STRESSFUL LIFE EVENTS IN THE ONSET OF DISSOCIATIVE (CONVERSION) DISORDERS

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BACKGROUND

Psychiatric diagnosis of hysteria depends on the recognition of mental conflict and the unconscious connection between conflict and symptom. In conversion reaction, patients unconsciously convert mental conflicts to symptoms that appear to be physical, but there is no organic cause found. Common symptoms of conversion reaction are muscular paralysis, deafness, blindness and tremors. Alternatively, mental conflict can also appear as severe mental dissociation in which patients may have periods of intense emotion and defective power of self-observation. In such mental conditions, patients may interact with others in a bizarre way[1].

Dissociative (conversion) disorders, previously known as hysteria, are quite common in our clinical practice despite the fact that its incidence has been decreasing in western countries[2]. As many as 4% of those attending neurology out patients clinics in the United Kingdom have been estimated to have conversion disorders. For both in and out patients in other European countries similar rates have been reported[2] . This decline may in incidence may be due to fact that with increasing literacy and changing socio cultural patterns, dramatic symptoms such as paralysis or hysterical convulsions are no longer socially acceptable. The change of attitude towards mental illness in western countries has now enabled the patient to seek medical help for the symptoms of anxiety and depression, which commonly accompany hysterical reactions.

In countries like Pakistan, the attitudes towards mental illness are still biased and the socio-cultural inhibitions can be so strong that they prevent an individual from seeking help for emotional and psychological disorders[3]. It is possible that in our culture, physical symptoms are more acceptable and patients expressing their complaints/distress in the form of dissociative (conversion) disorders are more likely to obtain medical help/ consultation. This cultural acceptance of the symptoms is an important factor that determines mode of reactions towards the stress. This probably is the reason why hysteria is a disorder that one commonly comes across in a psychiatric practice in Pakistan. Bodily symptoms representation is widely prevalent in the Asian sub continent. Cross-cultural studies showed that in eastern culture physical connotation of any illness has greater success in securing attention and acceptance than the expression of emotional distress. As our society appreciate or accept the physical symptoms more conversion disorder may be an adaptive way of expressing the difficulties faced by the person in the stressful situation[4].

Various studies reported from Pakistan showed that dissociative (conversion) disorders still accounts for up to 10% of admissions in psychiatric wards. Dissociative disorder was much more common in females as compared to males (60% vs. 4.20%). One such study conducted in the Institute of Psychiatry Rawalpindi General Hospital, Rawalpindi, Pakistan[5], revealed that depressive illness and dissociative (conversion) disorders was the second and fifth most common reason for admission in a psychiatry unit. A more recent community clinic based study with a sample size of 1430 patients has revealed the morbidity patterns of mental illnesses like depressive illness as (47%), while dissociative (conversion) disorders as (14%)[6,7]. This shows that conversion disorder is one of the commonest presentation in our country. However research on the subject is sadly lacking.

ROLE OF LIFE EVENTS IN PSYCHIATRIC DISORDERS

Amongst the environmental factors, the role of life events and their causal association with psychiatric disorders has been a particularly prolific enterprise in the behavioral and social sciences. The predominant view among clinicians and scientists was that individuals who developed symptom in response to stressful events were constitutionally predisposed to do so by “weak nervous system”. Sigmund Freud and Breuer (1895) held the opposite view suggesting that unconscious psychological processes determine how the individual behaves in response to stress and that traumatization contributes to the formulation of anxiety and stress related disorders. They both believed that to study responses to stressful life events, a careful analysis of mind’s internal milieu, thought processes and emotional response of the body to such stressors must be incorporated.

Life events are changes that occur suddenly in someone’s life. They do not necessarily be bad, and so we can view them as either desirable or undesirable. Holmes and Rahe introduced a life events scale in 1967. This consists

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of over 40 classes of life events. They classified life events according to how stressful they are. They suggested positive correlation between stressful life events and illness. Holmes and Rahe predicted that if a person has total Life Changing Units (LCU) below 15, then he has 35% chance of illness or accident within the next two years. Total Life Changing Units (LCU) over 300 increases it up to 80%. Another scale used is the Life Events and Difficulties Schedule by Brown and Harris. Particularly stressful life events include death of a spouse, divorce and marital separation. Other rated events include redundancy and retirement.

There is a good evidence to link life events with the onset of psychiatric illness. Psychiatric illnesses that can be associated with life events include depression, anxiety and deliberate self-harm. It is, however, difficult to decide whether life events are dependent or independent[8]. Results of four studies carried out in this regard by Ameil-Lebigre (1986) showed that significance of life events was more important than the volume of events in explaining the subject's vulnerability as well as in predicting high risk for developing mental disorders like depression[9].

The studies consistently show relationships between life stress and symptoms, which are present. Both in psychiatric and psychological literature the relationship between depression and stressful life events are now well known. While, this is well-known and documented fact that stressful life events usually precede depressive illness but is less well studied in case of dissociative (conversion) disorders. Despite an extensive literature review on Medline, Extra Med and the Indian Journal of Psychiatry, few studies on the topic were found despite the common observation in our clinical practice that stressful life events usually precede dissociative (conversion) disorders. The present article aims to give an overview of role of life events in conversion disorder.

