

## Relationship between Perceived Social Support and Readiness for Treatment in Patients with Conversion Disorder

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**Abstract:** Patients having Conversion disorder receives and reinforced by attention and social support thus they assume sick role unintentionally. Present study aims to examine the characteristics and symptoms of patients with conversion disorder while find out the relationship of perceived social support and readiness for treatment. This study was conducted in Lahore, Pakistan. Fifty Conversion patients diagnosed by psychologist/psychiatrist from different psychiatric departments of hospitals of Lahore were selected and were required to complete the questionnaires. To assess the perceived social support and readiness for treatment, Multidimensional Perceived Social Support scale (MPSS) and Client Motivation for Therapy Scale (CMOTS) was administered respectively. Pearson Product Movement Correlation and t-test was applied for statistical analysis. Results showed significant relationship between perceived social support and Readiness for treatment. No significant differences were found in both genders. Perceived social support is related with readiness for treatment in patients with conversion disorder. No significant gender differences have been found in perceived social support and readiness for treatment in conversion patients. The result can facilitate psychologist and other professionals to design the psychotherapy based on increasing sense of perception toward social support and motivational strategies for patients with conversion disorder.

**Keywords:** Conversion disorder, perceived social support readiness for treatment.

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### I. Introduction

Conversion disorder is a condition where patients present their problems with neurological symptoms such as numbness, paralysis, or seizures, but where no neurological explanation can be found.<sup>[1]</sup> It is thought that these problems arise in response to difficulties in the patient's life, and conversion is considered a psychiatric disorder in ICD-10 as well as DSM-V.<sup>[2,3]</sup> As far as history of the conversion disorder is concerned, prior to 1600, the hysteric affliction was linked with an illness of the uterus or given metaphysical explanations such as witchcraft or demonic possession.<sup>[4]</sup> In early 17th century, psychological explanation of hysteria appeared and classified as a variety of melancholy. Further it was a considered an affliction of the mind and its presence was considered same for both genders.<sup>[5]</sup> The original Freudian model suggested that the emotional charge of painful experiences would be consciously repressed as a way of managing the pain, but this emotional charge would be somehow "converted" into the neurological symptoms.<sup>[6]</sup>

Stone, Carson, and Sharpe suggested that patients do remain distressed by their symptoms in the long term.<sup>[7]</sup> Owens and Dein identified that the female to male ratio for the disorder ranges between 2:1 and 10:1. Conversion is most frequently found in women with history of child abuse.<sup>[8]</sup> Conversion disorder may present at any age but is rare in children younger than 10 years or in the elderly.<sup>[9]</sup> Studies suggest a peak onset in the mid-to-late 30s.<sup>[10]</sup> All over the world, there are different sociocultural factors related to mental disorders. In Pakistan, Irfan and Badar found that most frequently reported stressors in hysterical patients were related to family.<sup>[11]</sup>

Researchers identified that social support serve as coping mechanism in stressful life situation which may reduce psychological distress in an individual.<sup>[12,13]</sup> Moreover social support has been found closely related to overcome psychological symptoms and disorders.<sup>[14,15]</sup> Cobb defined social support the individual belief that one is cared for and loved, esteemed and valued, and belongs to a network of communication and mutual obligations.<sup>[16]</sup> According to Sarason, Pierce, and Sarason, perceived social support is the set of feelings that you are loved, valued, and unconditionally accepted.<sup>[17]</sup> Social support has been given various definitions, encompassing all social relationships.<sup>[18]</sup> Social support might be of instrumental help, emotional, appraisal and informational.<sup>[19,20]</sup>

Brugha and Bebbington pointed out the fact that the perception toward social support of a patient may determine his/her readiness for treatment as well as recovery.<sup>[21,22]</sup> Patients with conversion disorder get social reinforcement to promote their symptoms and rewards to strengthen their beliefs to assume sick role. It further leads toward resistance to get treatment.<sup>[23]</sup> Tickle and Crockford emphasized that motivational level of

individual plays a vital in the treatment of conversion disorder because it requires a great deal of effort on behalf of patient.<sup>[24]</sup>

Motivation for treatment has long been viewed by clinicians as critical determining factor that will affect patients to sustain their participation in treatment.<sup>[25,26]</sup> However, motivation at treatment intake has proven to be an inconsistent predictor of treatment retention and outcomes.<sup>[27]</sup> Motivation is the activation of goal-orientated behavior. Motivation is said to be intrinsic or extrinsic. Seligman and Martin suggested that motivation may be rooted in the basic need to minimize physical pain and maximize pleasure, or it may include specific needs such as eating and resting, or a desired object, hobby, goal, state of being, ideal, or it may be attributed to less-apparent reasons such as altruism, selfishness, morality, or avoiding mortality.<sup>[28]</sup>

## **II. Objectives**

The main objective of the research is to find out relationship between perceived social support and readiness for treatment in conversion patient. This research will help the psychotherapist as well as psychiatrist to understand the person's motivations for treatment who is suffering with conversion disorder in relation with perceived social support. Its findings will facilitate to enhance the patients willingness to participate actively in the diagnostic evaluation. Further it will be beneficial for the family members to understand the characteristics of conversion patients.

