



Original Article

Sociodemographic Characteristics and Psychosocial Stressors Among Patients with Dissociative [Conversion] Disorder: A Cross-Sectional Study

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ABSTRACT

Background: Dissociative (Conversion) disorder presents with neurological symptoms that are unexplained by organic pathology. Psychosocial stressors and adverse socio-demographic factors are central to its etiology; however, region-specific data from northern India remain sparse.

Aim: To describe the socio-demographic and clinical profile of patients with dissociative disorder and to examine the associations between psychosocial stressors and key demographic variables.

Methods: An exploratory cross-sectional study was conducted at the Psychiatry OPD of a tertiary care hospital in Northern India for the duration of 18 months. Seventy-five adults (≥ 18 years) fulfilling the ICD-10 criteria were recruited using purposive sampling. The instruments were a semi-structured proforma, the B.G. Prasad Socioeconomic Classification Scale, General Health Questionnaire-12 (GHQ-12), Hamilton Depression Rating Scale-17 (HDRS-17), Hamilton Anxiety Rating Scale (HARS), and the Presumptive Stressful Life Events (PSLE) Scale. Chi-square tests were used to assess the associations ($p < 0.05$).

Results: Participants were predominantly female (82.7%), young (54.7% aged 18–24 years), married (74.7%), and from lower socioeconomic strata (69.3% Class IV–V). Dissociative convulsions (34.7%) and motor disorders (33.3%) were most prevalent. Psychological distress (GHQ-12 > 2) was present in 64%; 30.7% had comorbid depression and 16% had significant anxiety. The leading stressors were conflict with in-laws (13.3%), family conflict (13.3%), bereavement (12.0%), and friendship ruptures (12.0%). Significant associations were found between stressors and age ($\chi^2 = 26.73$, $p < 0.05$), marital status ($\chi^2 = 11.19$, $p < 0.05$), educational status ($\chi^2 = 7.96$, $p < 0.05$), and socioeconomic class ($\chi^2 = 9.76$, $p < 0.05$).

Conclusion: Conversion disorder predominantly affects young, married women from lower socioeconomic strata. Interpersonal and family stressors are the principal precipitants. These findings advocate for a comprehensive care that is culturally responsive, trauma-sensitive, and collaborative.

Keywords: Conversion disorder; dissociative disorder; functional neurological symptom disorder; psychosocial stressors; socio-demographic profile; ICD-10.

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INTRODUCTION

Conversion disorder categorized as dissociative disorder (F44) in ICD-10 and functional neurological symptom disorder in DSM-5 is characterized by motor or sensory neurological symptoms that are inconsistent with recognized neurological diseases and are unexplained by organic pathology.¹ These signs include paralysis, non-epileptic (dissociative) convulsions,

tremor, dystonia, and sensory alterations. Even though these signs do not have any underlying pathology and are not deliberately produced by individuals, they produce significant functional difficulties.²

This condition makes up about 5-10% of all new cases presented to neurological clinic-based departments.^{3,4} An overwhelming female gender bias has been seen universally, with female to male ratios of 2:1 to 10:1.⁵ Teenagers and young adults are especially at risk since they experience the stress of growing up.⁶

The psychosocial stressors, including family conflict, marital discord, bereavement, academic failure, and child abuse, are critical aspects of the biopsychosocial causation of conversion disorder.^{7,8} There are several sociodemographic factors that increase the risk of developing the condition: low socioeconomic status, lack of education, rural living, and unemployment are associated with increased risk of the disorder.⁹ The cultural setting also influences the presentation of symptoms: in South Asian communities, strong stigmatization of mental disorders and health beliefs result in the somatization of psychological distress.^{10,11}

Conversion Disorder being a condition that burdens healthcare resources still remain a little explored entity in India; especially in a very populous state like Uttar Pradesh where health disparities are wide between rural and urban populations. This paper was intended to describe the socio-demographics and pattern of psychosocial stress associated with patients suffering from dissociative disorder in a tertiary care centre in northern India. The associations were established between stressor burden and various demographic variables.

