DYSFUNCTIONAL ATTITUDES AND DEMOGRAPHIC CORRELATES OF PATIENTS WITH CONVERSION DISORDER; AN EXPLORATORY STUDY

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ABSTRACT

Objective: To explore the possible etiological significance of dysfunctional attitudes among patients of conversion disorder and to investigate the demographic variables like gender, age, marital and socio-economic status of patients.

Design: Cross sectional study.

Place and Duration of Study: The study was conducted at different outdoor units of psychiatry departments of different private hospitals of Rawalpindi and Islamabad from October 2010 to December 2012.

Subjects and Methods: A total of 100 individuals, 50 referred patients of conversion disorder (diagnosed as per DSM-IV criteria) were recruited through convenient sampling, while 50 normal individuals from the normal population (who have never registered as psychiatric patients) matched for demographic variables of experimental group. Dysfunctional attitude Scale (DAS) in addition to demographic data sheet were used to obtain data from the sample after taking the consent. The data was analyzed by SPSS version 18 by using ANOVA and correlation techniques.

Results: The results showed that patients with conversion disorder exceeded the controls on the measure of dysfunctional attitude ($p > .05$). The findings also suggested that 82% female, 58%, unmarried, 90% younger and 58% patients with low socio-economic status suffer from conversion disorder among the sample.

Conclusion: Patients with conversion disorder exhibit higher dysfunctional attitudes as compared to normal individuals .It is more prevalent among females, unmarried, younger individuals belonging to lower middle socio-economic class mostly then males and those who are married, older and belonging to higher socio-economic status.

Key Words: Dysfunctional Attitudes, conversion disorder, demographic correlates.

INTRODUCTION

The conversion disorder is a type of somatoform disorders, and is characterized by episodes of pseudo-neurological symptoms, like seizures, paralysis and other sensory –motor symptoms, also, seizure like symptoms or unconscious fits.It has been reported to be one of the frequent diagnoses in psychiatric units in Pakistan[1]. There are four subtypes of conversion disorder identified in DSM-IV[2],with motor symptoms, sensory symptoms, seizures, and mixed presentation.

Conversion disorder is an argument of great controversy between proponents of psychological and physiological models[3].To explain the etiology of conversion disorder, different approaches have consensus on adopting a combined perspective derived from biological, psychodynamic, socio-cultural, and behavioral aspects[4]. It has been established that underlying diverse personality features or psychological conditions can be associated to the occurrence in this regard. The depression, rigid personality traits[5], and anxiety are also associated very frequently with conversion disorder.

Beck has proposed an etiological model of depression in which maladaptive cognitive schemas, expressed as global, rigid and inappropriate attitudes, place individuals at risk of mental disturbance[6,7]. These underlying assumptions are governed by individual's dysfunctional attitudes that depict the enduring segment[8] and specific depressogenic events in life trigger certain schemas specific to certain life event to which the individual is extra sensitive. Dysfunctional attitudes have been found associated with the episodes of depression and anxiety[9] while depression is identified as co-morbid state in different psychiatric illnesses in almost 80% in Pakistani population[10]. Dysfunctional attitudes have been associated with depression more frequently as compared to any other psychiatric condition in research history, while depression is associated with conversion disorder itself[11]. There have been attempts to understand psychological factors other than stressors and traumatic exposures[12] like defense mechanisms and emotional processing for

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attempting to discover appropriate solutions in the form of psychotherapeutic interventions. Exploring psychological profile is also important in determining causes of conversion disorder[15]. Usually the emphasis is placed on the deprssogenic nature of the attitudes as other studies have already confirmed underlying depression among patients with conversion disorder[16].

However, studies have documented the prevalence of dysfunctional attitudes in several disorders that is baseline for treating patients with traditional Cognitive Behavior Therapy (CBT)[17] and Mindfulness based CBT[18]. The successful use of CBT has been reported with some medically unexplained symptoms[19]. While implementing CBT model, patients of conversion disorder are reinforced to restructure their dysfunctional attitude/beliefs that brings greater reduction to psychogenic seizures[20]. The identification and intervention of dysfunctional attitudes of depressogenic nature could be helpful with CBT, which is expected to reduce the cognitive errors consequently reducing or eliminating conversion symptoms.

