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Case Report
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Diagnosing Deliberate Disability in DSM-5: A Case Report and Critique

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Abstract

We assessed someone with conversion disorder who had an unusual characteristic - they explicitly wished to remain disabled. There are many analogues to this in different parts of medicine, but none of them are perfect. Indeed, although we conclude that this is pathological, we do not think it is captured anywhere in DSM-5. In particular, though it would seem most obviously to be considered Factitious Disorder, the revised criteria for DSM-5 would now exclude it. This represents a challenge to the validity of those criteria.

Keywords: Conversion disorder; Functional neurological symptoms; Factitious disorder; Nosology; Apotemnophilia

Case Report

We assessed someone with conversion disorder who had an unusual characteristic - they explicitly wished to remain disabled. There are many analogues to this in different parts of medicine, but none of them are perfect. Indeed, although we felt that this was pathological, we did not think it could be captured anywhere in our current diagnostic schemes. This poses a challenge to the validity of those schemes, as we shall discuss. We have changed some details of the case as we do not have the patient's permission, for reasons which will become clear.

Our patient was in early middle-age, currently unemployed, wheelchair-bound, referred by the pain service to our outpatient functional neurology clinic. They had had pain in both legs which had developed over the preceding 10 years, in the context of increasing gym attendance and a leg trauma dating back to their childhood, but which did not profoundly impair their function, and they had continued to work full-time in financial services. One year ago they experienced work-place bullying, however, during which they developed a sudden-onset quadriplegia, which resolved within 24 hours to a paraplegia, including bladder and bowel dysfunction. An acute admission with neurological work-up including MRI brain and spine, evoked potentials and nerve conduction studies, found no organic explanation for their symptoms, and the diagnosis of conversion disorder was made. They were referred to the pain service, as pain was their primary concern, and subsequently lost their job after an angry outburst in their workplace.

Their childhood was notable for a lack of parental affection, and our patient felt they had to parent their younger siblings. This only changed following their childhood leg trauma, and only for as long as they were ill. Their family relationships broke down completely when, as an adult, the patient disclosed they were homosexual. They had a stable work and relationship history, and had been with their current partner for 2 years prior to their paralysis developing.

What was striking about their presentation to us was how angry they were - angry with reception staff, angry about being assessed, angry at our attempts to offer treatment. This included refusals to answer questions, as they were "none of [our] business", and denigrating remarks, such as "you're no good at your job", and eventually led to the interview being terminated as it was clear the patient was not willing to participate. They insisted, vehemently, that they would not contemplate anything directed to improving their symptoms, since their disability had been good for them, had made them happy, and they would not go back to being "depressed and walking". Indeed, they described a number of enjoyable social and personal activities in their wheelchair and did not endorse any depressive symptoms. Their only expressed frustrations were at the ongoing problems with their family and their difficulty in negotiating their disability benefits. They accepted the conversion disorder diagnosis, but said they would prefer the disability be made permanent, so people would be more understanding, and had previously considered amputation or an operative cord transection,

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but were not currently doing so. Their anger limited our attempts to explore their motivation or history further.

Discussion

This is in many respects a familiar presentation of conversion disorder - the childhood emotional neglect [1] and rewarded illness predisposing to somatisation, an illness model providing the symptom scaffold, and a preceding work-place stressor, rich with 'escape potential' [2], provoking the conversion symptoms. Where it diverges is in the fierce anger of the patient and the manifest resistance to recovery. The anger was not usually a feature of their presentation (according to the pain service, though we note their workplace incident), and the explicit resistance is absolutely unique in our experience of conversion disorder - to the extent that it must challenge the correctness of that diagnosis.

