PREVALENCE OF ANXIETY AND DEPRESSION IN PATIENTS WITH DISSOCIATIVE DISORDERS

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ABSTRACT

OBJECTIVE
The study was designed to see the frequency of co morbid anxiety, depression and mixed anxiety and depressive disorder among patients having dissociative disorder. The second objective is to see the relationship of gender, education, marital status, availability of social support, family system, and socioeconomic status with dissociative disorder patients co morbid with psychiatric disorders.

STUDY DESIGN
Cross sectional study design

PLACE AND DURATION OF STUDY
The study was conducted in the inpatient department of Psychiatry and Behavioral Sciences DHQ Hospital, Faisalabad from June 2010 to May 2011.

SUBJECTS AND METHODS
One hundred patients with dissociative disorder participated in this study through purposive convenient sampling technique. Diagnostic and research criteria of ICD-10 was employed to diagnose dissociative disorder, generalized anxiety disorder, depression (Mild, Moderate, Severe) and mixed anxiety and depressive disorder. SPSS 17 was used to analyze the data.

RESULTS
Out of 100 dissociative patients 51 (51 %) had a psychiatric co morbidity. 16 (31.37 %) had Generalized Anxiety, 19 (37.25 %) had mild depression, 10 (19.61 %) had moderate depression and 06 (11.76 %) had mixed anxiety and depressive disorder. Most of the patients were females (93 %), single (67 %), with low education (most of patients were educated till 8th grade i-e- 35 %), having no family history of mental illness (72 %) and no past psychiatric history (79%). 85 % of the sample had social support available to them.

CONCLUSION:
There is high psychiatric co morbidity among dissociative disorder patients. The prevalence is high among young, females, single, low educated people. Every dissociative patient must be screened for depression and anxiety. It needs to be communicated to mental health professionals and general practitioners/medical specialists should be sensitized about early diagnosis, management and referral. It will help decrease the stigma and burden of the disease.

KEY WORDS
Dissociative disorder, Generalized anxiety, Depression, Mixed anxiety and depressive disorder.

INTRODUCTION

Dissociative (conversion) disorder is a group of disorders having common theme in which there is partial or complete loss of the normal integration between memories of the past, awareness of identity, immediate sensation, and control of bodily movements. Diagnosis of dissociative disorder is made when there must be no evidence of a physical disorder that can explain the characteristic symptoms of this disorder and being associated closely in time with traumatic events or disturbed relationship.[1] Dissociative disorder is the condition that is exhibited by isolated neurological symptoms that cannot be explained in terms of known mechanisms of pathology and where there has been a significant psychological stressor found. Estimates of prevalence vary even more but it is estimated around 50 per 100,000.[2]

Dissociative disorder also constitutes one of the diagnostic groups with high relevance in emergency psychiatry.[3] It accounts for 14% to 29% of psychiatric patients in outpatients and inpatients respectively.[4,5]

Temporal relationship of a stressful event is very common in dissiciative disorders. [6, 7,8] Stress that give rise to the conversion symptoms can also be responsible for the fermentation of other psychiatric disorders. A number of studies are available to establish this hypothesis. For example a study showed that at least one psychiatric disorder was found in 89.5 % of the patients who were previously diagnosed as having conversion disorder. Generalized anxiety disorder, dysthymic disorder, and major depression was among the most prevalent psychiatric morbidities; others include undifferenciated somatoform disorder, simple phobias, obsessive compulsive disorder, and dissociative disorders not otherwise specified.[9] Another study showed that among Dissociative Disorder 43% had clinical anxiety and 73% had clinical Depression.[10]

Despite the above literature many things in Pakistan are still unanswered. The presentation of illness in form of physical symptoms is very common. The purpose of

current study is to see the frequency of co morbid Anxiety, Depression and mixed anxiety depressive disorder among dissociative disorder patients. The study will also see the relationship of gender, education, and marital status, availability of social support, family system, and socioeconomic status, among dissociative patients co morbid with psychiatric disorders.

SUBJECTS AND METHODS:

Participants:

One hundred patients with dissociative disorder from indoor department of Psychiatry and Behavioral Sciences, PMC, Faisalabad participated in this study through purposive convenient sampling technique.

INSTRUMENTS:

Patients were interviewed according to the diagnostic and research criteria of ICD-10 for Dissociative disorder, Generalized Anxiety Disorder, Depression (Mild, Moderate, Severe) and Mixed Anxiety and depressive disorder. Bio data form consisted of questions about personal and demographic variables was used to collect demographic information.

PROCEDURES:

Research protocol was presented to Ethical Review Committee of the Punjab Medical College. After the approval, Researcher approached participants in the indoor department of Psychiatry and Behavioral Sciences, PMC, Faisalabad. The researcher took informed consent from the patients. The Mental State Examination of Participants was done, then they were further interviewed according to Diagnostic and Research Criteria of ICD-10 for dissociative disorder, generalized anxiety disorder, depression and mixed anxiety and depressive disorder. All the Data were documented immediately and shifted to SPSS 17 to analyze.

RESULTS

The mean age of patients in dissociative disorder was 19 years with range from 18-21 years. The mean age of dissociative patients co morbid with Generalized Anxiety was 22 years; mean age of dissociative patients with co morbid Mild depression was 19 years; and dissociative patients co morbid with moderate depression had mean age of 24 years. In dissociative patients co morbid with Mixed anxiety and depression mean age was 30 years (see figure 1).

Out of 100 dissociative patients 51 (51%) had a psychiatric co morbidity with dissociative disorder. In co morbidity 51, 16 (31.37 %) had generalized anxiety, 19 (37.25 %) had mild depression, 10 (19.61 %) had moderate depression and 06 (11.76 %) had mixed anxiety and depressive disorder. Most of the patients were females (93 %), single (67 %), with low education i-e up till 8th (54 %) or uneducated (see table 1).

