ORIGINAL RESEARCH PAPER

Psychiatry

A STUDY OF PSYCHIATRIC CO-MORBIDITY, PERSONALITY PROFILE AND FAMILY ENVIRONMENT IN DISSOCIATIVE (CONVERSION) DISORDER

KEY WORDS: DISSOCIATIVE ,CONVERSION, FAMILY BURDEN, PSYCHIATRIC CO-MORBIDITY

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INTRODUCTION

The study of hysteria and dissociation begins at the end of the 18th century with shift of interest in these phenomena from the religious to the medical realm.In 1791, Eberhardt Gmelin described a German woman who alternately exchanged her peasant personality for that of an aristocratic French lady, each amnesic for the other's exist.

The relationship between dissociative disorders and trauma is well established. However, individuals with seemingly comparable traumas may differ greatly in the extent to which they dissociate, and it has become increasingly apparent in recent years that various factors in addition to the actual trauma play a role in the development of trauma-related psychopathologies. A stress-diathesis model has been proposed for both posttraumatic stress disorder (PTSD) and dissociative disorders, as only about 25% of exposed individuals develop PTSD and the proportion who develop dissociative disorders is not known. PTSD risk factors have been identified, but much less is known about factors predisposing to dissociative symptoms; high hypnotizability or suggestibility may be one risk factor. In a study examining the relationship between personality and dissociation in general psychiatric patients and healthy subjects, dissociation scores were predicted by the character traits of low self-directedness and high self-transcendence but not by temperament traits.In a community sample, mature defenses were found to correlate with low dissociation scores. A twin study failed to identify a genetic contribution to pathological dissociation, but, again, a general population sample rather than a sample of patients with dissociative disorders was studied.

Personality can be conceptualized as a mélange of heritable temperament and experience shaped character, although this model is oversimplified because both temperament and character are probably partly determined by complex variations in genotypes and neurochemical profiles and partly modifiable.

Conversion disorder is judged to be caused by psychological factors as the illness is preceded by conflicts or other stressors. The symptoms are not intentionally produced, are not caused by substance use, and the gain is primarily psychological and not social, monetary, or legal. As the duration of disorder increases co-morbid psychopathologies and the level of anxiety and especially the prevalence of depression increase. The etiology, pathogenesis, phenomenology and management continues to arouse debate. The proper diagnosis of these patients has important implications for their clinical course.

Conversion disorder patients have been females with average onset age of 25.9±7.5, a maximum of 11 years of education and prominent stress[10]. Another study reported many had motor symptoms, seizures or convulsions, mixed presentations and sensory symptoms.Mixed symptoms were seen in 38% followed by 26% motor symptoms in a study from Pakistan.

Anxiety, depression, borderline personality disorder, somatization disorder and post traumatic stress disorder are very common co morbid illnesses associated with conversion disorder. Temporal relationship of a stressful event is very common.At the end of the 19th century, Janet in France, Prince and James in the United States, and others across Europe were engaged in a lively transatlantic discussion about possible psychological and neurological mechanisms underlying cases of multiple personality, amnesia, and fugue.

As the 20th century began, however, interest in dissociation waned, and alternative theories, like psychoanalysis, According to Freud unconscious emotional conflicts appear as severe mental dissociation or as physical symptoms (conversion reaction) is not dependent upon any known organic or structural pathology. The underlying anxiety is assumed to have been "converted" into a physical symptom. And In behavior analysis, learning is the acquisition of a new behavior through conditioning and social learning. began their ascendance. However, clinical interest in dissociative phenomena has reoccurred in every war since the turn of the century with the observation of amnesia, fugues, and conversion symptoms in traumatized soldiers.

AIMS AND OBJECTIVE

1. To study psychiatric co-morbidity, personality profile and family environment in dissociative (conversion) disorder.
2. To assess family burden, in dissociative (conversion) disorder.
3.To compare there variables among males and females.

MATERIAL AND MTHODS

This study was conducted in the Department of Psychiatry, S.P. Medical College and Associated Group of Hospitals, Bikaner (Rajasthan).

A) Sample

100 dissociative (conversion) disorders patients who were admitted for the treatment in psychiatric ward and out patients clinic were recruited for the purpose of study (both male and female).

Inclusion criteria

- All patients either male or female (all age groups) admitted in ward and out patient clinic diagnosed as Dissociative (conversion) disorder according to ICD-10.
- Those willing to participate.
- Who understood the Questionnaire.

Exclusion criteria

- Patients of seizures disorder.

- Patients having organic brain disorder.
- Patients of mental retardation (MR).
- Those not willing to participate.

B) Tools

1. Informed Consent form.
2. Self –designed proforma
3. Clinical Profile Proforma
4. MINI-6 for psychiatric comorbidity
5. International personality Disorder Examination (IPDE) – ICD-10 module screening questionnaire
6. Family Environment Scale
7. Family burden interview schedule (FBIS)

METHOD

- The present study was a cross sectional study aimed at finding studying of psychiatric co morbidity, personality profile and family environment in dissociative (conversion) disorder and to assess family burden. Before conducting this study ethical approval was taken from ethical committees S.P. Medical College, Bikaner.

- 112 patients selected for study but 12 patients were not fulfilling the inclusion criteria for study. 6 female patients suffered from co morbid seizures disorders, 4 females patients had organic brain disorder and 2 males patients not willing to participate. SPSS 10 patients excluded from our study.

- Study included 100 dissociative (conversion) disorder patients whose informed consent was taken after explaining the nature and purpose of study. 100 patients included 60 female and 40 males.

