Studying Lived Experiences of Psychologists and Psychiatrists to Treat and Diagnose Conversion Disorder: An in-depth Analysis

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A thesis submitted in the fulfillment of the requirements
for the award of the degree of Master of Sciences
(Clinical Psychology)

Department of Professional Psychology

BAHRIA UNIVERSITY ISLAMABAD

JULY, 202

Approval for Examination

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DEDICATION

This dissertation is a tribute to the All-Powerful Allah, the universe's creator. This thesis is dedicated to my devoted parents, Mr. Sultan Faisal and Ms. Muquddus Begum, as well as my devoted siblings, Shahzad Faisal, Saud Faisal, Hawwa Noor, and Sultan Adam, who have supported me every step of the way. Last but not least, I dedicate this thesis to myself for persevering throughout the entire process.

ACKNOWLEDGMENT

First and foremost, I want to express my gratitude to Allah, the Almighty, the Most Gracious, the Most Merciful, the Lord of the 'Alamin (humankind, jinns, and everything that exists), for giving me the strength and assurance to complete this task.

My sincere gratitude goes out to my renowned supervisor, Dr. Shazia Yousaf, an amazing woman who has accompanied me with every step of my research endeavor. My ability to complete this thesis was facilitated by her direction and support. I'm confident that without her unwavering support and dedication, my thesis would not have been finished.

I also want to express my gratitude and appreciation for all of my instructors, especially Dr. Noshi Erum Zaman, Dr. Wizra Saeed, and Ma'am Ambreen, who have served as my mentors throughout my academic journey.

I owe my university a huge debt of gratitude for giving me the chance to do this task. My sincere gratitude also goes out to university librarians for their aid in providing pertinent materials.

My sincere and warm thanks to all my family and friends especially Iqra jabeen, who was there with me throughout this journey and guided me with every bit of the details selflessly, and Sila Rehmani, whose emotional support and positive statement kept me motivated throughout the journey, Qubsha Munir, for giving me the best advices which were worthy enough to look up to and Shahana Karim who selflessly provided me with the exciting and comfortable ride back home after a

tiresome day. I am very grateful to all of them who have helped me in carrying out this research.

I would like to thank my beloved mother for her precious prayers, support, and cooperation during the research process, and my deepest gratitude to my dearest father to fulfill my every need. Without their support, it was not possible for me to complete my thesis.

I am also grateful to respected Ms. Aiman who allowed us to sit in the well-being center to work in a peaceful environment.

A special thanks to all the participants especially, I am extremely thankful for their patience and interest in being involved in research.

ABSTRACT

The current research study was aimed at exploring the lived experiences of the Psychologists and Psychiatrists currently practicing in hospitals of Islamabad and Rawalpindi and private clinics in the field of Psychiatry and dealing with clients diagnosed with Conversion Disorder (CD). Semi-structured interviews were conducted to collect data. Ten participants were interviewed and were taken from hospitals of Islamabad and Rawalpindi. The Interpretative phenomenological approach (IPA) was used for data analysis. The major identified super-ordinate themes from interviews of Psychologists are: Diagnostic complications, Therapeutic failures obstacles, Therapeutic procedures and the superordinate themes identified from Psychiatrists interviews are: Assessment measures, Challenges in treatment, Treatment strategies. The current study highlighted the need for raising awareness about the significance of creating a special rehabilitation facility in hospitals for CD clients where the client's physical, emotional, and social needs are taken into consideration.

Keywords: *CD, Pseudo-seizures, Epilepsy, Psychologists, Psychiatrists*

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LIST OF ABBREVIATIONS

CD	Conversion Disorder
FNSD	Functional Neurological Symptoms Disorder
PNES	Psychogenic Non-epileptic seizures
SDs	Somatic Disorders
IPA	Interpretative Phenomenological Analysis
MRI	Magnetic Resonance Imagination
EEG	Electroencephalogram
CT	Computed Topography
TT	Trauma Therapy
PT	Physical Therapy
CBT	Cognitive Behavior Therapy
DBT	Dialectical Behavior Therapy

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CHAPTER 1

INTRODUCTION

As Conversion Disorder, is one of the most common disorders in people from rural regions, its care is difficult owing to factors including the client's lack of knowledge about this specific disorder, lack of education, and dependency on elderly family members.

Conversion Disorder's original definition, which has its roots in Sigmund Freud's psychoanalytic ideas, said that the "psychological" gets "converted" into the "physical." For instance, it was thought that a client who experienced severe seizures and could not relate to sentiments of anger was repressing painful emotions (Phoenix et al., 2017).

1.1 Background

Conversion Disorder is defined by the Diagnostic and Statistical Manual of Mental Disorders as neurological symptoms such as weakness, numbness, and occurrences that resemble seizures, anesthesia, swallowing difficulties, motor tics, difficulty walking, hallucinations, and dementia. Clients with CD's experience such symptoms as a result of a psychological reasons not because of any biological reasons (DSM-IV-TR, 2022).

Conversion Disorders, is characterized by neurological symptoms that are not led on by a medical reason. These features are real and not imagined, and they can have an impact on motor skills and perceptions. The diagnosis of CD is made when a person exhibits physical symptoms that do not seem to be related to a medical illness. (Smith, 2019).

In the course of human history, the CD has been identified, examined, and treated. CD was assumed to be a neurological condition in the nineteenth century, but there was no neuropathological explanation for it. Malingering was frequently confused with it. CD was transformed into a psychiatric illness according to "Janet and Freud's" beliefs, but as old concepts of CD fade in popularity and a neurobiology of conversion remains unknown, neurologists are once again confronted with a difficulty of no accepted model. Despite their support for psychological models, neurologists did not understand their clients in terms of physiology. The severity and irregularity of conversion, on the other hand, set it out clinically from other unexplained illnesses (Kanaan et al., 2009).

Many individuals didn't understand the difference between symptoms of CD and faking (Malingering). They regarded clients presenting with conversion symptoms as “agnostic" in terms of Neuro-biological theories. However, because neurologists have greater experience and expertise in this condition than psychiatrists in some areas, their persistent support for the cognitive behavioral model is noteworthy and warrants more investigation. One of the reasons for the model's durability is because it's used as a diagnostic tool to distinguish between conversion symptoms with a medical explanation and those symptoms whose origin is not based on a medical explanation (Kozlowska, 2005).

Conversion Disorder has been investigated since the early 1980s, although they remain challenging to identify and are contentious (Martini et al., 2014). Both physicians and clients must deal with the significant repercussions of this unresolved issue of diagnosing (Rosendale et al., 2018). The absence of standardized concepts for diagnosing and categorizing CD and somatic diseases is one of the key reasons that the medical community continues to remain perplexed. It means that conversion disorder was confused as psychological or physiological disorder. Some clinicians in past believed it falls under the

category of psychological domain and some clinicians believed it falls under the category of biological domain. The terms medically unexplained symptoms (MUS) and medically unexplained physical symptoms (MUPS) were frequently used interchangeably while diagnosing Conversion Disorder (Dinwiddie et al., 2013).

Many of the phrases used, such as "psychogenic" and "conversion," could be imprecise since psychologists and psychiatrists find it challenging to explain them (Daum et al., 2013). Since the term MUS does not suggest the existence of a pathogenic medical condition, general practitioners prefer to use it. However, a label like MUS doesn't tell us much about the pathophysiology of CD, leading some clients to believe they are "faking" their illness or that they must "prove" their condition. Because of this, it may be challenging to understand and integrate the client's situation (Kapland et al., 2013). Therefore, describing functional symptoms is a crucial component of treatment for CD and other somatic diseases in order to prevent confusing the clients about their condition and for which proper phrasing is essential (Reuber et al., 2015).

Another factor contributing to the problem in diagnosing CD is that it does not clearly fit into one group but rather varies greatly between the areas of neurology (the brain) and psychiatry (the mind). CD defies the dualistic division of mind and body since the body seems to be exhibiting symptoms, yet the mind is still the center of study (Rickards et al., 2014).

Based on the various functional neurological symptoms (FNS), clinical manifestations of CD might vary, but they must be severe enough to hinder function and require urgent medical attention. Symptoms can impact how the body moves, how it works, and how it is being perceived by them. Functional neurologic disorders are not understood to have a specific etiology. Based on the presentation of functional neurological symptoms, several processes are thought to play a role in the various theories about what occurs in the brain to develop symptoms. Therefore, even in the absence of sickness or abnormality, regions of the brain that regulate the operation of the muscles and senses may be implicated (Aminoff et al., 2021).

Symptoms of CD might arise unexpectedly after a traumatic experience or after a distressing incident. Modifications or abnormalities in the brain's anatomical, cellular, or metabolic processes may also act as triggers (Gilmour et al., 2020).

Theories have postulated that the disorder can be caused by a predisposition to, or be sustained by psychological, social, or biological factors. A trauma, a traumatic life experience, or an acute or ongoing stressor frequently precedes CD's symptoms. It is common to find that people with CD have a history of sexual and emotional abuse during childhood. CD is also psychologically influenced by ineffective coping mechanisms and underlying emotional conflicts. In comparison to clients with recognized neurological conditions, a client with CD is more likely to have specific psychological illnesses such as depression, anxiety, and personality disorders (Jessica et al., 2021).

Additionally, clients may also experience various somatic symptoms, including persistent pain, lethargy, or generalized weakness. The signs of CD may be "triggered" by physical trauma or genuine neurologic illness such as seizure or migraine. Clients who live in underdeveloped or rural areas, have lower socioeconomic levels, have less education, and are more prone to acquire CD (Rosaria et al., 2021).

1.1.1 Theoretical framework of Conversion Disorder

The theory that is followed throughout this research is theory presented by "Sigmund Freud".

1.1.1.1 Theory of Somatoform disorders and Immature Defense mechanisms

The founder of Psychoanalysis, Sigmund Freud, had a strong opinion on Conversion Disorder. Early in his career, Freud believed that conversion illness, previously known as hysteria, was a trauma-based condition. The somatization of hysteria, however, were subsequently interpreted by Freud as the consequence of a mental defense mechanism and were considered as symptoms of CD. The suppression of mental distress by CD's clients is seen from a Freud's theory viewpoint as a psychosomatic pathology, which is seen to be a defensive strategy for hysterical personas (Rosenbach et al., 2021).

The psychological underpinnings and causation of CD were explained by Freud. He believed that when a client has an urge or need that is suppressed owing to negative emotions like fear, rage, humiliation, or remorse, it manifests physically. The client really displays a figurative resolution to the same underlying mental condition as a consequence (Danielle et al., 2017).

Additionally, Freud once believed that hysteria was an indication of a theatrical, extraverted, egocentric, deceitful, and reliant individual. This viewpoint is no longer prevalent because these insights are seen as being too comprehensive because they disregard sociological, cultural, and spiritual components (Schwartz et al., 2011).

In Freud's work, he emphasized how suppressing tragic experiences for example sexual abuse could lead to conversion symptoms because they are too upsetting to be let into conscious awareness (Phoenix et al., 2017).

There are several other theories that are elaborated by clinical psychologists, neurologists and psychiatrists, and various other researchers such as "Perrie Janet". Janet's theory offers an alternative understanding in comparison to Freud's theories. Janet, a French psychologist who identified somatization in his traumatic clients as characteristic of hysteria now called as Conversion Disorder. He classified FNSD as a dissociative condition. Janet explained that: the primary fundamental issue is a deterioration of the capacity to carry out

intellectual or emotional distress at the same time, which leads to a reduction in the range of an individual's cognition, thus affecting one's own deeper understanding. (Paulraj et al., 2020).

About CD, Janet presented a "Diathesis-Stress-Trauma Model in which tension or trauma sets off thoughts and feelings that have an impact on a client's permanent thoughts. The individual with CD will not be able to handle the psychological strain and will have diminished personal consciousness. Along with diminished personal consciousness, it includes dissociation. The client's management ability is inclined and can only embrace a small number of feelings and concepts (Buhler et al., 2011).

Janet has explained that the fundamental symptoms of CD are evidence of the central nervous system's deterioration and weariness. According to Janet, the occurrence should be considered considering the surrounding factors rather than as a personal failing, and it is not classified as either good or bad. According to Janet, this disability was indeed a result of how individuals cope with and respond to difficult, traumatic events (Janet, 1989).

Social Learning theory by "Albert Bandura" demonstrates a different perspective on CD. According to Bandura, environmental conditions and individual characteristics have a significant impact on how individuals behave (Bandura, 1977).

Client could imitate the defense strategies they observe in their family and friends, particularly in their parents and other role models. Client will also communicate their emotions in a way that is accepted by society (Grace et al., 2021).

In eastern cultures like Pakistan an individual most typically exhibit bodily symptoms to express their emotional distress, because members of the family and caregivers are more likely to react to biological ailments than psychological ones (Mehmed et al., 2016). In the past, various researches have shown definite connections between CD, trauma, dissociation, human emotions, and suppression (Phoenix et al., 2017).

1.1.2 Models of Conversion Disorder

Conversion Disorder is mostly explained by following models:

1.1.2.1 Cognitive-behavioral model: According to a well-researched paradigm, memory traces of a particular symptom may be formed after awareness and knowledge about it. When a person becomes too concerned with or begins to search for symptoms of the condition, this depiction is said to be "activated," which leads to CD (Cascella et al., 2018). This stimulation crosses a cognitive boundary where it predominates over visual receptors and manifests as a real physical complaint. An illustration of this would be if someone witnessed a seizure on television or in film and then summoned up a memory or mental image of it. Subsequently, they feel anxious, or dizzy, and fear that they could be having pre-seizure signs. Because of their fear of having a seizure, a past seizure that has already occurred is brought to mind. Their conversion seizure fit is brought on by this triggered system. According to cognitive-behavioral frameworks, people naturally and unconsciously analyze their behaviors and perceptions. This model claims that psychological impact at intermediate stages of thinking may induce conversion symptomatology (Maria et al., 2021).

1.1.2.2 Neuro-biological Model: This model claims that CD is thought to be caused by modifications in orbitofrontal cortex functioning. The overall, hypothesis is that psychological pain or distress may excite prefrontal and thalamic parts of the brain, which further results in transmission to regulatory basal ganglia thalamocortical circuits, which subsequently lessen cognitive sensation or muscular functioning (Peeling et al., 2021).

Neurobiological researches suggest that, the left dorsolateral prefrontal cortex of people with CD has diminished functioning. The role of desire and commanded behavior is handled by the left dorsolateral prefrontal cortex region of the brain. With the use of Functional Magnetic Resonance Imaging (FMRI), these results were obtained after studying various clients with CD and other somatoform disorders. Results suggested that clients

suffering from CD are distinguishable from those who are diagnosed with Malingering (Spencer et al., 2017).

In 2006 neurologists conducted an experiment in which they examined the connection between mood and the manifestation of symptoms in clients diagnosed with CD. In the experiment clients were instructed to carry out an emotional exercise, FMRI revealed an unusual relationship between the activity of the primary motor region and the hippocampus (Voon et al., 2006).

In light of the foregoing discussion, it is important to note that this recent study examined the new issues connected to this condition. Due to the high prevalence of CD nowadays and the lack of a biological etiology, management of the illness is becoming increasingly challenging. Caretakers' ignorance of these disorders only makes matters worse. In order to understand CD and its treatment much better, information obtained from active practitioners who are dealing with conversion clients must be extremely beneficial.

1.2 Research Gap/Rationale

In order to better understand how psychologists and psychiatrists accurately diagnose and treat Conversion Disorder, this research study was conducted. Quantitative approaches have been used to study CD for a long time. Even though these studies have generated complaints checklists, medical standards, and viable therapeutics and diagnostic standards (Auffary et al., 2017).

The goal of the current study was to shed novel, useful light on the various approaches used by psychologists and psychiatrists to manage conversion disorder and the necessary steps that should be taken in order to lessen the emotional struggle that clients are going through.

Given that somatic illnesses account for a sizable amount of the sickness treated by doctors, this difficulty in diagnosing due to overlapping symptomatology with other disorders and treating has major implications for both medical professionals and people with CD. The expense of caring for these individuals is high and constant, and the number of casualties that illness takes on people's lives is tremendous (Paula, 2017).

Therefore, observations derived from the lived experience of clinical practices of clinical psychologists and psychiatrists, regarding the diagnosis and treatment of CD as well as the difficulties they encounter over the course of the remission period, may provide new insights. An Interpretative Phenomenological Analysis (IPA) of the experience described by Psychologists and Psychiatrists may provide fresh details about what makes this condition difficult to diagnose and treat, as well as the elements that may explain why clients with this disorder do not get well.

There are various studies and articles explaining “what is CD” or “The lived experiences of an individual with CD” but very few studies are conducted to explore the viewpoint of clinical psychologists and psychiatrists in Pakistan about this disorder.

1.2.1 Contextual Gap

Symptoms, diagnosis, therapy, relevance, and the need for clinical judgment have all been discussed in previous studies (Rebecca et al., 2015), as well as therapeutic problems (Furqan et al., 2017). Some of the contributing elements, such as how doctors diagnose and treat CD in the presence of all these obstacles, require investigation in the context of the actual working lives of mental health professionals in Pakistan.

1.2.2 Methodological Gap

The great majority of research methods utilized in earlier studies were quantitative in nature. There are few studies on CD that employed a qualitative methodological approach and IPA as an analytical approach. Therefore, this study utilized IPA.

1.2.3 Population Gap

This study discovered a demographic gap in past studies on CD since majority of western populations were examined in those studies. There aren't enough studies on Pakistani psychologists and psychiatrists. This study looked at the experiences of clinical practices of psychologists and psychiatrists who are now working at hospitals of Islamabad and Rawalpindi.

1.3 Problem Statement

The problem statement was to describe the persistent challenges that clinical psychologists and psychiatrists face while diagnosing and treating CD. Exploration also centered on understanding the various therapeutic techniques used by psychologists and psychiatrists while treating clients who were undergoing CD treatment. Because of this, a thorough examination of the lived experiences of clinical practices of psychologists and psychiatrists was carried out.

1.4 Research Questions

1. What assessment strategies are Psychologists and Psychiatrists using in order to diagnose CD?
2. How do Psychiatrists treat CD clients?
3. What therapeutic techniques/Therapies do Psychologists employ to treat clients diagnosed with CD?
4. What obstacles psychologists and psychiatrists are facing while diagnosing and treating CD clients?

1.5 Objectives

The purpose of this study was to examine how psychologists and psychiatrists cope with clients diagnosed with conversion disorder in their daily clinical practice. This study also aimed to investigate the various approaches used by psychologists and psychiatrists to address the issues that obstruct the treatment of clients with conversion disorder.

1.6 Significance of the study

This research offers a broad and thorough account of the CD phenomena from the viewpoint of psychologists and psychiatrists. The exploration of obstacles and how to overcome them will open the door to further investigation of the gaps in mental health fields, and enhance the morbidity related to them (Siddiqui, 2021). Additionally, it is stated that the findings could be applied in educational settings to test and modify knowledge on the diagnosis and treatment of CD. Future clinicians in Pakistan may get a greater understanding

from this study's summary of the treatment strategies utilized by psychologists and psychiatrists to treat CD. This study clearly indicated the need of having suitable, independent rehabilitation facilities where clients' psychological and medical needs are met.

This study brought attention to the problem that clients with CD need care and ongoing support from family members since they are stigmatized owing to the lack of understanding about CD, which leads to unsuccessful management. The results of this study will educate on how to treat CD clients. One of the most important outcomes of this thesis is that future clinicians who are new to the field will learn how to develop a strong therapeutic relationship with the client and be able to break the client's dissociation. For example, if a client presents with mutism and immobility, rapport-building and empathic understanding will enable the client to speak and start moving.

CHAPTER 2

LITERATURE REVIEW

Despite having been researched for more than 4,000 years, somatoform disorders (SDs) continue to be challenging to diagnose and give rise to controversy (Dinwiddie et al., 2013). Since somatic disorders make up a large fraction of the illnesses that doctors analyze, the persisting difficulties in diagnosis and treatment have severe negative repercussions on both clients and medical personnel (Rosendale et al., 2017). According to several studies, apart from depression and anxiety, SDs are the more prevalent mental illnesses in medical practice. In fact, SDs (36 %) were the most prevalent category of diseases among clients who attended a General Practitioner, and they finally exhibited a history of absolution (Toft et al., 2015).

The disorder has a substantial influence on each person's life, which results in large and continuous care costs for these patients (Svenson et al., 2005). Somatic disorders like CD have been explained, investigated, and managed throughout human history. Even so, the illness is still not fully recognized in modern times (Dinwiddie et al., 2013). The diagnosis of somatoform disorders usually includes MUS or MUPS; these words are frequently used interchangeably in the diagnosis of SDs. These words may be unclear to clients, and it may be challenging for professionals to clarify them. (Rosendale et al., 2017).

It is necessary for the human psyche to make meaning of suffering. It can be tough to comprehend, accept, and absorb illness of any kind. When suffering of above-mentioned physical symptoms is labelled as unclear, however, the scheme that we have used to understand our experiences, labelling them, is greatly undermined (Firestain et al., 2012).

In the European history, black magic raft became the center of attention, and CD which was preferably named hysteria in the Middle Ages, was assumed to be caused by demonic possession. This belief persisted until the late 17th century, when advancements in anatomization allowed for the diagnosis of nervous system disorders as the cause of untreated symptoms. Throughout the 18th, 19th, 20th, and 21st centuries, the neurological system hypothesis has persisted. Because medical research has been unable to identify a biological primary causative factor, the mind and its associated neurological system have become the focal point. It's important to realize that even while the condition's primary cause evolved, the term hysteria which was used to describe it, remained consistent (Scheurich et al., 2000). However, in the nineteenth century, France became the leading location for studying CD patients. A famous French neurologist, Charcot (1825-1893), used the teaching hospital “La Salpêtrière” to analyze and challenge the work of Briquet (1796-1881), a pioneer in the education of CD (Engelhardt et al., 2014).

The signs of conversion disorder, such as unconsciousness, circular repetition of the peripheral vision, were identified by Charcot, who was fascinated with establishing a connection between the neurological system and the symptoms he noticed in clients. Charcot was sure that these were signs relating to aberrant functioning of nervous system, which has an unknown cause. Like many others before him, Charcot's methods and beliefs were eventually disproved, allowing Freud and Janet, two of his pupils, to investigate their own assertions (Shorter, 1992).

The fundamental theoretical effort of Freud and Janet was to conceptualize medically unexplained symptoms. Each of them was concerned about explaining how the body with conversion symptoms might imitate the biological anatomy. The concepts of Freud on CD are considered as dominant in the field of psychology, and Freud’s work on these concepts gave rise to the modules of psychoanalytic evolution (Gordon et al., 2019).

Freud worked closely with Joseph Breuer to develop theories of CD and together they developed and published studies of CD in 1894 (Walsh, 2014). Freud coined the phrase conversion hysteria and presented the concept of conversion with Breuer. Janet's idea

focused on amnesia and identity confusion as well as other conscious awareness problems (Harvey et al., 2016).

Despite the neuropsychological and behavioral aspects of conversion illness, psychiatric diagnoses have never been able to satisfactorily incorporate it (Spiegel, 2010). As a result, the studies of Sigmund Freud about conversion were justified and approved and remarkably affected the discipline of psychology (North et al., 2015).

The term "functional" has recently come to be used to describe symptoms previously classified as "hysteria" or "conversion". CD falls under the category of "Somatic Symptom and Related Disorders" in the DSM-V, followed by the terms "Functional Neurological Symptom Disorder" in parentheses. This shift could be the consequence of research in which patients were asked which labels they found most useful. Despite being empirically unproven, the term has a lot of negative implications for clients (Stone et al., 2002).

An explanation for the experiences has long been sought for the explanation of CD. Psychodynamic, Cognitive, behavioral, and Neuro-psychological models are some of the concepts discussed in this thesis. When the fields of psychiatry and neurology separated at the turn of the twentieth-century, hysteria was one of the most widely used terminologies to characterize CD. Despite the fact that 'hysteria' was the first term used, it demonstrates how descriptions have evolved over time. (Edwards, 2009).

Conversion Disorder was considered as a feminine ailment caused by a restless uterus called "hustera", a word from which the word "hysteria" was derived in the Ancient Egyptians and then the Ancient Greeks era (Owens et al., 2006). Hippocrates wrote about how the dry womb moved up the throat in search of moisture, and Galen interpreted 'hysterical manifestations' as the result of restricted menstrual flow or abstinence from sexual intercourse (Singer et al., 2016). Augustine believed that hysteria was caused by demonic possession (Mendelson et al., 2016).

