

The Burden on Her Soul: Conversion Disorder in Developing Countries

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Abstract

Conversion Disorder is common in developing countries. In Pakistan, Dissociative disorders (including Conversion Disorder) represent between 5% and 13% of all inpatient psychiatric admissions. This case report and review describe a typical case of Conversion Disorder in a young female (the most high risk population) with symptoms that mimic various physical illnesses. A high index of suspicion for this illness in at-risk patients can lead to early diagnosis, prevent unnecessary and invasive medical or surgical interventions and conserve precious healthcare resources.

Keywords: Conversion Disorder, fits, physical illness, healthcare resources.

Introduction

Conversion Disorder is a common diagnostic problems

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faced by psychiatrists working in developing countries. In India, for example, a prevalence of up to 31% is reported among inpatients.¹ In Egypt it is one of the most frequently diagnosed conditions.² In Pakistan dissociative disorders are very common representing 12.4% and 4.8% of the admissions in inpatient psychiatric units.^{3,4}

Conversion disorder has been described in various shapes and forms since antiquity. A recent review⁵ refers to Egyptian physicians who described cases of women suffering from nonspecific symptoms: one bed-bound; another who could not open her mouth. They ascribed such symptoms to “starvation of the uterus”. These cases were described by Veith.⁶ According to Veith, the Greek physician Hippocrates coined the term “hysteria” in which the uterus (in Greek: hystera) dries up and wanders the body in search of moisture. Symptoms would then be caused by the uterus pressing on other organs. In countries like Pakistan, the generally low level of education and complete lack of awareness about mental health reinforces and perpetuates the illness. We discuss a typical case of Conversion Disorder presenting to our department and present a brief review of the current literature regarding this interesting condition.

Case Presentation

Ms. Y, 20, single, living with her parents is brought to our Outpatient Clinic by family. Since last week, she has become mute, says she cannot see out of her left eye, hear, swallow or move her arms, legs or torso.

She has developed episodic ‘fits’ where she falls down and sometimes develops thrashing movements of her legs (although she has never bit her tongue or become incontinent of urine or feces). She has no prior psychiatric history.

Detailed interviews with her family and later with her reveal that she was pressured by her family to become engaged to a cousin a year before the symptoms started. She developed symptoms consistent with Major Depressive Disorder, Single Episode. She received no treatment. Subsequently, there was family conflict and at one point, her father considered leaving his wife and asked Ms. Y to choose between him and her mother. Her symptoms started at this point.

Ms. Y was admitted for treatment of depression and Conversion Disorder. She had no history of seizures, fever, substance abuse, focal neurological signs suggesting a neurological illness or any other signs or symptoms suggestive of a medical or neurological illness.

Routine labs at our hospital revealed hemoglobin of 12.9 mg/dl, total leukocyte count of 4500, serum electrolytes, renal and liver function tests, urinalysis, a chest X-ray and CT Scan without contrast were all normal.

We made a presumptive diagnosis of Major Depression, Single Episode, severe, without Psychotic features as well as Conversion Disorder, with Mixed Presentation.

We started her on a combination of Escitalopram 10 mg a day to treat her depressive symptoms, Clonazepam 2 mg at bedtime to assist with sleep along with daily individual and family therapy. She responded well and by day 2 of her hospital stay, she was eating better and talking. She reported improved sleep and no ‘fits’ since admission.

On day 3 of her hospital stay, she was visited by several family members including some who had pressured her to marry. Later that afternoon, she became agitated and had a prolonged ‘fit’ where she held her breath and developed tonic contraction of her limb muscles, neck and back to the extent of bending her back like a bow. The episode lasted about 5 minutes and was associated with shallow and rapid breathing. There were no other signs or symptoms suggestive of a seizure. The doctor on duty (not a psychiatrist) gave her intravenous Diazepam and her blood pressure dropped to 70 systolic. She developed respiratory depression; a code was called and she was given CPR and transferred to the Emergency Department of our hospital where an EKG, routine labs and a Cardiology

consult revealed no significant abnormalities. By the next day, she was talkative and except for a few sore ribs, cheerful.

