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Функциональный больной между психиатрией и неврологией

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АННОТАЦИЯ

В статье представлен анализ современного подхода к истерии и диссоциативным (конверсионным) расстройствам. Дана оценка обоснованности их включения в психиатрический или неврологический раздел классификаций болезней. Особое внимание уделено диагнозу «функциональное неврологическое расстройство», вошедшему в некоторые классификационные системы. С позиции научной обоснованности рассмотрена необходимость неврологического подхода к диагностике и терапии диссоциативных расстройств.

Ключевые слова: функциональное неврологическое расстройство, диссоциативные (конверсионные) расстройства, истерия, МКБ-11.

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Patient with functional disorder between psychiatry and neurology

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ABSTRACT

The article analyzes the modern approach to hysteria and dissociative (conversion) disorders. The validity of their inclusion in the psychiatric or neurological section of disease classifications is assessed. Particular attention is paid to the diagnosis of “functional neurological disorder”, which is included in some classification systems. From the standpoint of scientific validity, the need for a neurological approach to the diagnosis and treatment of dissociative disorders is discussed.

Keywords: *functional neurological disorder, hysteria, dissociative disorders, conversive disorders, ICD-11, DSM-V.*

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In clinical practice, neurologists and psychiatrists often encounter patients who have diseases with complex symptoms that cannot be attributed to a specific psychiatric or neurological pathology. They cannot be unambiguously attributed to the so-called organic or hereditary-constitutional, or psychogenic disorders. They are usually classified as functional, neurotic, or somatoform [1–3]. These disorders present significant difficulties regarding diagnostics, therapy, and the organization of medical care, since patients with formal psychopathological symptoms, as well as neurological and somatic complaints, do not seek medical advice from psychiatrists but visit neurologists and general practitioners [4].

Some authors call functional disorders the “blind spots of psychiatry” [5], implying that they are understudied and receive insufficient attention from psychiatry. In addition, these disorders turn out to be therapeutically resistant, and patients are under the supervision of doctors of various specialties for many months and years without significantly improving their well-being.

This paradox has led to the migration of disorders that historically belonged to the field of psychiatry to neurological sections of the classifications. Changes made to the ICD-11 (International Statistical Classification of Diseases and Related Health Problems, 11th revision) and DSM-V (USA Diagnostic and Statistical Manual of mental disorders, 5th revision) were very large-scale and revolutionary. At the same time, researchers continue to raise the question of revising the boundaries of neurology and psychiatry. The point of view is that “the wall of partition between these medical specialties should be demolished” [6] and that the difference between neurological and psychopathological disorders is conditional, since both involve brain pathology.

In recent years, special attention has been paid to the study of the so-called functional neurological disorders [7–14], when physical symptoms (for example, paralysis) are detected beyond obvious brain damage. In contrast, neuroimaging confirms the existence of relationships between the fields involved in controlling movements and is responsible for attention and emotions [15]. The diagnostics of a functional neurological disorder is causally neutral, unlike, for example, the diagnosis of hysteria, since the connection of such disorders with psychogeny

(especially with unconscious ones) does not seem as apparent, based on studies of the last decade [5].

The traditional view, focused on the obligate detection of a psycho-traumatic factor as the primary diagnostic criterion, is currently considered archaic. According to some researchers, this causes a shift in diagnostic emphasis and a decrease in the role of psychiatrists in diagnosing functional disorders. It can be recalled that E. Krepelin, long before the concept of a functional neurological disorder, in his famous classification of mental disorders, divided psychogenic disorders and hysteria, apparently drawing attention to the lack of evidence linking hysteria with psycho-traumatic events. Nowadays, the validity of the neurotic triad described by K. Jaspers is questioned (neurosis is caused by mental trauma, it is evident in the clinical presentation of the disease, and at the end of its action or deactualization, the symptoms of neurosis should stop) [3]. In modern psychiatric classifications, first, neurotic disorders are divided by symptoms, and second, for many of them, the importance of psychological etiological factors recedes into the background. Changes are most clearly seen in depressive, obsessive-compulsive, and dissociative disorders.

A new insight into the etiopathogenesis of hysteria, which was first transformed into the so-called dissociative (conversion) disorder, and now appears as a functional neurological disorder, is of particular interest. On this occasion, it was stated that “a disorder of the mind and brain, which is a mysterious condition, once known as hysteria, challenges the separation of psychiatry and neurology” [16]. The dynamics of scientific ideas about hysteria and dissociative (conversion) disorders are reflected in the number of works focused on functional neurological disorders is growing dramatically and decreasing about hysteria and dissociative (conversion) disorders (Fig. 1).

A functional neurological disorder is diagnosed if the following criteria are revealed in the clinical presentation of the disease:

- 1) one or more symptoms that reflect movement or sensory impairments;
- 2) the symptoms cannot be explained by a neurological or other mental illness;
- 3) the symptoms cause severe stress or problems in the social sphere, work, or other aspects of life, or they are so significant that medical intervention is recommended.

