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Original Research Article

Clinical Profile, Coping Strategies, and Optimism–Pessimism Among Patients with Conversion Disorder: A Cross-Sectional Study from a Tertiary Care Centre in Western India

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Abstract:

Background: Conversion disorder (functional neurological symptom disorder) presents with motor or sensory symptoms incompatible with recognised neurological disease. Maladaptive coping styles and pessimism have been proposed as relevant to its clinical presentation, but much of the available evidence comes from samples that include only affected patients, without a comparison group.

Objectives: To describe the sociodemographic and clinical profile of patients with conversion disorder attending a tertiary care psychiatric department, and to examine, within this group, how coping strategies relate to optimism and pessimism.

Methods: In this cross-sectional study, 60 consecutive patients fulfilling DSM-5 criteria for conversion disorder were recruited from a tertiary care hospital in Gujarat, India, between December 2022 and December 2023. Coping strategies were assessed with the Brief-COPE and optimism/pessimism with the Revised Life Orientation Test (LOT-R). Spearman's rank correlation coefficient was used throughout to examine relationships between coping subscale scores and optimism/pessimism scores.

Results: Most patients were aged 10–30 years (66.6%), female (83.3%), of lower socioeconomic status (73.3%), educated up to high school (88.3%), and resident in rural areas (75.0%). Avoidant coping was the most frequently used strategy overall, particularly among younger patients and females. Problem-focused coping correlated positively with optimism ($\rho = 0.40$, $p = 0.001$) and negatively with pessimism ($\rho = -0.30$, $p = 0.02$), while avoidant coping correlated positively with pessimism ($\rho = 0.45$, $p = 0.0005$).

Conclusion: Among patients with conversion disorder in this tertiary care setting, younger age, female gender, lower socioeconomic status, and rural residence were common, and avoidant coping was associated with greater pessimism while problem-focused coping was associated with greater optimism. As the study did not include a comparison group without conversion disorder, these findings describe patterns observed within affected patients rather than risk factors for developing the disorder. They may nonetheless help inform psychotherapeutic approaches that target coping skills and outlook in this population.

Keywords: Conversion Disorder; Functional Neurological Disorder; Coping Strategies; Optimism; Pessimism; Brief-COPE; Life Orientation Test.

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Introduction

Conversion disorder has historically been described under the term hysteria, a diagnosis that fell out of formal psychiatric classification in 1968 but whose clinical phenomena persist under the contemporary labels of conversion disorder and functional neurological symptom disorder[1]. The disorder is characterised by motor or sensory symptoms that are incompatible with recognised neurological disease, cause clinically significant distress or impairment, and are not better explained by another medical or mental disorder. It is more frequently diagnosed in women and tends to present from adolescence through early adulthood, although it can occur at any age.[2]

Several theoretical frameworks have linked the onset and maintenance of conversion symptoms to the way individuals manage psychological stress. Coping has been broadly classified into problem-focused strategies, which are directed at modifying or resolving the source of stress, emotion-focused strategies, which aim to regulate the emotional response to stress, and avoidant strategies such as

denial, self-distraction, substance use, and behavioural disengagement.[2,3] Coping style has, in turn, been linked to broader markers of psychological adjustment, including dispositional optimism, defined as a general tendency to expect favourable outcomes, and its converse, pessimism.[4]

Most published descriptions of coping and optimism in patients with conversion disorder, including the present study, are based on samples that include only patients who already carry the diagnosis. Such designs can describe the clinical and psychological profile of affected patients and can examine how variables such as coping style and optimism relate to one another within that group. They cannot, however, establish whether a particular coping style or level of optimism increases the risk of developing conversion disorder, since this would require comparison with individuals who do not have the disorder. This distinction is important for interpreting the findings that follow.

With this in mind, the present study aimed to describe the clinical profile of patients with conversion disorder attending a tertiary care psychiatric department in Gujarat, India, and to examine the relationship between coping strategies and optimism/pessimism within this patient group. The specific objectives were:

- To describe the sociodemographic and clinical profile of patients diagnosed with conversion disorder.
- To describe the coping strategies used by these patients and how they vary by age and gender.
- To examine, within the patient group, the relationship between coping strategy scores and optimism/pessimism scores.

