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CONVERSION DISORDER-A DILEMMA FACING THE PSYCHIATRIST IN DEVELOPING COUNTRIES

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Conversion disorder is linked historically to the concept of hysteria. It is one of the commonest diagnos- tic problem faced by psychiatrists working in develop- ing countries. It in India, for example, the prevalence of up to 31% is reported among inpatients1. The prevalence in all psychiatric out patients setting in India was between 6-11%2 (Wig et al, 1982). In Turkey among outpatients who were admitted to a primary health care institution in a semi rural area, the prevalence of conversion symp- toms in the preceding month was 27.2%3. In Egypt it is one of the most frequently diagnosed condition4. In Pa- kistan dissociative disorders are reported to be one of the commonest diagnoses representing 12.4% and 4.8% of the admissions in inpatient psychiatric units5,6.

Keeping in mind such a high prevalence and the therapeutic challenges it offers it is surprising that there is very little if any scientific research on the subject. This may be understandable for developed countries as the disorder is rarely encountered in psychiatric practice in these countries. But lack of literature from developing countries is quite perplexing in view of the statistic just mentioned. It would be interesting to examine how much attention is paid to this common disorder in research and practice.

Conversion hysteria was perhaps the first psychi- atric diagnosis to receive psychological treatment. It would not be an exaggeration to say that much of the psychodynamic theory proposed by Freud is based on work with patients suffering from hysteria. Since 1842 when Freud first drew attention to the unconscious con- flicts underpinning the conversion symptoms, there has been little scientific evaluation of the treatments proposed for the disorder. On a systematic review of the literature for interventions to treat Conversion Disorder Rudy et al could only identify three randomised controlled trials7. These trials had a total sample size of 119 in all the studies combined together. No definitive intervention could be recommended by the authors.

Even more interesting is the scarcity of literature on aetiology. The presence of psychological stressor is the key criterion in evolution of conversion symp-

toms. For example, ICD-10 stipulates an “...evidence

for psychogenic causation, in the form of clear associa- tion in time with stressful events and problems or dis- turbed relationship ...” as important criterion for the di- agnosis8 While there is plethora of studies on stressful life events preceding depression, an extensive search for the literature on the subject, I could only identify few studies which have systematically studied the stressful life events in context of Conversion hysteria. Compared to vast literature on the role of stressful life events in de- pression where these are not essential criteria for diag- nosis, the amount and quality of literature in conversion disorder is strikingly poor.

What about training and research. It is relatively difficult to examine the education and training as empiri- cally as the literature on aetiology and interventions. In order to get an idea of the place of hysteria in training, I decided to look at the contents of questions in theory paper of FCPS examination of the College of Physicians and Surgeons, Pakistan considering that the examina- tion normally play a steering role in what trainee read and learn. It also reflects the importance we attach to a subject. I conducted a search of all the question papers for final examination of FCPS over the last 3 years. In a total of 114 questions, five definitely related to conver- sion hysteria and a further two could possibly be consid- ered as related to this subject. Being an examiner for several, years I can also confirm that the subject rarely surfaced in practical examination for FCPS-II.

What does this lack of attention reflects?. Although this can be attributed to general lack of research and systematic approach to the subject on any aspect of mental health in developing countries, my impression is that the problem is more deeply rooted. I feel that this perhaps reflects the unconscious conflicts we face in our attitudes about this disorder. Perhaps we have not been able to face the more deep rooted problems in embrac- ing the basic issues which underpin the aetiology and management of this disorder. The concept of conversion disorder has always evoked strong emotions from Freud- ian times as it challenges our basic notions about the concept of health and illness for a person in whom we can not locate ‘pathology’. Conversion symptoms pro-

voke a deep sense of frustration and anger in therapist

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when the patient neither present, nor behave like a “pa- tient” This is further aggravated by lack of any guidance in the literature on how to deal with these patients. Abuse by traditional healers is widely prevalent in those suffer- ing from conversion hysteria. Unfortunately, there is an-

ecdotal evidence for inhuman treatment even by the men- tal health professionals.

What needs to be done. Most of the studies report a high prevalence of the disorder amongst females, be- longing to the low and middle income group and in those having less education. The disorder has strong associa- tion with the socioeconomic status as is evident from decreasing incidence with improving socioeconomic conditions9. It appears that the incidence of disorder is perhaps a strong indicator of status of women in a par- ticular society. Therefore, the prevention of the disorder demands efforts on socioeconomic levels beyond the field of psychiatry itself. However, the mental health pro- fessionals will have to play a crucial role. Following needs to be done on urgent basis.

1. The most important step would be to develop the evidence base for treatment of conversion disor- der. A recent randomised controlled trial from Pakistan has demonstrated that brief behaviour therapy intervention is feasible and can be effec- tive in hospital setting10. There is urgent need for similar trials in community setting.
2. The professional bodies and the scientific journals in the region need to develope guidelines and re- search agenda to understand the aetiology man- agement of conversion disorder
3. The research on psychosocial factors need to in- form the policy on the prevention and providing appropriate services for the disorder.

Most importantly perhaps, we need to ask this question from ourselves. Do we equate the disorder with malingering? This may be too basic or perhaps too crude a question to be asked from a trained mental health pro- fessional. However, I believe honest answer to this ques- tion can help us to examine and understand our own beliefs, conflicts and attitudes about the disorder some of which may be too deep rooted to be conscious. Un-

educated, poor and voiceless women suffering most commonly from the disorder certainly deserve a better deal from the mental health professionals.

**REFERENCES**

1. Malik P, Singh P. Clinican. Characteristics and outcome of children and adolescent with conversion disorder. Indian Pediatrics 2002; 39:747-52.
2. Wig NN, Mangalwedhe K, Bedi H, Murthy RS. A fol- low-up study of hysteria. Indian J Psychiatry 1982;24: 120-5.
3. Sagduyu A, Rezaki M, Kaplan I, Ozgen G, Gursoy- Rezaki B. Saglik ocagina basvuran hastalarda dissosiyatif (konversion) belirtiler (Prevalence of con- version symptoms in a primary health care center). Türk Psikiyatri Dergisi 1997; 8:161–9.
4. Okasha A. Focus on psychiatry in Egypt. Br J Psy- chiatry 2004; 185:266-72.
5. Minhas FA, Farooq S, Rahman A, Hussain N, Mubasshar MH. Inpatient psychiatric morbidity in a tertiary care mental health facility: A study based on a psychiatric case register. JCPSP 2001; 11: 224-8.
6. Malik SB, Bokhari IZ. Psychiatric admissions in a teaching hospital: A profile of 177 Patients. JCPSP 1995; 9: 159-361.
7. Rudy R, House A. Psychosocial interventions for con- version disorder. Cochrane Database Syst Rev 2005; 19: CD005331.
8. WHO. ICD-10 Classification of Mental and Behavioural Disorders. Clinical description and diagnostic guide- lines. Geneva 1992.
9. Nandi DN, Banerjee G, Nandi S, Nandi P. Is hysteria on the wane? A community survey in West Bengal, India.Br J Psychiatry 1992;160: 87-91.
10. Khattak T, Farooq S. Behavior therapy in dissociative convulsions . JCPSP 2006;16:359-63.