# Prevalence of Conversion Disorder in Clinical Population in Main Government Hospitals of Lahore

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## Abstract

The study aimed to find the prevalence of Conversion Disorder in the main government hospitals of Lahore using the cross-sectional survey design with a purposive sampling strategy. The participants were patients from various regions in and out of Lahore, over a period of 45 days. Tests were administered starting with the collection of demographic information, then the patient health questionnaire (Kroenke et al., 2001), conversion symptom checklist (Bokharey & Rahman, 2013), and level of frustration tolerance scale from the symptom checklist-revised (Rahman et al., 2009). The respondents included all age groups and both genders from different cities. Out of 14,511 reported cases, 1,755 participants were interviewed by the research team to quantify the severity of the symptoms and to pinpoint the diagnosis of the cases being reported. Of these, 256 patients were found to be suffering from conversion disorder. Frequency, percentage, mean, and standard deviation were calculated in accordance with these patients. The current research concludes that the conversion disorder is occurring almost in 15% of respondents in main government hospitals of Lahore which was the highest in number among young women between the ages of 17-30 years. The majority of diagnosed cases were from Lahore City and Model Town Tehsils. The study also found most cases of conversion disorder were frequently comorbid with depressive and anxiety disorders. This research refined theoretical models of conversion disorder, highlights cultural and socioeconomic dynamics, and suggests improved diagnosis, treatment, and training methods. In the future, studies can be conducted in diverse settings, pursue longitudinal studies, and investigate cultural impacts to improve mental health policies and education.

*Keywords:* conversion disorder, prevalence, Lahore, hospitals, clinical population.

## Introduction

Conversion disorders have been defined by the APA, American Psychiatric Association, as conditions including impairments and abnormalities that impede deliberate cognitive or perceptual performance despite a significant underlying pathophysiological cause (American Psychiatric Association, 2022). Conversion disorders are simply described as those conditions that have no clinical cause or any neurological explanation and are characterized by movement or perceptual dysfunctional behaviors (APA, 2022; Fobian & Elliott, 2019). Conversion disorder is

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characterized by bodily signs that cannot be explained by an accident or sickness (Khan et al., 2006). A neurological or generalized medical disease is insufficient for clarifying the manifestations and symptoms of the disorder of conversion, which is additionally known as a functional neurological manifestation illness (Ballmaier & Schmidt, 2005). It is believed that psychological components like anxiety and challenges are linked to the deficiencies that can result in conversion disorder (Blitzstein, 2008). There have been very few studies on conversion disorder in Pakistan. The most common signs include "not being able to respond" and "abrupt actions," as well as high levels of worry and depression (Syed et al., 2001).

Sigmund Freud, who postulated that subconscious disagreement was responsible for certain signs that were not clarified by biological disorders, is credited with coining the expression conversion disorder. The term "conversion" describes the process of replacing a suppressed notion with a physical symptom (Breuer & Freud, 1955). Conversion symptoms of the disorder arise from the "conversion" of psychological discomfort onto bodily (neurologic) signs and symptoms, as opposed to being exaggerated or intentionally generated (Ballmaier & Schmidt, 2005). Consider the following scenario: you are involved in an automobile accident. You were not seriously injured, but you were still incapable of bending your upper arm the following morning. Your healthcare provider runs scans and diagnostics exams but uncovers absolutely nothing abnormal. In other words, the body might have transformed (altered) the feelings of grief and psychological trauma experienced throughout the accident through the physical manifestation of a paralyzed arm. These symptoms could seem weird, but they are genuine and beyond your capacity to control (Feinstein, 2011). According to the Encyclopedia of Mental Disorders, clients who interpret their psychological problems into bodily manifestations incur approximately nine times as much in medical expenses as those who do not, and about 82 % of adults with conversion disorder resign from their jobs as a consequence of their illnesses (Ali et al., 2011). Comparatively speaking to many other neurological and mental illnesses, conversion disorder has received very little research attention despite its clinical significance (Goldstein et al., 2020).

The Diagnostic and Statistical Manual-V-TR and The International Classification of Diagnostic Criteria-10 for conversion disorder adopt a sociocultural approach. The classification systemic technique aims to separate conversion disorder from the majority of other neurological diagnoses (Nicholson et al., 2011). The identification of the disorder of conversion constitutes an actual difficulty. Detailed mental histories and assessments are required to explain the origin of signs and symptoms, tensions, and concomitant illnesses (Marshall & Bienenfeld, 2013). In accordance with one research conducted in America, 47% of people diagnosed with conversion disorder had a certain kind of disruptive condition. Conversion disorder ought to be diagnosed after demonstrating strong clinical indicators that are inconsistent with biological illness or potentially contradictory throughout various elements of the investigation, and eliminating any possible health illnesses exhibited by symptoms are imitating (Stone & Sharpe, 2023).

