Table 16-4	Criteria for Diagnosis of Conversion Disorder
A. One or more symptoms affect voluntary motor or sensory function, suggesting a neurologic or other general medical condition.	
B. Psychological factors are judged to be associated with the symptom or deficit because the initiation or exacerbation is preceded by conflicts or other stressors.	
C. The symptom is not intentionally produced or feigned (factitious disorder, malingering).	
D. After appropriate investigation, the symptom cannot be fully explained by a general medical condition, by the direct effects of a substance, or as a culturally sanctioned behavior or experience.	
E. The symptom causes clinically significant distress or impairment in social, occupational, or other function or warrants medical evaluation.	
F. The symptom is not limited to pain or sexual dysfunction, does not occur exclusively during the course of somatization disorder, and is not better accounted for by another mental disorder.	

Table 16-5	Criteria for Diagnosis of Pain Disorder
A. Pain in one or more anatomic sites is the predominant focus and is of sufficient severity to warrant clinical attention.	
B. The pain causes clinically significant distress or impairment in social, occupational, or other important functions.	
C. Psychological factors have an important role in the onset, severity, exacerbation, or maintenance of the pain.	
D. The symptom or deficit is not intentionally produced or feigned (factitious disorder, malingering).	
E. The pain is not better accounted for by a mood, anxiety, or psychotic disorder and does not meet criteria for dyspareunia.	
Specify the following:	
• Acute: duration <6 months	
• Chronic: duration ≥6 months	

often inconsistent; patients may move a *paralyzed* extremity when they think that no one is watching.

Nonepileptic seizures, sometimes described as *pseudoseizures,* resemble epileptic seizures but are not associated with the electroencephalographic abnormalities or a clinical course characteristic of true epilepsy. Most cases resolve within 3 months of diagnosis. Referring to nonclassic presentations for seizures as *spells* can help avoid medicalization of these symptoms.

The course of the condition is often benign, although 20% to 25% of patients experience a recurrence. Good prognostic characteristics include symptoms of paralysis, aphonia, blindness; acute onset; above-average intelligence; presence of an identifiable stressor; and early diagnosis and psychiatric treatment. Poor prognostic characteristics include tremor and pseudoseizures. The rate of misdiagnosis of conversion symptoms averages 4%. Myasthenia gravis, multiple sclerosis, dystonias, and dyskinesias (abnormal movements) are conditions commonly mistaken for conversion disorder.

Pain disorder is diagnosed instead of a conversion disorder if pain is the predominant physical symptom. The *DSM-IV* divides pain disorders into those associated with psychological factors, those with both psychological and medical factors, and those in which the medical condition is the major factor in the pain symptom (Table 16-5). The diagnosis is considered acute if the condition lasts less than 6 months and chronic when it lasts 6 months or more.

RAP is the most common recurrent pain complaint of childhood and accounts for 2% to 4% of pediatric office visits. It is defined by intermittent pain with full recovery between episodes lasting more than 3 months. There is a strong relation between RAP and anxiety in children. Approximately 90% of pediatric patients have no clinical findings to account for their abdominal pain.

Common types of headaches are migraine and tension-type headache. Migraine may be associated with dizziness, gastrointestinal symptoms, and cyclic vomiting syndrome, characterized by recurrent and stereotypic episodes of intense, unexplained vomiting. Psychological factors frequently play a significant role in the complaint of a headache.

Functional chest pain can be seen in 10% of school-aged children and adolescents. Other common pain disorders are musculoskeletal pains (limb pain and back pain), fibromyalgia, and complex regional pain syndrome type I (previously known as *reflex sympathetic dystrophy*).

Reassurance is the primary treatment of pain disorder. Symptom diaries, including the events that precede and follow the pain episode, aid in initial assessment and ongoing management of the problem. Minimizing secondary psychological consequences of recurrent pain syndromes is important.

Hypochondriasis is the preoccupation with the fear of having a serious disease based on misinterpretation of bodily symptoms and functions. This fear should be present for 6 months. The presenting complaint is a physical sign or symptom, which is normal but is interpreted by the patient to indicate disease despite reassurance of a physician (e.g., a tension headache perceived as a brain tumor). This diagnosis is more commonly seen in late adolescence and adulthood. An underlying depression or anxiety disorder may be related to the symptoms. Prevalence of obsessive-compulsive disorder (OCD) is four times greater than in the general population. When the belief or preoccupation is limited to an imagined defect in appearance, the diagnosis is body dysmorphic disorder (BDD), not hypochondriasis.

Body dysmorphic disorder is a preoccupation with an imagined or slight defect in physical appearance that causes clinically significant distress or impairment in functioning. It is usually seen in adolescents (the male-to-female ratio being almost equal) and is distinguished from common developmental preoccupations with appearance by the presence of clinically significant distress and/or impairment in functioning. Any bodily area can be a focus, but excessive concerns about the skin (scars and acne) and body shape are common. Because BDD can be associated with shame and the need for secrecy, the diagnosis may be missed unless clinicians ask directly about symptoms. Parents of children with BDD report excessive mirror checking, grooming, attempts to *camouflage* a particular body area, and reassurance-seeking. Patients may cause self-injury as a consequence of attempts to fix the perceived flaw.