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Dissociative Phenomenology and General Health in Normal Population

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Abstract

Background: Dissociative symptoms are most commonly found in females and adolescents, and when discussing their background, they can be from lower socio-economic backgrounds and rural areas. They are always preceded by psychosocial stressors. Dissociative disorders previously known as "hysteria" have been described since antiquity and Hippocrates even hypothesised "wandering uterus" to be the cause for dissociation in females. With the advances in science, there has been shift from these religious and spiritual concepts to a scientific basis for dissociation.

Aim: To assess the dissociative phenomenology in normal population and to assess the subjective health in normal population.

Methods: A group of 100 (50 females & 50 males) were selected from the community using a snowball sampling technique.

Tools: Socio-demographic data sheet, General Health Questionnaire-12 and Dissociative Experience Scale-II were used.

Results: The study found that females differ from males in the reporting of subjective health rating (X^2=5.76, p=0.01) and similar results shown in terms of dissociative phenomenology (X^2=67.76, p=0.001).

Discussion: It has been found that only 4% from the female group and 2% from the male group rated their health under the "normal" category. 52% of females and 64% of males were categorised under "mild ill health" and 24% to 26% were in "moderate ill health", whereas 20% of female participants and 8% of male participants rated their health as "severely ill". In another domain of the study, dissociative phenomenology, 32% of female participants reported severe dissociative symptoms and 38% of male participants also showed similar results.

Conclusion: Dissociative disorder significantly affects the population but it is hard to diagnose due to factors such as; cultural factors, socio-economic factors etc. The study shows clearly that dissociative symptoms are found in the general population also.

Key Words: Dissociation, Phenomenology, General Health, Disorder, Healthy population

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1. Introduction

Dissociation is known as an experience of disconnection or lack of continuity between thoughts, memories, surroundings, actions and identity. People escape from reality in a way which is involuntary and unhealthy and later on this causes problems in the functioning of every-day life. Most of the time these symptoms develop as a reaction to trauma or stressful events and help people to avoid bad memories. These symptoms generally range from amnesia to alternate identities. Pierre Janet (1887) a renowned psychologist coined the term "Dissociation" for the first time and conceptualised dissociation as a difficulty in the integration of different systems of ideas and functions which constitute personality. He also explained that there is a significant relationship between traumatic experiences and memories. He was also claimed that stressful or traumatic memories remained as "unchanged unconscious ideas" (Avdibegovic, 2012). Janet stated that dissociation was the result of stress, which affects the individuals according to their susceptibility or their ability to cope with stress. Janet and other nineteenth-century investigators studied unusual cases of psychogenic memory disorders, dramatic changes in personality, discontinuities in consciousness and awareness, and sensorimotor disturbances that were attributed to the basic mechanism of dissociation (Nemiah, 1985, 1991).

However, researchers' interest has decreased throughout the subsequent decades. Evidenced by history, this decline can be attributed to a rise of behaviourism in academic areas and psychoanalysis in clinical practice. Theoretically, the works of Janet, Jung, and others concerning dissociation were largely ignored in favour of Freud's rival hypothesis of repression (Ellenberger, 1970; Frey-Rohn, 1974; Nemiah, 1985, 1991). However, a shift in perspective with new perspectives of multiple personality disorder (Putnam, 1989; Ross, 1989) and post-traumatic stress disorder in the 1980s, dissociation has become again an important theoretical as well as clinical consideration. Since then, the scientific study of dissociation has regained the importance. It has played an important role in psychopathology, as well as in understanding the normal states of cognitive emotional-motoric processes and relationships with underlying brain states.

In terms of recent conceptualisations of the construct itself, dissociation has been seen clinically and theoretically to involve alternations in consciousness that appear to involve a variety of individual memory processes (Kihlstrom et al., 1994). These processes or the lack thereof can manifest themselves in a variety of ways. Some of these include: (1) **de-personalisation and de-realisation** in the sense of not experiencing aspects of one's self or environment as real; (2) **amnesia** of either short or long term nature; (3) **absorption** such as the ability to be lost in a task; (4) the **existence of sub-personalities** that may be experienced as separate; and (5) **various forms of both trance experiences** and non-normal processing and experience within everyday life.

