



Conversion Disorder and Treatment Approaches Amongst Indigenous Peoples of Eyumojock Sub Division South West Region of Cameroon

Arrey John Arrey

Department of Sciences of Education, Higher Teachers' Training College, University of Maroua

ABSTRACT

The research topic titled “Conversion disorder and treatment approaches amongst indigenous peoples of Eyumojock sub division in Cameroon” was duly carried out following the general objective stated as; To examine conversion disorder and treatment approaches amongst indigenous peoples of Eyumojock sub division in Cameroon. As a qualitative study, the case study research design was retained with snowballing and purposive sampling methods which retained 4 participants. Interviews were carried out to collect data and content analysis to analyse data. Results showed that participants employed traditional approaches, psychotherapy, physical therapy, counselling, and distraction as treatment for sensory and motor symptoms of conversion disorder. Patients who undertook traditional therapies such as employment of herbs focused on physical relief was not adequate for trauma relief and enabled such patients encounter many conversion disorder episodes with longer duration than those who integrated psychotherapy, physical therapy, counselling and distraction. Also, the type of symptoms and manifestations displayed by patients during conversion episodes influenced treatment approaches patients employed according to the available resources and competences healers or health practitioners disposed. As a recommendation, patients should go through a comprehensive treatment of conversion disorder including psychological treatment approaches most especially such as cognitive behaviour therapy and psychoanalytic therapy to transform the ideas behind the lost object enacting trauma in patients harmless.

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***Corresponding Author**

Arrey John Arrey

E-mail: johnarrey15@gmail.com

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INTRODUCTION

For several decades much interest has been focused on addressing issues related to physical health rather than mental health in Cameroon. That is why one can easily find a medical doctor and not mental health workers (a psychologist, psychiatrist, clinical social workers, counsellors, and mental health nurses) in health districts and hospitals in Cameroon, whereas the WHO recommends parity between physical health and mental health (WHO, 2013). It is in this precarious situation of mental health that this study is laid down to establish relevant data on how conversion disorder is treated in Eyumojock sub division to understand if communities acknowledge and receive comprehensive care.

Our observation on the Indigenous peoples of Eyumojock sub division in Cameroon experiencing conversion disorder folded with the remark that the populations of this community employ different treatment approaches which lead to controversial relief of patients from episodes. The rate of recovery of a patient from conversion disorder differs in every patient and may be influenced by factors such as the treatment approach employed, active presence of stressors, support systems, comorbid conditions, identification and management of stressors concerned, patient's motivation, and the healthcare provider's experience (Freud, 1952; Stone et al., 2005; LaFrance et al., 2020). Some patients have favourable outcomes with particular treatment approaches while others may continue experiencing the symptoms, they undergo significant distress, anxiety, frustration and depression due to the symptoms which may complicate mental health (Reuber, 2013, 2016; Edwards & Bhatia, 2012).

The significance of the study is that individuals with conversion disorder will gain adequate information on the aetiology, symptom manifestation, and the different approaches appropriate in the treatment plan of the disorder. The indigenous population and community will adequately be informed on the existence of such a disorder, causes, prevalence, incidence, and how to address the disorder amongst themselves and health professionals. They will learn the emergence of symptoms and trends to follow to effect proper treatment. Mental health practitioners will familiarise themselves with additional and effective traditional remedies applied by the indigenous population at the appropriate moment. This will increase the number of approaches they apply to treatment enriching the field of psychopathology and clinical psychology. They will have a general view of other treatment approaches thought to be ineffective and seek for means to improve or annul them where they seem not ethical and unproductive to health.

Conversion disorder was classified by DSM-VI classified conversion disorder under psychosomatic disorders while DSM-5 classified it under somatic symptoms and related disorders. As a relevant

account, Owens and Dein (2018) presented conversion disorder as modern hysteria for hysteria had features common to conversion disorder. At that moment in late 18th century medical practitioners noticed symptoms in their patients which caused much pain and despair (Veith, 1965). Manifestations of patients were visibly real but could not be explained related to organic causes. Comer (2007) presented hysteria as a condition which is characterised by psychogenic (that is, originating from human mind) involuntary loss of neurological function, usually manifested as conversion or dissociative reactions. Hysteria was considered a medical condition or mental disorder that was classified under psychoneurotic disorders in DSM-1 in 1952 (APA, 1952). As a psychoneurotic disorder, it was understood to exhibit both psychological and physical symptoms which manifested during episodes or crisis, setting individuals out of control. It is also characterised by outburst of emotion or fear, irritability, laughter, and weeping. Hysteria basically manifested through violence by people causing the individuals not able to perceive reality.

From the times of antiquities hysteria was considered a wandering uterus in women following ancient medical theories such as Hippocratic theory provoking psychological and physical symptoms on the individual depending on which part of the body it migrated to. Galenic Medicine suggested that the uterus could migrate and affect other organs just like bodily humours whose imbalance caused illness (Galen, 215 AD; cited in Brock, 1916). Jean-Martin Charcot, showed that patients exhibited loss of sensation in body parts though there exists nerve locations on the body parts in 1887. The works of Josef Breuer and Freud on Anna O led to significant understandings in theory and practice of psychology and in medicines where the patient manifested various symptoms which could not be given medical foundations but which adversely affected the life of the patient (Freud, 1952). Through catharsis, at first, then hypnosis and psychoanalysis, treatment approaches established health of patients to any extent even though more reliable therapies continued to be sought for. The term 'conversion' had its origin in psychoanalytic theory proposing that unconscious psychic conflict is 'converted' into psychological symptoms (APA, 2013). The different diagnostic and statistical manuals of mental disorders over time provided various nomenclatures of hysteria as studies evolved and disclosed knowledge, by different authors at that moment who engaged in unveiling scientific truth about symptoms of conversion disorder. Therefore, many fields of studies such as psychology, and psychiatric medicines did milestones of inquiries concerning hysteria leading to attributions like conversion reaction, conversion disorder and finally functional neurological disorder (Comer, 2007). Examples of conversion disorders are as below.

- Sensory symptoms of conversion disorder include numbness, or tingling in a part of the

- body, vision problems (blurred vision, double vision, blindness), and loss of hearing.
- Motor symptoms are weaknesses or paralysis of the limb, difficulty in walking, abnormal movements (tremors, jerks, tics), loss of balance, difficulty swallowing (dysphagia), or speech problems (slurred speech, stuttering or loss of voice, mutism).
- Syncope in conversion in disorder refers to loss of consciousness or fainting which is psychogenic in character thus impacting the life of those affected, such as those who experience loss of loved ones. An episode of syncope is short, about seconds to few minutes and complications may involve other health issues such as age of the individual (aged people have longer recovery times), stress, heat, or dehydration impact duration and recovery and anxiety and panic attacks may last longer (APA, 2001). Episodes of syncope may occur so sudden without any warning or be preceded by associated symptoms (Grossman & Badireddy, 2025). The following behaviours or reactions are common after an episode of syncope – known as a postictal state; confusion, fatigue, or disorientation, occurring in a few minutes.
- Seizures in conversion disorder are non-epileptic and do not have a neurological basis. They may involve convulsions, loss of awareness and tremors, last longer than syncope and prevail with unusual movements or postures and patients have a postictal state (confusion or fatigue), tongue biting, the duration of conversion episode takes up to 6 months and above and longer recovery periods compared to syncope.