The prevalence of conversion disorder was estimated almost 80% in females mostly unmarried[21] and belonged to urban population, were single and unemployed with the mean age of years 23[22], majority of patients in both genders were unmarried and young. It further estimated the dissociative convulsions (63%) and high rates of depression (61%) and anxiety (60%)[23]

The present study aimed at investigating whether the patients with conversion disorder exhibit dysfunctional attitudes in comparison to normal individuals .It also attempts to explore which demographic variables show more prevalence to the disorder in the target population. It was hypothesized that dysfunctional attitudes will be higher among patients with conversion disorder as compared to normal individuals, also females, unmarried, younger and individuals with low socio-economic status will exhibit higher levels of dysfunctional attitudes as compared to males, older, unmarried, and individuals with higher socio-economic status respectively.

SUBJETS AND METHODS

The present research is based on cross sectional survey research design.The sample composed of 50 diagnosed patients of conversion disorder, both male and female with age range from 18-45 years, educational background was from intermediate and above, with different socioeconomic status and marital status. These patients were controlled for medicine and pharmacological treatment. The control group consist of 50 normal individual matched for demographic variables along with the diagnosed subjects selected from other medical units of the same hospitals. Those subjects were selected who have never been register to any psychiatric unit. A written informed consent was taken from all the subjects of the study along with assurance of confidentially to their personal information.

Important demographic information was collected through the demographic data sheet, which included, name, age, gender, education, marital status, income, duration of illness, family structure, residence and history of medical illness.

The Urdu version of Dysfunctional attitude Scale[24] translated by Naeem[25] was administered. The DAS is a 40-item self-report questionnaire designed to assess maladaptive thought patterns and cognitive styles that included stress with evaluation, perfectionist principles of performance, contributory attributions, and rigid ideation about the world. Total scores on the DAS can range from 40 to 280; with higher scores reflecting greater dysfunctional attitudes. The DAS has demonstrated good reliability and validity in both student and patient samples.

A cross-section descriptive study was carried out to achieve the objective and the data was collected from different psychiatric units of Rawalpindi and Islamabad, after taking the permission from authorities and consent from participants. They were briefed about the purpose of the research. The questionnaire were handed over to them and were asked to rate their responses against each items. As instruments were in Urdu language so participants have no difficulty in filling out the form.

To test the study hypothesis data was analyzed by using SPSS 18. Internal consistency was measured by reliability analysis and independent sample t-test was used to calculate mean differences between two groups for Dysfunctional attitude scale. ANOVA analysis was use to check the differences among three groups.

RESULTS

The sample consist of 50 conversion patient and 50 normal individuals out of 50 conversion patients out of conversion patients 41 are female and 9 are male patient. The results are discussed in detail in the following chapter.

Table 1 show that the alpha reliability of the Dysfunctional Attitude scale is .80, indicating a high value of alpha coefficient.

Table 2

Table 1

Reliabilities estimates and descriptive statistics of questionnaire (n= 100)

Scales	No of items	M	SD	Alpha	Range	Kurtosis	Skew
Dysfunctional Attitude scale	40	95.90	19.5	.80	1-7	-.17	.56

Mean, standard deviation and t-values for Conversion patient-normal individuals, male- female, married- unmarried, and younger-older conversion disorder patients on Dysfunctional Attitude scale (n = 100)

Table 2 shows the difference in dysfunctional attitude among conversion patients and normal individual. The results

		Dysfunctional Attitude scale			
	N	M	SD	t	P
Conversion patient Normal patient	50 50	195.70 156.75	31.33 27.43	5.81	.000
Male Conversion patient Female Conversion patient	9 41	185.75 209.77	24.43 31.85	3.28	.03
Younger Conversion patient (20-30 years) Older Conversion patient (31-40 years)	45 5	210.00 192.82	27.54 22.54	7.35	.000
Married Conversion patient Unmarried Conversion patient	26 24	201.11 191.12	32.95 26.04	6.81	.04