28% of the patients had family history of psychiatric illness; patients who had family history of Depression had higher rates of co morbid anxiety and depression with dissociative disorder (see table 2).

Most of the patients in the sample had social support available to them (see table 2).

In family system wise analysis generalized anxiety disorder and mixed anxiety and depressive disorder were more prevalent co morbidities in dissociative patients who lived in nuclear families while mild to moderate depression was seen more co morbid with dissociative disorder patients living in joint family system. Regardless of psychiatric co morbidity dissociative disorders were more common in 1st and 2nd born children than in subsequent birth orders.

DISSCUSSION:

The results showed that about half of the dissociative patients had a psychiatric co morbidity of mild to moderate depression, generalized anxiety and mixed anxiety depression. The evidence from other researches confirm that these disorders were common psychiatric co morbidities among dissociative patients[8,10,14]. It showed that dissociative patients had underlying depressive illness. Their inability to present the psychological symptoms of depression results in dissociation and related symptoms which receive more attention. In our setups depression, somatization, generalized anxiety disorder, phobias, and dissociative disorder are overlapping with each other due to presentation of physical symptoms. This suggests two plausible theories to explain the reason; at one hand these may be the co morbidities that occur by chance but this explanation of co occurrence does not sound that good. On the other hand it may be theorized that the depression in it self in mild or moderate form exposes its patients to the hypersensitivity to the stress and hence make them more vulnerable to dissociative disorders; that way it means if the depression is picked up earlier and treated properly, the patients may be saved from falling into the diagnosis of dissociative disorder.

Although in western culture the prevalence of dissociative disorder has decreased, but in our population it is still very high; may be because of lack of proper approach towards mental health facilities. The socio demographic characteristics of participants revealed that dissociative disorder is more among females, unmarried, and low educated people. Previous researches confirm these findings [8,10,11,12,13]; only one study showed more prevalence in married and contradicted our results10. The mean age of dissociative patients was between 19 – 22 years. This is in agreement with literature on dissociative disorder in general[10,11,12,13]. Another study found out the mean age of dissociative patients between 16 to 25 years[15]. This is high alarming state that dissociative disorder and depression is common among late teens and early twenties. So we must be careful in dealing and treating these disorders at young age.

The interesting thing in our study is availability of social support which is quite high in dissociative patients; 85% of the patients had the availability of reinforcement that helps sustain the symptoms and it also indicates that there are lapses in providing proper family education to the attendants / care givers/ family members of the dissociative patients. It also stresses that more emphasis should be paid on psycho education of the family about the secondary gains of the illness and ways to manage it.

Dissociative disorder was seen more prevalent in 1st and 2nd birth order than in sub sequent birth orders. Which hints at the fact that our society is tended to pay more attention on elder siblings than younger ones. Because of the fact that the dissociative symptoms are sustained in presence of attention and fulfillment of secondary gains

which are also dependent for their fulfillment, in part, on attention given to the dissociative patients. A second line of reasoning for fewer incidences of dissociative disorders in subsequent birth orders is that the children born with later birth orders are socially more adjusted and more realistic as per developmental theories of Freudians and neo Freudians. That is why they handle their stress appropriately and do not fall in the diagnosis of dissociative disorder.

Figure 1
Mean and range of the ages of dissociative patients with and without psychiatric co morbidities.

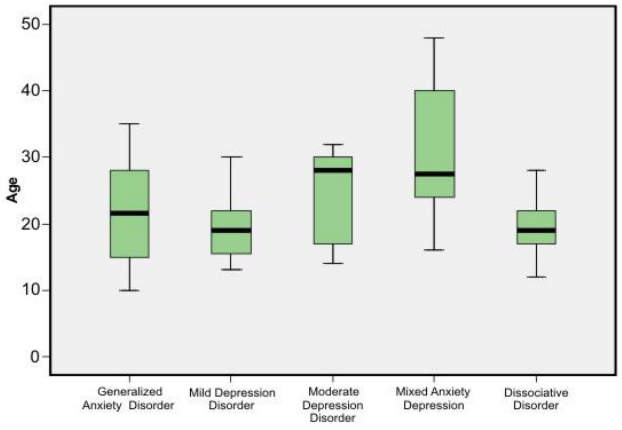

Table 1
Education level of the dissociative patients with and without co morbidity

Co-Morbidity	Education Illiterate	Primary	Middle	Matric	Intermediate	Graduation	
Generalized Anxiety Disorder	3	3	6	0	2	2	16
Mild Depression Disorder	4	5	6	1	2	1	19
Moderate Depression Disorder	2	1	4	3	0	0	10
Mixed Anxiety Depression	1	1	3	1	0	0	6
Dissociative Disorder without co morbidity	6	9	16	11	3	4	49
Total	16	19	**35**	16	7	7	100

Table 2
Past family psychiatric history of dissociative patients with and without psychiatric co morbidity

Family History Psychiatric Illness		Family Psychiatric Illness		Social Support	
		Yes	No	Yes	No
Co-Morbidity	Generalized Anxiety Disorder	3	13	12	4
	Mild Depression Disorder	5	14	18	1
	Moderate Depression Disorder	4	6	9	1
	Mixed Anxiety Depression	0	6	6	0
	Dissociative Disorder without co morbidity	16	33	40	9
Total		**28**	**72**	**85**	**15**

CONCLUSION

There is high a psychiatric co morbidity among dissociative disorder patients. The prevalence is high among young, females, single, and low educated people. Every dissociative patient must be screened for depression and anxiety. It needs to be communicated to mental health professionals and general practitioners/medical specialists should be sensitized about early diagnosis, management and referral. It will help decrease the stigma and burden of the disease.

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