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Research Article

Dissociative disorder in children and adolescents and their personality profile: a comparative study

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ABSTRACT

Background: Studies demonstrate the change in nature of dissociation in accordance with increasing age but there is dearth of literature studying the differential influence of personality factors in childhood and adolescent dissociation respectively. Personality attributes putatively determine the overt expression of nature of dissociative symptoms in childhood and adolescent dissociative symptoms differentially. Objective: Aim of this study was to compare the personality profiles of children and adolescents onset dissociative disorder.
Methods: 60 subjects with diagnosis of dissociative disorders were included in this study with 30 subjects with 8-12 years of age and 30 adolescents with 13-16 years of age. Children in the age group of 8-12 years were given children personality questionnaire (CPQ) and adolescents were given 16 PF (form B) which are a paper-pencil self-administered questionnaires.
Results: Both the groups were comparable for various socio-demographic and clinical variables except habitat and education. Children in younger age group were found to be more serious, taciturn, internally restrained, depressed and apprehensive. Adolescents on other hand were more aggressive, stubborn and aggressive.
Conclusions: Dissociation in childhood and adolescents is a malleable developmental phenomenon determined by core personality attributes.

Keywords: Childhood dissociative disorders, Adolescent dissociative disorders, Personality profiles

INTRODUCTION

Dissociation in children and adolescents may be seen as a result of a disturbance or alteration in normally integrative functions of identity, memory or consciousness[1] but the history of childhood dissociation parallels that of adolescents in terms of ebb and flow of professional interests. The beginnings of modern interest in childhood and adolescent dissociative disorders are subject to debate.

Children with dissociative disorders are frequently misdiagnosed because of their comorbid symptomatology like attention deficit and hyperactivity disorders, conduct disorders or oppositional defiant disorder, schizophrenia, various forms of epilepsy and affective disorders.[2] In early childhood dissociated aspect of the self-do not tend to have a well elaborated sense of autonomy. Instead feeling, thoughts and impulses that the child experiences as foreign may be projected onto transitional objects such as doll or fantasy playmates. Young children from traumatic backgrounds may present with a variety of dissociative symptoms such as trans like states,

perplexing forgetfulness, and behavioral and emotional fluctuations.[3] In young children fluctuating behavior may include unpredictable eruptions into tantrums of surprising intensity that appear out of context to what is going on around them. Although regressive behavior is frequently present, it may be hard to detect unless the child is assessed overtime.[4,5]

On the contrary, in adolescents, symptom pattern becomes more similar to those of adults.[6] Identity consolidation is a developmental task of adolescents and it appears that dissociative identity may consolidate as well.[7] Dissociative states tend to become more rigid displaying gender symptoms and a gender prevalence that is more comparable to that of adults.[8] The symptoms usually include frequency of self-destructive behavior, acting out and unstable relationships, often in shifting environment. Even when they live in a stable house their shifting patter of relatedness (e.g. alteration between regression and mistrust) often produces chaos anyway.

There are studies demonstrating the change in nature of dissociation in accordance with increasing age but there is dearth of literature studying the differential influence of personality factors in childhood and adolescent dissociation respectively. Considering the importance of personality attributes putatively determining the overt expression of nature of dissociative symptoms in childhood and adolescent dissociative symptoms, the primary aim of this study was to see the personality profile of children and adolescents onset dissociative disorder.

METHODS

Participants: The present study is a cross-sectional study. Participants for the study were recruited by the purposive sampling technique in which Total 60 subjects were taken from the age of 8 years to 16 years in relation to age, gender, education, religion, community, habitat, economic status, past history of abuse and duration of illness. The data included 30 children aged 8-12 years and 30 adolescents aged 13-16 years with the diagnosis of dissociative disorder. The data was collected from Child Guidance Clinic of Pediatric Department of SGRRIM & HS and associated Shri Mahant Indiresh hospital, Patel Nagar, Dehradun, India. The study has been approved by the research and ethics committee of the hospital. Informed consent was taken from all the subject's parents.

Measures: A socio-demographic data sheet was prepared specifically for the present study. The study consisted of socio-demographic characteristics (age, sex, education, religion, community, habitat, economic status, past history of physical/sexual abuse, duration of illness and diagnosis). Only those children and adolescents within the age of 8-16 years with no psychiatric co morbidity were included. After that, children between 8-12 years of age, were given children personality questionnaire (CPQ) and adolescents aged 13-16 years were given 16 PF (form B) which are a paper-pencil self-administered questionnaires. Two of the 16 factors of 16 PF (Q1, Q2) were excluded from the test since these were not present in CPQ to make the analysis and comparison more feasible.

Table 1: Comparison of Socio-demographic, clinical variables (Categorical) and personality profile. Legend: X2 (Chi Square); **Significance at p<.05 (2-tailed).

