Psychotic Symptoms in Dissociative (Conversion) Disorder in Two Tertiary Care Hospitals in Bangladesh

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Dissociative (conversion) disorder (DCR) has a long and controversial history. Some authors wish to classify it with somatoform disorders separate from dissociative disorders; many researchers keep it with DCR. Symptoms pattern also varies in different cultures. This study used the criteria of International Classification of Diseases Tenth Edition (ICD-10). Study was aimed to see the presenting symptom profile of dissociative (conversion) disorder more focusing on psychotic symptoms in tertiary care hospital in Bangladesh. This cross sectional observation was carried out in two different tertiary care hospitals in Dhaka city with preformed pretested questionnaire. Data were collected from 100 consecutive patients from July 2005 to June 2006 and data were analyzed by Statistical Package of Social Science (SPSS) 16.0. Pattern of dissociative (conversion) disorder indicated that symptoms presentations are different in Bangladesh which is difficult to categorize using existing criteria of ICD-10. Among 100 consecutive patients diagnosed as dissociative (conversion) disorder 13 patients had psychotic symptoms. Psychotic presentation of conversion disorder often creates doubts among the clinicians. Careful history taking, identifying the underlying psychosocial stressors will help clinicians to diagnose them accurately. It should be noted that the pattern of presentation in South Asia may be different due to role of culture on symptoms presentation in this region.

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Key words: Conversion disorder, Dissociative disorder, Psychotic presentation

Introduction

Dissociative (conversion) disorder has a long and controversial history and an uncertain status in modern psychiatry. There are differences in diagnostic criterion in Diagnostic and Statistical Manual Fourth Edition (DSM-IV) and International Classification of Diseases (ICD-10). In DSM-IV Conversion disorder is characterized by the presence of one or more neurological symptoms (like paralysis, blindness etc.,) that cannot be explained by neurological or medical disorders. In DSM-IV TR, Conversion disorder is broadly categorized under Somatoform disorder. In dissociative disorder there are disruptions in the integrated function of consciousness, memory, identity or perceptions of the environment. The disturbances may be sudden, or gradual, transient or chronic[1]. Conversion disorder is unified with dissociative disorder in ICD-10 as dissociative (conversion) disorder[2]. The researchers of ICD-10 are emphasizing more on the underlying causes of both dissociative and conversion disorders which are similar. Psychological precipitating factors cause both conditions. However DSM researchers placed conversion disorder in Somatoform Disorder to emphasize the importance of excluding the neurological and other organic disorders in differential diagnoses.

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In an effort to ensure they are not misdiagnosed. Conversion disorder was long been thought to be a misdiagnosis of neurological disorder. Dissociative (conversion) disorder replaced the term 'Hysteria' which was included in ancient Greek medical texts. At that time the disorder was thought to result from abnormalities of position or function of the uterus. After the seventeenth century the disorder was gradually thought to be a brain disorder. By the nineteenth century the gradual importance of predisposing constitutional and organic causes of the brain disorder were recognized[3]. Newer studies showed higher incidence of childhood physical or sexual abuse among the patients with dissociative (conversion) disorder patients[4]. Though the history of conversion disorder is long, it is a rare phenomenon in western countries. Culture plays a strong role in symptom variations across the globe. Castillo has argued that some symptoms, which are considered psychotic in western world, are culturally accepted in India and other cultures. For example Indian Yogis adopt a posture for long time as part of their mindfulness or as religious practice which is considered is catatonia in western countries[5]. So, cultural variations exist among the patients of conversion disorders in different regions. Moreover, the current ICD and DSM criteria have limitations defining the symptoms presented in South Asia. ICD-10 has existing limitations defining conversion and dissociative disorder[6,7]. From the above findings and empirical observations, the objective of the present study was to see whether the presentation of conversion disorder in Bangladesh is different from western presentations. The researchers thought that psychotic like symptoms were unique among the patients of dissociative (conversion) disorder. So, the study was carried out to see the presenting symptom profile of dissociative conversion disorder with emphasized focus on psychotic symptoms in tertiary care hospital in Bangladesh.