Leading psychologists, Freud (1856–1939) and Janet (1859–1947) had significant viewpoints on the disorder. Early in their professional life, Freud believed that hysteria—now known as conversion disorder—was an illness rooted in trauma (Sar et al, 2004). But subsequently,

Freud called the somatoform symptoms of hysterical "manifestations of conversion disorder," explaining these as a neurotic defense mechanism (Sharma et al, 2005). Furthermore, Freud observed that an individual must demonstrate both primary as well as secondary benefits in order to exhibit conversion disorder manifestations. The psychodynamic theory developed by Freud states that a person's unresolved traumatic incident experienced during early childhood or brutal and sexual impulses are contributing factors to conversion disorders (Ali et al., 2015). The person usually represses these disagreements and cravings given that they generate nervousness. The person automatically transforms their nervousness into physical manifestations whenever it tries to enter their conscious consciousness, which helps them escape their anxious state. The primary gain is the term used to describe this method of avoiding subconscious fear. According to Freud's other theories, the person could exhibit severe bodily signs of a condition in order to get sympathy and attention from others. This propensity was called secondary gain by Sigmund (Gaur et al., 2013).

Individuals suffering from the disorder of conversion might find it challenging to manage psychological anxiety, and their level of awareness will be compromised. It has a dissociative character in addition to being impaired in personal consciousness and the patient's capacity to comprehend a restricted range of concepts and feelings is diminished, and their ability to regulate themselves is compromised. In an impoverished country like the Islamic Republic of Pakistan, this might represent an important strain on limited resources for healthcare (Ali et al., 2015). To decrease the demand for healthcare and save healthcare resources, patients who exhibit the typical course of this condition should be diagnosed beforehand and given the necessary mental health therapy. It is critical to acquire an individual's clinical and mental health records as quickly and successfully as possible, while also being mindful of the best time and place to inquire concerning behavioural symptoms. In terms of therapy, no particular approach can be universally approved. Continuing follow-up appointments, together with treatment with cognitive behavioural therapy and physical therapy (for neuromuscular problems), have yielded good outcomes. Pharmaceutical therapy may be required for any associated psychological illnesses (Feinstein, 2011).

## Objectives of the Study

- To find the prevalence of Conversion Disorder among the clinical population in main government teaching hospitals of Lahore, Pakistan.
- To find the prevalence of conversion disorder co-morbid with other psychological disorders among the clinical population in government teaching hospitals of Lahore, Pakistan.

## Method

### Research Design

The cross-sectional survey research design was used in the study to assess the prevalence of Conversion Disorder.

**Sample and Sampling Strategy**

All patients coming to the outpatient and inpatient facilities in different psychiatric wards of government hospitals in Lahore, Pakistan were recruited as the sample of the present study for 45 days. 6 Main Government Hospitals of Lahore were taken. A purposive sampling strategy was used which is a non-probability method where participants are intentionally selected based on specific inclusion criteria relevant to the study. In screening, PHQ-9 or Conversion Symptom Checklist were used to ensure only individuals meeting the required characteristics, such as a diagnosis of conversion disorder, are included. The total reported cases were 14511 out of which 1755 were interviewed. Out of these 1755 cases who gave consent, 256 cases were diagnosed with conversion disorder. Table 1 shows the majority of the cases were women, accounting for 185 cases (72.26 %), while men comprised 71 cases (27.73 %). It was also found that the mean age of participants diagnosed with the conversion disorder found to be 28.81 years ($SD$ =12.23). The average monthly income of the patients was 6765.63 rupees ($SD$=18211.173) and the average monthly income of family was 41482.03 rupees ($SD$= 41309.43).

**Table 1**
*Demographics Characteristics of Participants*

| Demographics | $n$ | % |
|---|---|---|
| Gender | | |
| Male | 71 | 27.73 |
| Female | 185 | 72.27 |
| Education | | |
| 0 years of education | 73 | 28.50 |
| 5-10 years of educated | 79 | 30.90 |
| 10-16 years of education | 92 | 35.90 |
| More than 16 years of educated | 12 | 4.70 |
| Profession | | |
| Housewife | 64 | 25.00 |
| Student | 23 | 9.00 |
| Unskilled jobs | 14 | 5.50 |
| Skilled jobs | 42 | 16.40 |
| Unemployed | 113 | 44.10 |
| Religion | | |
| Islam | 244 | 95.31 |
| Christianity | 12 | 4.69 |
| Family System | | |
| Joint | 115 | 44.92 |
| Nuclear | 141 | 55.07 |
| Marital Status | | |
| Unmarried | 127 | 49.70 |

| | | |
|---|---|---|
| Married | 118 | 46.00 |
| Separated /Divorced/ Widowed | 11 | 4.30 |

**Assessment Measures**

*Patient Health Questionnaire (PHQ-9)*

The PHQ-9 is a 9-item self-administered tool designed to screen, diagnose, monitor, and measure the severity of depression. Each item corresponds to one of the diagnostic criteria for depression in the DSM-IV and assesses symptoms over the past two weeks. It provides a quick and effective way to identify individuals who may require further psychological or medical intervention.

*Conversion Symptom Checklist*

The Conversion Symptom Checklist is a structured tool designed to identify symptoms consistent with conversion disorder, which manifests as neurological symptoms (e.g., motor or sensory dysfunction) that cannot be fully explained by a medical condition. This checklist helps clinicians identify patterns indicative of psychogenic origins for physical symptoms, aligning with criteria from diagnostic frameworks like the DSM.

*Level of Frustration Tolerance Scale (Symptom Checklist-Revised)*

This scale, part of the broader Symptom Checklist-Revised (SCL-90-R), evaluates an individual's capacity to manage frustration without resorting to maladaptive or disruptive behavior. Low frustration tolerance is often associated with heightened emotional reactivity, stress, and difficulty coping, making it a crucial factor to assess in studies related to psychological disorders.

