



rural and remote services, indigenous and transcultural mental health services, consumer and carer service initiatives, mass media representations of mental illness and services (print and electronic). The MHS conference begins with separate indigenous, consumer, carer leadership and provider training forums, with all these constituencies coming together for the last 3 days.

## Conclusion

Mental health reforms in Australia have resulted in considerable achievements (see forthcoming paper in *International Psychiatry*). However, after 5 years of real growth of integrated community and local hospital mental health services from 1992 to 1997, many community-based psychiatric services are now being increasingly starved of resources, and others were never adequately developed. This plus increasing presentations involving severe comorbidity with substance misuse, particularly in males, has put severe pressure on emergency departments, acute in-patient units and consultation-liaison teams. Private sector resources are not rationally distributed and public health administrations siphon mental health budgets continually. Australia still compares poorly with other Western countries in terms of the proportion of its gross domestic product and health budgets spent on mental health (Rosen *et al.*, 2004). So although on paper the Australian National Mental Health Policy has been world class, its implementation has proven patchy and fragile. We now need to lift our game, and call for a consistent independent umpire, a National Mental Health Commission or equivalent.

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After 5 years of real growth of integrated community and local hospital mental health services from 1992 to 1997, many community-based psychiatric services are now being increasingly starved of resources, and others were never adequately developed.

## SPECIAL PAPER

# Fifteen-year follow-up of conversion disorder

H. R. Chaudhry, N. Arshad, S. Niaz, F. A. Cheema, M. M. Iqbal and K. A. Mufti

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The terms 'conversion', 'hysteria' and 'conversion hysteria' were used interchangeably to describe a condition characterised by a single somatised symptom, often pseudo-neurological in nature. DSM-III (American Psychiatric Association, 1980) expanded the concept of conversion to generalised symptoms involving loss or alteration of physical functioning suggestive of a physical disorder, along with a clinical indication that the conversion was an

expression of psychological conflict or need. The type of symptom or deficit should be specified as: with motor symptom or deficit, with sensory symptom or deficit, with seizure or convulsions, or with mixed presentation (Kaplan & Sadock, 2004).

Lifetime prevalence in the general population has been estimated at between 11 and 300 cases per 100 000. The prevalence is 5–14% of general hospital patients, 1–3% of out-patient psychiatric referrals and

In early studies, general medical aetiologies were later found in a quarter to a third of persons initially diagnosed with conversion symptoms.

The study reported here was an investigation into the psychiatric comorbidity present after 15 years among patients previously identified as having conversion disorder.

5–25% of psychiatric out-patients (Kaplan & Sadock, 2004). A higher prevalence is found in females than in males, with a female:male ratio ranging from 2:1 to 10:1.

Approximately 25% of emotionally normal post-partum and medically ill women report conversion symptoms during their lives. Lower socio-economic status is associated with higher prevalence rates, and this is evident in a comparison of developing with developed countries; the prevalence may be as high as 31% in some developing nations (Uguz & Toros, 2003).

Limited data suggest that conversion disorder is found more frequently in relatives of individuals with the disorder. Case series show an increased risk in monozygotic twins but not in dizygotic twins. Non-genetic familial factors such as incestuous sexual abuse in childhood may be associated with an increased risk of conversion disorder. The disorder may prove to be the only mechanism for communication that remains available to the child or adolescent (Lancman *et al*, 1994).

Age at onset is generally from late childhood to early adulthood; conversion disorder rarely occurs in children younger than 10 years. There is little information on psychiatric comorbidity in conversion disorder (Tomasson *et al*, 1991).

Factors complicating the diagnosis of conversion disorder include the presence of a coexisting physical illness, as the two conditions are not mutually exclusive: patients with incapacitating and frightening physical illnesses may appear to exaggerate symptoms. At the same time, patients with actual neurological illnesses may also exhibit conversion symptoms. More than a third of individuals with conversion symptoms have a current or prior neurological condition. In early studies, general medical aetiologies were later found in a quarter to a third of persons initially diagnosed with conversion symptoms (Lancman *et al*, 1994).

Conversion disorder has a favourable outcome in children and adolescents (Pehlivanurk & Unal, 2002). Mace & Trimble (1996) reported that the prognosis for chronic symptoms remains poor, but subsequent rediagnosis of neurological disease is less frequent than commonly supposed.

Another study showed that the outcome of non-epileptic seizure was poor. Depressive symptoms, suicidal ideation and suicide attempts were commonly found in these patients (Ettinger *et al*, 1999). One study reported a possible relationship of conversion disorder to affective illness (Kapfhammer *et al*, 1992).

