Family Functioning Among Depressive and Dissociative (Conversion) Patients

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ABSTRACT

Objective: To campare the family functioning, level of depression, anxiety and histrionic personality traits among depressive and dissociative (conversion) patients.

Study Design: A cross-sectional study.

Place and Duration of Study: The Psychiatry Unit of Government Lady Reading Hospital, Peshawar, on depressive and dissociative (conversion) patients admitted from January to May 2004.

Methodology: Purposive sampling technique was used for the assignment of 75 patients (n=75) with depressive illness and 75 patients (n=75) with dissociative (conversion) disorders groups who fulfilled International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD 10), criteria. Test package was administered individually to all the patients and scores compared for the groups.

Results: On family APGAR scale, no significant difference (t=-2.472, p=0.16) was found between the scores of the two groups. Patients with depressive illness scored high on Hamilton Rating Scale for Depression with mean score of 26.92 and on Hamilton Rating Scale for Anxiety with mean score of 23.45, while dissociative group scored high on Hysteria (Hy) sub-scale of Minnesota Multiphasic Personality Inventory (MMPI) with mean score of 13.17.

Conclusion: Dysfunctional family pattern is one of the contributing factor in developing and maintaining mental illnesses like depression and dissociative (conversion) disorders.

Key words: *Family functioning.   Depressive illness.   Dissociative (conversion) disorders.*

INTRODUCTION

Depression is a major unidentified disease, especially among women living in small communities of developing countries including Pakistan.[1] Socioeconomic adversity and relationship problems are major risk factors for anxiety and depressive disorders in Pakistan. In a review of 20 studies, Mirza and Jenkins found that the prevalence of anxiety and depression in Pakistan was 33%. Being anxious or depressed was associated with female gender, middle age, low-level of education, difficulties with finances, being a housewife, and relationship problems; a supportive family and friends may be of help.[2] Depression tends to run in families. Adoption studies show that children of depressed people are vulnerable to depression even when raised by adoptive parents.[3]

Hysteria is classically defined as a chronic polysymptomatic illness chiefly affecting women, presenting with somatization, while the underlying cause is totally different.[4]

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According to family system theorists, somatization permits the family to focus attention on illness behaviour while drawing attention away from other conflicts. Marital conflict has frequently been reported in the families of somatizing patients, and such families have been found to be less supportive, cohesive, and adaptable than the control families. The literature is replete with reports of families in which functional symptoms in children or adults mask the "real" conflict.[5-8] The family system may also influence the development of coping styles in childhood. Researchers have linked abnormal illness behaviour to a personality disorder and hypothesize that children develop chronic physical symptoms in reaction to their family environment. Somatizing behaviour may evolve from strategies developed in childhood to cope with family conflict. These strategies may be adaptive during childhood, but when they persist into adulthood and are used in diverse social environments, they become problematic. Behaviours arising from childhood experiences may be powerfully reinforced by family members or the family system.[9]

The support and involvement of family can play a crucial role in helping someone who is depressed or suffering from dissociative (conversion) disorders and vice versa. The objective of the present study was to determine the family functioning of the patients suffering from depressive illness and dissociative (conversion) disorders.

METHODOLOGY

It was an observational comparative study conducted at the Psychiatry Unit of Government Lady Reading Hospital, Peshawar, on the inpatients admitted during January to May 2004. Patients suffering from depressive illness or dissociative (conversion) disorders as diagnosed by consultant psychiatrist, as per ICD 10 criteria (WHO classification of psychiatric diseases),[10] between 16-60 years of age of either gender and able to give informed consent to participate in the study were included. Patients below 16 years, above 60 years and depressive illness and dissociative (conversion) disorders secondary to physical illnesses, psychiatric illnesses, and drug abuse were excluded.

Non-probability, purposive convenient sampling technique was used for the assignment of the patients to the groups. The sample comprised of 150 consecutive patients (n=150) divided into two groups. Group A consisted of 75 patients with depressive illness and Group B also consisted of 75 patients with dissociative (conversion) disorders.

