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Clinical Profile and Sociodemographic and Psychosocial Correlates of Conversion Disorder in a Tribal Population of Maharashtra.

Abstract:

Background:

Conversion disorder, also known as functional neurological symptom disorder, is characterized by neurological symptoms that are not explained by underlying organic pathology. Psychosocial stressors are frequently implicated in its onset, making it essential to explore clinical patterns alongside sociodemographic and stress-related factors.

Aim:

To assess the clinical presentation, sociodemographic characteristics, and associated psychosocial stressors among patients diagnosed with conversion disorder.

Methods:

A cross-sectional descriptive study was conducted in the Department of Psychiatry of a tertiary care hospital in Tribal region in Maharashtra from May 2025 to October 2025. A total of 25 patients fulfilling ICD-10 diagnostic criteria for dissociative (conversion) disorder were included. Data were collected using a semi-structured pro forma capturing demographic variables, clinical features, and precipitating stressors.

Results:

The mean age of the participants was approximately 21 years, with the majority belonging to the 18–30-year age group. Females constituted 64% of the sample. Most participants were students or homemakers and belonged to rural, nuclear family backgrounds. Motor symptoms were the predominant clinical presentation (84%). Psychosocial stressors were identified in 92% of cases, with family and marital conflicts being the most common (40%),

followed by academic stress (16%) and Ashramshala-related stressors (12%). A statistically significant association was observed between age group and type of stressor ($p < 0.05$).

Conclusion:
Conversion disorder is closely associated with identifiable psychosocial stressors, particularly among young females in tribal populations. Unique contextual factors such as residential Ashramshala schooling systems may contribute to vulnerability. Early recognition and culturally sensitive interventions are crucial for improving outcomes
Introduction:

Conversion disorder, currently termed functional neurological symptom disorder (FND) in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), presents with neurological symptoms that are incompatible with recognized neurological or medical conditions (1). These symptoms commonly involve motor or sensory dysfunction, including weakness, abnormal movements, non-epileptic seizures, blindness, aphonia, or gait disturbances, and are associated with significant distress or impairment in functioning (1,2).

Historically, the conceptualization of conversion disorder can be traced back to Sigmund Freud, who proposed that unconscious psychological conflicts are “converted” into physical symptoms as a defense mechanism (3). Although contemporary understanding has evolved beyond purely psychodynamic explanations, the biopsychosocial model remains central, emphasizing the interaction of psychological vulnerability, neurobiological factors, and environmental stressors in the genesis of symptoms (4).

Epidemiological studies indicate that FND is more prevalent among females, children and adolescents, and individuals from lower to middle socioeconomic backgrounds (5). In

pediatric populations, conversion disorder often presents with acute onset of symptoms following identifiable stressors, such as academic pressure, family conflicts, or interpersonal difficulties (6). Psychosocial stressors play a crucial role as precipitating factors, with evidence suggesting that adverse life events and maladaptive coping mechanisms contribute significantly to symptom development (7).

Clinical presentations are heterogeneous, with dissociative seizures (previously termed pseudoseizures) being among the most commonly reported manifestations in children and adolescents (2). Despite the absence of identifiable organic pathology, these symptoms are associated with considerable functional impairment, increased healthcare utilization, and diagnostic challenges for clinicians (4).

In the Indian context, sociocultural factors such as stigma, limited mental health awareness, and somatization tendencies influence both the expression and interpretation of psychological distress (8). Studies from India have highlighted the prominence of dissociative and conversion disorders in pediatric psychiatric populations, often linked to psychosocial adversity and environmental stressors (9,10). However, there remains a paucity of data from tribal regions of Maharashtra, where unique sociocultural dynamics, residential schooling systems (e.g., Ashramshala schools), and limited access to mental health resources may further shape the clinical profile and etiological factors of conversion disorder.

Given this background, the present study aims to explore the clinical presentation, sociodemographic correlates, and associated psychosocial stressors in children and adolescents diagnosed with conversion disorder in a tribal population of Maharashtra, thereby addressing an important gap in region-specific psychiatric literature.

Materials and Methods:

Study Design and Setting

The present study was designed as a cross-sectional descriptive study conducted in the Department of Psychiatry of a tertiary care teaching hospital situated in a tribal region of Maharashtra, India. The study was carried out over a duration of six months, from May 2025 to October 2025.

Sample Size and Sampling Technique

A total of 25 participants meeting the predefined criteria were included in the study. Subjects were recruited using a convenience sampling method, based on their availability during the study period.