The first results in the subject of neuropathology attempted to explain 'hysteria' symptoms by exhibiting neuroanatomical abnormalities prevalent in neurological illnesses (Pandey et al, 2012). Because there were no such abnormalities, Jean-Martin Charcot chose the term 'functional' rather than ‘structural' to characterize these 'hysteria' symptoms (Nicholson et al., 2011).

Charcot was a French neurologist who made substantial contributions to the fields of psychiatry, pathology, and medicine in the nineteenth century. As a professor of medicine at the Salpêtrière Hospital in Paris, he made numerous achievements, including developing the hypnosis technique while working on 'hysteria' and epilepsy (Pandey, 2012). He studied 'hysteria' and demonstrated how it could be generated by hypnosis, as well as giving very successful theatrical lectures that popularized hysteria at the time (Pandey et al, 2012). Charcot claimed to have demonstrated an isolated and universal form of 'hysteria' involving four stages: 1) tonic rigidity; 2) spectacular, circus-like acrobatic movements; 3) powerful manifestations of emotion; and 4) a delirious condition with tears and/or laughing, after which the person returned to normalcy (Malloy et al., 1995).

It has been claimed that the increase in women hospitalized to the Salpêtrière Hospital with 'hysteria' was from 5 to 500 in 1841-1842. Because the scenario was one in which women were reacting to household stress and were culturally believed to be more week, such theatrics were thought to have resulted in "hysteria" becoming "culture hysteria" (Edwards et al., 2009).

Fascinatingly, a neurological publication suggested that CD ought to be included in both neurological and psychiatric diagnosis categories in the ICD-11 (Stone et al., 2014). This appears to be a circle in history, as it was Charcot who first diagnosed 'hysteria' as neurological and later brought it into psychiatry (Stone et al., 2014).

Furthermore, Charcot's definition appears to be particularly relevant to the most current term, 'Functional Neurological Symptom Disorder,' as defined in the DSM-5 (APA,

2013a, 2013b). Janet's theories and Freud's psychoanalytic theories led to a trend away from such physical explanations in the nineteenth century. Janet was a French psychologist, philosopher, and psychotherapist who believed that conversion symptoms arose from 'dissociation' as a result of trauma, in which conscious experiences were no longer able to come together in a coherent, integrated way, and thus became dissociated/separated/unavailable from conscious experience (Hart et al., 1989). Those split experiences were considered to appear physically as conversion symptoms (Nicholson et al., 2011).

Freud suggested an alternate viewpoint in which traumatic experiences like childhood sexual abuse were converted to conversion symptoms because they were too upsetting to be let into conscious experience (Freud et al., 1985). The term "conversion" was coined by Freud and Breuer to describe the exchange of a repressed thought for a physical symptom (Owens et al., 2006). These early ideas influenced subsequent theories, and it was recognition of these that shifted conversion from a neurological to a psychiatric disorder and included it in diagnostic classification systems, which have used the terms "conversion reaction" (DSM-I, 1952), "hysterical neurosis (conversion type)" (DSM-II, 1968), "conversion disorder" (DSM-III, 1980), "dissociative (conversion) disorder" in ICD-10" (Nicholson et al., 2011).

Clinical Psychologists carried out clinical researches on pseudo seizures involving the therapist-client relationship and drew on psychoanalyst Heinz Kohut's theories to show that the elements of "mirroring," "idealization," and "twin ship transference" are exhibited in this client group (Kalogeria, 2004). These three aspects are defined as essential for the development of "self" which refers to the steady feeling of an existent unified identity (Siegel et al., 1996).

"Mirroring" is a process in which the client seeks acceptance and validation from the therapist, "idealization" is a process in which the client holds the therapist as a figure of calm and strength, and "twin ship transference" is a process in which the client seeks out similarities between both in the relationship (Blaustein et al., 2010). The way these aspects are perceived during a child's upbringing is supposed to influence the development of "self,"

in which the child learns how to engage with the world with strength, confidence, courage, and resilience (Sackellares et al., 2004). When a child does not acquire the above-mentioned processes or when trauma occurs, this is undermined (Blaustein et al., 2010).

Kohut's research has identified two types of traumas: 1) death or abuse (physical, sexual, or emotional) and 2) indifference. The first causes tension and dysfunctional relationships with bereaved people. In the event of abuse, this can entail adopting the aggressor's behavior, which has an impact on how relationships are formed outside of it. The second type of trauma occurs when a person is deprived of caring and care, leaving them feeling incomplete as a person (Schore, 2002).

According to studies, people who completed the processes of "mirroring, idealization, and twin ship transference" saw the other person as an extension of their own sense of self, resulting in a merging that answered needs that had not been supplied as a child. The other person is considered as an item that the client internalizes in this scenario. Their own bodies are then seen as objects, and if the therapist refuses to meet their wants or if their bodies do not react as they like, they will have "pseudo seizures" that are out of their control. Anger can then occur as a result of the lack of this integration, with the result that other people respond empathically to them or distance themselves from them (Schore, 2002).

Other types of ideas, ranging from learning to neurophysiological explanations, arose as a result of this. According to learning theories, the environment shapes behavior, and behavior that have a positive outcome or lessen negative outcomes are retained, while those that have negative consequences are avoided (Feinstein, 2011). In this way, 'conversion symptoms' can be viewed as the result of the reinforcement of dysfunctional behaviors. For example, obtaining attention for playing a sick role serves to reinforce the role's behavior, which continues to receive attention (Owens et al., 2006). On the other hand, sociocultural theories have provided an alternative perspective in which 'conversion symptoms' are seen as the outcome of previously suppressed emotions being revealed (Feinstein et al., 2011).

According to Neurophysiological hypothesis, certain nerve cells may be involved in how voluntary movement does not function normally in people with CD (Owens et al., 2006). Brain imaging studies have been conducted to investigate “Conversion Paralysis” which could occur at any of the stages listed below: 1) intention, in which the subject wishes to move a body part; 2) planning, in which the muscles must be prepared to coordinate for movement; or (3) delivery, in which the subject wishes to move the body part; or (4) delivery, in which the subject wishes to move the body part (Hallett et al., 2011).

For a long time, mental health specialists have been captivated and perplexed by CD, sometimes known as hysteria or hysterical conversion. The American Psychiatric Association has given CD a new name: Functional Neurological Symptom Disorder (FNSD), however the two words are interchangeable (APA, 2017). Completely irrelevant to an underlying neurological or medical illness, Functional Neurological Symptom Disorder is characterized by unexplained neurological symptoms such as seizures and aphonia, as well as sensory abnormalities such as blindness (Espay et al., 2018). Women are more likely to have these symptoms (APA, 2017).

Excessive negative affect and anxiety may aggravate a faulty top-down regulation mechanism, resulting in psychogenic neurological symptoms, according to one theory (Morris et al., 2018). Functional Neurological Symptom Disorder was one of the most common illnesses seen in Pakistani specialty care hospitals' psychiatric departments (Ijaz et al., 2017). In South Asian nations such as Pakistan, there is a very high prevalence of unexplained neurological complaints, however study in this field is limited (Bhavsar et al., 2016). Freud proposed the original and arguably most significant explanation of FNSD about a century ago. Unresolved childhood tensions, he argued, could lead to the development of hysterical conversion (Breuer et al., 1955). Later, the behavioral viewpoint held that FNSD symptoms are caused by role enactments that have been reinforced by the environment (Kring et al., 2012).

According to the sociocultural perspective of FNSD, it is more prevalent in developing countries, among the less educated, and in rural regions. An increase in psychological sophistication and technology breakthroughs has led to the acceptance of

anxiety and depression symptoms as acceptable means of expressing stress (Krendl et al., 2020). On the other hand, in developing countries such as Pakistan, the above-mentioned symptoms may go unnoticed due to a lack of emotional openness, whereas a FNSD symptom such as a pseudo-seizure, blindness, or other symptoms are more likely to receive attention and serve as a cry for help due to factors such as a lack of education and strong beliefs that the symptoms are caused by black magic and supernatural forces (Bokharey et al., 2013). It continues to state that CD is more common in collectivist countries like Pakistan, where direct expressing of emotions is discouraged due to sociocultural reasons like religious or family institutions (Georgas, 2010).

Family's role in the development of illnesses is seen as a key aspect in each culture, but the amount of significance varies (Bokharey et al., 2013). In CD, the role of family is also significant because to its cultural relevance. The struggle between not wanting to disappoint one's family and one's own wants has been identified as a significant contributor to the development of a variety of mental health conditions (Kanaan et al., 2018). Because any assessment of psychopathology, as well as the selection of the most effective treatment, must include an understanding of the patient's socio-cultural and familial context, it is critical to recognize the interdependence between psychiatric and sociocultural paradigms and processes (Murphy et al., 2019).

CD is one of the most common diagnoses in Pakistan, accounting for 12.4 percent of inpatient psychiatric admissions and being the fifth most common mental condition (Farooq et al., 2007). It's possible that the high incidence is due to the fact that in countries like Pakistan, people are still constrained by mythical and traditional gender norms in which women are not permitted to freely express themselves. Furthermore, such communities have oppressive sexuality regulations and attitudes, which may contribute to the high prevalence of CD (Bokharey, 2007).

The research on the origins of CD suggests that factors such as female sex, psychological distress, family conflicts, trauma, family conflicts, and socioeconomic issues play a significant role in the etiology of CD (Hung et al., 2009). A strong link between

stressful life events and CD can be established by evaluating earlier material. According to studies on the cause factors and temperamental features of individuals with CD, they were exposed to more stress, were emotionally vulnerable, and had a low stress threshold or resilience. As a result, it is important to investigate these stress-related phenomena, such as strength and coping skills, in relation to CD, and to compare and contrast the findings with controls, such as clients with general medical conditions, in order to arrive at a sound conclusion (kumar et al., 2006).

CHAPTER 3

RESEARCH METHODOLOGY

The methodology portion comprised of Research design, research epistemology, research approach, research strategy, population and sampling, data collection and data analysis, and research ethics.

3.1 Research Design

The research design of the present study is Qualitative Research Design. The method that was used in this research for analysis was “Interpretative Phenomenological Approach (IPA)”. Phenomenological approach is utilized to study lived experiences of participants to obtain greater knowledge about how participants interpret those experiences. This approach was selected because it focuses on the in-depth analysis of actual events and for examining alternative theories on conversion disorder. This approach has been determined to be a suitable fit for researching the health, and medical area since it gives specific information about the lived experiences of participants (Auffary, 2017).

3.2 Research Epistemology

The nature, origins, and boundaries of knowledge are all topics covered by epistemology (Pascal, 2011). Epistemology is significant because it affects how researchers structure their studies in an effort to gain knowledge (Moon et al., 2017). For the present research, epistemology is “Interpretive” in nature since it draws its knowledge from the unique experiences of the participants. Participants' responses are susceptible to their own preferences and are constrained by their surroundings. The acquired interpretivist information is subsequently interpreted to offer the participant's perspective an intersubjective meaning. The understandings from participant's worldviews serve as the foundation of the information gained. Therefore, this study was intended to connect directly to the established meanings that participants give to their experiences and that encompass the vast cultural and experiential worlds that these people's opinions and ideas are derived from.

3.3 Research Approach

An "Inductive" research approach was utilized. When using inductive reasoning, which is sometimes referred to as a "bottom-up" method of understanding, a researcher builds an abstraction or creates a description of the phenomenon they are studying using observations (Bernard, 2011). It entails creating objectives and research questions that are accomplished during the investigation process. Finding solutions to the research problems was its main goal. Participants' data were gathered in order to study the phenomena/research problem. To build the study's conceptual framework, themes were found. Identified themes were interpreted by using an Interpretive phenomenological analysis method.

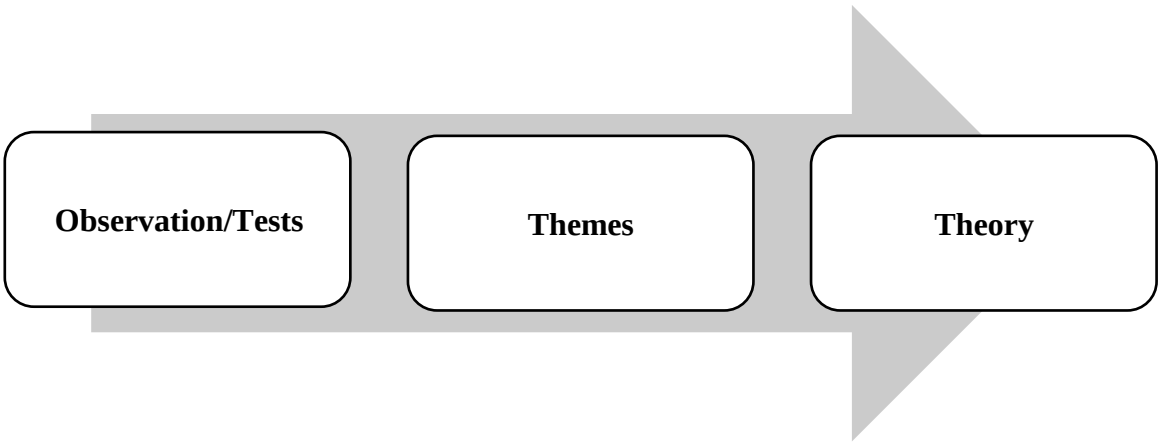
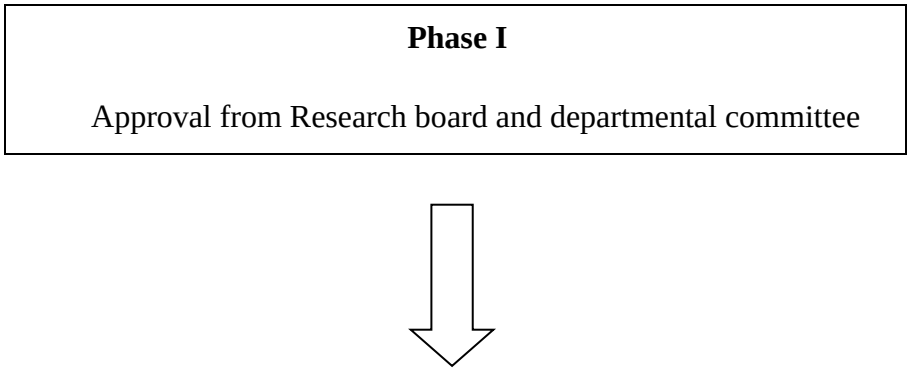


Figure 1: *Illustrated figure of Inductive Approach in which the researcher uses observations used to create an abstraction or construct a picture of the topic under study*

3.4 Research Strategy

This study's research strategy is qualitative in nature. A research strategy is a systematic plan that gives the study a direction (Chetty, 2021). To comprehend the perspectives of participants on the phenomena of CD, a qualitative research strategy is employed. It offered different insights on the research problem, which aided in fulfilling the study's goals. This research approach was used to examine human experiences in order to comprehend the phenomena.

The research strategy of this study is comprised of 6 phases. The following flow chart illustrates the phases:



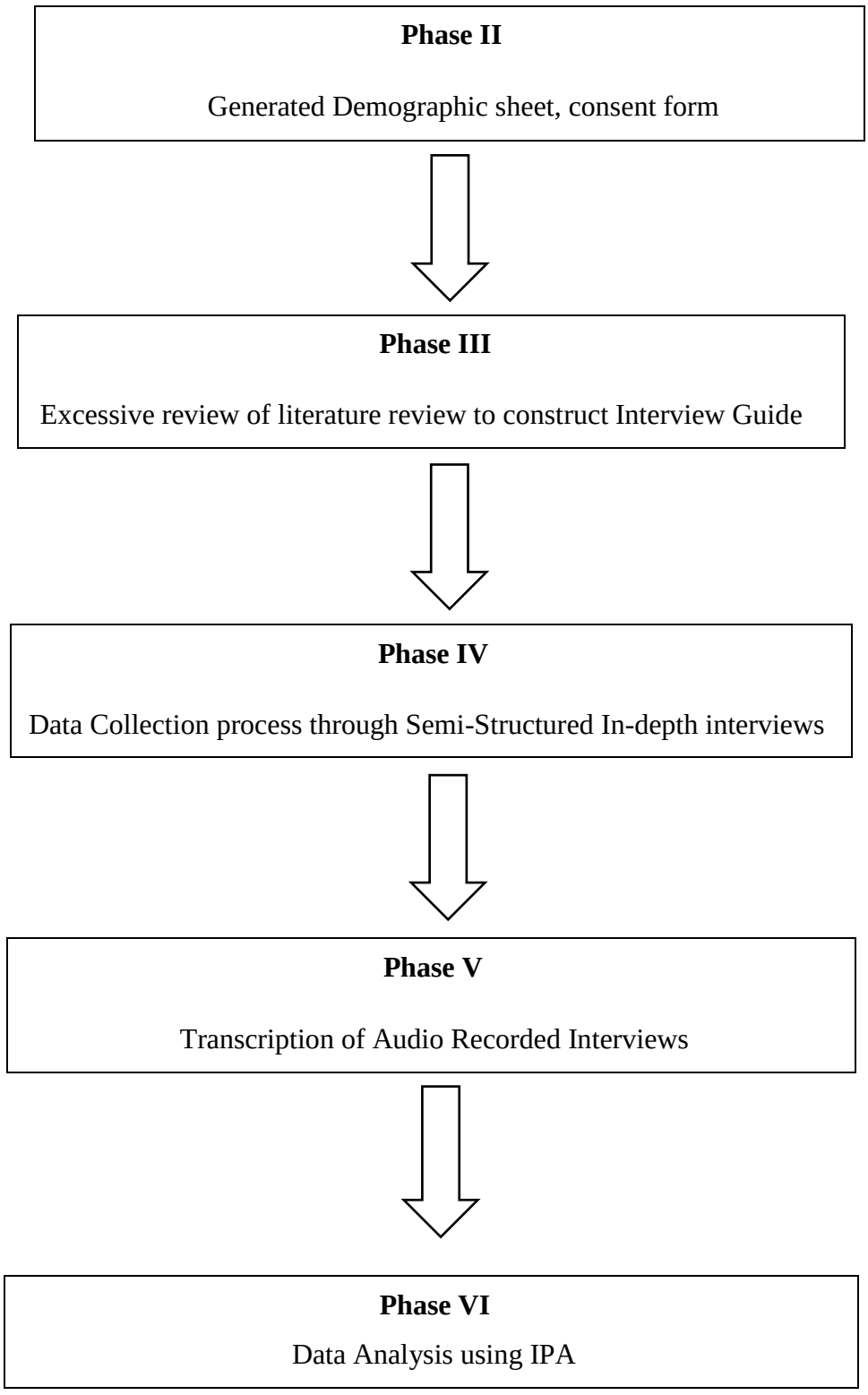


Figure 2: A figure representing research strategy of the Study

3.5 Population and Sampling

The sample of the study was collected using the purposive sampling technique. The sample was obtained from hospitals in Islamabad and Rawalpindi. Participants were "Psychologists/Psychotherapists and Clinical Psychiatrists" that are active practitioners working at hospitals in Islamabad/Rawalpindi or in private clinics. Ten participants were selected for the interview. Of these 10 participants, 5 are Clinical psychologists/Psychotherapists and 5 are Clinical Psychiatrists.

a) Inclusion Criteria

For Psychologists/Psychotherapists

1. The Psychologist/Psychotherapist who holds MS or Ph.D. degree in Clinical Psychology.

2. The participant with 5 years or above experience in the field.

3. Participants that are working/active clinical psychologists/psychotherapist dealing with CD clients.

For Psychiatrists

4. The Psychiatrists who are MBBS, and FCPS qualified.

5. The participant either with 5 years or above experience in the field.

6. Participants that are currently active practitioners and are dealing with CD clients.

b) Exclusion criteria

1) Psychologists/Psychotherapists and Psychiatrists that currently do not deal with patients with CD.

3.6 Demographic data sheet

The Demographic data sheet comprised demographic variables such as Age, Gender, Education, and Designation, Experience. The table that explains the characteristics of participants is as follows:

Table 1.1

Sociodemographic characteristics of participants

			f	(%)	M	SD
Characteristics	Age				45.80	10.43
Psychologists	Gender	Men	1	10		
		Women	4	40		
	Education	Postgraduate	3	30		

		Doctorate	2	20		
	Designation	Psychologist	5	50		
	Experience	More than 5 years	5	50		
Psychiatrists	Age				45.80	10.43
	Gender	Men	3	30		
		Women	2	20		
	Education	FCPS	5	50		
	Designation	Psychiatrist	5	50		
	Experience	More than 5 years	5	50		

3.7 Data Collection and Data Analysis

Data of the study was gathered through “Semi-Structured Interview” and “Purposive Sampling Technique” was used to choose participants from hospitals in Islamabad and Rawalpindi. For analysis of the research study, Interpretative Phenomenological Analysis is used. IPA was utilized for the interpretation of the collected data. Due to the exploratory nature of the study, this method was selected since it is most appropriate. The specific technique of IPA used that is named as "Hermeneutics", which is a two-stage interpretation

process in which the participant attempts to make sense of both their own perspective and that of others. After a comprehensive procedure, the analysis was completed. Purposive sampling was used to choose the sample. An extensive amount of literature was reviewed for construction of the interview guide. After conducting interviews and transcribing the data, the transcribed data was repeatedly read several times. After reading the transcript carefully, emerging themes were developed, and the themes were separated into Super-ordinate and Sub-ordinate themes.

Exploratory comments were analyzed on the basis of the respondent's point of view. Following this stage, a detailed interpretation of the emerging themes was carried out.

3.8 Research Ethics

The topic under study was evaluated by the committee and has been approved as it is not going to harm any individual. After getting approval from the departmental ethical board, and institutional review board (IRB) the research was conducted by following APA guidelines.

3.9 Research Tool

In the present study "Semi-Structured Interview guide" was constructed and used to take interviews from participants face to face at hospitals and in clinics. Open-ended questions were used to conduct the interview. Further probing questions were asked during an interview when needed.

3.9.1 Interview Guide

This research was conducted to get to know the views of mental health professionals in dealing with CD.

Opening Questions

1. Sir/Miss can you tell me which disorders you deal mostly in your daily practice?
2. Sir/Miss how many cases of CD are reported on daily basis?
3. Sir/Miss has you ever dealt with CD patients in your experience? Sir/Miss do you remember about your 1st case with CD?

Central Questions

1. Sir/Miss How do you evaluate/diagnose CD?
2. Sir/Miss according to you what are the risk factors that develops CD?
3. What are the complications while evaluating CD?
4. What measures you take to manage those complications?
5. Sir/Miss according to your experience how much time did the patients take to recover? (How long can CD last?)
6. What treatment do you recommend to patients with CD? (Medications)
7. What is the common gender ratio of CD

Ending Questions

1. Sir/Miss with due respect would you like to add something related to this topic?

3.10 Operational Definitions of variable

3.10.1 Conversion Disorder

CD is a mental condition marked by neurological symptoms such as blindness, immobility, or other symptoms which cannot be explained by a medical evaluation (Berger et al., 2020). Despite having no biological cause, CD has a major negative influence on a patient's capacity to operate. Furthermore, the symptoms are not controllable and are not thought to be purposefully exaggerated by the patient (Jessica, 2021).

CHAPTER 4

RESULTS

According to the study design that was broadly focused on the phenomenological approach, results were generated with implementation of Interpretative Phenomenological Analysis. IPA is a modern qualitative methodology developed specifically for psychology. It is widely used in health, clinical and social psychology along with other health disciplines. Jonathan Smith, a psychology professor at the Birbeck University of London, developed it. based on key ideas of Husserl, Heidegger and Merleau-Ponty. This form of qualitative data analysis focuses on lived experiences of clinical practices of individuals and how they give meaning to them. That is part of phenomenology (Smith et al., 2009).

In Context of current study these lived experiences of participants of the study were relevant to the phenomenon of CD (complications in diagnosing and treatment). It was with particular reference to actively treating clients with CD. On the second part of the analysis interpretation of the data was done by conceptualization of themes that emerged out of research data. This was done by detailed analysis of all participant cases and making sense of account of participant's perceptions, coding and themes analysis. Interviews were compared for similar and peculiar themes.