People with conversion disorder lose functioning in some part of their body (Nolen-Hoeksema, 2001). A person may have repeated episodes of conversion involving different parts of the body of a specific symptom type such as paralysis or seizures. These symptoms may vary significantly in duration; signifying that some symptoms which are ephemeral appear abruptly or suddenly, resolve quickly in hours or days. Some symptoms are persistent, therefore, last for weeks, months or years. The duration of a symptom is influenced by factors such as psychological stressors, individual coping mechanisms, social support, treatment interventions, comorbid conditions and the attitude of the patient which constitutes individual's perception and belief about the symptoms; greatly impact how he experiences and manages symptoms. However, known causes of conversion disorder are;

- Individuals who have a history of child abuse
- People having other mental health conditions, such as anxiety and depression
- Having a recent stressful or traumatic event such loss of loved ones, incidents or disasters.

- A health condition or event acting as a trigger for conversion disorder.
- Women who have been sexually abused or raped (Anderson et al., 1993).

Mayo Clinic (2022) holds that an episode of conversion disorder/functional neurologic symptoms disorder may appear suddenly after a stressful event, or with physical trauma, and that one cannot intentionally produce or control symptoms.

Appropriate diagnosis of conversion disorder is the primary indication for treatment pattern to be applied since conversion symptoms occur in comorbidity. Therefore, a comprehensive evaluation of medical or neurological causes for the symptoms and identifying psychological factors that contribute to the condition are significant to the relief of patients. The first and significant instrument employed for diagnosis of conversion disorder/functional neurological disorder is the Diagnostic and statistical manual of mental disorders-5 (DSM-5). This is done by comparing symptoms presented to the criteria for diagnosis in the diagnostic and statistical manual of mental disorders (DSM-5), published by the American Psychological Association. Diagnostic criteria for conversion disorder are;

- One or more symptoms that affect one's senses or body movement.
- Such symptoms cannot be explained by a neurological or other medical condition or another mental health disorder.
- Symptoms cause significant distress or problems in social, work or other areas, or they are significant enough that medical evaluation is recommended (APA, 2013).

Other aspects of diagnosis includes

- Medical history and physical examination
- Neurological examination, extends to the following tests
 - Brain imaging: Magnetic resonance imaging (MRI) and computed tomography (CT) scan to look for structural abnormalities in the brain.
 - Electroencephalogram (EEG): To rule out seizure.
 - Electromyography (EMG) and nerve conduction studies to assess nerve and muscle function.
 - Blood test: Is to check for infections, inflammations or other medical conditions.
- Psychiatric evaluation involves
 - Clinical interview
 - Psychological testing
- Diagnostic criteria constitutes
 - The presence of one or more symptoms of altered motor or sensory function.
 - Clinical findings provide evidence of incompatibility between the symptom

and recognised neurological or medical condition.

- The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Positive signs
 - Hoover's sign
 - Tremor that decreases with distraction
 - Sensory loss that does not follow a typical anatomical distribution (Comer, 2007).

Aetiology of conversion disorder

The causes of conversion disorder are attributed to stress or trauma that people encounter (Freud, 1952). People cannot adequately cope with traumatising memories or emotions associated with the incident or trauma. Sigmund Freud and his colleagues explained that conversion symptoms occur as a result of the psychic energy attached to repressed emotions or memories into physical symptoms. These symptoms represented or symbolised the particular concerns or memories that were being repressed. Experiences of conversion disorder were visible during the World Wars where soldiers who were still at war suddenly became blind or paralysed without any physical cause.

Children can mimic can mimic sick people who they dearly love and are closed to who go through any of the symptoms as paralysis on side of the body. They may also be paralysed on one body part without any physical cause. Conversion disorder is common among women who have been sexually abused or raped (Anderson et al., 1993). Some women developed PTSD and conversion mutism after being raped. Conversion disorder is also common in people who have experienced child abuse. Motor and sensory manifestations of conversion disorder are significant conversion reactions with underlying anxiety is converted into symptoms. Sensory disturbances include paraesthesia's (specific sensations) through hyperaesthesias (hypersensitivity) to complete anaesthesia's (loss of sensation).

Causes include:

- A history of child abuse
- Having other mental health conditions, such as anxiety and depression
- A recent stressful or traumatic event
- A prominent health condition or event acting as a trigger for conversion disorder.

Treatment approaches to conversion disorder

Treatment approaches to conversion disorder refer to methods and strategies adopted by healers, health practitioners and providers to diagnose and treat patients. They are diversified and patients employ them depending on their knowledge of symptoms, availability of resources, practitioners, competent mental health workers, coupled with traditional or cultural practices integrated by indigenous populations

such as those of the Eyumojock sub division to effect relief of patients. Examples of treatment approaches are listed below: Treatment of conversion disorder involves psychological and physical therapies depending on the symptoms and needs the patients manifest. Types of treatments involve:

- Psychotherapy involves psychoanalytic therapy, cognitive behaviour therapy and psychodynamic therapy.
- Physical therapy involves engaging patients in motor learning skills which include physical support, and reduced verbal guidance. Patients are introduced to exercises which work out motor tones gradually.
- Occupational therapy deals with interventions that assist patients in reducing frustration, enhance confidence and support patients to manage daily undertakings.
- Speech therapy constitute more of play with a sequence of activities that involve language-based board games set to strengthen coordination between the mouth and brain of an affected person.
- Medications employed in conversion disorder are usually anti-depressants that treat anxiety, depression, posttraumatic disorder, personality disorders and substance use disorders since they occur in comorbidity. When these are treated then multidisciplinary treatment is engaged.
- Relaxation techniques in treating conversion disorder constitute stress reduction methods such as muscle relaxation, breathing exercises, physical activities and breathing exercises.
- Hypnotic treatment involves adopting suggestion and relaxation techniques which serve to alleviate symptoms by enabling the conscious processing of forgotten traumatic memories of events and emotions that are repressed.
- Education (psychoeducation) involves informing or educating the patient and family members about the symptoms, the manner they manifest and the reassurance of recovery after treatment in order that patients get committed to the therapy.
- Multidisciplinary approach involves engaging a team of specialists interventions to address the complex physical symptoms and the underlying psychological factors such as cognitive behaviour therapy, physical therapy, and the therapies cited above.

To Beri and Reddy (2020) psychological treatments, especially operant behavioural treatment is remarkably successful in treating conversion disorder, using the technique of positive reinforcement. Cognitive behaviour therapy is effective in dealing with mental distortions that are at the onset of in-adapted thoughts and irrational beliefs. Physical therapy is been found effective in rehabilitation of patients through behavioural shaping and modification techniques,

where patients were encouraged with praises. Cultural or traditional practices are often integrated in treatment or solely employed by indigenous populations due to their beliefs about the causes of conversion disorder (Beri & Reddy, 2020; Furqan et al., 2017).

