Original Paper

STRESSFUL LIFE EVENTS AMONG PATIENTS WITH DISSOCIATIVE AND SOMATOFORM DISORDER

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Abstract

Introduction: **Stressful life events are part of the fabric of daily existence and often produce disorganized emotional, cognitive and physiological functioning. Somatoform and dissociative disorder categories emerge from a common root, hysteria of the hysteric patients present with features for which there are no apparent anatomical or physiological basis and which has a temporal relationship to a precipitating event.**

Objectives: **This comparative cross sectional study was carried out to compare various stressful life events between diagnosed somatoform and dissociative disorder patients.**

Methods: **A total 220 patients participated. They were interviewed through a structured Bengali questionnaire through face to face interview schedule. For the purpose of the comparison each of the somatoform and dissociative disorder patients participated equally, 110 from each group.**

Results: **The younger population was prone to develop dissociative disorder than somatoform disorder (33.6% to 12.7%). Married people seemed to be more likely to develop somatoform disorder than dissociative (87.2% to 64.5%), while unmarried people more likely to develop dissociative disorder (35.5% to 12.8%). House wives were observed to be more likely to develop somatoform disorder than dissociative disorder (78.18%-60.0%). There was statistical significance between the incidence of divorce/separation of the respondents and development of either somatoform or dissociative disorder ($p<0.05$). Majority of the respondents with unplanned pregnancy by the spouse (7.27%) appearing for examination or interview (2.73%), marriage/engagement (5.45%) and gain of a new family member (4.55%) tend to develop dissociative disorder. While majority of respondents with sexual problems (16.36%), burden of large loan (11.8%) seem to develop somatoform disorder.**

Conclusion: **There are certain factors which require equal consideration in such patients of these may shed some light on stressful life events associated with dissociative disorder and somatoform disorder.**

Key words: **Stressful life events, dissociative, somatoform disorder**

Introduction

Stressful life events are part of the fabric of daily existence and often produce disorganized emotional, cognitive and physiological functioning. Daily hassles, chronically stressful situations may play a role in experiencing stress by individual. In general practice, it is found that somatic symptoms, such as fatigue, chest pain and headache are extremely common complaints by the patients. Studies have found that over 20% and as many as 75% of all patients in the primary care settings present with psychological problems through somatic symptoms without any organic disease[1].

Somatoform and dissociative disorder categories have emerged from a common root - hysteria, a diagnosis given to a group of patients who presented with features for which there was no apparent anatomical or physiological basis and

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which had a temporal relationship to a precipitating event. Clinical experience and research findings from the studies done on these two disorders independently also suggested that somatoform and dissociative disorders share some vulnerability factors such as dissociative experience, personality traits, illness behavior, alexithymia and that stress (e.g. sexual and physical abuse) may be important in the formation of both disorders. The answer probably lies in the interaction of stress and vulnerability factors. In ICD-10, the diagnosis of a dissociative or conversion disorder is made when there is no physical cause for the symptom and there is evidence for a psychological causation, such as relationship with stressful events[2-4].

Somatoform disorders represent a group of disorders characterized by physical symptoms suggesting a medical disorder. However, somatoform disorders represent a psychiatric condition because the physical symptoms present in the disorder cannot be fully explained by a medical disorder, substance abuse or another mental disorder. Often, the medical symptoms patients experience may be from both medical and psychiatric illnesses[5,6].

The American Psychiatric Association in the Diagnostic and Statistical Manual for Mental Disorders included a specific category for somatic symptoms related to psychiatric origins called the somatoform disorders[7]. Specific somatoform disorders include somatization disorder, conversion disorder, pain disorder, hypochondriasis and body dysmorphic disorder. Both disorders have been found to have significant co-morbidity with one another (15%-30%). A significant number of patients with conversion disorder have been reported to have dissociative symptoms and vice versa. Both groups of patients have been reported to have a comparable element of associated anxiety, which is presumed to be the causative mechanism in both disorders[7].

Dissociative disorders are a group of psychiatric syndromes characterized by disruptions of aspects of consciousness, identity, memory, motor behavior or environmental awareness. The American Psychiatric Association in their diagnostic and Statistical Manual includes 4 dissociative disorders and one category for atypical dissociative disorder. These include dissociative amnesia (DA), dissociative identity disorder (DID), dissociative fugue, depersonalization disorder, and dissociative disorder not otherwise specified[7]. The differential diagnoses of dissociative amnesia are any organic mental disorders, dementia, delirium, transient global amnesia, Korsakoff disease, postconcussion amnesia, substance abuse, other dissociative disorders and malingering factitious disorder [8,9]. Present study was designed to compare various associated stressful life events between diagnosed somatoform and dissociative disorder patients with in a same hospital set up.

