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Clinical Patterns, Comorbidities and Stressors in Dissociative Disorders: A Hospital-Based Cross-Sectional Study

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ABSTRACT

Introduction: Dissociative disorders are characterised by disruptions in memory, consciousness, identity and perception of the self and environment. The high rate of comorbidity complicates diagnosis, emphasising the need for a comprehensive evaluation. Psychosocial stressors play a pivotal role in the onset and exacerbation of the disorder. Despite their high prevalence, there is a lack of systematic research on their clinical patterns, comorbidities, and psychosocial stressors. Most existing literature focuses on case studies or small-scale investigations. A detailed exploration of these aspects of the disorder facilitates early identification and management, ultimately enhancing patient outcomes. **Aims:** To analyse the clinical presentations, comorbid psychiatric conditions, and psychosocial stressors in dissociative disorders. **Methods:** A descriptive cross-sectional study was conducted from April 2025 to June 2025 at the Psychiatry Department of Nepalgunj Medical College among 50 patients aged 18-60 years, diagnosed with dissociative disorders, enrolled by convenience sampling. Unco-operative patients, those with severe psychiatric/medical illnesses, or cognitive disorders, were excluded. Sociodemographic and clinical data were recorded using a semi-structured proforma. **Results:** The majority of patients (88%) were from the age group 16 to 35, female (86%), married (60%), residing in a rural area (62%), belonging to nuclear families (70%) with lower middle-economic status (40%) and middle school education (32%) and anxiety disorder as a comorbidity. The most common clinical presentation was non-epileptic seizures, with the commonest stressor being family conflict. **Conclusion:** Our findings emphasise the need for family-based intervention as well as early psychosocial intervention and mental health support targeting these vulnerable groups.

***Keywords**:* Clinical Patterns, Comorbidity, Dissociative disorders, Stressor

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INTRODUCTION

Dissociative disorders (DDs) are a range of psychiatric conditions characterized by disruptions in memory, consciousness, identity, and perception of the self and environment, often manifested in response to psychological stress or trauma.[1] The prevalence of DDs varies across populations, influenced by cultural, psychological, and biological factors. Despite their clinical significance, DDs remain underdiagnosed and poorly understood, leading to challenges in treatment and management. Individuals with dissociative disorders frequently present with a wide spectrum of symptoms, including amnesia, depersonalization /derealization, identity disturbances, and conversion symptoms, often creating a diagnostic dilemma. The clinical presentation often overlaps with other psychiatric disorders, such as depression, anxiety disorders, post-traumatic stress disorder (PTSD), and somatic symptom disorders. This high rate of comorbidity complicates diagnosis and underscores the need for a comprehensive evaluation of associated mental health conditions. Psychosocial stressors play a pivotal role in the onset and exacerbation of DDs.[2] Childhood trauma, abuse, neglect, interpersonal conflicts, and adverse life events have been identified as major risk factors. Despite the growing recognition of DDs, there remains a lack of systematic research on their clinical patterns, comorbidities, and associated stressors in hospital-based settings. Most existing literature focuses on case studies or small-scale investigations. A detailed exploration of these aspects can contribute to a deeper understanding of these disorders, which could aid in early identification, ultimately improving patient outcomes. This hospital-based cross-sectional study aims to bridge this gap by analyzing the clinical presentations, comorbid psychiatric conditions, and psychosocial stressors in patients diagnosed with DDs.

METHODS

This study followed a hospital-based descriptive cross-sectional study design and was conducted at the Department