**Procedure**

All the participants who were diagnosed with conversion disorder and other psychological disorders co-morbid with conversion disorder were included in the study. The nature and purpose of the study were explained to the participants and they were provided written consent. The participants were selected on the basis of inclusion and exclusion criteria. In the study, the modified questionnaire was used. It was found that participants were able to understand the questionnaire completely and it took them approximately 20 to 25 minutes to complete it. The data was collected from Government hospitals from May 2024 to July 2024. The study was completed for period of 45 days.

**Ethical Considerations**

- First of all, the permissions were taken from the Department Doctoral Program Committee (DDPC). Permissions were also taken from the Institutional Review Boards of all included hospitals of Lahore in the study.
- Participants were explained about the nature and purpose of the study before administration of the questionnaire.
- All participants were given consent before administration through informed consent. Participants were informed of all of their rights before taking part in the research. Participants were informed that they are free to leave the study at any point.

- Participants were also informed that their identities will remain anonymous.
- Participants were also informed that the information they were providing would be kept confidential.
- Participants were also informed in case of any emotional stress they felt during the administration of the questionnaire they can visit the center for clinical psychology.

## Results

The results were calculated by doing the descriptive analysis on SPSS by computing frequency, percentage, mean, and standard deviations. The psychometric properties were found by performing the reliability analysis of the scales used in the study. The overall reliability analysis demonstrates that the scales used in this study possess good to excellent internal consistency, as indicated by Cronbach's alpha values ranging from .79 to .94. The total score for the Conversion Symptom Checklist (CSC) has a total of 75 items with a Cronbach's alpha of .95, indicating excellent reliability. The first factor of CSC which is mixed depression and anxiety symptoms subscale has 45 items with Cronbach's alpha of .93, indicating excellent reliability. The second factor motor symptoms subscale has 7 items with Cronbach's alpha of .84, indicating good reliability. The third factor which is the somatic symptoms subscale has 8 items with a Cronbach's alpha of .92, indicating excellent reliability. The fourth factor which is the mixed symptoms subscale has 8 items with a Cronbach's alpha of .75, indicating acceptable reliability. The fifth factor, the pseudo seizures subscale, has 7 items, with a Cronbach's alpha of .83, indicating good reliability. The Frustration Tolerance Scale (FTC) has 24 items with a Cronbach's alpha of .95, indicating excellent reliability and high internal consistency. The Patient Health Questionnaire PHQ-9 has 10 items with a Cronbach's alpha of .93 which indicates excellent reliability.

**Table 2**

*Severity of Conversion Disorder Symptoms*

| Symptoms | *n* | % |
|---|---|---|
| Minimal Symptoms | 36 | 14.06 |
| Mild Symptoms | 92 | 35.93 |
| Moderate Symptoms | 117 | 45.70 |
| Severe Symptoms | 11 | 4.29 |
| Total | 256 | 100.0 |

Table 2 shows the distribution of severity of symptoms in patients with conversion disorder. It was found that the majority of the patients reported moderate symptoms (*n* = 117, 45.70%) followed by those with mild symptoms (*n* = 92, 35.93%). This distribution indicates that there is a considerable prevalence of moderate symptomatology within the sample.
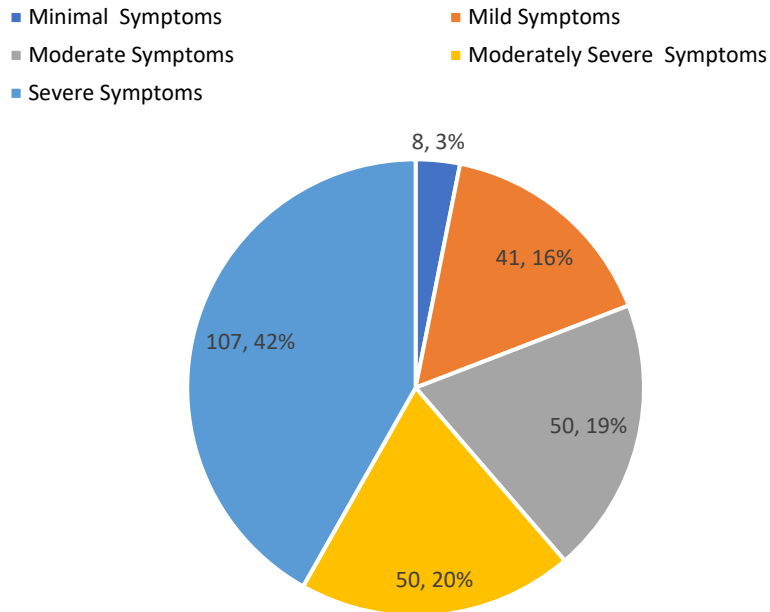
**Figure 1**