Demographic characteristics of all the subjects of two groups were obtained. To assess the family functioning, Family APGAR scale was administered to the subjects of the two groups. The measure consists of five parameters of family functioning: Adaptability, Partnership, Growth, Affection and Resolve (APGAR). (The acronym [APGAR] is comprised of the first letter of each parameter.) In addition, a test package consisting of Hamilton depression rating scale, Hamilton anxiety rating scale and Hy (hysteria) sub-scale of MMPI (translated into local language)[11-15] were individually administered to all the patients of depressed and dissociative (conversion) groups, in order to measure the severity of depression, anxiety and histrionic personality traits among the subjects of the two groups. As majority of the patients were illiterate, the scales translated into local language were read out to all of them by the researcher. The data was analyzed with SPSS version 10; mean, standard deviation, standard error of mean, degree of freedom and t-values with 0.5% level of significance were calculated for the scores on Family APGAR scale, Hamilton depression rating scale,

Hamilton anxiety rating scale and (Hy) hysteria sub-scale of MMPI in order to compare the results of the two groups.

RESULTS

The dissociative (conversion) group had a mean age of 20.76±6.52 years, while the depressed group had mean age of 24.56±8.91 years. Both disorders appeared to be predominantly common among females. Among the depressed group, 59 (78.7%) were females and 16 (21.3%) were males, while among the dissociative (conversion) group, 63 (84%) subjects were females whereas 12 (16%) were males. Among the depressed group, 38 (50.6%) were married, while 21 (28%) subjects among dissociative (conversion) group were married. Thirty-seven (49.3%) subjects from the depressed group and 54 (72%) subjects among dissociative (conversion) group were unmarried. Majority of the subjects from both groups were educated upto primary level–59 (78%) from depressed group and 60 (79%) among dissociative (conversion) group, 56 (74.7%) from depressed group. Fifty-three (70.7%) among dissociative (conversion) group were from rural background and 58 (76.4%) among depressed group and 57 (76%) among dissociative (conversion) group were from low socioeconomic class.

Table I shows that no significant difference was found between the scores of depressed and dissociative (conversion) groups on the Family APGAR scale (t=-2.430, p<0.016). It also indicates that the depressed patients and patients with dissociative (conversion) disorders differ significantly on HAM-D (M=26.92, SD=4.09) and (t=20.477, p<0.001) and on HAM-A (M=23.45, SD=4.25) and (t=7.399, p<0.001). The depressed patients scored markedly high on those scales. It indicates that the patients with depressive illness and dissociative (conversion) disorders differ significantly on Hy:(hysteria) sub-scale of MMPI (M=13.17, SD=2.52) and (t=-31.615, p<0.001). Patients with dissociative (conversion) disorders scored significantly high than depressed patients.

Table II shows that majority of the subjects of depressed group and dissociative (conversion) group, perceived their families as highly/moderately dysfunctional.

Table I: Mean (M), standard deviation (SD), standard error of mean (SEM), degree of freedom (df), t-values and probability (p) between scores of the depressed and dissociative (conversion) groups on Family APGAR scale, HAM-D, HAM-A and (Hy) subscale of MMPI (n=150).

Group	Test	n	M	SD	SEM	df	t	p
Depressed group	Family APGAR scale	75	3.57	3.08	0.36	148	-2.430	0.016
Dissociative (conversion) group		75	4.89	3.56	0.41			
Depressed group	HAM-D	75	26.92	4.09	0.47	148	20.477	0.001
Dissociative (conversion) group		75	15.01	2.94	0.34			
Depressed group	HAM-A	75	23.45	4.25	0.49	148	7.399	0.001
Dissociative (conversion) group		75	18.65	3.67	0.42			
Depressed group	Hy (hysteria) sub-scale of MMPI	75	2.71	1.36	1.36	148	31.615	0.001
Dissociative (conversion) group		75	13.17	2.52	2.52			

Table II: Frequencies and percentages of types of family functioning between depressed and dissociative (conversion) group.