Methods

This cross sectional study was carried out in the Department of Psychiatry of Bangabandhu Sheikh Mujib Medical University (BSMMU) and Dhaka Medical College Hospital (DMCH) in Dhaka Bangladesh from July 2005 to June 2006. Formal permission was taken from the institutional ethical committee. The respondents were adequately informed and written and verbal consent was taken. One hundred consecutive patients fulfilling the inclusion criteria's as per ICD-10 were included in the study. Patients having Autistic disorder, deaf and dumb, profound mental retardation was excluded. Patients and their reliable attendants were interviewed after getting consent from them. A semi structured questionnaire for the study of "Psychotic symptoms of dissociative (conversion) disorder in two tertiary care hospitals in Bangladesh" was applied. Psychiatric morbidity was diagnosed after thorough clinical assessment including detailed history taking and mental state examination by using ICD-10 Diagnostic Criteria for Research (DCR). A questionnaire "Symptom checklist for dissociative (conversion) disorder" based on the available symptoms presented in Bangladesh, was prepared by the researchers. The initial questionnaire was circulated to different psychiatrists and few additions and eliminations in the questionnaire were done. It has three domains, which again consist of i) Conversion symptoms (Table IV), ii) Dissociative symptoms (Table V) and iii) Psychotic symptoms (Table VI). However, each domain includes options other than the defined symptoms. There by new symptoms prevailing in this region may have been included. The questionnaire was pre-tested and finalized. Though the diagnosis was made by consultant psychiatrists depending on the criteria of ICD-10 DCR additional symptoms were noted using the checklist mentioned above (Symptom checklist for dissociative conversion disorder).

Results

The mean age of the patients were 23.4±9.0 years ranging from 10 to 48 years. Forty-one percent (41.0%) of the patients were less than 20 years where as 36% of them were in the range of 20-29 years. Majority (58%) came from Nuclear families and 42% from joint families. Most of the respondents were female 87% and Muslims (95%). Regarding the residence, 47.0% were residing in urban areas and 53.0% were in the rural areas. Mean year of schooling was 8.0±3.6 years ranging from 0 to 17 years. More than half (58%) of the patients had 6-10 years of schooling followed by 21.0% in the range of 1-5 years and 17.0% had schooling of 11 years or above. Among the studied

patients, 40.0% were students, followed by 39.0% who were housewives, and 11.0% were service holders (Table I).

Table I: Socio-demographic characteristics of the respondents (n=100)

Characteristics	Number	Percent
Age in years		
<20	41	41.0
20-29	36	36.0
30-39	15	15.0
≥40	08	08.0
Mean±SD (years)	23.4±9.0	
Range (years)	10 - 48	
Sex		
Male	17	17.0
Female	83	83.0
Habitat		
Urban	47	47.0
Rural	53	53.0
Years of schooling		
00	04	04.0
1-5	21	21.0
6-10	58	58.0
≥11	17	17.0
Mean±SD (years)	8.0±3.6	
Range (years)	00-17	
Occupation		
Student	40	40.0
Housewife	39	39.0
Service	11	11.0
Others	10	10.0
Marital status		
Unmarried	44	44.0
Married	53	53.0
Separated	02	02.0
Divorced	01	01.0
Monthly family income (Tk.)		
<5000	37	37.0
5000-9999	26	26.0
10000-14999	19	19.0
≥15000	18	18.0
Median (Tk.)	Tk. 6000.0	
Range (Tk.)	Tk. 12000-100,000	

Table II: Distribution of patients by duration of illness

Characteristics	Number	Percent
Duration of illness (weeks)		
<5	56	56.0
5-9	15	15.0
≥10	29	29.0

The duration of illness is mostly less than 5 weeks (56%) with range 1-54 weeks (Table II).

Table III: Distribution of patients by pattern dissociative conversion disorder

Pattern dissociative conversion disorder	No.	%
Mixed dissociative (conversion) disorders	34	34.0
Dissociative convulsions	33	33.0
Dissociative motor disorders	19	19.0
Dissociative anaesthesia and sensory loss	05	05.0
Dissociative amnesia	04	04.0
Dissociative fugue	03	03.0
Dissociative stupor	01	01.0
Trance and Possession disorder	01	01.0

Pattern of dissociative conversion disorder indicated that highest percentage (34.0%) had mixed dissociative disorders followed by dissociative convulsions (33.0%), dissociative motor disorders (19.0%), dissociative anaesthesia and sensory loss (5.0%), dissociative amnesia (4.0%) and other minor illness such as dissociative fugue (3.0), dissociative stupor (1.0), trance and possession disorder (1.0).

Pattern of symptoms among the 100 patients diagnosed as dissociative (conversion) disorder as per ICD-10 reveals that 91 % of the patients had conversion symptoms, 28% of the patients had dissociative symptoms and 13% patients had psychotic symptoms (Figure 1).