*Frequency And Percentage of Conversion Disorder Symptoms*
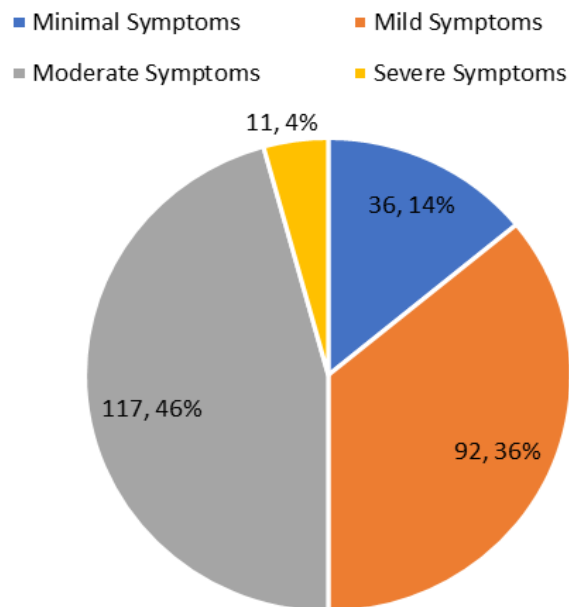


*Note.* Figure 1 shows the frequency and percentage of the severity of symptoms of Conversion Disorder in participants with Conversion Disorder on the CSC in Main Government Hospitals of Lahore ($N = 256$).

**Table 3**

*Severity of Depressive Symptoms in PHQ-9*

| Symptoms | *n* | % |
|---|---|---|
| Minimal Symptoms | 8 | 3.12 |
| Mild Symptoms | 41 | 16.01 |
| Moderate Symptoms | 50 | 19.53 |
| Moderately Severe Symptoms | 50 | 19.53 |
| Severe Symptoms | 107 | 41.79 |
| Total | 256 | 100.00 |

Table 3 shows the frequency and percentage of the severity of depressive symptoms in PHQ of participants reported with Conversion disorder. As shown in Table 3, the majority of the participants were found with severe depressive symptoms (*n*= 107, 41.79 %), while both moderate and moderately severe symptoms were reported by 19.5 % of the sample respectively.
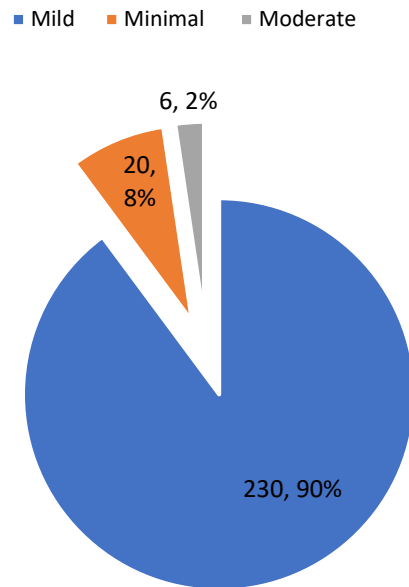
**Figure 2**

*Frequency and Percentage of Severity Level of Depression in (PHQ 9)*



*Note.* The figure 2 is also supported by results shown in Table 3, which showed that the majority of the participants were found with severe depressive symptomatology, while participants also reported having moderate and moderately severe depressive symptomatology.

**Table 4**

*Frustration Tolerance Severity Levels*

| Symptoms | *n* | % |
|---|---|---|
| Minimal Symptoms | 20 | 7.81 |
| Mild Symptoms | 230 | 89.84 |
| Moderate Symptoms | 6 | 2.34 |
| Total | 256 | 100.00 |

Table 4 shows the frequency and percentage of the severity of symptoms of Frustration Tolerance of participants reported with Conversion Disorder. It was found that the majority of the participants are classified with mild severity levels of frustration tolerance (*n* = 230, 89.84%).

**Figure 3**

*Percentage and Severity Levels on Frustration Tolerance Scale*



*Note.* The figure 3 is also supported by the Table 4, which indicates that majority of the participants were found with mild level of frustration tolerance.

**Table 5**

*Prevalence of Conversion Disorder*

| Disorder | n | % |
|---|---|---|
| Conversion Disorder | 256 | 14.86 |

Table 5 shows the frequency and percentage of reported cases of Conversion Disorder in different Government Hospitals of Lahore ($n = 256$) from a total sample of 1722 individuals.

**Table 6**

*Cases of Conversion Disorder in Hospitals of Lahore, Pakistan*

| Hospital Names | n | % |
|---|---|---|
| Punjab Institute of Mental Health (PIMH) | 83 | 32.42 |
| Mayo Hospital | 10 | 3.90 |
| General Hospital | 35 | 13.67 |
| Sir Ganga Ram Hospital | 32 | 12.50 |
| Gulab Devi Hospital | 82 | 32.03 |
| Jinnah Hospital | 14 | 5.46 |
| Total | 256 | 100.00 |

Table 6 shows frequency and percentage of cases diagnosed with Conversion Disorder reported in main government hospitals in Lahore ($N = 256$). It was found that the highest number of cases of conversion disorder were reported at PIMH with 83 cases (32.42%) and Gulab Devi Hospital with 82 cases (32.03%), which indicates that both of these hospitals have the largest representation in the sample. General Hospital and Sir Ganga Ram Hospital were found with moderate representation with 13.67 % and 12.50% of the cases, respectively.