Empirical review

Theoretical framework

Theories such as psychoanalysis of Sigmund Freud, Cognitive behavioural theory of Aaron T. Beck and the behavioural learning theory of Sigmund Freud coined the term conversion reaction or disorder in the year 1900 to describe a situation where psychological trauma, memories and difficulties are expressed as physical symptoms (Freud, 1952).

According to the psychoanalytic theory, conversion disorder emerged as a result of an individual's repressed childhood traumatic events such as aggressions, sexual desires (wishes, aspirations for intimacy, connection and pleasure), motivations, conflicts (repressed memories affecting mental health and behaviour) and expression through overt and covert manner to reveal their underlying motivations. This is typical of indigenes of Eyumojock sub division experiencing conversion disorder symptoms where the memories of their loved ones, the departed husbands, and children captivated and retained them in their loss. Even though dead and laid to rest they saw them as if still in physical existence where they sought to often communicate with and shared the usual responsibilities they undertook when alive. Freud noticed that conversion symptoms lack organic or biological basis, which reflect unconscious conflicts. Conversion signifies the substitution of a somatic symptom for a repressed idea. Examples of conversion symptoms as cited Freud are blindness, paralysis, psychogenic non epileptic seizures, motor tics, swallowing difficulties, anaesthesia, dementia, difficulty walking and dementia. According to Ruffalo (2025) patients who received long term therapy as in psychoanalytic therapy generally improve more on the basis of overall functioning than compared to those undertaking other therapies. To perspective of Ruffalo, patients consider that symptoms are related to underlying psychical conflict in order to improve pore significantly. Treatment unfolds in sessions between the therapist and patient through free association, interpretation of dreams, analysis of resistance and analysis of transference.

The cognitive behaviour theory holds that inappropriate cognitions and in-adaptive behaviours are at the root of conversion disorder. Aaron T. Beck (1921-2021), an American psychotherapist and psychiatrist developed this theory in 1960. He explained that distorted thoughts and beliefs about one's body and illness act as contributors to the development of conversion symptoms. The indigenous peoples of Eyumojock sub division experienced negative automatic thoughts attached to their pains, headaches and partial paralysis. They perceived sensory motor symptoms as well as syncope in episodes as moments which could

lead to their inactiveness rupturing from practicing subsistence agriculture as their profession. Individuals misinterpret bodily sensations, stress, and trauma as onset of serious sickness. The core of the therapy is the negative thoughts inhabiting the patient which are automatic, happening without the patient realising them which cause distress. The patient is taught to recognise these automatic negative thoughts so as to adequately respond rendering them none destructive in capacity. Nakao et al. (2021) informed that CBT is a psychotherapeutic treatment that assists individuals identify and change patterns of thoughts which are harmful and disturbing, and which negatively influence the individual's behaviour as well as emotions. CBT is effective in cognitive restructuring in improving conversion disorder symptoms. Maladaptive automatic thoughts about sensory and motor symptoms when challenged by a patient cognitively, become more adaptive and in-destructive because of the positive consideration of the event formerly seen as harmful.

Operant conditioning was developed by B. F. Skinner, an American psychologist in the 1930. It posits that through reinforcement symptoms perpetrate as patients receive attentions, advantages and care whenever symptoms of conversion disorder emerge. This leads to reinforcement and continuation. Individuals as such post or display maladaptive behaviours like avoiding activities due to the fear of conversion disorder symptoms, which reinforce the disorder. Behaviours such as attention and sympathy from others reinforce the believe, hence conversion symptoms, which is the disorder. Causes are attributed to stress and trauma which serve as triggering factors to the conversion symptom. Indigenous people of Eyumojock sub division affected by conversion disorder were totally rendered services during episodes such a support provided them for chores. The neighbourhood rallied to assist in up keep of farm activities so that patients acquired food from their own farmland. The services bolstered and reinforced the affected to remain in the episodes because of the gains. They were exempted from community labour and contributions because they were judges sick and unable to fulfil the demands of community participation.

Empirical review

A review by Ali et al., titled; Conversion disorder – Mind versus body: A Review exhibited information on this mental health condition. The works of these authors published on the Journal of Innovations in clinical neuroscience has contents disposing signs and symptoms of conversion disorder and the significance of clinical judgment in reaching the correct diagnosis. The authors reviewed existing literature and provided information on the causes, prevalence, diagnostic criteria and treatment methods employed currently for conversion disorder in their context. The demonstrated how neuropsychiatry and brain imaging have led to emergence of complex issues in neuroscientific psychopathology of this complex mental illness, conversion disorder. The authors extended research to

understand using appropriate instruments as above. Their methodology involved physical examination on patients, obtention of patients' histories and prevailed in making use of the psychiatric care, neuroimaging and applied therapeutic alliance. Results showed that 20 to 25% patients in special hospital setting had individual symptoms of conversion and 5% of patients in the same setting met the criteria for the full disorder. Our research topic is oriented to conversion disorder and treatment approaches as carried out by people of Eyumojock sub division. This will enable us to understand why they chose the particular treatment approach during interviews, and content and effectiveness of approaches employed to prevent relapse or encourage remission. We employed case study design, used DSM and observation of patience denoting the aspect of "the beautiful indifference (la belle indifference) with clinical interviews in collecting data.

Furqan et al. (2016) reviewed the conceptual, diagnostic and treatment challenges in a diagnosis of conversion disorder following the DSM-5 criteria for the disorder. Neuropsychiatric understanding, therapeutic challenges and treatment options were the main concerns in their case study of 1 patient, Molly. Methodology involved is a longitudinal case study with physical examination (laboratory findings), urine toxicology, computed tomography (CT), magnetic resonance imaging to screen organs and tissues of the body and use of electroencephalogram (EEG) were all applied for better results.. All the tests and exams investigated showed negative results for patient with conversion disorder who continued experiencing dyspnea, palpitations, feelings of doom which keep her from work. These authors recommended multidisciplinary approach for which is currently put in practice treating patients doubled with special interventions such as CBT, psychodynamic therapy to address underlying symptom formation. Our patients' hospital experiences will unfold in Cameroon with a different work environment. Being a rural area the study will uncover the means by which practitioners carry out effective diagnosis to eliminated comorbid conditions such as anxiety, depression from death trauma, and biological illnesses to isolate conversion disorder for proper treatment following the approaches available and applied.

Peeling and Muzio (2023) worked on functional neurologic disorder/conversion disorder in patients carrying out diagnosis, evaluation and management to review the role of the interprofessional team in improving care for patients with this condition. Their main objectives were to:

- Outline risk factors for developing functional neurologic disorder
- Carryout a description on the presentation of a patient with functional neurologic disorder
- Provide a summary of physical exam findings and treatment considerations for the patients.
- Identify the importance of improving care coordination among interprofessional team

members to improve patient outcomes affected by functional neurologic disorder.