Specific signs and symptoms of dissociation: a) memory loss (amnesia) for certain times, events, and personal information, b) a sense of being detached from self, c) a distorted perception, d) a blurred sense of identity, e) inability to cope with stress, g) mental health problems, such as depression, anxiety, and suicidal thoughts and behaviours. Freud, who was influenced by Charcot, worked on hypnosis. Together with Breuer, Freud opined that "conversion" was the situation in which the distressing feelings or emotions were changed into some type of somatic symptoms. He further explained that hysteria was a result of repression of the painful memories and these memories stuck in the person's unconscious mind and then were omitted from conscious awareness. He successively created a technique of psychotherapy in which the person described one's painful feelings in words, and the emotional pain hidden in one's unconscious (subconscious mind) would come to the surface of conscious awareness (Breuer & Freud, 1895/1995).

The Taxon Model of the dissociation proposed two continua: normal and pathological dissociation. The latter comprises of a distinct group of highly traumatised individuals - about 3.5% of the general population—who present with a specific cluster of symptoms consistent with severe dissociative psychopathology such as multiple dissociative disorder. These include severe de-personalisation, recurrent amnesia for current experiences, and identity alteration (Waller, Putnam, Carlson, 1996). Dissociative symptoms, such as dissociative amnesia and de-personalisation/de-realisation have been described trans-diagnostically (Loewenstein, et al., 2017; Lyssenko, et al., 2018). In the Iatrogenic Model, dissociation is viewed as a condition produced in highly hypnotisable, "fantasy-prone," "suggestible" patients

- many with Borderline Personality Disorder - by clinicians who believe in "repressed memories" and "multiple personalities" using "risky" treatments like hypnosis for "recovered memory therapy" to exhume forgotten traumas as the primary treatment goal, but instead "implant" false memories (Loewenstein, et al., 2017; Paris, 2012; Brand, Loewenstein & Spiegel, 2014). "Fantasy-prone" is a specific construct from hypnosis and cognitive research, which is described from healthy samples whose were highly hypnotisable with ability to generate an extraordinarily vivid, compelling fantasy life with cognitive slippage and difficulty in made difference between internal and external experience (Brand, Loewenstein & Lanius, 2014). This dissociation "epidemic" is based on "Freudian" ideas of complete repression of traumatic memories that are revealed under hypnosis (Paris, 2012). The Fantasy Model is conceptualising that dissociation is a cognitive trait that leads to fantasies/confabulations of traumatic experiences (Giesbrecht, et al., 2008).

The word "health" is referred to as a state of complete emotional and physical well-being. It can be defined in terms of physical, mental and social well-being. Health not only described as the absence of disease, but also the ability to recover from illness. There are many factors which play an important role for both good as well as bad health including genetics, environment, relationships, education, diet, exercise and coping strategies. Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others and make choices. Mental health is important at every stage of life, from childhood and adolescence through to adulthood. **Mental health** is also known as the level of psychological well-being or an absence of mental illness. It is the state of someone who is "functioning at a satisfactory level of emotional and behavioural adjustment".[1] From the perspectives of positive psychology or of holism, it may include an individual's ability to enjoy life and ability to balance life activities and efforts to achieve psychological resilience (Snyder, Lopez & Pedrotti, 2011).

According to the World Health Organization (WHO), mental health includes "subjective well-being, perceived self-efficacy, autonomy, competence, inter-generational dependence, and self-actualisation of one's intellectual and emotional potential, among others".[3]

The WHO further states that the well-being of an individual is encompassed in the realisation of their abilities, coping with normal stresses of life, productivity in work, and contribution in the community.[4]

Many of these states can occur in everyone's daily life as demonstrated by forgetfulness, absentmindedness, or absorption into books or films. Other dissociative symptoms may be rare and found only in psychopathological states. Such extreme dissociative processes as seen in fugue states, depersonaliation, or dissociative identity disorders clearly represent an important area for study. However, several theoretical questions remain to be answered in terms of the relationship between normal and pathological states of dissociation as well as the way each is developed. After reviewing the literature, it has been found that 36.4% had experienced at least 1 moderate or severe dissociative symptom during his or her lifetime (Logan, 2019). In the general population in Canada and Turkey research found a life-time prevalence of dissociative disorder of 12.2% and 18.3% respectively. A general population study in New York State found a 1-year prevalence of 9.1% for dissociative disorder and for a similar study done in Canada and New York, the results were 1.3% and 1.5% of the population for dissociative identity disorder. (Loewenstein, Frewen & Lewis-Fernández, 2017; Spiegel, et al., 2011; Sar, 2011). As there has been no study in Indian culture and as this is very important area for research, this study was designed to identify the presence or severity of the dissociative symptomology and subjective general health in the general population.