MATERIALS AND METHODS

Study design and setting

The study was a hospital-based cross-sectional study that took place within an 18-month span at the Psychiatry Outpatient Clinic of a tertiary care hospital located in Northern India.

Participants

Subjects included adults aged 18 years or more irrespective of their sex, fulfilling the ICD-10 criteria of Dissociative Disorder (F44), and giving written informed consent. Individuals excluded from the study were those with any form of present or past organic psychiatric condition, epilepsy, known neurological condition, or serious systemic disease.

Sample size and sampling

The average number of cases recorded per month during the previous one year in the out-patient department (OPD) registration of conversion disorder was 60. The minimum required sample size considering 5% error is 53, and this was increased to 75 to allow for attrition. Purposive sampling was done.

Ethical considerations

The ethical approval for the study was granted by the Institutional Ethics Committee before the study was embarked upon. Written consent was taken from all the participants. There was strict adherence to confidentiality and all the participants were made aware of this.

Assessment instruments

The semi-structured proforma eliciting socio-demographic and clinical variables had age, gender, religion, place of residence, marital status, occupation, education, type of family, birth order, duration of illness, nature of symptoms, previous childhood abuse, family history of psychiatric disorders, and subtype ICD-10 disorder as its variables. Socio-economic class of the subjects was derived by the B.G. Prasad Socio-Economic Classification Scale, Class I-V depending upon per capita monthly income of the family adjusted to AICPI (1988 index=100). GHQ-12 (with a binary scoring method 0-0-1-1) was used to measure psychological distress where the score more than 2 was considered significant distress. Depressive symptoms were determined by using HDRS-17 (where 0-7 none, 8-16 mild, 17-23 moderate, ≥ 24 severe) and anxiety symptoms by using HARS scale (≤ 17 mild, 18-24 moderate, ≥ 25 severe). Stressful life events were measured by PSLE scale (a standardized scale for Indians).

Statistical analysis

Data analyses were conducted using SPSS version 27.0 (IBM Corp., Chicago, IL, USA) and Epi Info version 7.2.6.0. Categorical data are reported in terms of frequencies and percentages. Relationships between psychosocial stressors and socio-demographic factors were tested using chi-square (χ^2) tests with $p < 0.05$ considered to be statistically significant.

RESULTS

Socio-demographic profile

Table 1 The following table summarizes the sociodemographic characteristics of 75 participants.

The sample consisted mainly of females (82.7%) making the female to male ratio approximately 4.8:1. Majority of the participants belonged to the age group of 18-24 years (54.7%) while over four fifth participants belonged to ≤ 31 years age group (81.4%). Majority of participants were married (74.7%) but the distribution between rural (53.3%) and urban (46.7%)

area was nearly equal. Occupation of homemakers was the commonest (37.3%) occupation followed by students (20.0%). Around 62.7% did not have senior secondary education while 10.7% participants were illiterate. The striking observation is that majority of participants belonged to lower/lower middle socioeconomic class (Class IV-V), i.e., 69.3%.

Table 1. Socio-demographic profile of study participants (n=75)

Characteristic	Category	n (%)
Age group (years)	18–24	41 (54.7)
	25–31	20 (26.7)
	32–38	7 (9.3)
	39–45	5 (6.7)
	46–54	2 (2.7)
Gender	Female	62 (82.7)
	Male	13 (17.3)
Marital status	Married	56 (74.7)
	Single	14 (18.7)
	Divorced	5 (6.7)
Domicile	Rural	40 (53.3)
	Urban	35 (46.7)
Education	Illiterate	8 (10.7)
	Primary (1–5th std)	20 (26.7)
	Secondary (6–9th std)	18 (24.0)
	Sr. Secondary (10–12th std)	16 (21.3)
	Graduation and above	13 (17.3)
Socioeconomic class†	Upper (Class I)	5 (6.7)
	Upper Middle (Class II)	7 (9.3)
	Middle (Class III)	11 (14.7)
	Lower Middle (Class IV)	31 (41.3)
	Lower (Class V)	21 (28.0)
Occupation	Homemaker	28 (37.3)
	Student	15 (20.0)
	Self-employed	11 (14.7)
	Employed	9 (12.0)
	Other / Unemployed	12 (16.0)
Family type	Nuclear	44 (58.7)
	Joint	31 (41.3)
Religion	Hindu	37 (49.3)
	Muslim	15 (20.0)
	Sikh	14 (18.7)
	Other	9 (12.0)