She was discharged home on Day 7 of her hospital stay on Escitalopram 10 mg a day and Clonazepam 2mg at bedtime. On her first outpatient clinic visit a week after her hospital discharge, she was doing well. She reported one incident where her tongue ‘twisted’ after an argument with a family member but recovered spontaneously. Her Clonazepam was tapered down to 1mg at bedtime with no adverse effects. Her depressive symptoms continued to improve and she remained free of conversion symptoms. Two months later her symptoms were in remission and she was considering several offers of marriage.

Discussion

Patients with Conversion Disorder present a diagnostic and management challenge. A careful psychiatric history and examination can identify the onset and nature of symptoms and the presence of stressors (if any). Often, psychological stressors are hard to find because a patient with conversion symptoms is not often able to explain psychological factors themselves – this being the reason that they need (albeit unconsciously) to express them as bodily symptoms.

A core feature of Conversion Disorder is the absence of a neurological or organic diagnosis. A recent study⁷ reviewed 73 consecutive patients with neurologically unexplained symptoms and found a low incidence of neurological conditions that might have explained their initial symptoms (3 out of 69 patients). Seventy – five percent of their sample had a psychiatric diagnosis (predominantly affective, anxiety, or somatization disorders) at presentation, and 45% were diagnosed with a personality disorder. In a follow-up study by Binzer and Kullgren⁸, none of the 30 patients with Conversion Disorder was subsequently reclassified as suffering from a neurological disease.

Factors associated with a good prognosis include male gender, acute onset, short duration of symptoms, an acute precipitating event, change in marital status (either marriage or divorce), premorbid psychiatric diagnosis, good premorbid health, and the absence of a coexisting medical condition. In contrast, poor prognosis is associated with subclinical personality pathology, coexisting medical illness, poor perception of their own wellbeing, and a high score on the Beck Hopelessness Scale and pending litigation. In children,

conversion symptoms may remit spontaneously. Pehlivanurk and Unal⁹ found that 85% of children with conversion disorders recovered completely at 4 years, and another 5% had shown some improvement. The mainstay of treatment of conversion disorders is psychotherapy. There is little evidence to guide pharmacotherapy in conversion disorder, and in the UK there are no NICE (National Institute for Clinical Excellence) guidelines available at present. The clinical evidence for pharmacotherapy in conversion disorder is extremely limited and consists of case reports only, including some reported therapeutic success with haloperidol, tricyclic antidepressants and ECT. These studies serve to emphasize the importance of screening for comorbid psychiatric conditions.

Conclusion

Conversion Disorder is a common condition in the medical and psychiatric setting in developing countries. Delays in diagnosis can result in unneeded and expensive medical and surgical interventions. A proactive approach to early diagnosis can reduce patient distress as well as clinician frustration. Such an approach can also result in substantial cost savings to both the patient and the healthcare system. In a third world country like Pakistan, this can represent a substantial drain on precious healthcare budgets. A patient who fits the typical pattern of this disorder should be identified early and provided appropriate mental health treatment to reduce patient burden and preserve healthcare resources.

Conflict of Interest Notification

We declare that, individually or collectively, there have been no involvements that might raise the question of bias in the work reported or in the conclusions, implications, or opinions stated in the following case report, including pertinent commercial or other sources of funding for the individual author(s) or for the associated department(s) or organization(s), personal relationships, or direct academic competition.

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Contribution of Authors

1. Dr. Ali Madeeh Hashmi

General supervision of the research group, conception of case report, acquisition of patient's data, interpretation of the data, drafting the article and final approval of the version to be published.

2. Dr. Nauman Mazhar

Acquisition of patient's data, interpretation of the data, drafting the article and final approval of the version to be published.

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Acquisition of patient's data, interpretation of the data, revising it critically for important intellectual content and final approval of the version to be published.

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