**Figure 4**

*Frequency and Percentage of Conversion Disorder Cases*
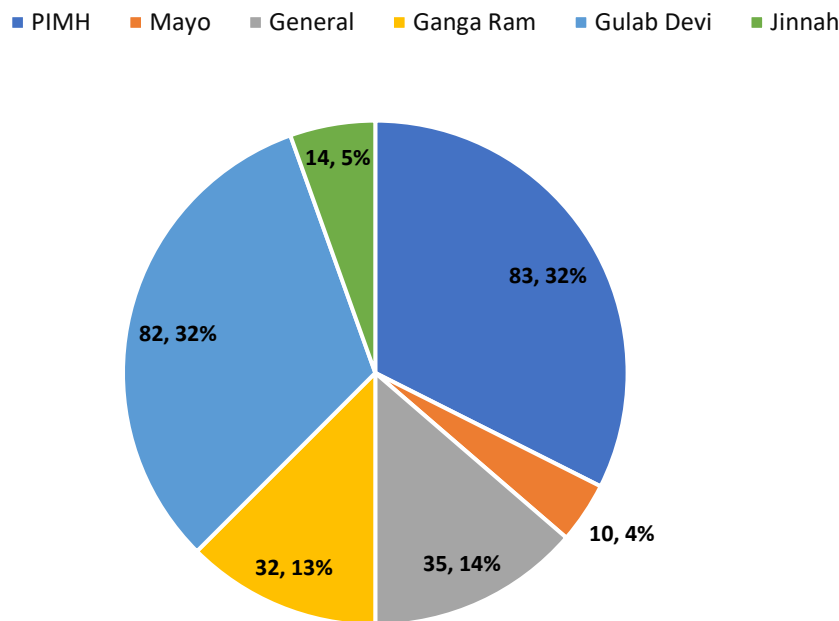


*Note.* Figure 4 shows the frequency and percentage of cases diagnosed with Conversion Disorder reported in main government hospitals in Lahore, Pakistan *(N = 256).*

**Table 7**

*Co-morbid Psychological Disorders with Conversion Disorder*

| Disorder | *n* | % |
|---|---|---|
| Conversion Disorder | 229 | 89.45 |
| Conversion and Anxiety | 04 | 1.56 |
| Conversion, Depression and Anxiety | 04 | 1.56 |
| Conversion and Depression | 09 | 3.51 |
| Conversion, Depression, Anxiety and Panic | 06 | 2.34 |
| Conversion and Schizophrenia | 03 | 1.17 |
| Conversion, Depression, Anxiety and PTSD | 01 | 0.39 |
| Total | 256 | 100.00 |

Table 7 shows the frequency and percentage of total cases diagnosed with Conversion Disorder and other psychological disorders co-morbid with conversion disorder reported in government hospitals of Lahore. The highest prevalence was found with the Conversion Disorder alone, with 229 cases (89.45%). Other co-morbid conditions were found less frequent such as with Depression and Conversion with only 9 cases (3.51%) and Depression, Anxiety, Conversion Disorder and Panic Disorder both comprising only 6 cases (2.34%). This distribution of cases highlights that predominance of Conversion Disorder as single diagnosis among the cases reported.

**Table 8**

*Frequency and Percentage of Conversion Disorder Cases in Tehsils of Lahore, Pakistan (n= 256).*

| Tehsil/Area | n | % |
|---|---|---|
| Lahore Cantonment | 12 | 4.68 |
| Raiwind | 5 | 1.95 |
| Lahore City | 45 | 17.57 |
| Shalimar | 17 | 6.64 |
| Model Town | 43 | 16.79 |
| Not specified Tehsils | 20 | 7.81 |
| Total Cases in Lahore Tehsils | 142 | 55.46 |

It was found that Lahore City has the highest number of cases with 45 cases (17.57%). While Shalimar showed a moderate number of cases accounting for 17 cases (6.64%), the total number of cases in Lahore Tehsil were 142 which represented 55.46% of the total reported cases were from Lahore.

**Table 9**

*Frequency and Percentage of Conversion Disorder Cases from Cities of Pakistan (n = 256)*

| City | n | % |
|---|---|---|
| Lahore | 144 | 56.25 |
| Sargodha | 5 | 1.95 |
| Kasur | 16 | 6.25 |
| Gujranwala | 9 | 3.51 |
| Kot Abdul Malik | 1 | 0.39 |
| Sialkot | 3 | 1.17 |
| Sahiwal | 1 | 0.39 |
| Patoki | 7 | 2.73 |
| Narowal | 3 | 1.17 |
| Okara | 5 | 1.95 |
| Multan | 2 | 0.78 |
| Kamoki | 3 | 1.17 |
| Faisalabad | 3 | 1.17 |

| | | |
|---|---|---|
| Pakpatan | 4 | 1.56 |
| Nankana Sahib | 6 | 2.34 |
| Bhawalnagar | 6 | 2.34 |
| Jhang | 1 | 0.39 |
| Toba Tek Singh | 1 | 0.39 |
| Dera Ismail Khan | 1 | 0.39 |
| Kot Momin | 1 | 0.39 |
| Sheikhupura | 8 | 3.12 |
| Wazirabad | 2 | 0.78 |
| Gujrat | 1 | 0.39 |
| Muridkee | 5 | 1.95 |
| Vehari | 2 | 0.78 |
| Rawalpindi | 2 | 0.78 |
| PhoolNagar | 3 | 1.17 |
| Mandi Bahauddin | 1 | 0.39 |
| Chakwal | 1 | 0.39 |
| Noshera | 1 | 0.39 |
| Pasroor | 1 | 0.39 |
| Khudian Khas | 1 | 0.39 |
| Bhawalpur | 1 | 0.39 |
| Jaranwala | 1 | 0.39 |
| Abbottabad | 1 | 0.39 |
| Dipalpur | 1 | 0.39 |
| Haveli lakha | 1 | 0.39 |
| Khanewal | 1 | 0.39 |
| Total | 256 | 100.00 |

