

Co-relation of Socio-demographic Determinants with Dissociative Conversion Disorder

Saurav Kumar¹, Swati Tyagi², P.K. Pardal³

ABSTRACT

Introduction: Conversion disorder is characterised by the occurrence of deficits without any endogenous cause influencing the voluntary motor / sensory functions, thus lacking the manifestations entirely explainable by a general psychiatric condition, substance misuse or culturally accepted actions. The signs present are spontaneous, and can resemble a neurological condition. Aim: The aim of the study was to find the socio-demographic determinants associated with this disorder and clinical presentation.

Materials and method: 300 patients were included in this study with selective sampling technique. Diagnosis of Dissociative conversion disorder was made according to ICD 10 DCR criteria. Patients with any neurological deficits or head injury were excluded from the study. A semi structured Performa was made to note down the socio-demographic determinants of the patients. Association between the socio-demographic detail and the disorder was noted down. Clinical presentation was also noted down.

Results: It was found to be more common amongst females (99%) especially in those who were uneducated (84%) and housewife (77%) with joint family type (67%) and rural background (66%) were also strongly associated with it. The most common clinical presentation was pseudo seizures (74%) followed by hyperventilation (13%), giddiness (9%) and dystonia (4%).

Conclusion: significantly higher number of females who were house wife presented with dissociative conversion disorder. it was more commonly seen in patient from rural background who were living in joint family we concluded that socio-demographic determinants play a very major role in dissociative disorder. The most common clinical presentation was pseudo seizures (74%) followed by hyperventilation (13%), giddiness (9%) and dystonia (4%).

Keywords: Dissociative Disorder, Socio-Demographic Determinants

INTRODUCTION:

Conversion disorder, also known as neurological functional symptom disorder¹, is characterised as a mental syndrome in which symptoms and signs involving active motor or sensory activity can not be clarified by a neurological or general medical condition.² Psychological causes, such as disputes or tension, are thought to be correlated with defects. The word conversion disorder was coined by Sigmund Freud who proposed that unintentional confrontation represents the presence of such signs not described by organic diseases. The term "conversion" refers to combining a somatic symptom with a repressed thought.³

Conversion disorder was retained in *DSM-5* and it received a new subtitle: "functional neurological symptom disorder." Diagnostic criteria for conversion disorder retained the medically unexplained requirement for symptoms to qualify for the diagnosis, requiring objective clinical evidence of internal inconsistency on neurological examination or incongruity with known neurological presentation of illness.

Popular examples of conversion symptoms include weakness, agitation, dystonia, psychogenic nonepileptic seizures (PNES), anaesthesia, swallowing problems, motor tics, trouble walking, paranoia, anaesthesia, and dementia.⁴ These effects are not specifically induced by neurological impact of individuals with conversion disorder; however, they are triggered by psychiatric dispute. Conversion disorder diagnosed patients don't feign signs and symptoms. Given the absence of a conclusive organic diagnosis, the suffering of the patient is very real and the clinical signs that the patient experiences can not be managed at will.⁵ While dissociative conversion disorders have been identified and diagnosed for some time, their aetiology, pathogenesis, phenomenology, and management continue to give rise to speculation. Such patients' correct diagnosis has significant consequences for their clinical path.^{6,7}

This study is an effort to know the various socio-demographic determinants associated with dissociative conversion disorder and most common clinical presentation associated with it.

Aim

The research aimed to identify the related socio-demographic determinants of this condition and the most typical clinical appearance

¹Assistant Professor, Department of Psychiatry, Shri Ram Murti Smarak Institute of Medical Sciences, Bareilly, Uttar Pradesh,

²Junior Resident, Department of Psychiatry, Shri Ram Murti Smarak Institute of Medical Sciences, Bareilly, Uttar Pradesh,

³HOD and Professor, Department of Psychiatry, Shri Ram Murti Smarak Institute of Medical Sciences, Bareilly, Uttar Pradesh, India

Corresponding author: Dr. Swati Tyagi, Junior Resident, Department of Psychiatry, Shri Ram Murti Smarak Institute of Medical Sciences, Bhojipura, Bareilly, Uttar Pradesh, India

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MATERIAL AND METHODS

This study was a hospital based cross sectional observational study conducted in the psychiatry department at a tertiary care centre. Prior to the report, authorisation was received from the Committee on Administrative Ethics. With selective sampling, adults over 18 who gave consent to participate in the study and were not having any co-morbid medical condition were taken as sample for the study. Diagnosis of dissociative conversion disorder was made according to ICD-10 DCR criteria.¹¹ Semi- structured socio-demographic data sheet was used to note down the details. Clinical presentation was also noted.

Inclusion criteria

Subjects of both sexes of age 18 years and above and fulfilling diagnostic criteria of dissociative (conversion) disorder according to ICD-10 DCR were included.