of Psychiatry, Nepalgunj Medical College Teaching Hospital, Kohalpur. A convenient sampling method was applied among the patients attending the psychiatry OPD and IPD from April 2025 to June 2025. The study population consisted of patients diagnosed with dissociative disorders. The diagnosis of dissociative disorder and its subtypes was made according to the eleventh revision of the International Classification of Diseases (ICD-11) by a registered psychiatrist. Patients aged 18-60 years diagnosed with a dissociative disorder were included. Uncooperative patients who were not willing to consent, patients with severe psychiatric disorders, severe cognitive impairment, and severe medical illness requiring intensive care were excluded. The calculated sample size was 50, considering the prevalence of dissociative disorder was 10%,[3] with 8.5% margin of error and 95% confidence interval. Ethical approval was obtained from the Institutional Review Committee (Ref. 61/081-082), Nepalgunj Medical College Teaching Hospital, Kohalpur. All the patients were informed about the purpose of the study in detail, and written informed consent was obtained. For patients who were unable to give consent, written consent was taken from their parents or guardians. The identity of the respondents and their responses were kept confidential. Patients were evaluated and diagnosed based on ICD-11 criteria. After taking a detailed history, a semi-structured pro forma was used to collect information about socio-demographic and clinical variables as well as types of stressors. The categorisation of stressors was done based on the most common types of stress mentioned in the presumptive stressful life events scale given by Singh et al (1984).[4]

Statistical Analysis

Descriptive statistics were performed to summarise the demographic characteristics and clinical findings of the study population. Continuous variables (e.g., age) were presented as mean ± standard deviation (SD). Categorical variables (e.g., gender) were summarised as frequencies and percentages. All data analyses were performed using IBM SPSS Statistics version 25.0 (IBM Corp., Armonk, NY, USA).

RESULTS

Table I shows the sociodemographic variables of the study population. Among the 50 participants, the majority were female (86.0%), while only 14.0% were male. The age of the participants ranged from 18 to 54 years, with a mean age of 26.48 years and a standard deviation of 7.96. The majority of patients (44.0% each) were within the age group of 18-24 years and 25-34 years, followed by 35-44 years (8.0%). Only a smaller proportion (4.0%) was from the older age group, 45–54 years. This indicates that most participants were young adults, with some variability in age distribution across the sample. Most participants (62.0%) were from rural areas, and the remaining 38.0% were from urban settings. A majority (70.0%) of the respondents were identified as Hindu, while Christianity, Buddhism, and Islam were practised by 14.0%, 12.0%, and 4.0% of the participants, respectively. The majority of respondents were married (60.0%), while 38.0% were unmarried and 2.0% were either divorced or widowed. More than half of the participants were unemployed (54.0%). Unskilled workers made up 18.0%, semi-skilled and skilled workers accounted for 6.0% each, 10.0% were clerks or shop owners, 4.0% were semi-professionals, and only 2.0% were professionals. The largest proportion had a middle school level of education (32.0%), followed by high school (28.0%), and primary school and diploma holders each accounted for 18.0%, 2.0% were illiterate, and 2.0% were post-graduates.

Sociodemographic variables		Frequency (Percentage)
Sex	Female	43 (86.0)
	Male	7 (14.0)
Age	18-24	22 (44.0)
	25-34	22 (44.0)
	35-44	4 (8.0)
	45-54	2 (4.0)
Residence	Rural	31 (62.0)
	Urban	19 (38.0)
Religion	Hindu	35 (70.0)
	Christianity	7 (14.0)
	Buddhism	6 (12.0)
	Islam	2 (4.0)
Marital status	Married	30 (60.0)
	Unmarried	19 (38.0)
	Divorced or widowed	1 (2.0)
Occupation	Unemployed	27 (54.0)
	Unskilled	9 (18.0)
	Clerk, shop owner	5 (10.0)
	Skilled	3 (6.0)
	Semi-skilled	3 (6.0)
	Semi-profession	2 (4.0)
	Profession	1 (2.0)
Education	Illiterate	1 (2.0)
	Primary School	9 (18.0)

Education	Middle school	16 (32.0)
	High school	14 (28.0)
	Diploma	9 (18.0)
	Postgraduate	1 (2.0)
Type of family	Nuclear	35 (70.0)
	Joint	11 (22.0)
	Extended	4 (8.00
Family history of dissociative disorder	Present	10 (20.0)
	Absent	40 (80.0)
Socioeconomic status	Lower-lower	7 (14.00)
	Lower upper	16 (32.0)
	Lower middle	20 (40.0)
	Upper middle	7 (14.0)

Total study population (n)=50. Mean age of the study sample =26.48±7.96 years

Table I: Demographic and clinical profiles of the patients

The majority (70.0%) belonged to nuclear families, followed by joint (22.0%) and extended families (8.0%). Less than 1/3rd (20%) of the patients had a family history of dissociative disorder. The highest proportion of participants (40.0%) belonged to the lower middle socioeconomic class. The lower upper class made up 32.0%, while both the lower-lower and upper middle classes each accounted for 14.0% of the participants.