Table 9 shows the frequency and percentage of Cities of total cases diagnosed with Conversion Disorder reported in Government hospitals of Lahore ($n$ = 256). The highest prevalence was observed in Lahore, which reported 144 cases (56.25 %) making it the city with the most significant number of cases. Kasur was found with the second highest prevalence with 166 cases (6.25 %), followed by Gujranwala, which reported 9 cases (3.51%). Other cities contributed less than 3.51% each to the total number of cases. The distribution highlights the majority of cases were concentrated in Lahore.

**Table 10**
*Frequency and Percentage of Conversion Disorder Cases at PIMH Lahore, Pakistan (n = 110, N = 11566).*

| | $n$ | % |
|---|---|---|
| Conversion Disorder | 110 | 0.95 |

Table 10 shows the frequency and percentage of total cases diagnosed with Conversion Disorder during one month at the Punjab Institute of Mental Health (PIMH) in Lahore, Pakistan *(n* =110), *N* =11566). This shows the patients with conversion disorder were relatively rare at the Punjab Institute of Mental Health during this time period.

**Table 11**

*Frequency and Percentage of Conversion Disorder Cases and other Co-morbid Disorders at PIMH Lahore (n = 110, N = 11566).*

| Disorder | n | % |
|---|---|---|
| Conversion disorder with mixed symptom presentation | 20 | 18.18 |
| Conversion disorder with motor symptom or deficit | 27 | 24.54 |
| Conversion disorder with seizures or convulsions | 18 | 16.36 |
| Conversion disorder with sensory symptom or deficit | 10 | 9.09 |
| Other dissociative and conversion disorders | 11 | 10.00 |
| Dissociative and conversion disorder, unspecified | 24 | 21.81 |
| Total | 110 | 100.0 |

Table 11 shows frequency and percentage of total cases diagnosed with Conversion Disorder during one month at Punjab Institute of Mental Health (PIMH) Lahore, Pakistan (*n* =110). It was found that three most prevalent comorbidity that were found were Conversion Disorder with motor symptom or deficit (*n* = 27, 24.54%), Conversion Disorder with mixed symptoms (*n* = 20, 18.18%) and Conversion disorder with seizures or convulsions (*n* = 18, 16.36 %).

**Table 12**

*Gender Distribution of Conversion Disorder Cases at PIMH Lahore (n = 110)*

| Gender | n | % |
|---|---|---|
| Men | 34 | 30.90 |
| Women | 76 | 69.09 |
| Total | 110 | 100.00 |

Table 12 shows frequency and percentage of reported cases with conversion disorder in different genders *(n* = 110). It shows that out of population of 11566, women have predominance of conversion disorder in the in the sample which includes 76 cases (69.09%) whereas men were found with fewer cases such as 34 only (30.90) at PIMH.

**Table 13**

*Conversion Disorder Cases by City at PIMH Lahore (n=110).*

| City | n | % |
|---|---|---|
| Lahore | 59 | 53.63 |
| Gujranwala | 4 | 3.63 |

| Gujrat | 2 | 1.81 |
|---|---|---|
| Hafizabad | 4 | 3.63 |
| Kasur | 12 | 10.91 |
| Kohat | 2 | 1.81 |
| Bahawalnagar | 1 | 0.91 |
| Mianwali | 2 | 1.81 |
| Nankana Sahib | 5 | 4.55 |
| Narowal | 6 | 5.45 |
| Okara | 4 | 3.63 |
| Sheikhupura | 4 | 3.63 |
| Sialkot | 2 | 1.81 |

Table 13 shows frequency and percentage of cities of total cases diagnosed with Conversion Disorder during 1 month at Punjab Institute for Mental Health. It was found that majority of the participants are from Lahore city which included 56 cases (53.6 %).

## Discussion

The result indicated that the prevalence of the conversion disorder has increased in recent years. If the trend has been analyzed globally, it was found from previous researches and surveys that the prevalence of conversion disorder was found that only 4 to 12 out of every 100,000 people are diagnosed with conversion disorder (Gabbard, 2005.). Also, if we see the trend of conversion disorder across different countries like the United States, it was found that Lifetime prevalence rates of conversion disorder are between 11 to 300 per 100,000 people (Hull, 2022). Some researchers have also shown that overall conversion disorder prevails at about 50 per 100,000. Globally, the prevalence of conversion disorder varies widely across different setups and populations. In general hospitals, conversion disorder is diagnosed in approximately 5-14% of patients. For outpatient referrals to psychiatrists, the prevalence ranges from 1-3%. Among psychiatric outpatients, the prevalence is notably higher, estimated at 5-25%. Additionally, about 20-25% of individuals in hospital settings may meet some criteria for a conversion disorder diagnosis (Hull, 2022).