Methods

Study Design and Setting: This was a cross-sectional, descriptive study conducted in the Department of Psychiatry, C. U. Shah Medical College and Hospital, Surendranagar, a tertiary care centre in Gujarat, India, between December 2022 and December 2023.

Participants: Patients presenting to outpatient or emergency psychiatric services with symptoms suggestive of conversion disorder were screened using the Structured Clinical Interview for DSM-5 (SCID-5-CV). Patients were included if they fulfilled DSM-5 diagnostic criteria for conversion disorder. Patients with abnormal findings on neurological examination were excluded. A convenience sample of 60 consecutive eligible patients who provided written informed consent was recruited over the study period; no a priori sample size or power calculation was performed, which is acknowledged as a limitation (Section 5).

Instruments: Sociodemographic data were collected using a semi-structured proforma developed by the department. Coping strategies were assessed using the Brief-COPE, a 28-item, four-point inventory that yields scores for problem-focused, emotion-focused, and avoidant coping.[2,3] Optimism and pessimism were assessed using the Revised Life Orientation Test (LOT-R), a 10-item scale from which an overall optimism score is derived after reverse-scoring the negatively worded items.[4]

Statistical Analysis: Sociodemographic and clinical characteristics are presented as frequencies and percentages. Relationships between Brief-COPE subscale scores and LOT-R optimism/pessimism scores were examined using Spearman's rank correlation coefficient throughout, in keeping with the ordinal nature of these scores; this is the only correlation method used in the study. Because every participant met diagnostic criteria for conversion disorder, conversion disorder status did not vary within the sample and could not itself be correlated with coping or optimism/pessimism scores; an analysis of this kind would require participants without conversion disorder for comparison and was not undertaken. A p-value below 0.05 was considered statistically significant. Given the small size of several sociodemographic subgroups (for example, n = 0 for upper socioeconomic status and n = 1 for Christian patients), cross-tabulations of coping and life-orientation scores by sociodemographic variable (Table 4) are presented descriptively, without formal significance testing.

Ethical Considerations: The study was approved by the Institutional Ethics Committee (Human Research), C. U. Shah Medical College, Surendranagar (Reference: CUSMC/IEC(HR)/ Pro.Approval-DI-47/2022/ OUT-165/2022, dated 22 November 2022). Written informed consent was obtained from adult participants and from parents or guardians of minor participants, with assent obtained from minors where appropriate.

Results

Sixty patients meeting DSM-5 criteria for conversion disorder were enrolled. Their sociodemographic characteristics are summarised in Table 1. Twenty-three patients (38.3%) were aged 10–20 years, the largest single age band, and a further 28.3% were aged 21–30 years. Fifty patients (83.3%) were female. Most patients had education up to high school level (88.3%), belonged to lower socioeconomic strata (73.3%), and resided in rural areas (75.0%). Housewives (31.7%) and labourers (30.0%) were the largest occupational groups, and most patients were Hindu (73.3%).

Table 1: Sociodemographic characteristics of patients with conversion disorder included in the study (N = 60)

Characteristic	n	% of patients (N = 60)
Age (years)		
10–20	23	38.3
21–30	17	28.3
31–40	12	20.0
41–50	5	8.3
≥ 51	3	5.0
Gender		
Male	10	16.7
Female	50	83.3
Education		
Up to high school	53	88.3
College	3	5.0
Bachelor's degree	2	3.3
Master's degree or higher	2	3.3
Socioeconomic status		
Lower	44	73.3
Upper middle	15	25.0
Lower middle	1	1.7
Upper lower / Upper	0	0.0
Marital status		
Unmarried	23	38.3
Married	20	33.3
Divorced	13	21.7
Widowed	4	6.7
Occupation		
Housewife	19	31.7
Labourer	18	30.0
Farmer	11	18.3
Student	9	15.0
Other	3	5.0
Religion		
Hindu	44	73.3
Muslim	15	25.0
Christian	1	1.7
Residence		
Rural	45	75.0
Urban	15	25.0

Table 2 summarises coping strategy use and optimism/pessimism scores by age group and gender. Avoidant coping was the predominant strategy in the youngest age group (66.7% in patients aged 10–20 years) and in females generally (53.0%), whereas problem-focused coping became more prominent with increasing age, reaching 100% in the small ≥51-year subgroup (n = 3). Pessimism scores were highest in the youngest age group (66.7%) and lowest in the 21–30-year group (18.2%).

