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UNRAVELLING THE ENIGMATIC MINDSCAPE: A DESCRIPTIVE STUDY ON INTRICATE PATTERNS OF DISSOCIATIVE DISORDERS

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ABSTRACT **Background-** Dissociative disorders, presumed to have psychogenic origin, often emerge as a response to traumatic events, insurmountable challenges, or strained relationships. They serve as a coping mechanism for individuals facing overwhelming stress. These exhibit variations in prevalence and manifestation across diverse cultures and geographical regions worldwide. **Aim-** To assess the prevalence and patterns of dissociative disorders among psychiatric inpatients over a comprehensive six-months period. **Materials and Methods-** This descriptive cross-sectional study was carried out at S.P. Medical College, Bikaner, Rajasthan from January 2023 to June 2023. The sample constituted Psychiatric inpatients who fulfilled the ICD-10 criteria for diagnosing dissociative disorders. After obtaining informed consent, a semi-structured proforma was used to gather sociodemographic information, document presenting signs and symptoms and establish a final diagnosis. **Results-** During the span of six months, a total of 867 patients were evaluated. Out of these, 250 patients were diagnosed with Dissociative disorder based on ICD-10 criteria. Majority of patients fell within the age group of 21-30 years (36.4%), were females (94.4%), married (52.8%), lived in rural areas (72.4%), belonged to joint families (65.6%), had positive family history of dissociative disorder (20.8%) and experienced psychosocial stressors. Dissociative convulsions (60.4%) were the most common presentation followed by Dissociative motor disorders (18.4%) and mixed dissociative disorder (16.8%). **Conclusions-** These findings led us to conclude that dissociation serves as a significant nonverbal communication process of the subconscious mind, asserting its importance in understanding and addressing these disorders.

KEYWORDS : Dissociative disorder, patterns, ICD-10

INTRODUCTION

Dissociative disorder involves loss of integration between memories, immediate sensations, awareness of identity and control over bodily movements. These disorders are believed to have a "psychogenic" origin, often emerging in close proximity to traumatic life events, unresolved and unbearable challenges or disrupted relationships. Consequently, interpretations and assumptions about individual's coping mechanisms in response to overwhelming stress can often be made.[1] Notably, the prevalence of dissociative disorders is higher in developing countries as compared to developed countries.[2]

As far as the presentation of dissociative disorder is concerned, almost any physical symptom can be manifested but the most frequent presentation often mimics neurological disease such as pseudo seizures, paraparesis, episodes of unconsciousness and aphonia. In India, there is a higher reported incidence of dissociative disorder among unmarried young adults with lower socioeconomic status, particularly more prevalent in females. This group also comprise a substantial number of illiterates and adolescent females.[3] Several Indian studies have delved into the clinical characteristics, emphasizing the role of stressors. The concept of "Role model" has been highlighted in earlier studies (Sridhar and Sudharkar, 1997), where a role is a spontaneously acquired, purposeful sequence of actions that develops under the influence of important individuals in a developing child's environment. Individuals with dissociative disorders may unknowingly model their symptoms on those exhibited by someone significant in their lives.[4]

The process through which psychological stress transforms into physical symptoms is not fully understood. Dissociative disorder is linked to conflicts or recent stressors. Holmes and Rahe established a relationship between stress and illness. The transformation of emotional arousal into physical symptoms is termed as Primary gain, while the external benefits derived from having those symptoms are referred to as Secondary gain. The somatic symptomatology of dissociative disorder alleviates anxiety and can lead to "la belle indifference", where a patient appears remarkably indifferent to their physical complaints.[5]

MATERIALS AND METHODOLOGY

AIMS AND OBJECTIVES

To assess the prevalence and patterns of dissociative disorders among psychiatric inpatients over a comprehensive six-months period.

Study settings

This was a hospital-based study conducted at Department of Psychiatry, Sardar Patel Medical College Bikaner, Rajasthan for a period of six months (January 2023 to June 2023), where 867 cases were admitted, out of which 250 cases fulfilled the inclusion criteria and were enrolled for the study. Approval from the Institutional Ethical Committee was obtained.

Study Design

Cross sectional, Descriptive study.

Inclusion criteria

Subjects of both sexes fulfilling the diagnostic criteria of dissociative (conversion) disorder according to ICD-10 were included.

Exclusion criteria

- Subjects with any other co-morbid Psychiatric disorders except symptoms of Depression & Anxiety.
- Those having known history of major systemic illness or neurological disorders including seizures.
- Those with history of head trauma, history of substance dependence, Learning difficulties/Intellectual disability.
- Those who were not willing to give consent for the study.