LIFE EVENTS AND CONVERSION DISORDERS

Tynnyunt conducted a study on hysterical patients in eastern Libya. Hundred cases of hysterical patients referred to the psychiatric services were included in the sample. Most of the hysterical patients (75%) experienced significant stresses immediately before the symptoms. However, the nature of stresses varied according to the sex. Males had conflicts related to work (50%), while females experienced examinations related conflicts (26%) in their study.

In another study conducted by House et al, the experiences of 56 women and 9 men were determined by using the Bedford College Life Events and Difficulties Schedule. They interviewed them about the events experienced 12 months before the onset of functional dysphasia. Thirty (54%) of the women had experienced a difficulty or event, which involved conflict over speaking out. Only 16% of a comparison group had such experiences[10]. A study from Pakistan reported that stressors were present and identifiable in most of these presenting with hysteria[11] .

A retrospective study titled as "Is hysteria still prevailing" conducted by Jain aimed at to find the prevalence and relationship of socio-demographic details in patients with conversion disorders. It also showed and found stress in most of the cases before the start of illness[12].

Harris interviewed fifty patients with a diagnosis of globus pharynges and 33 control patients attending the same ENT clinic using the Royal Holloway and Bedford College Life Events and Difficulties Schedule (LEDS). Information was elicited concerning life events and difficulties over the 12 months before globus onset, and this was compared with the experiences of the control patients, where appropriate, before the interview. Results indicated that glob us patients had significantly more severe events than the control patients throughout the year did. Moreover, glob us patients had significantly fewer close confiding relationships with their partners than did controls. Researchers concluded that both psychological diathesis and social stress factors were evident in the etiology of glob us pharynges[13].

Harden conducted a study on pseudo seizure and dissociative disorders. They diagnosed patients with psychogenic non-epileptic seizures (Pseudo seizures) as conversion disorder or dissociative disorder. Pseudo seizure patients frequently reported a history of physical and sexual abuse; they considered traumatic experience as part of the mechanism for producing dissociation. When patient especially documents history of sexual or physical abuse, pseudo seizures may be the manifestation of dissociative disorder. Traumatic experiences as a common mechanism may be involved in both disorders.

Sondralyn et al, observed the effectiveness of serial sodium amytal. Suspected cases of conversion disorder (n=21) were interviewed with the use of sodium amytal and compared their findings with the literature. Presenting symptoms included movement disorders, focal neurological defects; chronic pain, "spells" and pseudo seizures, interview with sodium amytal confirmed the presence of psychopathology and revealed underlying psychosocial stressor[14].

Bowman studied life events associated with pseudo seizures in 58 adults. According to them recent precipitants, usually related to current life problems or remote trauma had diverse and triggered affect. They found four patterns of remote and recent events, two related to trauma and two to inadequate emotional expression. They recommended, therefore, while evaluating pseudo seizure precipitants, clinicians should consider the meaning of recent events in the light of remote trauma, current life context, and dysfunctional familial patterns of handling affect[15].

Brunner studied the dissociative symptomatology and traumatogenic factors in adolescent psychiatric patients. One

ninety-eight adolescent psychiatric patients, completed the adolescent dissociative experiences scale and clinicians filled out a checklist of traumatic childhood events. The results showed increase in the degree of dissociative experiences with in-patients having history of sexual abuse, physical abuse, neglect, and stressful life events[16].

Ishikura reviewed all patients with dissociative (conversion) disorders. During the 15 years period, they admitted and treated 9 patients with dissociative amnesia or dissociative fugue and 10 patients with conversion disorders. Needs frustrated at the appearance of the symptoms and those unfulfilled at discharge were studied in both groups using Maslow's Hierarchy of Needs. The patients of both groups had frustrated needs. These symptoms tended to be accompanied more often by frustrations regarding a "need for love" in the dissociative disorders group and by frustration in the need for self-esteem and self-actualization in the conversion disorders group. The symptoms disappeared in the patients, whom situation completely improved (needs were fulfilled). However, the symptoms were not alleviated or unchanged in those in whom the problems remained unresolved[17].

The other comparative studies also showed that looking back on the year before symptoms onset, conversion patients clearly perceived more difficulties in global functioning compared with control. That was due to the higher number of life events experienced. Those events mostly perceived as negative, difficult to adjust to, were uncontrollable[18,19].

CONCLUSION

Research over the past years has established that people's psychological and physical health is profoundly affected by the life events. High proportion of the events directly reflect aspects of family life. How a person responds to stressful events reflects the adaptability and a resourcefulness of the person, previous experience in dealing with the stressful situations, and many other strength and weaknesses. Further researches needs to address this issue.

While the research in depressive disorders has elaborated various types of life events and their relationship with the depressive illness, the life events research in conversion disorder is still in infancy. Although an exhaustive search was conducted only few studies could be found on the subject. This may be due to the fact that the disorder is now relatively uncommon in industrialized nations. The lack of resources in developing countries and low priority for research mean that the systematic study of the disorder is lacking. Most of the studies reviewed in this article lack the scientific rigor. There is need for studies using the validated measures of life events, proper controls and standardized diagnostic criteria for the disorder. Almost all studies are hospital based, which make it difficult to generalize the results. These studies will have profound implications for research as well as the treatment of the disorder.

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