For causes of functional neurotic disorder, the authors pointed to psychological, social and biological factors which also serve as triggers for episodes. They affirmed that psychodynamic model and cognitive-behavioural model best provide explanations for the disorder. To them, the incidence of functional neurotic disorder varies across geographical settings and is approximately 4 to 12 per 10000 per year. Also, information retrieved from the population-based registries placed the rate of functional neurologic disorder at 50 per 100000 per year (Peeling & Muzio, 2023).

For methodology, the criteria to retain patients was based on the diagnostic criteria for functional neurologic disorder, according to DSM-5TR and based cased study where transcriptions were made from the data collected from in patients. They collected histories of patients where acute episode and persistent episodes contributed to the manifestations of the disorder in patients. Subtypes of functional neurologic disorder identified in patients were the psychogenic nonepileptic seizures, paralysis or weakness, Hoover's sign, anaesthesia or sensory loss, special sensory symptom, dystonia, gait disorder. Abnormal work collapsing weakness. They also worked on the visual and olfactory disturbances. They employed history and physical examination to diagnose functional neurologic disorder. Laboratory studies rules out underlying medical conditions, electroencephalogram (EEG) showed a lack of true seizure. Treatment focused on the discussions of feelings regarding symptoms as remarked by Peeling and Muzio (2023). They utilised psychotherapy such as CBT, physical therapy hypnosis, pharmacotherapy and trans-magnetic stimulation.

Functional neurological symptoms disorder, shown by statistics above, is rare in towns but prevails in rural areas where patients are ignorant of it, except for the physical symptoms they experience such as sensory and motor symptoms accompanied by paralysis and pain. The situation calls for attention as the choice of treatment approach may relief or aggravate or cause remission for the patients to integrate their services effectively and actively. Theories employed in this study are psychological theories, informing on repressed traumatic ideas having the power to influence behaviour. There is a cognitive theory discussing the impact of negative thoughts about a situation that have the magnitude of initiating distress and discomfort in sufferers, this is what summarises literature review of this study.

Objectives of the study

- To investigate sensory symptoms of conversion disorder and treatment approaches amongst indigenes peoples of Eyumojock sub division.

- To assess motor symptoms of conversion disorder and treatment approaches amongst indigenous peoples of Eyumojock sub division.
- To study syncope in conversion disorder and treatment approaches amongst indigenous peoples of Eyumojock sub division.

METHODOLOGY

This study is a qualitative study which will unfold through the case study research design since it is in-depth research and relevant with few subjects. The area of study is Eyumojock sub division in Manyu Division of the South West Region of Cameroon with headquarter, Eyumojock. Eyumojock sub division has 66 villages with Ejagham as the national language (Eyumojock Council Development Plan, 2011). The population of Eyumojock sub division is estimated to 46,771 inhabitants with a surface area of 3,442km² and it is a dense equatorial forest area where the people are engaged in subsistence agricultural farming with cocoa, cassava being the most cash crops, and timber as the prominent forest product (Ojong & Eneke, 2025). Eyumojock sub division is bordered in the north by Akwaya sub division, and Upper Bayang, in the East by Mamfe Central sub division, in the South by Mundemba and Toko in Ndian sub division, and in the west by the Republic of Nigeria.

There are many civil servants working within the different institutions such as forces of law and order, teachers, administrators and health practitioners. The target population is all residents who have experienced conversion disorder is not readily provided by medical statistics because indigenous peoples hold the view that the disorder is treated inclusively adopting traditional methods. The sampling method is snowballing because subjects located their counterparts since the researcher could not identify them himself. The sample retained is 4 subjects having experienced conversion disorder. The sampling is retained following inclusive and exclusive characteristics. Inclusion characteristic, patients were subjected to the criteria based on the diagnostic criteria for functional neurologic disorder, according to DSM-5TR as stated below.

- One or more symptoms of altered voluntary motor or sensory function.
- Clinical findings can provide evidence of incompatibility between the symptom and recognised neurological or medical conditions.
- Another medical or mental disorder does not better explain the symptoms or deficit.
- The symptom or deficit results in clinically significant distress or impairment in social, occupational or other vital areas of functioning or warrants medical evaluation.
- People having experienced conversion disorder,
- Being an indigenous people of Eyumojock sub division/residents of the division accustomed to the culture due to their long stay.

Exclusion characteristics are: Non sufferers of conversion disorder. The data is collected through the use of semi-structured interviews in the South West Region of Cameroon. Semi-structured interview provided basic contents on conversion disorder, treatment approaches such as traditional approaches, psychological approaches, community support and medical treatment, then symptoms of sensory disorder, motor symptoms of conversion disorder, and seizures in conversion disorder. Validity and reliability of interview guide were ensured by pilot interviews or pre-interviews to produce consistent results. Five interviews were organised with each subject with a duration of 45-60 minutes. The fifth interview was a summary of the previous four to denote information formerly articulated. Content analysis based on Freud's dream interpretation in classical psychoanalysis will be adopted by listening and understanding of manifest and latent aspects of speech. Content analysis adopting cognitive behaviour theories is also employed to identify mental distortions and in-adapted thoughts and beliefs causing conversion disorders, not forgetting the reasons articulated by subjects for their adoption of treatment approaches related to symptoms manifested.

FINDINGS

Findings show that all participants in the study were females with age range from 35 to 50 years hailing from villages such as Ebinsi, Ajayukndip and Afap of Eyumojock sub division in the South West Region of Cameroon. Interviews were organised with all the 4 participants in their residences at their convenience and conducive environment to avoid distraction and distortion of information. Participants suffered psychological stress and trauma from the death of loved ones, that is, spouse, daughter or son. Conversion disorder/functional neurologic disorder was defined by each patient/participant following the experiences and manifestations lived. Participants are accorded anonymous names to ensure their identification is safeguarded.

The first participant contained this information. Agbor is a female of 45 years old hailing from Ebinsi village in Eyumojock sub division of Cameroon in the South West Region. She is a Christian, a housewife and a farmer who practices subsistence agriculture. She attained secondary education up to form 3. For medical history, Agbor suffers from high blood pressure and conversion disorder since she lost her father in the year 2015. She had suffered about 6 recurrent episodes of conversion disorder since the death of her father with episodes taking more than 8 months accompanied by syncope. She is the only person experiencing conversion disorder in her family.

Agbor defines conversion disorder as a disease characterised by persistent body pains especially the members resulting from loss of loved ones. She explains that, "since I lost my father in 2015, things

have never been the same for me. News of his death was shocking because he was not sick. He collapsed while in a church feast and could not make it. I was so closed to my father. My body trembled and I shook, then, some relative calm was experienced. On the day of corpse removal, I collapsed and regained consciousness after 15 minutes as women who assisted in my recovery told me. I felt like I should die with my father. The departure of my father is serious deficiency in my life and I cannot let go of him in my mind. Conversion disorder is when I experience excruciating pain at my hands and legs, and then an automatic loss of voice as if without having cried". This subject experienced syncope because of the shock and recovered some 15 minutes of later, depicting climax of the bodily reactions and expressions of the loss. "At the occurrence of syncope I felt numbness, weakness of body and certain immobility, I could not explain the rest but those women, my, custodians recounted the event as unfolded until recovery to me. They say, I collapsed and they women surrounded me since they understood what I was experiencing. The patient is taken to the hospital for consultation and treatment where physical examinations are negative all the time she is attacked by a syncope. She recounts;

"All hospital test after syncope are always negative, except for the high blood pressure which I am on drugs".