Table 3

One Way Analysis of Variance of Scores of DAS on Three levels of socioeconomic status among with conversion Disorder (n=50)

	Lower socioeconomic (n = 29)		Middle socioeconomic (n=14)		Upper socioeconomic (n = 07)		
	M	SD	M	SD	M	SD	F
Dysfunctional Attitude	190.47	32.43	192.66	37.81	171.45	36.24	3.63**

df = (3 , 47), p**<.001

are statistically significant at 0.01, level of significance. Significant t-value indicates that the patients show higher dysfunctional attitude as compare to normal individuals. This result supports our first hypothesis. On the other hand when comparing male and female conversion patients, significant t-value indicates that the female patients show higher dysfunctional attitude as compare male patients. The difference in dysfunctional attitude among young and older conversion patients are also statistically significant at 0.01 level of significance indicating that the young patients show higher dysfunctional attitude as compare to older patients. At the end married and unmarried conversion patients were compared through t-test and results indicating mean differences married and unmarried, the married patients show higher dysfunctional attitude as compare to unmarried patients.

Table 4 shows the gender difference in dysfunctional attitude among conversion patients. The results are statistically significant at 0.05, level of significance. Table 5 shows Table 7 shows the educational differences in dysfunctional attitude among conversion patients. The results are statistically significant at 0.01, level of significance that the less educated patients show higher dysfunctional attitude as compare to more educated patients.

DISCUSSION

The findings of the present exploratory study complemented the assumption of presence of higher dysfunctional attitudes among the patients of conversion disorder as compared to normal individuals. This refers to a theoretical framework that recommends that the individuals with Psychogenic non-epileptic seizures have a vulnerable cognitive-emotional processing system that can predispose the individuals to suffer from the disorder[26]. Thus the findings from current research also enhances the prospect of dysfunctional attitudes as a contributory factor to the development of conversion disorder like in any other psychiatric illness possibly.

Although the manifestation of higher levels of dysfunctional attitudes cannot be assumed as an essential etiological factor of this specific disorder per se, but it could be considered as a component of cognitive pattern of the individuals who suffer from conversion disorder .Therefore dysfunctional attitudes have been recognized as more prevalent among different psychological disorders. The dysfunctional attitudes may contribute in terms of expression of intense emotion or strong need of attention .The symptoms could be taken as a more acceptable form of communication of some forbidden idea or feelings that is not appropriate otherwise. Such prohibitions are usually reinforced by the gender roles, religious connotations, beliefs and other socio-cultural influences[27]. Working with dysfunctional attitudes by cognitive behavior therapy can

produce better results[28,29].

As results indicate that women suffer from conversion disorder more frequently than males, there are several explanations regarding this phenomenon, as suggested by other studies[30,31].The phenomenon can be explained more appropriately in terms of cultural influences. For females it appears to be relatively more acceptable way to vent out intense emotions and gain attention while males relatively can express emotions more easily. Many studies have established the occurrence of conversion to be more recurrent in rural areas of a country, usually in lower socio-economic strata; since the educational opportunities are limited, hence they are less aware of mental and physical illnesses[32,33].The established family value systems in Pakistani culture do not allow individuals to be openly expressive, hence exhibit rigid or inappropriate pattern for expressing emotions that sometimes becomes the reason of suffering from conversion disorder. The majority of Pakistani population is less educated and belongs to lower socio-economic level, as the prevalence of conversion disorder was found more in lower socio-economic class in the present findings that is complimented by previous findings[34]. It was also noted that mostly younger individuals suffer from conversion disorder in comparison to older ,again consistent with previous findings from Pakistani culture[35].This could be justified with reference to adolescents' crises which are not being settled down in Pakistan appropriately due to many factors .The young people take time to solve their own emotional issues since the communication gap between elders and young generation persists in majority of cases. Conversion disorder could be taken as a tool used for communicating their needs to others. It refers to the immaturity and primitiveness in one's perception to conflicting situations and handling as well. Unmarried population is also an extension of the same issue, as results confirmed that most patients of conversion disorder are unmarried i.e. in their early years of life attempting to find solution for their inner conflicts.

