Relationship between Coping styles and Conversion Disorder Phenomenology: A Study from Eastern India

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Abstract

Background: Conversion disorder is a Functional Neurological Disorder under DSM-5 classification which arises mainly due to psychological conflicts and without any underlying clinical findings and/or biochemical abnormalities .Studies in the past have attributed faulty coping styles for genesis and maintenance of conversion disorder.Here we attempted to identify any socio-demographic variable and coping style that may be associated with the patients of Conversion disorder.

Aim: To study the socio-demographic variables ,clinical presentation ,coping styles adopted in patients of Conversion disorder.

Methods: 51 patients of conversion disorder fulfilling the inclusion criteria of the study were evaluated for socio-demographic variables, clinical features, coping styles using semi-structured pro forma.

Conclusion : Our population consisted of young adults(mean-30 yrs),mostly females(82%).Most of our patients were married(69%), comprising of housewives or students.43 % of the population had a past history of similar illness and a similar proportion had significant stressor provoking current episodes.

Predominant symptoms were unresponsiveness(39%) followed by SOB/palpitation(25%).The most used coping strategy was religious coping(94%) followed by "venting of emotions"(75%).Education, and Hinduism played minor protective roles while presence of stressor deployed both good and bad coping strategies and thus identified as the most vulnerable group in need of treatment .

Key words: *Conversion, problem-focussed coping, emotion focused coping, stressor.*

Introduction

Conversion disorder is a disorder characterised by motor, sensory, autonomic symptoms. The symptoms can affect multiple areas of the body(though not simultaneously) and cannot be explained by laboratory tests or physical conditions. There is an underlying theme of loss of integrity between consciousness, memory and and identity .i.e dissociation. There may be associated loss of sensation and loss of control of body movements which are supposed to have been precipitated or aggravated by a psychological stressful event(conflict)[1][2]The symptoms are produced ,though not consciously ,to get relief from the psychological conflict(Primary gain) and also to get attention from significant others(Secondary gain).Conversion patients form a major portion of psychiatric patients in developing countries[3][4][5]. Previous Indian studies evaluating clinical phenomenology have highlighted the role of stress[6][7] and 'modeling'[8] in producing conversion symptoms. However in DSM-5 ,a separate category called 'functional neurological disorder' has come for episodes removing the need for obvious stressors[9]. Previous Indian studies[10] also stressed that female sex, young age, low socio-economic status, joint family and illiteracy are potent risk factors for developing conversion. Illiterates and housewives were

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noted to be at highest risk.[11]However a recent study[12] found some contrasting characteristics regarding literacy and occupation of subjects(e.g students being the predominant sufferers).This finding and a dearth of studies regarding socio-demographic data and symptomatology in conversion patients of West Bengal prompted us to take up this study.

Coping is any effort at stress or conflict management. [13][14] These are done when demands are too taxing for the individual. It is mainly the strategies adopted by an individual in a stressful situation.

Coping may be of major two-types: problem focused coping and emotion-focussed coping.[15]

Problem -focused coping strategies are directed towards reducing or eliminating a stressor.[15] The COPE Inventory[16] Identifies active coping, planning, suppression of competing activities, restraint coping, seeking of instrumental social support as various types of problem-focussed coping .

Emotion-focussed coping strategies are directed towards changing ones emotional reaction.[15] The COPE inventory[16] include seeking of emotional social support, positive reinterpretation, acceptance, denial, religious coping as various types of emotion-focussed coping.

Ineffective strategies include: venting of emotions, behavioural disengagement, mental disengagement. These are mainly emotion-focussed but maladaptive.[16]

Meta-analyses of studies outside India have stressed the use of religious strategies for coping.[17]

DSM-5 have recently removed the need of underlying stressors for establishing diagnosis of Conversion disorder.

Material and Methods

Design:

It is a cross sectional descriptive study including diagnosed patients of conversion disorder.

Methodology

The psychiatric referrals from chest and medicine indoor patients department were screened for diagnosis of conversion disorder according to DSM-IV TR criteria. Consecutive diagnosed patients of conversion (using DSM-IV TR) were then interviewed for studying the socio-demographic characteristics ,clinical features and coping strategies for a 6-month period from July 2012 to December 2012.

Inclusion Criteria:

Cases obeying the criteria for conversion disorder according to DSM-IV TR were included .

Age >14 yrs

Exclusion Criteria:

No organic underlying cause.People with mental retardation were excluded from study.