Her syncope is usually treated traditionally because there is the believe that hospital treatment leads to death of patient. For syncope treatment, the practitioner collects herbs from the farm or in their keeping and ties on her. She explains,

"Two women search for the sensitive area of my body where air was hidden, since most of the parts were insensitive to their pressure, realised by pressing forcefully. They discover the sensitive area at my armpit, at times on the soles of my feet or at my genital organ".

She experiences both motor and sensory symptoms of conversion disorder by expressing sudden numbness, weakness of body, and airtight which led to unconsciousness. Discussing on a conversion episode, she emits the following,

"Syncope attack is suddenly and often. I cannot the source or how to stop it, except for this traditional treatment that recovers from the unconscious state. I feel very uncomfortable at this experience and not able to engage in my farm activities as usual".

The situation may go for up to eight months. In the days she remembers her father, the symptoms recur and those women in my family and neighbourhood keep close attention to her and harvest bahama grass and tie in a bundle with alligator pepper, then attach on her finger, toe or hair. This combination stops her from collapsing or recovery from syncope. It is the same time curative and preventive". The hallmark of conversion disorder to this patient is an experience of weakness of body and pains at hands and feet which lead to impairment from usual activities including her farmwork.

Recovery from syncope is ensured by application of herbs and pains from conversion episodes were resolved by body pain tablets, and much advice from women who are custodians of culture and customs about the cause, experience and treatment of conversion disorder episodes traditionally. They understand symptoms manifestation that could lead to syncope, even if the symptoms prevailed. The most dangerous aspect of conversion disorder is the syncope which to them may result to loss of life of the patient. Therefore, rapid interventions are necessitated to quell the danger and to restore individual to life.

"The presence, consolation and advice disposed by the community members brings comfort and healing effect and relief to me, she said. Their activities to me at the experience of conversion disorder leads to my healing. We can explain syncope but what causes physical pain is attributed at times to work but it persists even without carrying out work. I cannot really explain the source of the prolonged physical pain",

she explains. Agbor visits the hospital when her blood pressure increases and when sick of malaria and other medical conditions. She takes tablets for body pains but realises its persistence even with consumption of tablets.

The second participant, Bessem, is a female of 42 years old who is an indigene of Ajayukndip village of Eyumojock sub division in Manyu division of the South West Region of Cameroon. She is of the Ejagham tribe, a Christian who had her first conversion disorder onset at the age of 35 years of age after losing her husband in the year 2018. She frequent conversion disorder episodes before now, about 7 that had a long active period.

Bessem refers conversion disorder to the experience of pain on the back, chest, waist, which all emerged after the death of her husband, related to motor symptoms. She explains as such;

“Since I lost my husband in the year 2018 and in 2019, I started experiencing chest and waist pain, insomnia and constant headache which took 7 months duration”.

She recounts that her immune system was weakened initiating her to frequent illnesses after her husband died. She experienced grief-induced anorexia by not eating (crying, shaking legs, cleaning nasal discharge). This experience is continuous but has greatly reduced as years elapse. My husband died in December, 2018 and the approach of the very period in that month is marked by sudden manifestations of the pains mentioned above. My late husband has been too supportive and responsible and his father role has been so effective, but his departure has created a great gap and deficit which has kept me in anxiety, and depression all these years.

“The pains emerge so sudden especially when I express a need. A practical example is the approach of school reopening period which he takes care of purchasing all children’s school needs without my participation. I had certain responsibilities especially those of the cuisine but he provided finances and made major decisions for the family, she speaks with a tender voice..

I am actually handicap to decision making and could not reconcile taking decisions on time expecting he will come back to play his functions (she utters this sobbing and shedding tears). She acknowledges the existence of psychological pain in her, even desires to die with him. At night while she dreams discussing with the husband the pain exacerbates at the back and chest anchoring her to the bed, incapacitated to move to the husband who expresses desire for her. *“I could feel his imminent presence in the room but could not move to hold him because of the pain. It is as if he still lives physically but the deception and annoying part is not finding him when awake which increases my pain and suffering”.*

“I feel like I am a sad woman. I lost my self-esteem, confidence and apparently feel abnormal”,

she expresses her grief. She feels unsafe to confide to people and becomes sceptical to reveal some truths to other individuals because of insecurity. Thoughts of her husband were very lively in the early months he died, so much, she said. As years progressed from the time of his death, she has been considering to live and so become engaged and sought for ways to intentionally let go or forget about him. The phase of the mourning process known as “sackcloth” is our culture which I carried out to mourn my husband for a year. This period activated both physical pain and psychological pain memories which led her to seek death herself.

Forgetting the husband will be the primary source of healing to Bessem so she engaged in activities such as dancing, and even dancing competition with her children at home. She kept listening to all kinds of music especially makossa to distract me.

“I rejected God at first and blamed him for allowing my husband to die therefore prayers and attending church services were out of mention. The zeal for prayers emerged when I considered all things work for a purpose and that God is the ultimate creator who knows why certain things happen. Also, I do not like leaving my children behind alone so dying is not the best solution for me, I decided to bounce back – resilience”,

she illustrates with a smile. The integration of social groups assists her much. She joined village meetings with colleagues, and peer groups of widows and became president where they shared experiences. Some experiences shared were so devastating than hers and with that physical and psychological pain will reduce drastically. The women instead remarked that I was so strong the way I managed the mourning process. We had summits to encourage ourselves and the peers praised my strength for handling my situation. “Time is a great factor in healing, she said. As time elapsed my focus was drawn from death to life (wiping tears from the eyes with a steady voice). I see people dying and consider death is a reality to all. I conclude that I have to live. Even now, a month cannot exceed without me thinking of him, his kind of perfume, the position he sits in the parlour, and I have made the decision to remember him in a positive way and not in the negative which inflicts pain on me”, she discloses. Medicines and drugs were not helpful to me during the distressing moment of my husband’s death. For the solution to chronic insomnia I had for six months my friends prescribed me to take milk, much water, to eat late and heavily in the evening so as to sleep which I did but refused taking sleeping pills. Bessem had to visit three prominent hospitals in Yaoundé for diagnosis but results from the tests provided no biological illnesses. Another important factor that contributed for her relief was acceptance. She intentionally decides to let go even though the late husband’s images continue appearing her mind, this time exerting no negative influence on her, and the physical pain subsides gradually but relapse is frequent.

For the third participant, the name is Egbe. She is 49 years, a Cameroonian citizen from Etchitako quarter in Ajayukndip village in Eyumojock sub division of the South West Region. She articulates in the Ejagham national language. As a Christian, Egbe is a housewife who acquired First School Leaving Certificate in education. She has no major illness but for nerves she developed after the loss of her daughter in 2023. The experience of conversion episodes are frequent to her, until this day of interview which delay the progress of

farmwork. She can hardly carry out her farm duties as she did before.

