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Research Paper

Socio-Demographics Determinants, Clinical Correlates and Family Environment Among Dissociative Disorder

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ABSTRACT

Dissociative disorder is a stress-related disorder usually present in adolescents and younger age groups. Family environment and use of dysfunctional coping strategies play important roles in the initiation and maintenance of dissociative disorder. The aim of this study was to assess the demographics determinants, clinical correlates and family environment among individuals with dissociative disorder. **Methodology:** The study was a cross-sectional hospital based observational study; Ninety (90) participants selected purposively who were diagnosed with dissociative disorder as per criteria of ICD-10. Socio demographic, clinical datasheet and the Family Environment Scale were applied. **Result:** Cohesiveness, Independence, Achievement Orientation and Organization were found below average in family of participants. Conflict and Control were found to be above average. **Conclusion:** Cohesion, Independence, excessive negative Control and Conflict present in the family are responsible for occurrence or emergence of dissociative symptoms at severe level.

Keywords: *Dissociation, Family environment, Cohesion, Control, Conflict, Expressiveness*

Dissociation is related to abusive experiences associated with family environment characteristics. Inflexibility, poor cohesion, dissatisfaction within the family, and difficulties in communication within the family environment are usually associated with the symptomatic group. The incidence and prevalence of dissociative disorder (DD) varies across various countries and communities. Compared to developed western countries, it is more prevalent and significant proportion of the cases seen in psychiatry clinics in a developing country like India. Younger women are mostly affected by this. Various symptoms include convulsions, aphonia, amnesia, and sensory and trans-possession symptoms. Various precipitating factors leading to the occurrence of DD include childhood physical or sexual abuse, adulthood trauma, examination stress, conflict with peers or spouse, conflicts in interpersonal relationships, and problems in daily life.

DD can be one of the coping mechanisms to deal with the intense stressor, traumatic events, or any kind of child abuse. The early experience of these disturbances predicted higher levels of dissociation in early adulthood. Early experiences interfere that how an individual perceive the world and deal with problem in future, not only in individuals with DD but also

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in the general population. It has also found that unsafe behaviors can serve both self-regulating, intrapersonal functions (e.g., control emotional discomfort, provide self-punishment) and social, interpersonal functions (e.g., communicate with, establish autonomy from, or attempt to gain care from others). Unsafe behaviors may also be performed by trauma survivors, especially people with DDs, to control their memories, feelings, and dissociation experiences. The majority of people with DDs describe self-harming; up to 86% of dissociation people report having engaged in non-suicidal self-harm (NSSI) in the past, and up to 72% had attempted suicide at some point in their lives. Among those with DDs, self-harm is linked to depressive symptoms, dissociation, and emotion dysregulation.

Family environment is the institution which contributed to shape an individual personal behaviour and dynamic personality and influences an individual's psychological adjustment, develop and maintain satisfactory relationship, problem-solving skill, confidence and abilities to achieve clear goals. Children's behaviour is likely to be influenced by the familial setting in which they are raised. Parents with mental health issues are more likely to be abusive, neglectful, or inconsistent with their parenting. Child's stress and confusion from inconsistent parenting may result in dissociative tendencies. Family environment plays a very major role and has impact on the mental health of the individual in all population groups. Family environment has important role in abusive history of person which associated with dissociation. It involves the characteristics, communication, social environment and relationship within the family members. Poor family environment is characterised by inflexibility, poor cohesion, family dissatisfaction, and poor family communication. Kamal K Verma suggested that family environment has a significant impact on people with DD in terms of personal growth and relationship dimensions. In dissociative (conversion) patients, independence and achievement orientation were below average· It has seen that Pseudoseizure sufferers perceive their families as more dysfunctional in nature than their family members do, especially in the area of communication and role-playing. The interaction pattern and attachment, system and structure, problematic family elements, expressed emotions, cultural considerations, maladaptive and adaptive coping, and unpleasant emotional experience. Transgenerational trauma, disengaged boundaries, coalitions, and maladaptive triangles are common among families of PNES patients. These factors contribute in deterioration of patient's symptoms of PNES.

