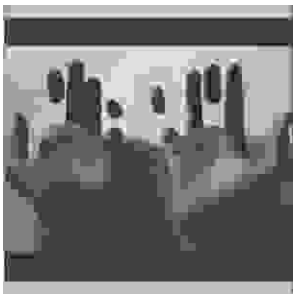
ORIGINAL PROF-1120

THE HYSTERIA;
CONVERSION DISORDERS



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ABSTRACT ... niazmaqsood@hotmail.com **Objectives:** To find out the sociodemographic characteristics of conversion disorders and to find if there is any difference between the presenting symptoms of rural and urban population. **Design:** A non-probability, purposive, hospital based sample. **Place and Duration of Study:** Psychiatry department of Victoria Hospital Bahawalpur, from February 2004 to April 2005. **Patients and Method:** A sample of 100-patients was collected. Both sexes were included. DSM-IV criteria for conversion disorder were applied for diagnosis of all these patients. Informed consent was taken for inclusion in the study. Patients suffering from concurrent physical disorders were excluded. The first author (NM.) using a semi-structured pro-forma interviewed all these patients. The sociodemographic characteristics and the clinical profile were collected. Statistical analysis was made with the statistical package for windows, SPSS (version –10). The applied method for group comparison was chi square- test. **Results:** The mean age of patients from the urban area was 24.26±7.25 years, as compared to 22.15±7.49 years for the patients from the rural area. Most of the patients were females and were married. Majority of the patients from the urban as well as from the rural area were uneducated and from the lower socio-economic class. The onset of illness was typically acute and sudden, with precipitating life event. Majority of the patients had family history of the illness and co-morbid psychiatric disorders. The presenting symptoms were either sensory, motor, mixed symptoms and psuedo-seizures. The presenting symptoms of patient from both urban (p value of 0.008), and rural area (P value =0.013), were statistically significant. There were no statistically significant association between the presenting symptoms and the area of living. The p values of the entire chi square tests were greater than (0.05). **Conclusion:** Prompt elimination of the symptoms of conversion disorder is important to prevent secondary gains from reinforcing it and causing it to persist or reoccur. Psychiatric services need to be developed and updated for the provision of prompt and efficient treatment, for the patients with these chronic and sometimes disabling conversion disorders.

Key words: Conversion disorder, presenting symptoms, area of living and precipitating stress.

INTRODUCTION

The annals of the history of medicine indicate that the first illness for which there is written documentation, was the disease of the "wondering womb" the poly symptomatic disease of women, which the Egyptians described in the Kahun Papyrus in1900 BC[1]. Hysteria has a very long and controversial history. The problem with hysteria is that it is heterogeneous in its manifestations and the variety of symptoms is very great, they are sometimes divided into dissociative and conversion symptoms[1]. This has generated some controversy about the nomenclature of hysteria and in the light of the recent attempts it is removed from the official terminology of the American Psychiatric Association[2].

The term conversion disorders and dissociative disorders refers to disorders that until recently were known as hysteria, i.e. conditions in which physical symptoms and certain mental symptoms occur without the physical pathology with which they are associated and with a psychological cause. In DSM-IV[2] two terms conversion and dissociative disorders are used to distinguish conditions with physical and mental symptoms respectively, while in ICD-10[3] the two terms are interchangeable.

The term dissociative is used to indicate apparent dissociation between different mental activities; the major dissociative reactions are amnesia, fugue, somnambulism and multiple personality disorders. The term conversion originated from the Freud's concept of hysterical neurosis that the mental energy is converted into certain physical symptoms. Although conversion disorder and dissociative disorders are classified separately in DSM-IV, it is important to recognize that there is a close relationship between conversion and dissociative disorders. One could view dissociative disorders as dissociation of central function of the brain i.e. identity, conscious awareness and memory. Whereas conversion is dissociation of peripheral system, in this context peripheral system refers to the internal psychological schema of the sensory motor system and the special senses.

An example of the conversion symptoms of motor system is the hysterical paralysis of a limb and conversion of a special sense would be hysterical blindness[4]. One of the most neglected areas in psychiatric illnesses, until recent years has been the field of conversion disorders[5]. Currently it has been recognized that the prevalence of conversion disorders is quite high and it is essential for the therapist to be able to recognize and treat these disorders[6].

In the light of this renewed commitment the present study was conducted at psychiatry department of Bahawalpur Victoria Hospital Bahawalpur, from February 2004 to April 2005. It was conducted to find out the sociodemographic characteristics of conversion disorders and to find if there is any statistically significant difference between the presenting symptoms of rural and urban population.

METHODS

A non-probability, purposive, hospital based sample of 100- patients were collected over the period of 14-months. Both sexes were included. DSM-IV[2] criteria for conversion disorder were applied for diagnosis of all these patients. This was not an intervention study so all these patients were admitted, investigated, managed and discharged according to the routine protocol of the hospital.