Egbe defines functional neurological symptoms disorder/conversion disorder as the partial paralysis she experiences at the right side of her body. She explains as such,

"This paralysis starts from my right hand, moves down to the right leg and find myself unable to actively utilise these members of the body. In other moments I have hearing difficulties and feared to totally lose hearing ability, she utters.

According to Egbe the partial paralysis and partial loss of hearing she experiences occur without signal or known triggers. She declares having a heavy head, insomnia, loss of weight, the nerves on her neck exert much pain following the symptoms. She suddenly experiences partial deafness causing her to strain when people visit or when engaged in discussion with her entourage. By asking people to repeat what they say makes her uncomfortable to discuss and some of the people have noticed this.

"I cannot pretend to control or have power over the episode at the onset, until after sometime. This may be related to the distress I go through because of the death of my daughter which occurred on the 1 May 2023",

she articulates. She speaks while crying that :

"Since I lost my daughter my life has never been the same. Part of me is gone. I remember the way she sings, dances, her sociability, and entertainment skills created much fun that kept us excited. She was a chorist full of intelligence and smartness. How can she forget her?",

she asked.

To resolve conversion episodes, for paralysis she remains seated at a specific place for some time while gently applying massage with my left hand on the right hand and leg. She then stands and displaces herself around the area to raise the muscle tone for proper mobility. There is success in utilising these exercises to be relief. Egbe admits that the partial loss of hearing is regulated because she intentionally fights back not to allow herself be deformed in any form, especially to complete deafness. She affirms that God decides on all aspects on earth and the death of her daughter is not exempted. Therefore, she lets go painful thoughts.

"For the nerves, I inhale Moringa snuff which is a type of product produced in Ghana. Moringa snuff

runs in my head, moves to the hand, and affected parts, sweat profuse all over my body and suddenly every physical sensation is gone. Moringa is effective for nerve relief and general treatment of other diseases",

she explains shaking her crossed legs. She is dependent on this moringa snuff, for relapse is eminent the days she forgets applying. This treatment demonstrates having ephemeral results because she recounts encountering more than 9 episodes since the daughter died causing distress and hindering her from her functions as a farmer and housewife.

The fourth participant, Takang, is a native of Eyumojock sub division hailing from Afap village in Manyu division. She is a Cameroonian of age, 50 years who speaks Ejagham and she is a Christian. Her medical history shows that she suffers from high blood pressure since 2023. As a teacher, she is a holder of a bachelor degree in education and a single mother. She recounts having experienced long episodes of conversion disorder which could not resolve until after her encounters with psychologist in a psychological unit for a period of two weeks.

Takang perceives conversion disorder as intense physical pain at the hands preventing her from convenient use of her hands to work.

"The pain occurs not because I have an injury or hurt them but it emerges so sudden and prevalent for about more than eight months at first and more at times",

she speaks. This comes with debilitating headache and intake of paracetamol as treatment fails.

"Paracetamol does not relieve this headache", she says.

"I lost my son on the 8th February 2023. He died in my own hands. It was a shocking situation to me. I could not contend this loss as my veins were likely to explode with a raging heart and it was as if blood spilled on my head and realised that I was falling off",

she informs shedding tears. Her son died in pains and she did not succeed to save him despite all trials. Indeed, she exclaimed having suffered from her son's death. Most often she remains withdrawn and lives in isolation. Food means nothing to her but eats a bit to keep the body intact. She deems no need listening to people's advice or interacting, especially as she believes her was murdered by evil people. She posits that her isolation resulted to anxiety and depression and is almost killing her.

While in pain her son and other relatives asked against her will to visit traditionalists or traditional healers when they realised that frequent medical visits and hospitalisations were futile to restore his health. She

did not visit native doctors for her own relief, even traditional practitioners. Takang informs that the image of her son haunts her even in dreams as she talks to him, and sees him everywhere together. She complains,

"I see dead people everywhere in dream and this is dangerous for me. I feel very incomplete without my son since I had only him as a boy". She narrates about the pain, *"the pain at my hands makes me very uncomfortable to the extent of being unable to do laundry myself. I have to depend on my daughter to assist but the most serious is not being effective as a teacher in the classroom. My hierarchy and other colleagues think it is a pretext for me keeping away from work.*

When the incident just occurred prayers had no place, she rejected God. As time elapsed, she reconsidered having prayers with priests because she saw the need of God navigating through the difficult experience, especially where debilitating pain has become her companion. She even asked for forgiveness from God. Distraction is partially effective in her situation in that it disorientated her attention from thoughts of her son occasionally. She goes to work, even though not too active, attends church services now and she integrated family and social groups too. I do not feel those pains at hands again, she says. Since drugs could not assist Takang, she was oriented to visit Trauma Centre Cameroon (TCC) in Yaoundé, an organisation in charge of refugees and people suffering from traumatic experiences.

"The psychologists worked with me for 2 weeks at the centre and I gained great relief. I am at my best right now, thanks to the psychotherapy. The pain is completely gone because the psychologist caused me to challenge the negative thoughts which impregnated my mind. I now have a reason to continue with life, she explains with a smile.

DISCUSSION

Conversion disorder/functional neurological symptom disorder is condition that causes much distress and impairment to those affected seriously. The study of the disorder with participants/patients has enabled to have more information about the prevalence of the disease in Eyumojock sub division in Cameroon. The main research question of this study was, how does conversion disorder influence treatment approaches amongst indigenous peoples of Eyumojock sub division? Conversion disorder/functional neurological symptoms disorder was defined and aspects such as causes, diagnosis, theories and treatment approaches were elaborated following related literature review. The following aspects enlighten the study:

The experience of the conversion disorder amongst indigenous peoples of Eyumojock sub division is a reality through sensory and motor symptoms. The four patients experienced traumatic events as a consequence to the death of their loved ones which seriously had a negative impact on their lives such as isolation, sadness, extreme crying, sobbing, loss of self-esteem, and lack of confidence and a sense of insecurity, to cite a few. Rothschild (2015) had underscored about the psychological effects related to grief concerning personal experiences and social implications elaborating on aspects such as emotional turmoil which include sadness, anger and guilt; the strain of grief in relationships as the bereaved can withdraw from social interactions and struggle to communicate their feelings and that cultural attitudes towards death and mourning have influence on individual experiences of grief.

To be diagnosed of functional neurological symptom disorder all the patients went through multifaceted diagnostic approach; physical, EEG, CT scan, and were treated of other diseases that exist in comorbidity such as anxiety and depression with medications to rule out the possibility of the other diseases which may also manifest through physical symptoms. Histories of the patients and neurological examinations were carried out to rule out organic causes. Patients with high blood pressure were treated of it but patients still experienced physical symptoms such paralysis, body pains at the members which occurred sudden in episodes. Clinical interviews enabled interaction where patients informed the interviewer of the existence and manifestation of the conversion symptoms which cause distress to them.