†B.G. Prasad Socioeconomic Classification Scale (updated, AICPI-adjusted). std = standard.

Clinical characteristics and psychological assessment

Table 2 presents the clinical and psychological profile. Half of the participants (50.7%) reported illness duration of 6 months to 1 year; only 4.0% had symptoms persisting beyond one year. Dissociative convulsions (34.7%) and dissociative motor disorders (33.3%) were the predominant ICD-10 subtypes, together accounting for 68.0% of cases; no cases of dissociative fugue were recorded.

A childhood history of physical abuse was reported by 28.0% and sexual abuse by 20.0%; 52.0% reported no abuse. A positive family psychiatric history was present in 40.0%. Significant psychological distress on GHQ-12 (score >2) was recorded in 64.0% of participants; an equal proportion (64.0%) had identifiable psychiatric comorbidity. Comorbid depression was present in 30.7% (mild 16.0%, moderate 12.0%, severe 2.7%); clinically significant anxiety was present in 16.0%.

Table 2. Clinical profile and psychological assessment findings (n=75)

Characteristic	Category	n (%)
Duration of illness	0–6 months	34 (45.3)
	6 months – 1 year	38 (50.7)
	≥1 year	3 (4.0)
ICD-10 subtype	Dissociative convulsions	26 (34.7)
	Dissociative motor disorder	25 (33.3)
	Dissociative anaesthesia/sensory loss	7 (9.3)
	Dissociative amnesia	6 (8.0)
	Trance and possession disorder	5 (6.7)
	Mixed dissociative disorders	4 (5.3)
	Dissociative stupor	2 (2.7)
Childhood abuse history	Physical abuse	21 (28.0)
	Sexual abuse	15 (20.0)
	None	39 (52.0)
Family psychiatric history	Present	30 (40.0)
	Absent	45 (60.0)
GHQ-12 significant distress (score >2)	Present	48 (64.0)
	Absent	27 (36.0)
Psychiatric comorbidity	Present	48 (64.0)
	Absent	27 (36.0)
Depression severity — HDRS-17	None (0–7)	52 (69.3)
	Mild (8–16)	12 (16.0)
	Moderate (17–23)	9 (12.0)
	Severe (≥24)	2 (2.7)
Anxiety severity — HARS	None (<7)	63 (84.0)
	Mild (8–17)	8 (10.7)
	Moderate (18–24)	2 (2.7)
	Severe (≥25)	2 (2.7)

GHQ-12: General Health Questionnaire-12; HDRS-17: Hamilton Depression Rating Scale (17-item); HARS: Hamilton Anxiety Rating Scale.

Psychosocial stressors

The most commonly identified stressors on the PSLE Scale were conflict with in-laws and family conflict (13.3% each), followed by death of a close family member and break with a friend (12.0% each), and marital conflict and broken engagement or love affair (8.0% each; Table 3). Rare stressors — large loan, self/family unemployment, trouble with neighbour, and change in working conditions — were each reported by only 1.33% of participants. Family-related and interpersonal stressors collectively dominated the psychosocial stressor burden.