Informed consent[7] was taken for inclusion in the study. Patients suffering from concurrent physical disorders were excluded from the present study. The first author *(NM.)* using a semi-structured pro-forma interviewed all these patients.

The sociodemographic characteristics[8] and the clinical profile of all the patients were collected. Statistical analysis was made with the statistical package for windows, SPSS (version –10)[9]. The applied method for group comparison was chi square- test if not indicated otherwise.

RESULTS

Our study group comprised of 35- patients from the

urban area, while 65 – patients was from the rural area. The sociodemographic characteristics of all these patients are summarized in Table-I.

Table-I. Sociodemographic characteristics.		
Variable	Urban, n=35 (%)	Rural, n=65 (%)
Age (mean)	24.26 ± 7.25 *	22.15 ± 7.49 *
Sex		
Females	33	62
Males	2	3
Marital Status		
Single	15	30
Married	18	34
Widowed	1	0
Separated	1	1
Education		
Uneducated	17	39
Primary	5	16
Middle	7	5
Secondary	3	3
Intermediate	2	1
Graduation	1	1
Employment		
House wife	17	29
Student	12	16
Government emloyed	2	4
Self employed	1	1
Others/staying at home	3	15
Socio-economical status		
Lower	13	39
Middle	21	26
Upper	1	0
** Mean (in years) ± Standard deviation.*		

Table-II. Clinical profile of the patients.		
Variable	**Urban, n=35 (%)**	**Rural, n=65 (%)**
Onset of illness		
Acute	33	62
Insidious	2	3
Course of illness		
Single episode	25	51
Recurrent	9	12
Chronic	1	2
Duration of illness		
One day	17	39
One week	5	16
One month	7	5
More than one month	3	3
Past history of psychiatric illness		
Present	19	31
Absent	16	34
Family history of psychiatric illness		
Present	22	44
Absent	13	21
Precipitating life event		
Present	31	59
Absent	4	6
Psychiatric illness		
Nil	14	24
Anxiety	4	9
Depression	8	16
Somatoform disorders	6	12
Schizophernia	2	1
Seizure disorders	1	3
Stay in hospital		
Three days	20	41
One week	12	19
More than one week	3	5
Presenting symptoms		
Sensory symptoms	2	5
Motor symptoms	10	19
Mixed symptoms	16	22
Psuedo-seizures	7	19

The mean age of patients from the urban area was 24.26±7.25 years, as compared to 22.15±7.49 years for the patients from the rural area. Most of the patients were females and were married. Majority of the patients from the urban as well as from the rural area were uneducated. There were no major difference between the sociodemographic characteristics of the two groups except; patients from rural areas were predominantly from the lower socio-economic class.

Table-II shows the clinical profile of all the patients. The clinical profile indicated that the onset of illness was typically acute and sudden, with precipitating life event. Majority of the patients had family history of the illness and co-morbid psychiatric disorders. Most of the patients needed only three days stay in the hospital for the index episode. The presenting symptoms were either sensory, motor and mixed symptoms or Psuedo- seizures.

The presenting symptoms of all these patients, from urban as well as rural population were statistically analyzed. The statistical analysis is presented in Table-III.

Table-III. The presenting symptoms of Urban and Rural population.

Area of living	Number	Mean ± SD*	DF*	x^2	P-value
Urban	35	2.80 ± 0.83	3	11.743	0.008
Rural	65	2.85 ± 0.94	3	10.754	0.013

* Standard deviation and DF* is the degree of freedom.

As shown in Table-III, the presenting symptoms of patient from both urban and rural area were statistically significant. The urban population had a p value of (0.008), while the p value for the rural population was (0.013).

To find out any statistically important association between the presenting symptoms and area of living a cross tabulation was devised and the results are presented in Table-IV.

Table-IV. Cross Tabulation of Presenting complaints and area of Living.

Variable	Chi square tests			
	Tests	Values	DF	P-Value
Presenting of illness and area of living	Pearson chi-square	1.719	3	0.633
	Likelihood Ratio	1.733	3	0.63
	Linear-by-Linear association	0.06	1	0.807

There were no statistically significant association between the presenting symptoms and the area of living. The p values of the entire chi square tests were greater than (0.05). These results are further discussed.

DISCUSSION

In the present study, 35- patients were from the urban area, while 65 – patients were from the rural area. The mean age of patients from the urban area was 24.26 ± 7.25 years, as compared to 22.15 ± 7.49 years for the patients from the rural area. Most of the patients were females and were married. Conversion disorder may be seen at any age, but it is most common in adolescents and young adults[10].