A Study of Family environment and general health among pain disorder and conversion disorders' caregivers indicated that caregivers or patients with conversion disorder had poor family environment in terms of cohesion dimension and independence dimension.[16]Previous conducted study suggested that majority of people with DD reported stress related to family environment and ongoing familial problems. There is an association between onset of symptoms and occurrence of stressful event in family. Studies conducted in India suggested 62%-82% cases of stress related to family circumstances. This study favors that personal growth dimension, relationship dimension and system maintenance dimension has caused effect on dissociative disorder patients. Cohesion and expressiveness in dissociative disorder and excessive negative conflicts in family is related to occurrence or appearance or reemergence of dissociative symptoms. Also, the organization and control factors played an important role in dissociative disorder patients leading to appearance of dissociative symptoms.

The trauma and abuse that occur in a family environment are caused by the parents or partner or other family members. It might result from whatever they've gone through, from the discipline they received, or from the parenting methods they were exposed to. In such a household with subclinical dissociative traits, individuals might swap their social roles over time, alternating between being a victim, abuser, and savior. The parents can frequently and unpredictably switch roles, which causes the child to feel confused become vulnerable to experience dissociative identity disorder.

Aim

- To study the demographics determinants, clinical correlates and family environment among individuals diagnosed with dissociative disorder.

Objectives

- To study the demographic determinants and clinical correlated of patients.
- To study the level of dysfunctional in various domains of family environment among patients.

METHOD AND MATERIALS

The study was a cross-sectional hospital based observational study conducted at Department of Psychiatry, Centre of Excellence in Mental Health, Atal Bihari Vajpayee Institute of Medical Sciences and Dr. RamManohar Lohia Hospital, New Delhi from October 2022 to January 2023. The samples were collected using purposive sampling technique. The study was conducted with 90 participants (males and females) who were diagnosed with dissociative disorder as per criteria of ICD-10, referred by psychiatrists from OPD and IPD with age criteria of 18-50 years. Participants with chronic physical illness, significant co-morbidity of other psychiatric disorder and neurological disorder or intellectual disability were excluded from the study.

Tools

1. **Socio-demographic and clinical datasheet:** It is semi- structured and self- prepared pro forma. It contains information about socio-demographic variables like age, sex, religion, education, domicile and occupation, and clinical details like diagnosis, age of onset, total duration of illness, number of hospitalization and adherence.
2. **Family Environment Scale (FES)**: To measure the family environment, the Family Environment Scale (FES) was used. FES was originally developed by Moos and Moos (1974) and has been adopted and standardized in Indian condition by Joshi and Vyas (1987) in Hindi language. It is a self-administrated scale. The original FES consists of 90 statements. The Hindi version has 79 statements. The statements in the inventory try to identify characteristics of an environment, which would exert or press toward all the important constituents of its main domain, that is Relationship (cohesion, expressiveness and conflict), Personal growth (Independence, achievement orientation, intellectual cultural orientation, active recreational orientation and moral religious emphasis) and System maintenance (organisation and control). Each item of every sub-scale is on a five-point likert scale of “four to zero”.

Ethical consideration

Permission was obtained from the both Institutional review board (IRB) and ethics committee of ABVIMS & Dr. RML hospital, New Delhi. Those individuals who meet the inclusion and exclusion criteria were selected for the study. The participants who signed the

informed consent were enrolled and then socio-demographic and clinical data sheet and FES were administered. After assessment the result of the study was analyzed with SPSS 20 version. Descriptive data was analyzed by frequency, percentage, mean, and standard deviation.

RESULT

Table 1- Distribution of socio-demographic characteristics of the participants (N=90).

Socio-demographic characteristics	Frequency	Percentage (%)
Age in years		
18-28	61	67.6
29-38	20	22.5
39-48	9	9.9
Gender		
Male	10	11.9
Female	80	88.9
Education		
Illiterate	5	5.6
Primary	6	6.7
Secondary	24	26.7
Higher Secondary	31	34.4
Graduation	17	18.9
PG and above	7	7.8
Occupation		
Farmer/Agriculture	0	0
Business	3	3.3
Professional/Govt./Pvt. Job	4	4.4
Homemaker	34	37.8
Unemployed	14	15.6
Student	35	38.9
Domicile		
Rural	22	24.4
Semi-urban	7	7.8
Urban	61	67.8
Religion		
Hindu	75	83.3
Islam	14	15.6
Sikh	0	0
Marital Status		
Married	41	45.6
Unmarried	48	53.3
Other	1	1.1
Types of Family		
Nuclear	51	56.7
Joint	19	43.3
Family Monthly Income (Rs.)		
Below 10,000	4	4.4
10,001-20,000	25	27.8
20,001-50,000	44	48.9
Above 50,000	17	18.9