Table 3. Frequency of psychosocial stressors identified on the PSLE Scale (n=75)

Psychosocial Stressor (PSLE Scale)	n	%
Conflict with in-laws	10	13.3
Family conflict	9	12.0
Death of close family member	9	12.0
Break with friend	8	10.66
Marital conflict	6	8.0
Broken engagement or love affair	6	8.0
Failure in examination	4	5.3
Major personal illness or injury	3	4.0
Financial loss or problems	3	4.0
Illness of family member	3	4.0
Lack of son	3	4.0
Lack of child	2	2.7
Appearing for examination/interview	2	2.7
Getting married or engaged	2	2.7
Rare stressors (≤ 1 report each)*	5	6.7

*Rare stressors (n=1 each): large loan, self/family unemployed, marriage of daughter/dependent sister, trouble with neighbour, change in working conditions/transfer. PSLE: Presumptive Stressful Life Events Scale.

Associations between psychosocial stressors and socio-demographic variables

Table 4 summarises the chi-square test results. Statistically significant associations were observed between psychosocial stressor type and age group ($\chi^2=26.73$, $p<0.05$), marital status ($\chi^2=11.19$, $p<0.05$), educational level ($\chi^2=7.96$, $p<0.05$), and socioeconomic class ($\chi^2=9.76$, $p<0.05$). Younger participants (18–31 years) disproportionately reported interpersonal and romantic stressors, whereas married individuals more commonly experienced in-law conflict and family conflict. Higher educational attainment was associated with greater reporting of relational stressors, and lower socioeconomic class with a higher overall stressor burden. Occupational status did not show a statistically significant association with stressor type ($\chi^2=2.32$, $p=0.75$).

Table 4. Associations between psychosocial stressors and socio-demographic variables (n=75)

Variable	Key observation	χ^2	p-value
Age group	Younger patients (18–31 yrs) more commonly reported interpersonal and romantic stressors; bereavement stressors were distributed across age groups	26.73	0.023*
Marital status	Married: higher in-law and family conflict; unmarried: more academic stressors and broken relationships	11.19	0.038*
Occupational status	Homemakers: family and in-law stressors; students: academic and peer stressors — no statistical significance	2.32	0.745

Educational status	Higher education associated with greater reporting of interpersonal and relational stressors	7.96	0.043*
Socioeconomic class	Lower class (IV–V) bore the greatest burden of bereavement, family conflict, and friendship stressors	9.76	0.042*

* $p < 0.05$ (statistically significant). χ^2 : chi-square statistic. All tests two-tailed.

DISCUSSION

This study provides a systematic socio-demographic and psychosocial characterization of 75 patients with conversion disorder at a tertiary care centre in Uttar Pradesh, India. The findings are largely consistent with, and meaningfully extend, data from comparable Indian settings.^{12–16}

The striking female preponderance (82.7%; F:M ratio ~4.8:1) aligns with internationally reported ratios of 2:1 to 10:1.5 This pattern is consistently documented across Indian studies Grover and Avasthi (2006) from Chandigarh,⁶ Bammidi et al. (2020) from southern India,¹⁷ and Kumar et al. (2020) from Uttar Pradesh.¹⁸ This is probably due to the combination of biological susceptibility, gender role stereotyping, and the social acceptability of bodily symptoms amongst South Asian females.¹⁰ The predominance of young age group (>80% under 31 years) correlates well with the literature on the vulnerability factors associated with the psychosocial stresses of young adulthood.^{6,7} The high rate of married subjects (74.7%) is consistent with both the age structure of the sample and the high marriage rates in Uttar Pradesh.

Almost 70% of the individuals belonged to either the lower or lower middle socioeconomic group. The statistical significance between the socio-economic status of an individual and his stressors ($\chi^2 = 9.76$, $p < 0.05$) demonstrates the way in which poverty increases the psychosocial vulnerability of an individual through economic hardship, inadequate coping mechanisms, and limited access to mental health services.⁹

Childhood maltreatment was seen in 48.0% of the patients where 28.0% were cases of physical abuse, while 20.0% had been victims of sexual abuse. This is consistent with the current literature regarding early childhood trauma being a risk factor for the emergence of conversion disorder.^{19,20} A family history of mental illness was seen in 40.0% of cases.