Inclusion Criteria

•Individuals aged 6 years and above

•Patients diagnosed with dissociative (conversion) disorder according to ICD-10diagnostic criteria

•Participants who provided informed consent (and assent in case of minors)

Exclusion Criteria

•Patients with known neurological conditions such as epilepsy or organic brain disorders

•Presence of major psychiatric comorbidities including psychotic disorders or severe mood disorders

•Cases where symptoms could be attributed to substance use or medical causes or other psychiatric condition

Study Instrument

Data were collected using a pre-designed semi-structured proforma tailored for the study. The instrument was developed to systematically record relevant information under the following domains:

•Sociodemographic variables: age, gender, education, occupation, marital status, residence, family type, and socioeconomic status

•Clinical characteristics: duration, onset, and course of illness

•Symptom profile: classification into motor, sensory, dissociative, or mixed presentations

•Psychosocial stressors: identification and categorization of precipitating factors such as family conflict, academic pressure, and occupational stress

•Background variables: past psychiatric history, family history, and substance use

•Treatment history: previous consultations and type of interventions received

Study Procedure

Each participant underwent a comprehensive clinical assessment, including detailed psychiatric history taking and mental status examination. Information was obtained from both patients and accompanying caregivers wherever necessary to ensure accuracy. The diagnosis of dissociative (conversion) disorder was established by a qualified psychiatrist in accordance with ICD-10 criteria. (2) Relevant medical and neurological conditions were excluded through clinical evaluation and review of available investigations.

Ethical Considerations:

The study protocol was reviewed and approved by the Ethics Committee prior to commencement. Written informed consent was obtained from all participants, and assent was obtained from minors along with parental consent.

Statistical Analysis:

Data were compiled and analyzed using Microsoft Excel.

•Descriptive statistics were applied to summarize categorical variables in terms of frequency and percentage

•Inferential analysis was performed using the Chi-square test to examine associations between categorical variables

•A p-value of less than 0.05 was considered statistically significant

Results:

A total of 25 patients diagnosed with conversion disorder were included in the study. The mean age of the participants was approximately 21 years, with the majority belonging to the 18–30-year age group, followed by children and adolescents.

Females constituted the larger proportion of the sample (n = 16, 64%), while males accounted for n = 9 (36%). Most participants were either students (n = 12, 48%) or homemakers (n = 10, 40%), with a smaller proportion being employed and unemployed.

A significant number of patients were from rural backgrounds (n = 16, 64%) and belonged to nuclear families (n = 19, 76%). The majority were from middle socioeconomic status (n = 17, 68%).

Psychosocial stressors were identified in 92% of patients, with family and marital conflicts being the most common in adults and academic stress in younger individuals.Among identified stressors, family and marital conflicts were the most common (40%), followed by academic stress (16%) and Ashramshala-related stressors including separation from caregivers and residential schooling factors (12%)

No statistically significant association was found between gender and presence of stressors ($\chi^2 = 0.02$, $p = 0.88$).

However, a trend towards higher stressors in females was observed.
A statistically significant association was observed between age group and type of stressor ($p < 0.05$), with academic stress predominating in younger individuals and family-related stress in adults.

Comparison with Previous Studies:

The findings of the present study are consistent with previous Indian studies which have reported higher prevalence of conversion disorder among females and young individuals. (19,20) Like Deka et al. and Gupta et al., motor symptoms were the most common presentation. (19,20,22) The predominance of psychosocial stressors aligns with findings from Reddy et al. (21)

Table 1: Sociodemographic Profile

Variable

Frequency

Percentage

Female

16

64%

Male

9

36%

Rural

16

64%

Nuclear family

19

76%

Middle Socio economic status

17

68%

Table 2: Clinical Presentation

Symptom Type

Frequency

Percentage

Motor

21

84%

Mixed

3

12%

Sensory

1

4%

Table 3: Presence of Stressors

Category

Frequency

Percentage

Present

23

92%

Absent

2

8%

Figure 1: Gender Distribution

Figure 2: Symptom Distribution

Figure 3: Presence of Psychosocial Stressors

Clinical Presentation

Motor symptoms were the predominant presentation, observed in n = 21 patients (84%).

The most common symptoms included:

- Pseudo seizures (n = 5, 20%)
- Syncopal episodes/unresponsiveness (n = 5, 20%)
- Weakness/paralysis (n = 4, 16%)
- Hyperventilation (n = 2, 8%)
- Aphonia/dysphonia (n = 2, 8%)
- Other less frequent symptoms included abnormal gait and sensory disturbances

Mixed symptom presentations were noted in n = 3 patients (12%), while isolated sensory symptoms were rare (n = 1, 4%).