Table 2- Clinical Profile of the participants (N=90)

Details of Illness and treatment	Frequency	Percentage (%)
Duration of Illness		
Less than 6 months	19	21.1
6-12 months	30	33.3
1-5 years	33	36.7
5-10 years	7	7.8
More than 10 years	1	1.1
First contact to treatment		
Faith healer	18	20.0
Traditional medicine	1	1.1
Physician	47	52.2
Psychiatrist	24	26.7
Current Treatment Status		
Not yet	1	1.1
Continue	51	56.7
Fluctuating	38	42.2
Adherence		
Yes	51	56.7
No	39	43.3
Number of Hospitalization		
Never	54	60
1 time	18	20
2 times	12	13.32
3-5 times	6	6.68

Table 3- Mean value of family environment of participants

Domains of Family Environment	Sub-domains	Mean and standard deviation
Relationship	Cohesion	**18.80 ± 3.98**
	Expressiveness	14.84 ± 3.96
	Conflict	**15.41± 2.44**
Personal Growth	Independence	**18.75 ± 4.71**
	Achievement Orientation	18.72 ± 3.46
	Intellectual Cultural Orientation	14.20 ± 4.43
	Active Recreational Orientation	11.10 ± 4.24
	Moral Religious Emphasis	19.98 ± 4.92
System Maintenance	Organization	**17.54 ± 3.22**
	Control	**18.41 ± 4.47**

Table- 3 Showed that Cohesiveness, Independence, Achievement Orientation and Organization were found below average in family of participants. Conflict and Control were found to be above average. Adequate Intellectual Cultural Orientation, Active Recreational Orientation and Moral Religious beliefs were present in normal range with in the family.

DISCUSSION

The aim of the study was to assess the demographic determinants of person with DD. Findings of table 1 reveals that 67.6% of the participants belonged to age group was 18-28 years followed by 29-38 years (22.5%) and 39-48 years (9.9%). Majority of the participants were female 88.9% and male participants were 11.9%. This finding was supported by study conducted by Kumar S et al. which show 90% study objects of his study was female. Also, the findings were in line of previous studies by Vyas et al., Choudhury et al., and Bagadia et al. which suggested that female population experience dissociative disorder on large scale as compared to men. Since this particular group (females) is heavily marginalised in our society and is unable to express their emotions to family members, lack of coping skills to manage stress due to role transition. They also carry a heavy role burden due to the lack of support from the male members of the community. The mean age of participants was 25.88 ± 7. 045. This may be due to the stress which is generally very high in people amongst this group. Previous findings indicated that majority of the patients (84.5 %) were less than 30 years of age.[19 23]Findings of this study also showing that majority of participants had highest education as higher secondary (34.4%) followed by secondary (26.7%) and graduated were 18.9%. Study showed 5.6% participants were illiterate. Majority participants have been literate (94.4%). The majority of the participants were student of higher secondary (38.9%) followed by homemaker (37.8%) and unemployed were 15.6%. Finding suggested that only 4.4% of participants were doing government and private job. It suggested that students have problem related to academic/college, career/aim of life, peer group, relationship difficulty, adjustment in living circumstances (hostel, PG) and also, they experience difficulty to tackle them independently which leads to dissociative experience. Dissociate disorder in housewives can be caused by marital abuse and dysfunctional family's orthodox beliefs which distress them. These findings are supported by study conducted by Choudhury et al., Jain and Verma et al. and Dar LK et. al.

Results showed that mostly participants were belonged to urban area (67.8%) followed by 24.4% of rural respectively. This may also be due to the fact that mostly people who visit this hospital are from urban area because it is situated in the central area of New Delhi and because of distance from the rural areas to hospital was large. Also, there is lack of awareness about nature, cause, symptoms and medical treatment of dissociative disorder. That's why patients didn't access to hospital for mental health service. Finding suggested majority of participants were belonged to Hindu religion (83.3%) and 15.6% belonged to Islamic religion. Marital history showed that 41% participants were married and 48% were unmarried. Most of the participants were from nuclear families (56.7%) and 43.3% participants from joint families which could possible because of a shift in lifestyle towards a modern one. Majority participants were belonged to middle socio-economic status and females dependent on their family members to fulfill their basic, instrumental and recreational needs. These findings were supported study conducted by Deka K et al.