2. Methods

Objective: To assess the dissociative phenomenology and subjective health rating in the general population.

2.1. Sample

A pilot study was conducted of 100 healthy participants from the community. The sample was selected on the basis of convenience and snowball sampling techniques. The sample was equally distributed i.e. 50 males and 50 females. The study took place from September 2019 to March 2020. The study sample was recruited from the Post Graduate Institute of Medical Science, Rohtak (Haryana).

All participants were enrolled in MBBS.

Inclusion Criteria: aged from 18 to 24 years, willingness to participant in the study, have no history of psychiatric or medical illness.

Exclusion Criteria: any history of psychiatric illness, or any major medical or neurological illness, substance dependence and refusal to give informed consent.

Ethical Consideration: all participants involved were human and all necessary concerns relating to the ethics of human participation were adhered to. All participants were only involved after giving their written informed consent and their satisfaction about the study procedure. Any human rights were not breached during the research.

2.2. Tools used

The following tools were used for measuring the criterion variables:

Socio-demographic and clinical data sheet: A socio-demographic record sheet was prepared for collecting the information about various areas of social, demographic and clinical variables. Information relating to age, sex, residence, marital status, education, types of family, occupation, onset of substance abuse, duration of substance abuse, past psychiatric history, history of multiple substance dependence, family history of psychiatric and substance abuse were recorded in a structured interview setting and the investigator recorded the information.

The standard psychometric tests used were:

1. General Health Questionnaire developed by Goldberg (1988). It consists of 12 items which are rated on a Likert scale which is for positive items is "Better than usual", "Same as usual", "Worse than usual" and "Much worse than usual" and for negative items is "Not at all", "Less than usual", "Same as usual" and "More than usual". The scoring is 0 to 3. The minimum score is 0 and the maximum is 36. The lowest score is indicative of better health and vice versa. For severity index the following criteria should be used; score lower than 3 (normal), score 4 to 11 (mild health problem), score 12 to 18 (moderate health problem) and a score more than 19 suggests a severe health problem.

2. Dissociative Symptom Scale developed by Bernstein and Putnam (1986). High levels of dissociation are indicated by scores of 30 or more e.g. 0% 10 20 30 40 50 60 70 80 90 100% (0=Never to 100=Always). It is one of the best screening scales amongst general dissociation screening scales. It is a 28-item self-report scale based on visual analog techniques. It has very good validity and reliability and good overall psychometric properties. This scale is used for severity assessment of the dissociative symptoms. It assesses on three subscales: amnestic, absorption or imaginative involvement, and depersonalisation or de-realisation experiences. DES-II has internal consistency of Cronbach's alpha = 0.901 for the normal population and Cronbach's alpha = 0.949 for clinical group (Kennedy et al., 2004). Carlson and Putnam (1993) reported the good convergent validity of DES-II with the Perceptual Alteration Scale (r = 0.52), the Tellegan Absorption Scale (r = 0.39), and the Ambiguity Intolerance Scale (r = 0.24). For assessment of severity or pathological symptoms of dissociation, the score should be more than 30.

2.3. Procedure

The main objective of the study was to assess the dissociative phenomenology and general health in the normal population. The participants were assured regarding the confidentiality of their information as well as their comfort during the testing. The purpose of the study was also made clear to them. All the participants were recruited only after their written informed consent for testing was given. After developing a rapport, the actual administration of the tests was started and instructions of all tests were given to them. The estimated time for the administration of tests was around 15 to 20 minutes.

3. Results

3.1. Statistical Analysis

The data were analysed using both descriptive (mean and standard deviation) and inferential statistical (X^2) techniques. For the significance of the severity the percentages and Chi Square test was used.