Exclusion criteria

Those with documented history of organic illness, including seizures and other comorbid mental disorders, such as anxiety disorder, depressive condition, etc., were removed. Following tools were used:

1. The ICD-10 DCR classification of mental and behavioural disorders⁸
2. A semi-structured proforma to record socio-

Socio demographic variables	Patients with dissociative conversion disorder (n=300)	
	No of cases	Percentage (%)
Age (in yrs)		
18-24	198	66
25-30	73	24
31-36	29	10
Sex		
Male	3	1
Female	297	99
Locality		
Urban	100	33
Rural	200	67
Religion		
Hindu	126	42
Muslim	174	58
Education		
Illiterate	250	84
Primary Education	22	7
Secondary Education	28	9
Family Type		
Joint	200	67
Nuclear	100	33
Occupation		
Employed	27	9
Unemployed	43	14
Housewife	230	77
Marital Status		
Married	243	81
Unmarried	57	19

Table-1: Socio- demographic details of patient suffering from dissociative conversion disorder

demographic details, clinical presentation at the time of examination.

RESULT

The study population was 300 patients. The age of subjects ranges from 18-36 years, with the mean of years. Out of 300 patients, 297(99%) were females and 3 (1%) were males. Among all the patients majority belong to rural area (n=200, 67%) and (n=100, 33%) belong to urban area. Among all the patients (n=243, 81%), were married and (n=57, 19%) were unmarried. Majority of patients (n=250, 84%) were illiterate, (n=28,9%) were primary educated (n=22, 7%), were literate. Out of 300 patients, (n=126, 42%) were Hindu and (n=174, 58%) were Muslim and (n=200, 67%) belongs to joint and (n=100, 33%) belongs to nuclear family. Occupationally out of 300 patients (n=27, 9%) were employed and (n=43, 14%) were unemployed and (n=230, 77%) were house wife. (Table -1) The most common clinical presentation was pseudo seizures (74%) followed by hyperventilation (13%), giddiness (9%) and dystonia (4%). (Table-2)

Clinical presentation	Patient with dissociative conversion disorder (n=300)	
	No. of cases	Percentage(%)
Pseudo-seizures	220	74
Hyperventilation	40	13
Giddiness	28	9
Dystonia	12	4

Table-2: Clinical presentation of patient suffering from dissociative conversion disorder

DISCUSSION

This study was conducted in a tertiary care hospital which has a large amount of patients coming from rural areas mostly the source of income in this population is through agricultural lands. This hospital caters patients from uttar Pradesh, uttrkhand and even boarder regions of Nepal since it shares a close proximity to all of these places. The incidence of conversion disorders in females was found to be greater in this study (99%) than in males (1%) very few males presented with this condition however females very commonly presented with this condition it can also be since this particular group is very suppressed in our society and this particular group is incapable of sharing the emotions with others in the family and along with that they also have a lot of familial burden on them with no support given by the male members in the society, and a majority of our patients were young adults in the 18-30 years age group (90%) this can be due to the stress which is generally very high in people amongst this group. Generally in this age group the females get married in these areas and enters a new family along with the new family they have to abide by the new rules and regulations of the family along with sharing the burden of the family taking care of the husbands need and the pressure of starting their own family, followed by those in the 31-36 years age group (10%). This correlates to the findings of Vyas et al.⁹ Bagadia et al.¹⁰ and Choudhury et al.¹¹ However,

these results obviously confirm the findings of the prevalence of conversion disorder already known. Much of our subjects have been literate (80 per cent) since educating a female still is a big issue in India mostly people concentrate on educating a male child rather than educating a female. Females are just educated at home and are mostly educated till primary classes after that they are mainly educated to carry out household so that in future they can take care of their family and be a good housewife. The majority sample population was, and thus, married (81 percent) housewife (71 percent). This is in line with Jain and Verma et al.¹² and Choudhury et al.¹¹ who noticed housewives and the main community was men. Up to 66 per cent of subjects belonged to the rural population this can also be due to the fact that mostly people who visit this hospital are from rural area because it is situated in the sub urban area and shares its closed proximity to a lot of villages and 24 per cent to the urban population. So it may be concluded that a lot of the subjects have an agricultural history since the most common means of earning in rural area is through agriculture, 75 percent of Indians are still earning through agricultural background. As many as 33 percent of the sample population is from patriarchal families, which may likely be attributed to the evolving trend of lifestyle into a modernised one. That is not in line with the Vyas et al findings.⁹

Motor signs were the most frequent (percent) occurrence, regardless of the population standing or level of literacy, the most frequent of which was fake seizure (74 per cent). It is also known as pseudo seizure which mimics true seizures but lacks signs of true seizures, generally it happens for a long time and no injury is reported it is followed by some stress and the patient generally lies down on the bed or seek physical support of others to save themselves from getting injured. Unlike true seizure patient do not remember the episode and generally it is for a very long time and is also made by palpitation and restlessness. This is in contrast to Roelofs et al.¹³ findings that paresis / paralysis was the most prevalent.

CONCLUSION

- Our study was done in a tertiary care hospital catering to maximum people belonging to rural area.
- The incidence was found to be very high among females.
- Majority of the patients were in the age group of 18-30
- Married females formed a majority in the study group.
- Housewives presented with this disorder very commonly.
- Majority of the patients were from rural background this can also be due to the fact that our tertiary care hospital caters mostly to rural people.
- Amongst the signs motor signs were found to be associated very commonly with these patients

Limitation of the study

1. As this was a cross-sectional study, the pattern of symptomatology in subsequent recurrence could not be studied thereof.

Further Recommendations

1. Community based study should be done since many patients don't come to hospital.
2. Follow up study should be done to see the impact of psychoeducation and pharmacological treatment.

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