Variable		Adolescents N1=30	Children N2=30	$\chi 2$	P
Sex	Male	13	20	3.30	.069
	Female	17	10		
Education	Primary	0	30	60.0	.03**
	Secondary	30	0		
Community	Tribal	12	8	1.20	.273
	Non-tribal	18	22		
Socio-economic status	Low	12	18	.069	.793
	Middle	13	17		
Habitat	Rural	17	7	6.98	.030**
	Suburban	3	6		
	Urban	10	17		
Past history of abuse	Significant	6	10	1.36	.243
	Not-significant	24	20		
Religion	Hindu	13	18	1.67	.432
	Muslim	13	9		
	Christian	4	3		
Family psychiatric history	Significant	4	26	1.66	.197
	Non-significant	8	22		

RESULTS

Both the groups were comparable for various socio-demographic variables like gender, religion, community, economic status except habitat (χ^2 = 6.98, p=.03) and education (χ^2 = 60.0, p= <.01). Moreover no significant difference was found in history of physical/sexual abuse and family history in both groups.

There were significant difference was in age (t=15.48, p=.001) and personality factors like Factor B (Lower vs. higher scholastic mental capacity) (t=4.08, p=.001), Factor E (submissiveness vs. dominance) (t=2.56, p=.013), Factor F (desurgency vs. surgency) (t=4.77, p=.001), Factor N (artlessness vs. shrewdness) (t=4.46, p=001), Factor O (untroubled adequacy vs. guilt proneness) (t=-2.52, p=014), Factor M/D (praxernia vs. autia) (t=3.93, p=.001) and Factor L/J (alexia vs. protension (t=-.320, p=.002).

There were no significant difference among other factors like Factor A (sizothymia vs. affectogthymia), Factor C (lower vs. higher ego strength), Factor G (weaker vs. stronger super ego strength), Factor H (threctia via parmia), Factor I (harria vs. premsia), Factor Q3 (low vs. high strength of self-sentiment), Factor Q4 (low vs. high urgic tension).

Table 2: Comparison of socio-demographic, clinical variables (continuous) and personality profile.

Variables	Adolescents N1=30 Mean (SD)	Children N2=30 Mean (SD)	t	P
Age (In years)	15.47 (0.63)	10.37 (1.70)	15.48	.001**
Duration of illness (In years)	1.99 (.65)	1.71 (0.59)	1.70	.093
Factor A (16PF/CPQ)	4.27(1.58)	3.83(1.97)	.942	.350
Factor B (16PF/CPQ)	5.57(2.22)	3.57(1.50)	4.08	.001**
Factor C (16PF/CPQ)	4.37(2.23)	4.10(1.79)	.50	.618
Factor E (16PF/CPQ)	7.50(1.71)	6.27(1.98)	2.56	.013**
Factor F (16PF/CPQ)	5.73(1.76)	3.87(1.22)	4.77	.001**
Factor G (16PF/CPQ)	4.60(1.35)	4.43(1.30)	4.85	.629
Factor H (16PF/CPQ)	5.50(1.18)	6.40(1.92)	-.865	.067
Factor I (16PF/CPQ)	7.03(1.50)	6.60(1.83)	1.00	.320
Factor N (16PF/CPQ)	7.13(1.71)	4.93(2.08)	4.46	.001**
Factor O (16PF/CPQ)	7.50(1.78)	8.57(1.48)	-2.52	.014**
Factor Q3 (16PF/CPQ)	7.40 (1.88)	7.10(1.64)	.656	.514
Factor Q4 (16PF/CPQ)	9.13(0.97)	8.77(1.48)	1.13	.261
Factor M (16PF) /D (CPQ)	5.70(1.70)	4.06(1.50)	3.93	.001**
Factor L (16PF) /J (CPQ)	6.27(2.06)	7.70(1.31)	-.320	.002**

Legend: *Significance at p<.05 (2-tailed)

DISCUSSION

Among all the various population groups studied type II This study showed that both the groups were comparable for various socio-demographic variables like gender, religion, community, economic status except habitat. More adolescents with dissociation belonged to rural set ups than children with dissociation. This could be due to lack of basic amenities acting as perpetuating factor for dissociation to persist from childhood to adolescence.

Children diagnosed with dissociative disorder are less intelligent with concrete thinking and serious, taciturn, and prudent in nature with a tendency to be doubtful, obstructive, reflective and internally restrained. They were also found to be more of socially clumsy, unpretentious and sentimental with apprehensive, worried, depressed and troubled while facing a situation, whereas in adolescent's aggression, stubbornness, and assertiveness was more prominent. They were found to be astute, polished, and socially aware with a tendency to be shrewd. Adolescents were also seen to be reserved, emotionally less stable with undisciplined self-conflict and a tendency to get upset and frustrated easily in comparison to children who show difficulty in trusting and accepting conditions, apprehensive, self-reproaching, shy and threat sensitive. Studies have shown that the frequency of dissociative symptoms increases the age[8] which could be due to more externalizing behavior in adolescent dissociation like aggression, being less emotionally stable as found in our study. Similarly studies have seen that 28% of 64 delinquent adolescents in juvenile probation met criteria of dissociative disorder.9 Important limitations of this study were that tools to compare personality profile were different for both the groups.

CONCLUSION

In summary, dissociation in childhood and adolescents may best be viewed as a malleable developmental phenomenon determined by core personality attributes determining the outcome and that may result in a wide range of severe symptoms.

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Ethical approval: The study was approved by the Institutional Ethics Committee

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