factors: different ethno-cultural beliefs, high anxiety, pain behaviors, poor English communication skills, and over-supportive families. Some patients had all five factors.

Finally, it is worth repeating that we are referred many patients with chronic pain as a primary feature and unexplainable secondary symptoms and presentation that lead some clinicians to diagnose a conversion disorder. These are rarely true conversion disorders but more often represent poor coping in the face of unrelenting pain and subsequent physical limitations with perhaps some exaggeration. Paradoxically, pain, despite its subjective nature, is rarely feigned by our conversion disorder patients and is the symptom most resistant (in our cases intractable) to treatment.

THE ROLE OF THE PHYSIATRIST

The physiatrist is in a unique position to contribute to the management of conversion disorders. The rehabilitation approach allows patient a "face-saving" way to recover. The physiatrist must ensure the diagnosis of a conversion disorder is accurate, that organic disease has been ruled out, and the patient is convinced that no organic disorder hinders recovery. Where appropriate tests have not yet been performed, the physiatrist must ensure they are done. A word of caution: The strategic behavioral rehabilitation approach requires a sophisticated and highly flexible team. The psychologist monitors the rehabilitation approach, ensuring that the team stays consistent with the program and dealing with each patient's unique reactions to the rehabilitation program.

CONCLUSIONS

Patients with a clearly delineated conversion disorder were admitted to a special rehabilitation program designed to treat these individuals. Patients with acute conversion disorders (< 1 month) were more likely to respond to a standard rehabilitation behavioral approach and had an excellent prognosis with rehabilitation. Over half of the patients with chronic conversion disorders responded to rehabilitation but only when a strategic behavioral rehab program was instituted. The program is not designed to work with organic disorders complicated by functional overlay.

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INTERDISCIPLINARY CHALLENGES IN TREATMENT

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Functional disorders resulting in physical symptomatology exist in that gray zone between "real" and "not-real," psychologic and organic, or in "new-age" terminology, at the mind-body interface. Uncertainty is a hallmark of these disorders—uncertainty in assessment, diagnosis, what and how to inform the patient, and, ultimately, uncertainty in treatment.

This uncertainty has led to a great deal of confusion and disagreement in the literature, with somewhat mutually exclusive bodies of literature developing in a number of disciplines. Although functional disorders are seen in all areas of medicine, and by all types of health care providers, efforts at treatment have been more constrained. Kathol[6] described "reassurance therapy," an approach to patients who are concerned by their symptoms who do not have serious disease. This approach includes: (1) question and examine the patient, (2) assure the patient that serious disease is not present, (3) suggest that the symptom(s) will resolve, (4) tell the patient to return to normal activity, (5) consider non-specific treatment, and (6) follow the patient. This approach can be used by any type of provider, with some degree of success. However, patients with persistent symptoms, particularly those with conversion disorder, may be more resistant to this approach.

Conversion disorder has been successfully treated in a number of ways; treatment providers have included psychiatrists, physiatrists, neurologists, and native healers. Patients with conversion disorder have historically been treated in a number of settings, most commonly in an inpatient

context. Occasionally, circumstances (patient choice, funding) will dictate an outpatient approach to treatment, although it is believed that in most instances this is less effective, particularly for a patient with subacute or chronic symptoms.[16] A variety of approaches to treatment have been described in the psychiatry and rehabilitation literature, including narcosuggestion,[26] group therapy,[27] individual psychotherapy,[15] hypnosis,[25] modality-based therapies such as electrical stimulation,[8] EMG biofeedback,[3] operant conditioning,[19] and a strategic-behavioral approach.[18]

This chapter describes some of the theoretical underpinnings of the challenges to treatment of the patient with conversion disorder experienced by the treatment team as a whole, and by individual members, as well as discipline-specific challenges experienced by various members of the treatment team. The discussion centers around treatment of patients in an inpatient rehabilitation setting, although the principles, challenges, and stratagems discussed will for the most part hold true in other treatment contexts.