These patients, Agbor, Bessem, Egbe and Takang experienced conversion disorder from age between 35 to 49 years, which implies conversion disorder affects people of different age ranges as well across lifespan. Findings on this study reveal that participants complain of experiencing distress and impairment in their daily functions, and therefore cannot execute their duties in homes, farms and social settings adequately, and Peeling and Muzio (2023) assert also that functional neurological symptom disorder affects patient's ability to function. Also, patients must encounter a stressful and traumatic event which may be at the basis of their experience of conversion disorder as all declare having lost significant persons in their lives. Death is separation and separation unveils the strength of bonding that existed in the relationships patients lived when their loved ones were alive, demonstrated by subsequent reactions after the death. Most patients while on grief, processed denial, acceptance of the situation and decided to let go the painful death separation before relief was initiated. This decision is a serious factor in the life of the bereaved because it initiates the onset of healing and relief which most affirmed by declaring "I realised that people also die here and elsewhere, death is general and affects each family anytime and anywhere. My husband, son, daughter is dead; I must live to take care of the other

children”, the bereaved woman declared. The declaration above signifies an intention to cooperate in the healing process which Linehan (2014) had laid emphasis on.

Sensory symptoms of conversion disorder manifestations are demonstrated in Agbor and Egbe. Agbor experienced syncope and remained immobile, weak and lost senses, especially the senses of feeling and hearing which influenced and attracted adoption of traditional treatment approaches of herbs (tying of Bahama grass and alligator pepper on part of body to bring forth healing and relief, as the indigenous peoples have their belief and treatment competences for the syncope and associated signs and symptoms that arise. Egbe experienced partial loss of hearing but by active decision refused to delve into complete deafness and so far led into relief. According to Frankl (1962) when a patient finds meaning in suffering as in the case of patients with conversion disorder, and the patient actively engages in his circumstances of seeking relief, he promotes healing. Also, it is affirmed that actively processed emotions may accelerate recovery from illness (Pennebaker, 1997).

For motor symptoms of conversion disorder, participants manifest through numbness, weakness or partial paralysis of right part of body, partial loss of speech, syncope, unconsciousness, pains at the members (legs and hands), chest, head and heart pain leading to insomnia at night. Participants inform that motor symptoms also occur suddenly and they have no control over them no matter their effort furnished; confirmed as, the affected individual cannot control conversion disorder symptoms (Ali et al., 2015). The different manifestations as bodily or physical symptoms are influenced or influence attitudes in patients. Such attitudes constitute beliefs of indigenes of Eyumojock sub division related to the dead and his intimacy of the dead with the bereaved, grief process which demonstrates cultural values and its significance to both the bereaved, village authorities, power that exist within cultural cycles and social interactions to give meaning to life.

Refusal to go through the grief process known as “sackcloth” in the custom of the Eyumojock people means dishonour to the dead husband, family and disrespect for culture and the sackcloth period as Bessem recounts caused much pain and episodes of conversion disorder where she desired to even die and meet the husband. Sackcloth demands some form of mistreatment by the culture of the widow of the bereaved such as wearing of completely same regalia (black clothes throughout mourning period), sleeping on hard ground using a floor mat, not bathing but allowed to undergo partial ablution until the end of grief process which lasted for a month with Bessem’s case, and restrictions for food and interactions. This punishment engages patients in profound self-communication impacted with misery and both a surge of physical pain which expresses psychological pain in patients.

Treatment approaches influenced by conversion disorder amongst indigenous peoples of Eyumojock sub division involve the traditional approaches where the experience of syncope by Agbor was treated with bahama grass and alligator pepper tied on body parts such as the hair, toes and fingers. This belief system provides gaps as to explain the power from Bahama grass and alligator pepper to treat patients with syncope. From the table above, this patient affirmed going through frequent relapse and episodes of conversion disorder because of ineffective response of the treatment approach, demonstrating that the source of the patient’s suffering is not rooted on the physical (hair, skin, or hands and legs) but elsewhere, repressed according to Freud (1952).

Patients who registered into peer groups of widows where they discussed common issues and provided psychosocial support to one another, regained strength, moral, resilience and effective coping strategies which caused the relief from the power the very thoughts as well as relief from symptoms of conversion disorder. While living the thoughts quite often their effects are continuous but cause less impairment than before. It is difficult to for her to yield from this pain and engage in life as she did before the death of her father, as she considers.

Egbe engages in physical therapy by carrying out physical exercises with experience of partial paralysis of right hand and legs or right part of the body. She utilises traditional approach where the inhaling of Moringa snuff (a herbal constitution) presents quick relief from physical pain from nerves and body areas undergoing symptoms of conversion disorder.

Takang affirms that headache initiated from sequels of episodes conversion disorder is not treated by paracetamol or other medications but got relief at the intervention of a psychologist during her stay in the premises of Trauma Centre Cameroon for two consecutive weeks with intensive psychological follow-up. She regained life as soon as this encounter in 2024 and her perspectives about her son’s death changed. The partial paralysis, headache, heavy head, loss of weight and nerves she developed have greatly subsided or healed. The remaining health hazard untreated is the high blood pressure whose threat is drastically reduced. Other psychological approaches which she adopted were isolation and withdrawal from people but proved ineffective. She declares that the intervention of psychologist at Trauma Centre Cameroon in Yaoundé assisted in transforming the debilitating thoughts that congested her mind and caused her desiring death. Takang also acknowledges that personal decision to let go her son’s death improved her health and enabled her undertake the activities she once refuted and rejected as vanity.

Patients who relied more on treatment approaches that favoured the physical body such as Agbor and Egbe adopting herbs for syncope and moringa snuff for paralysis experienced more relapse, hence many conversion disorder episodes than patients who practiced distraction, psychotherapy, psychosocial

support through peer group activities which handled both physical and psychological healing. While patients whose treatment approach or interventions were traditionally based inform of frequent relapse, dependence on the mechanism and many conversion disorder episodes, Bessem and Takang informed of permanent remission in adopting psychosocial treatment approaches leading to permanent relief of their paralysis, and all the pains they encountered.

Recommendations

Healthcare workers should organise caravans, symposiums, or pass information regarding diseases and symptoms through councils, village chiefs, church houses and local radio stations for community awareness. They should provide possibilities for individuals living with such diseases to meet them or inform them confidentially.

All indigenous people should visit hospitals and clinics when sick to get medical information about their situation s first before engaging on treatment administration.

They should adopt holistic treatment approaches to enable permanent remission from disease, which will prevent frequent hospital visits and careless expenses on physical pain whose origin is not biological but psychological.

CONCLUSION

Conversion disorder is existent in the community of Eyumojock sub division in the South West Region of Cameroon which has permitted a research study to discover lived experiences of the condition by patients. This qualitative study or case study design using semi-structured interviews exposed the manner four participants (patients) responded to the interviews with major and sub themes such as conversion disorder, treatment approaches, sensory symptoms of conversion disorder, motor symptoms of conversion disorder and syncope. From the findings the following assertions are constructed. Relief from conversion disorder by indigenous people of Eyumojock sub division is influenced by treatment approaches such as;

- Traditional approaches by using herbs at syncope and moringa snuff to relief nerves and body pains.
- Physical therapy through exercises such as flexing the hands, legs, and dancing.
- Re-education by gradually introducing partial paralysed body parts to movement they could not exert at conversion episodes.
- Psychological counselling and distraction at a specialised centre followed by a specialist such as a psychologist.
- Relief is also influenced by the decision of the affected to actively and deliberately inhibit symptoms' promoting relief.

