

Conversion Disorders and Dissociative Disorders - Together They are Strong!

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Opinion

The diagnosis of conversion disorder (CD) requires one or more symptoms of altered voluntary motor or sensory function; clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions, and the symptom or deficit is not better explained by another medical or mental disorder [1]. Both patients with conversion disorder and dissociative disorder (DD) frequently have psychiatric comorbidities. Conversion symptoms are observed in non-Western societies frequently. Childhood traumas and abuse are often seen both dissociative disorders and conversion disorder. It could be expected that these disorders might be seen much more in Western societies because of immigration linked different reasons.

Post-traumatic stress disorder, dissociation, somatization, and affective problems are the results of adaptations to trauma; they occur together, frequently, people with history of traumatization may suffer different combinations of symptoms over time [2]. CDs, DDs, and their comorbidities have been extensively investigated, but, to the best of our knowledge, the comorbidity of the two has not been widely investigated. CD is still a common clinical condition in Eastern countries, in terms both of general medicine and of psychiatric care. We therefore aimed to investigate the comorbidity of CD and DD as well as clinical characteristics of CD with and without DD.

In our study called "Psychiatric Comorbidity in Patients with Conversion Disorder and Prevalence of Dissociative Symptoms" 54 consecutive consenting patients were assembled by us and they were diagnosed firstly with CD according to DSM-IV-TR criteria who were sent to emergency psychiatric department for admitting the patients. SCID-I, SCI-D, and DES (Dissociative Experiences Scale) were operated in which 90.7% were female. A total of 37% of patients with CD had any dissociative treatment. The frequency of dissociative disorders

was followed as: 18.5% dissociative disorder not otherwise specified, 4.8% dissociative amnesia, and 3.7% depersonalization disorder [3].

Some particular differences were found between the study groups comorbidity of bipolar disorder, past hypomania, and current and past posttraumatic stress disorder respectively. Psychiatric comorbidity was excessive and age at onset was prior among dissociative patients related to patients without dissociative symptoms.

The age at onset of CD was also found to be significantly earlier in the DD(+) group compared to the DD(-) group (3). A family history of psychotic disorders and anxiety disorders was significantly more common among the DD(+) group compared to the DD(-) group.

If the psychiatric comorbidity excessive and onset of conversion disorder early in patients with dissociative symptoms, conversion disorder could have more severe course. Family history of psychiatric disorders like psychotic disorders and anxiety disorders are another severeness indicator that seen in patients with these comorbidities. Our patients gathered from psychiatric emergency department so, we have not any dissociative identity disorder. For that reason, large sample studies combining different treatment settings may provide a better understanding of the disorders and their interacting relation. It should be kept in mind that, presence of dissociation is interpreter of further unadorned psychopathology in patients with conversion symptoms.

References

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