The use of an interdisciplinary treatment model for conversion disorder has a number of advantages that contribute to successful outcomes after treatment.[16] However, interdisciplinary treatment for conversion disorder also involves a number of issues that can become barriers to desirable treatment outcomes. Barriers to successful treatment seem to occur in several different areas. These include clinician-negative countertransference toward the patient, as well as staff misinformation and negative attitudes about conversion disorder. This can occur particularly in relation to such topics as confusion between conscious versus unconscious symptom production, provider perception of symptom legitimacy, and clinician frustration with patient somatization. In addition, clinician fear regarding undiagnosed organic disease that might have been overlooked can also be a barrier to successful interdisciplinary treatment of the patient with conversion disorder. Finally, communication among clinicians in an interdisciplinary setting about diagnosis and treatment as well as the consistency of the treatment process can also be areas in which potential barriers to successful treatment can occur.

HELPING STAFF COPE WITH NEGATIVE EMOTIONAL RESPONSES TO PATIENTS

Even more than with other conditions, conversion disorder has the potential to stir negative countertransference reactions in clinicians working with these patients. Several authors have addressed the topic of countertransference in non-psychoanalytic settings, and their insights are helpful in understanding how clinicians working with conversion disorder patients can respond to this diagnosis emotionally as well as rationally.[4]

Countertransference has been defined as feelings or reactions generated within the clinician by the interaction with the patient.[23] Countertransference is by nature non-rational and not always in alignment with the facts of the situation. It can be influenced by clinically irrelevant patient factors or by unconscious forces within the clinician. It is typical of countertransference reactions for the clinician having them to be imperfectly aware of their influence on the clinician's perception of the patient. Most authors seem to agree that the more clinicians can make their countertransference accessible to themselves, the less their adverse reaction to the patient. By understanding their own emotional reactions to the patient, clinicians can have greater psychological distance and objectivity, which help neutralize reactions that might otherwise interfere with the clinician-patient relationship.[5,23,24]

CORRECTING STAFF MISUNDERSTANDINGS

Like other somatization disorders, conversion disorder sometimes results in lack of understanding and even resentment in clinicians. This tendency for patient somatization to trigger negative emotional reactions in clinicians seems common. In a study that analyzed the reactions of rehabilitation therapists and nurses to conversion disorder patients, common staff reactions included anger toward conversion disorder patients and feelings of being used and manipulated by them.[17] Other studies have found that in general health care outpatients[9] and in patients with fibromyalgia,[22] patient somatization predicted physician frustration more than any other single variable. Thus, there seems to be something about the presence of nonorganic physical symptoms such that they have a significant potential to trigger negative emotional reactions in clinicians. When clinical staff do not understand conversion disorder patients or even resent them, this can have negative consequences for the treatment process. Such misunderstandings or resentments may result in clinicians failing to engage with patients, reacting with hostility toward them, not using all of their skills in treatment, or even sabotaging treatment.

INCREASING STAFF PERCEPTION OF SYMPTOM LEGITIMACY

Conversion disorder and malingering are viewed by some as being on a continuum,[1] and the differential diagnosis between conversion disorder and malingering often remains difficult.[14] Our inability to always make a good separation between these two conditions may at times result in confusion among clinicians working with conversion disorder patients. This confusion may cause some clinicians to view patients with conversion disorder as though they were malingering. The patient is then evaluated by the clinician from a moral judgment point of view, rather than from a clinically based perspective. Better differentiation of conversion disorder from malingering would help resolve this issue. Relatedly, improvements in understanding and diagnosing malingering in more objective terms have been described.[10]

EDUCATING STAFF ABOUT UNCONSCIOUS NATURE OF SYMPTOMS

Several authors have addressed the issue of clinician concerns about symptom legitimacy in patients with conversion disorder.[11,12,17] There seems to be general agreement that clinicians perceive conversion symptoms negatively to the extent that they judge those symptoms as being the result of conscious psychological processes. On the other hand, when clinicians can be educated about the unconscious nature of the conversion symptoms, the perception of the clinician changes to one in which the symptoms are viewed as no longer under the control of the patient. Once the unconscious nature of the condition is accepted by the clinician, some of the stigma of conversion disorder is eliminated because moral judgments about the patient are replaced by understandable psychological mechanisms.