TOOLS:

1) Structured clinical Interview for diagnosis according to DSM-IV(SCID)

2) Semi-structured pro forma incorporating the age, sex, marital status, education, occupation past and family history, clinical features was used.

3) COPE Inventory :Multidimensional inventory to assess the different ways in which different people react to stress.

5 scales measure aspects of problem focused coping(active coping, planning, suppression of competing activities, restraint coping, seeking of instrumental social support); 5 scales measure aspects of emotion-focused coping (seeking of emotional social support, positive reinterpretation, acceptance, denial, turning to religion); and 3 scales measuring less useful coping responses (focus on and venting of emotions, behavioral disengagement, mental disengagement). Cronbach's alpha for most items ranged above 0.6, which is quite acceptable.[15]

Results and Discussion

Results:

The socio-demographic variables of our study population are recorded in table 1.

The mean age of our study population was 30.25 yrs. The females greatly outnumbered males(82.4% vs 17.6%).

Most of the people were Hindus(52.1%),married(68.6%). Most of the population consisted of housewives(54.9%) followed by students(17.6%).43.1% had a past history of similar illness.Details of demographic variables have been depicted in Table 1.

Most common presenting symptom(39.2%) were unresponsiveness; followed by respiratory(like shortness of breath, chest pain) (25.5%) and pseudo-seizures(17.6%).

On evaluation we found that 45.1% had an obvious stressor prior to the incident while 54.9% had no significant stressor. Nearly all stressor were related to problem with spouses/primary support group. Nearly 43% had previous history of similar episodes of conversion.

TABLE 1
Socio-demographic profile of our conversion patients

Mean age	30.5 yrs(range14-40 yrs)	
Sex	Female: male4.7:1	
Religion	Hindus-52.1%;Muslims-47.9%	
Marital status	Married-68.6%,Unmarried-21.6%,widowed-5.9%,Divorced-2%,Remarried-2%	
Past History	Present-43.1%;absent-56.9%	
Educational status	Graduates	29.4%
	Illiterates	23.5%
	Primary school completed	13.7%
	Middle school completed	15.7%
	High school completed	9.8%
	Higher secondary	7.8%
Occupation	Housewives	54.9%
	Students	17.6%
	Semiskilled worker/ Laborer	11.8%
	Business	5.9%
	Teacher	5.9%
	Unemployed	3.9%

Now we applied the COPE inventory to assess the coping strategies used.

Regarding problem focused coping strategies ‘restraint’ was significantly unused(86%).’Active coping’ and ‘planning’ was used by 53% and 51% respectively while ‘suppression’ and ‘instrumental social support’ were used by 47% and 41% respectively

Regarding emotion-focused coping strategies, the strategies named 'acceptance' and 'emotional support' were used by 43% and 49% respectively; 'religious' strategy was used by almost all(94%);whilst denial and positive reinterpretation were rejected almost uniformly(96% and 98% respectively).

As regards the less useful strategies, 'behavioral disengagement' was used by 57% ;'venting of emotions' was used frequently(75%) and 'mental disintegration' was used relatively infrequently(33%).

Thus it appears that the significant coping strategies include: active coping, planning ,acceptance, suppression, instrumental social support, emotional support, behavioral disengagement, mental disengagement and venting of emotions.

The patients were stratified into 5 age groups(14-19 yrs,20-24 yrs,25-29 yrs,30-34 yrs,35-40 yrs) and then studied the various coping strategies with age.

Active coping was used differently by the youngest and oldest strata(29% vs 64%); whilst planning was not (43% vs 56%).Use of 'planning strategies' was lowest in middle strata(29%).

Suppression usage did not show marked variability(57% vs 48%);here also it was used sparingly(29%)

Instrumental support use increased with age(14% to 56%).

The use of acceptance however decreased with age(86% vs 32%) while use of emotional support strategy somewhat increased with age(42% vs 64%).

The usage of 'behavioural disengagement' as a strategy showed marked decline with age(100% vs 44%) while that of venting increased somewhat(57% vs 72%);highest use was seen by the middle strata(90%).

Mental disintegration use was lowest In oldest strata(20%);in other age-strata it was used more or less uniformly(40-50%).

Now we tried to find out the coping strategies according to sex, religion, marital status, occupation etc. The table below shows usage of various coping strategies in our subjects according to sex , religion , past history and presence of stressful events.