Clinical patterns	Frequency (Percentage)
Non-epileptic seizure	22 (44.0)
Trans and possession	19 (38.0)
Paresis or weakness	4 (8.0)
Speech disorder	2 (4.0)
Visual disturbance	2 (4.0)
Sensory disturbances	1 (2.00)
Total	50 (100.0)

Table II: Distribution of Clinical Patterns Among Study Participants (N = 50)

The clinical presentation of the participants was varied (Table II). Non-epileptic seizures, reported by 44.0% of the participants, were the most frequent clinical presentation. Trans and possession states were the second most common, observed in 38.0% of cases. Paresis or weakness was reported by 8.0% of participants. Speech disorders and visual disturbances were each reported by 4.0%. The least common symptom was sensory disturbance, seen in 2.0% of cases.

Type of stressor	Frequency (Percentage)
Family conflict	9 (18.0)
Academic	6 (12.00)
Divorce or separation	5 (10.0)
Financial	4 (8.0)
Physical or sexual abuse	3 (6.0)
Death of close family member	2 (4.0)
Work related	2 (4.0)
Personal injury	1 (2.0)
Marriage	1 (2.0)
None	17 (34.0)
Total	50 (100.0)

Table III: Distribution of Stressors Among Study Participants (N = 50)

Out of the total participants, the majority (66%) reported an identifiable stressor; the most frequently reported stressor was family conflict, reported by 18.0% of respondents (Table III). Academic-related stress was noted by 12.0% of participants. Divorce or separation was reported by 10.0%, while financial stress affected 8.0% of individuals. Physical or sexual abuse was reported by 6.0% of participants. Work-related stress and the death of a close family member were each reported by 4.0%. Marriage and personal injury/illness were the least reported stressors, each by 2.0% of respondents. Notably, 34.0% of participants reported experiencing no identifiable stressor.

Comorbidity	Frequency (Percentage)
Anxiety	12 (24.0)
Depression	11 (22.0)
Bipolar affective disorder	9 (18.0)
Personality disorder	4 (8.0)

Substance use disorder	3 (6.0)
Post-traumatic stress disorder	2 (4.0)
Others	1 (2.0)
None	8 (16.0)
Total	50 (100.0)

Table IV: Distribution of Psychiatric Comorbidities Among Study Participants (N = 50)

In terms of psychiatric comorbidities among the participants, anxiety disorders were the most reported comorbidity, present in 24.0% of participants (Table IV), which was followed by depression in 22.0% and bipolar affective disorder (BPAD) in 18.0% of cases. Personality disorders were reported by 8.0% of participants. Substance use disorders were present in 6.0%, and Post-Traumatic Stress Disorder (PTSD) was seen in 4.0%. Other psychiatric conditions accounted for 2.0% of cases. Notably, 16.0% of the participants reported no psychiatric comorbidity.

DISCUSSION

This study aimed to explore the clinical patterns, psychiatric comorbidities and psychosocial stressors in patients diagnosed with dissociative disorders at a tertiary hospital. One of the most striking findings was a significantly higher predominance of female patients, which constituted 86.0% of the study sample. This finding, however, is consistent with multiple prior studies where the majority of patients with dissociative disorders were females, with proportions ranging from 80% to 86%.[5,6] In a study by Mohammad Y et al, in India, dissociative stupor was reported in 77% of females, supporting this gender disparity.

This gender difference may be attributed to socio-cultural as well as emotional factors. In many traditional societies, women often grow up in emotionally restrained environments with limited opportunities for emotional expression. The onset of puberty, societal expectations and gender roles may further compound emotional stress, contributing to the higher incidence of dissociative symptoms among females.