IPA was carried out as analysis method and in 2 phases: studying the phenomenon by entering into the universe of the respondents in the light of their lived experiences of clinical practices and how they gave meaning to their experiences in a unique way. Interpretation by analyst of the respondent's narrations was carried out in second phase to

conclude with the results. The approach was idiographic rather than nomothetic to bring in the unique output as per respondents' generated data.

The tables of Super-Ordinate themes are as follows:

Table 2: List of Super Ordinate Themes and Sub-Ordinate Themes emerged from Psychologists' Interviews

Super-Ordinate Themes	**Sub-Ordinate Themes**	**Sub-Categories**	**Exploratory comments**
Diagnostic Complication	Crisscrossing symptoms	Psychological Symptoms	When client is unable to bear emotional burden so, symptoms change into physiological symptoms.
		Physiological symptoms	Symptoms such as fits seems like epileptic fits but, they are different from true epileptic seizures
	Misreporting symptoms		Family does not report the correct information about the client's condition.

Therapeutic Failures obstacles	Beliefs	Superstitious Beliefs	Many families of the client misinterpret the situation and refer to it as the client is possessed by supernatural creatures (JIN).
		Attention seeking Beliefs	Due to lack of awareness and knowledge about this disorder, many family members assume that the clients are faking to seek attention.
	Unsupportive caretakers	Families Unawareness	Most of the caretakers are not aware about the client's condition (conversion disorder).
		Absence of social Support	Due to lack of education family members/caretakers of the client are not aware about this disorder that the

		client needs support and care.
	Care giver's defiant attitude	Family members of the client do not take these symptoms seriously and do not follow instructions given by the practitioner.
	Unaddressed basic needs	Basic needs of the client which need to be addressed timely. are misunderstood by the family members.
Gains	Primary Gains	There are certain primary gains of the client like health insurance etc. which should be properly assessed during history taking and initial sessions.
	Secondary Gains	Secondary gains need to be taken care because of there are certain cases where clients come up with gains.

Therapeutic Procedures	Psychological Therapies	Cognitive Behavior Therapy (CBT)	Cognitive Behavior Therapy is the most effective Therapy for conversion clients.
		Family Therapy	Family therapy is essential in order to psychoeducate the client and family collaboratively about the mechanism of conversion disorder and about the client basic needs.
		Counseling	Daily counseling of the client is necessary to enhance the client's condition daily.
	Physiotherapy	Muscle Rigidity	Clients should be referred to physiotherapist to overcome client's muscle rigidity, walking, difficulties etc.

Table 3: List of Super Ordinate Themes and Sub-Ordinate Themes emerged from Psychiatrists' Interviews

Super-Ordinate Themes	**Sub-Ordinate Themes**	**Sub-Categories**	**Exploratory Comments**
Assessment Measures	Medical Tests Verification	EEG, MRI	EEG and MRI should be carried out in order to check any physiological problem. It helps in ruling out physical causes of Conversion Disorder.
		Epilepsy Checklist	Sometimes the duration of the seizures is very less which indicates epilepsy seizures so, to clarify the nature of seizures symptoms should be check with a checklist called "Epilepsy checklist" to confirm the disorder.

		Detailed Inquiry	Detailed Inquiry/history should be taken from the client to understand the background/cause of the distress.
Challenges in treatment	Dependance	Medicinal Dependency	Most families and clients rely on medicines because they have no awareness about conversion disorder and its treatment.
	Unresolved Conflicts	Parental Conflicts	There are many underlying conflicts that remain unaddressed which results in Physical symptoms. Many clients have poor management skills because of which they are unable to cope with stress.
		Marital Conflicts	Marital Conflicts plays a major role in developing CD.

		Unexpressed emotions	Unexpressed emotions are basically the main reason why clients are unable to bear symptoms.
Treatment Strategies	Pharmacological Treatment	Anti-depressants	Medicines only work in case of co-existing disorder such as depression, anxiety, psychosis, epilepsy.
		Anti-Anxiety Medications	If there is co-morbid anxiety then anti-anxiety medications are prescribed.

This section highlights the lived experiences of the clinical practices of the potential participants and highlights the superordinate themes extracted from the data collected. Each superordinate themes have multiple sub-ordinate themes and sub-categories. The super-ordinate themes presented includes those themes extracted from Psychologists interviews are: “Diagnostic Complications, Therapeutic failure obstacles, Treatment Strategies, Therapeutic procedures. Super-Ordinate themes extracted from Psychiatrists interviews are: “Assessment Measures, Challenges in treatment, treatment strategies”. These section highlights the participant’s unique experiences, while demonstration of common experiences despite their unique circumstances.

4.1 Diagnostic Complications

4.1.1 Crisscrossing Symptoms

The findings of this study showed that according to the experience of respondent number one the primary superordinate theme that emerged out of narration of the interview protocol was diagnostic complication because of manifestation of mental stressors into physical symptoms. The researcher sensed that the theme holds a significant value because the respondent explained her own meaning of CD. The interviewee illustrated CD as "when psychological pain transforms into physical symptoms". The very initial extract from the interview is mentioned here to support this theme.

Interviewee (1): Respondent one narrates that

کنورژن ڈس آرڈر جو میری سمجھ کے مطابق ہے وہ یہ ہے کہ جتنے بھی نفسیاتی علامات ہیں وہ جسمانی علامات میں تبدیل ہو جاتے ہیں .میں یہی اپنے مریضوں کو سمجھاتی ہوں کہ نفسیاتی دباؤ اتنا زیادہ ہو جاتا ہے کہ آپ اس کو برداشت کرنے کے قابل نہیں ہوتے آپ کا جسم جھکڑ جاتا ہے اور وہی علامات جسمانی شکل میں تبدیل ہونا شروع ہو جاتے ہیں .اب اگر ہم یہاں پر دیکھے تو کنورژن ڈس آرڈر کہ جو علامات ہیں وہ وقتی طور کے لیے بھی ہوتے ہیں .کبھی کبھی علامات غائب ہو جاتے ہیں اور کبھی کبھی سو میٹک النص اتنی لمبی ہو جاتی ہے کہ وہ بہت درینہ بن جاتی ہے.

It emerges from these comments that when psychological stressors grow too much for a client to bear, the pain, burden, and disgrace they feel and hide manifest as physical symptoms, which may emerge for a brief period or may persist and develop into a chronic condition.

Interviewee (2): As reported by respondent two

According to the second respondent, CD occurs when a patient is unable to cope with excessive psychological tensions, and it then manifests as physical symptoms. CD happens when an individual is unable to communicate his or her emotions to those around them, or to ask for assistance with an issue from those around them.

The comments narrated by the respondent are as follows:

کنورژن ڈس آرڈر جو ہے وہ اصل میں جب ذہنی دباؤ بہت زیادہ ہو جا تے ہیں اور جو مریض ہوتا ہے ان کو ان مسائل کے ساتھ نمٹنا نہیں آتا, ان کو سننے سمجھنے والا کوئی نہیں ہوتا تو ان کے سائیکالوجیکل سٹریسرز جسمانی بیماری میں تبدیل ہونا شروع ہو جاتے ہیں ایسے مریض کے بارے میں اکثر لوگ کہتے ہیں اکثر لوگ یہی سوچتے ہیں کہ یہ دوسروں کی توجہ حاصل کرنے کے لیے ایسے کرتے ہیں لیکن میں اس بات کے بالکل خلاف ہوں کیونکہ دیکھو یہ ان کے کنٹرول میں نہیں ہوتا.

CD is characterized by the transformation of psychological distress into physical symptoms. There is usually a link between a stressor and the symptom or set of symptoms that the patient is experiencing.

The researcher interprets that the symptoms of CD overlaps with symptoms of Epilepsy. This disorder is often misdiagnosed because of the similar presentation of symptomatology. Paralysis, aphonia, ataxia, convulsions, or a loss of eyesight or another sensory modality are common symptoms that appear to be neurologic. CD symptoms are not under the control of the individual, although the intensity of the symptoms can be altered by the client in specific conditions e.g., intense concentration.

In up to 30% of cases, symptoms initially classified as CD are eventually attributed to an underlying medical cause. Nonconvulsive seizures (also known as pseudo seizures) are very common in clients with true epilepsy. A client who is interictal or has subcortical

seizure foci may initially have normal-looking EEGs. Even if a CD is suspected, this demonstrates the importance of undergoing a full medical and neurologic examination (Ruffman et al., 2005).

Interviewee 6: Respondent six reports that

ڈائیگنوز میں کافی بار ایسا ہوتا ہے کہ جو مریض کنورژن سیئزرز کے ساتھ آرہا ہو تو اسکی اوور لیپنگ ہو سکتی ہے جب تک کہ کوئی واضح اشارہ نہ ہو کنورژن ڈس آرڈر کا کبھی کبھی ایسا ہوتا ہے کہ سیئزرز کا دورانیہ اتنا کم ہوتا ہے ان کا جو ایپیلیپسی کے ساتھ اورلیپ کر رہی ہوتی ہے ایپیلیپسی والے سیئزرز کے ساتھ تو وہاں پہ تھوڑی سی مشکل آتی ہے ڈائیگنوز کرنے میں.

Certain aspects of the physical examination can point to psychological reasons. Certain convulsive activity and neurologic symptoms (e.g., bilateral convulsions with full alertness, fluent speech during and after abnormal activity motor activity that crosses the midline, and inconsistencies in the sequence of abnormal motions) are not consistent with a true seizure disorder. Clinicians may notice a client who appears weak or paralyzed but becomes fully functional when distracted; a client with functional blindness may react to a rapid, threatening visual stimuli.

Interviewee 2: According to Respondent 2

دیکھیں اصل میں بات یہ کہ جو مریض ہوتے ہیں وہ مختلف علامات کے ساتھ ساتھ آتےہیں کچھ ایسے ہوتے ہیں جن کو جھٹکے لگتے ہیں مطلب کہ فیٹس اور سوڈو سیزرز کنورژن ڈس آرڈرکے ساتھ ساتھ ایپیلیپسی اورلیپ کر رہی ہوتی ہے ایسے مریض کی فیملی کو لگتا ہے کہ مرگی کا دورہ پڑا ہے مطلب ایپیلیپسی لیکن ایسا نہیں ہوتا

The most common mimicker of epileptic seizures is psychogenic nonepileptic seizures. When Psychogenic Non-Epileptic Seizures (PNES) are linked to Epileptic Seizures in a patient, the situation becomes even more complicated.

Interviewee 3: Respondent 3 mentioned that

اسکے علاوہ سمٹمز فور موسٹ آف دی ٹائم اوورلیپ ود اپیلیپسی وچ نییڈزاے تھورو اکزیمینےشن بیفورڈائگنوسینگ.

Epilepsy misdiagnosis is common in individuals with Psychogenic Non-Epileptic Seizures. In fact, at least 25% of clients with a previous epilepsy diagnosis who are not responding to medication therapy are discovered to have been misdiagnosed (Benbadis, 2005).

It's crucial to highlight that diagnosing conversion disorder can be challenging at first for a variety of reasons.

Interviewee 5: Respondent 5 narrates that

کبھی کبھی علامات اوورلیپ کر جاتے ہیں جیسے کہ فیزیکل النس میں ہمیں تھوڑا سا پرابلم ہوتا ہےکہ وی نییڈ ٹو بی شیور کہ فیزکل عسپکٹس کی طرف سے دہ پیشنٹ از ڈن۔ کوئی ڈائریکٹ جسمانی بیماری نہیں ہونی چاہئے۔ اگر وہ چیز کلئیر ہو جائے اور سمٹمز کی پریزنٹیشن کلیئر ہو جائے تو میرا خیال ہے کہ عکسپیرینس کے ساتھ اور ود دہ پیسج آف ٹائم اتنا مشکل نہیں ہوتا ڈائگنوس کرنا۔

To begin with, clinicians are almost exclusively taught to look for (and rule out) physical illnesses as the source of physical symptoms. Furthermore, clinicians are more likely to treat for the more serious condition if they are unsure about the diagnosis, which

explains why so many people who are misdiagnosed with epilepsy are given antiepileptic medicines.

Second, seizure diagnosis is mostly based on the observations of others who may not be educated to distinguish between epileptic and nonepileptic convulsions. Finally, many doctors lack access to video electroencephalogram (EEG) monitoring, which must be done by an epileptologist (a neurologist that specializes in epilepsy). Unfortunately, once epilepsy is diagnosed, it is readily maintained without questioning, which explains the typical diagnostic delay and cost associated with PNES (Benbadis et al., 2018).

4.2 Therapeutic Failure

4.2.1 Beliefs

Many families of the clients with CD are unfamiliar with this disorder. Due to lack of awareness and unavailability of education some of their beliefs are not accurate. Many families hold beliefs such as superstitious beliefs that the individual with the symptoms like (paralysis, fits, blindness, mutism) have something to do with superficial possessions.

Interviewee 1: As reported by respondent one

مینلی جو ہمیں کہا جاتا ہے نہ کہ جن نکالنے والی بات تو اس وجہ سے یہ میرا فیورٹ ہے کیونکہ اکثر فیمیلیز جو کہ غیر تعلیم یافتہ ہوتے ہیں وہ یہ سوچتے ہیں کہ ایسے کنڈیشنز یعنی ہاتھ ٹھیڑے ہو جانا یا بلاینڈ ہو جانا کچھ نظر نہیں آنا تو اس حالت میں انُ کو لگتا ہے کہ یہ جن یا طاویز کا اثر ہے۔ انُکو عوئرنس نہیں ہوتی کنورژن ڈسآرڈر کے بارے میں تو انُکو سائکو عژوکیٹ کر کہ جب ٹریٹمینٹ شروع ہو جاتی ہےتووہ ٹھیک ہو جاتے ہیں اگر فیملی اور مریض کوپریٹیو ہو.

Interviewee 2: According to Respondent 2

بس وہ یہی سمجھتے ہیں کہ یہ تو ان پر جن کا اثر ہے تو پیر عالم کے پاس لے کے دم درود اور مارپیٹ کر کے اور کام خراب کر دیتے ہیں.

4.2.2 Unsupportive Family

CD is a serious undiagnosed condition, particularly among Pakistan's rural populations. Relationship issues and socioeconomic hardship are potential risk factors for CD in Pakistan. It is linked to middle age, that due to illiteracy, financial troubles, being a housewife, and relationship issues, unsupportive family members and friends. Families of somatizing patients typically report marital strife, and these families have been found to be less united and supportive. A person with CD might benefit greatly from the aid and participation of their family. Family members' ignorance about this condition has a severe detrimental impact on the client. Due to ignorance and a lack of education, the client's family does not support them. They fail to address the client's fundamental requirements, which lead to this condition. This is a very important element since it impedes the client's ability to receive therapy.

Interviewee 4: Respondent 4 stated that

آئی تنک دہ ویری کومن ون فیکٹر ہئیر ٹو ہینڈر دہ مینجمینٹ پروسیس از عنسپورٹیو فیملی۔ خاص طور پر جب میں سوچتی ہوں دیٹ جو مریض ہے وہ خود اووروہلمڈ ہوتا ہے بیکاز انکو فیزیکل سمٹمز آرہی ہوتی ہیں۔ آ تنک کہ فیملی میمبرز یا جو تھوڑا بہت کیئر کرتا ہو تو دے میٹر الوٹ ہیر۔ الوٹ آف ٹائمز فیملی ممبرز اکثر مریض کی زمہ داری اٹُھانے کے لئے ولنگ نہیں ہوتے یا پر اگر زمہ داری لے بھی لیتے ہیں تو وہ بہت جلدی تھک جاتے ہیں۔ اننکو لگتا ہے کہ یہ علامات جھوٹ ہیں۔

Interviewee 6: Respondent six illustrated that

مسئلہ یہ ہے کہ اکثر جو مریض ہوتے ہیں ان کے فیملی ممبرز بہت ان کو آپریٹو ہوتے ہیں جیسے کہ میں نے پہلے بھی ذکر کیا کہ جو غریب طبقے والے لوگ ہیں تو ان میں تعلیم کی کمی ہوتی ہے وہ مریض کی حالت کو نہیں سمجھتے ان کو پاگل اور ذہنی مریض سمجھ کر غلط ٹریٹ کرتے ہیں اور ان کو فل سپورٹ نہیں کرتے ادھر ہمارے پاس جب کنورژن سمٹمز کرونک ہوتے ہیں تو مریض کو ایڈمٹ کیا جاتا ہے ان کی فیملی ان کو بغیر انفارم کیے لے جاتی ہے بغیر ڈاکٹر کے پرمیشن کے لے جاتے ہیں ,لامہ ہو جاتے ہیں کیونکہ کنورژن ڈس آرڈر

کو ٹھیک ہونے میں وقت لگتا ہے اس وجہ سے اکثر فیملیز مریض کو سپورٹ نہیں کرتی اور مریض کو لے جاتے ہیں.

The researcher assumes that management of individuals with CD should not only focus on minimizing of presenting complaints, but also on assisting clients in establishing and maintaining supportive interaction with other family members in order to foster a positive self-image. Additionally, it was determined that if there is no change in these areas, there would ultimately be no improvement in these client's states of health, and they will continue to come with the same symptoms.

It's important to believe client if they are exhibiting signs of CD rather than dismissing them as fake. Even if the cause of these symptoms is unknown, they are extremely genuine. Be aware that when a neurologist or other specialist tells your loved one that the symptoms client exhibits aren't linked to a particular neurological disease or other medical condition, they may experience frustration and emotional discomfort. Assure them that you are aware of their symptoms and that you are committed to assisting them in locating qualified professionals who can assess and treat their problem.

4.2.3 Gains

The researcher interprets that somatizing behavior may arise as a result of childhood skills for coping with family conflict. These tactics may be useful in childhood, but they are no longer so. When they live into adulthood and are employed in a variety of ways, they become problems in social settings. Childhood experiences can lead to a variety of behaviors. Family members or the family system have a strong influence.

In Psychology, the terms primary gain and secondary gain are used to describe the powerful underlying psychological motivators that clients may have when they arrive with symptoms. It's worth noting that if the client recognizes these motivators, and especially if symptoms are invented or exaggerated for personal advantage, this is referred to as malingering. Internal motivations are boosted by primary pathological gain. For example, a client may feel terrible about his or her inability to complete a task. If a physical problem exists that justifies an inability, psychological stress may be reduced.

Interviewee 3: Participant three stated that

اگر اسولیشن میں ہیں اور پیور کنورژن ہیں اور آپ اسُکو میڈیسنز سے ٹریٹ کررہی ہیں تو وہ ایک یک نڈریس نیگبن جاتا ہےاور یہی یک نڈریس گین جو آبویس کامپلیکیشن کو رائز کرتی ہے، میڈیکلی ریانفورس ہو جاتی ہیں لیکن اسُکی مینیجمینٹ میں آپکو پتہ ہی ہوگا آپ نے یہ اڈینٹیفائی کرنا ہوتا ہے کہ یہ سیکینڈری گینز اور میڈیکلی ریانفورسڈ اور سیکینڈری ریانفارسمینٹ کونسی ہوتی ہیں جب آپ اسُ کو پہلے ریمو کرتے ہو تو آپکو اسُکی انڈرلائینگ کاز کا پتہ چل جاتا ہے۔ اسُ کے لیے میڈیسن کی ضرورت میجرلی نہیں پڑھتی۔

Primary gain can occur in any disease, but it is most seen in CD, a psychiatric disorder in which stressors appear as physical symptoms with no physiological reason, such as when a person goes blind after witnessing a murder. To the untrained eye, the "gain" may appear insignificant. Secondary gains are external motivators. If a client’s condition allows him/her to miss work, obtain financial remunerate or avoid household work these would be secondary gains.

Interviewee 1: Respondent one reported that

اس میں پرائمری اور سکنڈری گینز کا معاملہ ہے، گینز کتنے سارے ہوتے ہیں فآر عکزیمپل فیملی کے حالات فیملی کا بیہیوئر اور ورک ڈ ڈیلیر فانینشئل کمپنسےشن اور بہت کچھ۔ ایسے مریض اپنے میڈیکل کنڈیشن کو لے کہ فائدہ لیتے ہیں تو اٹ از ڈیفیکلٹ ٹو ڈیسائڈ ٹو عیدر ویلیڈیٹ اٹ فآر دیم آر نآٹ، تو اف فیملی والے انُکی ہر زِد کو پورا کرے وہ بھی ٹھیک نہیں ہے۔ یہاں پہ ڈیفیکلٹی ہے ک جو انسٹرکشنز ہم دیتے ہیں کلائنٹ کی فیملی اسُکو فالو نہیں کرتی اور مریض بھی نہیں.

4.3 Therapeutic Procedures

4.3.1 Psychological Treatment

An effective relationship between the therapist and the client is the basic requirement of the effective therapeutic procedure, once CD is diagnosed. The creation of a collaborative and goal-oriented treatment plan with the client and the active implementation of this treatment plan is essential for successful therapy. The underlying internal conflicts are so confusing that the client feels incapable of handling their condition.

These conflicts are stored in client's sub-conscious mind. if the client understands their condition and learn to break the emotional tie with the stressors that are the reason for the present condition of him or her, they can easily manage the bodily symptoms. After, acknowledgment of their condition client is capable to learn the stress coping skills in order to tackle the upcoming hurdles of their life.

Psychotherapy focused at explaining the emotional origins of symptoms is the cornerstone of CD treatment. The therapeutic procedure of CD clients involves psychological therapies such as Individual or group psychotherapy, behavioral therapy, hypnosis, biofeedback, and relaxation etc. For the management of non-epileptic fits Cognitive Behavior Therapy is considered as an effective therapy as confirmed by many studies (Ali et al., 2015).

Behavior therapies are more directed towards working on the factors such as self-esteem, increased capacity to express emotions, and improved communication skills etc. Physical Therapy is also effective in treating CD. Clients those present complaints of immobility, weak muscles or pain in joints, in this case physiotherapy helps them to overcome physical symptoms and avoid secondary issues like muscle weakening and stiffness that can emerge as a result of inactivity.

Progressive workouts that begin with simple tasks and progress to more difficult ones have been demonstrated to help people with neurological diseases and CD. By gradually reducing verbal and tactile cueing or other help while the client executes certain tasks, the physical therapist aims to improve the client's motor abilities (Kaur et al., 2012).

Clients with CD who had a rapid onset, a short duration, an early identifiable stressor, no ongoing disputes, good premorbid competence, and no comorbid psychiatric problems and support from caregivers might predict a favorable prognosis (Blitzstein et al., 2008).

Interviewee 9: As reported by the respondent nine

آ گو وِد این ایکلیکٹ ایپروچ آف کورس اٹ سٹارٹس وِد یو نو اے لوٹ آف بیسک بیہئوئرل مینجمینٹ ، اینڈ ایز آ سیڈ آ فـ وک س اے لوٹ مور آن ٹرامہ بیسڈ تیراپی سو، آ دیـ کمہ نڈ cbt وئیر کوائٹ اے بِٹ آف سومیٹک ایکسپیرینسگ از دئیر. سو، آ کـ مـ نڈیـد ,EMDR ،ڈو ہیئو دیٹ بیکراونڈ. سوورک وِد دوز ان کولیبوریشن وِد ویری بیسک بیہیوئیر مینیجمنٹ ٹیکنیک۔ دوز آر یوزویلی دہ ویز آگو، انلس وی نو دیٹ سمٹایمز دیٹ ود کنورژن دہ سمٹمز آر، دے ڈیساپیر ایز سڈن ایز دے کم سواٹِ سورٹ آف ڈیپنڈ اے لوٹ آف ایولیشن اور اِن دہ بیگینگ آف اِف دِ س پرسن ہیز لانگ ٹرم ہسٹری آف ڈیپرشن آر اینزایٹی آر وٹ آر دہ پاسبل کاززز اور وٹ کائنڈ آف ٹریٹمینٹ پلین کین آ میک دیٹس گوینگ ٹو بھی آوکے یو نو اٹِ ڈزنٹ سیم لائیک اٹِ واز اے لانگ سٹینڈنگ اشِو آر مور آف اے سڈن تنِگ میبی دئیر واز این انٹینسو ریورسیو تِینگ۔ سو ڈیپنڈنگ آن دیٹ تیراپی از ڈیزاینڈ بٹ آ گیس بیسڈ، بیہیوریل مینیجمینٹ ٹیکنیکس اینڈ دین آ گو ٹو ڈیپر ڈیپریشن CBT اینیشیلی، یوزولی اِٹس جسٹ اینڈ ٹرامہ اشوز۔

Interviewee 2: As Reported by the respondent two

آ یوز ایکلیکٹٹ ایپروچ وِد سچ پیشنٹس۔ اِس ہاسپیٹل میں زیادہ تر پیئشنٹس انایجوکیٹڈ ہوتی ہیں تو اُنکے ایز اے ہولیسٹک ایپروچ نہیں یوز کرتی میں بٹ سم ٹیکنیکس آف CBT اسکے علاوہ ڈیلی کاونسلنگ۔

The majority of individuals with functional neurological problems will require a multidisciplinary treatment approach. The treating clinician that maybe physical therapist, clinical psychologist, psychiatrist should work collaboratively with the clinician that

supervise the treatment of the respective client, and the treatment plan that is being followed should be agreed by all the clinicians that are working collaboratively. To clear any concerns about diagnosis, the mental health practitioner should maintain communication open with the referral provider and this is because sometimes client may present the symptom which was not revealed by the client earlier. Other established health care professionals should be notified of the functional neurological disorder's diagnosis, and there should be agreement on the message among all providers. One or two of the therapies should be carried out with the client on one time. If under processed therapy is not working than the treatment procedure should be revised with an alternative therapy. Carrying out multiple treatment procedures at the same time is unnecessary (Neal, 2018).