TABLE 2: COPING STRATEGIES USED VS CLINICO-DEMOGRAPHIC CHARACTERISTICS-I

COPING STRATEGY		SEX(Figure in bracket denote percentages)		RELIGION(Figure in bracket denote percentages)		PAST HISTORY(Figure in bracket denote percentages)		STRESSOR(Figure in bracket denote percentages)	
		Male (n=9)	Female (n=42)	Hindu (n=27)	Muslims (n=24)	Present (n=22)	Absent (n=29)	Present (n=23)	Absent (n=28)
Active coping	Present	6(66)	21(50)	18(66)	9(38)	12(55)	15(52)	16(70)	11(39)
	Absent	3(33)	21(50)	9(33)	15(62)	10(45)	14(48)	7(30)	17(61)
Planning	Present	7(78)	19(45)	16(59)	10(42)	12(55)	15(52)	15(65)	11(39)
	Absent	2(22)	23(55)	11(41)	14(58)	10(45)	14(48)	8(35)	17(61)
Acceptance	Present	3(33)	19(45)	12(44)	10(42)	11(50)	11(38)	13(57)	9(32)
	Absent	6(66)	23(55)	15(56)	14(58)	11(50)	18(62)	10(43)	19(68)
Suppression of competing activities	Present	6(66)	18(43)	13(48)	11(46)	13(59)	11(38)	13(57)	11(39)
	Absent	3(33)	24(57)	14(52)	13(54)	9(41)	18(62)	10(43)	17(61)
Instrumental Support	Present	2(22)	19(45)	13(48)	8(33)	10(45)	11(38)	12(52)	9(32)
	Absent	7(78)	23(55)	14(52)	16(67)	12(55)	18(62)	11(48)	19(68)
Emotional support	Present	3(33)	22(52)	15(56)	10(42)	12(55)	13(45)	16(70)	9(32)
	Absent	6(66)	20(48)	12(44)	14(58)	10(45)	16(55)	7(30)	19(68)
Behavioural disengagement	Present	4(44)	25(60)	14(52)	15(63)	15(68)	14(48)	10(43)	19(68)
	Absent	5(56)	17(40)	13(48)	9(37)	7(32)	15(52)	13(57)	9(32)
Mental disengagement	Present	2(22)	15(36)	6(22)	11(46)	6(27)	11(38)	7(30)	10(36)
	Absent	7(78)	27(64)	21(78)	13(54)	16(73)	18(62)	16(70)	18(64)
Venting out of emotions	Present	5(56)	33(79)	20(74)	18(67)	17(23)	21(72)	21(91)	17(61)
	Absent	4(44)	9(21)	7(26)	6(33)	5(77)	8(28)	2(9)	11(39)
Substance use	Present	4(44)	0(0)	3(11)	1(4)	1(5)	3(10)	3(13)	1(4)
	Absent	5(55)	42(100)	24(89)	23(96)	21(95)	26(90)	20(87)	27(96)

Table 3 shows coping strategies used vs rest of clinico-demographic characters(Marital status and system involved)