ADDRESSING CONCERNS ABOUT UNDERLYING ORGANIC DISEASE

Another barrier to successful treatment is concern on the part of other interdisciplinary clinicians that undetected underlying organic disease exists, which, if discovered, would account for the patient's symptom presentation. To some extent, this is a realistic concern in some patients, particularly those in whom the diagnosis of conversion disorder was made purely on the grounds of exclusion, as a certain

number of patients in this category are determined later on to have true organic disease.[7] The medical literature contains frequent examples of this type of diagnostic error. Complicating this issue a little further are those instances of conversion disorder that are found in combination with verified underlying organic pathology. A frequent example of this is non-epileptic seizures occurring in the same patient who also has authentic epileptic seizures.[21] Clinical staff may resist fully committing to a behaviorally based conversion disorder treatment program until their concerns in this area are addressed. Staff reassurance about this issue can take a couple of forms. The patient with conversion disorder should have undergone a thorough diagnostic evaluation to eliminate organic explanations for the symptoms. The outcome of this diagnostic process can be reviewed with the clinical staff, for whom this information will be reassuring. Additionally, if there are positive findings that are virtually pathognomonic for conversion disorder such as "magnetic gait" or symptom overflow, a discussion of this with rehabilitation therapists and nurses can be valuable in mobilizing staff commitment and eliminating doubts.

MAINTAINING AN APPROPRIATE LEVEL OF STAFF COMMUNICATION

The interdisciplinary treatment of conversion disorder represents a clinical situation in which communication among clinicians is particularly important. Communication among staff and coordination of their clinical activities can be facilitated by following several principles. Treatment is optimal when there is a core group of staff with specialized training in conversion disorder. The treatment team should meet frequently, and the treatment process would probably benefit from an early team meeting as soon in the patient's treatment as possible. Although it is becoming the trend for patients to attend their own team conference, this practice may not be recommended in behaviorally oriented treatment programs where patient insight needs to be de-emphasized. Team communication and consistency also seem to be enhanced through the use of written treatment protocols that help to coordinate and unify the efforts of staff from divergent treatment backgrounds (Table 1). Finally, team members need to communicate directly with each other and not

TABLE 1. Interdisciplinary Treatment Barriers and Recommended Solutions

Barrier	Solution
Negative countertransference	Increase clinician awareness of countertransference issues
	Increase staff empathy for patient's suffering
Resentment of non-organic symptom presentation	Staff education about unconscious nature of symptoms
	Increase staff empathy for patient's suffering
	Differentiate conversion disorder from malingering
Concern about underlying organic disease	Review with staff the details of extensive evaluation with negative findings
	Review with staff any clinical findings specifically positive for conversion disorder
Improve team communication	Core staff with specialized training in conversion disorder
	Team meeting early in the course of treatment
	Standardize treatment through written protocols
	Avoid team communication through patient
	Team meeting closed to patient

through the patient. Clinicians who get their information primarily from the patient could be significantly misled.

DEFINING HOW STAFF COMMUNICATE WITH THE PATIENT

There needs to be agreement among clinicians about how diagnostic information is to be shared with the patient and his or her family. Depending on the patient's psychological defenses and capacity for insight, information about the diagnosis may or may not be able to be directly shared with the patient. It can be harmful for some patients to be confronted with a psychiatric diagnosis that they are not prepared to accept. It is essential that there be good staff communication about this particular issue. Inadvertent mistakes in this area can be harmful to the patient and can terminate his or her ability to continue in treatment.

MAXIMIZING STAFF CONSISTENCY

Most rehabilitation medicine–directed treatment programs for conversion disorder are behaviorally based and do not necessarily require extensive patient insight for the success of the treatment program. Behaviorally based treatment programs need to be consistently applied in order to be successful. Consistency in this sense is enhanced when staff work from a shared set of assumptions and treatment principles. Threats to consistency can also arise out of the interdisciplinary treatment model. Staff from different backgrounds may bring different theories about conversion disorder and its clinical management to the treatment process. Clinicians from an insight-oriented mental health background in particular may have a perspective on treatment of conversion disorder that is at variance with that of the rest of the team. It is possible for mental health clinicians to alienate patients by questions that probe for psychological sources of conversion symptoms such as childhood sexual abuse.[20]

BARRIERS TO TREATMENT SPECIFIC TO EACH TEAM MEMBER

As noted throughout this chapter, there are a number of challenges that face members of the interdisciplinary team treating patients with conversion disorder. Many of these challenges are the same or similar across the team, yet as each team member has a unique role, there are some problems that are relatively discipline-specific. These are outlined below.