Tools used

1. The ICD-10 classification of mental and behavioural disorders
2. A semi-structured pro forma was used to document socio-demographic information, encompassing details such as age, gender, education, occupation, residence, marital status, family type and socioeconomic status; clinical presentations and psychosocial stressor precipitating dissociative (conversion) disorder.

METHODOLOGY

All the subjects were explained about the nature of the study and an informed written consent was obtained. They were then thoroughly evaluated based on detailed psychiatric history and mental status examination to elicit necessary information required in our semi-structured pro forma. Subsequently in order to rule out organic causes they underwent necessary radiological and laboratory investigations

for instance routine blood and urine investigations, EEG, NCCT Head or MRI Brain where indicated.

Statistical Analysis

Data was compiled and analysed in Microsoft Excel.

RESULTS AND OBSERVATIONS

Table 1: Hospital Statistics from January 2023 to June 2023

Month	Total number of inpatients	Males	Male dissociative patients	Females	Female dissociative patients
January	130	51	3	79	39
February	132	41	3	91	37
March	102	37	1	65	25
April	178	74	2	104	44
May	154	62	3	92	35
June	171	60	2	111	56
	867	325	14	542	236

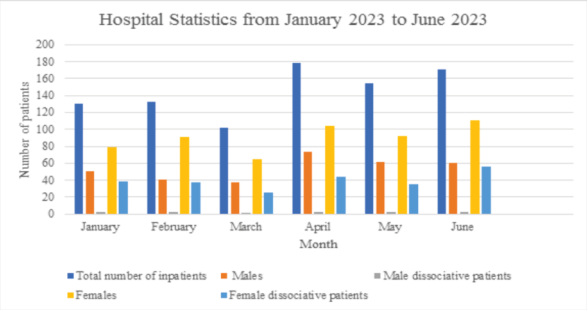


Table 2: Sociodemographic profile of study participants (N=250):

Variable	Variants	N	%
AGE	13-20 years	110	44.0
	21-30 years	91	36.4
	31-40 years	33	13.2
	>40 years	16	6.4
GENDER	Male	14	5.6
	Female	236	94.4
MARITAL STATUS	Unmarried	118	47.2
	Married	132	52.8
RELIGION	Hindu	211	84.4
	Muslim	39	15.6
PLACE OF STAY	Urban	69	27.6
	Rural	181	72.4
FAMILY	Nuclear	86	34.4
	Joint	164	65.6
EDUCATION	Illiterate	56	22.4
	Primary	85	34
	Secondary	68	27.2
	Higher secondary	33	13.2
	Graduate and above	8	3.2

(Table 2): A total of 250 Inpatients with confirmed diagnosis of Dissociative (Conversion) disorders according to ICD 10 criteria were included. The age ranged from 13 to 58 years with a mean of 23.92± 8.9 years. Most of the subjects were females 236 (94.4%), and most were in the age group of range 13-20 years 110(44%), followed by 21-30 years age group 91(36.4%), majority of them were married 132(52.8%) followed by the unmarried group 118 (47.2%), almost 181(72.4%) of the lot were from a rural background, belonging to joint family 164(65.6%) and most of them had primary education 85(34%).

Table 3: Attribution of psychosocial stressors and family history among study participants (N=250):

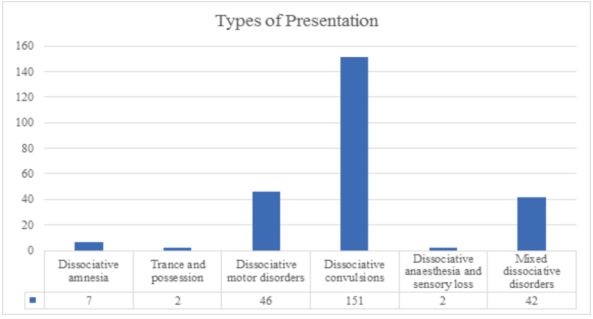
Variable	Variant	N	%
PSYCHOSOCIAL STRESSORS	Nil	2	0.8
	Academic difficulties	35	14.0
	Relationship issues	86	34.4
	Impending marriage	20	8.0
	Illness in family	22	8.8
	Conflict with family or in laws	58	23.2
	Sexual problems	7	2.8
	Others	20	8.0
FAMILY HISTORY OF DISSOCIATIVE DISORDER	No	198	79.2
	Yes	52	20.8

Table 3: shows that majority of patients had some associated psychosocial stressor associated with relationship issues 86(34.4%) outnumbering all, followed by conflict with family or in laws 58(23.2%), academic difficulties 35(14%) and so on. Family history of dissociative disorder was present only in 52(20.8%) patients.