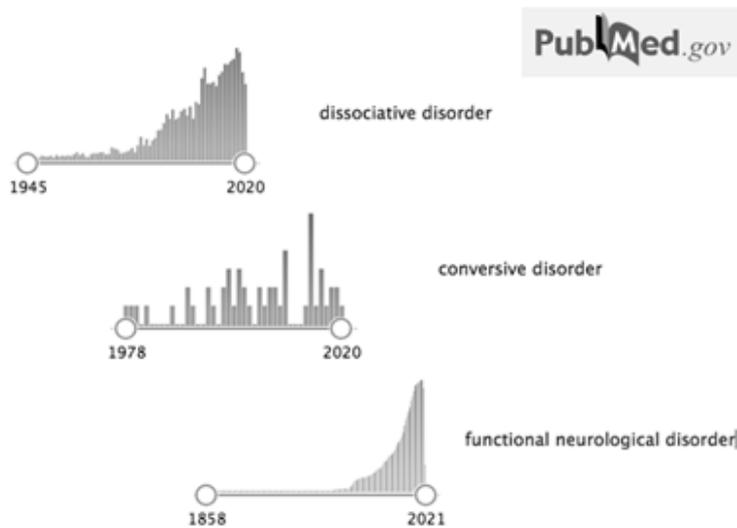


Fig. 1. Dynamics of publication activity on the subject of dissociative, conversion, and functional neurological disorders (according to PubMed).

- 6B60 Dissociative disorder with neurological symptoms
- 6B60.0 Dissociative disorder with neurological symptoms, visual impairment
- 6B60.1 Dissociative disorder with neurological symptoms, hearing impairment
- 6B60.2 Dissociative disorder with neurological symptoms, with vertigo
- 6B60.3 Dissociative disorder with neurological symptoms, with other sensory impairments
- 6B60.4 Dissociative disorder with neurological symptoms, with non-epileptic seizures
- 6B60.5 Dissociative disorder with neurological symptoms, speech impairment
- 6B60.6 Dissociative disorder with neurological symptoms, with muscle paresis or weakness
- 6B60.7 Dissociative disorder with neurological symptoms, with gait disturbance
- 6B60.8 Dissociative disorder with neurological symptoms, with movement disorder
 - .80 with chorea
 - .81 with myoclonus
 - .82 with tremor
 - .83 with dystonia
 - .84 with facial spasm
 - .85 parkinsonism
 - .8Y with other specified movement disorders
 - .8Z with unspecified movement disorders
- 6B60.9 Dissociative disorder with neurological symptoms, with cognitive impairment
- 6B60.Y Dissociative disorder with neurological symptoms, other specified disorders
- 6B60.Z Dissociative disorder with neurological symptoms, disorders unspecified

Fig. 2. Dissociative disorder with neurological symptoms (according to the International Classification of Diseases, 11th revision) [17]

When diagnosing, it is recommended to rule out an organic disease and identify positive criteria, that is, the patient’s erroneous ideas about the disease and its consequences, emotional reactions, and behavioral changes in response to these stressful symptoms [4]. Functional disorders include somatic and neurological disorders.

Despite the consensus of neurologists on a functional neurological disorder, there is a contradiction between the current classifications (ICD-11 and DSM-V). In the ICD-11, a functional neurological disorder is presented in the psychiatric section and described as a dissociative disorder with neurological symptoms (Fig. 2). In contrast, in the American classification, it is in the neurological section.

A functional neurological disorder is heterogeneous. Traditionally, it includes movement disorders, such as dystonia, paralysis, tremor, and balance disorders. However, a functional neurological disorder is often manifested by various somatic symptoms, such as dizziness, headaches, and non-epileptic seizures [18]. According to P. Pun et al. [19], the symptom distribution of functional neurological disorder is as follows (Fig. 3):

The data presented emphasize the heterogeneous approach of scientists to the concept of a functional neurological disorders. Since some researchers continue to rank them, somatoform disorders, among others, are classified in the ICD-11 as bodily

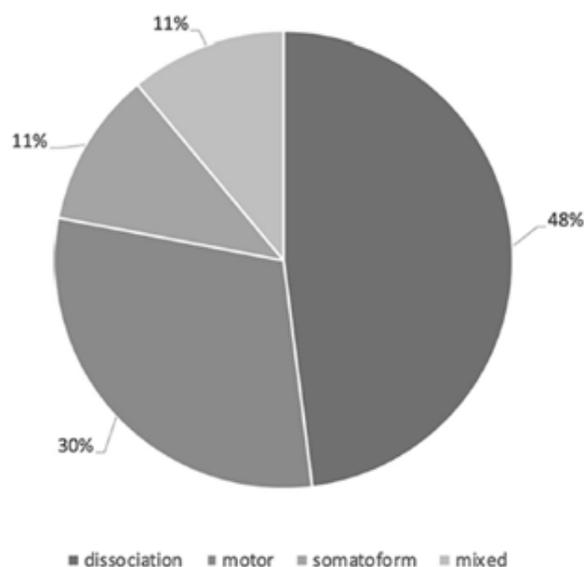


Fig. 3. Distribution of symptoms of a functional neurological disorder

distress. Diagnostic changes in functional disorders in psychiatric classifications included only motor disorders, whereas dissociative psychopathological disorders (amnesia, trances, fugues, compulsion,

depersonalization, and derealization) remained unchanged in the last category.

Thus, the analysis of modern ideas about dissociative disorders with neurological symptoms (functional neurological disorder) reveals the dissimilarity of views of neurologists and psychiatrists on etiopathogenesis. Attributing them to one or another field of professional activity decreases the quality of medical care provided to such patients. We can agree that functional disorders remain a “blind spot of psychiatry” [5] and require comprehensive research.

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