Figure 4: Clinical Presentation Distribution

Motor symptoms were predominant, with pseudoseizures and syncopal episodes being the most frequent presentations, followed by weakness, hyperventilation, aphonia, and mixed symptom profiles

Psychosocial Stressors

An identifiable psychosocial stressor preceding symptom onset was present in n = 23 patients (92%)

Among children and young adults, the most common stressors were:

- Academic/school-related issues (n = 4, 16%)
- Parental conflicts or family dysfunction (n = 3, 12%)
- Ashramshala-related Stress (separation, residential schooling, bullying) (n=3, 12%)

Among adults, the predominant stressors included:

• Family/marital conflicts (n = 10, 40%)

• Work-related stress (n = 3, 12%)

A small proportion of patients (n = 2, 8%) did not report any identifiable stressor

Table 4: Psychosocial Stressors Distribution

Stressor Type

Frequency (n=25)

Percentage

Family/Marital Conflict

10

40%

Academic Stress

4

16%

Ashramshala-related Stress (separation, residential schooling)

3

12%

Parental/Family Issues

3

12%

Work-related Stress

3

12%

No Stressor

2

8%

Figure 5: Psychosocial Stressor Distribution

Family and marital conflicts were the most common psychosocial stressors, followed by academic stress and Ashramshala-related stressors. A smaller proportion reported parental issues, work-related stress, or no identifiable stressor.

Table 5: Summary of Key Findings

Parameter	Frequency	Percentage
Female	16	64%
Male	9	36%
Motor Symptoms	21	84%
Mixed Symptoms	3	

12%

Sensory Symptoms

1

4%

Stressors Present

23

92%

Stressors Absent

2

8%

Discussion:

The present study demonstrates a clear predominance of conversion disorder among young females, consistent with previous Indian studies (8,19,20). The higher representation of students and homemakers suggests increased vulnerability in populations exposed to psychosocial stressors with limited coping mechanisms.

Motor symptoms, particularly pseudoseizures and syncopal episodes, were the most common clinical presentations, aligning with prior literature (19,20,22). This reinforces the need for careful clinical evaluation to avoid unnecessary neurological investigations and misdiagnosis.

A key finding of this study is the high prevalence (92%) of identifiable psychosocial stressors preceding symptom onset, supporting the central role of psychosocial factors in the etiopathogenesis of conversion disorder (10,11). Unlike Western literature, where trauma and abuse are more frequently reported (11), such factors were less prominent in

this population, highlighting important cultural variations in symptom expression.

A particularly significant contribution of this study is the identification of Ashramshala-related stressors as an important contextual factor. Residential schooling systems involve prolonged separation from caregivers, which may disrupt attachment and contribute to emotional distress in children (15,16). Additionally, academic demands in these structured environments may exceed coping capacities (23,24), while peer-related stressors such as bullying further increase psychological vulnerability (25–27).

Limited access to emotional support and mental health services in tribal and residential school settings may lead to somatization of psychological distress, manifesting as conversion symptoms (28). These findings strongly support the biopsychosocial model (5) and underscore the importance of contextual and cultural factors in understanding conversion disorder.

From a clinical and public health perspective, these findings highlight the need for:

- School-based mental health programs
- Early screening in residential schools
- Sensitization of teachers and caregivers
- Integration of culturally appropriate intervention

Conclusion:

The present study emphasizes that conversion disorder is closely linked to psychosocial stressors and is more frequently observed among young individuals, particularly females from rural and tribal backgrounds. The predominance of motor symptoms highlights the importance of careful clinical assessment to prevent misdiagnosis and unnecessary medical interventions.

A key finding of this study is the increased vulnerability among children residing in residential educational settings such as Ashramshala schools. Factors such as prolonged separation from family, academic pressure, peer-related stress including bullying, and limited access to emotional support systems appear to contribute significantly to the development of conversion symptoms in this group.

These findings reinforce the importance of adopting a biopsychosocial approach in understanding and managing conversion disorder (5). Early identification of underlying stressors, along with culturally sensitive and context-specific interventions, is essential for improving clinical outcomes.

There is a pressing need to strengthen mental health awareness and implement school-based mental health programs in residential and tribal educational settings. Training teachers and caregivers to recognize early signs of psychological distress can facilitate timely intervention and reduce the risk of chronicity.

Limitations: -

Although limited by a small sample size and cross-sectional design, this study provides valuable insights into the unique psychosocial determinants of conversion disorder in underserved populations. Future research with larger samples and longitudinal designs is recommended to further explore these associations and guide targeted interventions

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Conflicts of Interest & Financial Disclosure:

None of the authors have any financial or conflicting interests to disclose.

Availability:

On Data can be made available upon request. The corresponding author has full access to all the data in the study

and takes responsibility for the integrity of the data and accuracy of the data analysis.

Keywords:

Conversion Disorder; Functional Neurological Symptom Disorder; Psychosocial Stressors; Sociodemographic Factors; Tribal Population; Clinical Profile; Cross-Sectional Study

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