The Patient

It is a truism in current approaches to rehabilitation that the patient is considered an integral member of the treatment team. Conversion disorder is a diagnosis that challenges this concept like no other, owing to the perceived sensitive nature of the diagnosis. Is the diagnosis openly discussed, strictly avoided, or discussed in a roundabout fashion? Each individual will have a different ability to accept or understand that psychologic causes can lead to neurologic symptoms, with profound deficits in mobility, activities of daily living, etc. No one explanation works optimally for all patients, but a sensitive explanation of conversion as a rare and severe physical manifestation of psychologic stress, in which the communication between the brain and the affected body part is blocked, seems to be well tolerated by most people, especially when put in the context of everyday physical manifestations of stress, such as tension headache, nervous diarrhea, etc. This also opens the door to the role of physical therapy as a type of "retraining," allowing resumption of the normal flow of messages in the nervous system. Some individuals may express concern

that they have not perceived any undue stress in their life recently; this can be countered by an explanation that although "stress" may not have been consciously perceived, it was acknowledged on an unconscious level and expressed or responded to somatically without any conscious awareness. Open discussion of the key role of stress leads to an acceptance of the role of the psychologist on the team, which otherwise might be viewed with a degree of suspicion.

Physician

The physician has a key role on the treatment team, and one significant challenge is to assume responsibility for an accurate and timely diagnosis. The physician must be confident in the diagnosis of conversion disorder, and able to convey this to the treatment team to avoid any of the uncertainty that can undermine a behavioral treatment program. The diagnosis must be timely, to avoid ongoing workup or testing that will lead to uncertainty in the minds of the patient and treatment team. As a corollary, any consultants involved must be aware to avoid raising the question of diagnostic alternatives to the patient, unless absolutely imperative. "Are they sure you don't have MS?" offhandedly asked of a patient in the midst of a behavioral treatment program might be one of the most undermining questions in clinical medicine.

The treating physician must also have a sophisticated awareness of the patient's ability to cope with the diagnosis and/or explanation of the treatment approach. Too much, too little, or the wrong type of information can lead to a patient's reluctance to engage in treatment. The physician must tailor the explanation of the diagnosis and treatment rationale to optimize the patient's ability to engage in treatment.

Psychologist

The psychologist has the challenge of engaging at times reluctant or even hostile patients in an exploration of the possible etiologies of their conversion symptoms. These may be very obvious, or at times entirely obscure. The psychologist also acts as "point person" for the team, coordinating team members' approaches to the patient, maximizing consistency. The psychologist also can be challenged by the need to organize appropriate psychologic or counselling follow-up for the patient after discharge when necessary, to minimize the possibility of relapse of conversion symptoms.

Physical Therapist

Most patients admitted for inpatient behavioral treatment of conversion disorder have gait disturbance as a significant part of their conversion symptom complex, and as a result, the physical therapist often assumes a pivotal role in treatment. Therapists experienced with conversion patients will likely evaluate the patient with conversion disorder somewhat differently than they would a patient with neuromuscular disease. Assessment should focus on strength, sensation, quality of movement, and functional mobility. It should provide a basis from which to measure improvement. Education regarding movement disorder and physical deficits should be avoided. Instead, the patient (who is likely to be somewhat suggestible) is told to expect changes in sensation, which is a sign of improvement; this deflates the patient's need to hold onto unusual symptoms (e.g., altered sensation or pain) in this often highly somatically focused patient population.[13] An expectation is provided at the outset that the patient will return to normal function. A significant challenge for the PT can be to diminish the patient's desire for adaptive equipment, and to help the patient relax, avoiding tense, fearful behaviors. When any abnormal movements

start, the patient should be stopped or sat down in the wheelchair, if the behaviors are not resolved with verbal or physical cues. One of the greatest challenges for the therapist is to avoid inadvertently reinforcing abnormal behavior, and to remain calm, guiding the patient with appropriate reinforcement to improved function. Some helpful phrases in this regard include:

- Your muscles are normal and know how to work, don't concentrate on them, let them move automatically.
- Your body knows what to do; you need to relax and let the automatic functions take over.
- This will assist in reconnecting your brain with your muscles.
- When you perform this activity in this way, you will function normally. (Use suggestion to drive outcome.)[13]

Another challenge for the physical therapist may be having the family or significant other present during therapy, often with an associated increase in symptoms. If this occurs, it is important to let the family members know that the patient functioned better previously when he or she was not being observed. It is then particularly important to not have family present during transitions (e.g., between types of assistive devices). It is also important to generalize more normal mobility by having the patient walk all over the hospital and even outdoors, not just in the therapy gym (initially in a relatively quiet area to minimize the chance of an increase in abnormal gait or other behavior).

Lastly, it can be a challenge for therapists to alter their own ingrained habits, for example, changing their body language while working with a conversion patient, standing far enough away to show the patient that he or she is trusted not to fall.

Occupational Therapist

Most patients admitted for inpatient behavioral treatment of conversion disorder will work with their OT performing activities in therapy that are somewhat adjunctive or supportive of the treatment taking place in physical therapy. Activities performed in a standing position such as meal preparation may be undertaken once standing is allowed by PT. It may be difficult at times to find appropriately engaging therapy activities. In those relatively uncommon situations in which the upper extremities are the focus of the conversion symptoms, the OT will move to the forefront of treatment, immobilizing the upper extremity as needed (analogous to putting the patient with abnormal gait in a wheelchair) and devising a sequence of treatment activities.[2]

Speech Therapist

Most commonly, speech therapists do not have a role in the treatment of conversion disorder on an inpatient basis. Therefore, on the rare occasions when they become involved, rapid training in the behavioral approach utilized may be necessary, and assistance, usually from the team psychologist, in devising a treatment approach may be beneficial.

Nurse

In many ways, nurses and other inpatient unit staff have the most challenging role working with the conversion patient, as they are around the patient continuously and are the "keepers of consistency." Staff education (for all staff, including aides, housekeepers, dietary, etc.) may be helpful to avoid egregious lapses in consistency in the approach to the patient in such seemingly trivial areas as: are bed-to-chair transfers allowed independently?

Social Worker

An important responsibility for the social worker is to coordinate roles with the psychologist with regard to who is responsible for taking a detailed psychosocial history, communicating about psychosocial issues with family members when appropriate, etc. It is also important to have consistency among mental health staff about the extent to which underlying psychodynamic issues will be addressed and also about how important patient insight is to the outcome of the case.

Recreation Therapist

The challenge for the recreation therapist is to accept a relatively limited role in the inpatient treatment of conversion disorder patients. This is done to avoid making the inpatient environment inadvertently positively reinforcing of abnormal behaviors, slowing progress in treatment. Recreation therapy may be utilized more as a goal, for example, using a therapeutic community outing shortly before discharge to demonstrate generalizability of healthy behaviors to a community context.

Case Manager

The single greatest challenge for the case manager is to obtain authorization from payors to treat an ostensibly psychiatric diagnosis in an inpatient rehabilitation setting. This has caused great consternation on many occasions in the past. This has been addressed by emphasizing the patient's functional deficits in mobility, ADLs, etc., and when necessary submitting published literature on the topic to the payor, which helps to establish a credible precedent (and demonstrable outcomes) for the treatment approach.

CONCLUSION

To conclude, the at times profound functional deficits resulting from conversion disorder can be effectively treated in a rehabilitation setting. The interdisciplinary nature of the team is on full display when treating this diagnosis, and despite the many challenges to effective treatment of conversion disorder, the experienced, patient, accepting, effectively communicating team can "make miracles happen," and it can be a very gratifying experience for all concerned.

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