Table 1

Showing the descriptive analysis of demographic variables

Variables		Female		Male	
		Mean	SD	Mean	SD
Age		20.34	1.24	20.72	3.08
Education		12.6	1.21	12.48	1.11
		Frequency	Percent	Frequency	Percent
Residence	Rural	13	26	17	34
	Sub-urban	4	8	4	8
	Urban	33	66	29	58
Family Type	Joint	16	32	1	2
	Nuclear	34	68	49	98
History of Psychiatric Illness in	Absent	49	98	50	100
Family	Present	1	2	0	0
History of Medical Illness in	Absent	46	92	46	92
Family	Present	4	8	4	8
History of Substance Abuse in	Absent	50	100	49	98
Family	Present	0	0	1	2

Table 2

Showing the results of Frequency and percentages with Chi Square (Subjective General health and dissociative symptoms) (df=1)

Variables		Female		Male		Chi Square	p value
		Frequency	Percent	Frequency	Percent		
Subjective	Normal	2	4	1	2	5.76	0.01
General	Mild	26	52	32	64		
Health	Moderate	12	24	13	26		
	Severe	10	20	4	8		
Dissociative	Normal	34	68	31	62	9.00	0.003
Symptoms	Severe	16	32	19	38		

Significant at $p<0.01$ level

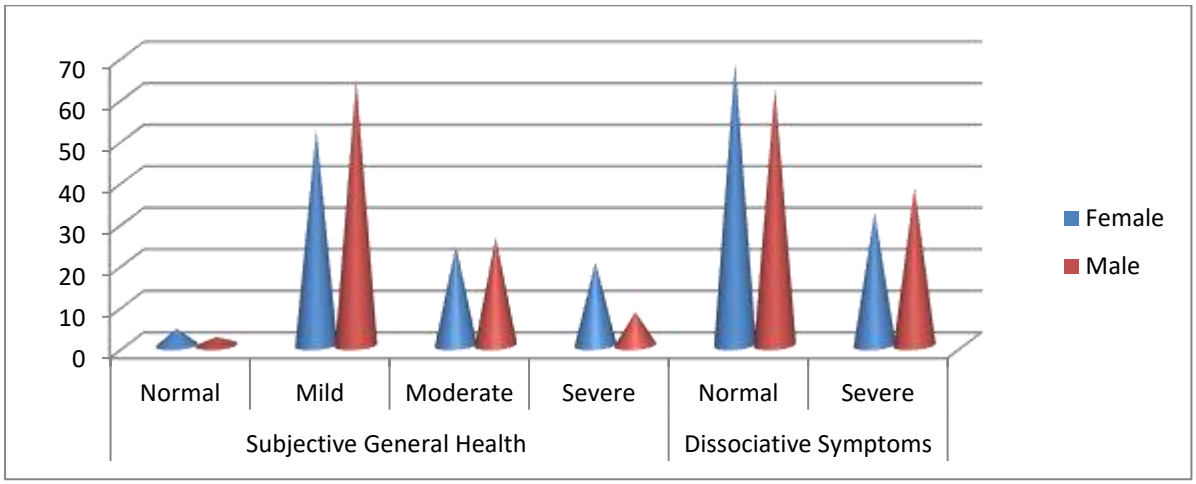

Figure 1: Shows the graphical presentation of percentages of General Health and Dissociative symptoms

4. Discussion

This study was planned with the aim to assess the dissociative symptoms as well as the subjective rating of the participants on their mental health. This study was conducted on an Indian population which is the first study which is to assess gender differences on these parameters in a healthy control, especially in students.

In the results it has been seen that the mean age (SD) of the female and male group varied from 20.34 (1.24) to 20.72 (3.08) respectively. The education mean (SD) of female participants was 12.60 (1.21) and mean (SD) of male participants was 12.48(1.11). In other demographic variables i.e. gender, both groups were equally distributed i.e. 50 in each. In occupation, religion and marital status all participants were students, Hindu and unmarried. In the residence domain 66% from the female group and 58% from the male group came from an urban background, 26% and 34% were from a rural background respectively and 8% in both groups of the sample were from a sub-urban background. Most of the participants belonged to a nuclear family i.e. 68% from the female group and 98% from the male group. 32% of the female and only 2% of the male participants were from joint families. In the domain of history of psychiatric illness in the family, 98% of female participants reported there was no history and in the male participants all reported an absence of any psychiatric illness in their family. In the medical illness domain, 98% of participants from both genders reported an absence of any major medical illness in their family. The majority of participants also reported no family history of substance abuse (Table 1).