Neurological symptoms which are a manifestation of a neuropsychological condition present with functional neurological disorders, which are genuinely at the confluence of neurology and psychiatry. When treating CD, it's important that treatment facilitators communicate with one another. To make sure that they all agree on the origins and treatments of different symptoms, neurologists, psychiatrists, and other medical experts should interact often.

4.4 Assessment Measures

4.4.1 Medical Tests Verification

It's critical to distinguish between CD and other somatoform diseases including factitious disorders and malingering when people pretend to have symptoms. Although CD symptoms are not intentional or under the client's conscious control, they are also not brought on by biological illnesses. Clients with CD should seek medical help right away for

a thorough examination, as the symptoms can be mistaken for a variety of other neurological and psychological diseases.

CD is difficult to diagnose because Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scans of the brain, as well as EEG, usually reveal no dysfunctions. Inpatient video-EEG monitoring and ambulatory video-EEG recording, along with a thorough mental history and physical exam results, can be used in conjunction with long-term monitoring to give very accurate diagnostic results (Pourkal et al., 2019).

The significance of long-term video-EEG monitoring and the expertise that epilepsy trained neurologists can provide for effective management and treatment is that experienced physicians can make a comprehensive and accurate diagnosis by evaluating the video-EEG test. The psychiatrist's skillful presentation of the diagnosis is one of the most important ways for the treatment of clients with CD. Many individuals with CD symptoms are unable to comprehend this internal conflict, which may be happening on a subconscious level. Clients should be educated to recognize the presence of psychological foundations, but more remarkably, clients should be counseled about the connection between conflict and physical problems, and they should be explained with this information.

Interviewee 4: As respondent mentioned in interview

آف کورس، ان ٹرمز آف لایک وین سمون کمز ٹو می اور آف کورس اف دے آر ایبل ٹو ٹاک آر اِف دے کم ود اے فیملی ممبر اور کیر ٹیکر ہو کین سپیک اباوٹ وٹس گوینگ آن، اِف دے ہیونٹ گان ٹو اے آ ڈنٹپروسیڈ فردر ود کنورژن EEG آر دیئر MRI میڈیکل ریپورٹس بیسڈ آن دیر یٹ یس سکینز آر دیر ڈسارڈرز۔ انِ جنرل بٹ انلس یو نو فار شور دیٹ دیئر از نو میڈکل کنڈیشن/اشِو دیٹ دس پرسن ہیز اینڈ آفٹر دیٹ بیسڈ اپون دئیر سمپٹمز اِف یو نو دے ہئیو گاٹ دہ ریکوائرڈ عکوپیشنل تیراپی اور فیزیوتیراپی ڈیپنڈنگ آن دیٹ دین آ وڈ کولابوریٹ ود سمون الس اینڈ سنڈ دم دئیر اینڈ وی ول کالیکٹولی ورک آن دئیر ڈیپریسئو سیمپٹمز۔

CD is characterized by psychogenic non-epileptic seizures. CD is a mental illness in which emotional distress appear as physiological symptoms. It is a subset of somatoform disorders. clients with CD represent a diagnostic challenge because of their complicated presentation. The most promising results come from a multidisciplinary approach to CD treatment that includes the connection between the physician and the client, appropriate interaction, accurate neurological/epileptic examination, assessment, and management, as well as various psychological therapies, physiotherapy where necessary, and medication when comorbidities exist.

Interviewee 1: Respondent one narrates that

ایسے مینج کرتے ہیں کہ فریکونسی، ڈیوریشن، ایکسپلورنگ سٹریسرز مینز نیچر آف سٹریسرز اور نان ایپیلیپٹیک فٹس کا جو کرائٹیریا ہے اسُکو پراپرلی پڑھ کہ فل ہسٹری لے کہ فیزیکل ٹیسٹس کو کنفرم کر کہ مطلب ہے کہ جو فیزیکل کازز ہیں جیسے ہیڈ اینجری، ڈیولپمینٹل مائلسٹونز، ہیں اسُکو رول آوٹ کر کہ ,اور باقی امپورٹینٹ ٹیسٹس ہیں وہ کنفرم کرتے ہیں۔

Interviewee 2: As the respondent 2 reports

آف کورس، ان ٹرمز آف لایک وین سمون کمز ٹو می اور آف کورس اف دے آر ایبل ٹو ٹاک آر اِف دے کم ود اے فیملی ممبر اور کیر ٹیکر ہو کین سپیک اباوٹ وٹس گوینگ آن, فردر ود کنورژن EEG آر دیئر MRI میڈیکل ریپورٹس بیسڈ آن دیر سٹ سکینز آر دیر ڈسارڈرز۔ انِ جنرل بٹ انلس یو نو فار شور دیٹ دیئر از نو میڈکل کنڈیشن/اشِو دیٹ دس پرسن ہیز اینڈ آفٹر دیٹ بیسڈ اپون دئیر سمپٹمز اِف یو نو دے ہئیو گاٹ دہ ریکوائرڈ عکوپیشنل تیراپی اور فیزیوتیراپی ٹیپنڈنگ آن دیٹ دین آ وڈ کولابوریٹ ود سمون الس اینڈ سنڈ دم دئیر اینڈ وی ول کالیکٹولی ورک آن دئیر ڈیپریسئو سیمپٹم.

4.5 Challenges in treatment

4.5.1 Dependency

The researcher hypothesizes that in society today, the majority of people with CD who report to psychiatric facilities or clinics are from low socioeconomic backgrounds and have no formal education. They are unaware of the mechanics of CD due to a lack of education. The core cause of CD is psychological, and psychotherapy rather than pharmacological treatment is required.

The majority of client's households prefer medication rather than psychological treatment. Medicines can only help with comorbidities. If the conversion is accompanied by depression, anxiety, or psychosis, the client should be referred to a psychiatrist. As a consequence, after client receive medications for CD, they quickly relapse with considerably more severe symptoms.

Interviewee 2: As reported by respondent 2

مریض ہماری دی گئ انسٹرکشنز کو کو فآلو نہیں کر رہے ہوتے، نہ فیملی والے فآلو کر رہے ہوتے ہیں۔ وہ میڈیسنز پہ ڈیپینڈ کرتے ہیں۔ انُ کو یہ نہیں پتہ کہ اِن کو سائکولوجیکل کیر کی ضرورت ہوتی ہے۔ ثو ایسے فیکٹرز ہینڈرز دہ ٹریٹمنٹ پروسس کیونکہ جو کانفلکٹ ہے ودان پیشنٹ مایئنڈ وہ تو حل نہیں ہوتا نہ میڈیسنز سے ہمارے باڈی کے اندر جو فیزیولوجیکل پرابلمز ہوتےہیں ہو حل ہوتے ہیں انسٹیڈ آف سائکولوجیکل۔

Interviewee 5: Respondent Five reports that

دہ تنگ دیٹ از ویری کومن ہیر از جب انسٹرکشنز ہم دیتے ہیں کلاینٹ کی فیملی اسُکو فالو نہیں کر رہی ہوتی اور کلاینٹ بھی فالو نہیں کر رہا ہوتا ہے۔ وہ ٹوٹلی میڈیسن پہ ڈیپینڈ کرتے ہیں کیونکہ دے ڈونٹ نو اینی تِنگ ایباوٹ کنورژن ڈسآرڈر کہ دِس ڈسآرڈر کہ دِس کاینڈ آف پیشنٹ نیِ ڈ ٹو بھی ٹو بی کیرڈ اینڈ لوڈ۔ جو سوشل سپورٹ کی بات ہے نہ تو اِٹ مینز ک جو بیسک نیڈز ہیں کلاینٹ ک وہ ٹھیک طرح سے ایڈرس نہیں ہو پاتے اور فیملی والے میسانڈرسٹینڈ کر لیتے ہیں۔ سو، یہ کنورژن ڈسارڈر کہ کلاینٹس کی مینجمنٹ میں ایک بڑا بیریر ہے۔

The researcher assumes that effective CD therapy tackles both the disease and any co-occurring disorders the clients may be experiencing. Additionally, the course of treatment will depend on the client's particular symptoms. Speech therapy may be helpful if a person's

symptoms include difficulties swallowing or speaking. It may be necessary to get physical or occupational therapy if a person has movement difficulties, paralysis, or weakness.

Behavioral treatment that focuses on stress minimization and relaxation strategies can also aid in symptom reduction. Psychotherapy can also help people with CD. Depending on any other co-occurring illnesses, the sort of treatment prescribed may vary. Cognitive behavioral therapy (CBT) can aid in the identification of negative or unreasonable thought patterns and the more effective response to difficulties. CBT can also assist people in developing stronger coping abilities for everyday situations. A person may benefit from additional forms of treatment if they have already suffered trauma. Family relationships that lead to stress and increase CD symptoms may be resolved via family therapy.

Medication to treat the symptoms of co-occurring conditions is commonly used in CD pharmacotherapy. Selected serotonin reuptake inhibitors (SSRIs), betablockers, analgesics, and benzodiazepines have all been demonstrated to be beneficial in studies. Antiepileptic medications are usually only utilized if they can also help with the cooccurring diagnosis (Smith, 2021).

4.5.2 Conflicts

The research revealed one major theme and that is unresolved conflicts. Disputes that have not been appropriately addressed are referred to as unresolved conflicts. Problems with family members, issues with parents/siblings, marriage conflicts, and conflicts with extended family members all contribute to the rise of these conflicts. Hurt, rage, grief, and jealousy are examples of unspoken conflicts.

The above symptoms, however, may go unnoticed in less developed nations like Pakistan due to a lack of psychological inquisitiveness, whereas symptoms like non-epileptic fits, visual impairment, and other various symptoms are more likely to receive attention and serve as a plea for assistance (Bokharey, 2013).

Due to factors like ignorance and strong beliefs that the symptoms are brought on by black magic and paranormal phenomena these symptoms are not addressed properly which leads to worsening of condition. The more often these requirements go unmet, the more serious the distressing condition will become. (Malik et al., 2012). It is been said that the direct expressing of emotions is discouraged due to sociocultural reasons like religious or family institutions in collectivist countries like Pakistan, that is why CD is very common here especially, in the rural areas of Pakistan (Georgas, 2010).

Family and family structure play an extremely important in role during the formative years of individual's life, but also all over one's lifetime. The majority of Pakistani population lives in extended family set ups, which include not only one's immediate family but also members of extended family. As a result, whatever occurs to one family member has an impact on the social and psychological well-being of the other family members (Rafique, 2017).

People in Pakistan do not have sufficient knowledge about psychological well-being (Munawar et al., 2020), therefore they are uninformed of the mental health challenges they are facing, leading them to use irrational techniques such as approaching spiritual healers to deal with the issues before seeking medical care (Choudhry et al., 2016). Even if they approach a physician for their well-being, their difficulties are generally dismissed by caregiver or clinicians who regard it as a histrionic strategy and attempt to manage the symptoms rather than the unresolved conflict. As a result, recognizing the stressful situations that persons with CD face in their daily lives would aid not only in the psychological well-being of client but also will assist the clinician to be more expert in managing CD.

Interviewee 10: As respondent ten reported that

دیکھیں یہ سارا جو ڈسسوسیےشن اور کنودژن ہے جو سومیٹوفارم سمٹمز ہیں انُ سب کا ایک بیسک تیم ہے ون دہ انریزولڈ کانفلکٹس اور ڈسٹرس کینوٹ بی ایڈریسڈ پراپرلی دین اٹ امرزز ٹو سم کائنڈ آف فیزیکل سمٹز جِسکی کوئی فیزیکل اکسپلینےشن نہیں ہوتی اور دیٹ از آل آن سبکونشیس لیول۔

Interviewee 3 illustrates that:

ڈسسوسیٹو ڈسارڈرز تو وہی انریزولوڈ کانفلکٹس کی وجہ سے ہوتے ہیں، جو ڈیفینس میکینیزمز یوز کرتے ہین ڈفرنٹ۔ اسُی کے ساتھ جو میری انڈرسٹینڈنگ ہے وہ یہ ہے کہ جو ڈسوسیٹو سمٹمز اور ڈسارڈرز اور یہی کنورژن ڈسارڈر تب ہوتا ہے جب آپکی باڈی کو کوئی ایموشنل طریٹ مہسوس ہو اور طریٹ سے مُراد ایموشنل ٹرامہ، ایکسٹریم سٹریس، ڈیپریشن اس قسِم کے جو مسلے ہوتے ہیں تو ہماری باڈی کا یہی ریسپانس ہوتا ہے وچ ریزلٹ ان کنورژن ڈسارڈر۔

Women have been observed to report a higher number of physical complaints than men (Bokharey et al., 2021). Women and men have diverse experiences with somatic symptoms, physiological discomfort, and physical health. Women, on average, report higher bodily distress and a greater number, intensity, and frequency of somatic symptoms than men (Barsky et al., 2001). Symptoms that are medically unexplained are prevalent in active medical clients, but they are not always psychopathological. Some individuals, on the other hand, have medically unexplained symptoms that are so acute and strong, so disabling and disruptive, and so persistent and chronic that they are diagnosed as psychopathological and a somatoform disorder. Women have a higher prevalence of somatoform disorders than men, with the paradigmatic somatoform disorder, somatization disorder, occurring up to ten times more commonly in women (Peekna et al., 2001).

Women (Wife, mother, daughter) sacrifices a lot in our society/culture due to strict family structures and male dominance, and they are restricted from their basic rights as a result. As a matter of fact, their emotions remain unaddressed, and their basic needs are not met, which leads to CD. Conflicts between immediate and extended family members persist for a long period among families with low socioeconomic situation and poor educational backgrounds and remain unresolved due to inadequate coping abilities. Sadness, hopelessness, and rage occur in our minds as a result of these feelings, causing considerable distress.

The fact that the women frequently suffer from CD than men, according to numerous studies, does not mean that men are immune to it. Men report CD less frequently, but when they do, they often have severe symptoms such as blindness and mutism. Lack of support, loneliness, financial restrictions, familial pressure, and workload are all factors that contribute to these symptoms in men.

Interviewee 3: Respondent Three narrated that

اچھا اس میں جو ہم بکُس میں پڑھ رہے ہوتے ہیں اسُ میں تو یہی تھا کہ کلاسیکلی تو ہی فیملز میں زیادہ دیکھا جاتا ہے لیکن اِن میں دونو پاپولیشن میں آجاتی ہے۔ ایڈولیسینٹ میں ہو جاتا ہے، انریزولڈ کانفلکٹس کی وجہ سے، میلز میں بھی دیکھے جاتے ہیں لیکن ان سب کی نسبت فیملز میں زیادہ ہوتا ہے۔ ۔ پاکستان میں یہ کہنا کہ میلز میں اکزیسٹ نہیں کرتا از ناٹ رائیٹ کیونکہ میلز میں بھی بہت بڑا چنک آپکو ملتا ہے خاص طُور پر جو ہوتا ہے نہ کہ اگر ہم دوسرے چنک میں چلے جائیں نہ اگر آپ سائکوسومیٹک لمپلینٹس کی بات کریں نہ جیسے ان ایکسپلینڈ میڈیکل سمٹمز تو اسُ میں میل پاپولیشنکافی آجاتی ہے۔

Interviewee 1: As narrated by respondent one

جنڈر وائیز تو اٹس مور کامن ان فیملز۔ اور میل میں بھی ہیں کچھ کیسز۔ دوز میل کلاینٹس ود کنورژن ڈسآرڈر انُ میں سمٹمز بہت کرانک ہوتے ہیں۔

Interviewee 5: According to respondent 5

ڈیفینٹلی فیمیل لیکن ہم نے بہت میل پےشنٹ بھی دیھکیں ہیں ود کنورژن سمٹمز اور میلز میں بھی جب سمٹمز ہوتے ہیں وہ بہت کرانک فیچرز ہوتے ہیں۔

4.6 Treatment strategies

4.6.1 Pharmacotherapy

Pharmacotherapy includes medicines can only help with comorbidities. If the conversion is accompanied by disorder that involves imbalance of neurotransmitters such as depression, anxiety, or psychosis, the client should be referred to a psychiatrist. Therefore, after client receive medications for CD, they quickly relapse with considerably more severe symptoms.

Interviewee 2: As reported by respondent 2

مریض ہماری دی گئ انسٹرکشنز کو کو فآلو نہیں کر رہے ہوتے، نہ فیملی والے فآلو کر رہے ہوتے ہیں۔ وہ میڈیسنز پہ ڈیپینڈ کرتے ہیں۔ انُ کو یہ نہیں پتہ کہ اِن کو سائکولوجیکل کیر کی ضرورت ہوتی ہے۔ ثو ایسے فیکٹرز ہینڈرز دہ ٹریٹمنٹ پروسس کیونکہ جو کانفلکٹ ہے ودان پیشنٹ مایئنڈ وہ تو حل نہیں ہوتا نہ میڈیسنز سے ہمارے باڈی کے اندر جو فیزیولوجیکل پرابلمز ہوتےہیں ہو حل ہوتے ہیں انسٹیڈ آف سائکولوجیکل۔

Interviewee 5: Respondent Five reports that

دہ تنگ دیٹ از ویری کومن ہیر از جب انسٹرکشنز ہم دیتے ہیں کلاینٹ کی فیملی اسُکو فالو نہیں کر رہی ہوتی اور کلاینٹ بھی فالو نہیں کر رہا ہوتا ہے۔ وہ ٹوٹلی میڈیسن پہ ڈیپنڈ کرتے ہیں کیونکہ دے ڈونٹ نو اینی تِنگ ایباوٹ کنورژن ڈسآرڈر کہ دِس کاینڈ آف پیشنٹ نیِ ڈ ٹو بی کیرڈ اینڈ لوڈ۔ جو سوشل سپورٹ کی بات ہے نہ تو اِٹ مینز کہ جو بیسک نیڈز ہیں کلاینٹ کے وہ ٹھیک طرح سے ایڈرس نہیں ہو پاتے اور فیملی والے میسانڈرسٹینڈ کر لیتے ہیں۔ سو، یہ کنورژن ڈسارڈر کہ کلاینٹس کی مینجمنٹ میں ایک بڑا بیریر ہے۔

The researcher assumes that effective CD therapy tackles both the disease and any co-occurring disorders the clients may be experiencing. Additionally, the course of treatment will depend on the client’s particular symptoms. Speech therapy may be helpful if a person's symptoms include difficulties swallowing or speaking. It may be necessary to get physical or occupational therapy if a person has movement difficulties, paralysis, or weakness.

Behavioral treatment that focuses on stress minimization and relaxation strategies can also aid in symptom reduction. Psychotherapy can also help people with CD. Depending

on any other co-occurring illnesses, the sort of treatment prescribed may vary. Cognitive behavioral therapy (CBT) can aid in the identification of negative or unreasonable thought patterns and the more effective response to difficulties. CBT can also assist people in developing stronger coping abilities for everyday situations. A person may benefit from additional forms of treatment if they have already suffered trauma. Family relationships that lead to stress and increase CD symptoms may be resolved via family therapy.

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Interviewee 9: As reported by the respondent nine

آ گو وِد این ایکلیکٹ ایپروچ آف کورس اٹ سٹارٹس وِد یو نو اے لوٹ آف بیسک بیہئوئرل مینجمینٹس ، اینڈ ایز آ سیڈ آ فاکس اے لوٹ مور آن ٹرامہ بیسڈ تیراپی سو، آ زوی cbt ، آ زوی ,EMDR ،ڈو ہیئو دیٹ بیکراونڈ سوورک وِد دوز ان کولیبوریشن وِد ویری بیسک بیہیوئیر مینیجمنٹ ٹیکنیک۔ دوز آر یوزویلی دہ ویز آ گو، انلس وی نو دیٹ سمٹایمز دیٹ ود کنورژن دہ سمٹمز آر، دے ڈیساپیر ایز سڈن ایز دے کم سو اٹِ سورٹ آف ڈیپنڈ اور اِن دہ بیگینگ اِف دِ س پرسن ہیز لانگ ٹرم ہسٹری آف ڈیپرشن آر اینزایٹی آر وٹ آر دہ پاسبل کاززِ اور وٹ کائنڈ آف ٹریٹمینٹ پلین کین آ میک دیٹس گوینگ ٹو بھی آوکے یو نو اٹِ ڈزنٹ سیم لائیک اٹِ واز اے لانگ سٹینڈنگ اشِو آر مور آف اے سڈن تنِگ میبی دئیر واز این انٹینسو ریورسیو تِینگ۔ سو ڈیپنڈنگ آن دیٹ تیراپی از ڈن اینڈ بٹ آ گیس بیسڈ، بیہیوریل مینیجمینٹ ٹیکنیکس اینڈ دین آ گو ٹو ڈیپر ڈیپریشن cbt اینیشیلی، یوزولی اٹِس جسٹ اینڈ ٹرامہ اشوز۔

Interviewee 2: As Reported by the respondent two

آ یوز ایکلیکٹٹ ایپروچ وِد سچ پیشنٹس۔ اِس ہاسپیٹل میں زیادہ تر پیئشنٹس انایجوکیٹڈ ہوتی ہیں تو انُکے ایز اے ہولیسٹک ایپروچ نہیں یوز کرتی میں بٹ سم ٹیکنیکس آف cbt اسکے علاوہ ڈیلی کاونسلنگ۔

Most individuals with functional neurological problems will require a multidisciplinary treatment approach. The treating clinician that maybe physical therapist, clinical psychologist, psychiatrist should work collaboratively with the clinician that supervise the treatment of the respective patient, and the treatment plan that is being followed should be agreed by all the clinicians that are working collaboratively. To clear any concerns about diagnosis, the mental health practitioner should maintain communication open with the referral provider and this is because sometimes patient may present the symptom which was not revealed by the patient earlier. Other established health care professionals should be notified of the functional neurological disorder's diagnosis, and there should be agreement on the message among all providers. One or two of the therapies should be carried out with the patient on one time. If under processed therapy is not working than the treatment procedure should be revised with an alternative therapy. Carrying out multiple treatment procedures at the same time is unnecessary (Neal, 2018).

Neurological symptoms which are a manifestation of a neuropsychological condition present with functional neurological disorders, which are genuinely at the confluence of neurology and psychiatry. When treating CD, it's important that treatment facilitators communicate with one another. To make sure that they all agree on the origins and treatments of different symptoms, neurologists, psychiatrists, and other medical experts should interact often.

CHAPTER 5

DISCUSSION

The Analysis technique used for the current study was IPA. The IPA approach is an approach for qualitative inquiry and contributes in analysis through two broad strategies; interpretation and phenomenology that are terms in title of IPA. This approach to analysis is concerned with interpretation as how the analyst derives meaning of the phenomenon explained by the respondent and makes sense of the meaning given by the respondent. The results are derived through following these steps and super-ordinate themes; the subsumption of series of related themes were formulated and the pattern of theme emergence is discussed in this section.

The collected information was recorded with the consent of the participant and those recording were transformed into written transcripts separately for each respondent. After the data had been transcribed, a list of emerging themes was taken from the transcripts of each participant. Emergent themes were used to extract a list of superordinate, subordinate themes and sub-categories. Using an interpretive phenomenological approach, these themes were thoroughly examined.