COPING STRATEGY		MARITAL STATUS(Figures in bracket indicate percentages)					SYMPTOMS(Figures in bracket denote percentages)				
		Married (n=35)	Unmarried (n=11)	widow (n=3)	Divorced (n=1)	remarried (n=1)	Chest (n=13)	Convulsion (n=9)	LOC (n=20)	Paralysis (n=3)	Multiple (n=6)
Active coping	Present	19(54)	6(55)	2(66)	0(0)	0(0)	7(54)	5(56)	9(45)	2(67)	4(67)
	Absent	16(46)	5(45)	1(33)	1(100)	1(100)	6(46)	4(44)	11(55)	1(33)	2(33)
Planning	Present	17(49)	8(73)	1(33)	0(0)	0(0)	7(54)	6(67)	7(35)	2(67)	4(67)
	Absent	18(51)	3(27)	2(67)	1(100)	1(100)	6(46)	3(33)	13(65)	1(33)	2(33)
Acceptance	Present	14(40)	7(64)	0(0)	1(100)	0(0)	8(62)	4(44)	8(40)	0(0)	2(33)
	Absent	21(60)	4(36)	3(100)	0(0)	1(100)	5(38)	5(56)	12(60)	3(100)	4(67)
Suppression of competing activities	Present	15(43)	7(64)	1(33)	1(100)	0(0)	8(62)	5(56)	6(30)	2(67)	3(50)
	Absent	20(57	4(36)	2(67)	0(0)	1(100)	5(38)	4(44)	14(70)	1(33)	3(50)
Instrumental Support	Present	16(46)	2(18)	2(67)	1(100)	0(0)	3(23)	3(33)	9(45)	2(67)	4(67)
	Absent	19(54)	9(82)	1(33)	0(0)	1(100)	10(77)	6(67)	11(55)	1(33)	2(33)
Emotional support	Present	18(51)	4(36)	2(67)	1(100)	0(0)	5(38)	3(33)	10(50)	2(67)	5(83)
	Absent	17(49)	7(64)	1(33)	0(0)	1(100)	8(62)	6(67)	10(50)	1(33)	1(17)
Behavioural disengagement	Present	18(51)	8(73)	1(33)	1(100)	1(100)	6(46)	4(44)	13(65)	2(67)	4(67)
	Absent	17(49)	3(27)	2(67)	0(0)	0(0)	7(54)	5(56)	7(35)	1(33)	2(33)
Mental disengagement	Present	10(29)	5(45)	1(33)	0(0)	1(100)	4(31)	4(44)	7(35)	1(33)	1(17)
	Absent	25(71)	6(55)	2(67)	1(100)	0(0)	9(69)	5(56)	13(65)	2(67)	5(83)
Venting out of emotions	Present	26(74)	8(73)	3(100)	0(0)	1(100)	10(77)	5(56)	15(75)	2(67)	6(100)
	Absent	9(26)	3(27)	0(0)	1(100)	0(0)	3(23)	4(44)	5(25)	1(33)	0(0)
Substance use	Present	3(9)	1(9)	0(0)	0(0)	0(0)	2(15)	1(11)	0(0)	1(33)	0(0)
	Absent	32(91)	10(91)	3(100)	1(100)	1(100)	11(85)	8(89)	20(100)	2(67)	6(100)

TABLE 3:USAGE OF COPING STRATEGIES VS CLINIC-DEMOGRAPHIC CHARACTERISTICS-II

Table 4 assesses the usage of various coping strategies vs rest of clinic-demographic variables(Occupation and education

COPING STRATEGY		EDUCATION(Fig in bracket show percentages)						OCCUPATION(Fig in bracket show percentages)					
		Illiterate (n=12)	Primary (n=7)	Middle (n=8)	High school (n=5)	H.S (n=4)	Post-grad (n=15)	Housewife (n=28)	Student (n=9)	Semiskilled worker(n=6)	Business(n=3)	Teacher (n=3)	Unemployed (n=2)
Active coping	Present	5(42)	1(14)	5(63)	2(40)	3(75)	11(73)	12(42)	6(67)	3(50)	3(100)	2(66)	1(50)
	Absent	7(58)	6(86)	3(37)	3(60)	1(25)	4(27)	16(58)	3(33)	3(50)	0(0)	1(33)	1(50)
Planning	Present	5(42)	0(0)	4(50)	2(40)	4(100)	11(73)	9(32)	7(78)	4(67)	3(100)	2(66)	1(50)
	Absent	7(58)	7(100)	4(50)	3(60)	0(0)	4(27)	19(68)	2(22)	2(33)	0(0)	1(33)	1(50)
Acceptance	Present	3(25)	4(57)	5(63)	2(40)	2(50)	6(40)	10(36)	5(56)	3(50)	1(33)	2(66)	1(50)
	Absent	9(75)	3(43)	3(37)	3(60)	2(50)	9(60)	18(64)	4(44)	3(50)	2(67)	1(33)	1(50)
Suppression	Present	5(42)	1(14)	5(63)	2(40)	1(25)	10(67)	9(32)	6(67)	4(67)	2(67)	2(66)	1(50)
	Absent	7(58)	6(86)	3(37)	3(60)	3(75)	5(33)	19(68)	3(33)	2(33)	1(33)	1(33)	1(50)
Instrumental Support	Present	6(50)	3(43)	2(25)	1(20)	1(25)	8(53)	13(46)	3(33)	3(50)	0(0)	2(66)	0(0)
	Absent	6(50)	4(57)	6(75)	4(80)	3(75)	7(47)	15(54)	6(67)	3(50)	3(100)	1(33)	2 (100)
Emotional support	Present	6(50)	4(57)	3(37)	1(20)	1(25)	10(67)	14(50)	4(44)	4(67)	0(0)	2(66)	1(50)
	Absent	6(50)	3(43)	5(63)	4(80)	3(75)	5(33)	14(50)	5(56)	2(33)	3(100)	1(33)	1(50)
Behavioural diseng-agement	Present	6(50)	7(100)	5(63)	3(60)	1(25)	7(47)	17(61)	6(67)	4(67)	0(0)	1(33)	1(50)
	Absent	6(50)	0(0)	3(37)	2(40)	3(75)	8(53)	11(39)	3(33)	2(33)	3(100)	2(66)	1(50)
Mental diseng-agement	Present	4(33)	2(29)	5(63)	2(40)	1(25)	3(20)	8(29)	4(44)	1(17)	0(0)	3 (100)	1(50)
	Absent	8(67)	5(71)	3(37)	3(60)	3(75)	12(80)	20(71)	5(56)	5(83)	3(100)	0(0)	1(50)
Venting out of emotions	Present	9(75)	6(86)	5(63)	4(80)	2(50)	12(80)	22(79)	7(78)	4(67)	1(33)	2(66)	2 (100)
	Absent	3(25)	1(14)	3(37)	1(20)	2(50)	3(20)	6(21)	2(22)	2(33)	2(67)	1(33)	0(0)
Substance use	Present	1(8)	0(0)	0(0)	0	0(0)	3(20)	0(0)	0(0)	3(50)	1(33)	0(0)	0(0)
	Absent	11 (92)	7 (100)	8 (100)	5 (100)	4 (100)	12 (80)	28 (100)	9 (100)	3 (50)	2 (67)	3 (100)	2 (100)