Flor-Henry et al[1] found that conversion disorder is more prevalent in females and up to 90% of the patients are women. Conversion disorder or hysteria is a female disease and the corresponding illness in men is psychopathy[11]. In the same way that it is rare for a man to have the definite syndrome of chronic hysteria, it is extremely rare for a woman to have the full blown syndrome of homicidal, sexual psychopathy[11]. Investigation have documented that there are the familial associations, which link psychopathy in men and hysteria in women. This would suggest that psychopathy in men and hysteria in women is fundamentally the same syndrome the expression of which is modified by gender. If it occurs on the male cerebral organization it is psychopathy and if it occurs on the female cerebral organization it is then hysteria[11].

Majority of the patients from the urban as well as from the rural area were uneducated. Most of these patients were housewives, while some of the girls were simply staying at home nothing else to do, no schooling and no skills for an employment. Patients from rural areas were predominantly from the lower socio-economic class. Studies have found that the prevalence of conversion disorder is almost 16 % among the psychiatric inpatients and it is 5 times more common in females[12,13]. Conversion disorder was much more prevalent in the rural population, in the lower socio-economic class and among those with less education[14].

In accordance with the earlier studies[13,14] the clinical profile indicated that more than 90% of these patients had a sudden and acute onset of symptoms, with majority of the patients having single episode with short duration of illness. More than half had a family history of conversion disorders. A precipitating life event was found in almost 90% of the patients. Some of the patient had a past history of other psychiatric disorders like anxiety, depression, somatoform disorder, schizophrenia and seizure disorders. Some of the medical and psychiatric illnesses predispose people to conversion disorder[15]. These symptoms often arise as secondary elaborations or exaggeration of an already existing illness, for example pseudoseizures may occur in epileptics after the epilepsy has been controlled with anti-epileptics[13].

In the present study we were interested to know the prevalence of presenting symptoms of conversion disorders like the sensory symptoms, motor symptoms, mixed symptoms and psuedo- seizures. These presenting symptoms were statistically significant while analyzed independently in urban and rural population. The urban population had a p value of (0.008), while the rural population had a p value (0.013). This indicates that the presenting symptoms are basically expressed in the four symptoms category of sensory, motor, mixed and psuedo-seizures which has universal validity[13,16].

During a single conversion episode, there is generally only one symptom. While subsequent episodes may involve the same or a different symptom.

It has been generally held that patients with conversion disorder unconsciously model their parenthesis on those of someone, important to them. This unconscious mimicry of symptoms is according to their knowledge of human anatomy and neurological disorders, not necessarily the normal distribution of neuronal pathways. For example the common sensory symptoms of anesthesia and parenthesis has a characteristic stocking and glove of the hands and feet while the hemianesthesia of the body beginning precisely along the midline. While the common motor disturbances are the paralysis and paresis involving one, two or all four limbs. The distribution of the involved muscle does not conform to the neuronal pathways, for example the hand is paralyzed from the wrist down or the entire forearm is weak. The motor symptom never involves a single muscle but movements and conforms to the patient's ideas of the form of symptoms. Reflexes are normal and there is no fasciculation's or muscle atrophy[13].

To find out if there is any important association between the presenting symptoms and the area of living devised a cross tabulation. As shown in Table-IV, the p values of the entire chi square tests were greater than (0.05), which is statistically not significant. Denoting that the individual presenting symptoms do not change due to

area of living. Patients from urban and rural areas have almost the same universal presenting symptoms of conversion disorder, i.e. the sensory symptoms, motor symptoms, mixed symptoms and psuedo- seizures.

Conversion symptoms are generally of short duration, with abrupt onset and resolution. Although they tend to remit spontaneously, a few become chronic and about 25 % of the patients experience recurrences[13]. More than 90% of our patients needed only short stay at hospital while only 6 % of these patients needed hospitalization for more than a weak. Patient symptoms becoming chronic are more likely when the precipitating stress is chronic and recurrent, when there is other psychopathology or when there is marked secondary gain. Patients with conversion disorder are also often grossly disabled especially when the symptoms have become chronic[17]. It is not uncommon to find patients who have become confined to wheel chairs[18]. Good prognostic signs include acute onset, massive environmental stress, good premorbid personality, and the absence of the other psychiatric disorders[13].

CONCLUSIONS

Prompt elimination of the symptoms of conversion disorder is important to prevent secondary gains from reinforcing it and causing it to persist or reoccur. If the symptoms do not improve rapidly or, if precipitating or perpetuating factors remain, then more definitive treatment is indicated. This may entail working with the family, since they may be perpetuating the symptoms, by rewarding and dependency. They may be overly solicitous and helpful. These families must learn to reward the patient autonomy, self-sufficiency and independence. But the longer the patient remains in the sick role and the more she/he has regressed the more difficult treatment becomes.

In our opinion psychiatric services need to be developed and updated for the provision of prompt and efficient treatment, for the patients with these chronic and sometimes disabling conversion disorders.

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but do not tell them so.