## **III. Hypotheses**

Keeping in view the literature review following hypotheses was formulated:

There would be a significant relationship between perceived social support and readiness for treatment.

## **IV. Methodology**

### **4.1 Participants**

Correlational research design was used on a sample consisted of conversion diagnosed patients (N= 50) by psychologist/psychiatrist. The participants were approached from different psychiatric departments of hospitals of Lahore i.e. Jinnah Hospital, Ganga Ram, Services Hospital, Punjab Institute of Mental Health. Purposive sampling was used. Both male and female patients with minimum primary education level and from middle socioeconomic class were included. Patients suffering with any co-morbid disorder of Axis I was excluded.

### **4.2 Measures**

A socio-demographic form, along with two standardized scales was used in this study.

#### **4.2.1 Demographic Form**

A demographic data sheet was used to gather the personal information about participants including their age, education, gender, occupation, family income, socioeconomic status, and marital status, number of children, family members, number of siblings, social activities and number of treatment.

#### **4.2.2 Multidimensional Scale of Perceive Social Support (MSPSS)**

Multidimensional Scale of Perceive Social Support was administered in order to assess perceived social support of patient with conversion disorder.<sup>[29]</sup> Scale consists of 12 items divided into factor groups relating the source of social support, namely family members (Fam), friends (Fri), or significant others. The original English version of the MSPSS has a 7 point Likert scale that ranged from 1 (very strongly disagree) to 7 (very strongly agree). Reliability alpha coefficient of the scale was calculated using SPSS that was .98 to make assurance that the translation of the scale was assessing the same thing that is assessed by the original scale. Standard scoring procedures were used for both scales used in the recent study.

#### **4.2.3 Client Motivation for Therapy Scale (CMOTS)**

Client Motivation for Therapy Scale (CMOTS) was administered to assess the readiness for treatment in conversion patients.<sup>[30]</sup> Scale contains 24 items designed to measure client motivation for therapy. Subscales are: intrinsic motivation, interjected regulation, integrated regulation, identified regulation, external regulation and amotivation. Reliability alpha coefficient of the scale was .93.

### **4.3 Procedure**

In order to conduct this research, some ethical considerations were kept in mind. The questionnaires were translated in Urdu after seeking permission from the author through e-mail. Standard procedure of translation and back translation was adapted. Official permission was sought from the administration of the selected departments for the data collection. The consent form was given to the participants and the nature of the

study was explained before administration of the questionnaires. The questionnaires were given to the participants to be filled by themselves. The duration of administration was of 20-40 minutes. After complete one scale, 10 minute break was given. After break, the second scale was conducted. After the data collection, the questionnaires were scored and quantitatively coded. Pearson product moment Correlation was calculated with the help of SPSS version 17.0 to investigate the relationship between perceived social support and readiness for treatment in patients with conversion disorder. Additionally to determine the significance difference in perceived social support and readiness for treatment in male and female independent t-Test was calculated.

## V. Results and Discussion

**Table 1**

Correlation between perceived social support and readiness for treatment in patients with conversion disorder (N= 50)	
<b>Variables</b>	<b>Readiness for treatment</b>
Perceived social support	.963*

df=48, \*p < 0.05

**Table 2**

Gender differences in perceived social support and readiness for treatment (N=50)					
Scales	Gender	M	SD	t	p*
MSPSS	Female	66.75	18.48	-.08	.93
	Male	67.75	23.16		
CMOTS	Female	113.3	29.82	-.114	.90
	Male	114.6	33.37		

df= 48, P\*>0.05

It was hypothesized that there is significant relationship between perceived social support and readiness for treatment in patients with conversion disorder. To investigate the relationship between perceived social support and readiness for treatment in patients with conversion disorder Pearson product moment correlation was used to find out the results (Table 1). Results indicate that there is significant positive correlation between perceived social support and readiness for treatment [ $r = .963, p < .05$ ]. Thus first hypothesis was proved that there is relationship between perceived social support and readiness for treatment in patients with conversion disorder.