Material and Methods

The study was comparative cross sectional study conducted at National Institute of Mental Health (NIMH), Sher-e-Bangla Nagar, Dhaka between the period of January 2010 to June 2010. Patients reported to the outpatient department (OPD) of the hospital during the study period and willing to participate in the study were included in the study. The sample size was fixed at 220. As it was a comparative study between somatoform and dissociative disorder patients, 110 patients were included in each group of disorder. Non-probability purposive sampling method was deployed.

For smooth conduction of the study, an interview schedule was developed that consisted of two parts. Initial part contained questions regarding socio-demographic characteristics of both group of patients. Later part focused on various stressful life events. It was a structured questionnaire, taken from presumptive stressful life event scale (PSLES). Interview was conducted using the Bengali version of questionnaire. Data was collected through face to face interview. Each time only one participant was interviewed.

All the data were checked and edited after collection. Observed data were entered into computer with the help of software SPSS windows program version [11.5]. Data obtained were compiled in tabulated form. Statistical analysis of received data was performed as required. Values were considered statistically significant if p value

is less than 0.05. Categorical data were expressed in percentage (%) and frequency (f).

Results

The mean age of the respondents was 26.19±7.20 years and the range of age was 19 to 58 years. Married people were observed to be more likely to develop somatoform disorder than dissociative; while unmarried people were more likely to develop dissociative disorder (Table II). House wives were found to be more likely to develop somatoform disorder than dissociative disorder (Table III) while students were more likely to develop dissociative disorder. Rural people were found to be more likely to develop somatoform disorder than dissociative disorder (61.82% to 44.55%), while urban people were more likely to develop dissociative disorder (55.45% to 38.18%). There was statistically significant difference ($p<0.05$) between incidence of divorce/separation of the respondents and development of either somatoform or dissociative disorder (Table IV).

Table -I: Distribution of the study population by age (n = 220)

Age group (in yrs)	Group of disorder		Total
	Somatoform disorder f (%)	Dissociative Disorder f (%)	
< 20	14 (12.7%)	37 (33.6%)	51
20 - 40	90 (81.8%)	66 (60.0%)	156
> 40	6	7	13
Total	110 (100.0%)	110 (100.0%)	220
Mean ± SD = 26.19 ± 7.20 Range = 19 - 58 years p<0.05 (Chi - square 14.142; df = 2)			

Table -II: Distribution of the study population by marital status (n = 220)

Marital status	Group of disorder		Total f
	Somatoform disorder f (%)	Dissociative Disorder f (%)	
Married	96 (87.2)	71(64.5)	167
Unmarried	14 (12.8)	39 (35.5)	53
Total	110 (100)	110 (100)	220

Chi - square 15.535 df = 1 p<0.05

Table -III: Distribution of the study population by occupational status (n = 220)

Occupational status	Group of disorder		Total f
	Somatoform disorder f (%)	Dissociative Disorder f (%)	
Unemployed	1	4	5
Student	13 (11.81%)	34 (30.9%)	47
Service	4	3	7
Business	2	2	4
Farming	4	0	4
House wife	86 (78.18%)	66 (60.0%)	152
Other	0	1	1
Total	110 (100.0%)	110 (100.0%)	220

Chi - square 18.957 df = 6 p = .004< .05
Chi - square 7.262 df = 2 p = .026< .05

Table -IV: Incidence of divorce/separation of the respondents

	Somatoform disorder		Dissociative Disorder		p value
	f	(%)	f	(%)	
Yes	0	00	4	3.64	0.044
No	110	100	106	96.36	
Total	110	100	110	100	

Relationship of development of the somatoform disorder and dissociative disorder to death of close family members, unsuccessful engagement or love affairs, personal illness, pregnancy (planned or unplanned), sexual problem and large loan burden are shown in following tables:

Table -V: Distribution of the respondents by death of close family members

	Somatoform disorder		Dissociative Disorder		p value
	NO	(%)	NO	(%)	
Yes	1	0.91	10	9.09	0.005
No	109	99.09	100	90.91	
Total	110	100	110	100	

Chi - square 7.751 df = 1

Table -VI: Distribution of the respondents by unsuccessful engagement or love affairs

	Somatoform disorder		Dissociative Disorder		p value
	NO	(%)	NO	(%)	
Yes	0	00	8	7.27	0.004
No	110	100	102	92.73	
Total	110	100	110	100	