- The active engagement of the patient in search of the cause of suffering and processing information about the relief, promotes healing.
- The patient that actively participates in the healing process facilitates healing thereby influencing the duration of conversion episode.

The fact that Agbor and Egbe employed traditional approaches (herbs and moringa snuff) to treat physical pain ignoring psychological pain (the root of conversion disorder) resulted to repeated episodes of the condition and delayed relief until at moment because they are ineffective in usual activities as they did before the physical symptoms affecting them. Bessem and Takang who resorted to physical therapy, psychotherapy, counselling, peer group insertion, and distraction observed better relief from sensory and motor symptoms of conversion disorder demonstrated by less frequency or none prevalence of conversion disorder episodes as before the intervention in these treatment approaches. These recommendations hold; -Patients (such as Agbor and Egbe) should go through psychological treatment approaches such as cognitive behaviour therapy and psychoanalytic therapy to transform the ideas behind the lost object enacting trauma in patients harmless.

Health practitioners should create awareness in Eyumojock sub division thereby sensitising the population on conversion disorder and possible effective treatment approaches.

Patients should integrate psychological and other treatment approaches such as behaviour reinforcement as comprehensive treatment to ensure adequate relief and healing.

Therefore, patients employ treatments available to them and integrate the self in the rate of relief or treatment. Whichever treatment approach is adopted, the decision to let go debilitating thoughts or psychological pain or interprets it supportively is expressive step to early recovery from conversion disorder episode or the number of episodes prevalent.

REFERENCES

- Ali, S., Jabeen, B., Pate, R. J., Shadid, M., Chinala, S., Nathani, M. (2015). Conversion disorder – Mind versus body: A Review. *Innovations in Clinical Neuroscience*, 12(5-6): 27-33.
- Ali, S., Jabeen, S., Pate, R. J., Shahid, M., Chinala, S., Nathani, M. & Shah, R. (2015). Conversion disorder-Mind versus body: A review. *Innovations in clinical neuroscience*, 12(5-6): 27-33.
- American Psychological Association (APA). (1952). *Diagnostic and Statistical Manual of Mental Disorder* (1st ed.). Washington, DC: American Psychology Association.
- American Psychological Association (APA). (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington D.C: Author.

- American Psychological Association. (1994). *Diagnostic and Statistical Manual of Mental Disorder* (4th ed.). Washington, DC: Author
- Beri, D. & Reddy, K. J. (2020). An overview of conversion disorder: prevalence, causes and treatment. *Acta Scientific Neurology*, (ISSN: 2582-1121). Vol.3. Issue 10.
- Brock, A. J. (1916). *Galen, on the Natural Faculties*. Cambridge: Harvard University Press.
- Edward, M. J. & Bhatia, K. P. (2012). Functional (psychogenic) movement disorders: merging mind and brain. *The Lancet Neurology*, 11(3), 250-260.
- Eyumojock Council Development Plan. (2011). *Eyumojock Council*. Unpublished.
- Frankl, V. E. (1962). *Man's search for meaning: An introduction to logotherapy*. Boston: Beacon Press.
- Freud, S. (1952). *The standard edition of the complete psychological works of Sigmund Freud* edited by James Strachey, Vol. 12. Hogarth Press.
- Furqan, N. M. B. B. S., Nathan, F. B. A. & Klein-Cloud, A. B. (2016). American Journal of Psychiatry Residents' Journal, Vol. 11, No. 7. <https://doi.org/10.1176/appi.ajp-rj.2016.110708>
- Furqan, N. M. B. B. S., Nathan, F. B. A. & Klein-Cloud, R. A. B. (2017). Conversion disorder with conceptual and treatment challenges. *American Journal of Psychiatry*. Vol. 11. No. 7. <https://doi.org/10.1176/appi.ajp-rj.2016.110708>.
- Grossman, S. A. & Badireddy, M. (2025). *Syncope*. <https://www.ncbi.nlm.nih.gov/books>.
- LaFrance, W. C. Jr., Perez, D.L. & Aybek, S. (2020). Functional Neurological (Conversion) disorder: A core neuropsychiatric disorder. *Journal of Neuropsychiatry Clinical Neuroscience*, 32(1): 1-3. Doi: 10.1176/appi.neuropsych.19090402
- Linehan, M. (2014). *Dialectical Behaviour Therapy (DBT) Skills training handouts and worksheets* (2nd ed.). New York: Guilford Publications
- Mayo Clinic. (2022). *Functional neurologic disorder/conversion disorder*. <https://mayoclinic.or/disease-conditions/conversion-disorder/symptoms-causes/syn-20355197>
- Nakao, M., Shirotaki, K. & Sugaya, N. (2021). *Cognitive behavioural therapy for management of mental health and stress related disorders*.
- Ojong, E. J. & Eneke, E. (2025). Infrastructural planning development projects realised from forest royalties in Eyumojock sub division, South West Region of Cameroon. *International Journal of Research in Engineering and Science (IJRES)*, Vol. 13, Issue1.pp.50-60. ISSN 2320-9364, ISSN (print): 2320-9356. www.ijres.org
- Peeling, J. L. & Muzio, M. R. (2023). Functional neurologic disorder. *National Centre for Biotechnology Information*. <https://www.ncbi.nih.gov/books/NBK551567/>
- Pennebaker, J. W. (1997). Writing about emotional experiences as a therapeutic process. *Psychological science*, 8(3), 162-166.
- Reuber, M. & Elger, C. E. (2013). Psychogenic nonepileptic seizures: review and update. *Journal of Epilepsy Behaviour*, Vol. (4), 205-216.
- Reuber, M. (2016). Etiology of Psychogenic Non-epileptic seizures: Toward a Biopsychosocial model. *Handbook of Clinical Neurology*, 139: 283-296.
- Rothschild, R. H. (2015). *The improbability of love*. New York: Alfred A. Knopf.
- Stone, J., Curt, W., LaFrance, Jr., Levenson, J. L., & Sharpe, M. (2010). Issues for DSM-5 Conversion Disorder. *American Journal of Psychiatry*, Vol. 167, pp. 626-7. Doi: 10.1176/appi.ajp.2010.09101440
- Stone, J., Hoeritzauer, L., Mcwhiter, L. & Carson, A. (2024). Functional neurological disorder: defying dualism. *Journal of World Psychiatry*, 23(1), 53-54. DOI: <https://doi.org/10.1002/wps.21151>.
- Veith, I. (1965). *Hysteria: The history of disease*. Chicago: University of Chicago.
- World Health Organisation. (2013). *Mental health action plan 2013-2020*. Geneva: WHO. <https://iris.who.int/bitstream/handle/10665/89966/9789241506021->

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