	Depressed group	Dissociative (conversion) group
Severely dysfunctional family score=0-5	61 (81.2%)	50 (66.6%)
Moderately dysfunctional family score=6-8	06 (8.0%)	07 (9.3%)
Highly functional family score=9-10	08 (10.0%)	18 (24.0%)

DISCUSSION

In the present study, both disorders were common among female patients. Kendler interviewed 1057 opposite gender twin pairs about their social supportive relations. Interestingly, social support reduced the risk for developing depression significantly in women while not in men. Women are thus more vulnerable to depression when social support is low.[16]

The patients of depressed and dissociative (conversion) groups reported disturbed interpersonal relationships by scoring low on Family APGAR scale. According to the Family APGAR scale scoring, the families which attained the score of 0–5 are considered as severely dysfunctional family, 6–8 as moderately dysfunctional family and 9–10 as functional family. The Family APGAR questionnaire has been used in numerous studies (mostly clinical) investigating family functioning. In clinical practice, Family APGAR scores have been associated with physician visits, immune responses, emotional distress, and depressive symptoms.[17-19]

Depressed group with mean score of 4.57±3.08 and dissociative (conversion) group with mean score of 4.89±3.56 perceived their families as highly dysfunctional. Bowman studied pseudoseizures in 58 adults. They also found that with other things dysfunctional familial patterns had affect in the precipitation of pseudoseizures.[20]

According to Lucire, exaggeration of physical symptoms (as in the conversion disorder) can be attributed to the state of relationships with close relatives and friends.[21]

Kuehner administered subjective Quality Of Life (QOL) questionnaire to depressed patients and concluded that patients with severe symptoms generally had a lower QOL and less supportive social relationships with families and partners.[22] Other studies by Malhi *et al.*, Krawetz *et al.* and Wood *et al.* also suggested that families of dissociative (conversion) patients were severely dysfunctional.[23-25]

The patients with depressive illness scored high on Hamilton rating scale for depression as compared to dissociative (conversion) group. Depressed group had mean score of 26.92±4.09 as compared to 15.10±2.94 mean score of dissociative (conversion) group. There was also significant difference found among the scores of three groups on Hamilton rating scale for anxiety, depressed group with mean score of 23.45±4.25 and

dissociative (conversion) group with mean score of 18.65±3.67. It appeared that patients with dissociative (conversion) disorders were either unable to express their depression and anxiety in psychological metaphor and, therefore, resorted to presentation in somatic symptoms of dissociation or conversion reaction. Alternatively, it was possible that dissociative (conversion) disorders were manifestation of underlying depressive symptoms, which manifested differently in patients with different personality attributes. It was more likely when seen in the context of significant difference found in the scores of the two groups on Hy:(hysteria) sub-scale of MMPI, dissociative (conversion) group with mean score of 13.17±2.52 scored significantly higher as compared to depressed group mean score of 2.71±1.36. A prospective control group study on clinical characteristics of patients with motor disability due to conversion disorder conducted by Binzer *et al.* also showed that 17% patients had histrionic personality disorder, a figure that compared well with previous studies 7% and 34% indicating that subgroup seems to display hysterical traits. Histrionic personality disorder may thus be a pre-disposing factor, emphasizing a definite contribution of personality to the pathogenesis and presentation of conversion phenomenon.[26] One study that investigated the relationship between somatic complaints; anxiety/tension and depression, showed that somatic and anxiety symptoms can be very useful in the detection of early depression.[27]

CONCLUSION

The management of patients with depressive and dissociative (conversion) disorders should, therefore, not solely be focused on symptom reduction but also to help them to establish and maintain supportive relationships with the rest of the family members to build a positive self-image. It has further been concluded that if there is no change in these domains, there will be no change in health status of these patients in the end and they will come repeatedly with the similar symptoms.

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