICD* system, is that no definitions or descriptions of the various disorders are given. This lack, combined with subtle changes in terminology (i.e.,

The *ICD-10* term "dissociative" is substituted for the *ICD-9* and *DSM-III-R* term "psychogenic.") virtually assures that there will be confusion amongst mental health professionals around the world when they refer to a certain illness.

Another troublesome issue is the inclusion of trance and possession states. Although this category was proposed for *DSM-III-R*, it was deleted because not all possession states are trancelike or dissociative in nature, and, even among those that are, not all are pathological (Coons, 1989). Examples of such nonpathological states include voodoo possession in Haiti, trance/possession in different Brazilian spiritist cults, and trance experienced by shamantic healers (Bourguignon, 1976).

A fourth troublesome problem is that the depersonalization/derealization syndromes are classified elsewhere in the *ICD-10*. Although this is also true of the *ICD-9*, it is not true of the *DSM-III-R*. There is general acceptance by North American psychiatrists that these syndromes are dissociative in nature and have a traumatic etiology (Putnam, 1985).

A final troublesome point is that multiple personality disorder (MPD) has been deleted. Presumably MPD could be listed under the "other" category. The reason behind the decision to delete MPD is unclear, but I suspect it is because psychiatrists in Europe, particularly in the United Kingdom, do not generally believe in the validity of MPD as a syndrome (Fahy, 1988). Despite beliefs to the contrary, MPD has existed and continues to exist outside of North America. In a recent review of the literature and clinical survey, we reported that MPD had been observed in twenty countries between 1840 and 1990 (Coons, Bowman, Kluft, & Milstein, 1990). Therefore, it appears quite clear that MPD is not a culture-bound syndrome and it definitely deserves inclusion in the *ICD-10*.

Looking beyond *ICD-10* and *DSM-IV*, I would like to suggest a classification scheme for dissociative and conversion disorders. This scheme would incorporate some of the ideas of both the *ICD-10* and the *DSM-IV*. In a sense, it is a compromise between the two classification systems.

### DISSOCIATIVE AND CONVERSION DISORDERS

- I. Dissociative Disorders
  - A. Psychogenic depersonalization disorder
  - B. Psychogenic amnesia
  - C. Psychogenic fugue
  - D. Psychogenic stupor
  - E. Multiple (dissociated) personality disorder
  - F. Dissociative disorder not otherwise specified (NOS)

## II. Conversion Disorders

- A. Psychogenic Motor Disorders
  1. Psychogenic seizures
  2. Psychogenic (conversion) paralysis
  3. Psychogenic (conversion) aphonia
  4. Psychogenic motor disorder NOS
  
- B. Psychogenic Sensory Disorders
  1. Psychogenic (conversion) blindness
  2. Psychogenic (conversion) deafness
  3. Psychogenic (conversion) anaesthesia
  4. Psychogenic sensory disorder NOS

In this proposed system dissociative and conversion disorders would be grouped together as in the ICD system. The term "psychogenic" would be retained in order to make it clear to nonpsychiatric clinicians that these disorders have a psychological and not an organic basis. Under dissociative disorders, MPD could be referred to as "dissociated personality" in order to reflect its worldwide occurrence separate from the nonpathological trance/possession states. The conversion disorders would be divided into two categories reflecting either motor or sensory involvement, and each type of conversion would be listed separately. The term "conversion" would be retained for those clinicians inclined to use it. The NOS category would be reserved to connote diagnostic uncertainty or the occurrence of a syndrome not quite meeting the criteria of the other disorders. Proposed disorders would be listed in an appendix and would be moved to their respective category if their existence were proven by further scientific investigation. An example of a proposed psychiatric disorder would be derealization without depersonalization.

Three other dissociative disorders would be added to this classification system, but would be placed in other diagnostic categories. Organic dissociative disorder would be included under organic mental disorders. Nocturnal dissociative disorder would appear under sleep disorders, since there is good evidence that dissociation may only occur at night (Schenck, Milner, Hurwitz, Bundie, & Mahowald, 1989). Finally, dissociation identity disorder would be located under disorders of childhood and adolescence to reflect dissociation occurring in that age range but not of sufficient extent to meet adulthood criteria of dissociative disorders (Peterson, 1990). ■

## REFERENCES

- Aktar, S., & Brenner, I. (1979). Differential diagnosis of fugue-like states. *Journal of Clinical Psychiatry*, 40, 381-381.
- American Psychiatric Association (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed.-revised). Washington, DC: American Psychiatric Press.
- Bourguignon, E. (1974). *Possession*. San Francisco: Chandler and Sharp.
- Coons, P.M. (1989). A cross-cultural comparison of trance states. In B.G. Braun (Ed.), *Proceedings of the sixth international conference on multiple personality/dissociative states*, p. 201. Chicago: Rush-Presbyterian-St. Luke's Medical Center.
- Coons, P.M., Bowman, E.S., Kluff, R.P., & Milstein, V. (1990). Cross-cultural occurrence of MPD: Additional cases from a recent survey. In B.G. Braun (Ed.), *Proceedings of the seventh international conference on multiple personality/dissociative states*, p. 42. Chicago: Rush-Presbyterian-St. Luke's Medical Center.
- Fahy, T.A. (1988). The diagnosis of multiple personality disorder: A critical review. *British Journal of Psychiatry*, 153, 597-606.
- Garcia, F.O. (1991). The concept of dissociation and conversion in the new edition of the *International classification of diseases (ICD-10)*. *DISSOCIATION*, 3, 204-208.
- Good, M.I. (1989). Substance induced dissociation and psychiatric nosology. *Journal of Clinical Psychopharmacology*, 9, 88-93.
- Peterson, G. (1990). Diagnosis of childhood multiple personality disorder. *DISSOCIATION*, 3, 3-9.
- Putnam, F.W. (1985). Dissociation as a response to extreme trauma. In R.P. Kluff (Ed.), *Childhood antecedents of multiple personality*, pp. 65-97. Washington, DC: American Psychiatric Press.
- Sartorius, N., Jablensky, A., Cooper, J.E., & Burke, J.D. (Eds.) (1988). Psychiatric classification in an international perspective. *British Journal of Psychiatry*, 152, (Supp. 1), 1-52.
- Schenck, C.H., Milner, D.M., Hurwitz, T.D., Bundie, S.R., & Mahowald, M.V. (1989). Dissociative disorders presenting as somnambulism: Polysomnographic video and clinical documentation (eight cases). *DISSOCIATION*, 2, 194-204.
- World Health Organization (1978). *Manual of the international statistical classification of diseases, injury, and causes of death* (9th revision). Geneva: Author.