- Socio demographic details of these 100 patients was assessed by the semi designed proforma and self designed clinical profile proforma was applied to obtain the brief history about the illness. Psychiatric co morbidity was assessed by using MINI-6 and Personality traits were evaluated by International Personality Disorder Examination (IPDE). Family environment scale was applied to evaluate Relationship, Personal growth, System maintenance of the family. Family burden was assessed by further using Family burden Interview Schedule (FBIS), questionnaire which was answered by the relative accompanying the patients.

- After application of all the tools to 100 patients, scoring was done and data was obtained. The data so generated was subjected to statistical analysis and the result obtained were discussed a cross with the available literature.

DISCUSSION

The present study was aimed to find out psychiatric co morbidity, personality profile and family environment in 100 dissociative (conversion) disorder patients (male and female) who were admitted in ward and attended outpatient clinic in the Department of Psychiatry, S.P. Medical College and Associated Group of Hospitals, Bikaner (Rajasthan).

Most of the patients included in our study had come to OPD clinic or admitted in the ward with the presenting complaints or symptom of clenching of teeth and unresponsiveness, 74(74%) out of 100 patients had symptom clenching of teeth and unresponsiveness, 45(75%) of them were females and 29(72.5%) were males. This was followed by the patients presenting with the complaints of numbness or loss of sensation, 12(12%) out of which 5(8.3%) and 7(17.5%) were females and males respectively followed by patients with abnormal body movements/tremors, 5(5%) out of which 3(5.0%) were females and 2(5.0%) were males.

As far as stressors are considered, majority of patients (n=63) reported family stress/problems. Out of 100 patients 35 being females and 28 being males had family stress/problems. The ICD-10 specifies that there should be convincing associations in time between the onset of symptoms of the disorder and 'stressful (life) events, problems, or needs'. However, Indian studies point out that stressors arefound in only 62-82% of cases of dissociative disorder

Comorbid suicidality in dissociative conversion disorder patients in our study was found to be 8% which included all females. None of the male in our study having dissociative conversion disorder had suffered comorbid suicidality, so that the females and significantly higher suicidality in our study when compared to males.

There were no significance differences between females and males in terms of other psychiatric/neurotic comorbidity in our study, although certain number of patients had comorbid psychiatric/neurotic illnesses with dissociative conversion disorder. Current study revealed that majority of dissociative conversion disorder patients had suffered comorbid depression and suicidality. This could be because of the long term stressors, which females mostly are unable to deal with due to the cultural background in India. Comorbid depression and suicidality could also be accompanying hormonal disturbances in females, be one of the reasons.

This finding is consistent with the results of previous studies carried out in India as well as in western countries. A previous study Malik et al (2010) depression and anxiety in dissociative (conversion) disorder patients at tertiary care psychiatric facility''. Results shows There was high frequency of clinically significant scores of anxiety (60%) and depression (61%) in patients presented with dissociative (conversion) disorder in current study that reflects the findings of other studies. There is an increasing need for screening and interventions for psychiatric co morbidity in Conversion Disorder patients.

Family member of females dissociative conversion disorder patients had more financial burden and disruption in leisure of whole family while the family member of the male dissociative conversion disorder had more burden for regular activity and work and effect on physical health and mental health of another family members.

So it can be said that dissociative conversion disorder patients impose some kind of burden over the family, be it a financial burden, physical or mental health or another family member or the interference with leisure of family or the relationship in family.

SUMMARY AND CONCLUSION

The prediction of psychiatric comorbadity, personality profile and family environment in dissociative (conversion) disorder has become a critical focus in dissociative conversion disorder. Present study was planned to

1) To study of psychiatric comorbadity ,personality profile and family environment in dissociative (conversion) disorder (males and females)

2) To assess family burden , in dissociative (conversion) disorder

We used MINI-6, IPDE, Family Environment Scale (FES), Family Burden Scale (FBS) in dissociative conversion disorder patients and their family members accompanying them. A cross sectional study was carried out. Subjects were drawn from the admitted patients of dissociative conversion disorder and those attending the outpatient door clinic (OPD) for the same. Sample size in our study was taken to be 100. Subjects were screened with screening proforma (consisting exclusion criteria). then subject sociodemographic data was recorded and each participants in the study was subjected to

selected measures for assessment (MINI-6 for psychiatric comorbidity, IPDE for personality assessment, family environment scale for family environment and FBIS for assessment of burden on other family members of dissociative conversion disorder patients).
Statistical analysis was done with the help of software SPSS-10.0.

Results indicate that:-

1. The patients of dissociative (conversion) disorder had psychiatric comorbidity like depression, suicidality and had personality traits or disorder and unhealthy family environment. It is clear from the finding of the present study that dissociative (conversion) disorder patients suffer from comorbid depression, suicidality.

2. Also most of the dissociative (conversion) disorder patients were diagnosed to be of borderline, histrionic, anxious personality types in females and males being dissocial and impulsive.

3. It is also clear that the family environment in term of personal growth dimension, relationship dimension and system maintenance dimension has caused effect on dissociative (conversion) disorder patients. Cohesion and expressiveness in dissociative (conversion) disorder patients and excessive negative conflicts in family is related to occurrence or appearance of dissociative symptoms, also the organization and control factors played and important role in dissociative (conversion) disorder patients leading to appearance of dissociative symptoms.

4. Present study also concludes that dissociative (conversion) disorder patients cause considerable degree of burden over other family members in term of leisure, physical and mental health, and financial burden, caregivers routines family interrelationship.

Thus results of the study shows that patients dissociative (conversion) disorder has psychiatric morbidity like depression and suicidality and has personality disorder like borderline, histrionic and anxious personality in females and dissocial and impulsive in males and disturbed family environment in females of personal growth dimension, relationship dimension and system maintenance dimension and that dissociative conversion disorder patients cause considerable degree of burden over other family member.