CONVERSION DISORDER-A DILEMMA FACING THE PSYCHIATRIST IN DEVELOPING COUNTRIES

Saeed Farooq

Conversion disorder is linked historically to the concept of hysteria. It is one of the commonest diagnostic problem faced by psychiatrists working in developing countries. It in India, for example, the prevalence of up to 31% is reported among inpatients[1]. 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 symptoms in the preceding month was 27.2%[3]. In Egypt it is one of the most frequently diagnosed condition[4]. In Pakistan dissociative disorders are reported to be one of the commonest diagnoses representing 12.4% and 4.8% of the admissions in inpatient psychiatric units[5,6].

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 psychiatric 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 conflicts 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 trials[7]. 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 symptoms. For example, ICD-10 stipulates an "...evidence for psychogenic causation, in the form of clear association in time with stressful events and problems or disturbed relationship ..." as important criterion for the diagnosis[8] 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 depression where these are not essential criteria for diagnosis, 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 empirically 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 examination 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 conversion hysteria and a further two could possibly be considered 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 embracing the basic issues which underpin the aetiology and management of this disorder. The concept of conversion disorder has always evoked strong emotions from Freudian 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 provoke a deep sense of frustration and anger in therapist when the patient neither present, nor behave like a "patient" 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 suffering from conversion hysteria. Unfortunately, there is an-

Correspondence:

Saeed Farooq, MCPS, FCPS.
Associate Professor and Head Department of Psychiatry,
PGMI, Lady Reading Hospital, Peshawar, Pakistan
E-mail: sfarooqlrh@yahoo.com

ecdotal evidence for inhuman treatment even by the mental health professionals.

What needs to be done. Most of the studies report a high prevalence of the disorder amongst females, belonging to the low and middle income group and in those having less education. The disorder has strong association with the socioeconomic status as is evident from decreasing incidence with improving socioeconomic conditions[9]. It appears that the incidence of disorder is perhaps a strong indicator of status of women in a particular society. Therefore, the prevention of the disorder demands efforts on socioeconomic levels beyond the field of psychiatry itself. However, the mental health professionals 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 disorder. A recent randomised controlled trial from Pakistan has demonstrated that brief behaviour therapy intervention is feasible and can be effective in hospital setting[10]. 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 research agenda to understand the aetiology management of conversion disorder
3. The research on psychosocial factors need to inform 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 professional. However, I believe honest answer to this question 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. Uneducated, poor and voiceless women suffering most commonly from the disorder certainly deserve a better deal from the mental health professionals.

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