LIMITATIONS

One weakness of current study is the limited and area bound sample. Including larger number of patients with conversion disorder across several areas of the country could have yielded more reliable information. Likewise, some other screening instrument could be more appropriate to recruit patients with conversion disorder other than the use of DSM-IV criteria.

CONCLUSION

In the first place, evidence of etiological factors and underlying characteristics of conversion disorder is in its infancy in Pakistan ,secondly the psychological management and intervention is based on that first-hand information itself . The present research, as an initial step towards it attempted to identify the depressogenic dysfunctional attitude among patients of conversion disorder as compared to the individuals who have never been diagnosed with any psychiatric disorder in addition to exploring different demographic correlates of the same disorder in Pakistan. The results concluded that patients with conversion disorder exhibit higher levels of dysfunctional attitudes while females, younger, unmarried and individuals with low socio-economic status exhibit higher dysfunctional attitude as compared to their correlates. The findings would be helpful with respect to the implementation of psychotherapeutic plan, predominantly Cognitive Behavior Therapy for challenging the dysfunctional cognitions in order for the symptoms of conversion to improve and managed for future as well. Additionally the demographic information is also additional information regarding the target population; this could be helpful to predict the likelihood of the disorder with certain variables.

REFERENCES

1. Minhas FA, Farooq S, Rahman A, Hussain N, Mubasshar MH. Inpatient psychiatric morbidity in a tertiary care mental health facility: A study based on a psychiatric case register. J Coll Psysician Surg Pak 2001;11:224-8.
2. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. Washington, DC: APA; 1994.
3. David A, Halligan P. Cognitive neuropsychiatry: potential for progress. J Neuropsychiatry Clin Neurosci 2000;12:506-10.
4. Binzer M, Kullgren G. Conversion symptoms - what can we learn from previous studies? Nord J Psychiatry 1996;50:143-52.
5. Wynick S, Hobson RP, Jones RB. Psychogenic disorders of vision in childhood ('visual conversion reactions'): perspective from adolescence: a research note. J Child Psychol Psychiatry 1997;38:375-9.
6. Beck AT. Cognitive therapy and the emotional disorders. New York, NY: Penguin Books; 1976.
7. Kovacs M, Beck AT. Maladaptive cognitive structures in depression. Am J Psychiatry 1978;135:525-33.
8. Beck Aaron T.; Rush, A. John; Shaw, Brian F.; Emery, Gary. Cognitive therapy of depression. New York: The Guilford Press. 1979.
9. Tschacher W. The dynamics of psychosocial crises: time courses and causal models. J Nerv Ment Dis 1996;184:172-9.
10. Alvi T, Minhas FA . Type of presentation of dissociative disorder and frequency of co-morbid depressive disorder. J Coll Physicians Surg Pak 2009;19:113-6.
11. Pehlivanturk B, Unal F. Conversion disorder in children and adolescents: clinical features and comorbidity with depressive and anxiety disorders. Turk J Pediatr 2000;42:132-7.
12. Brown RJ. Psychological mechanisms of medically unexplained symptoms: an integrative conceptual

model. Psychol Bull 2004;130:793-812.

13. Yu C. Dream intensity profile as an indicator of the hysterical tendencies to dissociation and conversion. Dreaming 2010;20:184-98.

14. Kozlowska K, Scher S, Williams LM. Pattern of emotional cognitive functioning in pederiatic conversion patients: implications of conceptualization of conversion disorder. Psychsom Med 2011;73:775-88.