The analysis of the study's data revealed a pattern of repeated superordinate themes that operate as major impediments to diagnosing and treating CD. In the context of regular fieldwork, these themes appeared to have personal value, meaning, and purposes for each responder. Each of the responses of the ten participants seems to have both similarities and distinctions.

It is a common about CD that it includes symptoms that are similar to other disorders such as depression, epilepsy, anxiety etc. The client suffers from symptoms such as tremors or difficulty walking, difficulty swallowing or feeling a lump in the throat, episodes of inattention, numbness or a loss of touch sensation, speech issues like slurred speech, hearing issues or deafness, and cognitive difficulties involving learning and memory. When a person undergoes through various stresses and pressures and are unable to express their inner burden that results in physical symptoms in the form of paralysis, vision issues like double vision or blindness, seizures (also known as pseudo-seizures or nonepileptic seizures), abnormal movements (Amin et al., 2021).

Numerous additional conditions, including depression, anxiety, and somatization, are linked to CD. Somatization is the process by which psychological discomfort brought on by unresolved conflicts and unmet fundamental needs of clients manifests as physical manifestations. Because somatization can be brought on by a mood illness that jeopardizes mental health, CD is connected to mood disorders. Functional neurological diseases such as CD's pathophysiology is poorly known. Functional imaging, physiological monitoring, and structural examinations of the brain have started to shed light on the matter.

According to research conducted by clinical psychologist Tazvin ijaz; some psychiatric classification systems utilize the diagnostic label of CD, which is classified as Functional Neurological Symptom Disorder. It’s often used for clients who have neurological symptoms including numbness, blindness, paralysis, or fits, which are distressing and can be linked to psychosocial factors but are not compatible with a known organic origin. These symptoms are believed to be a result of chronic mental health conditions like depression or stressful situations that negatively impact a client's mental health. Despite given the designation of FNSD, CD remained in the DSM. The revised criteria still include the same set of symptoms with the need for a psychological stressor to exist and the need for impersonating to be proven false. In DSM-5 CD is as a somatoform disorder, in ICD-10 CD is a dissociative condition. As it accounts for 12.4% of admissions in Pakistani psychiatric in-clients (Attika et al., 2017), CD is one of the most commonly

reported psychiatric issues in our culture. Our societal tendency to accept physical symptoms rather than psychological issues is one of the key factors contributing to the progressive rise in the incidence rate of CD (Tazvin et al., 2017).

The original meaning of CD, which has its origin in Sigmund Freud's theories of psychoanalysis, which explains that the psychological emotions which are left in our unconscious mind gets the shape of physiological symptoms. For instance, it was believed that a client experiencing violent seizures and being unable to relate to thoughts of rage was concealing tough emotions that were showing themselves physically (Kannan, 2018). One of the participants mentioned CD as an indication of a condition in which physical symptoms appear when our unconscious mind is so overwhelmed with emotional tensions and there is no one to listen to or comprehend them. These disputes are still unresolved and unaddressed.

CD is difficult to diagnose (Pamula, 2017). It has been assumed that the symptoms are psychological disorders since doctors have theoretically and practically distinguished them from neurological (organic) disease. However, the psychological mechanism and how it differs from simulating (conscious simulation) have remained difficult. Despite the infrequent, misinterpretation of neurological disorders as CDs continues to worry medical professionals, especially psychiatrists who might not be aware of the helpful ways in which neurologists can rule out organic disease. The diagnosis is uncommon in psychiatry because the symptoms must have a psychiatric explanation and feigning must be ruled out by existing diagnostic criteria (Timothy et al., 2010).

The different diagnostic words currently employed by the DSM-V and ICD-10 show a large overlap with several other mental symptoms, which has been demonstrated. CD comorbidly exist with dissociative disorders, borderline personality disorder, dysthymic disorder, major depression, and somatization disorder (Malingering). According to the findings of a study conducted in Turkey, 89.5 percent of people who were given the diagnosis of "CD" also had another comorbid condition such as generalized anxiety disorder,

major depression, obsessive compulsive disorder, dysthymic disorder, simple phobia. (Sar et al., 2004).

Numerous differential disorders, as indicated above, are most likely to share symptoms with the diagnosis of CD. Therefore, it can be difficult to diagnose CD. Functional Neurological Symptom Disorder is diagnosed after a few medical tests, including an EEG, MRI, CT and urine tests. If these medical examinations are negative, the type of stresses are then investigated. When medical testing come back negative, it indicates that the problem is psychological in origin, and stressor investigation supports this. Without performing necessary medical testing, a diagnosis of CD shouldn't be established because seizures and other symptoms could be brought on by an organic condition or physical harm.

A diagnosis of CD may only be made after considering the presentation, course, medical examinations, and treatments that don't consider the symptoms of changed voluntary motor or sensory function with proof of clinical incompatibility (Nasir, 2017).

CD diagnosis is still a clinical difficulty (Danielle et al., 2017) because the practical relevance of the standard diagnostic requirements for associated psychological stresses and the exclusion of Malingering is limited. Malingering is notoriously difficult to prove or deny in real life, and there isn't necessarily a physiological reason for it. Although they are not present in a significant fraction of clients, studies of psychological precipitants in infancy and adulthood have tended to support the relevance of stressful life events prior to symptom onset at the group level (Stone et al., 2015).

Therefore, a complete mental history and examination are required to explain the evolution of symptoms, the existence of stressors, and the presence of coexisting illnesses. After confirming accurate clinical findings that are inconsistent or incompatible with organic disease across many examination components and after ruling out any underlying medical disorders by going through medical tests that the symptoms are mirroring, CD should be diagnosed (Ali et al., 2017).

Major depression accounts for a considerable chunk of the clients who report having CD according to the respondents to the current study. Clients also mention anxiety and CD in response to negative emotions, proving that these two disorders frequently coexist with CD.

The factors that restrict the therapeutic process, and also worsen the therapist's interactions with the clients are their lack of knowledge regarding this condition, families from ignorant backgrounds retain steadfast views about conversion that qualify as superstitious possessions. Family members seek for spiritual healers before visiting a general practitioner. This contributes to the severity of physical symptoms by deferring them in the unconscious mind.

According to the sociocultural perspective of CD, it predominates in developing countries, among the ignorant, and in backward regions. In Pakistan, there is lack of psychological understanding and awareness about psychological therapeutic processes the CD may go unnoticed or misunderstood by the family members. On the other hand, symptoms like blindness, or pseudo-seizures are more likely to gain attention and serve a plea for help due to lack of education and holding unfaltering perceptions that the symptoms are brought on by black magic and paranormal activities. Additionally, it states that CD is more prevalent in collectivistic societies like Pakistan, where direct emotional expression is restricted due to sociocultural factors including religion and familial structures.

The study's respondents shared their opinions on the sociocultural perspective of CD, which holds that most women clients resist their therapists by withholding truthful information about their conditions out of concern for their families. They prefer not to discuss their private situations outside of their homes because this disorder is especially prominent in those from economically disadvantaged level or people with far less education. Owing to the prevalent idea of men dominance in rural communities, domestic violence is a highly typical occurrence.

Most women clients fail to provide accurate information due to the fear of the aggressive tendencies of their husbands, in-laws, father, or brothers. They worry that they will be penalized if other family members find out the truth about their distress. So, the conflicts remain unresolved, this is really problematic for the therapist, the client, and the therapeutic process. Unresolved tensions worsen the client's painful state rather than aid in the recovery of conversion disorder.

The general low level of education and absolute lack of knowledge about mental health in nations like Pakistan promote and prolong the sickness. Diagnoses and treatment of clients with CD might be difficult. The development and form of symptoms as well as the presence of stressors can be determined by a thorough psychiatric history and examination. Because a client with conversion symptoms frequently struggles to explain psychological reasons on their own, they are forced to communicate them as physical symptoms. As a result, psychological pressures are frequently difficult to identify (Ali et al., 2012).

Every culture acknowledges that family plays a significant role in every condition. It has been acknowledged as a significant contributing element to the emergence of numerous mental health difficulties that the tension between not desiring to disappoint one's family and one's own goals (Kanaan et al., 2018). Not only in Pakistan but in every society, families are important throughout an individual's life, not just during the developmental years. The majority of people in our country live with kin family members (joint family), which may include one's parents as well as grandparents, uncles, aunts, cousins, and other relatives. As a result, anything that occurs to one family member affects the social and psychological wellbeing of the entire family (Rafique, 2017).

It frequently appears as though people are living under the same familial set up since families have such a strong impact on their members' thoughts, feelings, and behaviors. Each culture has its own importance, and those who belong to it often adopt the customs that have been passed down through the years. Like this, the societal trend toward mental health is significant since people's actions reveal a lot about how important it is. Compared to Eastern

cultures, such as those of Asian countries, Western cultures, which are more developed, have a greater awareness of mental health issues (Altweck et al., 2015).

People who are unaware of mental problems are less likely to seek treatment from a mental health professional, which suggests that there is a knowledge gap about culturally pertinent etiological elements. People in Pakistan tend to choose non-scientific approaches, such as seeing spiritual healers, to address their mental health difficulties before seeking medical attention. This is because they lack sufficient understanding about mental health, which makes them ignorant of the issues they are facing (Choudhry et al., 2016). Even if they do get medical help, the worries are usually rejected, either by the family member or the physicians who consider it as just an attention-seeking tactic and try to treat the symptoms without treating the underlying cause. As a result, comprehending the stressful circumstances that CD clients face would assist general practitioners as well as mental health doctors manage the root of the problem more effectively rather than only treating the presenting complaints.

Another aspect that inhibits therapeutic procedure is, family involvement in their health, as well as the reliance of clients from low socioeconomic backgrounds on medical care. As already mentioned, due to ignorance, people rely on medications and turn to faith healers before visiting a regular practitioner. People in rural areas hold a strong belief that there is a medical treatment for every ailment. According to one of the interviewees, "most clients depart against medical advice thinking that the client is not improving despite taking medications; they are unaware of the fact that medications only function in the cases of comorbidities such as depression, anxiety, or other somatoform disorders." The life of the sufferer is severely under supported by many families. They don't comprehend what is going on in the client’s life, and the client is unable to articulate their demands due to a dominant family member's anger-related fear. The client is not given the proper forum to articulate his or her needs. Even when the family or primary caregivers have been psychoeducated on the client’s condition, once the client is discharged, they do not implement the instructions.

According to a study conducted by family system theorists: conversion disorder enables the family to deflect attention away from other disputes and focus it on disease behavior. Families of somatizing clients typically report marital strife, and these families have been found to be less supportive, cohesive, and flexible than control families. The literature is filled with accounts of families where the "true" conflict is hidden by functional symptoms in kids or adults. Family participation and support can be quite helpful for those who are sad or struggling with CD, as well as the opposite (Amir, 2019).

For the treatment of CD each general practitioner mainly, clinical psychologist/psychotherapist have their own way of dealing with CD. Each of the Psychologist/Psychotherapist deal with their client with CD with a different treatment plan. As for Psychiatrist, it has been concluded from finding that they (Psychiatrists) refer these clients to psychologist/psychotherapist if conversion is in isolation. For the comorbid conditions mentioned above, medications are recommended by psychiatrists. CD is one of the key conditions that Cognitive Behavior Therapy (CBT) successfully treats. Each therapist employs a different CBT strategy to treat clients.

It has also been proved via various researches that cognitive-behavioral therapy (CBT) is effective in treating CD. CBT teaches client’s stress management strategies and new behavioral responses, educates them about functional neurological illnesses and the stress response cycle, and assists client’s in recognizing and altering problematic thought patterns that exacerbate their symptoms (Gaston et al., 2018).

Many psychologists use an eclectic approach, combining CBT, DBT, and Trauma Therapy (TT) to treat clients with CD. CD affects the muscles, joints, and limbs of certain people. They are paralyzed and unable to walk or move. Physical therapy therefore aids in reducing the discomfort brought on by paralysis. It is advised to initiate psychotherapy gradually. As part of this, clients are given strategies to help them escape pervasive symptoms as well as instructed to keep a record of their symptoms and the triggers that led to them in order to start generating a recovery process.

Hypnosis has been shown to be beneficial for treating somatoform disorders including CD. Numerous psychotherapies, such as psychodynamic psychotherapy, frequent exposure for those with comorbid disorder such as Post Traumatic Stress Disorder, insight meditation psychotherapy, hospitalization initiatives, psychoeducational therapeutic approaches, and Brain stimulation over the motor cortex, are among the other therapeutic strategies that are effective in treating CD (Mary et al., 2018).

It is important to describe psychotherapy in terms of how it will lessen the client's symptoms. To lessen the predisposition, to communicate distress through physical symptoms and to develop new behaviors that alter the long-standing, unconscious pattern that causes those symptoms, participation in a therapy process that alters "the way the brain processes information" is crucial. Similar justifications can be given for taking part in physical therapy (PT), which aims to alter the way complicated motor programs are processed and encourage the development of more adaptable movement or locomotor (gait) patterns.

It has been demonstrated that physical therapy (PT) is effective in treating CD's motor and gait symptoms. PT helps clients learn about their condition, teaches them about their ability to move normally, and helps to prevent maladaptive motor reactions. The PT program's rigidity and instructional component both seem to be crucial elements for effective treatment of CD. The referring clinician should make the mainstream recommendations available to the physical therapist and be a resource for continued consultation if the physical therapist is unfamiliar with CD. Clients with functional neurological disorders are more likely to incur from psychiatric disorders like PTSD, depression, anxiety, and hypochondriasis. As a result, selecting the best Antidepressant or Anxiolytic medication, Benzodiazepines if any, should be based on how well the diagnosed psychiatric comorbidities are being treated. Clinical judgement should be applied as to when it is appropriate to commence drugs to treat comorbid psychiatric illnesses. (Neal et al., 2018).

Numerous people seek mental health treatment to resolve problems that may have a spiritual component, such as faith, dignity, aim, significance, and integrity. There are several situations where a client's faith (spirituality) or religious beliefs might not be good for them. Clients could forego helpful procedures, if they contradict with their religious principles. Client can also think that their decision to seek treatment for a mental illness shows a lack of faith in God or that their symptoms are a sign of moral inadequacy (René, 2011). The religious convictions of a depressed client may further intensify their sense of guilt and wrongdoing (René, 2011). Medical advice is given to guide about the procedure of handling clients with "Bio-Psycho-Social-Spiritual Model" whose treatment may be jeopardized by their religious views as well as those who have had religious opinions forced upon them in a respectful manner (Griffith, 2010).

The BPS-S model is a contemporary, humanistic, and comprehensive understanding of the individual. A renowned scholar/researcher "George Engel" involved in the psychosomatic paradigm; he introduced the approach of BPS-S model to medicine. According to Engel, "any effort in health care must take into account all 3 dimensions, physiological, cognitive, and societal/Interpersonal." He stated that in order to fully comprehend and address client's suffering, Physicians must concurrently address the medical, cognitive, and Interpersonal aspects of illness (Saad et al., 2017). Several clients state that religion play a vital role in their life (Verhagen, 2010). Many people construct their perspectives, attitudes, opinions/beliefs, and conduct with the aid of spirituality (Abernethy, 1998).

The need for using the "Bio-Psycho-Social-Cultural-Spiritual (BPSCS)" Model with conversion clients surfaced as one of the indigenous themes throughout the theme's extraction process. The client's physiological, mental/emotional, social, cultural, and religious concerns are the main focus of the BPSCS model. These five areas of the client's life are examined through this paradigm. The ideal treatment plan for CD is one that is created using this paradigm. This model answers the questions such as: What causes this disorder? Is nature of dissociation or conversion fits physiological or psychological? What

are the factors that aids to the worsening of these symptoms? How the culture that the client belongs to think of CD and how that culture/culture views affect the client? how much faith the client has in themselves? (Woll et al., 2012).

The biopsychosocial-cultural-spiritual model is a comprehensive strategy that identifies the relationship between the welfare of client's physical, psychological, social, and spiritual needs. (Beng, 2004). Illness is seen as a disruptive force in the physiological relationships that can affect all other associative aspects of client's, who are considered to be associated with the client. This all-encompassing approach to client care emphasizes the intrapersonal relationships between the client's mind and body connection as well as their relationships with their families, friends, and communities. The biopsychosocial-spiritual paradigm is frequently employed in clinical settings, particularly when caring for clients who are terminally ill (Woll et al., 2008).

Despite these potential harmful impacts of some religious activities and beliefs, a substantial amount of research demonstrates that both religiosity and spiritual practices are often linked to favorable health outcomes (Moreira et al., 2014). Clients who are coping with often fatal mental disorders might find comfort, meaning, and purpose in religion and spirituality. In fact, according to various studies more than 80% of clients, they turn to their religious practices and beliefs to help them deal with societal expectations/pressures and complications related to their mental health (René, 2011).

Numerous additional conditions, including depression, anxiety, and somatization, are linked to CD. Somatization is the process by which psychological discomfort brought on by unresolved conflicts and unmet fundamental needs of clients manifests as physical manifestations. Because somatization can be brought on by a mood illness that jeopardizes mental health, CD is connected to mood disorders. Numerous elements related to neurobiology, in addition to the psychological causes of the condition, are being investigated by scientific study to see whether there is any proof that the neurobiology may play a role in CD particularly. Functional neurological diseases such as CD's pathophysiology is poorly

known. Functional imaging, physiological monitoring, and structural examinations of the brain have started to shed light on the matter.

In individuals with functional neurological diseases, volumetric MRI investigations provide evidence of abnormalities in both cortical and subcortical brain structure (Neal et al., 2018). Reduced volumes were discovered in the lentiform, thalamic, and caudate nuclei in a group of individuals with motor functional neurological abnormalities and unilateral limb weakness. Others comparing the thalamic volumes of individuals with neuromuscular CD to age-matched comparison participants discovered considerably lower bilateral volumes in the clients. There have been several cortical alterations reported. For instance, individuals with motor functional neurological problems were shown to have symmetrically thicker premotor cortexes, whereas those with psychogenic conversion fits had bilateral cerebellar atrophy and motor and premotor cortex atrophy in the right hemisphere (Aybek et al., 2014).

It is uncertain if these alterations are a direct result of or a side effect of brain circuitry changes. Functional neurological disorders have previously been characterized by the absence of observable brain changes, but changes in grey matter volume/amount are now widely acknowledged in psychiatric conditions like major depressive disorder, bipolar disorder, posttraumatic stress disorder (PTSD), and somatic symptom disorder with pain. Neurological dysfunction is not an exception to these results (Wise et al., 2016).

Therefore, it is recommended to use more flexible criteria, which will promote collaboration between neurology and psychiatry in the diagnosing and treatment of these individuals (Stone et al., 2010).

According to the intricacy discussed above, some medical experts find that treating clients with CD to be an interesting task while others find it uncomfortable (Owen et al., 2006). Additionally, some medical professionals still seem to hold attitudes that are influenced by historical perspectives that suggested simulating CD (Nicholson et al., 2011).

An investigation into neurologists' perceptions of and attitudes about CD revealed that neurologists shown to have a lack of engagement once these symptoms were established, low degree of accountability when it was believed that the cause of the symptoms was not systematic in nature, and a degree of disbelief for instance, it had been supposed that malingering was occurring (Kanaan et al., 2009).

This study also revealed that neurologists were inclined to see this domain as outside of their knowledge and as something that should be left to psychiatrists and Psychologists who were thought to be more qualified (Kanaan et al., 2009). The following remarks from neurologists regarding their clients with CD were found in a New York Times article: "Conversion patients have a terrible reputation in the medical profession", "We don't like them", "Somewhere deep down, we genuinely think they're fabricating it", and "The other reason we don't like them is because they don't get well, and when we can't do good by them, we don't like to work with them" (Kinet, 2006).

This Research study findings reveal that there is a variation in attitudes of clinicians working with clients diagnosed with CD. Conversion Disorder, according to some of the respondents who are identified as clinical psychologists with more than five years of experience, is their favorite type of disorder to treat because they get to see clients develop healthy stress coping mechanisms, transform their negative thoughts and perceptions into healthy emotions, for seeing such clients who once saw their lives as a complicated trap now see their life as an opportunities to seek out and learn new things and live their lives to the fullest. After a comprehensive therapy process, it is worthwhile to observe this kind of transformation. On the other hand, because the psychological domain is the underlying cause of this condition, psychiatrists see clients with CD as clients who need psychological treatment rather than pharmacological treatment and refer these patients to Psychologists.

Others in the study considered clients diagnosed with CD as an unpleasant experience. They claim that this is because most clients with this diagnosis don't always follow the therapist's recommendations. Since they rely on medications, they do not believe

in psychological psychotherapies. This element significantly slows down the therapeutic process. This demonstrates how medical experts' opinions and attitudes can differ greatly and be impacted by older historical concepts.

5.1 Implications

The implications of this study can be applied in educational settings, practical field settings, and policy-making settings since the study's findings gave us incredibly valuable knowledge regarding the fundamental requirements and fundamental understanding of CD. Some of the most important implications of this study's findings are listed below.

5.1.1 Theoretical Implications

There is not enough evidence to back up the theory/researches that elaborates the opinions of mental health professionals on their actual interactions with CD clients. The management of CD clients in Pakistani culture is not well documented. Active psychologists/psychiatrists offered their experiences in this study, which might support young or inexperienced practitioners in the field of psychiatry to deal with CD client's needs in their daily practice.

5.1.2 Practical Implications

More study is required in order to improve our understanding of the connections between psychiatric morbidity and disability on the one hand, and the accessibility to, and types of health-seeking attitudes and behaviors of the local population, as well as other sociodemographic, cultural, and economic factors as these factors affect the accessibility of alternative management strategies (where applicable, through a prospective, experimental study design).

In view of the situation, strategies for common mental health issues should unquestionably be thoroughly explored. According to psychiatrists' and psychologists' perspectives, the research study done can help direct future researchers toward having a comprehensive understanding of the phenomena of CD. It is emphasized on how to address these issues with regard to the character and attitude of clients as they relate to the elements that impede the diagnostic and treatment processes. Therefore, any conversion-related research can benefit from guidelines that can be used in both the academic and medical fields.

5.1.3 Policy Implication

Since there is a lot of talk on how the client's family is contributing to his or her illness getting worse and their need on medication, Due to a lack of knowledge about CD, this research will open the door for the inclusion of families of conversion clients in psychoeducational programs for them as well as the creation of resources for the local population to access these services before the client's problem worsens.

Another aspect of this theory is that it points out the necessity of creating a special rehabilitation program for clients who have undergone conversion, one with less family involvement and sufficient resources to handle such clients.

5.2 Limitations and Suggestions

The current study, which is exploratory in nature, is based on ten idiographic cases. In a qualitative research, interpretative phenomenological analysis was used as the analytical method. To produce the outcomes of the current study, phenomenological, interpretive, and hermeneutic analysis modes were prioritized. The study's contribution is the creation of findings based on the respondents' distinctive lived experiences at the exploratory level. In

essence, as opposed to a nomothetic technique, the results produced are not typical of the group from which the sample was drawn and cannot be applied to the entire community. The findings include a collection of respondents' actual experiences, which show how each respondent dealt with CD clients and what they thought of it. The current study explores problems that are associated to CD as well as variables that impede the management of clients with CD and how the respondents handle such issues. Due to their availability, only two Pakistani cities—Islamabad, Rawalpindi had specialists chosen for the current study. It is advised that professionals from other cities be chosen for future studies for the study to be generalized. The expert interviews were recorded as they were taking place. Three interviews were performed online, making it difficult to evaluate the interviewee's nonverbal signs. It is advised to conduct interviews in person to examine the participants' nonverbal clues in relation to the subject or experience that is being asked.

The participant's aversion to the inquiries about their personal experiences is another drawback of the current study. Participants are expected to answer in a way that is considered appropriate in society and to mention discussing it in private. Self-report scenarios-based questionnaires can be utilized to obtain more information from the possible participants in order to get over this constraint.

Due to their hectic schedules in the hospital and clinic settings, the study's potential participants were unable to offer as much information as they could have. Therefore, to get over this restriction, it is advised to speak with them when they have spare time and get their permission before scheduling a meeting.

5.3 Future researches and directions

This study is a step toward learning more about CD in rural areas of Pakistan, where the illness is identified in a high proportion of the population. This will contribute to the creation of literature on this specific disorder in order to expand CD therapy. Additionally, studies on the actual experiences of people with CD are required. Such studies can contribute to the provision of fact-based information that will highlight the necessity of specialized rehabilitation support for clients undergoing CD.