In terms of age distribution, the participants in our study ranged from 18 to 54 years, with a mean age of 26.48 ± 7.96 years. These findings are comparable to other studies that reported similar age distributions, including those by Chowdhury JM et al[7], and Sharma et al.[2] Like the finding by Sharma et al where the majority of patients were from the 21 to 30 age group;[5] our study also showed participants (44.0% each) in the age groups of 18-24 and 25-34 years, indicating that young adulthood remains a vulnerable period for the development of dissociative disorders. A significant portion of our sample (62.0%) came from rural backgrounds, with 70.0% from nuclear families. These findings are in concordance with multiple prior studies, including that by Nizam et al, that observed a similar pattern, with 66.66% of cases from rural areas and 74.50% from nuclear families.[8] Limited mental health resources, stigma, and lack of awareness in rural communities may contribute to the higher reporting or emergence of dissociative disorders in such populations. Higher prevalence in nuclear families may be attributed to epidemiological trends, which show a growing number of nuclear families, as well as the lack of a proper support system in nuclear families. Additionally, 60.0% of our participants were married, reflecting earlier findings that showed dissociative disorders, more common in married individuals, with reported rates up to 74%.[5] Marital responsibilities, interpersonal conflicts, and social pressures could serve as major stressors contributing to symptom manifestation in this group.

Educationally, the largest subgroup had middle school education (32.0%) and 54.0% were unemployed, with 40.0% belonging to the lower middle socioeconomic class. These figures align closely with other studies, where most participants were young adults, females, unemployed, from rural settings, low socioeconomic backgrounds, and nuclear families.[9] These socioeconomic variables likely reflect the limited coping resources and increased vulnerability in individuals from disadvantaged backgrounds. Regarding clinical presentation, the most frequently observed symptom in our study was non-epileptic seizures, reported by 44.0% of patients. This is consistent with clinical patterns described by Bhat et al[10] who noted that dissociative convulsions were the most common form of dissociation. Similarly, Gupta et al[11] reported pseudo-seizures as the predominant presentation (29.7%). These manifestations might be socially acceptable ways of expressing psychological distress, especially in communities where direct expression of emotional turmoil is discouraged. The most frequently reported psychosocial stressor in our sample was family conflict (18.0%). This aligns with findings by Reddy et al[12] who reported family disharmony in the majority (41.82%) of their cases, and Thapa et al[13] who also found family conflict as the most common precipitating factor. Another study observed that 44% of patients experienced stress related to family problems.[14] In general, the literature highlights that stressors such as discord with in-laws, forced marriage, and strained relationships with spouses or parents are highly prevalent in dissociative disorder cases.[15]

From a psychiatric standpoint, anxiety disorders were the most common comorbidity in our study (24.0%), followed by depression (22.0%). This is consistent with other findings that show anxiety frequently coexisting with dissociative symptoms.[16] However, some studies, including that by Thapa et al, have reported a higher prevalence of depression (35%) in comparison to anxiety in these patients.[17] These variations may be influenced by the personal judgement of the clinician due to overlapping symptoms between depression and anxiety, as well as diagnostic criteria used, population differences, and the nature of clinical assessments.

LIMITATIONS

The study was conducted in a single tertiary care hospital. It is cross-sectional nature does not allow for establishing a causal

relationship between psychosocial stressors and dissociative symptoms. A relatively small sample size in our study may limit its generalisability. No standardised tool was used to quantify the degree of psychosocial stressors. Recollection of stressors during the interview can have some recall bias. The diagnoses were made clinically, which may be subject to individual bias.

CONCLUSION

Our study found a higher prevalence of dissociative disorders among young adult females, particularly those from rural backgrounds, nuclear families, and lower socioeconomic strata. The most common clinical presentation was non-epileptic seizures, with family conflict emerging as the leading psychosocial stressor. Anxiety and depressive disorders were the most frequent psychiatric comorbidities. These findings highlight the importance of integrating early psychosocial intervention and mental health education into treatment plans for better outcomes, especially targeting this vulnerable population. Psychoeducation to family members and family-based therapies could be of great help. Also, the higher prevalence of associated psychiatric comorbidity highlights the need for routine screening of other psychiatric disorders in patients presenting with dissociative symptoms.

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