FNSD was one of the most common illnesses seen in Pakistani tertiary care institutions' psychiatric departments (Shahid et al., 2015). Unexplained neurological symptoms are relatively common in South Asian nations such as Pakistan, however, studies in this area are limited (Stone & Sharpe, 2023). If discussing the rate of conversion disorder specifically in Pakistan, it was found that conversion disorder was found to be more prevalent in developing countries about 31 % as compared to the developed nations (Hull, 2022). Also, it was reported that Conversion disorder was found to be 4.8 % in outpatients and 12.4 % in the in-patient population (Dayani et al., 2019). It was also found that Conversion Disorder accounts for 5% to 13% of all psychiatric inpatient admissions in Pakistan (Hashmi et al., 2012). By comparing these results with our research results

it was found that results seemed to support the previous findings and it was found that the prevalence rate of conversion disorder has been increased in Pakistan ($n = 256$, % = 14.6%).

**Conclusion**

In Pakistan, one psychological explanation for the prevalence of conversion disorder in women is that it may manifest physically as a result of unresolved psychological conflicts. Women in Pakistan are particularly vulnerable due to societal norms that discourage them from expressing their emotions and feelings openly. Moreover, for men, emotional expressiveness is often perceived as a sign of weakness, which further exacerbates the issue (Khan et al., 2014). These cultural factors contribute to the prevalence of conversion disorder, as underlying psychological conflicts are not effectively addressed or expressed.

As conversion disorder can occur at any age, many researches indicates that the prevalence of conversion disorder was found to be more common with adolescents and adults. As the results of the study indicated age range for the conversion disorder was found to be between 20-30 years old (112,43.8%) and 30 to 45 years old. (80, 31.2 %). The result of the present research was found to be consistent with the previous researches such as most participants who were diagnosed with conversion disorder were found in the age range of 18-30 (43.64%), followed by 35.39% participants who were aged 31-45 years (Blitzstein, 2008). Another study was found with similar results like the most commonly affected group with conversion disorder in their study were young adults (38.0%) between the age of 18-30 years, followed by children and adolescents (36.0%) in the age group of 6-17 years (Bashar et al., 2020).

The results showed that conversion disorder was found to be significantly co-morbid with depressive disorder. It was found that most of the participants with conversion disorder were found with severe depression (41.8%). These results were found to be consistent with previous researches such as a previous study showing high comorbidity of conversion disorder with depression (35%) and anxiety symptoms (29 %), and with both of them (Khan et al., 2006). Another previous research also suggested that a high frequency of participants diagnosed with dissociative (conversion) disorder have clinically significant scores of anxiety (60%) and depression (61%) (Malik et al., 2010). From past researches, it has been found that the most common psychiatric disorders coexisting with conversion disorder were depression (50 %) (Maqsood et al., 2013).

**Limitations and Recommendations**

The study faced several limitations, including time constraints, extreme weather conditions, and challenges with hospital permissions. Due to limited time, future studies should allocate more extensive periods for data collection. The hot weather made data collection in hospitals difficult, so scheduling during cooler months or providing climate-controlled transport and equipment would be beneficial. The lengthy permission processes also hindered progress, suggesting that future researchers initiate approvals well in advance and use digital communication to expedite the process. Strikes at several hospitals led to temporary halts in data collection, highlighting the need for contingency plans to address such disruptions. Additionally, restrictions

on data collection from inpatient wards in some hospitals limited the scope, so negotiating access with hospital administrations beforehand is advised. Since the data was only collected from government hospitals in Lahore, the findings cannot be generalized to private hospitals or broader community samples. Future research should include private hospitals and community samples to improve generalizability.

**Implications**

The study offers significant theoretical and practical implications. It contributes to refining existing models of conversion disorder, especially in the context of cultural and socioeconomic factors, which can guide future research and theoretical frameworks. Practically, the findings can inform healthcare strategies, improve diagnostic and treatment methods, enhance practitioner training, and promote culturally responsive therapies. Ultimately, the research aims to reduce stigma and encourage early help-seeking, leading to more effective management and treatment of conversion disorder.

## References

Ali, S., Jabeen, S., Arain, A., Wassef, T., & Ibrahim, A. (2011). How to use your clinical judgment to screen for and diagnose psychogenic nonepileptic seizures without video electroencephalogram. *Innovations in Clinical Neuroscience*, *8*(1), 36–42.

Ali, S., Jabeen, S., Pate, R. J., Shahid, M., Chinala, S., Nathani, M., & Shah, R. (2015). Conversion disorder—Mind versus body: A review. *Innovations in Clinical Neuroscience, 12*(5–*6*), 27–33.

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). American Psychiatric Publishing.

Ballmaier, M., & Schmidt, R. (2005). Conversion disorder revisited. *Innovations in Clinical Neuroscience, 12*(5-6). 27-33.

Bashar, F., Khan, R., & Hussain, F. (2020). Demographic characteristics and clinical features of conversion disorder in a tertiary care hospital. *Journal of Psychological Disorders, 8*(2), 125–132. https://doi.org/10.5455/jpd.202008020125

Blitzstein, S. M. (2008). Recognizing and treating conversion disorder. *AMA Journal of Ethics, 10*(3), 158–160. https://doi.org/10.1001/virtualmentor.2008.10.3.cprl1-0803.

Bokharey, I. Z., & Rahman, N. K. (2013). Development of an indigenous symptom checklist for conversion disorder. *Pakistan Journal of Psychological Research, 28*(1), 125–140.