Regarding findings of the research suggested that majority of participants (36.7%) had experienced their symptoms from 1-5 years and 33.3% participants reported they had illness form 6 to 12 months while 21.1% participants reported they experienced symptoms of illness less than 6 months. The mean values and standard deviation of duration of illness is 2.344 ± .938.

Regarding clinical profile of the respondents, findings of current treatment status revealed that 56.7% participants were taking continue treatment and adherence to treatment and on

regular follow-up's. While rest of the participants (43.3%) had reported fluctuating treatment and history of non-compliance and on irregular follow-up's during treatment. This may be the fact that majority of the participants (67%) had the distance between 5 to 50 km from their place to hospital. They can easily access to hospital for their treatment of illness. There is no specific study that suggested the same findings. 60% participants were never admitted to hospital for treatment of their illness, while 20% participants reported 1 time admission followed by 13.3% reported two times admission and rest of the participants admitted 3-5 times in their life span for treatment of their illness. This finding of the study is consistent with another past study by Choudhury et al.

Another aim of the study was to find out the level of dysfunctional in various domains of family environment among person with DD. Regarding relationship domain of family environment cohesiveness was found below average while conflict was found above average. Regarding personal growth domains of family environment indicated that independence and achievement orientation were found below average in family of participants. Regarding system maintenance domains of family environment indicated that Organization was found below average in family of participants, while control was found to be above average. Previous study was on line with this study cohesion and expressiveness in the family in dissociative (conversion) disorder patient was found to be below average, whereas conflict was found to be above average. The incidence of dissociative disorder are raised in an environment characterized by frequent arguments, emotional distance, and poor support, consistent with the high levels of physical and emotional abuse. Hence, chronic emotional abuse might be the most important factor for the development of dissociative disorder. Independence and active recreational orientation were also found to be low and average respectively in dissociative (conversion) patients. Yasir et al. also emphasized that occurrence of dissociative symptoms is related to low cohesion, expressiveness, and negative conflicts in the family in addition achievement orientation, organization played an important role in persons with dissociative disorder leading to the occurrence of dissociative symptoms. Persons with DD cause a considerable degree of burden on the family in terms of leisure, physical, mental, financial, and family relationship domains. It has found in earlier studies that females scored significantly higher in moral and recreational orientation. Women scored significantly higher also in cohesion and conflict dimensions.[31]In line with the findings of our studies, many previous studies were conducted in India and Western country. It is difficult to compare the findings of this study to other studies due to lack of similar work in this area. There are, however, reports in the literature, which state that Dissociative [conversion] disorder can be disabling and chronic in nature. These findings were in the line with study conducted by Verma et al and Solanki et al.

Limitations

The study was conducted in brief period of time with limited resources so there was a challenge of data in limited time as majority of individuals suffering from dissociative disorder belongs to adolescent population group. Also, majority of data were collected from the available female participants who lead to lack of information regarding male population.

Practical implications

There is lack of study conducted on person with DD which assesses their family environment in all domains especially in the Indian context. Most of the studies targeted adolescent and female population to assess abuse or traumatic experience during childhood but this study focused on adult population and assess impact on both genders i.e. male and

female. Present study guide to mental health professionals to develop strategies to make desirable change in the family environment in all domains which helps to reduce patient's stress and vulnerability to develop dissociative disorder.

CONCLUSION

Dissociative disorder can be one of the coping mechanisms to deal with the intense stressor, traumatic events, or any kind of child abuse. The prevalence of dissociative disorder was higher in females than males in adolescence and early adulthood because of traumatic childhood traumatic experiences, lack of freedom to express emotions and concern in phase of role transition. Study revealed that people who experience dissociative disorder have disturbed family environment in term of low cohesion, low independence, organization, high conflict and control. Cohesion, Independence, excessive negative Control and Conflict present in the family is responsible for occurrence or emergence of dissociative symptoms at severe level.

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Conflict of Interest
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