The prevalence of dissociative seizures (34.7%) and motor problems (33.3%) is consistent with previous studies conducted among Indian and South Asian populations.^{17,18,21} The dramatic and episodic nature of the seizure-like episodes may have cultural significance and could help attract the attention of families and healthcare practitioners in a way that sensory complaints may not.

There was a high incidence of psychological comorbidity: 64.0% suffered from severe distress according to the criteria established by the GHQ-12; 64.0% were suffering from some form of psychiatric comorbidity, 30.7% were suffering from depression, and 16.0% were suffering from anxiety.

Interpersonal and familial sources accounted for the majority of psychosocial stressors, with in-law conflict (13.3%) and family conflict (12%) being the most common combined. This is consistent with patterns seen in northern India, where family systems act as both a main support system and a source of interpersonal stress, especially for young wives.^{24,25}

The association between age and stressor type ($\chi^2 = 26.73$, $p < 0.05$) suggests that psychosocial stress exposure is stage-specific, with younger subjects more vulnerable to romance and peer sources of stress. The association with marital status ($\chi^2 = 11.19$, $p < 0.05$) is similarly a matter of life-stage expectations, with domestic stressors prevailing among married subjects and academic and relational stressors among the unmarried. Table 5 provides context for current results in the South Asian literature.

Table 5. Comparison with selected published studies on conversion disorder in South Asia

Study (Year)	Setting	n	Female (%)	Mean age (yrs)	Dominant stressors
Present study (2024)	Shahjahanpur, UP, India	75	82.7	22.4	In-law conflict, family conflict, bereavement
Bammidi et al., 2020 ¹⁷	Southern India	100	75.0	24.5	Family conflict, marital issues

Kumar et al., 2020 ¹⁸	Uttar Pradesh, India	60	78.3	26.0	Family conflict, domestic violence
Ranjan et al., 2019 ¹⁴	Bihar, India	80	71.0	25.8	Family stressors, academic stress
Sharma et al., 2017 ¹³	North India	50	80.0	23.1	Marital conflict, in-law conflict
Roy et al., 2017 ²²	Bangladesh	100	79.0	26.0	Family conflict, bereavement
Sharma KK et al., 2024 ¹⁶	India	80	77.5	27.2	Family conflict, financial stressors

UP: Uttar Pradesh. Mean age estimated from study data where not explicitly reported.

Strengths and limitations

This study offers comprehensive, multi-instrument assessment using validated psychiatric rating scales and a culturally standardized stressor tool in an under-studied population. Limitations include a single-centre purposive sample limiting generalizability, the cross-sectional design precluding causal inference, and the absence of structured diagnostic interviews (MINI/SCID) for comorbidity assessment. Cultural and gender-based influences on symptom expression were not explored in depth. Future multi-centric longitudinal studies with standardized diagnostic instruments are warranted to establish causal pathways and evaluate targeted interventions.

CONCLUSIONS

The conversion disorder among this group of people in northern India is more common among young married females belonging to lower socioeconomic backgrounds and poor educational attainments. Primary stressors for the majority of people are interpersonal and family-related issues like strain between in-laws, disharmony among families, grief, and disruptions in friendships. Stressor patterns tend to differ based on age, marital history, education background, and socioeconomic class. High frequency of associated depression and anxiety disorders underscores the necessity of proper mental health assessments.

DECLARATIONS

Conflict of interest: None declared.

Funding: No external funding was received for this study.

Ethics approval: Approved by the Institutional Ethics Committee, Varun Arjun Medical College and Rohilkhand Hospital, Shahjahanpur.

Informed consent: Written informed consent was obtained from all participants.

Author contributions: SD: study design, data collection, analysis, manuscript writing. SMT: conceptualization, supervision, critical review. PA: supervision, critical review. All authors approved the final manuscript.

Data availability: Available on reasonable request to the corresponding author.

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