TABLE 4 : USAGE OF COPING STRATEGIES VS CLINIC-DEMOGRAPHIC CHARACTERS-III

We then used one way analysis of variance(ANOVA) to find out whether there was any statistical significance in the coping strategies used when assessed across various clinic-demographic variables. The results are shown in table 5.

TABLE 5: STATISTICAL SIGNIFICANCE OF THE COPING STRATEGIES AS ASSESSED AGAINST VARIOUS CLINICO-DEMOGRAPHIC VARIABLES

Coping strategies	P-values of different clinico-demographic variables								
	Age	**Sex**	**Religion**	**Marital status**	**Occupation**	**Past History**	**Symptom**	**Stressor**	**Education**
Active coping	0.491	0.373	0.038	0.667	0.475	0.845	0.889	0.031	0.121
Planning	0.561	0.579	0.218	0.348	0.062	0.665	0.449	0.067	0.007
Acceptance	0.385	0.522	0.845	0.179	0.85	0.399	0.376	0.083	0.646
Suppression of competing activities	0.652	0.202	0.872	0.472	0.352	0.139	0.404	0.228	0.222
Instrumental social support	0.415	0.211	0.293	0.24	0.436	0.597	0.359	0.154	0.649
Emotional support	0.311	0.309	0.332	0.567	0.566	0.502	0.341	0.007	0.430
Behavioural disengagement	0.299	0.417	0.454	0.465	0.389	0.161	0.746	0.083	0.163
Mental disengagement	0.031	0.446	0.077	0.49	0.096	0.434	0.874	0.698	0.500
Venting out of emotion	0.624	0.157	0.941	0.386	0.587	0.7	0.443	0.012	0.779
Substance Use	0.613	0.00	0.367	0.979	0.00	0.456	0.203	0.219	0.427

When the usage of various coping strategies was assessed against age, only the usage of mental disengagement appeared to be statistically significant(P value-0.031).

When assessed across sex, only the usage of 'substance use' coping strategy appeared statistically significant(P value 0.00).

The usage of "active coping" as coping strategy was statistically significant, when assessed across religion(P value 0.038),66% of Hindus applied this against 38% of Muslims.

Marital status did not affect the coping strategies used (P-value >0.05 for all strategies).

Occupation also did not affect much the usage of coping strategies(planning and mental disengagement came close with P –values close to 0.05).Substance use was however significant(P-value 0.0) especially among semi-skilled workers(50%) and businessmen(33%). Planning was least used by housewives(32%) and unemployed(50%) compared to others(66-100%)

Past history of illness and system involved did not have much bearing on the usage of various coping strategies(P-value >0.05).

Presence of stressor, however significantly affected the usage of "active coping"(P-value 0.031),"emotional support"(P-value 0.007) and "venting of emotions"(P-value 0.012).It also affected uses of "planning", "acceptance" and "behavioural disengagement" also with P-values being very close to statistically significant(0.06 to 0.08).

Education significantly affected the usage of "planning"(P-value 0.007).Most of the illiterates preferred "venting out" as the strategy(75%) while all other strategies were used less.