5.4 Conclusion

This present study, which is qualitative in nature, explores the lived experiences of psychologists and psychiatrists in treating CD. Interpretative Phenomenological Analysis is the analytical technique employed (IPA). In order to comprehend the results, emerging themes are manually extracted and categorized into Super-Ordinate and Subordinate themes. The study's key results are thoroughly detailed above. It is concluded that the therapy process is hindered by excessive family participation and a lack of psychological knowledge. There aren't many settings that are ideal for treating CD. A suitable rehabilitation facility that takes the client’s physical, emotional, social, and spiritual needs into account is something that must be developed. The general public must be made more aware of the need of receiving mental health care, and there is a need to develop, evaluate, and put into practice different measures to lessen the societal and self-stigma connected to Conversion Disorder.

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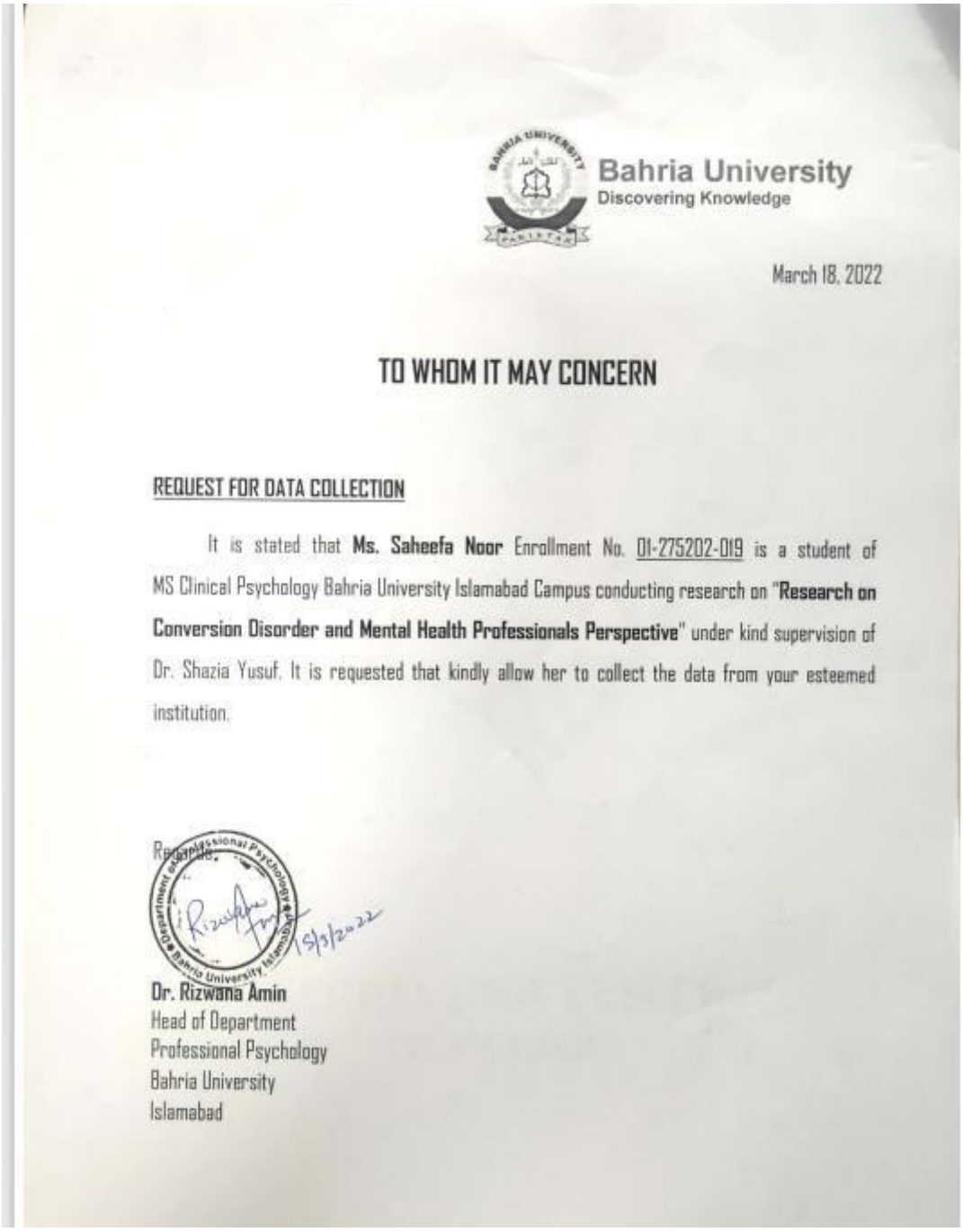
Appendix-A

Permission Letter



Bahria University
Discovering Knowledge

March 18, 2022

TO WHOM IT MAY CONCERN

REQUEST FOR DATA COLLECTION

It is stated that **Ms. Saheefa Noor** Enrollment No. 01-275202-019 is a student of MS Clinical Psychology Bahria University Islamabad Campus conducting research on "**Research on Conversion Disorder and Mental Health Professionals Perspective**" under kind supervision of Dr. Shazia Yusuf. It is requested that kindly allow her to collect the data from your esteemed institution.

Regards,

Department of Professional Psychology
Bahria University Islamabad

19/3/2022

Dr. Rizwana Amin
Head of Department
Professional Psychology
Bahria University
Islamabad

Appendix-B

INFORM CONSENT

Asalam-u-alikum, I'm Saheefa Noor, student of Bahria University Islamabad Campus. I'm currently enrolled in MS Clinical Psychology, Semester 4rth. I am conducting research on

"Studying Lived Experiences of Mental Health Professionals in treating and diagnosing CD: An In-depth Analysis". Sample of my research is Active Clinical Psychologists and Psychiatrists who are currently dealing patients with CD. Therefore, I request you to kindly allow me to take interview from you. Your decision to participate in this study is complete voluntary. If you decide to not participate in this study, you may withdraw from your participation at any time. It is to be assured that confidentiality will remain consistent. All information taken from the study will be coded to protect each subject's name. No names or other identifying information will be used when discussing or reporting data. I shall be very grateful if you allow me to take an in-depth interview.

Thank you

Supervisor's Signature: _____

Signature of Interviewer: _____

Appendix C

انٹرویو گائیڈ (اردو)

سوال نمبر ۰۱ سر / میس کیا آپ مجھے بتا سکتے ہیں کہ آپ اپنے روزمرہ کی مشق میں ذیادہ تر کن نفسیاتی بیماری کے ساتھ نمٹتے ھیں ؟

سوال نمبر ۰۲ سر / میس روزانہ کی بنیاد پر کنورژین ڈیس آرڈر)سی ڈی(کے کتنے مریض رپورٹ ہوتے ہیں؟

سوالنمبر۰۳ سر / میس کیا آپ نے روزانہ کی مش میں کبھی)سی ڈی(کے مریض کا جائزہ لیا ہے ؟

سوال نمبر ۰۴ سر / میس آپ کنورژین ڈیس آرڈر)سی ڈی(کا کیسے علاج کرتے ہیں ؟

سوالنمبر ۰۵ کنورژین ڈیس آرڈر)سی ڈی(کا علاج کرتے وقت کیا مشکلات آتی ہیں ؟

سوالنمبر ۰۶ سر / میس آپ ان پیچیدگیوں کو کیسے ہل کرتے ہیں ؟

سوالنمبر ۰۷ سر / میس آپ کے مطابق یہ نفسیاتی بیماری باقی سومیٹوفارم ڈیس آرڈر (آیس ڈی) سے کتنی مختلف ہے ؟- ذیادہ تر کیا علامات ہوتی ہیں ؟

- ذیادہ تر کون سے مریض آتے ہیں مرد یا عورت ؟
- انکی سماجی و اقتصادی حیثیت کیا ہوتی ہے؟

سوالنمبر ۰۸ سا / مِیس آپ کے مطابق کنورژین ڈیس آرڈر) سی ڈی(کی وجوہات کیا کیا ہیں ؟

سوالنمبر ۰۹ سر / مِیس کیا آپ بتاینگے کہ کنورژین ڈیس آرڈر) سی ڈی(کے مریضوں کے جسمانی رپورٹوں کے نتائج اور ان کا علاج کیسے ہوتا ہے ؟

- کنورژین ڈیس آرڈر (سی ڈی) کے لیے کون سی ادویات ذیادہ مؤثر ہیں؟
- کیا نفسیاتی معا لجہ اس کے علاج کے لیے بہت ہے؟
- کیا آپ اپنے مریض کو ماہرِ نفسیات کے پاس ریفر کرتے ہیں؟

سوالنمبر ۰۱۰ کنورژین ڈیس آرڈر (سی ڈی) کو ٹھیک ہونے میں کتنا وقت درکار ہوتا ہے؟

سوالنمبر ۰۱۱ سر / مِیس انٹرویو کے اختتام میں اسِ موضوع کے متعلق آپ کی کیا رائے ہے ؟

Appendix D

Interview Guide (English Version)

Studying Lived Experiences of Psychologists and Psychiatrists to treat and diagnose CD-An in-depth Analysis

1. Sir/Miss How do you evaluate/diagnose CD?
2. Sir/Miss according to you what are the risk factors that develops CD?
3. What are the complications while evaluating CD?
4. What measures you take to manage those complications?
5. Sir/Miss according to your experience how much time did the patients take to recover?
    a. (How long can CD last?)
6. What treatment do you recommend to patients with CD? (Medications)
7. What is the common gender ratio of CD
8. Sir/Miss with due respect would you like to add something related to this topic?

Appendix- E

انٹرویو نمبر :۱

سوال نمبر ۱ :میم آپکا کنورژن ڈسآرڈر کے بارے میں کیا خیال ہے؟

جواب :کنورژن ڈس آرڈر جو میری سمجھ کے مطابق ہے وہ یہ ہے کہ جتنے بھی نفسیاتی علامات ہیں وہ جسمانی علامات میں تبدیل ہو جاتے ہیں .میں یہی اپنے مریضوں کو سمجھاتی ہوں کہ نفسیاتی دباؤ اتنا زیادہ ہو جاتا ہے کہ آپ اس کو برداشت کرنے کے قابل نہیں ہوتے آپ کا جسم جھکڑ جاتا ہے اور وہی علامات جسمانی شکل میں تبدیل ہونا شروع ہو جاتے ہیں .اب اگر ہم یہاں پر دیکھے تو کنورژن ڈس آرڈر کہ جو علامات ہیں وہ وقتی طور کے لیے بھی ہوتے ہیں .کبھی کبھی علامات غائب ہو جاتے ہیں اور کبھی کبھی سو میٹک النص اتنی لمبی ہو جاتی ہے کہ وہ بہت درینہ بن جاتی ہے

سوال نمبر ۲ :آپکا کنورژن ڈسارڈر کے مریضوں کے ساتھ ایکسپیرئینس کیسا رہا؟

جواب :کنورژن ڈسارڈر از آلویز مائی فیورٹ کائنڈ آف ڈسارڈر فار می کیونکہ مریض کو ایسے اپنی آنکھوں کے سامنے اپنے سٹریس کے ساتھ نمٹتا ہوا دیکھ کر بہت اچھا لگتا ہے۔ دوسری بات یہ کہ وہ نیو ایڈیپٹنگ اور کوپنگ سکلز سیکھ لیتے ہیں اور انُکی لایف فلارش ہو جاتی ہے۔ اِٹس ویری سےٹیسفایئنگ ٹو س ی دیم لایئک دیٹ۔مینلی جو ہمیں کہا جاتا ہے نہ کہ جن نکالنے والی بات تو اس وجہ سے یہ میرا فیورٹ ہے کیونکہ اکثر فیمیلیز جو کہ غیر تعلیم یافتہ ہوتے ہیں وہ یہ سوچتے ہیں کہ ایسے کنڈیشنز یعنی ہاتھ ٹھیڑے ہو جانا یا بلاینڈ ہو جانا کچھ نظر نہیں آنا تو اس حالت میں انُ کو لگتا ہے کہ یہ جن یا طاویز کا اثر ہے۔ انُکو عوئرنس نہیں ہوتی کنورژن ڈسآرڈر کے بارے میں تو انُکو سائکو عژوکیٹ کر کہ جب ٹریٹمینٹ شروع ہو جاتی ہےتووہ ٹھیک ہو جاتے ہیں اگر فیملی اور مریض کوپریٹیو ہو دیٹس دہ ریزن اٹ از مائی فیئورٹ۔ آئی رئیلی اینجوئیڈ مائی ورک ود کنورژن پیشنٹس۔

سوال نمبر ۳ :کنورژن ڈسارڈر کو ڈائیگنوز ہونے میں کیا مشکلات آتی ہیں؟

جواب :ڈائیگنوز میں کافی بار ایسا ہوتا ہے کہ جو مریض کنورژن سیئزرز کے ساتھ آرہا ہو تو اسکی اوور لیپنگ ہو سکتی ہے جب تک کہ کوئی واضح اشارہ نہ ہو کنورژن ڈس آرڈر کا کبھی کبھی ایسا ہوتا ہے کہ سیئزرز کا دورانیہ اتنا کم ہوتا ہے ان کا جو ایپیلیپسی کے ساتھ اورلیپ کر رہی ہوتی ہے ایپیلیپسی والے سیئزرز کے ساتھ تو وہاں پہ تھوڑی سی مشکل آتی ہے ڈائیگنوز کرنے میں فار موسٹ آف دہ ٹائم فیملی والے پراپر انفارم نہیں ہوتے ایباوٹ دہ سمٹمز ، ایباوٹ پیشنٹس کنڈیش وِچ از آلسو ون آف دہ بیسک چیلنج اِن کنفرمِنگ کنورژن ڈسآرڈر۔

سوال نمبر ۴ :کنورژن ڈیسارڈر کو ڈائگنوز کرتے ہوے جو مشکلات آتی ہیں اسُکو آپ کیسے مینج کرتے ہیں؟

جواب :ایسے مینج کرتے ہیں کہ فریکونسی، ڈیوریشن، ایکسپلورنگ سٹریسرز مینز نیچر آف سٹریسرز اور نان ایپیلیپٹیک فٹس کا جو کرائٹیریا ہے اسُکو پراپرلی پڑھ کہ فل ہسٹری لے کہ فیزیکل ٹیسٹس کو کنفرم کر کہ مطلب ہے کہ جو فیزیکل کازز ہیں جیسے جیڈ اینجری، ڈیولپمینٹل مائلسٹونز، ہیں اسُکو EEG رول آوٹ کر کہ ترو ,اور باقی امپورٹینٹ ٹیسٹس ہیں وہ کنفرم کرتے ہیں۔

سال نمبر ۵ :کنورژن ڈسارڈر کو مینج کرنے میں کیا مشکلات آتی ہیں؟

جواب : اس میں مینجمینٹ میں یہ معاملہ ہے کہ آ سِٹل ریمیمبر ون آف مائی کلائنٹ، اٹ واز ویری کاملیکیٹڈ کیس، اٹ گاٹ ۶ منتس ٹو مینج۔ شی واز ہیونگ کنورژن سمٹمز۔ تھوڑی سی دیر کے لیے فٹ آتا تھا ایک جِن ٹائپ آف تِنگ پر سیٹل ہو جاتی تھی اینڈ شی واز فرام اے ویری ایجوکیٹیڈ فیملی بٹ اسُکی فیملی کمپلاینٹ نہیں تھی۔ اسُ پیشنٹ کے ساتھ دیٹ واز دہ ماسٹ ڈیفیکلٹ تنگ ٹو مینج ان کنورژن ڈسآرڈر۔ آ گیس شی واز ان ارلی ٹونٹیز۔ اسُ سے ہم نے مار بھی بہت کھائی ہے، یہ کیس بہت کرانک تھا۔ اسِکی مینجمینٹ میں بہت ڈیفیکلٹیز آئی تھی۔ آپکے پاس ایک سپیشل سپورٹ ہوتی ہے تو مینجمنٹ ایزی ہو جاتی ہے۔ اے لیٹل بٹ آف سپورٹ فرام کیرگیور اِز اِز ویری ایمپورٹینٹ۔ اس میں پرائمری اور سکنڈری گینز کا معاملہ ہے، گینز کتنے سارے ہوتے ہیں فآر عکزیمپل فیملی کے حالات فیملی کا بیہیوئر اور ورک ریلوٹڈ فانینشئل کمپنسےشن اور بہت کچھ ایسے مریض اپنے میڈیکل کنڈیشن کو لے کہ فائدہ لیتے ہیں تو اٹ از ڈیفیکلٹ تو ڈیسائڈ تو عیدر ویلیڈیٹ اٹ فآر دیم آر نآٹ، تو اف فیملی والے انُکی ہر زد کو پورا کرے وہ بھی ٹھیک نہیں ہے۔ یہاں پہ ڈیفیکلٹی ہے ک جو انسٹرکشنز ہم دیتے ہیں کلائنٹ کی فیملی اسُکو فالو نہیں کرتی اور مریض بھی نہیں۔ وہ کلیرلی میڈیسنز پہ ڈیپینڈ کرنا چاہتے ہیں کیونکہ انُکو کنورژن ڈسارڈر کے بارے میں نہیں پتہ ہوتا کے دس کائنڈ آف پیشنٹ نیڈز ٹو بھی کیرڈ اینڈ لوڈ۔ جو سوشل سپورٹ کی بات ہے نہ تو اِٹ مینز کہ جو بیسک نیڈز ہیں کلاینٹ کی وہ ٹھیک طرح سے ایڈرس نہیں ہو پاتی اور فیملی والے مس انڈسٹینڈ کر لیتے ہیں۔ سو یہ کنورژن ڈسآرڈر کی مینجمنٹ میں ایک بہت بڑا بیریر ہے۔ اور اگر ہم اپنی سوسایٹی کو دیکھیں تو جِن والا کانسیپٹ اِز ویری کامن کیونکہ ہاتھ پاوں ٹھیڑے ہو جانا اور جٹکے لگنا، کچھ پیشنٹس میوٹ ہو جاتے ہیں، اور بلائینڈنس آ جاتی ہیں۔ سو، دیز آر دہ

فیکٹرز جو کہ ہنڈرز ٹریٹنگ کنورژن ڈسارڈر۔

سوال نمبر ۶ :جینڈر وائز کونسے مریض زیادہ ریپورٹ کرتے ہیں؟

جواب: جنڈر وائیز تو اٹس مور کامن ان فیملز۔ اور میل میں بھی ہیں کچھ کیسز۔ دوز میل کلائنٹس ود کنورژن ڈسآرڈر انُ میں سمٹمز بہت کرانک ہوتے ہیں۔

سوال نمبر ۷ :کونسی فارم آف ٹریٹمینٹ بیسٹ ہوتی ہے کنورژن ڈسارڈر کے لیے بہتر ہے؟

جواب :میڈیسنز تو میں زیادہ تر پریسکرائب کرتی ہی نہیں ہوں۔ دے نیڈز سائکولوجیکل کیر، اگر کوئی ٹوئیر فیزیکل سمٹمز ہیں ادر وایز سایکولوجیکل ڈیمج ہے اس میں اور کیر بھی سایکولوجیکل ہوتی ہے۔

سوال نمبر ۸ :آپکے مطابق کنورژن ڈسارڈر کے کیا وجوہات ہیں۔

جواب :بیسکلی، وین یو آر انایبل ٹو ایکسپرس یورسیلف، وین دیر ایز نو ون ٹو لیسن دین یو نیڈ ٹو ایڈوپٹ سم ادر ویز دیٹ کاززِ کنورژن ڈسارڈر۔ پور مینجمینٹ سکلز ہوتی ہیں، پور کوپنگ سکلز ہوتے ہیں دیٹ آلٹو لیڈز ٹو کنورژن ڈسارڈر۔

سوال نمبر ۹ :کنورژن ڈیسارڈر کو ٹھیک ہونے میں کتنا ٹایم لگتا ہے؟

جواب :دیکھو اگر فیملی سپورٹیو ہے اگر فیملی آپکے ساتھ کمپلای ک رہی ہے، اگر کلاینٹ آپکے ساتھ کووپریٹ کرتا ہے تو میرا خیال ہے کہ اِسکو میکسیمم ۲ ہفتے لگیتے ہیں۔ لیکن کچھ کیسس ایسے بھی ہوتے ہیں کہ جِس میں آپکے ساتھ نہ فیملی سپورٹ ہے نہ اتنی انڈسٹینڈینگ ہے تو وہاں پہ ٹائم بہت لگتا ہے۔ ٹو، ویکس بھی لگتے سکتے ہیں، منتس بھی اور سال بھی۔

سال نمبر ۱۰ :میم آپ پیشنٹس پہ کونسی تیراپی ایپلایئ کرتے ہیں؟

جواب :cbt, مینلی اور اگر کلاینٹ پڑھا لکھا ہو تو اسُ کے ساتھ اور بھی مزہ آتا ہے

سوال نمبر ۱۱ :میم کوئی ایسی بات کنورژن ڈسارڈر کے بارے میں جسکو آپ شیر کرنا چاہینگی۔

،جواب :وی نیڈ ٹو سایکو ایجوکیٹ پیپل ایباوٹ کنورژن ڈسارڈر سو دیٹ انُکی سٹریس کوپنگ اچھی ہو لوگوں کو اپنی سٹریس مینجمنٹ ٹھیک رکھنی چاہیے تاکہ لوگ کنورژن کی طرف نہ جا سکے۔

انٹرویو نمبر :۲

سوال ممبر ۱ :سر آپ ڈیلی بیسز پہ کتنے پیشنٹس کو ڈیل کرتے ہیں آن ڈیلی بیسز آر ویکلی

جواب :اب اس میں تو ایکزکٹ فیگر ریکارڈ دیکھ کہ پتہ لگیکا لیکن کافی فریکونٹلی آتے ہیں جیسے اگر اگر ڈیپریشن کے مریض آتے ہیں تو انُکے ساتھ بھی کنورژن سمٹز ہمیں دیکھنے پڑتے ہیں۔ آن ایورج اگر ہم دیکھیں تو ۱/۳پیشنٹ تو ہوتے ہی ہیں جن میں کنورژن پیشنٹس بھی ہوتے ہیں لیکن انُکا میجر چنک ڈیپریشن کا ہی ہوتا ہے۔ اینزائیٹی/ڈیپریشن کے بعد آپکے پاس کنورژن ڈسارڈر بہت زیادہ ہیں۔ موسٹ فریکونٹ ہےسایلوسز اور ڈیپریشن اس کے ساتھ کئی دفعہ کومورببیڈیٹی میں ایکزسٹ کرتا ہے۔کئی دفعہ اسولیشن مہں بھی ہوتا ہے لیکن زیادہ تر پیشنٹس میں آپکو ڈیپریشن کے سمٹمز کے ساتھ مِل رہے ہونگے۔ جتنا فریکوینٹ آپکے پاس ڈیپریشن ہوگا اُتنا فریکوینٹلی آپکے پاس ڈیپریشن ہوگا اور اُتنا فریکوینٹ اسُکے ساتھ ساتھ ایکزیسٹ کر رہا ہوگا۔

سوال نمبر ۲ :آپکو اپنے کیریر کا پہہلا کیس یاد ہے؟

جواب :ہاں، بلکل یاد ہے۔ وہ تو وہ پیشنٹس تھے جو میں ہاوس جاب میں اپنے ٹریننگ ڈیز میں ایسسٹ کرائے تھے۔ میں نے مینیج اور سوپروائز کیے تھے اور عہ مجھے یاد ہے۔

سوال نمبر ۳ :سر آپ کنورژن ڈسارڈر کو کیسے ڈائگنوز کرتے ہیں، اور جو کاملیکیشنز آتی ہیں ڈایگنوز کرتے ہوئے اسکو کیسے مینج کرتے ہیں؟

جواب :وہ تو یہی ہے نہ کہ کلینیکل ڈائگنوسز کا اپنا کرائٹیریا ہوتا ہے تو جب کلینیکل انٹرویو میں ایکسزامیناچن کے دوران اسُ میں جو ہم جب جب سوڈو سیزرز اور ٹرو سیزرز کی ڈیفرینشیشن کرتے ہیں تو آسکو تو ہم سپورٹ کرتے ہیں ود کلئر اینویسٹیگیشن مینز کہ اسُ میں جو ایک کمپلیٹ ورک اپ ہوتا ہے۔ایپیلیپسی کا ٹیسٹ بھی ایک دفع کروا لیتے ہیں لیکن اسُ میں وہ ڈائیگنوسز آپ کہھ لیں کہ جو ویٹ کیری کرتی ہے نہ چیزہ وہی ہوتا ہے کہ ہم اڈینٹیفائی کر سکے کہ اسُکے کلینیکل فیچرز کیا ہیں، انُکی کلینیکل فریکوینسی کتنی ہے، کتی دیر وپیلیپسی کے فٹس ہیں یا وہ سوڈو سیزرز ک آرہے ہیں۔