Table 4: Distribution of Types of Presentation

Variable	Variant	N	%
TYPES OF PRESENTATION	Dissociative amnesia	7	2.8
	Trance and possession	2	0.8
	Dissociative motor disorders	46	18.4
	Dissociative convulsions	151	60.4
	Dissociative anaesthesia and sensory loss	2	0.8
	Mixed dissociative disorders	42	16.8

Table 4 shows "Dissociative convulsions (pseudo seizures)" 151(60.4%) were the most common type of clinical presentation followed by Dissociative Motor disorders 46(18.4%) which included paresis, hyperventilation, dizziness, limb paralysis, aphonia/ dysphonia and astasia abasia followed by Mixed dissociative disorders 42(16.8%). As many as 7 cases (2.8%) reported with Dissociative amnesia, 2 cases (0.8%) each of Trance and possession and Dissociative anaesthesia and sensory loss.



DISCUSSION

This study clearly demonstrates the different patterns of presentation of patients with dissociative disorders, where majority of them land up in Emergency settings with seizure like activity, loss of consciousness, aphonia, hyperventilation, sensory or motor loss or any vague symptom unexplained by any medical condition. The presentation and prevalence vary in different geographical regions due to difference in culture, lifestyle, education level and many other sociocultural factors. Therefore, in Indian context, a diagnosis like multiple-personality disorder is exceptionally uncommon. Some researchers propose that dissociative identity disorders and possession states are interconnected variations of same phenomenon, as indicated in studies by ***Varma et al***. (1981), ***Chaturvedi*** (1993), ***Isaac & Chand*** (2006) and ***Chaturvedi & Bhugra*** (2007)[6].

Furthermore, Indian society is patriarchal, chauvinistic and restrictions are more often imposed on females who are married, residing in rural setting, married, living in joint family. This explains higher incidence of dissociative disorder in females 236 (94.4%), and most were in the age group of range 13-20 years 110(44%) and had some associated psychosocial stressor associated. This corresponds with findings by ***Deka & Chaudhury et al***[4]. Most of them were married 132(52.8%). This is in line with the findings by ***Jain and Verma et al***[7] who found housewives and married to be the predominant group. Highest incidence is seen among those who had primary education 85(34%) which is in contrast with findings by ***Anuradha et al study***[8] which showed highest incidence among postgraduate level than among Secondary and primary school level. Most of patients were from a rural background181(72.4%) and belonged to joint family 164(65.6%). Similar results were found in study by ***Yadav et al***[9]**.**

This study showed that prevalence of Dissociative convulsions was

151(60.4%) whereas Dissociative Motor disorders, Mixed dissociative disorders, Dissociative amnesia, Trance and possession and Dissociative anaesthesia and sensory loss was 46(18.4%), 7 (2.8%), 2 (0.8%) and 2 (0.8%) respectively. The study conducted by ***Khattri et al***, in Pokhara, Nepal revealed that the prevalence of dissociative convulsion was 86.3%, 7.6% were diagnosed with dissociative motor disorders and 6.1% patients exhibited trance and possession disorder.[2]

Malik & Bilal et al's research in Pakistan revealed that dissociative convulsions was the prevailing presentation at 63%, followed by dissociative motor disorder at 24%, mixed dissociative disorder at 8%, dissociative anaesthesia and sensory symptoms at 4% and trance and possession disorder at 1%.[10]

In a research endeavor at the emergency psychiatric and acute care service of NIMHANS conducted by ***Reddi et al*** [11], the prevalence of dissociative disorders was identified as 11.5 per 1000. The frequent presentations encompassed dissociative motor disorder, dissociative convulsions and mixed dissociative disorder.

CONCLUSION AND FUTURE DIRECTIONS

By observing and analysing our study population, we reached a conclusion that Dissociative disorder in this region of Rajasthan is more common in young females who are married, residing in joint families in rural settings and having definitive psychosocial stressor. The most common presentation found in our study was Dissociative convulsions.

These findings led us to conclude that dissociation serves as a significant nonverbal communication process of the subconscious mind, asserting its importance in understanding and addressing these disorders. Moreover, these patients constitute a sizeable proportion of our outdoor and indoor patients, further studies should be conducted at community and socio-cultural level.

These patients should be managed by establishing therapeutic alliance, talking through, relaxation techniques, psychoeducation, cutting down secondary gains, pharmacotherapy.

Limitations

The sample size was small, from same geographical area having similar cultural influence on presentation of symptoms and absence of structured assessment of symptoms. So the results could not be generalised to other population across India. Moreover, this was cross sectional study, the pattern of presentation in subsequent recurrence and chronicity could not be studied thereof.

Conflicts Of Interest

Nil

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