Additional statistical analysis was conducted to measure the difference in perceived social support and readiness for treatment in male patients and female patients with conversion disorder. To investigate gender differences in perceived social support and readiness for treatment in patients with conversion disorder, independent sample t-test was used to find out the results (Table 2). Table 2 shows that there are no significant gender differences in perceived social support and readiness for treatment in patients with conversion disorder [ $t = -.08, df = 48, P > 0.05$ ]. Independent sample t-test was used to see whether there is difference between male and female with conversion disorder of perceived social support and readiness for treatment. Thus additional hypothesis was rejected that perceived social support and readiness for treatment will be scored high in male patients as compare to female patients with conversion disorder.

Diagnosis and treatment of conversion disorder remains controversial throughout the history of psychiatry. Even the emergence of its diagnosis laid the basis of psychogenic model.<sup>[8]</sup> Recently, researchers focused to explore the ambiguity related to etiology and causal factors.<sup>[25]</sup>

Salient feature for the diagnosis of conversion disorder is a distortion or deficiency in neurological functioning without any organic lesion. Conversion disorder is manifested with pseudo-neurological symptoms in both classifications that must be distinguished from true medical findings. Historically, hysteria was perceived as female disease. Early Egyptian physicians attributed the symptoms of hysteria specifically related to women.<sup>[6, 7, 31]</sup>

Psychosocial factors related to conversion disorders are considered as disturbances in interpersonal relationship and social communication. Consequently appear in avoidance from obligation, expression of emotion, symbolize a feeling or belief.<sup>[26]</sup> Females was considered as inferior than male and had no right to express their feeling as well as emotions openly; so they were more prone to develop hysterical symptoms. In Sub-continent, these redundant thoughts are still prevailing. But, present research found no significant gender differences in perceived social support and readiness for treatment among patient with conversion disorders. Personality characteristics along with social, cultural and ethnic background may contribute in development of conversion disorder.

Stressful circumstances may affect a person's physical and psychological well-being. On the other hand, it may affect individual's perceptions and beliefs. Patients with conversion disorder get social reinforcement to promote their symptoms and rewards to strengthen their belief to assume sick role.<sup>[26]</sup> This reinforcement comes from the sources of family, friends and significant one. Ancient Greeks considered human

being as a social animal. Individual always enjoys social ties like family, friends and significant ones around him. Social support helps to alleviate emotional and psychological distress of an individual. Therefore, it has mediating effects on one's physical and psychological well-being.

Parents, siblings, peers, colleagues and significant others are consistent sources of social support.<sup>[1]</sup> Perceived social support is the result of the operation of cognitive personality variables such as attribution style, locus of control, or relational schemas. Social support satisfies the recipient's individual social needs like self-esteem, affiliation, and approval or moral support.<sup>[20, 21, 22]</sup> Excessive social support may strengthen negative behaviors of a person.<sup>[26]</sup> Instead a moderate level of social support may increase readiness for treatment in a person. Readiness refers to the patient's positive attitude and preparedness to enter into a therapeutic relationship for the purpose of resolving problems. It is comprised of attributes and attitudes associated with an interest and motivation in personal changes of a psychological or emotional nature, willingness to participate actively in treatment, acknowledgement of personal problems, and disposition of accept responsibility of problems of one's life. Caretaker and health care professionals may have negative attitude towards patients having conversion disorder. Ahern, Stone and Sharpe concluded that illness beliefs of patients with conversion symptoms need to be understood in the context of the beliefs of the health professionals looking after them.<sup>[31]</sup> In this regard, it is inevitable to explore the perception of sufferers towards their environment and treatment.

Analysis indicates there is significant relationship between perceived social support and readiness for treatment among patients with conversion disorders. These results are consistent with previous studies.<sup>[15, 16, 23]</sup> Individuals who perceive less social support, their level of psychological will be high and it will affect their motivation towards treatment.

## **VI. Conclusion**

The sample size was small so the results of the study cannot generalize to the whole population. This study involves views of patients' only so, in future researches physician and family rating can be included. Data was restricted to only adult patients of conversion disorder while the study can be replicated with patients having other psychiatric problems. The present study revealed that perceived social support is positively related with the perception of treatment and readiness for treatment among patients having conversion disorders. According to the result it is proved that if patients with conversion disorder perceive their social support positively they will get the treatment and it will reduce the rigidity and it will facilitate to improve their symptoms. It will facilitate to design the psychotherapy based on increasing sense of perception toward social support and motivational strategies can be applied for them. This research will help the psychotherapist as well as psychiatrist to understand the person's motivations for treatment who is suffering with conversion disorder in relation with perceived social support. Its findings will facilitate to enhance the patients willingness to participate actively in the diagnostic evaluation. Further it will be beneficial for the family members to understand the characteristics of conversion patients.

## **Acknowledgements**

I am thankful to the authors for giving me permission to use the concerned scales for the purpose of data collection. I would like to thank the psychiatry departments who gave me permission to collect data from their hospitals. I am also grateful to the participants to be the part of this study.

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