اور ڈیفیکلٹی اِن ڈایگنوسنگ تو عیرلی ہوتا ہے لیکن سوڈوسیزرز اور اور ایپیلیپسی کو ڈیفرینشیٹ عام طور پہ ہم کرتے ہیں۔ اسُ ٹائم زرا اہتیاط کرنے کی ضرورت ہوتی ہے۔ اسُکی مینیجمینٹ زیادہ ٹریکی ہوتی جاتی ہے۔ پِر

مینیجمینٹ اینڈ کیر پہ ٹائم لگتا ہے لیکن ڈایگنوسز ہو جاتی ہے ایزیلی۔ کم کیسز ایسے ہوتے ہیں جِن میں کمپلیکس سینارئیو ہوتا ہے۔ چیزیں کنفیوز کر رہی ہوتی ہے جس میں دونو چیزیں آپکو ساتھ مِل رہی ہوتی ہے۔ جس میں ایپیلیپسی کے ساتھ چونکہ ایموشنل برڈن ہوتا ہے، ا ن ریزولڈ کونفلیکٹس ہوتے ہیں تو دونو فٹس اکھٹے آرہے ہوتے ہیں۔ ایپیلیپسی اور سوڈوسیزرز اسُ میں آپکو کئی دفعہ مشکل ہوتی ہے۔ اور دوسری بات یہ ہے کہ آپکا ایکسپیرینس بھی میٹر کرتا ہے۔ جب آپ نیو ہو اِس فیلڈ میں تو آپکو کنفیوژن ہو سکتی ہے۔ نُکو بہت کیرفولی دیکھنا پڑھتا ہے لیکن ایکسپیرینس کے ساتھ ساتھ سکلز ڈیولپ ہو جاتی ہے۔ چیزیں کلیر ہونا شروع ہو جاتی ہے بٹ اٹِ ڈزنٹ مین کہ آپ ودآوٹ اینویسٹیگیشن کیس کو ڈائیگنوز کرو۔ اوبایسلی اٹس اے ٹریکی ڈایگنوسز اہتیاط کرنی پڑتی ہے۔

سوال نمبر ۴ :کنورژن ڈسآرڈر کو ڈائیگنوز کرنے کے ٹائم جو کنفیوجناتی ہے اسُکو کیسے مینج کرتے ہیں؟
جواب :اِس طرح کہ آپکو ٹرو ایپیلیپٹک فیٹس مل رہے ہوتے ہیں تو آپ کو مینج کرنا ہوگا لیکن اسُکے ساتھ باقی سوڈو سیزرز کی جو مینیجمینٹ ہے یہی ہم پروسیڈ کرتے ہیں۔

سوال نمبر ۵ :جینڈر وائز کونسے مریض زیادہ ریپورٹ کرتے ہیں؟

جواب: اچھا اِس میں جو ہم بُکس میں پڑھ رہے ہوتے ہیں اسُ میں تو یہی تھا کہ کلاسیکلی تو ہی فیملز
،میں زیادہ دیکھا جاتا ہے لیکن اِن میں دونو پاپولیشن میں آجاتی ہے۔ ایڈولیسینٹ میں ہو جاتا ہے انریزولڈ کانفلکٹس کی وجہ سے، میلز میں بھی دیکھے جاتے ہیں لیکن ان سب کی نسبت فیملز میں زیادہ ہوتا ہے۔ ۔ پاکستان میں یہ کہنا کہ میلز میں اکزیسٹ نہیں کرتا از ناٹ رائیٹ کیونکہ میلز میں بھی بہت بڑا چنک آپکو ملتا ہے خاص طُور پر جو ہوتا ہے نہ کہ اگر ہم دوسرے چنک میں چلے جائیں نہ اگر آپ سائکوسومیٹک لمپلینٹس کی بات کریں نہ جیسے ان ایکسپلینڈ میڈیکل سمٹمز تو اسُ میں میل پاپولیشن کافی آجاتی ہے۔

سوال نمبر ۶ :کنورژن ڈیسارڈر کے وجوہات کیا کیا ہیں؟

جواب :اچھا ایویڈینس بیسڈ جو میری انڈسٹینڈنگ وہ یہ بتاتی ہے کہ جو کنورژن ڈسارڈر ہے میں جو بات کر رہا ہوں ڈیسوسیش کی بات کر رہا ہوں۔

ڈسسوسیٹو ڈسارڈرز تو وہی انریزولوڈ کانفلکٹس کی وجہ سے ہوتے ہیں، جو ڈیفینس میکینیزمز یوز کرتے ہینڈفرنٹ۔ اسُی کے ساتھ جو میری انڈرسٹینڈنگ ہے وہ یہ ہے کہ جو ڈسوسیٹو سمٹمز اور ڈسارڈرز اور یہی کنورژن ڈسارڈر تب ہوتا ہے جب آپکی باڈی کو کوئی ایموشنل طریٹ مہسوس ہو اور طریٹ سے مُراد ایموشنل ٹرامہ، ایکسٹریم سٹریس، ڈیپریشن اس قسِم کے جو مسلے ہوتے ہیں تو ہماری باڈی کا یہی ریسپانس ہوتا ہے وچ ریزلٹ ان کنورژن ڈسارڈر۔

سوال نمبر ۷ :کونسی ٹریٹمینٹ از بیسٹ فار کنورژن ڈسآرڈر؟

جواب :سایکولوجیکل ٹریٹمینٹ اِز بیسٹ فار کنورژن ڈسارڈر۔ کنورژن ڈسارڈر کو اگر آپ میڈیکلی ٹریٹ کرتے ہیں تو کئی دفعہ کاونٹر پروڈیٹٹیو بھی ہو جاتا ہے۔ کوئی نقصان کر سکتا ہے۔ اگر اسولیشن میں ہیں اور پیور کنورژن ہیں اور آپ اسُکو میڈیسنز سے ٹریٹ کررہی ہیں تو وہ ایک سیکیمڑی گین بن جاتا ہےاور یہی سیکیمڑی گین جو آبویس کامپلیکیشن کو رائز کرتی ہے، میڈیکلی ریانفورس ہو جاتی ہیں لیکن اسُکی مینیجمینٹ میں آپکو پتہ ہی ہوگا آپ نے یہ اڈینٹیفائی کرنا ہوتا ہے کہ یہ سیکینڈری گینز اور میڈیکلی ریانفورسڈ اور سیکینڈری ریانفارسمینٹ کونسی ہوتی ہیں جب آپ اسُ کو پہلے ریمو کرتے ہو تو آپکو اسُکی انڈرلائینگ کاز کا پتہ چل جاتا ہے۔ اسُ کے لیے میڈیسن کی ضرورت میجرلی نہیں پڑھتی۔

انٹرویو نبر :۳

سوال نمبر ۱ :میم آپکے خیال میں کنورژن ڈیسارڈر کیا ہے؟

جواب: کنورژن ڈس آرڈر جو ہے وہ اصل میں جب ذہنی دباؤ بہت زیادہ ہو جا تے ہیں اور جو مریض ہوتا ہے ان کو ان مسائل کے ساتھ نمٹنا نہیں آتا ,ان کو سننے سمجھنے والا کوئی نہیں ہوتا تو ان کے سائیکالوجیکل سٹریسرز جسمانی بیماری میں تبدیل ہونا شروع ہو جاتے ہیں ایسے مریض کے بارے میں اکثر لوگ کہتے ہیں اکثر لوگ یہی سوچتے ہیں کہ یہ دوسروں کی توجہ حاصل کرنے کے لیے ایسے کرتے ہیں لیکن میں اس بات کے بالکل خلاف ہوں کیونکہ دیکھو یہ ان کے کنٹرول میں نہیں ہوتا

سوال نمبر ۲ :میم آپ اپنے ڈیلی پریکٹس میں کتنے کنورژ ڈسارڈر کے مریض کو دیکھتے ہیں؟

جواب :کافی، کافی پیشنٹس آتے ہیں اسِ ڈسارڈر ک ساتھ، ایسپیشلی لو سوشیواکنامک سٹیٹس سے بیلونگ کرتے ہیں انُ میں موسٹ کومن ہے کنورژن ڈسارڈر۔ اور ایکزیکٹ نمبر تو میں نہیں بتا سکتی کیونکہ آ ڈونٹ ریمیمبر ایکزیکی بٹ کافی ہوتے ہیں۔ اِن مائی ڈیلی پریکٹس ویکلی ضرور کوئی نہ کوئی مریض دیکھنے کو ملتے ہیں مینز ۶ اور ۷ ایک ہفتے میں۔

سوال نمبر ۳ :میم کنورژن ڈسارڈر کو ڈایگنوز کرتے ہوے کیا مشکلات آتی ہیں؟

جواب: دیکھیں اصل میں یہ بات یہ کہ جو مریض ہوتے ہیں وہ مختلف علامات کے ساتھ ساتھ آتےہیں کچھ ایسے ہوتے ہیں جن کو جھٹکے لگتے ہیں مطلب کہ فیٹس اور سوڈو سیزرز کنورژن ڈس آرڈرکے ساتھ ساتھ ایپیلیپسی اورلیپ کر رہی ہوتی ہے ایسے مریض کی فیملی کو لگتا ہے کہ مرگی کا دورہ پڑا ہے مطلب ایپیلیپسی لیکن ایسا نہیں ہوتا ور کچھ پیشنٹس ایسے آرہے ہوتے ہیں کہ وہ بلکل میوٹ ہوتے ہیں جنکے ساتھ کافی ٹائم لگانا پڑھتا ہے ٹو بریک دئیر میوٹیزم، ۲ ٹو ۳ گھنٹے بھی کچھ پیشنٹس لے لے لیتے ہیں ک وہ اتُھ کی کچھ بولیں، ہم پیشنٹ سے ہسٹری پوری لیں، انفارمیشن لیں ساری کے وٹ ایکچولی از دہ پیرابلم اِن پیشنٹس لایف، انُکی فیملی تو انِفارمڈ ہی نہیں ہوتی، فیملی صحیح ،ریپورٹ نہیں کر رہی ہوتی۔ سو کچھ پیشنٹس کے سمٹمز ڈیپریشن کے ساتھ اوورلیپ کر رہی ہوتی ہیں علامات میکس اپ ہو جاتے ہیں، کچھ مریض بلاینڈنس کے ساتھ آتے ہیں، کچھ پیرالیسس کے ساتھ آتے .ہیں سو وائل ڈایگنوسنگ ہمیں کیرفلُ رہنا ہوتا ہے کہ مِس ڈائگنوس نہ ہو جائے۔

سوال نمبر ۴ :میم آپ اِن چیلینجز کو کیسے مینیج کرتی ہیں؟

جواب :ڈیتیلڈ ہسٹری، فیزیکل کاززز کو رول آوٹ کر کہ، ایپیلپٹک سیزرز کی کراٹیریا کو اور نانایپیلیپٹیک سیزرز کی کراٹیریا کو اڈینٹیفائی کر کے، ڈیوریشن آف فٹس کو اڈینٹیفائی کر کہ فریقیونسیآف فٹس اور سائیکولوجیکل سٹریسرز کو اڈینٹیفائی کر کہ پِر ڈائگنوس کرتے ہیں۔ ای ای ج اور باقیمیڈیکل ٹیسٹس کلئیر کر کہ کوئی اور میڈیکل کنڈیشن تو نہیں ہے سو، آفٹر کنفارمنگ دِس دین وی ڈائگنوز اٹِ۔

سواک نمبر ۵ :ایسی کیا وجوہات ہیں جسکی وجہ سے کنورژن ڈسارڈر کو ٹریٹ کرنے میں دشواری آتی ہے؟

جواب :مسئلہ یہ ہے کہ اکثر جو مریض ہوتے ہیں ان کے فیملی ممبرز بہت ان کو آپریٹو ہوتے ہیں جیسے کہ میں نے پہلے بھی ذکر کیا کہ جو غریب طبقے والے لوگ ہیں تو ان میں تعلیم کی کمی ہوتی

ہے وہ مریض کی حالت کو نہیں سمجھتے ان کو پاگل اور ذہنی مریض سمجھ کر غلط ٹریٹ کرتے ہیں

اور ان کو فل سپورٹ نہیں کرتے ادھر ہمارے پاس جب کنورژن سمٹمز کرونک ہوتے ہیں تو مریض کو ایڈمٹ کیا جاتا ہے ان کی فیملی ان کو بغیر انفارم کیے لے جاتی ہے بغیر ڈاکٹر کے پرمیشن کے لے جاتے ہیں ,لاہ ہو جاتے ہیں کیونکہ کنورژن ڈس آرڈر کو ٹھیک ہونے میں وقت لگتا ہے اس وجہ سے اکثر فیملیز مریض کو سپورٹ نہیں کرتی اور مریض کو لے جاتے ہیں ہ فیملی پراپر ریپورٹ کرتی ہے مریض کی حالت کے طابق اور نہ ھماعے بتاے گئے انسٹرکشنز پر عمک کرتی ہیں۔ کبھی ،کبھی پیشنٹ ڈر کی وجہ سے کچھ نہیں ریویل کرتے ود دہ توٹ اف کہ گھر والو کو کچھ پتہ نہ چلے

کچھ گھروں میں ایسے اشوز ہوتے ہیں ڈومیسٹک وایلنس کے۔ وہ میڈیسنز پہ ڈیپنڈ کرتے ہیں۔ انُ کو یہ نہیں پتہ کہ اِن کو سائکولوجیکل کیر کی ضرورت ہوتی ہے۔ ثو ایسے فیکٹرز ہینڈرز دہ ٹریٹمنٹ پروسس کیونکہ جو کانفلکٹ ہے ودان پیشنٹ مایئنڈ وہ تو حل نہیں ہوتا نہ میڈیسنز سے ہمارے باڈی کے اندر جو فیزیولوجیکل پرابلمز ہوتےہیں ہو حل ہوتے ہیں انسٹیڈ آف سائکولوجیکل۔

سوال نمبر ۶ :کنورژن ڈسارڈر کو ٹریٹ کرنے کے لئے کونسی ٹریٹمنٹ بیسٹ ہوتی ہے؟

جواب :سائکولوجیکل ٹریٹمنٹ لیکن جب کوموربیڈیٹی ہو رو پِر اننکے لیے میڈیسنز کی ضرورت پڑھتی ہے۔

سال نمبر ۷ :میم آپ اپنے پیشنٹس کے ساتھ کونسی تیراپی یوز کرتے ہیں؟

جواب :ا یوز ایکلیکٹک اپپروچ ود سچ پیشنٹس۔ اس ہاسپیٹل میں زیادہ تر مریض اناڑوکیٹیڈ ہوتے ہیں تو انُکے ساتھ سی بی ٹی ایز اے ہولیسٹیک اپپروچ نہیں یوز کرتی میں بٹ ٹم ٹیکنیکس آف سی بی ٹی اسِکے علاوہ ڈیلی کاونسلنگ۔

انٹرویو نمبر :۴

سوال نمبر ۱ :سر آپ کے خیال میں کنورژن ڈسارڈر کیا ہے؟

جواب :کنورژن ڈسارڈر از بیسیکالی جب مریض کے سٹریسز اتنے زیادہ ہو جاتے ہیں کہ انُ سر برداشت نہیں ہوتا اسُ کو کوپ کرنے کے قابل نہیں ہوتے تو وہ سمپٹز فیزیکل فارم میں چینج ہو جاتے ہیں اور ایسا لگتا ہے کہ انُ کو کوئی میڈیکل پرابلم ہے بٹ اگر اسولیشن میں ہیں کنواژن تو وہ پئیر سائیکولوجیکل ڈسارڈر ہے۔

سوال نمبر ۲ :سر آپ کنورژن ڈسارڈر کو ڈائگنوس کیسے کرتے ہیں؟

جواب :کرایٹیریا اور سمٹمز کو دیکھ کہ کرتے ہیں۔ اسُ سے پہلے ڈیٹیلڈ انفارمیشن لینی ضروری ہیں کیونکی اِن کے ساتھ ساتھ فار موسٹ آف دہ ٹائم کوموربیڈیٹیز بھی پائی جاتی ہیں۔ فار ایکزیمپل ڈیپریشن اور اینزائیٹی۔

سوال نمبر ۳ :سر کنورژن ڈسارڈر کو ڈائگنوس کےنے کے ٹئم کیا مشکل آتی ہے؟

جواب :اچھا اگر مینادکو اسِ پراپیکٹئو سے بتاوں تو اسِکی اوورلیپنگ آتی ہے ایپیلیپسی کے ساتھ تو آپ نے اہتیاط کرنی ہوگی، ایسے سمٹز کو اڈینٹیفائی کرینگے اور اسِ کی اوورلیپنگ ڈیپریشن کے ساتھ بھی اکثر آجاتی ہے سو آپ نے دونو کو سیپریٹلی مینج کرنا ہوتا ہے۔

سوال نمبر ۴ :سر آپ اِن مشکلات کو کیسے ٹیکل کرتے ہیں؟

جواب :ڈیٹیلڈ ہسٹری سے، مریض سے بات کر کہ بیٹا، ای ای ج کو دیکھتے ہوئے۔ دیکھیں بیٹا ایسے مریض کو نہ آپ ایک اوپن پلیٹ فارم دیں وہ اپنے دکُھ کا اظہار خود کرینگے تو آپکو بھی پتہ چل جاتا ہے کہ کونسا ڈائگنوسز ٹاپ پہ آتا ہے۔ بٹ آپ فیزیکل فائنڈنگز کے بغیر ڈایگنوسز کو اپرو نہیں کر سکتے۔

سوال نمبر ۵ :سر آپ کے خیال میں کیا ٹریٹمینٹ پلین کنورژن ڈسارڈر کے لئے بیسٹ ہے؟

جواب :بیٹا سایکولوجیکل، لیکن اگر کوموربیڈیٹی کے ساتھ ہو تو یعنی ڈیپریشن اور اینزائٹی کے ساتھ تو میں اینٹی ڈیپریسنٹس پریسکرائب کرتا ہوں اور سائکولوجیکل ہیلپ کے لیے سائکولوجسٹ کے پاس ریفر کر دیتا ہوں۔

سوال نمبر ۶ :سر کنورژن ڈسارڈر کی ٹریٹمنٹ میں کیا دشواری آتی ہے؟

جواب :بیٹا، یہ ہے نہ کہ ایسے پرابلمز کا نہ لوگوں کو پتہ نہیں ہوتا تو انُ کو سمجھانا مشکل ہوتا ہے اور فیملی بڑی اینول ہوتی ہے اِس مثلے میں کیونکی انُکی سپورٹ کے بغیر اسِکا ٹھیک ہونا مشکل ہے

سوال نمبر ۷ :سر آپ آخر میں کچھ سجیسٹ کرنا چاہتے ہیں؟

جواب :جو مجھے لگتا ہے نہ وہ یہ ہے کہ ایسے مریضوں کے لیے پی ائم سی کو چاہیے کہ الگ سیٹ اپس بنائے جہاں پہ انُکی الگ سے مکمل کئر ہو ٹھیک ہے کیانکہ اسِکی اب بہت ضرورت ہے ایسے سیٹ اپس جہاں پہ فیملی کی ڈومینینس زیادہ نہیں ہو۔

انٹرویو نمبر :۵

سوال نمبر ۱ :سر آپ کے خیال میں کنورژن ڈسارڈر کیا ہے؟

جواب :کنورژن ڈسارڈر از ٹرانسفارمیشن اف سائکولوجیکل سمٹز انٹو فیزیکل سمٹز وین دہ پیشنٹ اِز اِن سوئر ڈسٹریس تو وہ ڈسسٹریس فیزیکل سمٹز کی شیپ میں آنا شروع ہو جاتا ہے۔

سوال نمبر ۲ :سر آپ کنورژن ڈسارڈر کو ڈائگنوس کیسے کرتے ہیں؟

جواب :جو ڈی ایس ایم کا کراٹیریا، ہے اسُکو دیکھ کی ڈائگنوس کرتے ہیں۔

سوال نمبر ۳ :سر کنورژن ڈسارڈر کو ڈائگنوس کےنے کے ٹئم کیا مشکل آتی ہے؟

جواب :مشکل یہ ہوتی ہے کہ کچھ مریض میکس سمٹمز کے ساتھ آ رہے ہوتے ہیں تو اس پہ ڈائگنوسز میسپلیس ہونے کا چانس ہوتا ہے زیادہ۔ اور زیادہ تر پیشنٹس انایجاکیٹڈ ہوتے جو کنورژن ڈسارڈر کے ساتھ ریپورٹ ہوتے ہیں تو انُکو سمجھ نہیں آتی ہمارے باتوں کی۔

سوال نمبر ۴ :سر آپ اِن مشکلات کو کیسے ٹیکل کرتے ہیں؟

جواب :میڈیکل ٹیسٹس کو ویریفائی کر تھے ہیں اور پیشنٹ سے بات چیت کر کہ سمٹمز کلیر ہو جاتے ہیں اور ڈایگنودز بھی کنفارم ہو بجاتی ہے۔

سوال نمبر ۵ :سر آپ کے خیال میں کیا ٹریٹمینٹ پلین کنورژن ڈسارڈر کے لئے بیسٹ ہے؟

جواب :سایکولوجیکل ٹریٹمینٹ از ویری سوٹبل فار کنورژن کییونکہ میڈیسنز سے انڈرلاینگ کاز ٹھیک نہیں ہوتی۔ تیراپی سے ہوتی ہے۔

سوال نمبر ۶ :سر کنورژن ڈسارڈر کی ٹریٹمنٹ میں کیا دشواری آتی ہے؟

جواب :انکمپلاینس آف پیشنٹ اینڈ فیملی، چونکہ لوگوں کو اِس کے بارے میں زیادہ تر پتہ نہیں ہوتا تو وہ میڈیسنز کو زیادہ تر پایفر کرتے ہیں اور تیراپی کو فالو نہیں کرتے ٹو تیراپی ورک نہیں کرتی پر اینڈ دیٹ اِز ناٹ گوڈ فار پیشنٹ ایز ویل ایز تیراپسٹ۔

سوال نمبر ۷ :سر آ پ کونسی تیراپی فالو کرتے ہیں فار ٹریٹمنٹ اف کنورژن ڈسارڈر؟

جواب :اچھا اِس میں یہ ہے کہ انایجوکیٹڈ کلاینس کے ساتھ تو کاونسلنگ اور سپورٹئیو تیراپی اور ایجوکیٹڈ کے ساتھ سی بی ٹی لیکن کامیب وہی ہوتے ہیں جو انسٹرکشنز کو فالو کر رہے ہوتے ہیں۔

سوال نمبر ۱ :سر ڈیلی بیسز پہ کنورژن ڈسارڈر کے کتنے پیشنٹس ریپورٹ ہوتے ہیں؟ جواب :ڈیلی بیسز پہ تو اتنا شورلی نہیں بتا سکتا بٹ ویکلی ۵ ٹو ۶ پیشنٹس ریپورٹ ہوتے ہیں۔

سوال نمبر ۲ :سر آپ نے اپنے کیرئر میں سی ڈی کے مریض کو ٹریٹ کیا ہے؟

جواب :یِس، ہر مہینہ، آجکل یہ ڈسارڈر بہت زیادہ ہے۔ مجھے اب بھی یاد ہے جب مہں اپنے ہاوس جاب پہ تھا تو میں اپنے سینیر کنسلٹےنٹ کے انڈر آبزرویشن میں تھااینڈ آ ڈیلٹ وِد مائی مرسٹ پیشنٹ عِ دُ کنورژن ڈسارڈر۔ وہ میل تھا انُ میں سمٹمز کافی کرانک تھے اینڈ ٹریکی تھے۔ ایٹ دیٹ ٹائم ا توٹ کہ اِس ڈیسارڈر کو ٹریٹ کرنا وِل بھی ویری اینٹرسٹنگ بٹ جےسے ٹائم گزرتا گیا ناو آ فیل لایک ک کنورژن کہ کنورژن ڈسارڈر کو ٹرٹ کرنا از اے لےٹل بٹِ ٹایرینگ اور اِٹ ٹیکس یور فلُ پوٹینشل اِف دہ پیشنٹ اِز وِد کرانک سمٹمز۔