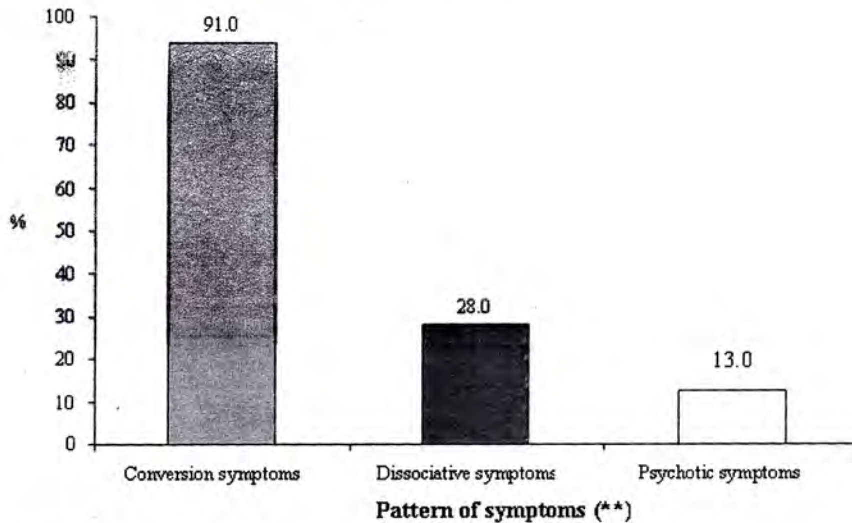

Figure 1: Distribution of patients by pattern of symptoms (**multiple response; n=100)

Table IV: Distribution of patients by conversion symptoms

Conversion symptoms	No.	%
Experience seizure resembles epilepsy	43	43.0
Experience blurring of vision	36	36.0
Unable to talk or only could whisper	34	34.0
Difficulty to swallow or feeling of lump in the throat	29	29.0
Experience Paralysis/Paresis of whole body or part of it	27	27.0
Experience loss of consciousness	27	27.0
Experience trembling/shaking of hands/legs	14	14.0
Unable to see	08	08.0
Unable to hear or could do with great difficulty	07	07.0
Double vision	06	06.0

(**Multiple response)

Neurological symptoms: Among the respondents, the highest conversion symptoms were experiences of seizures resembling epilepsy (43.0%). The next most common presentations was experiences of blurred vision (36.0%), inability to talk or ability to only whisper (34.0%), difficulties with swallowing or feeling of lump in the throat (29.0%), experiences with paralysis/paresis of whole body or part of it (27.0%), experiences of loss of consciousness (27.0%), experiences of trembling/shaking of hands/legs (14.0%), inability to see (8.0%), inability to hear or ability to hear with great difficulty (7.0%), double vision (6.0%) (Table IV).

Table V: Distribution of patients by dissociative symptoms

Dissociative symptoms	No.	%
Did you ever lose your memory (ed: like you could not recall your personal identity/relatives most period of a day)	21	21.0
Have you ever experience possessed by Zin or ghosts? (or your relatives told about such events which you could not recall properly)	04	04.0
Did you ever wonder away from home when you could not recall your whereabouts?	03	03.0
Did you ever lose your childhood memories (like you could not recall an important event of childhood but your close relatives or others told you about that event)	00	00.0
Did you experience another person exist inside your mind?	00	00.0

Dissociate symptoms: Loss of memory (e.g.: like you could not recall your personal identity/relatives most period of a day) 21.0% followed by experiences or thoughts of possession by supernatural forces (or your relatives told about such events which you could not recall properly) (4.0%), wandering away from home without recollection of whereabouts (3.0%); however, no patients complained of loss of childhood memories or experiences of another person existing inside their minds (Table V).

Table VI: Distribution of 13 patients according to category of psychotic symptoms (n=21**)

Pattern of symptoms	Number	Percentage
Hallucinations (like hearing voices which others don't hear or seeing things, person which other's don't see etc)	12	57.1
Disorganized behavior (unprovoked excitement, posturing, self mutilations	06	28.6
Delusions	03	14.3
Disorganized speech	00	00.0
Believe that people are trying to do harm	00	00.0
Excessive self importance or have the capability of doing things which are impossible for others	00	00.0
Believe TV, news paper is showing/writing programme/article referring one	00	00.0
Believe that thoughts are being taken away? Or any invisible power is controlling thoughts, or belief that thoughts are being introduced in one's head against his will?	00	00.0

*Multiple responses

Psychotic symptoms: Among the total 100 consecutive patients diagnosed as dissociative (conversion) disorder 13 patients had psychotic symptoms. Of them total 21 different psychotic symptoms were found among the respondents. Twelve patients had hallucinations; five had auditory (fragmentary sounds noise, calling him/her by name etc.), 7 had visual hallucinations (see something which others do not see etc. Six patients experienced excessive aggressive impulse without any provocation, bizarre behavior like dancing/whirling around, spitting here and there, taking up a posture for a prolonged time etc., three patients had delusions like believing people were taking about them, or were looking at them specially (Table VI). In the present study psychotic symptoms (n=13) were not more than conversion (n=91) and dissociative symptoms (n=28).