Table 2: Coping strategies and optimism/pessimism scores by age group and gender

Group (n)	Problem-focused (%)	Emotion-focused (%)	Avoidant (%)	Optimism (%)	Pessimism (%)
Age 10–20 (n=23)	10.0	23.3	66.7	33.3	66.7
Age 21–30 (n=17)	12.5	63.6	23.9	81.8	18.2
Age 31–40 (n=12)	60.0	10.0	30.0	75.0*	15.0*
Age 41–50 (n=5)	31.0	60.0	9.0	66.7	33.3
Age ≥ 51 (n=3)	100.0	0.0	0.0	NR	NR
Male (n=10)	30.0	30.0	40.0	66.7	33.3
Female (n=50)	17.3	29.7	53.0	77.8	22.2

Table 3 presents the correlation between Brief-COPE subscale scores and LOT-R optimism/pessimism scores across the whole sample. Problem-focused coping correlated positively with optimism (ρ = 0.40, p = 0.001) and negatively with pessimism (ρ = -0.30, p = 0.02). Avoidant coping correlated positively with pessimism (ρ = 0.45, p = 0.0005) and showed a weak, non-significant negative correlation with optimism (ρ = -0.20, p = 0.10). Emotion-focused coping showed weak, non-significant correlations with both optimism and pessimism.

Table 3: Spearman's rank correlation between Brief-COPE coping strategy scores and LOT-R optimism/pessimism scores (N = 60)

Coping strategy	ρ (Optimism)	p (Optimism)	ρ (Pessimism)	p (Pessimism)
Problem-focused	0.40	0.001*	-0.30	0.02*
Emotion-focused	0.25	0.05	0.15	0.15
Avoidant	-0.20	0.10	0.45	0.0005*

*Statistically significant at $p < 0.05$.

Table 4 presents a descriptive cross-tabulation of coping and life-orientation scores against the remaining sociodemographic variables (education, socioeconomic status, marital status, occupation, religion, and residence).

Table 4: Coping strategies and optimism/pessimism scores by remaining sociodemographic subgroups

Subgroup (n)	PF (%)	EF (%)	Avoid. (%)	Optimism (%)	Pessimism (%)
Education: High school (53)	10.0	40.0	50.0	17.0	83.0
Education: College (3)	30.0	40.0	30.0	28.0	72.0
Education: Bachelor's (2)	45.0	33.0	22.0	56.0	44.0
Education: Master's+ (2)	53.0	34.0	13.0	46.0	54.0
SES: Lower (44)	18.3	14.2	67.5	16.3	83.7
SES: Middle (16)	20.0	43.2	36.8	64.5	35.5
SES: Upper (0)	—	—	—	—	—
Marital: Married (20)	23.7	46.0	30.3	54.7	45.3
Marital: Unmarried (23)	46.2	32.6	21.2	43.5	56.5
Marital: Divorced (13)	16.8	28.9	54.3	23.1	76.9
Marital: Widowed (4)	52.6	14.3	33.1	19.6	80.4
Occupation: Student (9)	28.9	27.9	43.2	64.3	35.7
Occupation: Labourer (18)	36.5	43.4	20.1	46.8	53.2
Occupation: Farmer (11)	54.2	40.1	5.7	42.9	57.1
Occupation: Housewife (19)	24.3	28.9	46.8	48.7	51.3
Occupation: Other (3)	23.5	65.3	11.2	57.3	42.7
Religion: Muslim (15)	12.6	36.1	51.3	36.2	63.8
Religion: Christian (1)	53.2	20.0	26.8	62.0	38.0
Religion: Hindu (44)	62.1	12.0	25.9	54.7	45.3
Residence: Rural (45)	17.5	10.0	72.5	34.2	65.8
Residence: Urban (15)	45.2	32.0	22.8	64.6	35.4

PF = problem-focused coping; EF = emotion-focused coping; Avoid. = avoidant coping. No significance testing was performed for this table; percentages are descriptive only.