سوال نمبر ۳ :کنورژن ڈیسارڈر کو ڈیل کرنے میں کیا کامپلیکیشنز آتی ہیں؟

جواب :دیکھیں پرابلم ہوتا ہے ڈیفرینشیٹ کرنے میں انُ لوگوں کو جو ایپیلیپسی ہے یہ کنورژن کی کرائٹیریا کو صہیح انڈسٹینڈ اور سٹڈی نہ کر سکے۔ ابویسلی چیلینجنگ یہ ہوتا ہے کہ جو اینیشیل پرےشینٹےشن ہوتی ہے اسُ میں جو فیملی ریپورٹ کرتی ہے ہو ایپیلیپٹک فام آف سیزرز ہوتی ہے فار ایکزیمپل دورے پڑنا ۔ سو اٹِ از چیلنجینگ کہ ہمارے کنٹری میں فیمیلیز کو سایکو ایجوکییشن نہیں ہے۔ وٹ ا مین ٹوسے کہ وہ ڈیفرینشیٹ نہیں نہیں کر پاتے کہ ڈیوریشن آف ایپیلیپسی فٹِ اور ڈیوریشن آف ڈیسوسیٹیو فٹِ کتنی لمبی ہوتی ہے اینڈ ود دیٹ ایپیلیپسی کے ساتھ آنکھوں پہ اندہیرا آنا ، متلی آجانا، یورینیشن، ٹنگ بائٹ اور ڈیوریشن آف فٹِ۔ سو یہ ساری چیزیں فیمیلیز ریپورٹ کرتی ہیں سو آن دہ بیسز آف دیٹ وی سٹارٹ ڈیلنگ اٹِ تو ریزلٹس آر ناٹ ڈیزارڈ بعد میں ترو فردر اینوسٹیگیشن تنگز سٹارٹس ٹو گیٹ کلیر ایباوٹ دہ ہول سینارئیو۔

سوال نمبر۴ :سر آ اِن چیلیمجز کو کیسے مینج کرتے ہیں ؟

جواب :فار اِس ہم تو ماڈسلے گائیڈ لاینز گالو کرتے ہیں۔ فرسر مور اگر میں آپکو بتاوں کہ ڈیسوسیٹیو ڈیسارڈرز کی رووٹ کاز میں دیکھیں تو پیشنٹ کی پرسنالٹی کو اسیس کر کہ، سٹریسرز کو دیکھ کہ، یہ کنفارم کرتے ہیں کہ کوئی اینٹیلیکچول ڈیسایبیلیٹی تو نہیں ہےجِسکے ساتھ کنورژن سمٹز ارہے ہیں، اینڈ لیٹس سے کہ اور کوئی فیملی پریشر یا اور کوئی سوشل ریزن جیسے ڈیط آف سپاوس، فانینشیل کنسٹرینٹس۔ ڈیورس، سو یہ ساری باتیں کنفرم کر کے کہ کس ریزن کی وجی سے ڈیسوسیٹ کر رہا ہے۔ اور ڈیسوسیشن باقی بیماریوں کے ساتھ بھی ہوتی ہے جیسے کہ ڈیپریشن اور اینزائٹی سو اسُکا بھی خیال رکھنا چاہیے

سوال ممبر ۵ :کنسے جینڈر میں کنورژن ڈیسارڈر زیادہ ہوتی ہے؟ اور وجوہات کیا ہیں؟

جواب :اچھا ایکورڈینگ ٹو مائی ایکسپیرینس تو فیمیل میں اور بچوں میں جنکو ساتھ ساتھ ایپیلیپسی چل رہی ہوتی ہے۔ اور اسِکے علاوہ سایکولوجیکل سٹیسرز، ا ن ریزولڈ کانفلیکٹس، اور مختلف پریشرز ہیں جو صہیح دے ایڈریس نہیں ہوتے اینڈ اٹِ لیڈز ٹو سمٹز لائیک دیٹ اور کچھ میڈیکل کنڈیشنز کی وجہ سے بھی کاز ہوتی ہے۔

سوال نمبر ۶ :آپکے مطابق کونسی ٹریٹمینٹ اِز بیسٹ فار کنورژن ڈیسارڈر؟

جواب :میرے مطابق اِن پیشنٹس کے لیے بائیو سایکوسوشل کلچرل سپیریچول ماڈل کی ضرورت ہوتی ہیں۔ میڈیسنز کو موربیڈیٹی کے لیے ٹھیک رہتی ہے۔ جیسے ڈیپریشن۔ تو پِر اسُکے بعد اسُکی سائکولوجیکل تیراپی سٹارٹ کرتے ہیں، بیہیوریل

تیراپیز کرتے ہیں اور فردر نے سوشل اور فیملی ایجوکیشن، فیملی تیراپی، مطلب وی ہیو ٹو ڈیل پیشنٹس ایز اے ہولیسٹک اپپروچ۔

سوال نمبر ۷ :کنورژن ڈسارڈر کو ٹھیک ہونے میں کتنا ٹائم لگتا ہے؟

جواب :اٹِ ریزول سپانٹینیسلی ایز ویل، آپ نے خود دیکھا ہوگا ایسے ایز اے سائکولوجسٹ، اگر انسٹرکشنز کو ٹھیک سے فالو کرے تو ۲ ہفتو میں ٹھیک ہو جاتا ہے، اگر مریض کمپلائنٹ نہیں تو پِر ٹائم لگتا ہے۔ زیادہ کرانک سمٹز ہو تو بھی ۲ مہینے کچ لگ سکتے ہیں۔

انٹرویو نمبر :۶

سوال نمبر ۱ :سر ڈیلی بیسز پہ کنورژن ڈسارڈر کے کتنے پیشنٹس رپورٹ ہوتے ہیں؟

جواب :ڈیلی بیسز پہ تو اتنا شورلی نہیں بتا سکتا بٹ ویکلی ۵ ٹو ۶ پیشنٹس رپورٹ ہوتے ہیں۔

سوال نمبر ۲ :سر آپ نے اپنے کیرئر میں سی ڈی کے مریض کو ٹریٹ کیا ہے؟

جواب :یس، ہر مہینہ، آجکل یہ ڈسارڈر بہت زیادہ ہے۔ مجھے اب بھی یاد ہے جب مہں اپنے ہاوس جاب پہ تھا تو میں اپنے سینیر کنسلٹےنٹ کے انڈر آبزرویشن میں تھااینڈ آ ڈیلٹ وِد مائی مرسٹ پیشنٹ عِ دُ کنورژن ڈسارڈر۔ وہ میل تھا انُ میں سمٹمز کافی کرانک تھے اینڈ ٹریکی تھے۔ ایٹ دیٹ ٹائم ا توٹ کہ اِس ڈیسارڈر کو ٹریٹ کرنا وِل بھی ویری اینٹرسٹنگ بٹ جےسے ٹائم گزرتا گیا ناو آ فیل لایک ک کنورژن کہ کنورژن ڈسارڈر کو ٹرٹ کرنا از اے لےٹل بٹِ ٹایرینگ اور اِٹ ٹیکس یور فلُ پوٹینشل اِف دہ پیشنٹ اِز وِد کرانک سمٹمز۔

سوال نمبر ۳ :کنورژن ڈیسارڈر کو ڈیل کرنے میں کیا کامپلیکیشنز آتی ہیں؟

جواب :دیکھیں پرابلم ہوتا ہے ڈیفرینشیٹ کرنے میں انُ لوگوں کو جو ایپیلیپسی ہے یہ کنورژن کی کرائٹیریا کو صہیح انڈسٹینڈ اور سٹڈی نہ کر سکے۔ ابویسلی چیلینجنگ یہ ہوتا ہے کہ جو اینیشیل پرےشینٹےشن ہوتی ہے اسُ میں جو فیملی رپورٹ کرتی ہے ہو ایپیلیپٹک فام آف سیزرز ہوتی ہے فار ایکزیمپل دورے پڑنا ۔ سو اٹِ اِز چیلنجینگ کہ ہمارے کنٹری میں فیمیلیز کو سایکو ایجوکیشن نہیں ہے۔ وٹ ا مین ٹوسے کہ وہ ڈیفرینشیٹ نہیں نہیں کر پاتے کہ ڈیوریشن آف ایپیلیپسی فٹِ اور ڈیوریشن آف ڈیسوسیٹیو فٹِ کتنی لمبی ہوتی ہے اینڈ ود دیٹ ایپیلیپسی کے ساتھ آنکھوں پہ اندہیرا آنا ، متلی آجانا، یورینیشن، ٹنگ بائٹ اور ڈیوریشن آف فٹِ۔ سو یہ ساری چیزیں فیمیلیز رپورٹ کرتی ہیں سو آن دہ بیسز آف دیٹ وی سٹارٹ ڈیلنگ اٹِ تو ریزلٹس آر ناٹ ڈیزارڈ بعد میں ترو فردر اینوسٹیگیشن تنگز سٹارٹس ٹو گیٹ کلیر ایباوٹ دہ ہول سینارئیو۔

سوال نمبر۴ :سر آ اِن چیلیمجز کو کیسے مینج کرتے ہیں ؟

جواب :فار اِس ہم تو ماڈسلے گائیڈ لاینز گالو کرتے ہیں۔ فرسر مور اگر میں آپکو بتاوں کہ ڈیسوسیٹیو ڈیسارڈرز کی رووٹ کاز میں دیکھیں تو پیشنٹ کی پرسنالٹی کو اسیس کر کہ، سٹریسرز کو دیکھ کہ، یہ کنفارم کرتے ہیں کہ کوئی اینٹیلیکچول ڈیسایبیلیٹی تو نہیں ہےجِسکے ساتھ کنورژن سمٹز ارہے ہیں، اینڈ لیٹس سے کہ اور کوئی فیملی پریشر یا اور کوئی سوشل ریزن جیسے ڈیٹ آف سپاوس، فانینشیل کنسٹرینٹس۔ ڈیورس، سو یہ ساری باتیں کنفرم کر کے کہ کس ریزن کی وجی سے ڈیسوسیٹ کر رہا ہے۔ اور ڈیسوسیشن باقی بیماریوں کے ساتھ بھی ہوتی ہے جیسے کہ ڈیپریشن اور اینزائٹی سو اسُکا بھی خیال رکھنا چاہیے

سوال ممبر ۵ :کنسے جینڈر میں کنورژن ڈیسارڈر زیادہ ہوتی ہے؟ اور وجوہات کیا ہیں؟

جواب :اچھا ایکورڈینگ ٹو مائی ایکسپیرینس تو فیمیل میں اور بچوں میں جنکو ساتھ ساتھ ایپیلیپسی چل رہی ہوتی ہے۔ اور اِسکے علاوہ سایکولوجیکل سٹیسرز، ا ن ریزولڈ کانفلیکٹس، اور مختلف پریشرز ہیں جو صہیح دے ایڈریس نہیں ہوتے اینڈ اٹِ لیڈز ٹو سمٹز لائیک دیٹ اور کچھ میڈیکل کنڈیشنز کی وجہ سے بھی کاز ہوتی ہے۔

سوال نمبر ۶ :آپکے مطابق کونسی ٹریٹمینٹ اِز بیسٹ فار کنورژن ڈیسارڈر؟

جواب :میرے مطابق اِن پیشنٹس کے لیے بائیو سایکوسوشل کلچرل سپیریچول ماڈل کی ضرورت ہوتی ہیں۔ میڈیسنز کو موربیڈیٹی کے لیے ٹھیک رہتی ہے۔ جیسے ڈیپریشن۔ تو پِر اسُکے بعد اسُکی سائکولوجیکل تیراپی سٹارٹ کرتے ہیں، بیہیوریل تیراپیز کرتے ہیں اور فردر نے سوشل اور فیملی ایجوکیشن، فیملی تیراپی، مطلب وی ہیو ٹو ڈیل پیشنٹس ایز اے ہولیسٹک اپروچ۔

سوال نمبر ۷ :کنورژن ڈسارڈر کو ٹھیک ہونے میں کتنا ٹائم لگتا ہے؟

جواب :اٹِ ریزول سپانٹینیسلی ایز ویل، آپ نے خود دیکھا ہوگا ایسے ایز اے سائکولوجسٹ، اگر انسٹرکشنز کو ٹھیک سے فالو کرے تو ۲ ہفتو میں ٹھیک ہو جاتا ہے، اگر مریض کمپلائنٹ نہیں تو پِر ٹائم لگتا ہے۔ زیادہ کرانک سمٹز ہو تو بھی ۲ مہینے کچ لگ سکتے ہیں۔

انٹرویو نمبر :۷

سوال نمبر1 :آپ روزانہ کتنے کنورژن ڈسارڈر کے مریضو کو چیک کرتی ہیں؟

جواب :روزانہکے بیسز پہ تو میں نہیں بتا سکتی لیکن آن ایویرج اِن اہ ویک ہمارے ہاسپیٹل میں ۳ ٹو ۵ مریض ہوتے ہی ہوتے ہیں۔

سوال نمبر ۲ :میم سی ڈی کے مریضوں کو ٹھیک ہونے میں کتنا ٹائم لگتا ہے؟

جواب :دیکھیں سی ڈی میں ریکوری ٹائم لگتا ہے ڈیفرینٹلی کینکہ ملٹپل فیکٹرز ہوتے ہیں جیسے کہ ڈیوریشن آف سمٹز کےا ہیں، فہملی سپورٹ کیسے ہے، فیملی دائکوایجوکیشن کا ریسپونس کیا مِلا ہے۔ پیشنٹ کے اپنے دائکوسوشل سرکمسٹانسز کیسے ہیں۔ جب شورٹٹرم سمٹمز ہو اور فیملی سپورٹیو ہو تو اسُ میں ڈیفینیٹلی ہمارے پاس چانسز زیادہ ہوتے ہیں ریکورئی مینجتنے سمٹمز کرونک ہوتے جاتے ہیں اتُنا ریکوری ٹائم زیادہ ہوتا جاتا ہے۔

سوال نمبر ۳ :کنورژن ڈسارڈر کے وجوہات کیا ہے؟

جواب :کنورژن ڈسارڈر کے کازز میرے خیال مینتو سایکاسوشل سرکمسٹانسز ہی بنتے ہیں۔ بائولوجیکل بیسز آف سی ڈی پی بھی ریسرچز ہو رہی ہینکہ دئر آر سم چینجز اِن نیرو ٹرانسمیٹر لیولز۔ ڈیپریشن اور باقی دیگر ڈیسارڈرز بھی کاز بنتی ہے۔ لیکن ۹۰ فیصد سایکولوجیکل فیکٹرز ہیں فیملی کی طرف سے کوئی اشو ہے۔ ا ن ریزولڈ کانفلیکٹس جو کی ڈسکس نہیں ہو پا رہی ہوتی، تو ہہی پہ ہی کنورژن سامنے آتا ہے۔

سوال نمبر ۴ :کنورژن ڈسارڈر کو ڈایگنوز کرنے میں کیا مشکلات آتی ہیں؟

جواب: کبھی کبھی علامات اوورلیپ کر جاتے ہیں جیسے کہ فیزیکل النس میں ہمیں تھوڑا سا پرابلم ہوتا ہےکہ وی نیڈ ٹو بی شیور کہ فیزکل عسپکٹس کی طرف سے دہ پیشنٹ از ڈن۔ کوئی ڈائرکٹ جسمانی بیماری نہیں ہونی چاہئے۔ اگر وہ چیز کلئیر

ہو جائے اور سمٹمز کی پریشنٹیشن کلیئر ہو جائے تو میرا خیال ہے کہ عکسپیرینس کے ساتھ اور ود دہ پیسج آف ٹائم اتنا مشکل نہیں ہوتا ڈائگنوس کرنا۔

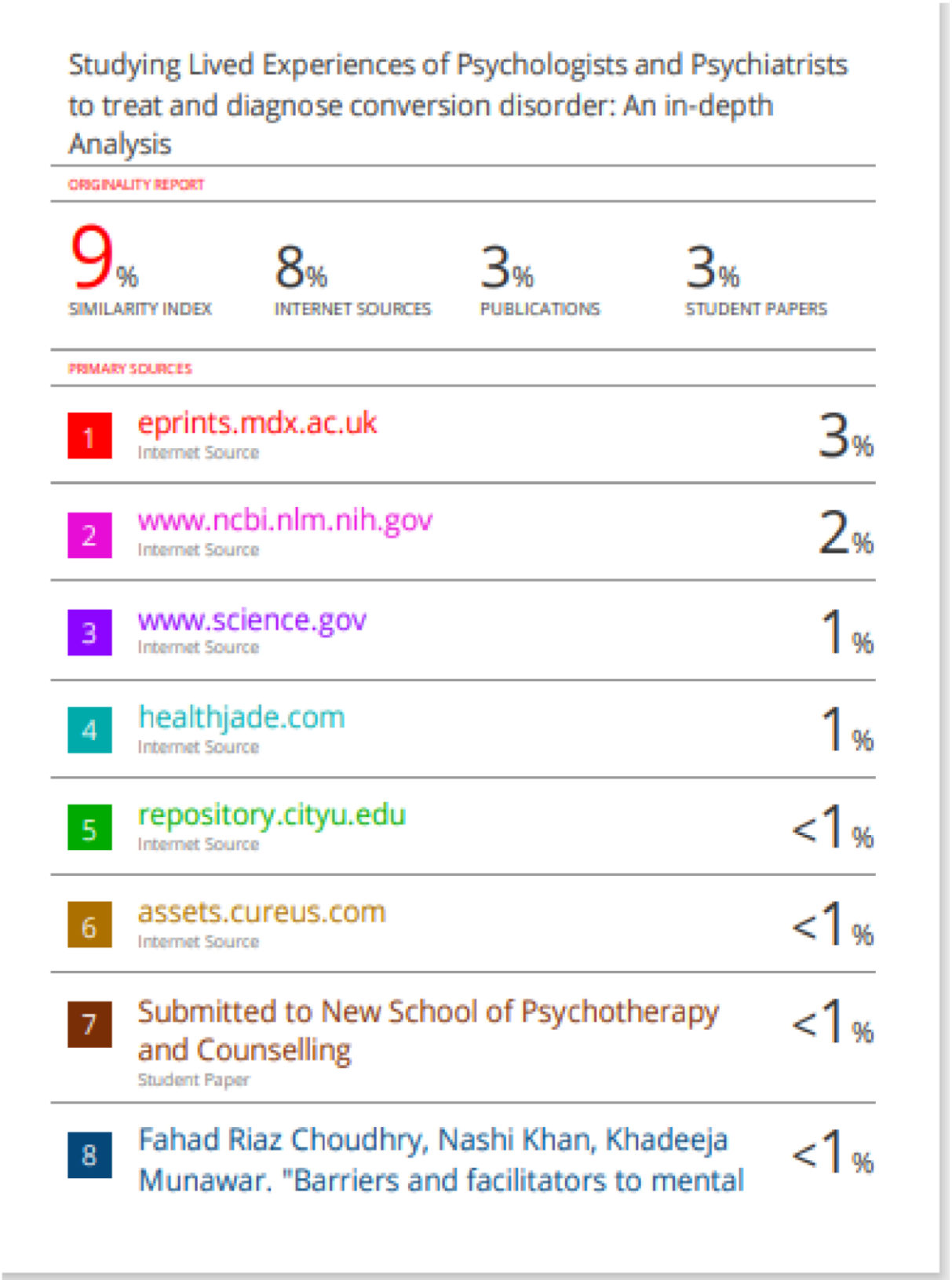
سوال نمبر ۵ :ایسے کامپلیکیشن کو کیسے مینج کرتے ہیں؟

جواب :اسُکے لیے ڈیفینیٹلی جو انُکے ٹرےٹینگ فیزیشن ہے انُ سے کانٹیکٹ میں رہتے ہیں۔ انُ سےڈائیریکٹ بات کرتے ہینجو فائنڈنگز ہے اسُکو ڈیسکس کرتے ہیں دین وی ریچ ٹو اے کانسنسز کہ یہ فیزیکل سمٹز النس ہے مینز کہ یہ سمٹمز فیزیکل ڈومین میں آتے ہیں یا سائکیٹری میں۔ اگر دونو ہے تو پر بوت ڈائمینشنز سے ٹریٹمنٹ کرنی ہوتی ہے۔

سوال نمبر ۶ :وٹ اِز دہ جینڈر ریشو فار کنورژن دڈیسارڈر؟

جواب :ڈیفینیٹلی فیمیل لیکن ہم نے بہت میل پیشنٹ بھی دیکھیں ہیں۔ جب میلز میں سمٹز آتی ہیں تو وہ بہت کرانک ہوتی ہے۔

Appendix-F



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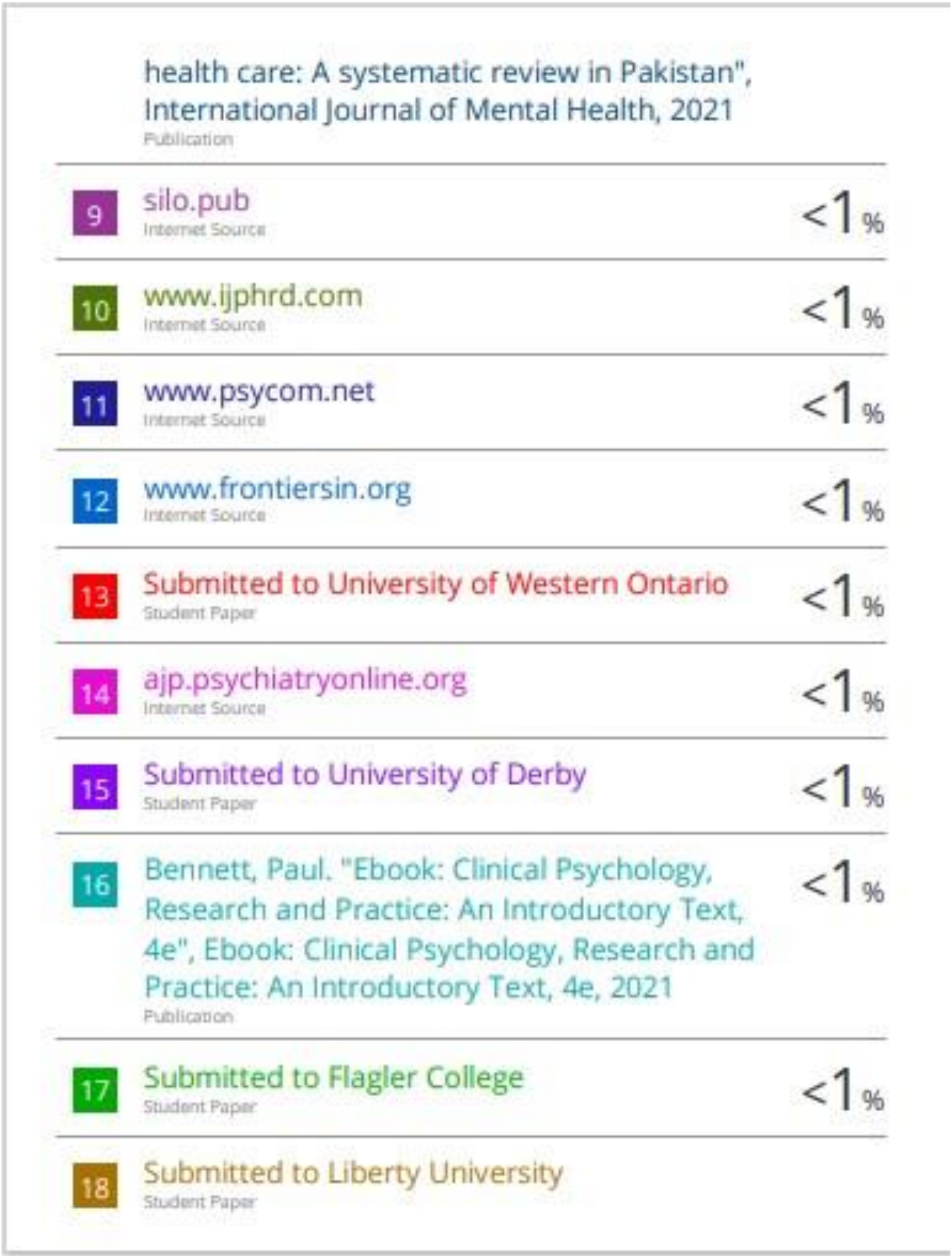

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