A presentation like this is of course rare, but resembles many others to a degree. Medicine has many patients who appear to show, at the very least, a willful disregard for the management of their long-term health condition (think of diabetic young people), or an unwillingness to engage in the treatment their doctor recommends (think of elderly people with Parkinson's) - but we do not consider their motivation is to be ill. There are others who embrace, and even identify with, their condition (think of the deafness advocate) - but they would reject the 'disability' label entirely [3]. There are others who seek care the doctor thinks inappropriate (think of borderline personality disorder) - but they are seeking treatment. There are others who seek disabling procedures (think of apotemnophilia) - but they are seeking to reduce dysphoria [4]. How do we diagnose a determination to be disabled - as a lifestyle choice? But before answering that, we must surely decide whether it should be diagnosed as a disorder at all.

Deciding what counts as a mental disorder is difficult-to the extent that Mental Health legislation and diagnostic manuals typically do not attempt a definition - but perhaps the most successful attempt has been Wakefield's conception of mental disorder as 'harmful dysfunction' [5]. In our case, finding the 'harm' is relatively straight forward: the patient's determination to be disabled is not a fantasy, it leads to a very real refusal to accept a treatment that would have every chance of achieving a complete remission, if not cure [6], were they cooperative. Of course, there are a wide range of dangerous behaviours, such as downhill skiing, that clearly involve harm that we would not consider disorders, which is why the second factor-the 'dysfunction' (the pathology)-is required, and which is less obvious in our case. The obvious place to look for dysfunction would be the patient's expressed desire for disability. However, the desire to be ill, or to receive the benefits of illness, is common, if not universal. In particular, it was in a conversion disorder such as our patient's that Freud first described 'resistance' to treatment and the 'secondary gain' of illness [7]. Could our patient have a normally-functioning illness desire-at least normal for conversion disorder? But the desire is invariably implicit in conversion disorder. Though Freud noted the resistance "might be to a greater or less extent conscious" [7] (p.270), he was writing before factitious disorder was conceived and split off as a separate disorder [8]. The explicit resistance expressed by our patient sits uncomfortably with a conversion disorder diagnosis. While our case could simply represent conversion disorder with unusual insight or candour, it does not feel like a virtue. On the contrary, it is easy to see resistance so ferocious and deliberate as shifting the patient along the 'spectrum of condemnation' [9] from conversion disorder to factitious disorder, and exceeding whatever protective evolutionary function a desire for care may serve.

So, factitious disorder seems like the obvious diagnosis, conceived as the disorder to capture a dysfunctional desire for disability [8]. Unfortunately, the criteria in DSM have changed. Although it might seem like the obvious place for our patient, DSM-5's Factitious Disorder equally obviously excludes them. DSM-5 dropped the criterion of abnormal motivation in favour of deception [10], since assessing motivation relied on inference rather than observation, and since without deception the diagnosis might otherwise include routine cases of deliberate self-harm [11]. But in our patient's presentation there was nothing deceptive-quite the opposite - though that can never be fully excluded [12].

However, deception is not a simple concept, and by no means unitary [13]. Depending on how it is construed, conversion disorder almost certainly involves deception, albeit unconsciously-for example, it involves the simulation of neurological disorders that deceives doctors, and neurologists' diagnostic tests for conversion disorder are aimed at identifying the 'falsification of signs' [14]. What is perhaps meant by the authors of DSM-5 is 'lying' or 'purposeful' deception, but that again requires an inference, rather than an observation. Furthermore, according to online members of factitious disorder groups, lying is only a feature of a few [15]. And the requirement that factitious disorder involve falsification or induction of symptoms seems to treat those with the 'good fortune' to develop a significant medical condition quite differently from those who need to reproduce one, which seems arbitrary if the intent and the effects are the same. Again, according to online factitious disorder groups, patients are just as happy to employ their pre-existing conditions, if they have them, to get the level of care they desire [15].

The case we presented was unusual, but we believe it represents a mental disorder. The place where it would seem to belong is factitious disorder, but the new criteria in DSM-5 would exclude them. It has long been argued [16] that factitious disorder includes both deceptive and self-harming groups. Our case would suggest that the current criteria's focus on deception at the expense of motivation gets it wrong, excluding a whole sub-group, while, worryingly, potentially including conversion disorder.

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