Breuer, J., & Freud, S. (1955). Studies on hysteria. In J. Stachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud,* (Vol. II 1893-1895, pp. VII-XXXI, 1–311). The Institute of Psycho-Analysis.

Dayani, K. S., Soomar, S. M., & Dossa, K. S. (2019). Conversion disorders in mental health care: A basic review of literature. *Mathews Journal of Psychiatry & Mental Health, 4*(1). https://doi.org/10.30654/mjpmh.10023

Derogatis, L. R. (1994). *SCL-90-R: Symptom checklist-90-R: Administration, scoring, and procedures manual* (3rd ed.). National Computer Systems.

Feinstein, A. (2011). Conversion disorder: Advances in our understanding. *Canadian Medical Association Journal, 183*(8), 915–920. https://doi.org/10.1503/cmaj.110490

Fobian, A. D., & Elliott, L. (2019). A review of functional neurological symptom disorder etiology and the integrated etiological summary model. *Journal of Psychiatry & Neuroscience, 44*(1), 8–18. https://doi.org/10.1503/jpn.170190

Gabbard, G. O. (2005). *Psychodynamic psychiatry in clinical practice* (4th ed.). American Psychiatric Publishing.

Gaur, V., Yadav, R. M., Jagawat, T., & Tandon, P. (2013). Anxiety and depression in females with (conversion) dissociative disorder. *Delhi Psychiatry Journal, 16*(1), 25–31.

Goldstein, L. H., Deale, A. C., Mitchell-O'Malley, S. J., Toone, B. K., & Mellers, J. D. (2020). An evaluation of cognitive behavioral therapy as a treatment for dissociative seizures: A pilot study. *Cognitive Behavioral Neurology, 17*, 41–49. https://doi.org/10.1159/000504429

Hashmi, A. M., Mazhar, N., & Malik, A. K. (2012). The burden on her soul: Conversion disorder in developing countries. *Annals of King Edward Medical University, 18*(1), 9.

Hull, M. (2022, April 28). *Conversion disorder facts and statistics*. The Recovery Village. https://www.therecoveryvillage.com/mental-health/conversion-disorder/conversiondisorder-statistics/

Kalogjera-Sackellares, D. (2004). *Psychodynamics and psychotherapy of pseudoseizures*. Crown House.

Khan, F., Bhimani, M., Afreen, T., & Zaman, M. (2014). Conversion disorder in young people of Karachi: A 20 years retrospective review. *ISRA Medical Journal, 6*(4), 285-288.

Khan, S., Ladha, A., Khan, S. K., Khan, S. F., Malik, A. A., Memon, Z., Nabi, S. G., Adnan, H. Y., & Naqvi, H. A. (2006). Presentation and features of conversion disorder at a tertiary care hospital in Karachi. *Pakistan Journal of Neurological Sciences, 1*(3), 128–131.

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Malik, M., Bilal, F., Kazmi, S., & Jabeen, F. (2010). Depression and anxiety in dissociative (conversion) disorder patients at a tertiary care psychiatric facility. *Rawal Medical Journal, 35*(2), 224–226.

Maqsood, R., Hussain, R., & Shah, I. (2013). Coexisting psychiatric disorders in patients with conversion disorder: A retrospective study. *Journal of Mental Health, 22*(4), 197–203.

Marshall, S., & Bienenfeld, D. (2021, July 13). *Conversion disorder*. Medscape. https://emedicine.medscape.com/article/287464-overview?form=fpf

Nicholson, T. R., Stone, J., & Kanaan, R. A. (2011). Conversion disorder: A problematic diagnosis. *Journal of Neurology, Neurosurgery & Psychiatry, 82*(11), 1267–1273. https://doi.org/10.1136/jnnp.2008.171306

Rahman, N. K., Dawood, S., Rehman, N., Mansoor, W., & Ali, S. (2009). Standardization of Symptom Checklist-R on psychiatric and non-psychiatric sample of Lahore city. *Pakistan Journal of Clinical Psychology, 8*(2), 21–32.

Sar, V., Akyüz, G., Kundakçi, T., & Dogan, O. (2004). Childhood trauma, dissociation, and psychiatric comorbidity in patients with conversion disorder. *American Journal of Psychiatry, 161*(12), 2271–2276. https://doi.org/10.1176/ajp.161.12.2271

Shahid, M., Ali, S. M., & Khan, S. (2015). Functional neurological symptom disorder: A retrospective analysis in a tertiary care psychiatric department in Pakistan. *Journal of Neurological Sciences, 2*(1), 45–50.

Sharma, I., Giri, D., Dutta, A., & Mazumder, P. (2005). Psychosocial Factors in Children and Adolescents with Conversion Disorder. *Journal of Indian Association for Child and Adolescent Mental Health*, 1(4),13-19. https://doi.org/10.1177/0973134220050403

Spratt, E., Bhatia, K., & Pataki, C. (2014). *Somatic symptom disorders.* Medscape. https://emedicine.medscape.com/article/294908-overview?form=fpf

Stone, J., & Sharpe, M. (2023). *Functional neurological symptom disorder (conversion disorder) in adults: Treatment*. Wolters Kluwer.

Syed, E. U., Ashraf, S., & Naqvi, H. (2001). Conversion disorder: Difficulties in diagnosis using DSM-IV/ICD-10. *Journal of the Pakistan Medical Association, 51*(8), 276–279.