Deka et al. (2007) reported in their study that dissociation was more commonly seen in students (50.90%) and homemakers (38.18%). In another longitudinal study conducted by Maaranen, et al., in 2008 on a general population they found that 98 subjects were high dissociators and after a 3 year follow-up, 28 of them were still high dissociators, whereas amongst 70 subjects, the dissociative score declined below the cutoff score. During the follow-up period, 28 of 1399 subjects became new high dissociators, and constantly low dissociators consisted of 1371 of 1399 subjects.

In Table 2 it has been found that only 4% from the female group and 2% from the male group rated their health under the normal category. 52% and 64% of females and males respectively rated themselves under mild ill health, 24% to 26% were in moderate ill health, whereas 20% female participants and 8% male participants rated their health as severely ill (Fig. 1). Overall, the Chi Square value showed that there is significant difference between both genders in term of subjective rating of their general health (χ^2= 5.76, p=0.01).

In the another domain of the present study i.e. dissociative phenomenology 32% of female participants reported severe dissociative symptoms and 38% of male participants also showed similar results. In this study, male participants experienced more severe dissociative symptoms which are in contrast to a previous study. These results may be because of the role assigned to them by society. Males are more responsible for the family and they also had more stress about the future compared to females and these stressful events definitely caused the dissociative experiences. In the results of the present study 68% to 62% of participants reported no experience of any dissociative symptoms in their life. The Chi Square vale (χ^2= 9.00, p=0.003) depicts that there is significant difference in both groups (Table 2 & Fig. 1). In support of the results of the present study another study also suggests that dissociation is significantly more common in females than males (3.5:1) (Reddy, Patil, Nayak, Chate & Ansari, 2018). In the review, few studies showed similar results in which showed that around 36.4% had experienced at least 1 moderate or severe dissociative symptom during his or her lifetime and in terms of gender the life-time prevalence of dissociative disorder is 12.2% and 18.3% in females and males respectively (Logan, 2019; Loewenstein, et al., 2017; Spiegel, et al., 2011). A study conducted in Finland on the general population showed that pathological dissociation was around 3.5% and high scores on dissociative scale were found to be significantly associated with depression and suicide (Maaranen, et al. 2008).

Limitation and strength: In this study a few limitations were found which need to be accounted for. The sample size is not enough to generalise the results. In the study some important variables such as stressful life events are not considered. In this study for comparison of the results, a clinical group or students from other stream also need to be included. However, there are some limitations but it has some positive points which are very important and beneficial also for mental health professionals. This study

pointed out significant findings which denote that there are significant increasing symptoms in the general population which need to be considered. This study also helps to plan further research in this area.

Future direction: On the basis of the present study's findings there is a need of focus on this high risk group. The present study also provides a direction for mental health practitioners in this area to also pay attention to. Such types of study are rare and this area needs to be a focus for further research. This study also helped indicate further research ideas. There is also a need to focus on other psychological aspects such as personality type, coping skills, problem solving, psychological distress and trauma etc. which are directly related with dissociation. This study is a novel idea and also helps to plan for further research on the basis of the findings of the study.

5. Conclusion

Dissociation is more common in adolescents, students, and in those from lower socio-economic status and rural areas. In the present study dissociation is significantly higher in females than males. It always occurs in the background of increased stressful life events and in the presence of significant psychosocial stressors. This is the most common disorder which is misdiagnosed and frequently found in the community. It also plays an important role in emerging other psychiatric illnesses and many other psychological issues. This study highlights that dissociation is not a disorder which is found only in psychiatric illness, it is also seen in the general population. The findings of this study also showed that males are also equally or more likely than females to have these dissociative experiences during adolescence and early adulthood i.e. 38% and 32% respectively. 20% of females rate their general health poor than which is a higher number than of males.

Conflict of Interests

Authors declare no conflict of interests.

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