15. Awad H, Softic J. Psychical & psychological characteristics of patients with non-epileptic seizures. Med Glas (Zenica) 2011;8:224-8.

16. Hurwitz T, Kosaka B. Primary psychiatric disorders in patients with conversion. J Depress Anxiety 2001;4:4-10.

17. Allan LA, Woolfolk RL. Cognitive behavior therapy for somatoform disorders. Psychiatr Clin North Am 2010;33:579-93.

18. Gaston B, James H. Brief mindfulness based psychotherapeutic intervention during inpatient hospitalization in patients with conversion and dissociation. Clin Case Stud 2011;10:95-109.

19. Whiting P, Bagnall AM, Snowden AJ, Cornell JE, Mulrow CD, Ramírez G. Intervention for the treatment and management of chronic fatigue syndrome: a systematic review. JAMA 2001;286:1360-8.

20. Goldstein LH, Chalder T, Chigwedere C, Khondoker, MR, Moriarty J, Toone BK, et al. Cognitive-behavioral therapy for psychogenic nonepileptic seizures: a pilot RCT. Neurology 2010;74:1986-94.

21. Ahmad R, Riaz Z. Socio-demographic and clinical characteristics of patients with conversion disorder. Pak Psychol Res 2007;22:107-22.

22. Alvi T, Minhas FA. Type of presentation of dissociative disorder and frequency of co-morbid depressive disorder. J Coll Physicians Surg Pak 2009;19:113-6.

23. Malik M, Bilal F, Kazmi S, Jabeen F. Depression and anxiety in dissociative (conversion) disorder patients at a tertiary care psychiatric facility. Rawal Med J 2010; 35:224-6.

24. Weissman AN, Beck AT. Development and validation of the dysfunctional attitude scale: a preliminary investigation [Online]. 1978 [cited on 2012 Nov 10]. Available from URL: http://elib.uum.edu.my/kip/Record/ED167619

25. Naeem F. Tranlation of dysfucntional attitude scale in urdu. 2007;Upublished work

26. Baslet G. Psychogenic non-epileptic seizures: a model of their pathogenic mechanism. Seizure 2011;20:1-13.

27. Schwartz A, Calhoun A, Eschbich C. Treatment of conversion disorder in an African American Christian woman: cultural and social considerations. Am J Psychiatry 2001;158:1385-91.

28. Simons AD, Garfield SL, Murphy GE. The process of change in cognitive therapy and pharmacotherapy for depression: changes in mood and cognition. Arch Gen Psychiatry 1984;41:45-51.

29. DeRubeis R, Hollon S, Grove W, Evans M, Garvey M, Tuason V. How does cognitive therapy work? Cognitive change and symptom change in cognitive therapy and pharmacotherapy for depression. J Consult Clin Psychol 1990;58:862-9.

30. Carson AJ, Ringbauer B, Stone J, McKenzie L, Warlow C, Sharpe M. Do medically unexplained symptoms matter? A prospective cohort study of 300 new referrals to neurology outpatient clinics. J Neurol Neurosurg Psychiatry 2000;68:207-10.

31. Nimnuan C, Hotopf M, Wessely S. Medically unexplained symptoms: an epidemiological study in seven specialities. J Psychosom Res 200l;51:361-7.

32. Stefánsson JG, Messina JA, Meyerowitz S. Hysterical neurosis, conversion type: clinical and epidemiological considerations. Acta Psychiatr Scand 1976;53:119-38.

33. Tomasson K, Kent D, Coryell W. Somatization and conversion disorders: comorbidity and demographics at presentation. Acta Psychiatr Scand 1991;84:288-93.

34. Maxion H, Fegers S, Pfluger R, Wiegand J. Risk factors of classical conversion syndrome—psychogenic seizures and paralyses—observations at a neurologic clinic with 172 patients. Psychother Psychosom Med Psychol 1989;39:121-6.

35. Ahmad R, Riaz Z. Socio-demographic and clinical characteristics of patients with conversion disorder. Pak J Psychol Res 2007;22:107-22.