The study reported here was an investigation into the psychiatric comorbidity present after 15 years among patients previously identified as having conversion disorder.

## Methods

The study was conducted in the out-patient department of Sir Ganga Ram Hospital and Free Psychiatric Clinic, Ahbab Hospital, Ravi Road, Lahore. Over 2 years (1986–88) 137 patients were diagnosed with

conversion disorder by a consultant psychiatrist on the basis of DSM-III criteria. Patients of both genders were included; those suffering from organic or other psychiatric illness were excluded. The patients' age, gender, marital status and family psychiatric history were noted. In 2003, that is 15 years later, 107 of these patients were reassessed on the basis of DSM-IV criteria (American Psychiatric Association, 1994) (30 patients were lost to follow-up) on the same variables and for the presence of psychiatric comorbidity, by a rater who was masked to the initial diagnosis.

## Results

Out of the sample of 107 patients, 89 (83%) were female and 18 (17%) were male. The mean age of the sample at the original assessment was  $23.2 \pm 4.3$  years. At that time, 62 (58%) were married and 45 (42%) were unmarried; 78 (73%) had a family history of psychiatric disorder.

At follow-up, 21 patients (20%) still had conversion disorder and 4 (5%) patients were reported to have epilepsy (among them three patients with partial complex seizures and one with tonic-clonic seizures). One patient had an arteriovenous malformation and two patients had vascular headache. In this study 20 (19%) patients had comorbid major depressive disorder; 59 (55%) patients did not fulfil the criteria of DSM-IV for any disorder.

## Discussion

Attempts have been made over the past century to abolish and then to reinstate the condition by using different labels, and conversion hysteria continues to attract controversy (Ron, 1994; Webster, 1996, p. 5).

Crimlisk *et al* (1998) reported a high level of psychiatric comorbidity in patients with conversion disorder in their investigation of psychiatric/neurological morbidity and indicators of prognosis among 73 patients with unexplained motor symptoms. The present study used a similar research design and produced comparable findings.

Another study (Spierings *et al*, 1998), conducted in The Netherlands, reported that 62% patients with conversion disorder had a history of organic illness, whereas only 5% patients had an organic disease at follow-up. The present study produced similar findings at 15-year follow-up.

A study conducted in New York in 1996 found that depressive symptoms, suicidal ideation and suicide attempts were common in patients with conversion disorder (Ettinger *et al*, 1999). The present study did not record suicidal ideation and suicide attempts but the results regarding depressive symptoms are similar to those of the New York study.

Scheidt *et al* (1992) also reported the presence of depressive symptoms at follow-up in a third of their sample with psychogenic tremor ( $n = 17$ ). In addition, physical illness was also present during the



follow-up. The present study found that 19% of patients with conversion disorder also had depression, but it did not examine physical illness. The results of the two studies regarding depressive disorder are similar.

Finally, Lancman *et al* (1994) examined the presence of comorbidity among patients with conversion disorder and reported that 48% of the sample were taking anticonvulsants. The results of the present study regarding comorbidity of epilepsy with conversion disorder are in line with these findings.

## Conclusions

Conversion disorder is more common in married women with a family history of psychiatric disorder. High levels of psychiatric comorbidity exist with conversion disorder. Emphasis must be given to the better use of neurodiagnostic tools for the evaluation and the management of comorbidity. Further studies are required to explore this aspect.

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Attempts have been made over the past century to abolish and then to reinstate the condition by using different labels, and conversion hysteria continues to attract controversy.

## ASSOCIATIONS AND COLLABORATIONS

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The vision of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) is of 'a fellowship of psychiatrists working with and for the general community to achieve the best attainable quality of psychiatric care and mental health'. It is the principal organisation representing the specialty of psychiatry in Australia and New Zealand; it currently has around 2600 Fellows, who account for approximately 85% of psychiatrists in Australia and 50% of psychiatrists in New Zealand. The RANZCP sets the curriculum, accredits training and training programmes, and assesses trainee psychiatrists. In addition, it administers a continuing professional development programme for practising

psychiatrists, has a role in policy development, publishes two scientific journals – the *Australian and New Zealand Journal of Psychiatry* and *Australasian Psychiatry* – and holds an annual scientific congress.

## Organisation and history

General Council is the governing body of the RANZCP. Its core functions are served by four boards: the Fellowships Board, the Board of Practice Standards, the Board of Professional and Community Relations, and the Board of Research. Each board oversees committees. Sub-specialties of psychiatry are represented through faculties (the Faculty of Child and Adolescent

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