Age significantly affected the usage of "mental disengagement" coping strategy.

Discussions

We conducted an observational study on 51 consecutive patients of conversion in a tertiary referral centre in West Bengal for clinic-demographic variables and to study the coping strategies employed by them.

In our study females greatly outnumbered males(82.4% vs 17.6%) ,a fact seen in earlier Indian studies as well .[10][11]Most of our patients belonged to the age group 35-40 yrs(47%) which is in contrast to the earlier Indian studies[12] which reported conversion to be commoner among younger adults. About 77% of our population were literates ,similar to the rates noted in earlier Indian study (80%). [12]However 47% of our population had at least 10 yrs of formal education(high school passed and above), which is again in contrast to the previous Indian study.[12]

Hindus accounted for 51% and muslims 49%. Religion had a great impact on education(P-value 0.00).

The average age of our population was 30.5 yrs and female majority meant most of them were married (68.6%)and were housewives(54%) .This was in contrast to a previous Indian study[12] which noted students as the majority group. However most of other previous Indian studies[11] have noted housewives to be the predominant group.

Most common presentation was that of unresponsiveness. respiratory symptoms and pseudo seizures respectively.This is again in contrast to the previous Indian study[12] which reported pseudo seizure as most common(71%) as well as other studies outside India[18] which reported paresis to be the most common presenting symptom.

In our population 45% had an obvious stressor provoking the episode and a high proportion of married people meant that nearly all of them were due to problem with spouse .This is an important finding in the light of DSM -5 which has eliminated the need for presence obvious stressor.

Coming to the usage of coping strategies we found a that the clinico-demographic variables affected the various strategies used in an interesting manner.

Regarding the problem-focussed coping strategies, usage of active coping was shaped mostly by stressor,religion(Hinduism) and somewhat by education. The people on the oldest age bracket however preferred to use it,though there was no statistically significant impact of age on usage of active coping. Sex, marital status, occupation had little effect on usage of this strategy.

Usage of 'planning' was significantly affected by education .Thus education appear protective for patients.

The coping strategy 'restraint' was almost universally rejected.

Usage of 'instrumental social support' was not significantly affected by the clinic-demographic variables.

Coming to emotion-focussed coping, 'religious coping' was the universal strategy irrespective of clinic-demographic variables.

Usage of 'acceptance' was not significantly influenced by any factors.

Usage of 'emotional social support' was greatly influenced by presence of stressor(P-value of 0.007) while other factors had little impact.

The useful strategies of 'denial' and 'positive reinterpretation and growth' were unfortunately universally rejected.

Coming to the less useful strategies, usage of 'behavioural disengagement' was not significantly affected by any variables.

Usage of 'mental disengagement' was significantly influenced by age(P-value 0.03) with people in the eldest group using it the least.

Usage of 'venting out' was significantly influenced presence of stressor(P-value 0.012).

Usage of substance use was heavily influenced by sex and occupation(p-value 0.00) for obvious reasons.

Thus we find the protective influence of education and age as it encouraged more use of problem focused coping strategies like active coping and planning and shut out the avoidance coping strategies like 'mental disengagement' or 'behavioural disengagement'.

Hindu religion and employment appeared protective as they encouraged usage of 'active coping' and 'planning'respectively. This is probably the effect of religion on education(P-value 0.00)

Presence of stressor was the single most important factor; it seemed to deploy most of the coping strategies. But it also brought with it ineffective and potentially dangerous strategies like 'venting of emotions' .Thus this group identified as the potential vulnerable group in need of treatment.

There were some good strategies that were universally rejected like restraint, denial, positive reinterpretation and growth and humour.

Religious coping was universally used as demonstrated by previous studies.[17]

Conclusions and Recommendations

Our study showed that conversion is a disease of young people, particularly housewives and is quite prevalent among literates. Presence of education and employment helps in the development of some adaptive problem-focussed and emotion-focussed strategies. However presence of stressor made the people deploy a large number of strategies some of which may be harmful. Thus the people with stressor appeared to be most vulnerable and in urgent need of treatment. Some useful problem and emotion-focussed coping strategies which were virtually rejected by the people, could be instilled in them to help them adapt better.

Our study was hospital based, cross-sectional ,had a small sample size and the patients were not followed up. Larger community-based longitudinal studies are needed to identify the maladaptive coping strategies more accurately and also to study the impact of socio-demographic variables , the analysis of which has so far yielded different results in various Indian studies.

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