Chi - square 8.302 df = 1

Table -VII: Distribution of the respondents by major personal injury or illness

	Somatoform disorder		Dissociative Disorder		p value
	NO	(%)	NO	(%)	
Yes	0	00	5	4.55	0.024<.05
No	110	100	105	95.45	
Total	110	100	110	100	

Chi - square 5.116 df = 1

Table -VIII: Distribution of the respondents by pregnancy of wife (wanted or unwanted)

	Somatoform disorder		Dissociative Disorder		p value
	NO	(%)	NO	(%)	
Expected	0	0.00	1	0.91	0.034<.05
Unexpected	1	0.91	8	7.27	
Not applicable	109	99.09	101	91.82	
Total	110	100	110	100	

Chi - square 6.749 df = 2

Table -IX: Distribution of the respondents by sexual problem of the respondents

	Somatoform disorder		Dissociative Disorder		p value
	NO	(%)	NO	(%)	
Yes	18	1	6.36	4 3.64	0.002<.05
No	92	83.64	106	96.36	
Total	110	100	110	100	

Chi - square 9.899 df = 1

Table -X: Distribution of the respondents by large loan burden of the respondents

Large loan burden	Group of disorder		Total f
	Somatoform disorder	Dissociative Disorder	
Yes	13	3	16
No	97	107	204
Total	110	110	220

Chi - square 6.740 df = 1 p = .009 < .05

Discussion

Dissociative and somatoform disorders form a significant proportion of the caseload in psychiatry clinics in a developing country. For these disorders the subtypes prevalent in developing countries are different from those in developed countries; hence research findings from developed countries may not be easily compared for developing countries[10].

The mean age of the respondents was 26.19±7.20 years (ranging from 19 - 58 years). There was statistical significance between age of developing somatoform or dissociative disorder ($p<0.05$). Most (81.8%) of the somatoform disorder was observed to be among the age group of 20-40 years. Younger population was prone to develop dissociative disorder than somatoform disorder (33.6%-12.7%). There was statistical significance between the marital status while considering development of either somatoform or dissociative disorder ($p<0.05$). Married people were observed to be more likely to develop somatoform disorder than dissociative (87.2%-64.5%), while unmarried people mostly developed dissociative disorder (35.5%-12.8%).

There was statistically significant relationship between the occupational status with development of either somatoform or dissociative disorder ($p<0.05$). House wives were more likely to develop somatoform disorder than dissociative disorder (78.18%-60.0%), while students were more likely to develop dissociative disorder (30.9%-11.81%). Again, there was statistically significant influnce of place of residency while considering development of either somatoform or dissociative disorder ($p<0.05$). Rural people developed somatoform disorder more than

dissociative disorder (61.82%-44.55%), while urban people were more likely to develop dissociative disorder (55.45%-38.18%).

A study by Saxe et al revealed that mental disorders were more common among rural population[9]. As the average urban population spent more time in interacting so they utilized the family support in a better manner. This finding is consistent with this study, which reveals increasing somatoform disorder patients in rural areas than dissociative disorder patients which might be associated with low educational level and low socioeconomic status[9,11,12].

In this study statistically significant ($p < 0.05$) relation between incidence of divorce/separation of the respondents and development of either somatoform or dissociative disorder ($p<0.05$) was observed. All the respondents with unsuccessful affair tend to develop dissociative disorders. This study also showed statistically significant relation of developing dissosiative disorder in respondants with personal injury, unplanned pregnancy and having illness of family members.

Some events are commonly experienced by general population, e.g. death of a close family member, getting engaged or married, pregnancy of wife, illness of family member, etc. as compared to death of spouse, divorce, wife begins or stops working, and outstanding personal achievement, which are experienced less often in the population. These observation are similar to previous studies[13-15].

Present study revealed majority (18 out of 22) respondents with sexual problems and loan burdens (13 out of 16) seem to develop somatoform disorder. Various studies showed that neurotic patients experienced a variety of life events in different walks of life more often than dissociative disorder. Life events, namely broken engagement or love affair, failure in examination were more common in dissociative disorder than in somatoform disorder[16,17].

The findings of this study are not similar to the findings of another study that reveals that, dissociative and somatoform disorder patients experienced the events that were commonly experienced by general population but it does not show any significant difference between them[18,19].

Conclusion

It has often been contented that mere exposure to stresses is not a sufficient explanation of illness in ordinary human experience. There are certain other factors which require equal consideration. The above profile of a small group of such patients sheds some light on stressful life events associated with dissociative disorder and somatoform disorder. Psychiatry or mental health has long been a much neglected area in our health service. Time has come to rethink on mental health and reorient health services as the prevalence and socio - economic burden of mental health problem are not small.

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