Discussion

In this study mean age of the patients were 20.2±6.4 years and age range 8-40 years. In this study 83% patients were female and 17% were male. Among the respondents 53% were from rural areas. The symptoms were more common among females than males and also more common in rural areas than urban areas[1]. The mean duration of

illness was 10.7 weeks. More than half of the patients duration of illness was less than 5 weeks (56%). Firoz et al. in a study found that 65% of patients duration of illness was less than 4 weeks, which is lower than the present study[8].

Among the 100 consecutive patients 34 patients had mixed dissociative (conversion) disorder, 33% had dissociative convulsions, 19% had dissociative motor disorders. Guz et al. found highest subtype of their sample of dissociative (conversion) disorder is (45%) mixed type of dissociative (conversion) disorder[9]. The symptoms of dissociative (conversion) disorder were grouped into three categories of symptoms. These are 'conversion', 'dissociative' and 'psychotic' subtypes. Conversion symptoms included motor, pseudo-seizure, sensory symptoms. Among them pseudo seizure was 43%. Other symptoms were blurring of vision 36%, aphonia 34%, breathlessness 30%, lump in the throat 29%, paralysis 27%, unconsciousness or fall without major injury 27% blindness 08% and deafness 07%. Besides, 21% had complaints of dissociative Amnesia, 04% had dissociative possession, 3% had dissociative fugue. Firoz at al found 44.17 % of their patients having pseudo seizure 16% had ataxia, 3.34% having amnesia, and 1.67% having fugue[8]. In this study we have found multiple responses. Every patient was thoroughly checked for his/her symptoms.

Our central question was to see psychotic symptoms, if any, are present, in the Bangladeshi context. There were limitations defining psychotic symptoms. We have taken the study sample by using ICD-10, Diagnostic Criteria for Research (DCR criteria) and it does not include psychotic symptoms[2]. We only diagnose using ICD-10 criteria and once we did that we included all the symptom presentations. Hence psychotic symptoms were sought or identified only among the respondents who fulfilled the criteria of ICD-10. We included psychotic symptoms as associated symptoms. These psychotic symptoms were different from the psychotic symptoms of psychotic disorders like Schizophrenia and Delusional Disorders or Brief Psychotic Reaction. The psychotic symptoms as we labeled in this study were more elementary in nature. For example auditory hallucinations would be 'hearing somebody is calling one by name behind their back', visual hallucination would resemble 'seeing ghost in a big tree', or 'someone standing in front who cannot be discarded at will' etc. Few patients adopted postures which they maintained for a pronged time. Some patients having psychotic symptoms like 'believed they were susceptible to harm'. However, these symptoms were fragmented, not persistent like what we see in psychotic disorders. In this cross sectional study it was not possible to identify them for a long time to see the persistence of these symptoms. In the study design we had three sets of symptoms; 'conversion', 'dissociative' and 'psychotic' symptoms. We have seen that out of 100 patients, 91 patients had 'conversion' symptoms, 28 patient had 'dissociative' symptoms and 13 patients had 'psychotic symptoms (multiple responses) (Figure 1). Due to multiple responses probably mixed type of dissociative (conversion) disorder was found as most prevalent in the present study. Moreover, psychotic symptoms were found more in mixed type of dissociative (conversion) disorder but this finding was not found to be significant. Our initial aim of the study was to see if the rate of psychotic symptoms were significantly more among the respondents. Psychotic symptoms were found in 13 patients only. Though the psychotic symptoms were not significantly more among the respondent yet the existing ICD-10 criteria failed to identify these symptoms. Besides, typical psychotic symptoms like persistent auditory hallucination, bizarre delusions disorganized behavior were not present among the respondents in present study. So, the psychotic symptoms described in present study were unique.

Conclusion

Present study raised the issue of presence of psychotic symptoms in dissociative (conversion) disorder. These symptoms were fragmented, not consistent like psychotic symptoms of psychotic disorder and more of simple (elementary) nature. This often creates doubts among the clinicians whether they are psychotic in nature. Careful history taking, identifying the underlying psychosocial stressors will help clinicians to diagnose them accurately. Also the researchers should keep in mind the pattern of presentation in South Asia may be different due to role of culture on symptoms presentation in this region. Further

large multi-centered study can be helpful to generalize the study results.

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