Discussion

In this clinic-based sample, conversion disorder was most often diagnosed in young patients and in women, a pattern broadly consistent with prior clinical literature describing a typical onset between adolescence and early adulthood and a higher frequency in females.[1] The predominance of patients from lower socioeconomic and rural backgrounds in this sample is in keeping with the hospital's catchment population and may also reflect differential access to alternative health services, although this could not be examined directly in the absence of a comparison group.

Avoidant coping, encompassing denial, self-distraction, substance use, and behavioural disengagement, was the most frequently reported strategy overall and was particularly common among younger patients and females. This is consistent with theoretical models of coping in which avoidant strategies are distinguished from problem-focused and emotion-focused strategies and are generally considered less adaptive when relied upon over time.[2,3] Clinical approaches to functional neurological disorder, including

cognitive behavioural therapy, have specifically targeted avoidance behaviours and unhelpful illness beliefs as part of an integrated treatment strategy[5], and the present findings may support incorporating structured coping-skills work into management plans for similar patients, even though this study cannot establish that avoidant coping caused or worsened the disorder.

Within the sample, problem-focused coping was associated with higher optimism and lower pessimism, while avoidant coping was associated with higher pessimism. This pattern is consistent with dispositional optimism theory, in which optimistic individuals are thought to favour active, engaged coping responses while pessimistic individuals are more prone to disengagement and avoidance when faced with adversity.[2,6] Because the data are cross-sectional, the direction of this relationship cannot be determined from this study: it is equally plausible that a pessimistic outlook predisposes patients to avoidant coping, that prolonged reliance on avoidant coping fosters pessimism, or that both arise from a shared underlying vulnerability.

These findings should not be read as evidence that avoidant coping or pessimism increases the risk of developing conversion disorder, nor that the sociodemographic distribution reported here reflects the prevalence of conversion disorder in the general population. Both inferences would require a comparison group of individuals without the disorder, which this study did not include. What can be concluded is that, among patients who already carry the diagnosis, avoidant coping and pessimism tend to occur together, and problem-focused coping and optimism tend to occur together, which may be clinically useful when planning psychotherapeutic intervention.

Limitations

- No comparison group without conversion disorder was included; the study can describe patterns within affected patients but cannot establish risk factors, causal relationships, or population prevalence.
- The sample was drawn from a single tertiary care hospital, which limits generalisability to community settings or other regions.
- Recruitment used a convenience, non-probability sample of consecutive attendees rather than a randomly selected sample.
- No a priori sample size or power calculation was performed; the sample of 60 patients may be underpowered for some of the subgroup comparisons presented.
- The cross-sectional design does not allow inferences about the temporal or causal direction of the relationship between coping style, optimism/pessimism, and conversion disorder.
- Several sociodemographic subgroups were very small (for example, n = 3 for patients aged 51 years and above, and n = 0 for upper socioeconomic status), which limits the reliability of the descriptive comparisons in Table 4.
- Data were collected by self-report and structured interview and are subject to potential recall and reporting bias.
- Inter-rater reliability for SCID-5-CV-based diagnosis was not formally assessed.
- No multivariable or adjusted analysis was performed to account for potential confounding among the sociodemographic variables examined.
- No follow-up data were collected, so the course of symptoms, coping, and optimism over time could not be assessed.

Conclusion

In this tertiary care sample, patients with conversion disorder were predominantly young, female, of lower socioeconomic status, and residents in rural areas. Avoidant coping was the most commonly used coping strategy, particularly among younger patients and females, and was associated with greater pessimism, while problem-focused coping was associated with greater optimism. Because the study lacked a comparison group, these findings describe the clinical and psychological profile of affected patients rather than risk factors for the disorder. They suggest that interventions aimed at strengthening problem-focused coping skills and addressing pessimistic outlook may be a useful component of psychotherapeutic management in this population, a hypothesis that would need to be tested in studies with a comparison group and, ideally, longitudinal follow-up.

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